

minnesota model policies for forensic compliance

How to Ensure Victims of Sexual Assault in Your Community
Receive the Care that Federal and State Law Require

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part i. introduction

introduction

The federal Violence Against Women Act of 2005 (hereinafter VAWA 2005) requires states and territories that receive STOP (Services Training Officers Prosecutors) formula grant funds to certify that they are in compliance with certain rules about the medical forensic examination provided to victims of sexual assault and other rules dictating the appropriate response to sexual assault victims.¹ Specifically, these rules require that victims need not participate in the criminal justice system or cooperate with law enforcement in order to receive a medical forensic examination, or receive reimbursement for charges incurred on account of the examination.² These two rules are referred to as "forensic compliance mandates." Because these two rules have significantly changed the criminal justice response to sexual assault, they have been referred to as "the earthquake in sexual assault response."³

For victims who choose to report the assault to law enforcement, VAWA 2005 also requires that victims cannot be compelled to undergo a polygraph examination as a condition of the investigation moving forward.⁴

Minnesota receives approximately \$2 million in STOP funds annually.⁵ Therefore, Minnesota must certify that it is in compliance with these rules in order to continue to receive this funding. Minnesota is in compliance with these rules through two state statutes, Minn. Stat. § 609.35 (2003) and § 611A.26 (2007).

Although Minnesota is in compliance with these rules through statute, many details associated with the implementation of these rules remain uncertain. This uncertainty causes confusion for sexual assault victims as well as the professionals providing services to victims. For example, in some Minnesota jurisdictions, there is confusion about where sexual assault evidence collection kits from victims who have not yet decided whether to report the case to law enforcement will be stored or how long such kits will be stored. Because responsibility for payment of the medical forensic exam falls to the county where the assault occurred, there is great variation in payment practices across Minnesota's eighty-seven counties. In some jurisdictions, the use of reporting options, often referred to as anonymous reporting, create confusion. Few Minnesota jurisdictions have policies in place that allow a victim to change a case that began as unreported to a standard report to initiate

¹ 42 U.S.C.A. §3796gg et seq. For the full text of H.R. 3402 Violence Against Women and Department of Justice Reauthorization Act of 2005, see United States Department of Justice Federal Legislation webpage, available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:h3402enr.txt.pdf

² 42 U.S.C.A. §3796gg-4.

³ Kimberly Lonsway & Sgt. Joanne Archambault (Ret.), *The Earthquake in Sexual Assault Response: Police Leadership Can Increase Victim Reporting to Hold More Perpetrators Accountable*, Police Chief Magazine (Sept. 2010) available at http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display&article_id=2201&issue_id=92010 (last visited March 3, 2011).

⁴ 42 U.S.C.A. §3796gg-8.

⁵ The Minnesota Department of Public Safety, Office of Justice Programs (OJP) is responsible for distributing STOP funds to individual programs or agencies in Minnesota. According to OJP, VAWA requires fifty percent of these funds be utilized to support criminal justice based special projects, five percent to support court-based efforts, and forty-five percent to deliver direct support services to victims.

an investigation. Finally, few Minnesota jurisdictions have written policies in place on any of these topics.

So, although Minnesota is compliant with the letter of the law, more work needs to be done to ensure Minnesota is compliant with the spirit of the law as well. This document is designed to assist Minnesota jurisdictions with the creation and implementation of written policies on forensic compliance topics. We hope this document can help eliminate confusion and ensure that victims of sexual assault in Minnesota receive the care that they are due under both federal and Minnesota law.

The Sexual Violence Justice Institute at the Minnesota Coalition Against Sexual Assault

This document is a product of the Sexual Violence Justice Institute (SVJI), a special project of the Minnesota Coalition Against Sexual Assault (MNCASA). SVJI's mission is to encourage the victim-centered investigation and prosecution of sexual assault cases by supporting multidisciplinary collaboration and providing multidisciplinary teams with training and resources. In Minnesota, these teams are most often called SMARTs, or Sexual Assault Multidisciplinary Action Response Teams.⁶ SVJI provides intensive technical assistance to twelve SMARTs within Minnesota, as well as to several national teams. Because of these connections, we are in a unique position to see the benefits that multidisciplinary collaboration lends to the challenges associated with meeting forensic compliance mandates.



SVJI's Forensic Compliance Project

SVJI was awarded a grant from the State of Minnesota, Department of Public Safety, Office of Justice Programs (hereinafter OJP) for a project to improve the quality and management of the medical forensic examination process for victims of sexual assault, in response to the VAWA 2005 forensic compliance mandates.

SVJI's Forensic Compliance Project began in August 2009 and concluded in July 2011. The Forensic Compliance Project was managed by Sara (Thome) Gonsalves, Project Attorney, and a multidisciplinary Advisory Board of well-qualified professionals. The Advisory Board met a total of six times to discuss forensic compliance mandates within Minnesota, determine strategy on the most complex points and develop some of the recommendations set forth in this document. Individuals and agencies who contributed to the Advisory Board included:

- The Minnesota Chiefs of Police Association;
- Trisha L. Cook, Minnesota Indian Women's Sexual Assault Coalition;
- Sarah Fries, Program for Aid to Victims of Sexual Assault;
- Shellene Johnson, Minnesota Coalition for Battered Women;
- Minnesota Hospital Association;
- Individual Sexual Assault Nurse Examiners (SANEs) and Sexual Assault Forensic Examiners (SAFEs) representing SANE programs and hospitals statewide, including:
 - Dr. Bergeron, Essentia Health Duluth Clinic;
 - Ellen Johnson, SANE-A, RN, CEN, CPEN, Regions Hospital;
 - Valerie Evje, RN, SANE-A/P;
 - Cory A. Morff-Whitman, RN, BSN;
- The Minnesota County Attorneys Association;
- The Minnesota Sheriff's Association; and
- The Minnesota Bureau of Criminal Apprehension.

⁶ Across the nation, multidisciplinary teams addressing the community and criminal justice response to sexual assault are also known by other acronyms, such as SART or SAIC. See Part II, The Language of Forensic Compliance: Glossary.

How to Use This Document

This document is designed to provide Minnesota jurisdictions with important information, considerations, and practical examples in order to implement victim-centered written policies on forensic compliance mandates. In jurisdictions where written policies may already be in place, this document is designed to help assess whether those policies are victim-centered, and contain provisions that meet the spirit behind forensic compliance mandates, and not just the letter of the law.

This document is designed for use by all disciplines responding to sexual assault victims: healthcare professionals, law enforcement officers, victim advocates, prosecutors and other community agencies engaged in the response to and support of victims. Guidance on how to best utilize and engage these various disciplines is also contained within this document.

Throughout this document, frequently asked questions about forensic compliance mandates are addressed. Frequently asked questions are set apart with the symbol to the right. Although some frequently asked questions may reflect the reality within your jurisdiction and some may not, we recommend reading the entire document to obtain a holistic view of forensic compliance mandates and the strategies we propose to meet these mandates.



Jurisdictions will be guided through a series of “decision points,” or questions that must be addressed in order to ensure compliance with forensic compliance mandates. Decision points are set apart with the symbol to the left.

This document also addresses federal and Minnesota law that affect forensic compliance mandates. Statutory language is set apart with the symbol to the right.



Finally, model policies are provided. Model policies are examples of written policies that we believe represent a victim-centered approach to meeting forensic compliance mandates. Model Policies are set apart with the symbol to the left.

Limitations of This Document

The recommendations and model policies provided have been tailored to correspond with Minnesota statute, demographics and other characteristics, therefore, this document is not intended to provide guidance to other states, or tribal or territorial governments outside Minnesota.

VAWA 2005 forensic compliance mandates primarily affect the response to adult and adolescent victims of sexual assault, therefore, this document will only address this population, and will not focus on the medical or legal response to child victims/pediatric patients.

Finally, the recommendations and model policies provided here are not intended to serve as mandates or definitive examples of best practice. Because the VAWA 2005 forensic compliance mandates went into effect relatively recently (2009), the tools, policies or practices that may emerge as “best practice” are still in development. Our hope is to provide education, guidance, and concrete examples of policies that may work, and foster the implementation and further innovation of these policies within Minnesota.

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In addition, this document would not have been possible without the guidance, thoughtfulness and expertise provided by the Forensic Compliance Advisory Board. SVJI at MNCASA expresses deep gratitude to all Advisory Board member agencies listed above as well as these additional individuals who provided guidance and review for this document: Karine Zakroczymski, SANE-A, Unity Hospital SANE Program, Sgt. Ann Clancey, Duluth Police Department and Lindsey Garfield, Forensic Scientist, Minnesota Bureau of Criminal Apprehension.

part ii. the language
of forensic compliance:
glossary

the language of forensic compliance: glossary

In order to understand forensic compliance mandates and the methods put into place to achieve compliance, it's necessary to learn some new terminology. Since forensic compliance mandates went into effect relatively recently (2009), some of these terms are still developing. Across the state and nation, different terms are used to mean different things. The purpose of this glossary is to standardize some of the new or less familiar terms to create more ease in discussing these topics within multidisciplinary teams, across jurisdictions and within this document.

Alternative Reporting Options – the term used to collectively refer to the numerous forms of reporting methods used in Minnesota and across the nation. Alternative reporting options are distinguishable from a standard report made to law enforcement, which will trigger an investigation. Alternative reporting options are put into place to allow victims more control over the information they choose to share with law enforcement, if any, following a sexual assault. In this document, the term "alternative reporting options" is used to collectively refer to Jane Doe, Restricted, Confidential, Anonymous, Blind, Graduated, Third Party, or other alternative reporting methods.

Anonymous Reporting – the term most commonly used to refer to the process of sexual assault victims seeking services following the assault without sharing their identity with law enforcement or without making a standard report to law enforcement. There is no single format or definition for anonymous reporting across the nation or within Minnesota. In some jurisdictions, victims seeking the medical forensic examination without reporting the assault to law enforcement are said to be electing their option to make an "anonymous report," or have an "anonymous kit" collected. In other jurisdictions, victims may directly or indirectly share some information with law enforcement about the assault, like the location, the date and time, or the perpetrator's name, but keep their identity anonymous. These types of reports may also be referred to as Jane Doe, Restricted, Confidential, Blind, Graduated, or Third Party reports.

Case conversion – the victim-initiated process of changing what began as a case that was not reported to law enforcement to a case that is reported to law enforcement. Depending on the terminology used in your jurisdiction, this might mean that the victim is electing to change an "anonymous" report or "anonymous" kit to a "standard" report to request in turn that law enforcement conducts an investigation.

Chain of Custody - a legal term that means the movement and location of physical evidence from the time it is collected to the time it is presented in court.

Criminal sexual conduct – the term used within Minnesota statute to collectively refer to all criminal conduct related to sexual violence. Within this document, the term “sexual assault” will be used to refer to all acts of sexual violence, including those that may be able to be charged as criminal sexual conduct in the first – fifth degrees. See Minn. Stat. §§ 609.341 – 609.351.

Forensic compliance – the term used to discuss whether certain laws about the medical forensic exam are being followed. There are both federal and Minnesota laws that dictate how the medical forensic exam must be offered to sexual assault victims, and how that exam must be managed. These laws will be discussed in this document.

Medical forensic exam – the examination offered to victims following a sexual assault, which may be conducted by a Sexual Assault Nurse Examiner, RN, physician, or some combination of these healthcare professionals. The exam has several components. The examiner gathers a verbal history of the assault from the patient. A physical examination of the patient is also conducted in order to document and treat any injury and collect and preserve biological and physical findings that may serve as evidence in a criminal matter, if the case is reported to law enforcement. Therefore, as its name implies, the medical forensic exam has a dual role: 1) provide medical treatment to the patient, and 2) collect and preserve any forensic evidence of the assault that might be present on the patient’s body and/or through the patient’s verbal statements.

Minnesota Bureau of Criminal Apprehension – also known as the BCA, or the state crime lab, the Minnesota Bureau of Criminal Apprehension is a part of the Minnesota Department of Public Safety. The BCA analyzes evidence from crime scenes for the purposes of law enforcement. There are two BCA laboratory locations in Minnesota; one in St. Paul and one in Bemidji. The BCA processes and analyzes the contents of sexual assault evidence collection kits in reported criminal sexual conduct cases, upon request from law enforcement or county attorney’s offices. While there are other laboratories across the state that process evidence for the purposes of law enforcement (i.e., Hennepin and Anoka counties have their own crime laboratories) and privately-operated laboratories that process evidence for other purposes (i.e., biologic samples for purposes of employment, and civil legal cases such as paternity or personal injury), the BCA is the lab that processes the vast majority of sexual assault evidence collection kits.

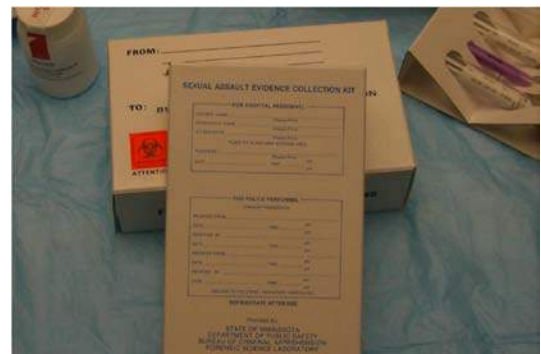
Restricted kits/restricted reports – the term used to describe sexual assault evidence collection kits or sexual assault cases that have the potential to be connected with an active sexual assault investigation, but have not yet been converted by the victim to a standard report. In some jurisdictions, these cases or kits may be referred to as “anonymous cases” or “anonymous kits,” or “unreported cases” or “kits from unreported cases.” The United States military also uses this terminology, but has different policy on how restricted cases can be converted.

SANE/SAFE – Sexual Assault Nurse Examiner or Sexual Assault Forensic Examiner. These acronyms refer to the healthcare professionals who are specially trained to provide care to patients following a sexual assault. Sometimes, physicians who are specially trained to provide sexual assault patient care refer to themselves as SAFEs in order to distinguish themselves from nurses providing similar care. In some jurisdictions across the nation, people use SAFE to refer to the Sexual Assault Forensic Exam. It isn't necessary for a healthcare professional to be a SANE or a SAFE in order to complete the medical forensic exam.

SANE-certified – the term used to describe an individual registered nurse or another healthcare professional who has completed a forty-hour adolescent/adult or pediatric Sexual Assault Nurse Examiner training, and has successfully completed the SANE certification examination. There are separate certification examinations for adult/adolescent and pediatric SANE specialties. SANE-A refers to individuals who are certified to perform adult/adolescent medical forensic exams, and SANE-P refers to individuals who are certified to perform pediatric medical forensic exams. It isn't necessary for a healthcare professional to be SANE-certified in order to complete the medical forensic exam.

SANE-trained – the term used to describe an individual registered nurse or another healthcare professional who has completed a forty-hour adolescent/adult or pediatric Sexual Assault Nurse Examiner training, but who has not yet taken or successfully completed the SANE certification examination. It isn't necessary for a healthcare professional to be SANE-trained in order to complete the medical forensic exam.

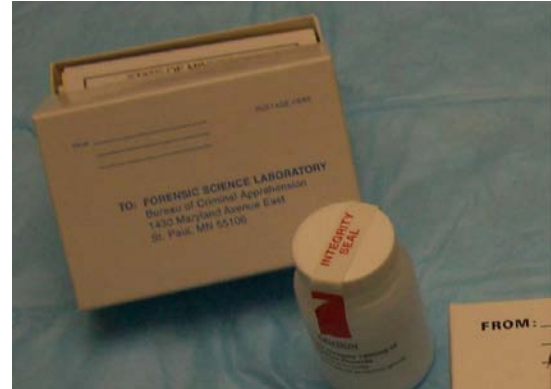
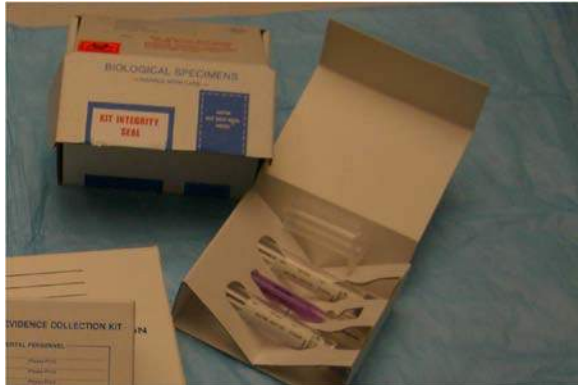
Sexual Assault Evidence Collection Kits – also known as the “kit,” or “rape kit,” sexual assault evidence collection kits are created and distributed by the Minnesota Bureau of Criminal Apprehension. The purpose of the kit is to standardize, as much as possible, the collection of potential biologic evidence from the victim's body during the medical forensic exam. The kit contains envelopes, swabs, blood tubes, basic instructions for healthcare professionals on the collection of forensic evidence and a “Patient Information and Sexual Assault History Form” to be filled out by the SANE/SAFE and packaged in the kit upon completion.



SMART/SART – the acronyms used to refer to Sexual Assault Multidisciplinary Action Response Teams or Sexual Assault Response Teams. These terms refer to multidisciplinary groups that respond to individual sexual assault cases, and/or develop and monitor protocols for the response to all sexual assault cases within a county or another jurisdictional boundary. Across the state and nation, these types of multidisciplinary teams may be known by other acronyms, such as SAIC (Sexual Assault Interagency Council).

Standard report – a sexual assault that the victim chooses to report to law enforcement to initiate an investigation. The term standard report is used to distinguish from instances where the victim has not yet decided whether to report the assault to law enforcement (see restricted kit/restricted case).

Toxicology Collection Kit – also known as a “DUI kit,” or “tox kit” these kits are created and distributed by the Minnesota Bureau of Criminal Apprehension. The purpose of these kits is to standardize the collection of blood and urine for the purposes of toxicology testing. One kit contains a urine cup and another kit contains blood tubes.



VAWA 2005 – The term used to refer to the federal Violence Against Women Act of 2005. VAWA 2005 contains explicit rules for states, territories and tribes that receive certain federal funds. States receiving these funds must certify that they are in compliance with rules about how the medical forensic examination is offered to victims of sexual assault, and how that exam is managed. In addition to rules about the medical forensic exam, VAWA 2005 contains other rules dictating how sexual assault cases can be investigated. Several VAWA 2005 mandates will be explored within this document.

part iii. what is
“forensic compliance?”

what is “forensic compliance?”

“Forensic compliance” is the term used to discuss whether certain laws about the medical forensic exam are being followed. There are both federal and Minnesota laws that dictate how the medical forensic exam must be offered to sexual assault victims, and how that exam must be managed. This document will first explore the requirements set forth in the federal law.

a. VAWA 2005

VAWA 2005 outlines the most recent requirements for the medical forensic exam and other requirements regarding the response to sexual assault. VAWA was first signed into law as part of the Violent Crime Control and Law Enforcement Act of 1994, recognizing the need to address violent crime that disproportionately affects women.⁷ VAWA was re-authorized, with amendments and changes, in both 2000 and 2005.

VAWA 2005 requires states and territories that receive STOP (Services Training Officers Prosecutors) formula grant funds to certify that they are in compliance with certain rules about the medical forensic exam and other rules dictating the response to sexual assault victims.⁸ Minnesota receives approximately \$2 million in STOP funds annually.⁹ Therefore, the State of Minnesota must certify that it is in compliance with rules about the medical forensic exam and other rules about how sexual assault investigations are conducted in order to continue to receive this funding.

Specifically, VAWA 2005 provides:



Nothing in this section 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.*¹⁰

In other words, in order to be considered compliant, all states, Indian tribal governments and territories receiving VAWA STOP formula grant monies must certify that they meet two requirements:

⁷ 42 U.S.C. § 3711 et. seq.

⁸ 42 U.S.C.A. §3796gg et seq.

⁹ The Minnesota Department of Public Safety, Office of Justice Programs (OJP) is responsible for distributing STOP funds to individual programs or agencies in Minnesota. According to OJP, VAWA requires fifty percent of these funds be utilized to support criminal justice based special projects, five percent to support court-based efforts, and forty-five percent to deliver direct support services to victims.

¹⁰ 42 U.S.C.A. § 3796gg-4(d)(1) (2005).

- 1) ensure victims are offered and provided medical forensic examinations without requiring the victim to cooperate with law enforcement or participate in the criminal justice system; and
- 2) ensure that victims do not have any out-of-pocket expenses associated with the medical forensic examination.¹¹

These two requirements are referred to as “forensic compliance mandates.”

In addition to the forensic compliance mandates, VAWA 2005 issued another mandate relating to how sexual assault cases can be investigated. In order to be eligible for STOP formula grant funds, states, tribal governments and territories must also certify that they are in compliance with the polygraph testing prohibition. With regard to the polygraph testing prohibition, VAWA 2005 provides:



No law enforcement officer, prosecuting officer or other government official shall ask or require an adult, youth or child victim of an alleged sex offense as defined under federal, tribal, state, territorial or local law to submit to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of such an offense.¹²

So, in order to be considered compliant, no jurisdiction receiving VAWA STOP monies may require the polygraph testing of sexual assault victims as a condition for proceeding with an investigation of the offense.

Compliance Deadline

VAWA 2005 provided all states, Indian tribal governments and territorial governments receiving STOP monies with four years to come into compliance with these mandates, and were required to certify their compliance prior to January 5, 2009. The State of Minnesota certified that Minnesota is in compliance with these rules by the deadline.¹³

No guidance on implementation

Although VAWA 2005 requires states to certify that they meet these mandates, it does not articulate the *method* of compliance, or *how* states must implement these mandates. Therefore, states differ greatly in their approach to compliance. While compliance with the polygraph testing prohibition is fairly straightforward, compliance with the forensic compliance mandates is more complicated. As a result, some states developed statewide planning committees or advisory boards to develop strategies to meet the forensic compliance mandates.¹⁴ Minnesota, through SVJI @ MNCASA, developed an advisory board. This document is informed by that board’s work.¹⁵

¹¹ 28 C.F.R. § 90.14(a).

¹² 42 U.S.C.A. § 3796gg-8(b) (2005).

¹³ Minnesota is compliant with the requirements of VAWA 2005 through state statute, Minn. Stat. § 609.35 (2003) and Minn. Stat. § 611A.26 (2007).

¹⁴ For example, North Dakota and South Carolina implemented multidisciplinary work groups to discuss and set policy addressing forensic compliance mandates.

¹⁵ For more information on the Advisory Board, see Part I. Introduction.

b. purpose of vawa 2005 forensic compliance mandates

There are several reasons why VAWA 2005 imposed the forensic compliance mandates.

Increase victim access to prompt medical forensic care

One purpose is to increase sexual assault victims' access to medical care and forensic evidence collection in the aftermath of an assault when medical care is most healing and biologic evidence is more likely to be present for collection. Victim advocates recount many crisis calls where victims express fear of injury, pregnancy or sexually transmitted infections (STIs), but are deterred from seeking medical care because these fears are outweighed by the fear of speaking with law enforcement or reporting the crime. VAWA 2005 recognizes that victims should not face barriers to seeking critical medical care following an assault.

Prior to VAWA 2005 forensic compliance mandates taking effect in 2009, some states required law enforcement to first authorize the victim's medical forensic exam, a policy that deterred many victims from seeking medical care or forensic evidence collection. Now, by ensuring victims of sexual assault have access to the medical forensic examination without reporting the case to law enforcement unless they choose to do so, victims receive medical care and forensic evidence collection that they may not have otherwise sought.

Prompt medical care benefits victims by providing treatment and options that ensure better physical and mental health in the future. Access to prompt medical care may reduce the number of significant health consequences following the sexual assault, like unwanted pregnancy or STIs. Prompt medical care may also decrease chronic health problems like post-traumatic stress disorder, depression, eating disorders, alcohol and substance abuse and pelvic pain suffered by victims.¹⁶

In addition, prompt forensic evidence collection increases the chance that viable evidence will be collected and preserved; this forensic evidence may be essential to an investigation and criminal prosecution, if the victim chooses to convert the case to a standard report in the future.

Increase victim access to justice

Another purpose of VAWA 2005 is to increase the reporting of sexual assault cases to law enforcement, and ultimately, increase victim access to justice.¹⁷ Some research studies show that

¹⁶ For an overview of chronic health conditions that may complicate a victim's short and long-term mental and physical health, see Illinois Coalition Against Sexual Assault, *By the Numbers, Emotional and Physical Effects of Sexual Assault* available at <http://www.icasa.org/forms.aspx?PageID=%20470> (last visited March 12, 2011). In addition, Rebecca Campbell, Ph.D. has conducted numerous research studies on the chronic health consequences of sexual assault and how medical screening and other interventions can thwart the development of these chronic conditions. Many of Dr. Campbell's research studies are available online at http://vaw.msu.edu/core_faculty/rebecca_campbell/recent_publications.shtml (last visited March 11, 2011), including two articles which were consulted for this document: *Gynecological Health Impact of Sexual Assault*, 29 RESEARCH IN NURSING & HEALTH, 399–413 (2006) and *The Physical Health Consequences of Rape, Assessing Survivors' Somatic Symptoms in a Racially Diverse Population*, 31 WOMEN'S STUDIES QUARTERLY, 90 (2003).

¹⁷ Obtaining "justice" means different things to different victims. In recent years, there has been an increased emphasis to pursue forms of justice besides the traditional notion that justice must equal jail or prison time for the offender. For more information the "justice is more than jail" civil legal approach to ensure victim rights and healing, see Jessica E. Mindlin & Susan H. Vickers, Eds., National Victims Rights Law Center, Inc., *Beyond the Criminal Justice System: Using*

approximately sixty percent of sexual assaults are never reported to law enforcement,¹⁸ while other studies show as many as eighty-four percent are never reported to law enforcement.¹⁹ While the ranges presented by studies like these vary, it is clear that sexual assault remains one of the most under-reported crimes in our nation.

VAWA 2005 recognizes that many victims need some “breathing room” after the assault to learn about and weigh their options. In the past, victims were asked to make the decision whether to report to law enforcement in the midst of many competing pressures. When confronted with the only option at the time, “report or no report,” many victims chose not to report at all. The hope is that some victims who say “no” to reporting – if forced to make the decision during their initial contact with a healthcare professional – might eventually say “yes” if allowed to get the exam first and then have some time to deal with surrounding pressures.²⁰

“by providing victims with the opportunity to gather information, solidify their support system, and establish rapport with first responders, we hope to create an environment that encourages reporting, even for those victims who initially feel unable, unwilling, or unsure about doing so.”²¹

There are many logical reasons why victims may initially hesitate to report the assault to law enforcement.²² Some victims think that reporting the crime to law enforcement will be fruitless because they will not be believed. Other victims do not want to believe, or do not recognize, that they have been the victim of a crime. Some victims blame themselves for the assault, and spend time trying to characterize what behavior led to the assault, hoping to avoid such behavior in the future. Many victims are terrified that the assailant will further hurt them or a family member if a report to law enforcement is made. Moreover, many victims are painfully aware of society’s doubt or blame of victims in well-publicized cases. Some victims may have outstanding warrants or may have been engaged in illegal behavior at the time of the assault; facts which may cause them to

the Law to Improve the Lives of Sexual Assault Victims, A Practice Guide for Attorneys and Advocates (2008) available at <http://www.victimrights.org/> (last visited March 11, 2011).

¹⁸ U.S. Department of Justice, 2005 National Crime Victimization Survey available at <http://www.icpsr.umich.edu/icpsrweb/NACJD/studies/22746?archive=ICPSR&q=U.S.+Department+of+Justice%2C+2005+National+Crime+Victimization+Survey&x=18&y=12> (last visited April 5, 2011).

¹⁹ National Victim Center, *Rape in America: A Report to the Nation* (1992) available at http://www.musc.edu/ncvc/resources_prof/rape_in_america.pdf (last visited March 9, 2011) at 6.

²⁰ Kimberly A. Lonsway, Ph.D., Sgt. Joanne Archambault (Ret.), *Reply to Article: “Receiving a forensic medical exam without participation in the criminal justice process: What will it mean?”* 7 JOURNAL OF FORENSIC NURSING 78 - 88, (2011) at 80.

²¹ End Violence Against Women International, Template Memorandum of Understanding available at <http://www.evawintl.org/forensiccompliance.aspx?subpage=3#TEMP> (last visited March 3, 2011).

²² Dr. Sarah E. Ullman, *Talking About Sexual Assault: Society’s Response to Victims* 42 (American Psychological Association 2010).

hesitate to report the assault to law enforcement. Finally, numerous research studies show how trauma can impact the brain and complicate a victim's ability to recall, organize and communicate memories.²³ Therefore, the effect of trauma on the brain can also make a victim's decision to report the assault to law enforcement extremely difficult in the days and months post-assault.

While few victims *report* the assault to law enforcement, many victims *disclose* the assault to someone else in their lives. Research shows that victim disclosure is usually not a one-time, all-or-nothing event.²⁴ Thus, victim disclosure should be viewed as more of a *process* than an event, with victims testing listeners with bits of information at a time, gauging the listener for a supportive response. When victims take a courageous step to disclose the sexual assault to a healthcare professional, they should be rewarded with compassion and concern, not pressure to report the assault to law enforcement. The hope is that if victims feel believed and supported the first time they disclose the assault, they will feel more empowered to tell others, and may decide to engage law enforcement at some point in the future.

While research shows that victim *disclosure* is often healing, the legal system was not designed to promote healing.²⁵ The process of reporting the assault law enforcement, participating in the investigation and any subsequent criminal case is often traumatic for victims and may not ultimately increase victim healing. While victims should not be discouraged from reporting the assault to law enforcement, the VAWA 2005 forensic compliance mandates require states to implement special processes that acknowledge and counteract some of the intense pressures faced by sexual assault victims. By eliminating the requirement that victims first speak with law enforcement before receiving the medical forensic exam, one immediate pressure may have been eliminated. Although some victims will never decide to report the assault to law enforcement, VAWA 2005 is clear that those individuals must still have access to a medical forensic exam.

Conclusion

Thus, the VAWA 2005 forensic compliance mandates were designed to spark a significant change in how formal systems like healthcare and the criminal justice system respond to sexual assault. Jurisdictions should adapt or create victim-centered policies that take into account the reality of how many victims disclose and encourage victims to report in a way that may be more comfortable for them. By doing that, jurisdictions may ultimately see an increase in reports made to law enforcement. Furthermore, by allowing victims who are unsure about reporting access to the medical forensic examination, such evidence will be available in the future if and when that victim chooses to convert the case. The presence of physical evidence capable of being analyzed for DNA or toxicology often leads to better prosecution outcomes.²⁶ An increase in reports made to

²³ For an overview of relevant research studies on how the body and mind respond to trauma in the context of sexual assault, see Kaarin Long, Caroline Palmer & Sara G. Thome, *A Distinction Without A Difference: Why the Minnesota Supreme Court Should Overrule its Precedent Precluding the Admission of Helpful Expert Testimony in Adult-Victim Sexual Assault Cases* 31 Hamline J. Pub. L & Pol'y 569, 592-607 (August 2010), available at http://www.mncasa.org/Documents/index_175_2534215409.pdf or by contacting the Sexual Violence Justice Institute @ MNCASA at svji@mncasa.org.

²⁴ Dr. Sarah E. Ullman, Talking About Sexual Assault: Society's Response to Victims 44 (American Psychological Association 2010).

²⁵ Dr. Sarah E. Ullman, Talking About Sexual Assault: Society's Response to Victims 153 (American Psychological Association 2010).

²⁶ See e.g., Hon. Donald Shelton, et al., *A Study of Juror Expectations and Demands Concerning Scientific Evidence: Does the "CSI Effect" Exist?* 9 VANDERBILT JOURNAL OF ENTERTAINMENT AND TECHNOLOGY LAW, available at

law enforcement and more successful prosecutions may mean safer communities for us all. After all, we cannot hold offenders accountable without first hearing from victims. However, this will only occur if the process of reporting the assault to law enforcement is made more comfortable for victims now. This document is intended to assist your jurisdiction in the creation and implementation of victim-centered policies that may achieve these results.

c. is minnesota compliant with vawa 2005?

Yes. Minnesota is compliant with the VAWA 2005 mandates through state statute, Minn. Stat. § 609.35 (2003).



Minn. Stat. §609.35 (2003) COSTS OF MEDICAL EXAMINATION

(a) Costs incurred by a county, city, or private hospital or other emergency medical facility or by a private physician for the examination of a victim of criminal sexual conduct when the examination is performed for the purpose of gathering evidence shall be paid by the **county in which the criminal sexual conduct occurred**. These costs include, but are not limited to, **full cost** of the rape kit examination, associated tests relating to the complainant's sexually transmitted disease status, and pregnancy status.

(b) Nothing in this section shall be construed to limit the duties, responsibilities, or liabilities of any insurer, whether public or private. However, **a county may seek insurance reimbursement from the victim's insurer only if authorized by the victim**. This authorization may only be sought after the examination is performed. When seeking this authorization, the county shall inform the victim that if the victim does not authorize this, the county is required by law to pay for the examination and that the victim is in no way liable for these costs or obligated to authorize the reimbursement.

(c) The applicability of this section does not depend upon whether the victim reports the offense to law enforcement or the existence or status of any investigation or prosecution.²⁷

Subsection (a) designates the county where the assault occurred as the entity responsible for the "full cost" of the "rape kit examination." Therefore, victims in Minnesota are not responsible for the cost of the exam themselves.

Subsection (b) outlines how the county may seek reimbursement from the victim's health insurance for the cost of the exam. Because any county action here is dependent on victim consent, however, this does not violate VAWA 2005 mandates.

²⁷ Emphasis added.

Finally, subsection (c) states that the county where the assault occurred is responsible for payment of the medical forensic examination regardless of a victim's decision to report the assault to law enforcement or the existence of any investigation or prosecution.

These provisions put Minnesota into compliance with VAWA 2005 mandates. For more information on how Minn. Stat. § 609.35 regulates exam payment, see Part VI. Section A.

If Minnesota is compliant now, why does more work need to be done?

Although Minnesota is in compliance with the forensic compliance mandates through Minn. Stat. § 609.35, many details associated with the implementation of these mandates remain uncertain. This uncertainty causes confusion for sexual assault victims as well as the professionals providing services to victims. For example, in some Minnesota jurisdictions, there is confusion about where restricted kits will be stored or how long such kits will be stored. Because responsibility for payment of the medical forensic exam falls to the county in which the assault occurred, there is great variation in payment practices across Minnesota's eighty-seven counties. In some jurisdictions, the use of alternative reporting options, often referred to as anonymous reporting, create confusion. Few Minnesota jurisdictions have policies in place that allow a victim to easily convert a restricted case to a standard report. Few Minnesota jurisdictions are vigorously investigating or charging converted cases. Finally, few Minnesota jurisdictions have written policies in place on any of these topics.

So, although Minnesota is compliant with the *letter* of the law, more work is needed to ensure Minnesota is compliant with the *spirit* of the law. This document will provide guidance to Minnesota jurisdictions to transcend the current letter of the law approach and establish policies that more closely align with the *spirit* and purpose of the VAWA 2005 mandates.

Letter and Spirit of VAWA 2005

Ensuring that Minnesota is compliant with the letter of VAWA 2005 is relatively easy: victims must be provided with a medical forensic exam free of charge and without being required to report the assault to law enforcement. Making that option *viable and meaningful*, however, is more complicated and requires collaboration, compromise and commitment among diverse professionals in your jurisdiction. So, your jurisdiction must ask: Once the medical forensic examination is provided to a victim of sexual assault who has not yet decided whether or not to report the case to law enforcement, *what happens next?*

the ultimate question:
“is there any possibility that converted cases will be successfully
investigated and prosecuted in our jurisdiction?”

When thinking of the policies currently in place in your jurisdiction, we hope you can answer “yes” to this “ultimate question.” If so, then you are well on your way to fulfilling the *spirit* of compliance. If the answer to the ultimate question is “no,” then this document will help you to engage more community partners and create policies that will help you get to “yes.” The following chart will also assist your jurisdiction in the pursuit of the spirit of VAWA 2005.

letter of the law	spirit of the law
<p>Victims have access to medical forensic examination without cooperating with law enforcement <i>Minn. Stat. 609.35(c); VAWA 2005</i></p>	<p>Victims have access to quality medical forensic examinations that promote healing and ensure evidence viability and integrity for the future</p>
<p>Costs associated with medical forensic exam are not charged to victim; county where the assault occurred pays for the medical forensic exam <i>Minn. Stat. 609.35(a); VAWA 2005</i></p>	<p>The county responsible for payment of the medical forensic examination reimburses provider at a rate that reflects the true cost of healthcare, the expertise of the professionals conducting the exam and the individual treatment needs of each victim</p>
<p>If seeking insurance reimbursement, county does not ask victim for insurance information prior to exam and victim is informed that county is responsible for payment <i>Minn. Stat. 609.35(b)</i></p>	<p>Victims are not needlessly or irresponsibly referred from one hospital to another when they present for a medical forensic examination</p>
<p>Victims provided medically accurate and unbiased written information on emergency contraception options and immediately provided with emergency contraception <i>Minn. Stat. 145.4712(1)</i></p>	<p>Storage of restricted kits is handled in victim-centered way that allows ample time for victims to convert and ensures viability of evidence</p>
<p>Victims provided medically accurate and unbiased written information on STI risk and immediately provided with STI prophylactic medications <i>Minn. Stat. 145.4712(2)</i></p>	<p>Law enforcement vigorously investigates converted cases; prosecutors charge converted cases</p>
<p>Minors have the ability to consent to and withhold consent for medical forensic examination <i>Minn. Stat. 144.343</i></p>	<p>Victim-centered reporting options are established that give victims more control over what information they choose to share with law enforcement and when they choose to share it</p>
	<p>Restricted kits are not submitted to Bureau of Criminal Apprehension for DNA or toxicology analysis</p>
	<p>Victim privacy is maintained through exam billing process and restricted kit storage process</p>
	<p>All responders better understand medical mandated reporting and a minor's ability to consent to or withhold consent to the medical forensic examination</p>

part ix. collaboration,
compromise &
commitment: the
necessity of a
multidisciplinary
approach to forensic
compliance

collaboration, compromise & commitment: the necessity of a multidisciplinary approach to forensic compliance

“ . . . what was once unheard of can become routine best practice.”²⁸

collaboration

“Who do we need at the table?”

Ensuring victim access to the medical forensic examination without reporting the assault to law enforcement is not the sole responsibility of healthcare professionals. Instead, forensic compliance topics cross all of the disciplines involved in the criminal justice and community response to sexual assault. Traditionally, the core disciplines involved in this response include:

- Law Enforcement
- Prosecution
- Victim Advocacy: community-based as well as systems-based
- Healthcare professionals; and
- Corrections

At a minimum, individuals representing these core disciplines must be working together to set policy to address forensic compliance mandates within your jurisdiction. Despite the challenges that are sometimes associated with multidisciplinary collaboration, victims in your jurisdiction will be

²⁸ Marti Anderson, *Forensic Compliance in Iowa: History Shows Collaboration is Key*, SEXUAL ASSAULT REPORT Vol. 14, No. 1 (Sept./Oct.2010) at 14.

better served if all disciplines have an opportunity to have input into the written policies. It isn't possible for one discipline to meet all of these challenges alone.

Because meeting forensic compliance mandates also requires some out-of-the-box problem solving, it will also be beneficial to involve some individuals from disciplines that may not be traditionally involved in the direct response to sexual assault victims. For instance, when discussing where restricted kits should be stored, it may be necessary to partner with the evidence technicians with your local law enforcement agency. Or, when setting policy to ensure victims do not receive bills for the medical forensic examination, it may be necessary to partner with employees of your hospital billing department. The community partners that jurisdictions usually find helpful to engage for forensic compliance issues include:

- 911 dispatch/operators
- Local crime scene specialists
- Hospital billing department staff²⁹
- County billing department staff
- Hospital emergency department nurse managers and physicians
- Hospital legal counsel
- Hospital social work departments; and/or
- Evidence room technicians or custodians from law enforcement agencies

It's crucial to have representatives from all of these disciplines engaged if both the letter of spirit of forensic compliance mandates will be met in your jurisdiction. Across disciplines, professionals must have a good understanding of each others' roles and guiding principles in order to be successful. *Moreover, because some adjustments to existing policy and procedure will likely be required, it is also advisable to have people on your multidisciplinary team who are in a position to make policy decisions in their agencies.*

The benefits and challenges of a multidisciplinary response

The benefits of working within a multidisciplinary framework are many. Strong multidisciplinary teams with active participants are able to communicate openly and honestly with one another: these partnerships are therefore better able to adapt existing policy, or create new policy, to reflect any changes needed to meet forensic compliance mandates. Because all disciplines have the opportunity to educate one another and have input, all disciplines have a greater degree of commitment to the process and a better understanding of each other's roles and daily realities. Such increased understanding and commitment thus has the potential to lead to a more victim-centered approach, and individual team members may find it easier to fulfill their day-to-day responsibilities with the support of the team. By sharing scarce resources, the team is able to tackle issues that may have been insurmountable alone. Finally, a team that is able to hold its members accountable can avoid repeating the same errors. All team members become better within their discipline with the shared wisdom of the multidisciplinary team.

Despite these benefits, multidisciplinary collaboration is not always easy or fun! With true

²⁹ To find out which agency in your county is responsible for exam payment, *See Appendix C: Sexual Assault Exam Payment Contacts* (2011). This document is also available by contacting Minnesota Department of Public Safety, Office of Justice Programs (OJP), Crime Victim Reparations at 651-201-7300 or at https://dps.mn.gov/divisions/ojp/forms-documents/Documents/SA_Exam_Contacts.pdf (last visited July 28, 2011).

multidisciplinary collaboration, professionals - who are striving to be better at what they do - come together to dissect how the system is (or isn't) working. This process obviously subjects their individual performances and the performance of their agencies overall to criticism. Strong teams can learn how to benefit from this diversity and collective wisdom, and establish good communication patterns and mutual respect. While some teams might thrive under the challenges presented by forensic compliance, the same challenges could strain other teams. This is true for several reasons, discussed here.

compromise

"We aren't on the same page!" Differing professional priorities

Differing professional priorities held by individual team members have the potential to create tension. For example, by ensuring that all victims have access to a medical forensic exam without reporting the assault to law enforcement, individual law enforcement officers may feel like they are being prevented from doing what they do best – investigating crime. Law enforcement professionals may believe that advocates or healthcare professionals should be doing more to encourage victims to report. In particular, law enforcement officers who have worked hard to develop investigative skills may feel their efforts have been undermined.

In our experience, the complex issues associated with forensic compliance can help a multidisciplinary team move to the next level of collaboration, or they can create tensions that ultimately weaken the team. To move forward, we encourage team members to be honest about their concerns, and redirect difficult conversations back to what the team's overall goal should be – providing a victim-centered response.

"This problem is too big. Where do we start?"

Once you have individuals from multiple disciplines in your community engaged, where do you start? First, expect to meet more than one time as a group to address how your jurisdiction will meet or sustain forensic compliance mandates. This is not a task that can, or should, be completed in one meeting. There is no one model for forensic compliance that will fit each Minnesota jurisdiction perfectly. Each jurisdiction has different strengths, weaknesses, specialties and resources. For that reason, there isn't one-size-fits-all model for compliance that can simply be cut-and-pasted into existing policies. Instead, we hope your team will approach this task as making a series of decisions.

There are several recommended ways to get your multidisciplinary team started. The first option is to pose the Forensic Compliance Quiz to the members of your team to gauge the knowledge among team members on forensic compliance topics within Minnesota. This thirteen-question, true-false quiz is located in the Appendix A. Also located in Appendix A is the answer key for the quiz. Have all members of the team take the quiz to gauge what knowledge people already have and what issues might be causing confusion. Grading the quiz isn't recommended; some team members may feel embarrassed that they don't know current law or policy on forensic compliance mandates. The quiz and answer key should be utilized as a way to start the conversations, and nothing more. One Minnesota jurisdiction modified the Forensic Compliance Quiz to include

policies already in place there; we encourage other jurisdictions to do the same.³⁰

Another way to get your multidisciplinary team started is to review this document in bite-size pieces, starting with Part II, The Language of Forensic Compliance: Glossary. Before meaningful conversations can occur with regard to this topic, it is imperative that all team members are able to understand each other, a topic discussed in more detail below. By reviewing this document together section-by-section, your team can more efficiently make decisions. It might be possible for one member of the team to review a section, and present it to the rest of the team members, leading the discussion. This way, not all team members are responsible for reading the entire document, but can share the work.

“We can’t understand each other.”

The choice of language used matters a great deal when it comes to sexual assault, so we shouldn’t underestimate the potential impact of the language we use to describe the tools associated with forensic compliance. Educators urge professionals such as police officers and prosecutors to use language that effectively articulates the seriousness of sexual assault, both in written reports and in the courtroom.³¹ We now have the same opportunity with forensic compliance. SVJI has modeled the use of consistent, positive language to the Minnesota SMARTs we support, and we have watched as this language has caught on. For this reason, we also encourage you to model consistent, victim-centered language when discussing forensic compliance mandates.

For example, we noticed that team members struggled to put a label on cases that began as unreported cases, but where the victim later decided to report to law enforcement. Some teams called these cases “delayed,” while others labeled them as “deferred” or “change-over” cases. Numerous research studies show that delayed reporting is seen by many people, including jurors, as a reason to doubt the truthfulness of the victim’s story.³² With this concern in mind, we encourage the use of the term “converted” instead. Being aware of the distrust jurors have for “delayed” reports, we thought it best to use a more neutral term to convey that process. Using other terms risks creating the perception that the delivery of the medical forensic exam in cases like this is futile, and that resources have been wasted.³³

For the convenience of your multidisciplinary group, a glossary has been created, containing definitions for the most frequently used terms associated with forensic compliance. The glossary is contained in Part II. We suggest beginning one of your multidisciplinary team meetings by reviewing this glossary to be sure everyone is able to understand the language being used.

³⁰ See Appendix A: Modified Forensic Compliance Quiz, District One Hospital, Rice County, Minnesota.

³¹ See, e.g., End Violence Against Women International Online Training Institute, *Effective Report Writing: Using the Language of Non-Consensual Sex* available at <http://www.evawintl.org/olti/Courses.aspx> (last visited March 3, 2011).

³² For an overview of relevant research studies on how jurors view “delayed reports” of sexual assault, see Kaarin Long, Caroline Palmer & Sara G. Thome, *A Distinction Without A Difference: Why the Minnesota Supreme Court Should Overrule its Precedent Precluding the Admission of Helpful Expert Testimony in Adult-Victim Sexual Assault Cases* 31 Hamline J. Pub. L & Pol’y 569, 584 - 586 (August 2010), available at http://www.mncasa.org/Documents/index_175_2534215409.pdf or by contacting the Sexual Violence Justice Institute @ MNCASA at svji@mncasa.org.

³³ See Kimberly A. Lonsway, Ph.D., Sgt. Joanne Archambault (Ret.), *Reply to Article: “Receiving a forensic medical exam without participations in the criminal justice process: What will it mean?”* 7 JOURNAL OF FORENSIC NURSING 78 - 88 (2011) at 81.

“Our existing policies won’t allow for this.”

It’s best if all members of the multidisciplinary team are aware that existing policies will most likely have to be modified to accommodate forensic compliance mandates. For this reason, it is also advisable to have people on your multidisciplinary team who are in a position to make policy decisions in their agencies. Existing policies that are in direct opposition to forensic compliance mandates must be repealed in order to provide the best service to victims and stay in compliance with both the federal and Minnesota law. It’s also best to acknowledge the time that modification of policies on these issues may take: it is doubtful that any changes can be completely accomplished in a single meeting.

commitment

“We already work well together, so why is there any need to write our policies down?”

Minnesota jurisdictions must incorporate forensic compliance principles into their written policies, even if things seem to be working well now. Written policies benefit individual responders and team members as well as agencies as a whole, because, by articulating each discipline’s responsibilities in a step-by-step format, all team members can better understand each others’ roles. When the system is better understood by all responding individuals and agencies, service to victims is more timely, professional and holistic. In short, victims are better served if all responders have committed to a particular policy and put that policy into writing.

The benefits of having written policies in place are numerous:

1. Precision

Written policies are more precise than verbal policies. In most cases, it is easier to misinterpret verbal instructions than it is written instructions.

2. Legitimacy

Written policies carry more authority than verbal policies. Written policies lend legitimacy to the topic; that is, written documents are seen as more official. Written policies also normalize what may be seen by some as a novel or strange approach. For example, having a written policy describing the process for case conversion normalizes the case conversion process, and tells those working outside the criminal justice system (i.e., jurors) that the conversion policy is an accepted process that was developed by professionals and is routinely offered to all victims, as opposed to being a special process put into place for only a handful of victims favored by the system for some reason.

3. Consistency to the message and the purpose behind the policy

Written policies are more consistently applied than verbal policies. Further, if the purpose behind the policy is explained within the written document, there will be greater understanding of the potential impact of not following the policy in a certain instance.

4. Consistency across time and personnel

Written policies survive the loss of team members and address the constant challenge of turnover among agency staff. For example, when the specific details of how emergency department personnel should interact with victim advocates are formalized in writing, it is more likely that this interaction will be consistent even when a new emergency department manager is hired. Sometimes process of writing down policies is called “building institutional memory.”

5. Legal implications

A legitimate concern is often raised about the potential legal implications of written policies. For instance, an agency head may be concerned that having a written policy could expose the agency, its employees, or both to lawsuits or complaints for failure to carry out each and every responsibility articulated in the policy. While written policies are needed to improve service to sexual assault victims, not all situations are the same and some may require a response that varies from the written policies. Rigidly applying a policy may not be in the best interest of the victim.³⁴

Often, multidisciplinary groups choose to include a disclaimer with their written policies to address this concern.³⁵ For instance, an appropriate disclaimer might read:

“This protocol was created to help effect a more victim-centered approach toward sexual assault crimes, and does not afford a criminal defendant any additional rights or procedural protection beyond those that exist by law. The protocol contains general operating guidelines only. In some scenarios, various protocol steps may be added, omitted or amended as appropriate.”³⁶

Responding agencies must bear in mind that no disclaimer, however robust, can insulate agencies from every type of lawsuit. People may rely on various laws, policies or rights that may or may not be written down in order to bring suit for damages. It is likely that legal counsel for hospitals, law enforcement agencies, advocacy programs and other responding agencies will want to review and comment on any written policies developed to comply with forensic compliance mandates. Therefore, we recommend engaging legal counsel from those agencies early on in the process.

“How do we create policies that are victim-centered? What does that mean?”

We encourage your multidisciplinary team to use the following “simple rules” for victim-centeredness as a guide in the development of policies addressing the forensic compliance mandates.³⁷ Keeping these rules in mind, as well as pursuing the spirit of compliance, will ensure the policies you develop will provide viable options for sexual assault victims.

³⁴ Anita Boles & John Patterson, *Improving Community Response to Crime Victims: An Eight-Step Model for Developing Protocol* 92 (Sage, 1997).

³⁵ nita Boles & John Patterson, *Improving Community Response to Crime Victims: An Eight-Step Model for Developing Protocol* 92-93 (Sage, 1997).

³⁶ Ramsey County (Minnesota) Sexual Assault Protocol Team, *Ramsey County Adult Sexual Assault Response Protocol*, Version 3 (2010) available at

<http://www.jwrc.org/LinkClick.aspx?fileticket=%2bDq6VfGuQ%2fA%3d&tabid=224&mid=784>

(last visited March 3, 2011).

³⁷ See Sexual Violence Justice Institute @ MNCASA, *Becoming Victim Centered*, available at http://www.mncasa.org/Documents/svji_5_3454697050.pdf (last visited March 9, 2011) or by emailing svji@mncasa.org.

Consider the victim first

The victim and their unique needs and abilities should be considered first.

Listen generously

Listen with belief; acknowledge the violation. Listen with patience; walk with victims as they determine their own path. Listen with compassion; give voice to the victim's experience. Listen with faith; believe in the victim's resilience. Listen generously to victims, colleagues, team members, community members to affect the change we seek. Create safe places for people to tell their stories.

Promote victim self-agency

An agent is "one that acts or has the power or authority to act." Promoting victim self-agency is about providing the supports and information that enable victims to act in their own best interest relative to the unique circumstances of their lives. In this context, crisis intervention is about providing the supports necessary to re-engage or increase a victim's own coping abilities to the point decision-making is again possible. Informed decision-making means the victim knows what could be gained or lost in the options available to him or her. Assistance should be geared to providing information and support to help in decision-making relative to the victim's own goals of establishing safety, healing, and seeking justice.

In the forensic compliance context, promoting victim self-agency may mean providing victims with ample time to make an informed decision about reporting the assault to law enforcement.

Coordinate and collaborate in the victim's interest

Coordinating disparate and fractured elements of a community response can improve a victim's experience with the criminal justice system and lead to better case outcomes. Coordinating primarily in the system's own interests can re-victimize victims and jeopardize case outcomes.

In the forensic compliance context, coordination and collaboration across disciplines is fundamental to designing policies that will ensure Minnesota jurisdictions are meeting not only the letter of the law, but the spirit of the law as well.

Ensure victim safety

Ensure victims have the information, resources, and supports to be or move toward safety. This can include access to confidential services, privacy protections, access to legal remedies for protection, notification of an offender's release, and consideration of the unintended consequences to victims of the policy decisions we make.

In the forensic compliance context, ensuring victim safety means understanding that victims may not feel comfortable reporting the assault to law enforcement right away out of safety concerns.

Seek just solutions for all

Be honorable, fair, lawful, and free from bias.

Hold self and others accountable

Be able to explain and answer for our own actions and decisions. Ask others to do the same.

In the forensic compliance context, this might mean regularly asking colleagues or team members "is what we're doing really meeting the spirit of the law?"

part v. decision points
and model policies

decision points and model policies

There is no one-size-fits-all model policy for meeting forensic compliance mandates that can simply be cut-and-pasted into any existing policies for sexual assault response that your jurisdiction may have. Each Minnesota jurisdiction has different strengths, specialties and resources that may make any one model policy presented here impossible or impractical. For that reason, we encourage your multidisciplinary team to approach this task as making a series of decisions related to forensic compliance, instead of simply choosing one model policy to adopt without having corresponding conversations.

a. the importance of involving advocacy services



How will your jurisdiction ensure victims have the opportunity to work with advocates?

It is imperative that victims of sexual assault be offered the services of an advocate, no matter when or where the victim may present for care or information. If there is no advocacy program in your jurisdiction, or if advocacy services in your jurisdiction are limited, please contact the Minnesota Department of Public Safety, Office of Justice Programs, Crime Victim Grants Unit or SVJI @ MNCASA to discuss how to collaborate with existing advocacy programs or establish such programs to better meet victims' needs.³⁸

It's difficult for our hospital to address all of the concerns that sexual assault patients have. For example, many victims don't know whether they want to report the assault, and want our opinion on what to do. Victims are scared of what will happen if their case goes to trial, or they want to know how to get a restraining order. What should we do?



Immediately call a victim advocate to respond upon the patient presenting at the hospital. This practice is recommended because hospitals that call an advocate immediately find that more patients utilize the services of an advocate. With an advocate attending to diverse needs such information on the criminal justice

³⁸ For more information, contact the Minnesota Department of Safety, Office of Justice Programs, Crime Victim Grants Unit at 651-201-7300, or SVJI @ MNCASA at svji@mncasa.org.

system or safety, the healthcare professional is free to focus on the delivery of appropriate medical forensic care. Many patients feel as though their problems are a burden, so if asked whether they want to speak with an advocate, they may decline, not wanting to have another person burdened to respond. However, more patients will speak with an advocate if the advocate is already present and waiting to assist. If the patient declines speaking with an advocate at this point, the advocate should leave, but may leave some information to make it easier for the patient to make contact in the future.

Active support for victims

Advocacy is commonly defined as “active support” for victims.³⁹ Advocates can assist victims with exploring and understanding their options and empowering victims to make their own informed decisions. Advocates are trained to provide comprehensive, confidential support to victims. In Minnesota, advocates who have completed a forty-hour sexual violence advocacy training and work under the direction of a supervisor in a crisis center can claim privileged communications with victims.⁴⁰

Victim advocates can be present during the medical forensic examination if requested by the victim, and can assist victims with making a report to law enforcement. Victim advocates can provide options to help victims stay safe, access their civil legal options and understand the criminal justice system. Victim advocates are skilled at connecting victims with other community-based services, like employment, child care, food or housing. Advocates also provide support for secondary victims such as a victim’s family or partner, and participate in prevention efforts. In addition, advocates are often active in policy and systems change efforts that help to improve services to all victims, not just the individual victims with whom they work.

Involving advocacy results in better outcomes for victims

The use of victim advocates who provide support and information to sexual assault victims has been shown to lead to better outcomes for the victim. In hospital settings, victims who had help from an advocate were more likely to receive comprehensive medical care and less likely to experience secondary victimization.⁴¹ Secondary victimization is defined as the victim-blaming attitudes, behaviors and practices engaged in by community services providers, which result in additional trauma for rape survivors.⁴²

³⁹ Minnesota Coalition Against Sexual Assault, *Sexual Violence Advocacy in Minnesota: A Guide for Trainers* (2011) at 511.

⁴⁰ See Minn. Stat. § 595.02 (k) (2007). By making conversations between trained advocates and victims privileged, advocates cannot be compelled to testify to the content of those conversations during a criminal case, if any. Such privilege helps ensure that such conversations and relationships between advocates and victims are healing, not hurtful, for victims. There are some exceptions to advocate privilege. See Minnesota Coalition Against Sexual Assault, Factsheet: *Communication Between an Advocate and a Survivor May Not Always be Confidential*, available at http://www.mncasa.org/Documents/svji_facts_2_1766096975.pdf (last visited March 16, 2011).

⁴¹ Rebecca Campbell, *Rape Survivors’ Experiences with the Legal and Medical Systems: Do Rape Victim Advocates Make a Difference?* 12 VIOLENCE AGAINST WOMEN 1 – 16 (2006) available at http://vaw.msu.edu/core_faculty/rebecca_campbell/Articles/Campbell%20%282005%29.pdf (last visited March 16, 2011).

⁴² Rebecca Campbell et al., *Preventing the Second Rape: Rape Survivors’ Experiences with Community Service Providers*, 16 JOURNAL OF INTERPERSONAL VIOLENCE 1240 (2001) available at

http://vaw.msu.edu/core_faculty/rebecca_campbell/Articles/Campbell,_Wasco,_Ahrens,_Sefl_&_Barnes_%282001%29.pdf
(last visited March 16, 2011).

Conclusion

We recommend introducing advocacy services to victims as soon as victims present to the hospital or another location. Advocates are skilled at providing various services to victims, and are able to establish rapport with victims, in part due to privileged communications. Working with an advocate is proven to result in better outcomes for victims, and may make the jobs of healthcare professionals or other professionals easier.

b. referring patients to another hospital



How will your jurisdiction ensure victims are not needlessly or irresponsibly referred to another hospital to receive the medical forensic exam?

It takes a great feat of courage for victims of sexual assault to seek professional help in the aftermath of an assault. For some victims, the first response they receive to their disclosure will color the way they cope with the assault for the rest of their lives. If victims are greeted with doubt, uncertainty or indifference, they may never trust another person with the information that they have suffered an assault. It is imperative that all professionals who may be the first in line to interact with a sexual assault victim are well-informed about that victim's options.

Thus, healthcare professionals must exhibit both competence and confidence when working with sexual assault patients. VAWA 2005 requires states to certify that victims have access to the medical forensic examination regardless of the victim's decision to report the assault to law enforcement. Accessing the medical forensic exam without a report to law enforcement is meaningless, however, if healthcare professionals themselves do not feel confident or competent to *deliver* the exam.

Confidence and competence in the treatment of sexual assault patients can be gained in a variety of ways, discussed here.

Our hospital doesn't have a SANE Program or any individual trained or certified SANEs. Our registered nurses and physicians perform these exams now. Is this acceptable?

Yes, it is acceptable to have registered nurses and physicians concurrently perform the medical forensic examination if your hospital does not have a SANE program or does not employ any (or enough) SANEs. SANE programs are difficult to staff and sustain financially. Although SANEs are trained to provide superior sexual assault patient care, evidence collection, and are trained to testify in court if needed,⁴³ most hospitals in Minnesota do not employ SANEs or have an established SANE program. Moreover, across Minnesota, there are few certified SANEs.⁴⁴ In those hospitals, registered nurses and physicians may conduct the exam. Usually, a registered nurse will take the patient's verbal history of the assault and will collect urine, blood and other types of forensic evidence located



⁴³ For instance, in one study, patients seen by Sexual Assault Nurse Examiners as opposed to RNs or physicians with no formal training on evidence collection or medical treatment of sexual assault patients received a higher quality of care. Higher quality of care was demonstrated by longer examinations, greater percentage of completed consent forms, and greater percentage of completed evidence kits for prosecution. Derhammer, Lucente, Reed & Young, *Using a SANE Interdisciplinary Approach To Care of Sexual Assault Victims*, 26 JOURNAL ON QUALITY IMPROVEMENT 8, 488-495 (2000).

⁴⁴ According to information collected by the Minnesota Chapter of the International Association of Forensic Nurses (IAFN) in 2010, there are approximately forty-eight SANE-A certified individuals in Minnesota. SANE-A indicates a certification that has been obtained in Adolescent-Adult sexual assault patient care.

externally on the victim's body, and a physician will conduct the pelvic exam to document any injury internally or collect evidence internally. The physician will order any medications that are required. Thus, all of the elements of the medical forensic exam are within the scope of practice of registered nurses and physicians.



Our hospital doesn't have a SANE Program or any individual trained or certified SANEs. Our area sees so few sexual assault patients, that it is difficult for our staff to remember how to conduct the medical forensic examination. We usually tell the victim that he or she will have to go to another hospital to have the examination. Is this okay?

Transferring sexual assault patients should be avoided.⁴⁵ We encourage your hospital to develop the competency needed to provide the medical forensic exam, no matter how few patients you may see presenting for this reason. Affordable SANE trainings are held in Minnesota annually.⁴⁶ If for some reason this is not possible, however, then the next best course of action is to establish a responsible referral policy. Even responsible referral policies, however, take the risk that referred patients will not show up at the receiving hospital for care. For that reason, we encourage hospitals considering a referral policy to use it as a short-term strategy only, while continuing to work towards building the capacity to confidently and competently treat sexual assault patients.

What must be included in a responsible referral policy?

Your hospital's emergency department nurse manager, physicians, and the hospital's legal counsel should be consulted in the development of any referral policy. A responsible referral policy must contain the following elements:

1. Complies with the Emergency Medical Treatment and Active Labor Act (EMTALA)

A responsible referral policy must contemplate how EMTALA provisions will be addressed. EMTALA is a federal statute which governs when and how a patient may be refused treatment or transferred from one hospital to another when the patient is in an unstable medical condition.⁴⁷ The purpose of the statute is to prevent hospitals from rejecting patients, refusing to treat them, or transferring them to another hospital because they are unable to pay, are undocumented immigrants, or are

⁴⁵ U.S. Department of Justice, Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescent* (2004) at 59, available at <http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf> (last visited March 9, 2011).

⁴⁶ For information on upcoming SANE trainings, please contact the Minnesota Chapter of the International Association of Forensic Nurses (IAFN) at <http://www.mnforensicnurses.org>; the National IAFN at <http://www.iafn.org/> or SVJI @ MNCASA at svji@mncasa.org.

⁴⁷ 42 USC § 1395dd et seq. (1986). For a summary of EMTALA requirements, see Edward C. Liu, Congressional Research Service, *EMTALA: Access to Emergency Medical Care* (2010) available at <http://aging.senate.gov/crs/medicare20.pdf> (last visited March 3, 2011).

covered under Medicare or Medicaid programs.

EMTALA applies only to "participating hospitals," or those hospitals which have entered into provider agreements under which they will accept payment from the Department of Health and Human Services under the Medicare program. In practical terms, this means that it applies to virtually all hospitals in the United States. Its provisions apply to all patients, and not just to Medicare patients.

The relevant provisions of EMTALA for the purposes of this document are:



"Any patient who comes to the emergency department requesting examination or treatment for a medical condition must be provided with an appropriate medical screening examination to determine if he is suffering from an emergency medical condition. If he is, then the hospital is obligated to either provide him with treatment until he is stable or to transfer him to another hospital in conformance with the statute's directives."⁴⁸

Therefore, in virtually all Minnesota hospitals, before the hospital refers a sexual assault patient to another facility, an EMTALA screening must be performed. Care should be taken to ensure that the EMTALA screening is performed in a private examination room (not in a public triage area) as soon as possible following the patient's arrival at the Emergency Department. Care should also be taken not to disrupt potential evidence on the patient's body or clothing during an EMTALA screening (see the section "Institutes provisions to minimize lost evidence or negative health consequences" below).

2. Is well known and in writing

A responsible referral policy must be well known to both the referring hospital and the receiving hospital. Ideally, this referral policy should also be in writing. It is unacceptable for referring hospitals to refer patients to another hospital without having a formal, written referral policy in place; verbal agreements alone are not sufficient. MNCASA has received calls from victims who were referred from one hospital to another, only to learn that the hospital to which they were referred also would not conduct the medical forensic exam.

3. Is "soft"

A responsible referral policy must be "soft." That is, even in the place of a formal written agreement, hospital staff at the referring hospital must call ahead to ensure the patient will receive timely attention at the receiving hospital. The referring physician and primary care nurse must call ahead to make arrangements for the smooth continuation of patient care. Having a soft referral policy in place may reduce the time that a patient needs to wait, may eliminate the loss of evidence from the patient's body, and may help eliminate patient frustration and confusion during the

⁴⁸ 42 U.S.C. § 1395dd et seq. (1986).

referral process.

4. Involves advocacy

A responsible referral policy must also immediately offer victim advocacy services to the patient. Patients should be informed that working with an advocate could help the referral to another facility go more smoothly. Patients should be informed that advocates are equipped with helpful information about the criminal justice process, alternative reporting options, and information that can assist the patient with safety planning, such as restraining orders or shelter options.⁴⁹

5. Contemplates patient transportation

A responsible referral policy will contemplate distance between the referring and receiving hospitals and make suggestions for how to minimize any transportation burden to patients. In some jurisdictions, victim advocacy programs may be able to help facilitate patient transportation to the receiving hospital. If this isn't possible, however, will patients be encouraged to drive themselves to the receiving hospital? If so, is there any way to alleviate the financial hardship and other complications this may create?

6. Institutes provisions to minimize lost evidence or negative health consequences

Any delay in the delivery of medical forensic care poses some risk of the loss of evidence. For instance, while a patient is waiting to be seen or while a patient is being transported to an accepting hospital, he or she may have to urinate, an activity that may wash potential evidence from his or her body, or eliminate the ability to gather urine that is still viable to be analyzed for evidence of drug-facilitated sexual assault (toxicology).⁵⁰ Any delay in the delivery of medical forensic care also increases the risk that patients will eat, smoke, wash, brush their hair, apply makeup, change clothing, or participate in numerous other behaviors that could eliminate evidence of the sexual assault.

In order to eliminate the potential of losing evidence, a responsible referral policy will therefore require the referring hospital to warn the patient not to engage in any of these behaviors while they are en route to the accepting hospital, or provide instructions regarding acceptable ways to manage behaviors that can't wait. A responsible referral policy will also assist a patient with the proper collection of urine *prior to* the patient's transfer, if needed. Because it is so crucial to collect the first urine void of a patient, making arrangements to properly collect this evidence and ensure the chain of custody of the sample during a patient transfer must be addressed in the referral policy.

7. Contains an agreement to cross-train staff on sexual assault patient care

Finally, a responsible referral policy will contain a commitment by the referring hospital to train some designated healthcare professionals in the delivery of the medical forensic exam, and a

⁴⁹ For more information on the benefits of working with advocates, please see Part V, Section A. Involving Advocacy Services.

⁵⁰ Lindsey Garfield, Forensic Scientist, Minnesota Bureau of Criminal Apprehension, *Frequently Asked Toxicology Questions for the Sexual Assault Forensic Examiner*, webinar recording February 16, 2011. Webinar recording is available by emailing svji@mncasa.org.

commitment by the receiving hospital to provide that training. We encourage the development of such an educational partnership to ensure that all Minnesota hospitals that provide emergency care are eventually competent and confident in the delivery of the medical forensic exam.

Conclusion

Ensuring victim access to the medical forensic exam without a report to law enforcement is meaningless if healthcare professionals themselves do not feel confident or competent to deliver the exam. Therefore, hospitals in Minnesota that provide emergency care must strive to be confident and competent in the delivery of the medical forensic exam. There are different ways to achieve this. If your hospital does not have a SANE program, registered nurses and physicians can deliver quality care to sexual assault patients. If registered nurses and physicians do not feel competent to conduct medical forensic exams, a responsible referral policy may be established, but referring patients to another hospital should be avoided whenever possible, because patients may be frustrated or confused by the referral. If your hospital establishes a referral policy, we encourage using such a policy only temporarily while simultaneously building the capacity of your hospital to treat sexual assault victims on-site in the future.⁵¹

⁵¹ For more recommendations on how to build the capacity of hospitals to respond to sexual assault patients, please see U.S. Department of Justice, Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescent* (2004) 57 - 59, available at <http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf> (last visited March 9, 2011); the Minnesota Chapter of the International Association of Forensic Nurses (IAFN) at <http://www.mnforensicnurses.org> (last visited March 16, 2011); the National IAFN at <http://www.iafn.org/> (last visited March 16, 2011) or email SVJI @ MNCASA at svji@mncasa.org.

c. exam timeframes



How will your jurisdiction ensure patients are not refused the medical forensic examination without a more thorough assessment with regard to the timeframe between the assault and the exam?

Victim access to the medical forensic examination without reporting the assault to law enforcement is meaningless if patients are denied access to the exam for other reasons. Besides a healthcare professional's lack of competence or confidence to conduct the exam, another factor that affects victim access to the exam is confusion over what period of time post-assault the medical forensic exam should be conducted. For example, SVJI @ MNCASA has heard concerns from victims who were refused a medical forensic examination despite presenting to the hospital within two days of the assault.

This section will explore the issue and provide important information for your team to consider when reviewing current policy on the period of time post-assault medical forensic exams will be offered by your local hospital.

What has practice been in the past?

In general, the practice in Minnesota has been to offer medical forensic exams to victims of sexual assault who present within 72 hours (3 days) post-assault. Advances in technology have led to the ability to retrieve viable forensic evidence from exams conducted after 72 hours, however. Practice around the nation varies, but many programs now routinely offer medical forensic exams beyond the 72 hour timeframe. In 2009, all Twin Cities metro-based SANE programs moved to a standard timeframe of 120 hours (5 days) post-assault. This policy change has led other SANE programs and hospitals across Minnesota to review their policies.

Most hospital and SANE program policies specify that no matter what timeframe may be articulated in the policy, departures from that timeframe should be allowed when the victim's situation warrants a later examination. For example, even in hospitals where policy may currently limit the exam to 72 hours post-assault, a victim who presents later who also reports she had not bathed during that timeframe may still be offered an exam. Another situation in which departures from an established timeframe are often made is in the event the victim has limited mobility, like confinement to a bed or wheelchair.

Why did many hospitals or SANE programs limit the timeframe to 72 hours in the past?

It is difficult to make sense of why the 72 hour timeframe was established in the first place. In some jurisdictions, the answer to this inquiry is simply "because we have always done it this way."⁵²

⁵² Joanne Archambault, *Time Limits for Conducting a Forensic Examination: Can Biological Evidence be Recovered 24, 36, 48, 72, 84 or 96 Hours Following a Sexual Assault?* Available at http://www.mysati.com/enews/May2005/practices_0505.htm (last visited March 21, 2011).

As stated above, most programs utilizing a 72 hour timeframe utilized that timeframe as more of a guideline than a rule, extending the timeframe in certain situations. Some programs used the 72 hour timeframe as a rigid rule, however, and would not recommend or pay for examinations for victims presenting later. The origin of the 72 hour timeframe was probably based not on the length of time for the most effective evidence collection, but rather on the most effective medical treatment. For the most effective pregnancy and sexually transmitted infection (STI) prophylaxis, administration of medical treatment is required within 72 hours of the assault.

Perhaps because of this guideline, practitioners and lay persons also assumed that effective evidence collection was also limited to 72 hours. In truth, the possibility of effective evidence collection goes beyond 72 hours.

What does medical research say?

There is a lack of reliable scientific information regarding what evidence may be available at different times and under different circumstances. Forensic examiners have received little feedback over the years regarding their evidence collection techniques because a large portion of exams have never been analyzed. Therefore, it has been difficult for forensic examiners to form best practice about what types of evidence should be gathered from different collection sites (oral, anal, vaginal) or via different collection techniques (swabbing, woods lamp, toxicology) at various timeframes post-assault.

Despite these limitations, there are numerous studies that show that forensic evidence may be present long after 72 hours post-assault. Some studies, including some conducted decades ago for general obstetric and gynecological purposes, have shown the presence of sperm in the vagina long after 72 hours; in fact, some studies have documented such evidence present 12 days after an assault or consensual intercourse.⁵³ Studies have also shown evidence of certain drugs in urine after 72 hours post-assault.⁵⁴

So, what timeframe is now recommended?

According to the United States Department of Justice, *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*, recommended practice is to acknowledge that viable forensic evidence can exist beyond 72 hours and that cases must be evaluated on an individual basis to consider each victim's unique needs.⁵⁵ Rigid application of any timeframe, even past 72 hours, is not recommended practice.⁵⁶ Because technology continually improves the sensitivity of the tests used to analyze evidence collected during the exam, any timeframe set now will have to be re-evaluated in the future.

⁵³ A.J. Morrison, *Persistence of Spermatozoa in the Vagina and Cervix*, 48 BRITISH JOURNAL OF VENEREAL DISEASE, 141-143 (1972).

⁵⁴ U.S. Department of Justice, Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents* (2004) available at <http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf> (last visited March 21, 2011).

⁵⁵ U.S. Department of Justice, Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents* (2004) at 67 available at <http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf> (last visited March 21, 2011).

⁵⁶ Joanne Archambault, *Time Limits for Conducting a Forensic Examination: Can Biological Evidence be recovered 24, 36, 48, 72, 84 or 96 Hours Following a Sexual Assault?* Available at http://www.mysati.com/enews/May2005/practices_0505.htm (last visited March 21, 2011).

It is now also recommended practice to acknowledge that offering the medical forensic examination post 72 hours has benefits beyond potential evidence collection. For example, new advances in medical care including pregnancy and STI prophylactic medications may be effective up to 120 hours post-assault.⁵⁷

Conclusion

It is necessary to ensure that each victim receives a comprehensive assessment as to whether the medical forensic examination is warranted at various timeframes post-assault, instead of relying on a one-size-fits-all, rigidly-applied timeframe. If your jurisdiction rigidly imposes a short timeframe (less than 72 hours) without offering a comprehensive assessment to each victim, we encourage your multidisciplinary team to reconsider and change policy to reflect more current practice.

⁵⁷ See, e.g., Lisa Zindler, *New Developments in Pregnancy Prophylaxis* webinar recording. Webinar recording is available by emailing svji@mncasa.org.

d. restricted kit storage location

“evidence is more than bags, boxes and body fluids. it may be someone’s only opportunity to seek justice”⁵⁸



Where will your jurisdiction store the evidentiary kits or related evidentiary items from cases where the victim hasn’t yet decided whether to report the assault to law enforcement (restricted evidentiary kits)?

There is no Minnesota or federal law that dictates where restricted evidentiary kits or other evidence collected in a restricted case must be stored.⁵⁹ As a result, Minnesota jurisdictions must set their own policies on storage location.

Determining where to store such kits may be challenging. Before making a decision on an appropriate storage location, a multidisciplinary group in your jurisdiction must meet to review existing policies and the particular characteristics of available storage facilities. Restricted evidentiary kits must be stored in a location that ensures both the integrity and viability of the evidence. The potential evidence contained in such kits may be a victim’s only opportunity to seek justice, if that victim chooses to convert the case and involve law enforcement at a later date. Proper evidence storage locations are those that meet the factors set forth below.

What factors should be considered when determining an appropriate storage location?

Any facility seeking to store evidence should review the factors highlighted below, as well as additional factors set forth by the State of Minnesota, Office of the State Auditor, in a document titled *Best Practices Review: Property and Evidence Room Policies and Procedures Manual*.⁶⁰ While that document is focused on best practices for proper evidence storage within law enforcement facilities, the recommendations articulated there also apply to other locations considering storage of biological evidence or other items of evidence submitted in potential criminal cases.



⁵⁸ Bonnie Price, MSN, RN, SANE-A/P, *Receiving a Forensic Medical Exam Without Participating in the Criminal Justice Process: What Will It Mean?* 6 JOURNAL OF FORENSIC NURSING (2010) at 84.

⁵⁹ Some other states have set the location for storage of evidence from restricted cases by statute. See e.g., IOWA CODE §709.10 (subd.1) (2004).

⁶⁰ This document was published February 16, 2011 and is available at <http://www.auditor.state.mn.us/reports/qid/2011/bestpractices/bestpracticespropertyevidencerooms.pdf#page=21> (last visited March 17, 2011).

This section conveys what conditions are considered *ideal* to ensure the viability and integrity of evidence. Keep in mind that even in less-than-ideal conditions, however, sometimes evidence is still found viable, and evidence which may have been stored in less than ideal conditions shouldn't be assumed to be worthless.

1. Limited Access /Security

Restricted evidentiary kits or other evidentiary items collected in a restricted case must be stored in a secure location. A secure location not only prevents public access, but also limits access to only one or two specially-trained agency employees. It is imprudent to utilize storage areas that allow multiple people access to the evidence.⁶¹ Agency heads should dictate through written policy who within their respective agencies shall serve as authorized evidence technicians.⁶²

Secure storage locations must have locked entries, an electronic card-access entry system or other systems that have the ability to restrict access to designated agency employees. Some locations have the ability to monitor and record which agency employees had access to the storage location and when. For instance, in some hospitals, there is a system in place known as Pyxis MedStation System® to restrict and record access to keys that open rooms storing medications or other items that must be carefully controlled.⁶³

2. Chain of Custody

"Chain of custody" is a legal term that means the movement and location of physical evidence from the time it is collected to the time it is presented in court. Sometimes the testimony of each individual who had possession of the item is required to establish chain of custody.⁶⁴ In any type of criminal case, each item of evidence collected must be accounted for at all times and remain under strict control. If there is a break on the chain of custody, questions may arise about the integrity of the evidence: that is, it may be alleged that the evidence was tampered with, altered or cross-contaminated during the time it was unaccounted for.

A representative from your County Attorney's Office must be asked to influence the policies associated with evidence storage and chain of custody for restricted kits.⁶⁵ The County Attorney is the one who must withstand court challenges to proper evidence handling if the case is converted and prosecuted.

3. Climate control

An appropriate storage location must be protected from the elements, and have climate control mechanisms in place. Climate control is necessary to ensure that the biologic samples collected as part of the kit, or any additional items of evidence, are preserved and remain viable for future

⁶¹ International Association for Property and Evidence (2007).

⁶² International Association for Property and Evidence (2007) .

⁶³ For more information, see <http://www.carefusion.com/products-and-services/products-services-categories/medication-management/pyxis-medstation-system.aspx> (last visited February 17, 2011).

⁶⁴ BLACK'S LAW DICTIONARY, 8th ed., 2004 at 244.

⁶⁵ Working closely with local prosecutors when developing any evidence storage policy is also recommended by the State of Minnesota, Office of the State Auditor, *Best Practices Review: Property and Evidence Room Policies and Procedures Manual*, 15 (2011).

analysis if the victim chooses to convert to a standard report.

Refrigeration recommended

It is accepted best practice to store restricted kits under refrigeration as soon as possible.⁶⁶ It is also best practice to store toxicology kits, or blood and urine samples, associated with restricted kits under refrigeration. Appropriate temperature ranges for refrigeration are 33.8° - 42.8° Fahrenheit.⁶⁷

Room temperature storage not recommended

Room temperature storage is only acceptable in exceptional circumstances. If refrigeration is not possible, restricted kits (but *not* the toxicology kits containing blood or urine associated with restricted kits) may be stored at room temperature *temporarily*, but only if the evidence within the kit has been *completely dried*.⁶⁸ Appropriate temperature ranges for room temperature storage are 55° - 75° Fahrenheit.⁶⁹ Long-term room temperature storage is not recommended because it is difficult to ensure that the biologic samples collected within kits are completely dry. Depending on the items collected, complete drying of the samples could take days or even weeks. For instance, if a tampon or a condom is collected, how will the forensic examiners within your medical facility ensure the samples are completely dry before storing them at room temperature? Even if your facility utilizes swab dryers, the drying time depends on the saturation level of the item. Long-term room-temperature storage of restricted kits should therefore only be contemplated after a consultation with the Minnesota Bureau of Criminal Apprehension.⁷⁰

Freezing not recommended

Each time a kit goes through a freeze/thaw cycle, moisture may be introduced to the samples within. It is the presence of moisture that will degrade the quality of the sample, making future DNA or toxicology analysis difficult or impossible. Likewise, freezing the toxicology kit (blood and urine samples) is not recommended if alcohol is suspected, as a loss of ethanol could occur from freezing the sample. If no alcohol is suspected, it is permissible to freeze urine samples. However, since it is well-documented that alcohol is the most commonly used drug to facilitate sexual assaults, freezing of the toxicology kit is not recommended.⁷¹

⁶⁶ Minnesota Bureau of Criminal Apprehension, *DNA Evidence Identification, Collection, and Preservation for Law Enforcement*, available at <http://www.bca.state.mn.us/Lab/Documents/DNABrochure05.pdf> (last visited February 8, 2011). Evidentiary kits collected in cases that have been reported to law enforcement must also be stored in similar conditions.

⁶⁷ Interview with Kate Lentz-Lockhart, Forensic Scientist, Minnesota Bureau of Criminal Apprehension, February 1, 2011.

⁶⁸ Minnesota Bureau of Criminal Apprehension, *DNA Evidence Identification, Collection, and Preservation for Law Enforcement*, available at <http://www.bca.state.mn.us/Lab/Documents/DNABrochure05.pdf> (last visited February 8, 2011).

⁶⁹ Interview with Kate Lentz-Lockhart, Forensic Scientist, Minnesota Bureau of Criminal Apprehension, February 1, 2011. To schedule a consultation, contact the BCA laboratory location that serves your jurisdiction.

⁷⁰ Lindsey Garfield, Forensic Scientist, BCA, *Frequently Asked Toxicology Questions for the Sexual Assault Forensic Examiner*, webinar recording February 16, 2011. Webinar recording and materials are available by emailing svji@mncasa.org. See also National District Attorneys Association, American Prosecutor's Research Institute, *Prosecuting Alcohol-Facilitated Sexual Assault* available at <http://www.vaw.umn.edu/documents/prosecutingalcohol/prosecutingalcohol.pdf> (last visited March 3, 2011).

⁷¹ While some Minnesota statutes dictate how long certain types of evidence must be retained, evidence retention policies for other types of evidence differ greatly among Minnesota law enforcement agencies.

4. Existing protocol, policy or procedure

It is necessary to examine current policies for locations you are considering for the storage of restricted kits. Existing policies may make kit storage impossible or burdensome. For example, one Minnesota hospital was hesitant to store restricted kits even though they have a locked refrigerator available within the Emergency Department that could be used for those kits alone. An existing hospital policy requires all refrigerators to be checked twice daily to ensure proper temperature. The policy is in place to ensure that medications are kept at a consistent temperature. The refrigerators are not equipped with external temperature gauges, so refrigerators must be opened twice a day to check the temperature, and this task must be completed by various staff members. Although the kits kept inside are individually sealed, the hospital staff felt as though having different staff members open up the refrigerator each day is not best practice for chain of custody purposes. Furthermore, opening the refrigerator multiple times daily could upset the temperature balance and introduce moisture into the kit, which could degrade the samples. In order to alleviate this problem, the hospital purchased another small refrigerator which was equipped with an external temperature gauge and a lock that was accessible to only two staff members.

In addition, existing policy at law enforcement agencies about the storage of evidence may complicate the storage of restricted kits. Specifically, law enforcement agencies have policies in place that dictate how evidence will be received, and the duration of storage for certain types of evidence. Please see Section 5 below, which discusses evidence inventory or tracking methods that may make the storage of restricted kits more feasible.

Thus, it is important to consider the presence of existing policy and procedure that may complicate the storage of restricted kits. In some instances, it will be necessary to revise those current policies in order to establish best practice for the storage of restricted kits.

5. Ability to inventory evidence/tracking methods

Appropriate storage locations will also possess the ability to track, or inventory, the receipt and storage of restricted kits in a way that maintains victim confidentiality. Appropriate tracking systems utilize a case number or code, as opposed to a victim name. Using a case number or code will both protect victim confidentiality and will ease the process of case conversion. Having such a tracking system in place can ensure that the evidence is accounted for and able to be located at all times in the event the victim chooses to convert the case. The ability to track and inventory such kits is necessary to maintain chain of custody and protect the integrity of the evidence in the event the case is converted to a standard report in the future. The use of a responsible case tracking system will meet the spirit of both VAWA 2005 and Minnesota law.

Some storage facilities will have existing policies in place that may complicate the storage of restricted kits. For example, most storage facilities require a victim or defendant name or police report number in order to inventory evidence. For this reason, it will be necessary to establish some sort of an identifier that meets both the needs of the storage facility and maintains victim confidentiality. Several Minnesota jurisdictions have approached this challenge by creating policies that allow the healthcare professional completing the sexual assault evidence collection kit or providing other treatment to victim to obtain an Incident Criminal Report number (ICR, or police report number) in order to aid in the tracking and inventory of the evidence. For example:



"A Sexual Assault Nurse Examiner (SANE) will make a sexual assault report on behalf of a victim and receive an ICR without divulging the identity of the victim. The report will be made by calling 9-1-1. The 9-1-1 call taker will provide an ICR to the SANE."

The SANE who examines the victim will call 9-1-1 and provide the location at which the assault occurred along with the date and time it occurred and will request an ICR for an Anonymous CSC Report. An officer should not be dispatched at this time. When calling back to request an officer respond to pick up the evidence kit and take it to property, the SANE will provide the ICR from the original report to the call taker. At this time, the call will be reopened and a jurisdictional officer assigned to respond to the appropriate hospital to collect and store evidence. The officer will enter comments and disposition when this process is complete."⁷²

This policy allows law enforcement to rely on an already-established method for evidence storage, through the use of an ICR number attached to the restricted kit. The ICR number is not linked to the victim's name, however, as the SANE making the call will provide her name as the reporting party instead. The case will not be investigated, as it is classified separately as "CSC Anonymous." The ICR number is put on the outside of the kit, not the victim name, and the victim is provided with the ICR number in order to facilitate conversion of her case in the future if she chooses.

Other jurisdictions have contemplated the use of bar coding to track and inventory restricted kits.

6. Transportation of Evidence Collected in Restricted Cases

Jurisdictions must consider how restricted kits and additional evidentiary items, if any, will be transported to the storage facility. If your jurisdiction has decided to store restricted kits at the hospital, you will need to discuss how kits will be moved to the secure storage area within the hospital from the examination room.

If restricted kits will be stored at a location other than the hospital, your jurisdiction will also need to consider how the kits will be transported. For example, if your jurisdiction has decided to store restricted kits with law enforcement, how will kits be transported that maintains chain of custody and climate control to ensure the integrity and viability of the evidence? For example:



Once the victim/patient has left the hospital, the healthcare professional will call law enforcement dispatch or Goodhue County Sheriff's Office (GCSO) and will request a deputy to transport the evidentiary kit to the central law enforcement evidence storage facility at GCSO. The evidence will be maintained by a designated healthcare professional until released through a chain of custody transfer to the responding GCSO deputy."⁷³

⁷² This model tracking and identifier policy has been adapted from the Southern St. Louis County SMART Anonymous 3rd Party Reporting Process. For full text of this policy, see Appendix B.

⁷³ This model evidence transportation policy has been adapted from the Goodhue County Adult Sexual Assault Response Protocol, created by the Goodhue County Sexual Assault Multidisciplinary Action Response Team (SMART), February 1, 2011.

Some large jurisdictions, like Texas, send restricted kits through the mail to regional storage facilities. Their policy provides:



"Evidence will be packaged in a box that is completely sealed with heavy tape. The seal shall be initialed so that part of the initials are on the box and part on the tape. The box must be able to withstand standard shipping. Contents may include:

- A sealed sexual assault evidence collection kit, the victim reference sample shall be in the form of a dried buccal swab in its own packaging and may be enclosed in kit.
- Sealed paper bags containing victim's clothing (should be limited to victim's underwear unless there is a compelling reason to believe that any other item contains biological evidence from the suspect).
- **No blood or urine samples shall be included.**"⁷⁴

While mailing evidence may work well for large jurisdictions like Texas that store restricted kits at regional storage centers that may be hours away, this process might not be necessary if the distance between the hospital and storage facility is relatively short. This process could provide a viable option, however, for Minnesota counties with long distances between hospitals and appropriate storage facilities.

7. Adequate Space

The amount of space needed is a concern for any agency considering storage. In Minnesota, the number of restricted kits currently being stored is unknown. It is also unknown how many more victims will seek a medical forensic examination as the general population learns that the receipt of that exam does not depend on the victim's report to law enforcement. How many restricted kits will be collected in your jurisdiction will depend on population and the presence of any education or outreach efforts.

When issuing guidelines for its local jurisdictions, the Maryland Governor's Office of Crime Control and Prevention urged jurisdictions to prepare for a 10 – 30% increase in the number of evidentiary kits that would be collected.⁷⁵ There is currently no Minnesota state-wide data available to either support or discredit the estimate offered by the Maryland Governor's Office.

Although it is difficult to predict the number of restricted kits that may be collected across Minnesota, one thing is predictable – the actual size of the sexual assault evidence collection kit. The kit is small, measuring just 7"W x 4 1/2"D x 2 1/4"H, about the size of an average paperback book. The kits are made of rigid cardboard and may be stacked on top of one another, as long as the contents within are completely dry. Agencies will probably be able to store fifty or more kits

⁷⁴ by the Goodhue County Sexual Assault Multidisciplinary Action Response Team (SMART), February 1, 2011.

⁷⁴ Texas Department of Public Safety, *Instructions for Submission of Sexual Assault Evidence in Cases without Law Enforcement Reporting* available at http://www.evawintl.org/images/uploads/TX_InstructionsForMailingEvidence.pdf (last visited March 17, 2011).

⁷⁵ *VAWA Compliance*, Maryland State STOP Grant Adminstrating Agency, Governor's Office of Crime Control and Prevention, available at www.goccp.maryland.gov/.../Maryland-Domestic-Violence-Policies-VAWA-Compliance.ppt (last visited February 3, 2011).

within one standard-sized refrigerator. The toxicology kits are also small. If your jurisdiction chooses to collect and retain blood and urine in restricted cases as well, there may be adequate storage for that evidence as well. For more information on the toxicology kits, please see Frequently Asked Question “Where should we store other items that may have evidentiary value collected in restricted cases?” below.

8. Store evidence from restricted and reported cases separately

When law enforcement agencies have agreed to store restricted kits, we recommend storing restricted kits separately from evidence collected in reported cases. This practice will minimize confusion, and will help ensure that evidence from a reported case isn’t destroyed or that evidence from restricted cases will be mistakenly submitted to the BCA for DNA or toxicology analysis.

While adequate storage space is usually of concern to agencies considering storage, the amount of space that will ultimately be needed to store restricted kits will likely be manageable.



Are law enforcement agencies an appropriate place to store restricted kits?

Yes, law enforcement agencies are an appropriate place to store restricted kits, as long as the evidence room can meet or exceed all of the factors listed above. One national organization considers it best practice to have restricted kits stored within law enforcement evidence rooms.⁷⁶

Are hospitals an appropriate place to store restricted kits or additional evidence collected in restricted cases?

Yes, hospitals may be an appropriate place to store restricted kits, as long as the hospital storage area can meet or exceed all of the factors listed above, and can make arrangements to store evidence *long-term*. Most hospitals in Minnesota do not have an established Sexual Assault Nurse Examiner (SANE) program. Moreover, even where a SANE program does exist, there may be no dedicated storage space where evidence can be properly stored according to the factors listed above. Some Twin Cities metro hospital SANE programs do have storage locations that are separate from the storage for kits from reported cases and have limited access. However, even in these facilities, finding space for long-term storage of restricted kits may be difficult. In Part V. Section E., the recommended *minimum* storage duration for restricted kits is eighteen months. Most hospitals will not be equipped to store restricted kits for eighteen months or longer, as storing evidence long-term is not a role that hospitals are accustomed to fulfilling.⁷⁷



⁷⁶ End Violence Against Women International. See Kimberly A. Lonsway, Ph.D., Sgt. Joanne Archambault (Ret.), *Reply to Article: “Receiving a forensic medical exam without participations in the criminal justice process: What will it mean?”* 7 JOURNAL OF FORENSIC NURSING 78 - 88 (2011) at 78.

⁷⁷ Bonnie Price, MSN, RN, SANE-A/P, *Receiving a Forensic Medical Exam Without Participating in the Criminal Justice*

Another important consideration is that individual SANEs usually do not receive the necessary education to serve in the role of property or evidence technician. While forensic nurses are highly qualified to collect and package evidence, they do not usually receive training on proper techniques needed for long-term storage of that evidence.⁷⁸

Therefore, because of the lack of SANE programs, special training on proper evidence storage, or hospital-based storage areas that meet all of the factors above and can accommodate long-term storage, it may be challenging to establish an appropriate storage location for restricted kits within a hospital.



Why aren't other locked, restricted or private locations appropriate storage locations?

It is never acceptable to use locked desk drawers, locked filing cabinets, a private office, or lockers for storage, no matter where they may be located.⁷⁹ Such locations offer little, if any, climate control to preserve the viability of the evidence. Such locations are not secure enough to ensure chain of custody and evidence integrity and may not survive potential court challenges if the case is later converted and prosecuted.

Similarly, it is never acceptable to release restricted kits to the victim's custody or control. Victims of other crimes are not required to maintain the integrity or viability of evidence, so it is unacceptable to burden victims of sexual assault with proper evidence storage. Moreover, it will be difficult, if not impossible, for victims to maintain storage conditions at their home that would ensure the evidence viability. Most importantly, however, the integrity of any physical evidence in the custody and control of the victim will certainly face court challenges if that case is later converted and prosecuted. The defense in such a case could allege that the victim contaminated the evidence while it was in the victim's possession. Therefore, it is never acceptable to release restricted kits to the custody of the victim.

Where should we store other items that may have evidentiary value collected in restricted cases?

Potential evidence of a sexual assault isn't limited to the swabs or other biologic evidence that may be collected from the victim's body and contained within the sexual assault evidence collection kit. Potential evidence may be present on other items, like bed sheets, the victim's underwear or other clothing worn during or after the assault. In addition, blood and urine collected for toxicology analysis may be collected from the victim. This section will address where



Process: What Will It Mean? 6 JOURNAL OF FORENSIC NURSING (2010) at 84.

⁷⁸ Bonnie Price, MSN, RN, SANE-A/P, *Receiving a Forensic Medical Exam Without Participating in the Criminal Justice Process: What Will It Mean?* 6 JOURNAL OF FORENSIC NURSING (2010) at 84.

⁷⁹ Bonnie Price, MSN, RN, SANE-A/P, *Receiving a Forensic Medical Exam Without Participating in the Criminal Justice Process: What Will It Mean?* 6 JOURNAL OF FORENSIC NURSING (2010) at 82.

additional evidentiary items may be stored.

Additional physical items

Due to space limitations, some jurisdictions have decided to limit what other items may be collected and stored in restricted cases. For instance, some jurisdictions limit additional items of clothing to just underwear worn by the victim during or after the assault.⁸⁰ Underwear, even multiple pairs packaged separately, is usually small enough to store without taking up too much space. Any additional evidence collected must be packaged separately from the BCA evidentiary kit, with each item being packaged in an individual paper bag. Any additional items being collected, just as the biologic samples collected by swabs in the evidentiary kit, must be completely dried before being stored long-term.⁸¹

Photographs

Where to store any photographs taken to document injury to the victim must also be taken into consideration. In reported cases, these photos are usually copied onto a disc and are released to law enforcement, along with the sexual assault evidence collection kit. In restricted cases, however, any photographs taken must be stored elsewhere. Photographs could be stored within a patient's medical file, or could be stored on disc, and packaged separately from, but attached to the sexual assault evidence collection kit. Whether or not refrigeration could impact the quality of a photo disc should be considered.

Blood and urine

If blood and urine have been collected, it must be packaged separately from the sexual assault evidence collection kit, in two additional kits known collectively as a Toxicology Kit, or DUI kit. One kit contains blood tubes and the other contains a urine cup. Blood and urine must be refrigerated in order to maintain viability.⁸² Due to space limitations, some jurisdictions will not collect blood and urine in restricted cases.⁸³ While there is nothing in the federal or Minnesota law that requires blood or urine to be collected or preserved in restricted cases, it is recommended practice to do so, despite space considerations. Obtaining the victim's blood and urine preserves potential evidence of a drug-facilitated sexual assault. Evidence of this nature may be important to corroborate the victim's story of the assault, or corroborate the victim's level of impairment at the time of the assault.⁸⁴

⁸⁰ Due to limited storage space and a high volume of restricted cases, the Regions Hospital Sexual Assault Nurse Examiner Program, located in St. Paul, Minnesota, most often limits additional items of clothing collected to underwear that the victim was wearing during or after the assault.

⁸¹ Interview with Kate Lentz-Lockhart, Forensic Scientist, BCA, February 1, 2011.

⁸² See Section 3, Climate Control, above.

⁸³ See Section 6, Transportation of Evidence Collected in Restricted Cases, above.

⁸⁴ Lindsey Garfield, Forensic Scientist, Minnesota Bureau of Criminal Apprehension, *Frequently Asked Toxicology Questions for the Sexual Assault Forensic Examiner*, webinar recording February 16, 2011. Webinar recording available by emailing svji@mncasa.org.



The best option for our jurisdiction is to store restricted kits with law enforcement. Our local police department doesn't have a refrigerator in their storage facility, nor does it have an evidence technician. What should we do?

Some law enforcement agencies in rural Minnesota may not possess full-time evidence technicians, large amounts of storage space, or refrigerators within their storage space. One rural Minnesota county used a novel approach to solve this problem, electing to use a regional storage area for the restricted kits in the county.⁸⁵ The small police departments within the county were concerned that their evidence rooms would have to purchase refrigerators or purchase more refrigerators in order to store the restricted kits. Law enforcement was also concerned that victims might not remember which specific township they had been assaulted in, if they chose to convert their case to a standard report in the future and needed to locate the kit. As a result of these concerns, and after several conversations, the Sheriff's Office offered to store all restricted kits collected in the county, no matter which police department might have jurisdiction over the crime if it was later investigated.

The Sheriff's Office felt comfortable making this offer for several reasons. In this county, the Sheriff's Office is the county entity designated to pay for the exam under Minnesota statute.⁸⁶ The Sheriff's Office possessed a larger evidence room and more refrigerators than any other agency, and employed a full-time evidence technician. One central storage location in the county ensures that victims have only one point of contact if they decide to convert their case later on. Unlike the police departments within the county, the Sheriff's Office has multiple deputies on duty at any time, and is therefore able to respond to the county's hospitals within a reasonable period of time, to transport and store a restricted kit. Finally, the Sheriff's Office has a history of providing assistance to the police departments within the county, so assisting in this way was accepted.

As a result, this jurisdiction is closer to fulfilling the spirit of the law with regard to forensic compliance, because they instituted a policy that meets the needs of victims, ensures the integrity and viability of the potential evidence, and takes advantage of the unique features and resources of their community. It is also clearly a credit to the collaborative leadership of this particular Sheriff's Office.⁸⁷

⁸⁵ Goodhue County, Minnesota.

⁸⁶ See Minn. Stat. §609.35 (2003) subd. 1. See also Part VI. A, discussing exam payment in general.

⁸⁷ Credit for leading this collaborative effort must be given to Captain Pat Thompson, Goodhue County Sheriff's Office, Red Wing, Minnesota, and all members of the Goodhue County Sexual Assault Multidisciplinary Action Response Team (SMART).

Conclusion

Ensuring victim access the medical forensic exam without a report to law enforcement is meaningless if the evidence collected is not stored in such a way that preserves both the integrity and viability of the evidence. Therefore, Minnesota jurisdictions must strive to establish storage locations for restricted kits or other evidence collected in restricted cases that can ensure evidence will be able to be used as it was intended: to corroborate a victim's story, to be viable for DNA or toxicology analysis, and increase the chance of obtaining a conviction, if the victim chooses to convert the case.

e. restricted kit storage duration

“you should have more time to decide whether you want to report a sexual assault, perhaps the most difficult decision of your life, than you have to decide whether to return a pair of shoes.”⁸⁸



For what period of time will your jurisdiction store restricted kits or additional evidence from restricted cases?

There is no federal or Minnesota law that dictates how long restricted kits or additional evidence collected in restricted cases must be kept. Because the VAWA 2005 forensic compliance mandates went into effect in January 2009, there has not been time to conduct research on what period of time might be considered sufficient for most victims to seek help, weigh options and convert their case to a standard report if they so choose. In the absence of clear legislative or research-based guidance, Minnesota jurisdictions must set their own policies on storage duration.

We ask Minnesota jurisdictions pondering this issue to approach the problem through multidisciplinary conversations focusing on three main considerations:

- If you’ve decided that restricted kits will be stored with law enforcement agencies, is it possible to store those kits for a period of time consistent with that agency’s established **evidence-retention policies**? What is the agency’s established evidence-retention policy for similar types of evidence?
- No matter where you’ve decided that restricted kits will be stored, is it possible to store restricted kits for the **minimum period of time of eighteen months** recommended by SVJI @ MNCASA?
- Is it possible for your jurisdiction to store restricted kits for the **statute of limitations**?

Each of these considerations is explored in a frequently-asked question format below.

⁸⁸ Lindsay Gullingsrud, Sexual Violence Prevention Coordinator, Minnesota Coalition Against Sexual Assault.



Is there federal or Minnesota law or policy that sets storage duration for restricted kits?

No, there is no federal or Minnesota law on the storage duration for restricted kits or additional evidence collected in restricted cases. There is Minnesota law that addresses the retention of evidence in cases where a conviction has been obtained.⁸⁹

For evidence collected in cases which are unsolved, pending, or awaiting disposition, retention policies differ across Minnesota law enforcement agencies. For instance, in Ramsey County, a model evidence retention policy calls for retaining the biological evidence in a criminal sexual conduct case (1st to 3rd degree) permanently if the case may be chargeable when the DNA was identified.⁹⁰ We recommend that your multidisciplinary team engage local law enforcement agencies to determine what the evidence retention policy may be for similar evidence (i.e., sexual assault evidence collection kits in reported cases that may be pending, where no suspect has been identified, etc.).

We've heard that in some other states, restricted kits are kept for the statute of limitations. Is this true?

Yes, this is true. The statute of limitations is a law that establishes a time limit for prosecuting a crime, based on the date the offense occurred and other factors.⁹¹ In a national survey in early 2008, twenty-seven percent of respondents reported their states store evidence from restricted cases for the statute of limitations. Some of our neighboring states, Iowa and North Dakota, are among those that retain restricted evidence for the statute of limitations. In Iowa, this policy is codified in statute:



⁸⁹ For instance, Minn. Stat. § 590.10 provides, "All government agencies must retain and preserve any biological evidence relating to identification of a defendant that is used to secure a conviction in a criminal case *until expiration of the individual's sentence*, unless earlier disposition is authorized by court order. However, the agencies need only retain the portion of the specimen that was used to obtain an accurate biological sample used to obtain a conviction. Failure to retain the evidence may result in sanctions to the appropriate party."

⁹⁰ See Ramsey County Uniform Evidence Retention Policy available at <http://www.co.ramsey.mn.us/NR/rdonlyres/CFFF14C4-0F44-4BD9-9995-0186E9C17085/15111/RamseyCountyEvidenceRetentionPolicy1.pdf> (last visited March 18, 2011)

⁹¹ BLACK'S LAW DICTIONARY, 8th ed., 2004 at 1451. Only the statute of limitations for criminal matters is discussed here. The statute of limitations for civil matters is beyond the scope of this document. The purpose of a criminal statute of limitations is to limit exposure to criminal prosecution to a certain fixed period of time following the occurrence of those acts the legislature had decided to punish by criminal sanctions. Such a limitation is designed to protect individuals from having to defend themselves against charges where the basic facts have become obscured by the passage of time and to minimize the danger of official punishment because of acts in the far-distant past. Such a time limit may also have the salutary effect of encouraging law enforcement officials promptly to investigate suspected criminal activity. *Toussie v. United States*, 397 U.S. 112 (1970).



Iowa Code § 709.10 SEXUAL ABUSE – EVIDENCE (2004).

When an alleged victim of sexual abuse consents to undergo a sexual abuse examination and to having the evidence preserved, a sexual abuse evidence collection kit must be collected and properly stored with the law enforcement agency under whose jurisdiction the offense occurred or with the agency collecting the evidence to ensure that the chain of custody is complete and sufficient.

If an alleged victim of sexual abuse has not filed a complaint and a sexual abuse evidence collection kit has been completed, the kit must be stored by the law enforcement agency for a **minimum of ten years**. In addition, if the alleged victim does not want their name recorded on the sexual abuse collection kit, a case number or other identifying information shall be assigned to the kit in place of the name of the alleged victim.⁹²

A retention period of ten years is consistent with the longest statute of limitations available for certain instances of sexual assault in Iowa.⁹³

In North Dakota, the policy has not yet been codified in statute, but is articulated in recommended policies for law enforcement. This policy states:

“Sexual assault evidence collected from non-investigated cases should be kept by law enforcement for a minimum of seven years or until the victim turns twenty-two, whichever occurs later.”⁹⁴

A retention period of seven years is consistent with the longest statute of limitations available for certain instances of sexual assault in North Dakota.⁹⁵

Thus, other jurisdictions have concluded that storage of restricted kits for the maximum period of time allowable under statute of limitations is good policy.

⁹² See Maryland Coalition Against Sexual Assault, *Ensuring Forensic Medical Exams for All Sexual Assault Victims A Toolkit for States and Territories* available at http://www.mcasa.org/uploads/docs/mcasa_toolit_final.pdf (last visited March 21, 2011).

⁹³ See IOWA CODE § 802.2 (2007).

⁹⁴ North Dakota Forensic Medical Examination Multidisciplinary Working Group, *Recommended Law Enforcement Practices: Transportation, Tracking and Storage of Forensic Evidence in Sexual Assault Cases*.

⁹⁵ See NDCC § 29-04-03.1 (2009).



What is the statute of limitations for sexual assault cases in Minnesota?

Determining the statute of limitations that may apply to any individual incident of sexual assault in Minnesota is difficult; always consult with a prosecutor before advising a victim what statute of limitations may apply to his or her individual case. The question of whether the statute of limitations has passed depends on many factors associated with the incident. For instance, the statute of limitations may be tolled, or temporarily stopped, if certain facts have occurred, such as the perpetrator living outside of Minnesota for a period of time.⁹⁶ Minn. Stat. § 628.26 subdivisions (e), (f) and (k) apply to the statute of limitations in criminal sexual conduct cases.

(e) Indictments or complaints for violation of sections 609.342 to 609.345 if the victim was under the age of 18 years at the time the offense was committed, shall be found or made and filed in the proper court within the later of nine years after the commission of the offense or three years after the offense was reported to law enforcement authorities.

(f) Notwithstanding the limitations in paragraph (e), indictments or complaints for violation of sections 609.342 to 609.344 may be found or made and filed in the proper court **at any time after commission of the offense, if physical evidence is collected and preserved that is capable of being tested for its DNA characteristics.** If this evidence is not collected and preserved and the victim was 18 years old or older at the time of the offense, the prosecution must be commenced within nine years after the commission of the offense.

(k) In all other cases, indictments or complaints shall be found or made and filed in the proper court within three years after the commission of the offense.⁹⁷

Thus, criminal charges may be filed **at any time** if physical evidence is collected and preserved that is capable of being tested for its DNA characteristics, and if the crime would be charged as 1st, 2nd, or 3rd degree Criminal Sexual Conduct. It will be difficult, if not impossible, to know at the time of the medical forensic examination whether a restricted case would be charged as 1st, 2nd or 3rd degree criminal sexual conduct, but because evidence is being collected at that time that is capable of being tested for its DNA characteristics, we encourage your jurisdiction to discuss whether retention of restricted kits for the statute of limitations is possible. The benefits and challenges associated with a policy such as this are discussed here.

⁹⁶ See Minn. Stat. 628.26 (subd. 1), providing: The limitations periods contained in this section shall exclude any period of time during which the defendant was not an inhabitant of or usually resident within this state.

⁹⁷ Emphasis added.



What are the benefits and challenges to storing restricted kits or additional evidence in restricted cases for the statute of limitations?

Promotes justice for victims and defendants

The first benefit to a policy that stores restricted kits or other evidence collected in restricted cases perpetually is that it may be considered victim-centered. Because a policy like this provides ample time for victims to convert the case to a standard report, it allows for the various events in victim's lives that may act as a trigger to convert their case to a standard report. As discussed at length in Part III, there are many factors that go into a victim's decision whether to report the case, and there are many events in a victim's life that may remind the victim of the assault, or encourage a report. Some victims may need a significant period of time to alter their circumstances in such a way to feel comfortable reporting the case to law enforcement. Many advocates, law enforcement officers and prosecutors recall anecdotes where victims have reported to law enforcement years after an incident; some of these cases have resulted in a conviction.⁹⁸ Another benefit to a policy like this is that it may promote justice for defendants if the victim chooses to convert the case. By retaining evidence for a long period of time, the evidence could be used to exonerate someone in a serious crime, in the same way it could be used to implicate someone in a serious crime.

Benefit to law enforcement and prosecutors

Law enforcement officers and prosecutors may be reluctant to destroy evidence that has been collected before the statute of limitations has expired, understanding its potential to increase the chances of a conviction if the victim chooses to convert the case in the future. Many prosecutors speak of a phenomenon known as the "CSI effect," or a heightened expectation among jurors in criminal matters that in order to convict a defendant, DNA evidence must exist. While studies debate how influential the CSI effect may really be,⁹⁹ most prosecutors would agree that they would rather have a kit available for testing than not.

Another benefit to a policy that stores evidence from restricted cases for the statute of limitations is that some counties may feel as though they have a fiscal investment in the potential evidence within the restricted kit. Others may find it irresponsible to quickly destroy evidence which may, if the victim chooses to convert the case, implicate someone in a serious crime.

⁹⁸ For instance, the author worked as a court advocate on a case where the victim, assaulted numerous times as a teenager by a family friend, reported the assaults to law enforcement following a trip back to her hometown, where she had a chance meeting with the perpetrator at a store. The trauma sparked by this chance meeting triggered the victim to report the assaults, even though it had been more than ten years since the last incident. During a pre-text phone call arranged by the police where the victim confronted the perpetrator, the perpetrator admitted to assaulting her, as well as several other young women. The perpetrator was ultimately convicted of multiple felony counts. An article about this case is available here: http://azdailysun.com/article_f6d31479-26f0-5b29-9a62-63c0fa2bf406.html?mode=comments (last visited February 22, 2011).

⁹⁹ See e.g., Hon. Donald Shelton, et al., A Study of Juror Expectations and Demands Concerning Scientific Evidence: Does the "CSI Effect" Exist? 9 VANDERBILT JOURNAL OF ENTERTAINMENT AND TECHNOLOGY LAW, available at <http://law.vanderbilt.edu/publications/journal-entertainment-technology-law/archive/index.aspx> (last visited March 16, 2011).

Accounts for advances in technology

A policy that retains restricted kits for the statute of limitations is responsible because it preserves evidence, allowing it to be analyzed using ever-improving technological and investigative tools. Because we are not able to predict what types of tools may be developed that make the analysis of this evidence more efficient or more precise, it stands to reason that potential evidence should be retained for the maximum amount of time possible.

Meets the spirit of VAWA 2005

Some of the purposes of VAWA 2005 forensic compliance mandates include increasing victim access to justice by changing the way victims of sexual assault may seek medical forensic care, and by changing the way we permit victims to report the sexual assault to law enforcement. Logic dictates that the longer we keep evidence, the more victims we may have convert the case. Increasing the number of sexual assaults reported to law enforcement is clearly one of the statutory purposes of VAWA 2005.

What are the challenges to storing evidence from restricted cases for the statute of limitations?

Agencies that have agreed to store evidence from restricted cases may find the perpetual storage of such evidence impossible due to legitimate concerns over available space and financial resources. If it is impossible for the agency within your jurisdiction to store these kits for the statute of limitations, then consider another length of time that is feasible for the agency yet will still retain the restricted evidence for at least eighteen months to allow victims time to convert the case.

For more information on how the statute of limitations may be applied to criminal sexual conduct cases, please see Appendix F: MNCASA Fact Sheet: Statute of Limitations Criminal Sexual Conduct.



Why a minimum of eighteen (18) months?

Over the course of SVJI's Forensic Compliance Project, numerous advocates, survivors, law enforcement officers, prosecutors and healthcare professionals have been asked for their opinions on what period of time might be sufficient for most victims to convert the case. It's difficult, if not impossible, to set a period of time that will be sufficient for all sexual assault victims. Some victims may decide early on that reporting the assault is not the best decision for them, while others may experience a triggering event months, or even years later, that will prompt them to convert at that time.

We also heard from both advocates and victims that the anniversary of the assault is often a triggering event. An anniversary may prompt a victim to come forward, seek help for the first time or in a new way, or consider converting their case to a standard report. Thus, retaining restricted kits for a minimum of eighteen months may allow victims sufficient time after the one-year anniversary of the assault to seek help, and have time to convert the case.



Won't the evidence be worthless (degraded) if it's stored for eighteen months or longer?

No. If biologic evidence is properly collected, dried and stored, it can be successfully analyzed decades after being collected.¹⁰⁰

Our policy is to keep restricted kits as long as we have available storage space. Is this an acceptable policy?

No, this type of policy is not acceptable. A policy like this is unpredictable and will result in victims being treated inconsistently. Victims deserve clear information on which to base their decision to report the assault to law enforcement; a policy that can only guarantee that a restricted kit will kept "as long as we have room" is therefore unacceptable.



Conclusion

Restricted kits or other evidence collected in restricted cases must be stored for a period of time that provides victims with sufficient time to learn about, weigh, and potentially pursue their option to convert the case to a standard report. Such evidence is invaluable and may lead to the conviction or exoneration of someone in a serious felony, should the victim choose to convert the case.

There is no guidance from VAWA 2005 or Minnesota law on exactly how long restricted evidence must be kept. In addition, there has not been sufficient time to conduct research studies to determine what period of time most victims might consider sufficient. Thus, Minnesota jurisdictions must set their own policies on storage duration.

We encourage your multidisciplinary team to consider whether it is possible to store evidence collected in restricted kits for the maximum period of time set by the statute of limitations. In Minnesota, there is no statute of limitations for cases that may be charged as criminal sexual conduct in the 1st, 2nd or 3rd degree and where evidence has been collected that is capable of being tested for its DNA characteristics. A policy like this would have several benefits. First, it would provide victims with ample time to obtain a change in their circumstances, like moving away from home, to feel comfortable to convert their case. Law enforcement and prosecutors may be hesitant to destroy evidence that has been collected prior to the statute of limitations, understanding its potential to increase the chances of a conviction if the victim chooses to convert the case in the future. Other states, like Iowa and North Dakota, have determined that storing restricted kits for the maximum statute of limitations is good policy.

If this approach isn't possible for your jurisdiction, then we recommend establishing another storage policy that retains restricted evidence for at least eighteen months. The one year anniversary of the assault is often a triggering event for victims. Ensuring these kits are kept beyond the one-year

¹⁰⁰ Interview with Kate Lentz-Lockhart, Forensic Scientist, Minnesota Bureau of Criminal Apprehension, February 1, 2011.

anniversary of the assault may be sufficient for the majority of victims to seek help, learn about their options and get into contact with those who can help them convert their case to a standard report. **Policies that retain these kits longer than eighteen months are strongly recommended.**

Of course, whatever storage duration is chosen by your jurisdiction should be put into written policies, and all responders should be educated on that policy.

f. case conversion

Case conversion is the term used to describe the victim-initiated process of changing what began as an unreported case to a case that is reported to law enforcement (a “standard” report). Depending on the terminology used in the jurisdiction, this might mean that the victim is electing to change an “anonymous” report to a “standard” report to request that law enforcement now conduct an investigation.



How will your jurisdiction ensure that case conversion is a realistic, accessible option for victims?

Minnesota jurisdictions must establish written policies explaining how victims can change a restricted case to a standard report (case conversion). Case conversion should be made as simple as possible for victims. Case conversion policies must be communicated with victims both verbally and in writing. Clear, written case conversion policies are essential to meeting the spirit of forensic compliance mandates. Only if case conversion policies are well-articulated and well-known to victims will victims utilize the option to convert. Only if case conversion policies are written and approved in a multi-disciplinary framework will they be respected, followed and considered legitimate by all participants in the criminal justice system.

The type of conversion process you put into place will depend on the resources you have available in your jurisdiction. A multidisciplinary group must consider the following factors in order to develop a process that will work for the victims and professionals in your jurisdiction, and articulate the answers in a written format.

1. Who will the victim contact to convert the report?

Consider which agency in your jurisdiction is best-equipped to assist victims with a case conversion. For example, does the advocacy program in your jurisdiction have the ability to take calls or in-person appointments with victims in order to convert a case? If your jurisdiction is storing restricted kits with law enforcement, will law enforcement be the point of contact for victims hoping to convert the case?

We recommend selecting an agency that has the ability to respond to a victim’s call 24 hours a day, 7 days a week. Selecting an agency that has limited live response capabilities isn’t recommended. For example, requiring victims to leave a message on voicemail in order to convert a case, or limiting case conversion to standard business hours (i.e., Monday – Friday, 9 – 5) won’t achieve the level of response most victims will be comfortable with.

We also recommend that the selected agency’s employees are well-versed in victim’s rights, and who can answer frequently asked questions that sexual assault victims may have about the criminal justice system, safety and alternative reporting options.

Finally, due to frequent employee turnover in all agencies, we recommend designating a *position*, not an *individual*, as the point of contact for case conversions. For example, in the written information provided to victims, the point of contact should read something like this: “In order to convert your case to a standard report in the future, a process which will release evidence to law enforcement and permit law enforcement to conduct an investigation into the assault, please call the Director of Advocacy Services with Agency Y at the following number.”

2. How will the victim make the connection?

Consider how the victim will make the connection with the selected agency. Will there be a designated phone number that victims will call or a designated email address where a message may be sent? Is it possible to establish a toll-free number for this purpose? Is it possible to include information about the case conversation procedure on an agency’s website?

3. How will the restricted kit collected be linked to a converted report?

Ensuring that any evidence collected during the medical forensic examination is easily located and linked to converted case will take some planning. For example, if restricted kits in your jurisdiction will be stored with medical facilities, how will a kit be located and transported to law enforcement once the victim converts the case? Will the victim be asked to sign a release of information or a consent form releasing the kit or any additional evidence to law enforcement at that time? If so, who will explain the release or consent form? Who will call law enforcement to take custody of the kit at that time?

4. What information will the victim need in order to convert the case?

Consider what information the victim will need during his or her initial call or visit to convert the case. Will the victim need the date and time when the medical forensic examination, if any, was conducted? Will the victim need a medical chart number or another number that may have been used to inventory or store the restricted kit or additional items of evidence that may have been collected? It is best practice to include any information the victim will be asked to provide on the written pocket card provided to the victim (see below).

5. Will victims be notified prior to kit destruction?

Consider the feasibility of contacting victims prior to the expiration of time to convert the case. For instance, in one jurisdiction that stores kits for eighteen months, the advocacy program contacts victims whose kits have been stored for just over twelve months. Victims are reminded of the deadline and that the kit will be destroyed at the eighteen-month mark if the victim does not convert prior to then. At this time, victims are again offered advocacy services, counseling or other options that they may need to facilitate their recovery. Other jurisdictions, due to a large volume of restricted cases, have decided contacting all victims is not feasible. Some jurisdictions have decided that contacting victims prior to kit destruction is not victim-centered, due to the potential risks associated with it. Those risks are explored here.

Opt-out provision, contact preferences and information sharing

If this is a service your jurisdiction decides to offer, victims must be aware of your intent to do so, and must be offered the opportunity to opt out of notification. We encourage providing a short description of the notification process into the hospital’s medical forensic examination consent

form, along with a description of how victims can opt out of notification. Victims choosing to be notified prior to kit destruction should also have control over *how* they will be contacted: by phone, by email, or by mail. The opportunity for the victim to opt out should be available *at any time* after the exam. Consider who a victim could contact at some point in the future to opt out of notification.

Additionally, your multidisciplinary team, along with hospital legal counsel, must carefully consider how victim contact information will be shared between the hospital and the agency chosen to notify the victim (if different from the hospital). For instance, if an advocacy agency is chosen to notify victims, how will the advocacy agency receive the victim's contact information, and is it possible for information sharing of this type to comply with HIPAA provisions?¹⁰¹ One way to address this might be to include the plan to share information in the medical forensic examination consent form, along with the additional recommendations above.

Carefully craft notification language

Because there is no way to contact victims that will perfectly protect their confidentiality, take time to carefully craft what language your jurisdiction will use when calling or writing to victims about kit destruction. The language used should be vague enough to protect victim confidentiality in the event the call or letter is received by someone other than the victim, but specific enough so that victims are aware of the reason for the notification. Such language might look like this:



"Dear Client,

We are contacting you in order to notify you of an important deadline. On April 30, 2009, you were provided with some assistance from our agency. On that day, you were told that you would have until October 30, 2011 to decide whether to move forward. We have not heard from you. If we do not hear from you before October 30, 2011, important information will be destroyed, and will not be available in the future. For more information about how to move forward, or more information on your options, please contact us at the following number.

Sincerely,
Agency Name"

6. What should be included in the written information to victims about the case conversion?

Victims should be provided some sort of written information to help make case conversion process more feasible. Some jurisdictions have decided to provide victims with a business card or small "pocket card" that explains the case conversion process and explains how the victim can go about making the connection and identifying herself. Providing some information in writing will allow victims to return to the information at a later date to be reminded about his or her options. Like all written information created for victims, efforts should be taken to translate those materials for individuals who may not speak English.

¹⁰¹ HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. For general information on HIPAA, see <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html> (last visited on March 10, 2011). Because HIPAA regulations are complicated, it is always best practice to consult with your local hospital's legal counsel whenever the sharing of information about patients between agencies is contemplated.

Ideally, the written information should contain the following:

- phone number for local advocacy agency, to encourage victim to reach out for more information;
- phone number, email address and contact name for the victim to call to initiate case conversion (if different from local advocacy agency);
- date victim was seen for the medical forensic exam;
- name of the medical facility providing the exam;
- location where the restricted kit will be stored;
- duration of restricted kit storage, or date of restricted kit destruction;
- whether the victim can expect a reminder phone call, email or letter about kit destruction and how to opt out of this at any time; and
- brief description of what the victim can expect when initiating the conversion process.

In addition, some jurisdictions have chosen to include information that is meant to be educational on the possible drawbacks of waiting to report the assault, and possible benefits to prompt reporting. If your jurisdiction chooses to include information like this, be careful of the tone used. Victims receive many societal and internal messages on the possible difficulty of reporting their assault to the police. It is important that any written information should communicate to victims that they will be believed and treated with respect if they choose to convert the case. For example, such information might read:



"Deciding to report a sexual assault to the police can be a difficult decision. If you decide to change your case to a standard report, please be aware that it may be more difficult to investigate the assault as more time goes by. If you decide to report the assault to law enforcement, we are ready to hear your concerns, and every effort will be taken to ensure a complete investigation is conducted. For more information on reporting the assault to law enforcement, we encourage you to contact your local advocacy program at #."¹⁰²

Another example reads:

"The healthcare professional will provide an information card to the victim. The information card will contain the following information:
The anonymous identifying (ICR) number of evidentiary kit;
Date of the exam and length of time evidence will be held;
Contact phone number for the Goodhue County Sheriff's Office, the agency responsible for holding the evidence;
Instructions on how to proceed should victim/patient decide to report to law enforcement; and
Name and contact information for advocacy support agencies."¹⁰³



¹⁰² This language was adapted from a note card provided to victims who complete a restricted kit in Maine.

¹⁰³ This model policy on what written information on case conversion will be provided to victims was adapted from the Goodhue County Adult Sexual Assault Response Protocol, created by the Goodhue County Sexual Assault Multidisciplinary Action Response Team (SMART), February 1, 2011.

The information card will look like this:

Front

THIS IS THE IDENTIFICATION NUMBER OF YOUR RESTRICTED KIT.
YOU WILL BE ASKED TO PROVIDE THIS NUMBER IF YOU DECIDE TO
REPORT THE CASE TO LAW ENFORCEMENT IN THE FUTURE:

_____ (ICR #) _____

THIS IS THE DATE YOUR RESTRICTED KIT WILL BE DESTROYED
UNLESS WE HEAR FROM YOU (SEE REVERSE).
YOU WILL NOT BE CONTACTED TO REMIND YOU OF THIS DATE.

_____ (DATE) _____

Back

IF YOU NEED IMMEDIATE EMERGENCY HELP,
CALL 911

IF YOU DECIDE TO REPORT THE CASE TO LAW ENFORCEMENT,
CALL GOODHUE COUNTY SHERIFF'S OFFICE AT #

IF YOU NEED MORE INFORMATION OR SUPPORT,
CALL THE CONFIDENTIAL SUPPORT LINE AT #



"If you decide you would like to make a standard report to law enforcement, you should call the SANE Program at #. You will need to sign a release allowing the SANE Program to provide your identifying information and other documentation and evidence from your exam to law enforcement. If you decide you do not wish to go forward and would like the evidence from your exam to be destroyed, you should call the SANE Program at #. Physical evidence will be held by the law enforcement agency for a minimum of eighteen months. Before destroying any evidence, law enforcement agency will contact the SANE Program and the SANE Program will make reasonable attempts to contact you. For this reason, it is your responsibility to update your contact information with the SANE Program. The SANE Program is not responsible for loss or destruction of evidence held by law enforcement.

Preferred method of contact – please complete all that apply:
Landline phone :Caller can leave a message? Yes ____ No ____

Cell phone: Caller can leave a message? Yes ____ No ____
Email address: Please be sure your email account allows you to receive emails from this email address:
Standard mail:

“ 104



Our jurisdiction has never seen a victim convert a case. How many victims choose to convert?

Although there is not a lot of information available on how many victims will convert their case or *when* a conversion is likely to take place, it is clear that when victims are provided with accurate information from which to make an informed decision, time, and access to advocacy services, some victims will convert their case to a standard report.

To date, the only published data on case conversion comes from the United States military. The U.S. military also uses the terms “restricted” to mean a case where the victim has not yet decided whether to involve law enforcement and the term “unrestricted” to mean a standard report. The ability for victims on military bases to make a restricted report was implemented in 2005. In that first year, the Department of Defense found that twenty-five percent of victims who initially used the restricted reporting process later chose to convert to unrestricted, or standard, reports. Data from 2008 suggest that approximately fourteen percent of service members who initially filed a restricted report in 2008 later converted to a standard report.¹⁰⁵ Because these numbers are isolated to unique populations, the results may not be able to be generalized to the public; however, this data is the first published data available showing how many victims may convert the case.

There is also some preliminary data available from Florida and Minnesota. In one Florida county with a population of close to a million residents, 61 restricted kits were collected between 2007 and 2009. Of that number, 15 were later converted to a standard report, a twenty-five percent conversion rate. In 2010, a Twin Cities SANE Program conducted 164 sexual assault evidence collection kits. Of that number, 156 were reported to law enforcement, and eight were restricted. Of the eight restricted kits, two victims converted, also a twenty-five percent conversion rate.¹⁰⁶

If your jurisdiction has never seen a victim convert a case, we recommend your multidisciplinary team examine how victim-centered your case conversion process may be, by reviewing the factors

¹⁰⁴ Adapted from “Reporting Options,” Program for Aid to Victims of Sexual Assault, St. Louis County, Minnesota.

¹⁰⁵ Sabrina Garcia, Margaret Henderson, Options for Reporting Sexual Violence, FBI Law Enforcement Bulletin, available at <http://www.fbi.gov/stats-services/publications/law-enforcement-bulletin/May-2010/options-for-reporting-sexual-violence> (last visited December 27, 2010) citing Department of Defense Report of Sexual Assaults in CY 2005 at <http://www.sapr.mil/contents/references/2005%20RTC%20Sexual%20Assaults.pdf>. This number may be elevated, however, because within the military, some conversions are permitted by third parties, not just the victim. For instance, in some cases, the conversion may have been initiated by a superior officer made aware of the assault. When establishing a case conversion process in your jurisdiction, it is not recommended to permit anyone other than the victim to convert the case.

¹⁰⁶ Unity Hospital SANE Program statistics, Allina Hospital systems, 2010.

recommended above. For example, are all responders within your jurisdiction aware of a victim's ability to convert? Are victims being provided ample time to convert? If your jurisdiction only offers a short window (less than eighteen months) before destroying the evidence, that period of time needs to be extended. Are victims well-educated about the ability to convert? How is information about the process being conveyed to victims?

Conclusion

Victim-centered case conversion policies must be put into place in order to meet the spirit of VAWA 2005. When discussing what type of a case conversion policy to establish, your multidisciplinary team must consider the factors and model policies provided above. Case conversion policies must be incorporated into other written policies on sexual assault response, and efforts to continually educate all responders and victims choosing restricted reports about the case conversion policy should be made.

g. submitting restricted kits for dna or toxicology analysis



How will your jurisdiction ensure that restricted kits or other evidence collected in restricted cases is not submitted to the Bureau of Criminal Apprehension or another regional crime laboratory for DNA or toxicology analysis?

"DNA analysis" means the process through which deoxyribonucleic acid (DNA) in a human biological specimen is analyzed and compared with DNA from another human biological specimen for identification purposes.¹⁰⁷

There are no provisions in either VAWA 2005 or Minnesota law requiring the submission or DNA or toxicology analysis of restricted kits. In fact, this practice is strongly discouraged. Submitting evidentiary kits to the BCA without the consent or knowledge of the victim is contrary to the spirit of both VAWA 2005 and Minnesota law, and raises other significant concerns explained here.

Minnesota Bureau of Criminal Apprehension Will Not Accept Restricted Kits

First, the practice of submitting restricted kits for analysis is not recommended because it is contrary to established BCA policy and Minnesota law.

The BCA Evidence Handling Manual states:

The laboratory will receive and examine evidence submitted by any law enforcement agency, medical examiner office and on occasion from county attorney investigators who are investigating a potential criminal action within the State of Minnesota. Evidence is also accepted from agencies outside the State of Minnesota with whom the laboratory has special agreements. The acceptance of evidence from other entities is at the discretion of the Director or as ordered by the courts.

Evidence will not be accepted from private individuals.

If the case is **non-criminal**, not capable of being charged criminally, or not probative in a cause of death determination, the laboratory may decline to examine the evidence.

¹⁰⁷ Minn. Stat. §299C.155 subd. 1 (2005).

The bureau shall perform DNA analysis and make data obtained available to law enforcement officials in connection with *criminal investigations* in which human biological specimens have been recovered. Upon request, the bureau shall also make the data available to the prosecutor and the subject of the data in any subsequent *criminal prosecution* of the subject. The results of the bureau's DNA analysis and related records are private data on individuals, as that term is defined in section 13.02, and may only be used for law enforcement identification purposes.

BCA policy and statute make it clear that the BCA only accepts evidence which has been submitted by law enforcement agencies or forwarded by county attorney's offices connected with *criminal investigations* or *criminal prosecutions*. Because restricted kits are not yet connected with criminal investigations, but only have the *potential* to be connected with criminal investigations in the future if the victim chooses, restricted kits should never be submitted for analysis.

BCA resources will be wasted if restricted kits are submitted for analysis. It will take evidence custodians time to sort restricted kits that have been mistakenly submitted from those associated with active criminal investigations. Further time will be wasted by contacting the submitting party, and returning the evidence to them. Each time the evidence is handled, chain of custody must be maintained. Each time the evidence is transported, there is the risk that temperature changes will degrade the samples contained within.

Contrary to spirit of VAWA 2005

Submitting restricted kits to the BCA for analysis is also contrary to the spirit of VAWA 2005 because that practice could compromise victim safety and autonomy. As discussed above, VAWA 2005 requires states to ensure that survivors of sexual assault are not obliged to "participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam . . ." Submitting and analyzing kits from restricted cases would require, at some level, victim cooperation with law enforcement. If a kit is analyzed, and a DNA profile is obtained and entered into the FBI's Combined DNA Index System (CODIS), there could be a match linking the DNA profile to a known person/offender. CODIS is a computer software program that operates local, state, and national databases of DNA profiles from convicted offenders, unsolved crime scene evidence, and missing persons for the purposes of solving crime.¹⁰⁸ Such a match is often called a "hit."

If a "hit" is obtained, victims could be forced to cooperate with prosecution. Some jurisdictions across the nation have justified the processing of restricted kits by citing the public safety interest in identifying serial rapists. While this is a valid interest, it must be balanced with the individual wishes and safety concerns of the victim, and the victim's right to an exam without cooperating with law enforcement under both federal and Minnesota law. If this practice was put into place, many follow-up questions emerge. For instance, if the kit from an unreported case is processed and

¹⁰⁸ See U.S. Department of Justice, DNA Initiative <http://www.dna.gov/solving-crimes/cold-cases/howdatabasesaid/codis/> (last visited March 16, 2011).

produces a “hit,” how will the victim be contacted? If the victim is still hesitant to cooperate, what would be the response from law enforcement or prosecution? Is it possible that a case would be pursued without the victim’s cooperation, and if so, at what cost to the victim? This practice could compromise victims’ healthcare privacy and wishes, negatively affecting their emotional and physical well-being and diminishing the advancements spurred by VAWA 2005. Our national partners share the concern that strong victim-centered provisions should be in place *prior* to establishing a policy to analyze restricted kits.¹⁰⁹ No such provisions are currently in place in Minnesota.

Further, if victims are aware that the kits will be processed whether or not they report the assault to law enforcement, they might be deterred from seeking critical medical care following an assault. This result would be a direct violation of the intent of VAWA 2005. Victims deserve to be correctly informed of what will happen to restricted kits.



We’ve heard a lot about cold cases and rape kit backlogs recently. What do cold cases and rape kit backlogs have to do with the forensic compliance mandates?

Cold Cases

Considerable media attention has been given to cold cases both nationally and in Minnesota. A cold case is a case that has been reported to law enforcement, but has gone unsolved. Initiatives have been taken to reduce the number of unsolved cases. For example, the Hennepin County Attorney’s Office received a federal grant to re-examine certain unsolved criminal sexual conduct cases. The re-examination focused on criminal sexual conduct cases which were reported within Hennepin County since 1991 and where the biological evidence had never been submitted to or analyzed by the Minnesota Bureau of Criminal Apprehension (BCA).¹¹⁰

Cold cases have little to do with forensic compliance mandates. The re-examination of cold cases is focused on cases that have been *reported to law enforcement*, but have remained unsolved for a variety of reasons. Because the victim has chosen to involve law enforcement in these cases, it is appropriate for law enforcement to conduct an investigation and submit biological evidence to the BCA for analysis in the course of the investigation. As discussed above, it is inappropriate to submit restricted kits or additional evidence from restricted cases to the BCA for analysis for numerous reasons, like wasting resources or jeopardizing victim safety and autonomy. Restricted kits or cases are not, and should not, be considered “cold cases.”

¹⁰⁹ See Maryland Coalition Against Sexual Assault, *Ensuring Forensic Medical Exams for All Sexual Assault Victims: A Toolkit for States and Territories*, available at http://www.mcasa.org/uploads/docs/MCASA_ToolKit_FINAL.pdf (last visited Dec. 7, 2009) at 35.

¹¹⁰ Steve Redding, *Cold Cases: DNA Evidence and Sexual Assault*, presented at Key Issues in the Prosecution of Sexual Assault Cases, July 21, 2010. Unsolved homicides from that time period were also re-examined.

Rape Kit Backlogs

Considerable media and legislative attention has also been given to the issue of “rape kit backlogs” across the nation.¹¹¹ A backlog results when evidentiary kits from *reported* sexual assault cases are not submitted to crime labs for analysis. There are many reasons why kits may not be submitted for analysis. Recently, Minnesota Senator Al Franken and other members of the legislature have introduced legislation targeted at reducing these backlogs. In addition, the federal government has issued a special grant opportunity dedicated to conducting inventories of backlogs in several cities across the nation, in order to understand the reasons why kits may not have been submitted and to develop best practice on the issue.

Like cold cases, rape kit backlogs have little to do with forensic compliance mandates. Backlogs result from the failure to submit evidence kits collected in sexual assault cases that have been *reported to law enforcement*. Because the victim has chosen to involve law enforcement in these cases, it is appropriate for law enforcement to conduct an investigation and submit biological evidence to the BCA for analysis in the course of the investigation. To date, the term “backlog” does not refer to restricted kits being stored with various agencies. SVJI @ MNCASA has been working with Senator Franken’s office, among others, to ensure that any efforts taken to reduce rape kit backlogs through the submission and analyzing of kits do not mistakenly or intentionally include *restricted* kits in that effort. For the reasons described at length above, it is never appropriate to submit restricted kits for analysis by the Bureau of Criminal Apprehension.

Conclusion

Your jurisdiction must ensure that restricted kits and other evidence collected in restricted kits is not submitted to the BCA or another regional crime laboratory for DNA or toxicology analysis. Doing so is contrary to BCA policy, Minnesota statute, and may waste resources. Submitting restricted evidence to the BCA or another regional crime laboratory is contrary to VAWA 2005, because such a practice could violate victim privacy, autonomy, and could require the victim to cooperate with law enforcement in the future.

¹¹¹ See, e.g., Human Rights Watch, *Testing Justice: The Rape Kit Backlog in Los Angeles City and County*, available at: <http://www.hrw.org/en/reports/2009/03/31/testing-justice> (last visited March 3, 2011).

h. alternative reporting options



Will your jurisdiction implement alternative reporting options for victims of sexual assault?

“Alternative reporting options” is the term used to collectively refer to the numerous forms of reporting methods used in Minnesota and across the nation. Alternative reporting options are distinguishable from a standard report made to law enforcement, which will trigger an investigation. Alternative reporting options are put into place to allow victims more control over the information they choose to share with law enforcement, if any, following a sexual assault. In this document, the term “alternative reporting options” is used to collectively refer to Jane Doe, Restricted, Confidential, Anonymous, Blind, Graduated, Third Party, or other alternative reporting methods.

There is no standard definition for any of these terms; different jurisdictions and even different professionals within the same jurisdiction or on the same team will mean different things by each of these terms. In our experience working with multidisciplinary teams, we have noticed a benefit if all team members take the time to get on the same page about what terms they will use, and what they will mean by the chosen term. For instance, frustration abounds on teams that start to debate the advantages and disadvantages of anonymous reporting without first ensuring that all members had a consistent understanding of what was meant by that term. By using the umbrella term “alternative reporting options,” we have found that teams can better appreciate the big picture of the issues involved and successfully discuss what features they would like to employ in an alternative reporting option policy, instead of getting hung-up on what the individual terms might mean.

Is the establishment of alternative reporting options required?

No. There is no state or federal law that requires alternative reporting options to be established. Some jurisdictions are establishing them voluntarily, however.¹¹² Some jurisdictions have established them to make certain policies run more smoothly, like restricted kit storage or case conversion. In addition, some jurisdictions find carefully-structured alternative reporting options victim-centered. We recommend that your multidisciplinary team has several discussions to determine how alternative reporting options may benefit agencies and victims in your jurisdiction.

What is the purpose for establishing alternative reporting options?

While victims must be provided access to the medical forensic exam without sharing any information with law enforcement, *alternative reporting options may be put into place to allow victims the option to preserve evidence in addition to physical evidence collected as part of the*

¹¹² See S. 254, Justice for Survivors of Sexual Assault Act of 2011. In its current form, this legislation could also affect how payment for medical forensic examinations is conducted nationwide. Full text of proposed legislation is available at <http://thomas.loc.gov/cgi-bin/query/z?c112:S.254>: (last visited March 3, 2011).

medical forensic exam. For instance, alternative reporting options may allow victims to share specifics on where the assault occurred (like a description of the room or house), who else may have been present, the offender, and other information that is best preserved to protect against the passage of time or fading of memory.

What do alternative reporting options look like?

Perhaps the best way to introduce alternative reporting options is through example.



“A Sexual Assault Nurse Examiner (SANE) will make a sexual assault report on behalf of a victim and receive an ICR without divulging the identity of the victim. The report will be made by calling 9-1-1. The 9-1-1 call taker will provide an ICR to the SANE.”

The SANE who examines the victim will call 9-1-1 and provide the location at which the assault occurred along with the date and time it occurred and will request an ICR for an Anonymous CSC Report. An officer should not be dispatched at this time. When calling back to request an officer respond to pick up the evidence kit and take it to property, the SANE will provide the ICR from the original report to the call taker. At this time, the call will be reopened and a jurisdictional officer assigned to respond to the appropriate hospital to collect and store evidence. The officer will enter comments and disposition when this process is complete.

The SANE Coordinator will track names of alleged perpetrators. If the alleged perpetrator is reported by another victim, SANE personnel will ensure attempts are made to contact any other reporting victims.”¹¹³

In this example, the SANE makes the “report” on behalf of the victim. Doing so results in several benefits: By calling 911, the SANE is assisted in determining the exact location of the jurisdiction where the assault occurred. This serves a dual purpose: the SANE can ensure that the bill for the medical forensic examination is being forwarded to the correct county, and the SANE is able to obtain an ICR number that can be used to track the kit, identify the kit and make the location of that kit easier if the victim chooses to convert. This way, identifying victim information is not needed for the outside of the kit. Additionally, law enforcement has an idea as to how many sexual assaults are occurring within the jurisdiction, and are able to use an ICR number to track and inventory restricted kits in the same way they track and inventory evidence in reported cases.

What are the potential benefits to establishing an alternative reporting option?

If victims are permitted to share some information about the assault, but maintain their anonymity and preserve their right not to report the assault to law enforcement, trust may be built between victims and responders. Such trust may encourage victims to convert the report and participate in the criminal justice process in the future.

¹¹³ This model tracking and identifier policy has been adapted from the Southern St. Louis County SMART Anonymous 3rd Party Reporting Process. For full text of this policy, *see* Appendix B.

If victims are permitted to share some information about the assault, but maintain their anonymity and preserve their right not to report the assault to law enforcement, the community may learn more about the patterns of sexual violence in the community like location or frequency.¹¹⁴

If a police report number accompanies the restricted kit or additional evidence collected in a restricted case, it may make storage of that evidence or linking that evidence to the victim, in the event a victim converts to a standard report in the future, easier.

The preservation of some information about the assault may make it easier for victims to pursue civil options even if they never choose to pursue criminal options.

A policy like this also preserves information about the assault in the event the victim's circumstances change, and she eventually feels more comfortable making a report (i.e., initially the victim didn't feel as though she would be believed, but now the crime fits within a pattern of serial rapes and now feels as though law enforcement may believe her).

What are the potential disadvantages to establishing an alternative reporting option?

Responders may be tempted to use information gathered in a way that violates the letter or spirit of VAWA 2005 (more on this point below).

Alternative reporting options can be cumbersome to administer, explain to victims and monitor. Only if your jurisdiction is equipped to do this right should alternative reporting options be established.

Before choosing to establish an alternative reporting option, your jurisdiction must consider each of these points:

1. What's the *purpose* of establishing an alternative reporting option in your jurisdiction? What potential *benefit* are you hoping to achieve for victims or agencies by collecting additional information from the victim?
2. *What* information will victims have the opportunity to provide? Will victims have the opportunity to provide as much or as little information as they wish, or will there be some limit to what is collected?
3. Will *persons other than the victim* be allowed to make a report on behalf of the victim? For instance, may healthcare professionals, an advocate or another third party share information on the victim's behalf with law enforcement?
4. *Who* will communicate to the victim how the alternative reporting option works?
5. *How* will information on the alternative reporting structure be communicated to victims? For instance, will that information be communicated to victims both verbally and in writing? What tools

¹¹⁴ Sabrina Garcia, Margaret Henderson, Blind Reporting of Sexual Violence, FBI Law Enforcement Bulletin, June 1999, Vol. 68 No. 6 available at http://new.vawnet.org/Assoc_Files_VAWnet/FB699_blindSV.pdf (last visited December 27, 2010).

could be used to explain alternative reporting options to victims (brochures, consent forms, pocket cards, business cards, information on a website)?

6. How will information gathered as part of the alternative reporting option be *used*? Acknowledge the possibility that responders will be tempted to use any information that is shared by the victim. For instance, what will happen if several victims disclose the name of the same perpetrator or the same assault location? Will law enforcement feel compelled to investigate information like this in order to ensure public safety? What will happen if a high-profile perpetrator is named? It might be too much to promise victims that information that they share will *never* be used and that they will *never* be required to participate in prosecution.¹¹⁵

7. *How long* will any information collected be retained? Will information collected in the form of an alternative report be filed with law enforcement? If that information is classified as “informational only,” or a “third party report,” how often are those reports culled?

8. Will any information collected as part of an alternative reporting structure be counted into responding agencies’ statistics? How might this complicate or misinterpret statistics? For instance, If that information is classified as “informational only,” or a “third party report,” how must law enforcement report those statistics on how those cases were cleared or resolved? If informational reports are used to document restricted kits or cases, procedures should be developed to ensure that they are linked with the evidence being stored and retained for the same period of time restricted kits are being stored in your jurisdiction. In some jurisdictions, informational-only reports are only kept for a year.¹¹⁶

Conclusion

As discussed in Part III, the majority of sexual assaults are not reported to law enforcement. In order to address this stark reality, some creative approaches to how responders interact with sexual assault victims must be taken. Establishing alternative reporting options may be one way to do this.

Your jurisdiction must discuss whether any alternative reporting options will be made available for victims of sexual assault. Neither VAWA 2005 nor Minnesota law requires the implementation of alternative reporting options, but many jurisdictions have implemented them voluntarily. Carefully crafted alternative reporting options can help make restricted kit storage or case conversion policies run more smoothly. Alternative reporting options that allow victims to share additional information about the assault (like the perpetrator’s name, or other details of the assault) may increase the chances of a successful investigation and prosecution in the event the victim converts the case, because important details of the assault will be preserved.

¹¹⁵ See Kimberly A. Lonsway, Ph.D., Sgt. Joanne Archambault (Ret.), *Reply to Article: “Receiving a forensic medical exam without participations in the criminal justice process: What will it mean?”* 7 JOURNAL OF FORENSIC NURSING 78 - 88 (2011) at 83.

¹¹⁶ Kimberly Lonsway & Sgt. Joanne Archambault (Ret.), *The Earthquake in Sexual Assault Response: Police Leadership Can Increase Victim Reporting to Hold More Perpetrators Accountable*, Police Chief Magazine (Sept. 2010) available at http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display&article_id=2201&issue_id=92010 (last visited March 3, 2011).

By establishing alternative reporting options for sexual assault, we take into account the distinct pressures that complicate a sexual assault victim's decision to report the assault to law enforcement and the fact that victim disclosure is often a step-by-step process, not a one-time event. By establishing alternative reporting options, we acknowledge that existing systems may not work well for sexual assault cases and make an attempt to make adjustments that may lead to an eventual increase in the reporting of sexual assaults.

i. data collection

The need for data on the success of forensic compliance policies is critical.¹¹⁷ There is currently no national or statewide data collection mechanism to track the number of restricted kits, the number of victims who choose to convert to a standard report, or how other policies created to address forensic compliance mandates are working. While individual agencies or programs, like SANE programs, may informally collect such data,¹¹⁸ there is no one source that compiles or analyzes data.

For these reasons, we strongly encourage Minnesota jurisdictions to consider how they might collect data about the progress of the policies they put into place on forensic compliance. For example, it would be helpful to have a better idea of how many victims choose to convert a case to a standard report, and in what period of time most victims convert. Additionally, it would be invaluable to know what factors or services were made available victims in the aftermath of the assault that may have influenced victims to convert the case. We understand that collecting data like this might require agencies to coordinate data collection, or that some data may have to be shared between agencies. Therefore, we encourage Minnesota jurisdictions to consider how they can collect data such as this while continuing to maintain victim confidentiality. If comprehensive data collection across agencies isn't feasible for your jurisdiction, consider collecting evidence from just one agency, or for a limited period of time.

Not only will data like this allow local programs to better serve victims in the future, it is possible that funders will eventually require similar data be reported. Thus, we encourage your multidisciplinary team to discuss how data collection on points such as the ones above may be instituted. More guidance from SVJI @ MNCASA on what data collection tools, or what data may be most helpful, is forthcoming.

¹¹⁷ See Kimberly A. Lonsway, Ph.D., Sgt. Joanne Archambault (Ret.), *Reply to Article: "Receiving a forensic medical exam without participations in the criminal justice process: What will it mean?"* JOURNAL OF FORENSIC NURSING (publication forthcoming, 2011) at 20.

¹¹⁸ Florida collected some limited data from 2007 – 2009 on the number of restricted kits collected and how many conversions took place. This data is available through End Violence Against Women International, at http://www.evawintl.org/images/uploads/FL_DataCollection.pdf (last visited March 12, 2011).

part vi. minnesota
statutes that
dictate sexual
assault victim/patient
care

minnesota statutes that dictate sexual assault victim/patient care

Besides the requirements set forth in VAWA 2005, Minnesota has several statutes that set forth separate requirements on the type of care, both medical and otherwise, that sexual assault victims/patients must receive. A complete understanding of these statutes is imperative, because, in addition to the perceived need to report the assault to law enforcement, many other aspects associated with seeking support post-assault act as barriers for victims. For example, many victims don't seek the medical forensic exam following an assault because they don't believe that they will be able to pay for it, or they are afraid a bill will be sent to their health insurance, violating their privacy with family members who may share the health insurance policy.

This section will present these statutes and answer the most commonly asked questions about their interpretation or implementation.

a. minn. stat. 609.35 (2003) costs of medical examination

"the fact that the community would assume responsibility for my medical costs brought me back to the notion of a world that i could belong to: a group gathered at the top of the mountain, furious enough to pay."¹¹⁹

As discussed in Part III, Minnesota has a statute putting the state into compliance with the VAWA 2005 mandates, Minn. Stat. § 609.35. This statute was enacted in 2003, nearly six years prior the

¹¹⁹ Patricia Francisco Weaver, *TELLING: A MEMOIR OF RAPE AND RECOVERY*, 43 (HarperCollins 1999).

VAWA 2005 mandates taking effect in 2009. Thus, Minnesota has already formally recognized the barriers that exam payment and reporting the assault to law enforcement created for victims, and responded accordingly.

Despite the existence of Minn. Stat. § 609.35, however, there remains significant variation and confusion across Minnesota as to how exam payment is handled. SVJI @ MNCASA is frequently asked to clarify payment responsibility or comment on payment amount or processing. This conversation isn't limited to Minnesota; how payment for the medical forensic exam should be handled has also been the focus of legislation and debate nationwide.¹²⁰

Like all statutes, some language is clear, while other language isn't clear, and is therefore left up to various interpretations.



Minn. Stat. § 609.35 (2003) COSTS OF MEDICAL EXAMINATION

(a) Costs incurred by a county, city, or private hospital or other emergency medical facility or by a private physician for the examination of a victim of criminal sexual conduct when the examination is performed for the purpose of gathering evidence shall be paid by the county in which the criminal sexual conduct occurred. These costs include, but are not limited to, full cost of the rape kit examination, associated tests relating to the complainant's sexually transmitted disease status, and pregnancy status.

(b) Nothing in this section shall be construed to limit the duties, responsibilities, or liabilities of any insurer, whether public or private. However, a county may seek insurance reimbursement from the victim's insurer only if authorized by the victim. This authorization may only be sought after the examination is performed. When seeking this authorization, the county shall inform the victim that if the victim does not authorize this, the county is required by law to pay for the examination and that the victim is in no way liable for these costs or obligated to authorize the reimbursement.

(c) The applicability of this section does not depend upon whether the victim reports the offense to law enforcement or the existence or status of any investigation or prosecution.

¹²⁰ See e.g., S. 254, Justice for Survivors of Sexual Assault Act of 2011. Full text of proposed legislation is available at <http://thomas.loc.gov/cgi-bin/query/z?c112:S.254>: (last visited March 3, 2011).

What is clear?

1. County where the assault occurred is responsible for payment. Subsection (a) gives responsibility for exam payment to the county where the sexual assault occurred. Frequently, it is misunderstood that the county where the exam occurs, the county where the victim resides or Crime Victims Reparations is responsible for payment; subsection (a) clarifies that that none of those entities are responsible for payment. For more information on Crime Victim Reparations, see a frequently asked question on this point below.

2. County is responsible for certain medical forensic care. Subsection (a) provides that the county where the assault occurred is responsible for the “full cost” of the rape kit examination (for a discussion of what “full cost” may be, see below), and the cost of STI and pregnancy testing (note that testing is different than treatment).

3. County where assault occurred may seek reimbursement from victim’s health insurance, but only with the victim’s authorization. Subsection (b) states that the county where the assault occurred may seek reimbursement from the victim’s health insurance (if any) for the cost of the exam. However, the county must first obtain the victim’s consent to seek reimbursement, and may not try to obtain the victim’s consent until *after* the exam has been performed. Additionally, the county must inform the victim that the county is required by law to pay for the cost of the exam.

Subsection (b) provides victims with a choice; some victims may not prefer to have the bill sent to a county office for payment. Victims are often focused on guarding their privacy. It is possible that a victim is a county employee herself or has family or friends who work for the county. This is especially true in rural counties. In those situations, a victim may feel safer having the bill processed outside the county, through her private health insurance. In other situations, a victim may be terrified to have her health insurance billed, especially if the health insurance bills or notices are sent to the victim’s parents or another family member. If not handled properly, billing the county, billing the victim directly or billing a victim’s health insurance may result in a forced disclosure of the sexual assault.

4. The county where the assault occurred is required to pay for the exam even if the victim chooses not to report the assault to law enforcement or whether there is any active investigation or prosecution. Subsection (c) provides that the county’s responsibility to pay is in no way changed if the victim chooses not to report the assault to law enforcement, nor is payment contingent upon the existence of any active investigation or prosecution in the event the victim does report the assault.

What isn't clear?

1. How billing will occur if the patient chooses not to report. Subsection (c) is silent as to how billing will occur if the victim does not report the assault to law enforcement. Subsection (c) is silent as to whether any victim identifying information must accompany a bill associated with an exam where the victim has not chosen to report the assault to law enforcement.

2. Which county office is responsible for payment. Subsection (a) is silent as to which *entity* within each county is responsible for exam payment; as a result, different county offices across the state are responsible. The statute permits counties to establish their own process and does not dictate which county office must handle the payment. Thus, in some counties, the County Attorney is responsible, in others, the County Sheriff or another county office is responsible.¹²¹

3. What services are included in the "rape kit examination." Subsection (a) is silent as to what services are part of the "rape kit examination," nor is there a definition of that term offered elsewhere in Minnesota statute. This leads to confusion about which services are for the purposes of evidence collection and which are for medical diagnosis or treatment.

4. What is meant by "full cost." Subsection (a) is also silent as to how much "full cost" is; as a result, there is a patchwork of payment amounts across the state. No minimum or maximum cost is articulated. This issue is discussed in the frequently asked question below.



My office pays the bills for these exams. We understand our statutory obligation to pay, and we want to do the right thing, but each bill is for a different amount; they are completely unpredictable. How much should our county be paying the hospital to provide this service? How much is full cost? How much is reasonable?

At this time, it is not possible to name one amount or a range of amounts that should be considered "reasonable" for a number of reasons. First, healthcare costs are a constantly changing landscape. What may be considered reasonable today may not seem reasonable one year from today. One factor of this constantly changing landscape is the uncertainty associated with the national healthcare legislation and how the implementation of this legislation may affect medical forensic care. Second, a hospital's cost of doing business is affected by geographic location, the expertise of the healthcare professionals working there, and the hospital's classification level. Finally, sexual assault patients are individuals, and not an identical class of patients requiring the same amount of

¹²¹ Data compiled by SVJI @ MNCASA shows that County Sheriff's Offices are the entity responsible for payment in approximately 52 Minnesota counties; County Attorney's Offices in 17 counties; Victim Service Agencies in 7 counties, Social and Human Services agencies in 4 counties; and in the remaining 7 counties, other agencies, like the county auditor, or a county block grant, are responsible for exam payment.

care. Sexual assault patients present with varied concerns, injuries and needs; therefore, each patient may require different levels of medical forensic care. Comprehensive medical care and thorough forensic evidence collection take time and may be expensive.

We frequently hear concerns from hospitals and SANE programs that the rate of reimbursement they receive does not reflect the quality of care provided, or the true cost of the medical forensic exam. Currently, hospitals make up the difference by writing off or “absorbing” costs associated with care, seeking out grant funding to cover some costs, or billing patient insurance for the medical costs associated with the exam (with patient consent). Under-compensating for this specialized care will result in the loss of SANE programs statewide. Loss of SANE programs dramatically affects the quality of patient care, the quality of evidence collection, and therefore the ability for victims to seek justice.

There is some outdated data available on the median cost of medical forensic exams in Minnesota.

While it may not be possible to determine one reimbursement rate that will adequately reimburse all hospitals for each medical forensic exam conducted, there is some outdated data that describe median medical forensic exam cost that can be used as a starting point. According to the Minnesota Department of Health, “Median charges are most useful for assessment of typical charges because they are not affected by extreme values. The median charge of a hospital patient seen for [sexual assault] and treated in the [Emergency Department] ranged from \$803 to \$901 between 2002 and 2007.”¹²² This data should be utilized as a starting place only, keeping in mind the age of the data, rising healthcare costs and other complicating factors described above.

Some costs are considered usual and customary and should be anticipated. While it may not be possible to determine one reimbursement rate that will adequately reimburse all hospitals for each medical forensic exam conducted, there *are* some expenses associated with the provision of medical forensic care that should be considered “usual and customary.”

As stated above, Minn. Stat. 609.35 (a) provides:

“Costs incurred by a county, city, or private hospital or other emergency medical facility or by a private physician for the examination of a victim of criminal sexual conduct when the examination is performed for the purpose of gathering evidence shall be paid by the county in which the criminal sexual conduct occurred. These costs include, but are not limited to, full cost of the rape kit examination, associated tests relating to the complainant's sexually transmitted disease status, and pregnancy status.”

There are several different ways to interpret this language

One way to interpret this language is that *any and all costs* incurred by the hospital must be reimbursed by the county where the assault occurred.

¹²² Minnesota Department of Health, Sexual Violence Data Brief: Sexual Violence 2002-2007, at 3 available at <http://www.health.state.mn.us/injury/pub/svviolencedatabrief2002-2007.pdf> (last visited March 16, 2011).

Another way to interpret this language is that only the full cost of the “rape kit examination” must be reimbursed by the county where the assault occurred, along with STI and pregnancy testing, *but no other costs must be reimbursed.*

We gain some guidance by reading Minn. Stat. § 609.35 along with other federal legislation and policy on exam payment. Federal regulation provides, “a state. . . shall not be entitled to funds unless the state . . . incurs the full out-of-pocket costs of forensic medical exams for victims of sexual assault. Full out-of-pocket cost means any expense that may be charged to a victim in connection with a medical forensic examination for the purpose of gathering evidence of a sexual assault.”¹²³ The National SANE Protocol, developed by the U.S. Department of Justice provides, “Examples of [full out of pocket cost] may include a fee established by the facility conducting the exam. Often, medical services that are not related to evidence gathering will not be covered by this requirement.”¹²⁴

Thus, while costs associated with “forensic evidence collection” are clearly the responsibility of the county where the assault occurred, the costs associated with “medical services not related to evidence gathering” may not be. The county, therefore, may only pay costs associated with forensic evidence collection and remain in compliance with VAWA 2005. Drawing the line between what is “forensic evidence collection” and what are “medical services not related to evidence gathering” is difficult, however, and there are many factors to consider:

Costs that must be covered by the county where the assault occurred

1. Costs related to evidence collection.

Usual and customary costs of evidence collection include:

- cost of EMTALA screening;
- examination room charge for the period of time the victim was receiving medical forensic care. While the period of time for exams vary, an average period of time is between three and four hours;¹²⁵
- personnel costs of attending SANEs, RNs, physicians, or other healthcare professionals such as phlebotomists. Charges for personnel will depend on the expertise of the healthcare professional providing care;
- materials and procedures that are utilized to perform evidence collection, such as tubing, speculums, blood draws, urine collection, or materials associated with forensic photography, such as photo discs for storage of photos. Charges for the use of other specialized forensic evidence collections tools, like alternative light sources, are also usual and customary.

2. Costs related to testing for pregnancy and STIs. Costs related to the baseline determination of a victim’s pregnancy or STI status must be paid for by the county where the assault occurred. Please

¹²³ 28 C.F.R. § 90.14(a).

¹²⁴ U.S. Department of Justice, Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescent* (2004) at 49, available at <http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf> (last visited March 9, 2011).

¹²⁵ Rape, Abuse and Incest National Network, available at <http://www.rainn.org/get-information/aftermath-of-sexual-assault/preserving-and-collecting-forensic-evidence> (last visited March 9, 2011).

note the difference between *testing* for pregnancy or STIs and *treatment* to prevent pregnancy or STIs.

Costs that may be covered by the county where the assault occurred

Medical services.

Usual and customary costs of medical services may include:

- The cost of prophylactic medications provided to the victim for the prevention of STIs or HIV;
- The cost of prophylactic medications provided to the victim for the prevention of pregnancy; and
- The cost of medical treatment such as stitches, casting of broken bones or other wound care;
- The cost of tools used for medical diagnosis such as X-rays or additional medication evaluations or testing; and
- The cost of follow-up medical treatment.

If the county where the assault occurred will not pay for costs such as these, or reimburses at a rate that requires hospitals to absorb numerous costs, here are some options to consider:

1. Engage hospital billing and county payment offices as multidisciplinary partners

We recommend that you engage representatives from both the hospital billing department and county office responsible for payment on a regular basis to discuss exam payment. Schedule an annual (or more frequent) meeting between your multidisciplinary team and hospital billing to discuss the cost of the most common types of care or procedures provided to sexual assault patients. This meeting should provide the opportunity for all parties to negotiate, make adjustments, cross-educate, and discuss any problems with billing that may have occurred over the previous year and how to mitigate them. By negotiating what “full cost” means within the jurisdiction and by educating all team members, victims will be better informed about how exam billing may occur.

2. Encourage the use of a standard billing form within your jurisdiction.

If there is more than one hospital within your jurisdiction, we encourage the use of a single, standard billing form, to make the processing of payments easier for the county billing office responsible for payment. Some Minnesota jurisdictions are currently working to establish a standardized billing form. SVJI @ MCNASE is considering the development of a single, statewide billing form that may make this process easier for hospitals seeking payment as well as county offices responsible for payment. More information is forthcoming.

3. Look for alternative funds to cover costs the county cannot

It may be possible to secure grant funding or donations to cover some costs associated with the

medical forensic exam that the county cannot. In a wonderful example of community collaboration, the Unity SANE Program, which responds to seven different hospital locations across the Twin Cities metro, collaborated with the Mercy and Unity Hospital Foundation to provide funding for some costs. The funding pays for prophylactic medicationssexually transmitted diseases and pregnancy. This funding can also be utilized to pay for HIV prophylactic medicationthe patient has no medical insurance. Significantly, physicians in this hospital system agreed to provide a medical screening at no cost to the patient, and some of the hospital sites agreed to waive the facility fee (unless the sexual assault patient needs additionalcarearea physician).¹²⁶

In another wonderful example of collaboration, two hospitals located in one community agreed to cover costs associated with the medications most typically provided to sexual assault patients as an in-kind donation to the community-based SANE Program.¹²⁷

4. Establish new community partnerships to provide some medical care to victims at no cost or at a low-cost.

If your county billing office will not cover the costs associated with some medical services provided to patients, like some medications or follow-up medical care, we encourage you to establish new partnerships with any local community-based clinics to provide this care.¹²⁸ In addition, the Unity SANE Program was also able to forge a relationship with a local community-based clinic that provides reproductive and sexual healthcare services. This clinic agreed to provide free follow-up medical care to victims of sexual assault. Use caution, however, when referring out for time-sensitive care (like pregnancy prophylaxis or STI prophylaxis treatments that are generally only effective up to 120 hours post-assault), as patients have a difficult time meeting follow-up appointments.

5. Contact SVJI @ MNCASA to provide exam payment education and/or negotiation tools

SVJI @ MNCASA may be able to assist your jurisdiction by helping to clarify exam payment through a presentation or by providing this document or other resources to your team or others within your jurisdiction. SVJI @ MNCASA can also provide information on how other Minnesota jurisdictions have handled exam payment challenges.

¹²⁶ Credit for this collaborative effort must be given to Mercy and Unity Hospital Foundation and Karine Zakroczymski, Unity SANE Program Manager, as well as other local affiliated organizations.

¹²⁷ Credit for this collaborative effort must be given to St. Mary's medical Center and St. Luke's Medical Center and the Program to Aid Victims of Sexual Assault (PAVSA) SANE Program, located in Duluth, Minnesota.

¹²⁸ Illinois has established a voucher program to ensure sexual assault victims can access free follow-up medical care at certain community clinics or at the hospital where they were seen for the medical forensic exam if they choose to do so. For more information on this novel approach, see <http://www.icasa.org/docs/legal%20forms/saseta%20billing%20information.pdf> (last visited March 16, 2011).



Our hospital sees sexual assault patients who present for a medical screening, but don't want any evidence collection. May we charge the county where the assault occurred for the medical screen?

Perhaps, if the county in which the assault occurred is willing to pay for costs other than those most often associated with evidence collection, like prophylactic medications for STIs or pregnancy.

Occasionally, victims in our jurisdiction receive a bill for all or a portion of the medical forensic exam. What should we do?

Billing victims for the cost of the medical forensic examination is contrary to both the letter and spirit of VAWA 2005 and Minn. Stat. § 609.35. Billing victims for the cost of the exam may prevent victims from accessing medical and forensic evidence collection services. Billing victims for the cost of the exam results in secondary victimization, which can have lasting and complicating effects on the victim. At times, victims have been billed but have been unable to pay, so the bill has gone to collections. This practice can lead to long-term negative financial consequences to victims.



As discussed at length above, victims may receive a bill for "medical care" that is not clearly the responsibility of the county under Minn. Stat. 609.35. By having a clearly articulated agreement and written policy within your jurisdiction, however, it is possible to arm both healthcare professionals and advocates with the information they need to explain the billing process to victims. Victims must be fully aware of how and for what services they may be billed. If victims in your jurisdiction are receiving bills, it is imperative that a multidisciplinary group meet immediately to determine how to ensure victims do not mistakenly receive bills for costs associated with forensic evidence collection, and whether victims can expect to receive a bill for medical services not paid by the county (if that is the case).



Why do victims of sexual assault receive special treatment by having access to a free medical exam?

Sexual assault victims are not receiving special treatment. As described in the glossary, the purpose of the medical forensic examination is twofold: medical attention and forensic evidence collection. The medical forensic exam is therefore part of the processing of the crime scene. The county pays the costs for most other criminal investigations whether or not the case is prosecuted (for example, the county will pay for the costs associated with combing grass for bullet casings or dusting a room for fingerprints). The difference here is that the crime scene is the victim's body; the hospital is the site where the evidence collection work is done.



Our hospital serves the residents of several counties. It's confusing for our hospital to know which Minnesota county to bill for the exam, since each county has a different billing department. Is there a way to make the billing process easier? Yes. A list of county billing contacts is maintained and frequently updated by the Minnesota Department of Public Safety, Office of Justice Programs, Crime Victims Reparations. The most updated version of the list is available on Crime Victims Reparations website. At time of press, this website was under construction and the specific location of the document is uncertain. For access to the document, please call 651-201-7300. The 2011 version of this document is also located in Appendix C. SVJI @ MNCASA is working with the Minnesota Hospital Association to help educate Minnesota hospital billing department staff members about this resource.

When will the Crime Victims Reparations program pay for these exams?

The county in which the assault occurred is considered the payor of first resort for medical forensic exams, whether the victim chose to report the assault to law enforcement or not.¹²⁹ In order to be eligible for Crime Victims Reparations funds, the victim must **report the crime to law enforcement** and must **cooperate fully** with the investigation and prosecution of the case.¹³⁰ Thus, charges associated with medical forensic exams conducted in restricted cases are *not* eligible for reimbursement by Crime Victims Reparations funds.



Furthermore, in reported cases, Crime Victims Reparations funds are only available to pay for charges associated with the medical forensic examination that are *not* covered by the county in which the assault occurred.

So, *only* if the case was reported to law enforcement and the victim is cooperating fully with the investigation and *only* if the county in which the assault occurred has *not* reimbursed the health care provider fully will the victim be eligible for Crime Victim Reparations.

If the hospital in your jurisdiction automatically sends bills for medical forensic exams to Crime Victims Reparations, this must immediately stop. Please work with your hospital billing department to instead send bills to the county where the assault occurred.

¹²⁹ Minn. Stat. § 609.35 (c) (2003).

¹³⁰ Additional eligibility requirements apply. For more information on Minnesota's crime victim reparations funds, call 651-201-7300 or visit <https://dps.mn.gov/divisions/ojp/help-for-crime-victims/Pages/crime-victims-reparations.aspx>



Our county payor (County Attorney, Sheriff, etc.) refuses to pay unless the assault is reported to law enforcement and/or the victim's name is provided on the bill. The county payor says there is pressure from the county auditor to provide the victim's name, so that they know the bill is "legitimate." What should we do?

Requiring victims to report the assault to law enforcement in order to access the medical forensic examination or render payment for the medical forensic exam paid is a violation of both VAWA 2005 and Minn. Stat. § 609.35.

Although nothing in VAWA 2005 or Minn. Stat. § 609.35 specifically states that a county payor cannot request a victim's name in order pay the bill, this practice is discouraged as it is contrary to the spirit of both VAWA 2005 and Minn. Stat. § 609.35. A victim who is forced to provide her name to the county office in order to facilitate payment is, in a way, being asked to cooperate with law enforcement, especially in counties where the county sheriff or the county attorney is the entity responsible for payment. This is especially true in rural counties, where providing one's name to a county office will more likely break a victim's sense of confidentiality and autonomy over her decision to report. The practice of requiring a victim name in order to pay for an examination bill is strongly discouraged, and may put Minnesota at risk for the loss of federal funding.

Often, county payors are under significant pressure from county auditors to document and account for all county expenses. Try negotiating the use of another identifier that will satisfy the county auditor's needs yet still maintain victim confidentiality. It may be possible to use some combination of medical facility name, patient number, examiner name, date and time to serve as an identifier. For example, a potential identifier may be: 02122011CountyHospitalAnonymousCase1. For more information on potential identifiers that do not include the victim's name, please see Part VI, Section E., Restricted Kit Storage Location.

If county officials insist that they must know a victim's name or other identifying information as part of his or her obligation to protect the community, encourage that official's participation on a multidisciplinary group or in other meetings to discuss the provision of sexual assault services within the county. Encourage your county official to learn about general trends about sexual assault within your jurisdiction, instead of requiring detailed victim-specific information. For more information on how to engage law enforcement within the multidisciplinary framework, or how to overcome differences in professional perceptions, see Part IV, Collaboration, Compromise and Commitment: The Necessity of a Multidisciplinary Approach to Forensic Compliance.

If refusal to pay on this point persists, you may seek help from the Grants Director of Crime Victim Grants Unit with the Minnesota Department of Public Safety, Office of Justice Programs by calling 651-201-7300.



Our jurisdiction is on the Minnesota border. Sometimes, there is confusion about who to bill when the assault occurred outside Minnesota, but the victim travels to Minnesota to have the exam. What should we do?

This scenario is common in border cities. After being assaulted, victims may travel to their hometown, or to a medical facility they may be more familiar with in order to access the medical forensic examination. If you provide services to victims in a border town, it is essential to understand how exam billing works in other states as well as in Minnesota. Some of our neighboring states have one centralized fund that pays for medical forensic examinations. When unsure of how billing in another state works, contact that state's sexual assault coalition for more information. SVJI @ MNCASA can also put you in touch with an appropriate contact person in another state coalition office.

For more information, see Appendix F: Minnesota Coalition Against Sexual Assault Fact Sheets: Payment for Sexual Assault Exams When the Assault Occurs in One State but the Exam Occurs in a Different State.

How is payment for the medical forensic exam handled if the exam occurs at an Indian Health Services (IHS) facility or if the assault occurred on tribal land?

Many factors may complicate payment for a medical forensic exam conducted at an Indian Health Services (IHS) facility, or when the assault occurs on tribal land. Complicated jurisdictional issues and other factors come into play for sexual assault cases occurring on tribal land. Factors that must be known in order to answer this question include: the exact location of the assault, the victim's or suspect's tribal enrollment status, whether the tribal land in question is governed by P.L. 280 provisions, and whether the FBI, tribal law enforcement or the Minnesota county involved would ultimately have jurisdiction over the crime, if reported.



Generally speaking, if a patient receives a medical forensic exam at an IHS facility, the patient should not receive a bill for the evidence collection or any other related medical care, as care rendered by IHS facilities is free for enrolled tribal members.

We recommend you call a multidisciplinary team meeting to discuss how payment for medical forensic examinations occurs if your jurisdiction includes responding to Native victims and/or if some medical forensic care is being performed by IHS facilities, or in other healthcare settings.

Conclusion

Although Minnesota has a state statute that addresses payment for the medical forensic exam, this statute is not clear on all details related to exam payment. While the cost of forensic evidence collection is clearly the responsibility of the county where the assault occurred, the cost of

associated medical treatment is not clearly the responsibility of the county. It isn't always easy to draw a line between what services are considered "evidence collection" and what services are considered "medical care." Individual counties and hospitals have interpreted the statutory language in different ways. As a result, there is a patchwork of payment practices across Minnesota.

In order to best serve victims in your jurisdiction, it is necessary to address exam payment in a multidisciplinary way. Thus, we urge Minnesota jurisdictions to learn more about what services are considered "usual and customary" and how much it costs the local hospital to provide those services.

By doing so, we hope to move Minnesota closer to the spirit of VAWA 2005 by ensuring victims do not incur *any* "out of pocket costs" associated with the medical forensic exam, and that payment is handled in such a way that victim privacy is as protected.

b. mandated reporting

It is important to understand mandated reporting laws and how they interact with the requirements of VAWA 2005. VAWA 2005 requires states to certify that victims need not report the assault to law enforcement in order to access the medical forensic exam. But, for instance, many healthcare professionals wonder how their responsibility to make mandated reports in certain situations can co-exist with the VAWA 2005 mandates. This section will address this concern, as well as the concerns of other professionals working with sexual assault victims.

Because mandated reporting laws depend on so many factors, like the type of information disclosed, who it is disclosed by, and who it is disclosed to, it is understandable why these laws create significant confusion for all professionals, not just healthcare professionals. Different professionals may misunderstand each other's mandated reporting responsibilities. For this reason, we strongly encourage multidisciplinary teams to discuss mandated reporting and the types of situations where team members may be mandated to report *before* an emergency situation arises. By taking the time to better understand each team member's professional obligation, your team will be better able to respond to these confusing issues when they arise.

Please note: This section is not intended to serve as an all-inclusive definitive resource on mandated reporting for all professionals. We encourage your team to seek out other training on this issue, so that all team members are well-informed and aware of any updates to the law or how the laws are interpreted. Suggestions on where to access more training will be highlighted throughout this section. This section is only intended to lend some clarity to the most frequently asked questions when it comes to mandated reporting, and how the obligation to report the assault to law enforcement may or may not conflict with the requirements of VAWA 2005.

Frequently-asked questions with regard to medical mandated reporting are addressed first. Then, frequently asked questions with reporting the sexual assault of children or vulnerable adults are addressed.



Our hospital always calls law enforcement when a victim of sexual assault presents at the Emergency Department. They say that healthcare professionals in Minnesota are mandatory reporters of sexual assault. Is this true?

In Minnesota, healthcare professionals are *not* mandated reporters of sexual assault if the patient is a competent adult.¹³¹ A competent adult is someone who cannot be defined as legally vulnerable under vulnerable adult laws.¹³²

Unfortunately, there isn't just one Minnesota statute that clearly states that

¹³¹ For a discussion of how medical mandated reporting works in other states, see *Sexual Assault Reporting Requirements for Competent Adult Victims*, available at <http://www.usmc-mccs.org/famadv/restrictedreporting/National%20Rape%20Reporting%20Requirements%206.15.06.pdf>

¹³² See Minn. Stat. § 626.5572 subd. 21. See also frequently-asked question "Who is a vulnerable adult? Who must report the assault of a vulnerable adult?" page 109.

healthcare professionals are not mandatory reporters of sexual assaults suffered by competent adults. Instead, we have to infer that conclusion based on what other statutes do say or do not say.

To break this problem down, we must examine the relevant statutes:

VAWA 2005

This statute requires that states receiving federal STOP formula grant funds must ensure that victims are provided with a medical forensic exam regardless of the victim's decision to report the assault to law enforcement. *This statute supports a victim's right to a medical forensic examination without having to report the assault to law enforcement.*



Minn. Stat. § 609.35

This statute provides that the cost of the medical forensic exam is the responsibility of the county in which the assault occurred. Subsection (c) is clear that exam payment is the responsibility of the county in which the assault occurred even if the victim does not report the assault to law enforcement. *This statute supports a victim's right to a medical forensic examination without having to report the assault to law enforcement.*

Minn. Stat. § 626.52 (2007) Reporting of suspicious wounds by health professionals

If a sexual assault patient also presents with a suspicious wound, however, a healthcare professional may have to make a mandatory report to law enforcement about the suspicious wound. This statute provides:

(1) **Definition.** As used in this section, "health professional" means a physician, surgeon, person authorized to engage in the practice of healing, superintendent or manager of a hospital, nurse, or pharmacist.

(2) **Health professionals required to report.** A health professional shall immediately report, as provided under section 626.53, to the local police department or county sheriff all *bullet wounds, gunshot wounds, powder burns, or any other injury arising from, or caused by the discharge of any gun, pistol, or any other firearm*, which wound the health professional is called upon to treat, dress, or bandage. A health professional shall report to the proper police authorities any wound that the reporter has reasonable cause to believe has been inflicted on a perpetrator of a crime by a dangerous weapon other than a firearm as defined under section 609.02, subdivision 6.

(3) **Reporting burns.** A health professional shall file a written report with the state fire marshal within 72 hours after being notified of a *burn injury or wound* that

the professional is called upon to treat, dress, or bandage, if the victim has sustained *second- or third-degree burns to five percent or more of the body, the victim has sustained burns to the upper respiratory tract or sustained laryngeal edema from inhaling superheated air, or the victim has sustained a burn injury or wound that may result in the victim's death.* The state fire marshal shall provide the form for the report.¹³³

Because this statute **does not** include sexual assault as a “suspicious wound” triggering a mandatory report by a healthcare professional, it supports the inference that the **sexual assault itself is not a suspicious wound** requiring a mandatory report. If a sexual assault patient presents with a suspicious wound in addition to the sexual assault, it is clear a mandatory report of the **wound** must be made, but the fact that the patient was also a victim of a sexual assault need not be reported.



Who is a mandated reporter of the sexual assault of a child?

Certain professionals are mandated reporters of the sexual assault of a child.

Minn. Stat. § 626.556 subd. 3 defines who must report:

(a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person is:

(1) *a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement;* or

(2) employed as a member of the **clergy** and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subd. 1, paragraph (c).¹³⁴

¹³³ Emphasis added.

¹³⁴ Emphasis added.

Thus, professionals like law enforcement, healthcare professionals and advocates are mandated reporters of the sexual assault of a child. **However, not every situation of the sexual assault of a child requires a mandated report. Only if the sexual assault is committed by certain persons with a “significant relationship” to the child, or certain persons who have a “position of authority” over the child must the sexual assault be reported.**

Thus, not every professional on your team may be a mandated reporter of the sexual assault of a child in every fact scenario. For this reason, we encourage multidisciplinary teams to discuss mandated reporting and the types of situations where team members may be mandated to report *before* an emergency situation arises. By taking the time to better understand each team member’s professional obligation, your team will be better able to respond to these confusing issues when they arise, and will avoid blaming one another in the emotional reaction that sometimes occurs in these types of cases.

We also encourage your team to access additional, comprehensive training on this topic. The Minnesota Department of Human Services has a helpful online training resource titled “An Interactive Informational Guide on Mandated Reporting,” available at <http://www.dhs.state.mn.us> (last visited March 18, 2011).



Who is a vulnerable adult? Who must report the sexual assault of a vulnerable adult?

Only certain adults are considered vulnerable; and only certain professionals must report a sexual assault of a vulnerable adult.

Minn. Stat. § 626.5572 subd. 21 defines vulnerable adult as:

(a) "Vulnerable adult" means any person 18 years of age or older who:

- 1) is a resident or inpatient of a facility
- 2) receives services at or from a facility required to be licensed to serve adults under sections 245A.01 to 245A.15, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);
- 3) receives services from a home care provider required to be licensed under section 144A.46; or from a person or organization that exclusively offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under

sections 256B.04, subd. 16, 256B.0625, subd. 19a, 256B.0651, 256B.0653 to 256B.0656 and 256B.0659; or

4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment.

(b) For purposes of this subdivision, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual."

Not all professionals are mandated reporters of the sexual assault of a vulnerable adult.



Minn. Stat. § 626.5572 subd. 16 provides:

"Mandated reporter" means a professional or professional's delegate while engaged in:

- (1) social services;
- (2) law enforcement;
- (3) education;
- (4) the care of vulnerable adults;
- (5) any of the occupations referred to in section 214.01 subd. 2 [any occupation regulated under a health related licensing board]¹³⁵
- (6) an employee of a rehabilitation facility certified by the commissioner of jobs and training for vocational rehabilitation;
- (7) an employee or person providing services in a facility as defined in subdivision 6; or
- (8) a person that performs the duties of the medical examiner or coroner.

¹³⁵ Clarification added.

Please note that since advocates are not engaged in the activities named in this statute, they are not considered mandated reporters of the sexual assault of a vulnerable adult. Thus, advocates should not disclose this information without first obtaining the victim's informed consent. It is crucial for your multidisciplinary team to understand the differences between professional obligations in order to best work together.

We also encourage your team to access additional, comprehensive training on this topic. The Minnesota Department of Human Services has a helpful online training resource titled "Vulnerable Adults Mandated Reporting," available at <http://registrations.dhs.state.mn.us/WebManRpt/> (last visited March 18, 2011).

For more information, see Appendix MNCASA Fact Sheet: Mandated Reporting of the Maltreatment of Vulnerable Adults: What is Required? Please note, however, that this Fact Sheet is written for advocates, not for all professionals responding to sexual assaults.



If healthcare professionals do make a mandatory report of a sexual assault as required by Minnesota law, because the victim is a child or a vulnerable adult whose assault falls under mandatory reporting requirements, will that mandatory report be a violation of VAWA 2005?

In the event that a healthcare professional makes a mandated report because the victim was a child or vulnerable adult whose assault falls under mandatory reporting requirements, that mandated report will not violate VAWA 2005. This is true for two reasons.

First, there has been guidance from the U.S. Department of Justice, Office on Violence Against Women (OVW) that mandated reports by healthcare professionals do not violate VAWA 2005, because, in most states, making a mandated report is possible without disclosing the identity of the victim. Second, because the victim still does not have to *cooperate* with law enforcement if a mandated report is made, there should not be a violation of VAWA 2005, although this practice could be seen as violating the spirit of VAWA 2005.¹³⁶

In Minnesota, this also seems to hold true. Minn. Stat. § 626.53 describes *how* a mandatory report must be made.¹³⁷ This statute is silent to whether the report must contain the victim's name. In

¹³⁶ See United States Department of Justice, *Facts about the Office on Violence Against Women Focus Areas*, available at <http://www.ovw.usdoj.gov/ovw-fs.htm#fs-focus-areas> (last visited March 12, 2011).

¹³⁷ Minn. Stat. §626.53 Report by Telephone and Letter.

(1) Reports to sheriffs and police chiefs. The report required by section 626.52, subd. 2, shall be made forthwith by telephone or in person, and shall be promptly supplemented by letter, enclosed in a securely sealed, postpaid envelope, addressed to the sheriff of the county in which the wound is examined, dressed, or otherwise treated; except that, if the place in which the patient is treated for such injury or the patient's wound dressed or bandaged be in a city of the first, second, or third class, such report shall be made and transmitted as herein provided to the chief of police of such city instead of the sheriff. Except as otherwise provided in subdivision 2, the office of any such sheriff and of any such chief of police shall keep the report as a confidential communication and shall not disclose the name of the person making the same, and the party making the report shall not by reason thereof be subpoenaed, examined, or forced to testify in court as a consequence of having made such a report.

(2) Reports to Department of Health. Upon receiving a report of a wound caused by or arising from the discharge of a

reality, however, this plays out in different ways across the state. Because the statute is silent on this point, it is possible that a victim's name may be disclosed as part of the mandated report. However, even if this does occur, since the victim would not have to *cooperate* with law enforcement, a violation of VAWA 2005 should not occur.



Our hospital has to call law enforcement to respond to the hospital when a sexual assault victim presents because law enforcement officers are the only ones who have the sexual assault evidence collection kits. Is there another way to get the kits?

Yes, there are alternative ways to obtain sexual assault evidence collection kits that do not involve contacting law enforcement. Contacting law enforcement to respond for this reason may make victims feel intimidated, or that they must report in order to access the exam. Sexual assault evidence collection kits can be obtained by contacting the BCA Laboratory closest to you. The kits are free and can be mailed directly to your hospital. Contact either BCA Laboratory listed below to request kits:¹³⁸

BCA Laboratory
1430 Maryland Avenue East
St. Paul, MN 55106
651-793-2900
bcalab@state.mn.us

BCA Laboratory
Bemidji Regional Office
3700 North Norris Court NW
Bemidji, MN 56601
(218) 755-6600

Often, we hear from hospitals that are concerned that the sexual assault evidence collection kits they have on hand have “expired.” Nothing within the kits expire except for the blood tubes; there is a preservative in the blood tubes that loses its effectiveness after a time. If this occurs, the BCA recommends simply changing out the blood tubes for fresh tubes and using the rest of the kit as it is.

Conclusion

Mandated reporting causes significant confusion in Minnesota and across the nation, especially when it comes to sexual assault.

Healthcare professionals in Minnesota are not mandated reporters of the sexual assault of a

firearm, the sheriff or chief of police shall forward the information contained in the report to the commissioner of health. The commissioner of health shall keep the report as a confidential communication, as provided under subdivision 1. The commissioner shall maintain a statewide, computerized record system containing summary data, as defined in section 13.02, on information received under this subdivision.

¹³⁸ Minnesota Bureau of Criminal Apprehension, *DNA Evidence Identification, Collection, and Preservation for Law Enforcement*, available at <http://www.bca.state.mn.us/Lab/Documents/DNABrochure05.pdf> (last visited February 3, 2011).

competent adult victim. If a competent adult victim of a sexual assault also presents with a "suspicious wound," healthcare professionals may only report the suspicious wound and not the fact that the patient also suffered a sexual assault. How this situation plays out "on the ground" however, differs.

If a healthcare professional or another professional is required to make a mandatory report because the victim is a child and the perpetrator has a significant relationship with that child, or is in a position of authority over that child, or because the victim is a vulnerable adult, that report will generally not be thought to violate VAWA 2005, since the victim may not be required to *cooperate* with law enforcement.

Different professionals may misunderstand each other's mandated reporting responsibilities. For this reason, we strongly encourage multidisciplinary teams to discuss mandated reporting and the types of situations where other professionals may have to make a mandated report *before* a situation arises on this topic. We also encourage your team to take advantage of the additional training opportunities on mandated reporting listed within this section. By taking the time to understand other professionals' obligations, you will be able to respond better as a team when this issue arises.

c. emergency care to sexual assault victims

Minnesota has a statute that requires a certain level of prophylactic, or preventative healthcare, be provided to patients who have been sexually assaulted. Minn. Stat. § 145.4712 (2007) addresses prophylactic care for both pregnancy and sexually transmitted infections (STIs). In Minnesota, sexual assault resulted in an estimated 12,700 sexually transmitted infections and 1,500 pregnancies in 2005 alone.¹³⁹ The statute's aim is to reduce these staggering numbers.

Prophylactic care for pregnancy

Subdivision 1 of Minn. Stat. § 145.4712 discusses what type of consultation and treatment is required for female sexual assault patients with regard to pregnancy prophylaxis. Medications that are used to prevent pregnancy are called emergency contraception generally, and may also be referred to by their brand names or other commonly-used names such as Plan B, ella, or the Morning-After Pill. Such medications have guidelines from the manufacturers outlining the timeline in which they are recommended and effective; research shows some medications are effective up to 120 hours post-assault.¹⁴⁰



Minn. Stat. § 145.4712 (2007)

Subdivision 1. EMERGENCY CARE TO FEMALE SEXUAL ASSAULT VICTIMS

(a) It shall be the standard of care for all hospitals that provide emergency care to, at a minimum:

- (1) provide each female sexual assault victim with medically and factually accurate and unbiased written and oral information about emergency contraception from the American College of Obstetricians and Gynecologists and distributed to all hospitals by the Department of Health;
- (2) orally inform each female sexual assault victim of the option of being provided with emergency contraception at the hospital; and
- (3) immediately provide emergency contraception to each sexual assault victim who requests it provided it is not medically contraindicated and is ordered by a legal prescriber. Emergency contraception shall be administered in accordance with current

¹³⁹ Minnesota Department of Health, *Costs of Sexual Violence* (2007) at 11 available at <http://www.health.state.mn.us/injury/pub/svcosts.pdf> (last visited March 12, 2011).

¹⁴⁰ American College of Obstetricians and Gynecologists (ACOG). For more in-depth information on how the different forms of emergency contraception medications work, please see Lisa Zindler, *New Developments in Pregnancy Prophylaxis* webinar. Webinar recording available by emailing svji@mncasa.

medical protocols regarding timing and dosage necessary to complete the treatment.

(b) A hospital may administer a pregnancy test. If the pregnancy test is positive, the hospital does not have to comply with the provisions in paragraph (a).

Prophylactic care for sexually transmitted infections (STIs)

Subdivision 2 of Minn. Stat. § 145.4712 discusses what type of consultation and treatment is required for male and female sexual assault patients with regard to prophylaxis for STIs.

Medications that are used in this context to prevent pregnancy are different classes of antibiotics. Such medications have guidelines from the manufacturers outlining the timeline in which they are recommended and effective; research exists to show efficacy up to 120 hours post-assault.¹⁴¹

Minn. Stat. § 145.4712 (2007)

Subdivision 2. EMERGENCY CARE TO MALE AND FEMALE SEXUAL ASSAULT VICTIMS

It shall be the standard of care for all hospitals that provide emergency care to, at a minimum:

- (1) provide each sexual assault victim with factually **accurate and unbiased written and oral medical information** about prophylactic antibiotics for treatment of sexually transmitted diseases;
- (2) orally inform each sexual assault victim of the option of being provided prophylactic antibiotics for treatment of sexually transmitted diseases at the hospital; and
- (3) **immediately provide** prophylactic antibiotics for treatment of sexually transmitted diseases to each sexual assault victim who requests it, provided it is not medically contraindicated and is ordered by a legal prescriber.

¹⁴¹ See Centers for Disease Control (CDC) 2010 STD Treatment Guidelines, available at: <http://www.cdc.gov/std/treatment/2010/> (last visited February 23, 2011) and Ellen Johnson, RN, CEN, CPEN, SANE-A, STIs: Addressing Sexual Assault Patient Concerns and Providing Appropriate Care webinar recording available at <http://cc.readytalk.com/play?id=6s53fe> (last visited March 12, 2011). Webinar materials also available by emailing svji@mncasa.org.



Our Catholic-affiliated hospital says that they are not required to provide emergency contraception to sexual assault patients. Is this true?

No. Catholic-affiliated hospitals must still comply with the requirements of Minn. Stat. § 145.4712 subd. 1. Although access to emergency contraception has been increasing generally, there are still obstacles to its availability in hospitals affiliated with the Catholic Church. This is so because health care provided in these hospitals is based on guidelines developed by the United States Conference of Catholic Bishops titled *Ethical and Religious Directives for Catholic Health Care Services*.¹⁴² These guidelines are based on religious teachings that prohibit using artificial contraception or providing abortions.

Despite these teachings, however, the Catholic Church issued Directive 36 for Catholic Health Services, which instructs hospitals to make emergency contraception available to victims of sexual assault.¹⁴³ Directive 36 allows emergency contraception to “a female who has been raped to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization.” Minn. Stat. § 145.4712 subd. 1(b) allows for pregnancy testing to be completed prior to the provision of emergency contraception. Thus, Minnesota law makes allowances that coincide with Directive 36, so no Catholic-affiliated hospital may deny emergency contraception to a sexual assault patient.

For more information on emergency contraception and the sexual assault patient, please see Appendix F MNCASA Fact Sheet Emergency Contraception: Compassionate Care for Sexual Assault Victims.

Our hospital doesn’t “immediately provide” emergency contraception to sexual assault patients. Instead, the patient is told to access the medications at a local pharmacy. Is the hospital meeting the requirements of the law?



Hospitals providing emergency contraception must immediately provide emergency contraception to sexual assault patients provided it is not medically contraindicated. Emergency contraception may be contraindicated if a patient is taking conflicting medications, has a medical condition or has alcohol or drugs in her system that may harm her if she ingests emergency contraception at the time of the medical forensic exam. In these situations, it may be appropriate to delay taking emergency contraception until later (but

¹⁴² Committee on Doctrine of the National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition*, available at <http://www.nccbuscc.org/bishops/directives.shtml#partfour> (last visited March 13, 2011).

¹⁴³ Committee on Doctrine of the National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition*, Directive 36, available at <http://www.nccbuscc.org/bishops/directives.shtml#partfour> (last visited March 13, 2011).

within the effective period of time – generally within 120 hours). However, hospitals must still provide the medications prior to the patient’s discharge to take later as directed. It is often difficult or embarrassing for patients to obtain emergency contraception themselves later at a local pharmacy. Moreover, patients may not be able to afford the medication or have access to it in a timely manner if expected to obtain it themselves. Thus, in order to be in compliance with statute, hospitals must “immediately provide” the medication to patients, even if the patient ingests the medication after discharge from the hospital.



What about prophylactic care for HIV/AIDS?

Minn. Stat. § 145.4712 subd. 2 contemplates that medically accurate written and oral information also be provided to victims of sexual assault on HIV risk and prophylactic care. The risk of HIV transmission from a sexual assault, while low, is a common concern of patients and therefore must be addressed. The administration of prophylactic medications for possible HIV infections is extremely expensive. Most counties do not reimburse for the cost associated with HIV prophylactic medications.¹⁴⁴ It is up to the healthcare professional treating the patient to explain and assess the risk of HIV transmission and determine when prophylactic medications may be indicated. In the event HIV prophylactic medications are indicated, it is not usually possible to “immediately provide” those medications at the time of the medical forensic examination because those medications are difficult for patients to tolerate and must be carefully administered and monitored over several months of treatment. Instead, healthcare professionals usually refer patients to a primary health care provider, infectious disease clinic, or public health department in order to treat patients for potential HIV exposure.

Our hospital staff doesn’t provide any information in writing to sexual assault patients explaining either STI or pregnancy prophylactic medications. What should we do?

Your hospital must provide patients with medically accurate and unbiased written information explaining STI and pregnancy prophylaxis options in order to be in compliance with Minn. Stat. § 145.4712. The Minnesota Department of Public Health has easily-accessible handouts on prophylactic medications for STIs and pregnancy available on their website. These handouts comply with the requirements set by Minn. Stat. § 145.4712.



Factually accurate and unbiased written information on **STIs** in four languages (English, Spanish, Russian and Hmong) is available here:

<http://www.health.state.mn.us/divs/idepc/dtopics/stds/infoaboutstds.html> (last

¹⁴⁴ See Part VI, Section A.

visited March 18, 2011). Factually accurate and unbiased written information on **emergency contraception** is available here:
<http://www.health.state.mn.us/divs/fpc/profinfo/sexualassaultact.pdf> (last visited March 18, 2011).

These handouts are also available in Appendix D and Appendix E. Please check the Minnesota Department of Health website, however, for the most up to date information. In March 2011, SVJI @ MNCASA requested the Minnesota Department of Health to review the handouts for accuracy and make any necessary updates. In addition, we requested that the emergency contraception information be translated into various languages in the same way the STI information has been. More information on the availability of updated versions and translations is forthcoming.

d. minor consent to medical and mental health treatment



The ability to have a medical forensic exam without reporting the assault to law enforcement only applies to adult victims, right? Do minors also have the right to a medical forensic exam without reporting the assault to law enforcement?

Minors do have the right to a medical forensic examination without reporting the assault to law enforcement, in certain situations. Healthcare professionals must have a clear understanding of laws dictating a minor victim's ability to consent to the medical forensic exam and laws mandating the reporting of child sexual abuse. Hospitals should offer regular trainings on medical mandated reporting and minor consent to medical care and how these obligations and rights might intersect with sexual assault patient care. Such trainings should be conducted in a multi-disciplinary framework, so there is a good understanding across disciplines on what various professional roles require. Trainings that incorporate role playing are highly encouraged, to better illustrate how to make decisions in the midst of these difficult and confusing situations.

There is Minnesota law granting minors the ability to consent to receive medical and mental health treatment.



Minn. Stat. § 144.343 provides:

Minor's consent valid. Any minor may give effective consent for medical, mental and other health services to determine the presence of or to treat pregnancy and conditions associated therewith, venereal disease, alcohol and other drug abuse, and the consent of no other person is required.

In addition, § Minn. Stat. 144.344 provides:

Medical, dental, mental and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional's judgment, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment.

Is the medical forensic exam included as “medical services?”

Yes. While the statute doesn’t specifically list the medical forensic exam as a medical service, this statutory language is often interpreted to include the medical forensic examination. Thus, minors have the ability to consent to the receipt of the medical forensic exam themselves, and the consent of no other, additional person is required. While this point has been the subject of some discussion nationally, it is well-established in Minnesota that a minor’s ability to consent to medical care includes the ability to consent to the medical forensic examination.

Who is a “minor?”

Unfortunately, the statute does not define who, specifically, is considered a “minor.” It is generally accepted, however, that thirteen is the age at which a minor’s ability to consent is recognized.

When is it mandatory to report the sexual assault of a minor?

Please see Part VI, Section B. Mandated Reporting.



Our hospital has had situations where a minor’s parents or law enforcement have insisted that we perform the examination on the minor, but the minor refuses. Do minors have the right to refuse a medical forensic exam?

Yes, minors do have the right to refuse a medical forensic examination. Because Minnesota statute grants minors the ability to consent to a medical forensic exam, logic dictates that minors also have the ability to withhold consent to a medical forensic exam.

This situation has played out in a variety of ways in Minnesota hospitals. In some situations, parents suspect that their minor child is (consensually) sexually active, and the parents insist on a medical forensic examination to confirm or deny this suspicion. In other situations, parents suspect that their minor child was sexually assaulted, and insist on a medical forensic examination to preserve evidence and treat any injury. In yet other situations, law enforcement insists that a minor submit to a medical forensic examination, stating that since the minor may be a victim, the examination must be conducted to gather evidence. In some cases, law enforcement has obtained a warrant to gather evidence from a minor victim’s body, claiming that a warrant will trump the minor’s ability to withhold consent to the exam.

Clear guidance in these situations is offered by the National SANE Protocol, developed by the U.S. Department of Justice: “In all cases, the medical forensic examination should never be done against the will of patients.” Performing a medical forensic exam against the patient’s will presents serious medical and legal ethics problems. In addition, performing a exam against the will of a patient seriously compromises a victim’s trust of all professionals working in the system. Minor victims are often the most vulnerable victims in our society, and the demand to gather evidence in these cases is usually made with the protection of the minor in mind. However, it is our belief that by respecting a minor’s ability to control his or her own body, we uphold the values that condemn

the assault against them in the first place. We hope to empower victims, not further degrade their own control over their body by forcing an invasive examination that can be extremely invasive. By creating an environment of respect, not pressure, it is our hope that more victims will eventually choose to cooperate with law enforcement.

Healthcare professionals as well as other professionals on your team must have a clear understanding of a minor patient's ability to consent to or withhold consent to the medical forensic exam. Hospitals should offer regular trainings on minor consent to medical care and how these obligations and rights might intersect with sexual assault patient care. Such trainings should be conducted in a multi-disciplinary framework, so there is a good understanding across disciplines on what various professional roles require. Trainings that incorporate role playing are highly encouraged, to better illustrate how to work through these difficult situations.

Conclusion

Minor victims of sexual assault, usually defined as thirteen years of age and older, have the right to consent to or withhold consent to the medical forensic examination. Because these are difficult situations to work through, we strongly encourage your multidisciplinary team to discuss how a situation like this might be handled *before* there is a stressful situation within an Emergency Department. By having a plan in place, all responding disciplines will better understand the professional responsibilities, obligations and philosophies that drive one another's response.

For more information on minor consent to medical care, please see Appendix F. MNCASA Fact Sheets: Minor Consent for Medical and Mental Health Treatment.

e. polygraph prohibition

Both VAWA 2005 and Minnesota law prohibit the use of polygraph examinations of sexual assault victims as a condition for proceeding with the investigation of the offense. VAWA 2005 provides:



(a) In order to be eligible for grants under this subchapter, a State, Indian tribal government, territorial government, or unit of local government shall certify that, not later than 3 years after January 5, 2006, their laws, policies, or practices will ensure that no law enforcement officer, prosecuting officer or other government official shall ask or require an adult, youth, or child victim of an alleged sex offense as defined under Federal, tribal, State, territorial, or local law to submit to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of such an offense.

(b) Prosecution

The refusal of a victim to submit to an examination described in subsection (a) of this section shall not prevent the investigation, charging, or prosecution of the offense.¹⁴⁵

Minnesota law also prohibits this practice, providing:

Minn. Stat. § 611A.26 POLYGRAPH EXAMINATIONS; CRIMINAL SEXUAL CONDUCT COMPLAINTS; LIMITATIONS

1. Polygraph prohibition. No law enforcement agency or prosecutor shall require that a complainant of a criminal sexual conduct offense submit to a polygraph examination as part of or a condition to proceeding with the investigation, charging, or prosecution of such offense.

2. Law enforcement inquiry. A law enforcement agency or prosecutor may not ask that a complainant of a criminal sexual conduct offense submit to a polygraph examination as part of the investigation, charging, or prosecution of such offense unless the complainant has been referred to, and had the opportunity to exercise the option of consulting with a sexual assault counselor as defined in section 595.02, subdivision 1, paragraph (k).

¹⁴⁵ 42 U.S.C.A. §3796gg-8.

3. Informed consent requirement. At the request of the complainant, a law enforcement agency may conduct a polygraph examination of the complainant only with the complainant's written, informed consent as provided in this subdivision.

4. Informed consent. To consent to a polygraph, a complainant must be informed in writing that:

(1) the taking of the polygraph examination is voluntary and solely at the victim's request;

(2) a law enforcement agency or prosecutor may not ask or require that the complainant submit to a polygraph examination;

(3) the results of the examination are not admissible in court; and

(4) the complainant's refusal to take a polygraph examination may not be used as a basis by the law enforcement agency or prosecutor not to investigate, charge, or prosecute the offender.

5. Polygraph refusal. A complainant's refusal to submit to a polygraph examination

shall not prevent the investigation, charging, or prosecution of the offense.

6. Definitions. For the purposes of this section, the following terms have the meanings given.

(a) "Criminal sexual conduct" means a violation of section 609.342, 609.343, 609.34, 609.345, or 609.3451.

(b) "Complainant" means a person reporting to have been subjected to criminal sexual conduct.

(c) "Polygraph examination" means any mechanical or electrical instrument or device of any type used or allegedly used to examine, test, or question individuals for the purpose of determining truthfulness.

The purpose of these laws is to eliminate barriers to the reporting of sexual assault cases and encourage law enforcement to use investigative methods that are more reliable and creative than a polygraph. In some jurisdictions across the nation, the practice of using polygraph examinations on sexual assault victims was routine, relied on and sometimes required. Other crime victims were not treated in this way, which sent a message that sexual assault victims were not to be believed, and fueled the myth that many sexual assaults are falsely reported.¹⁴⁶

¹⁴⁶ For an overview of relevant research studies on the myth of false sexual assault reports, see Kaarin Long, Caroline Palmer & Sara G. Thome, *A Distinction Without A Difference: Why the Minnesota Supreme Court Should Overrule its Precedent Precluding the Admission of Helpful Expert Testimony in Adult-Victim Sexual Assault Cases* 31 Hamline J. Pub. L & Pol'y 569, 588-591 (August 2010), available at http://www.mncasa.org/Documents/index_175_2534215409.pdf or by contacting the Sexual Violence Justice Institute @ MNCASA at svji@mncasa.org.

By preventing law enforcement from requiring sexual assault victims to undergo a polygraph examination as a condition of the investigation being pursued, we hope that more victims feel believed, and will continue to participate in the criminal justice system.

If your jurisdiction requires sexual assault victims to comply with a polygraph in order to move forward with an investigation, please call the Minnesota Department of Safety, Office of Justice Programs, Crime Victim Grants Unit at 651-201-7300.

There are many creative investigative techniques that do not require the victim to endure a polygraph examination. SVJI @ MNCASA can work with your jurisdiction to bring training and resources to aid in sexual assault investigations. One resource, End Violence Against Women International, has an affordable online training institute designed to improve the investigation and prosecution of sexual assault cases.¹⁴⁷

For more information on the polygraph prohibition, see Appendix F, Minnesota Coalition Against Sexual Assault Fact Sheets: Limitations on the Use of Polygraph Exams in Criminal Sexual Conduct Cases.

¹⁴⁷ See End Violence Against Women International, Online Training Institute, available at <http://www.evawintl.org/olti/Courses.aspx> (last visited March 3, 2011).

appendix

Sexual Violence Justice Institute (SVJI) @ MNCASA

Forensic Compliance:

*How to Ensure Victims of Sexual Assault Receive
the Care that Federal and State Law Require*



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Objectives

- What is "forensic compliance?"
 - Federal law
 - State law
- What's happening on the ground?
- SVJI's Forensic Compliance Project
- Example of a compliant system
- Is your jurisdiction compliant?

What is "forensic compliance?"

New requirements for states, territories and tribes receiving federal Violence Against Women Act (VAWA) money:

- (1) Victim must have access to medical forensic exam without cooperating with LE; and
- (2) Victim cannot bear the cost of the exam.

VAWA 2005 language

Nothing in this section 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.*

42 USC § 13925g-4(b)(3)(D)(i)

Why the change?

- Trauma, safety considerations, self-blame makes decision to report to law enforcement very difficult
- Some states required law enforcement to authorize exam
- Desire to increase victim access to time-sensitive healthcare & evidence collection
- Evidence collection is connected to better prosecution outcomes

Deadline and Consequences

- January 5, 2009
- Non-compliance could jeopardize agencies that receive VAWA Stop Funds –law enforcement, prosecution, shelters, advocacy
- States must be able to certify that they are in compliance with VAWA language to continue to receive VAWA \$\$\$

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Is Minnesota compliant?

- Yes, technically.....

See Minn. Stat. 609.35 (handout)

Minn. Stat. § 609.35

What is clear:

- County where assault occurred is responsible for payment (a)
- County may seek reimbursement from insurance, but only after articulated process (b)
- Jurisdictions must offer exam option regardless of victim's cooperation with law enforcement (c)

What isn't clear:

- What process jurisdictions must put in place to be sure victim is offered exam without cooperating with law enforcement
- Which entity within county responsible for payment
- How much the county must pay
- How victim privacy will be protected during payment processing
- What other costs may be covered – follow up exam, RX

What else does state law require?

- Minn. Stat. 144.344
Minor consent for medical and mental health treatment
- Minn. Stat. 145.4712
Emergency Care to Sexual Assault Victims

Letter vs. Spirit of VAWA

Letter – provide exams without requiring victim cooperation with law enforcement; victim cannot bear burden of exam payment

Spirit – store evidence for victim-centered period of time; make case conversion feasible; vigorously investigate and pursue converted cases

Victim-Centered Approach

- Consider the victim first
- **Listen**
- Promote victim self-agency
- **Coordinate and collaborate in the victim's interest**
- Ensure victim safety
- **Seek just solutions for all**
- Hold self and others accountable

What's happening on the ground?

- 87 different approaches to payment
- 87, possibly more, approaches to:
 - Location of evidence kit storage
 - Duration of evidence kit storage
 - Process to convert a case
 - Victim notification of kit destruction
 - Reporting options

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Reporting Options

- Also known as:
 - Jane Doe
 - Anonymous
 - 3rd party
- Availability, implementation vary across state and nation
- NOT required by federal or state law; but are
 - Victim-centered
 - Helpful

What's happening on the ground?

- Confusion about other issues that frequently arise in context of exam:
 - Medical mandated reporting
 - Minor consent to medical care
 - Emergency contraception
 - STI treatment
 - Victims referred out to another hospital for exam

SVJI's Forensic Compliance Project

- 2009 – 2011
- Statewide multidisciplinary advisory board
- Created *Minnesota Model Policies for Forensic Compliance*

Example of a Compliant System

Southern St. Louis County

- SMART team
- Community-based advocacy program runs SANE program
- 2 hospitals where exams are performed
- About 100 exams a year

Compliant System

Reporting options for victims

- In place since 2008
- LE initiated anonymous reporting option due to young adults reporting they had been assaulted as a juvenile – no evidence to proceed

Compliant System

Reporting options for victims

1. standard report
2. anonymous 3rd party report (see following slide)
3. no report
 - hospital stores kit 6 months
 - usually done if assault happened in jurisdiction that won't accept anonymous reporting option

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Compliant System

Anonymous 3rd party report

- Forensic examiner calls dispatch to get ICR (Incident Criminal Report) number – this is the kit identifier.
- Code LE uses is "Criminal Sexual Conduct – Anonymous." No investigation occurs.
- Forensic examiner makes report on behalf of victim
- LE in county where assault occurred transports and stores evidence kit, including blood and urine

Compliant System

Possible kit identifiers:

- Forensic examiner name, date, time
PamTurner09102009
- Hospital chart number
St. Joseph09-12345
- Pseudonym, location, date
JaneDoeStearnsCounty09102009

Compliant System

Kit storage location and duration

- Kit storage depends on independent LE time frame – *minimum 18 months*
- LE gives advocates one month to contact victim before destruction

Compliant System

Process for converting a case

- Victim can call advocacy program for help in conversion
- Victim given ICR# so can convert themselves by calling law enforcement
- County Attorney has agreed not to consider these reports "delayed" for charging purposes

Is your jurisdiction compliant?

- How can you tell?
- If yes, how can you stay in compliance & take next steps?
- If no, how can you come into compliance?



Remember, strive to be compliant with the spirit of the law, too!

Who should be at the table

- If your jurisdiction has a SART/SMART team, great!
- If not, convene a meeting with:
 - Advocates
 - Medical professionals
 - Law enforcement
 - Prosecutors
 - Dispatch
 - Medical billing
 - County entity responsible for payment (if not included above)

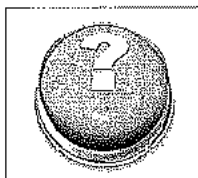
How to start the conversations

- Be aware of challenge -- can bring team together or cause stress to a team
- Take time to clarify terms at the start -- get everyone on the same page
- Encourage the development of written policies
- Start small -- don't try to tackle all issues at once

Top 3

1. Victims do not need cooperate with law enforcement in order to receive medical forensic exam
2. Victims do not have to pay for medical forensic exam
3. Individual jurisdictions are reacting to these requirements in different ways -- form a multidisciplinary team to learn more

Questions?



Forensic Compliance Quiz

Please check the discipline that applies to your role:

- ☐ Law enforcement ☐ Advocacy ☐ Prosecution
☐ Medical practitioner ☐ Medical administrator ☐ Other _____

All questions refer to jurisdictions in Minnesota.

	True	False
1. Victims must report to law enforcement in order to obtain a medical forensic exam.	T	F
2. Medical facilities must provide a prescription for emergency contraception to victims if requested.	T	F
3. State law determines <i>how long</i> an evidentiary kit in an unreported case must be stored.	T	F
4. State law determines <i>where</i> an evidentiary kit in an unreported case must be stored.	T	F
5. I know how long an evidentiary kit from an unreported case will be stored in the county(ies) where I work (How long? _____).	T	F
6. Victims must first pay for a medical forensic exam and then receive reimbursement.	T	F
7. The county in which the assault took place is always responsible for the cost of a medical forensic exam.	T	F
8. The county must have the name of a non-reporting victim of sexual assault before paying for the medical forensic exam.	T	F
9. The county in which the medical forensic exam was conducted is responsible for the cost of the exam.	T	F
10. There is a standard cost for a medical forensic exam statewide.	T	F
11. Victims must always provide insurance information prior to receiving a medical forensic exam.	T	F
12. There are alternative reporting options available to victims of sexual violence in the county(ies) where I work, such as anonymous, 3 rd party, or Jane Doe reporting options.	T	F
13. The only person allowed to conduct a medical forensic exam is a certified Sexual Assault Nurse Examiner (SANE).	T	F



Forensic Compliance Quiz Answers

We hope that this document helps you assess whether your jurisdiction or medical facility is compliant with federal and state law determining how the medical forensic examination is provided to victims of sexual violence.

For more information on how MNCASA is working to ensure victims have better access to the medical forensic exam, please visit us at http://www.mncasa.org/forensic_compliance.html

- | | True | False |
|---|------|-------|
| 1. Victims must report to law enforcement in order to obtain a medical forensic exam. | T | F |
| <i>Answer:</i> False. Both federal law [Violence Against Women Act of 2005] and Minnesota law [Minn. Stat. 609.35(c)] provide that a victim must be offered a medical forensic exam <i>regardless</i> of his or her decision to report the assault to law enforcement. | | |
| 2. Medical facilities must provide emergency contraception to victims if requested. | T | F |
| <i>Answer:</i> True. According to Minn. Stat. 145.1742, all hospitals that provide emergency care must immediately provide emergency contraception to each sexual assault victim who requests it, provided it is not medically contraindicated and is ordered by a legal prescriber. If an individual physician refuses to prescribe emergency contraception, the facility must provide another staff person to prescribe it. | | |
| 3. State law determines <i>how long</i> an evidentiary kit in an unreported case must be stored. | T | F |
| <i>Answer:</i> False. There is currently no state law determining how long an evidentiary kit from an unreported case must be stored. The purpose of storing such kits is to allow victims time to feel safer, and learn about and weigh options before making a decision whether to report the assault to police. Across Minnesota, such kits are stored for various periods of time. Some jurisdictions store them for 90 days, some for 18 months or longer. MNCASA is currently working on model policies to help jurisdictions determine what period of time is victim-centered. | | |
| 4. State law determines <i>where</i> an evidentiary kit in an unreported case must be stored. | T | F |
| <i>Answer:</i> False. There is currently no state law determining where evidentiary kits from an unreported case must be stored. The purpose of storing such kits is to allow victims time to feel safer, and learn about and weigh options before making a decision whether to report the assault to police. Across Minnesota, such kits are stored at either hospitals or law enforcement facilities. MNCASA is currently working on model policies to help jurisdictions determine where such kits should be stored. | | |
| 5. I know how long an evidentiary kit from an unreported case will be stored in the county(ies) where I work (How long? _____) | T | F |
| <i>Answer:</i> This answer will vary. If you do not currently know how long evidentiary kits will be stored in the county(ies) where you work, we encourage you to find out in order to better serve victims. If there is no such policy in your jurisdiction, we encourage you to convene a meeting with representatives from law enforcement, advocacy, medical, | | |

prosecution, dispatch, corrections and any allied professionals, to set policy on this issue. MNCASA is currently working on model policies to help jurisdictions determine where and for how long such kits should be stored.

6. Victims must first pay for a medical forensic exam and then receive reimbursement. T F

Answer: False. According to Minnesota law, victims are not required to first pay for the exam and then seek reimbursement. The county in which the assault occurred is responsible for exam payment and that county should be billed directly by the hospital. There is sometimes confusion as to which costs are related to evidence collection and which costs are related to medical care. For example, the hospital may charge \$400 for evidence collection and another \$150 for medications. In that situation, the county is responsible for the \$400 charge, but the victim may have to pay for the \$150 in medications, even though the medications were related to being a victim of a crime. MNCASA is currently working on model policies to help clarify which charges should be the responsibility of the county.

7. The county in which the assault took place is always responsible for the cost of a medical forensic exam. T F

Answer: True. According to Minn. Stat. 609.35(a), the county in which the assault took place is responsible for the cost of a medical forensic exam. A victim concerned about his/her privacy may not want the county to pay for the exam, however. In that case, the victim may submit the cost to medical insurance. In order to ensure that victims are not pressured into billing their insurance provider, this option may not be addressed until *after* the exam has been completed.

8. The county must have the name of a non-reporting victim of sexual assault before paying for the medical forensic exam. T F

Answer: False. There is no formal requirement for the county to have the name or other identifying information (like social security number) of the victim in order to pay for a medical forensic exam. However, some counties refuse to pay a bill without this information for auditing reasons. MNCASA is currently working on model policies to help county payors institute payment processes that do not require the victim's name or other identifying information.

9. The county in which the medical forensic exam was conducted is responsible for the cost of the exam. T F

Answer: False. According to Minn. Stat. 609.35(a), the county in which the *assault* occurred, not the county in which the *exam* occurred, is responsible for payment. So, if a victim is assaulted in County A, but travels to County B for the exam, County A is still responsible for the costs of the exam.

10. There is a standard cost for a medical forensic exam statewide. T F

Answer: False. Minn. Stat. 609.35(a) provides only that the county in which the assault occurred must pay the "full cost" of the exam. Different counties have different interpretations of "full cost," and have negotiated a rate that hospitals will accept. As a result, there is a patchwork of payment amounts across the state. MNCASA is currently working on model policies to help jurisdictions determine what charges, at a minimum, should be included in the "full cost" of the exam.

11. Victims must always provide insurance information prior to receiving a medical forensic exam. T F

Answer: False. Minn. Stat. 609.35(b) provides that victims must not be required to provide their medical insurance information prior to receiving the exam. *After* the exam, the county can request reimbursement from a victim's insurance provider, but only with the victim's consent. When requesting a victim's insurance information, the county must also inform the victim that the county in which the assault occurred is ultimately responsible for the exam cost.



12. There are alternative reporting options available to victims of sexual violence in the county(ies) where I work, such as anonymous, 3rd party, or Jane Doe reporting options. T F

Answer: This answer will vary. If you do not currently know whether there are alternative reporting options available to victims of sexual violence in the county(ies) where you work, we encourage you to find out, in order to better serve victims. If there is no such policy in your jurisdiction, we encourage you to convene a meeting with representatives from law enforcement, advocacy, medical, prosecution, dispatch, corrections and any allied professionals, to set policy on this issue. MNCASA is currently working on model policies to help jurisdictions determine what types of reporting options are victim-centered and feasible.

13. The only person allowed to conduct a medical forensic exam is a certified Sexual Assault Nurse Examiner (SANE). T F

Answer: False. Although SANEs are trained to provide superior patient care, evidence collection, and are trained to testify in court if needed, most hospitals in Minnesota do not have a SANE program. In those hospitals, registered nurses and physicians may conduct the exam. If the hospital in your jurisdiction does not have SANEs, what happens? Do Emergency Department nurses or physicians seem confident conducting the exam? Does the hospital refer the patient out to another facility? MNCASA is currently working on model policies to help jurisdictions put responsible and victim-centered referral policies in place. MNCASA is also working to help improve the standard of care provided to victims of sexual violence, whether that patient presents to a hospital with a SANE program or not.

Sexual Assault Exam Competency Quiz¹

Name _____

Refer to ED policy ED-D-35 in order to answer the following questions.
Return to ED Nurse Manager by December 31, 2010.

TRUE	FALSE	For each statement below, mark whether it is true or false.
		1. District One Hospital's ED policy ED-D-35 applies to sexual assault victims aged 13 and older.
		2. Victims under age 13 (or ages 13-17 if a family member is the alleged perpetrator) should be referred to Midwest Children's Resource Center.
		3. Evidentiary kits should not be collected if the sexual assault occurred more than 3 days (72 hours) ago.
		4. Victims must report to law enforcement in order to obtain a medical forensic exam.
		5. The county in which the assault occurred is required to pay for all costs associated with the sexual assault evidentiary exam.
		6. All victims should be told that an advocate is readily available and should be asked if they would like to have an advocate called.
		7. Sexual assaults must be reported to law enforcement if a dangerous weapon was involved in the assault.
		8. The District One Hospital "Consent for Services" (the form that every patient signs) covers collection of evidence, including photographs and no additional consent is required.
		9. Gloves are to be worn when handling all evidence in order to avoid contamination of evidence with the healthcare worker's own DNA.
		10. All clothing items may be placed together in one paper bag, then sealed with a hospital ID sticker.
		11. Rice County law enforcement will accept evidentiary kits for storage even if the victim chooses not to report the crime.
		12. When the victim chooses not to report, the evidentiary kit must still be labeled with the patient's name and visit ID #.
		13. Medical facilities must provide emergency contraception to victims if requested.
		14. The victim must receive written information from MN Department of Health regarding emergency contraception.
		15. The Rice County SMART survey is to be completed only by the victim.

¹ This quiz was adapted by Cheryl Arnold, RN, ED/OP Nurse Manager, District One Hospital, Faribault, Minnesota.

SEXUAL ASSAULT REPORT™

LAW ■ PREVENTION ■ PROTECTION ■ ENFORCEMENT ■ TREATMENT ■ HEALTH

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Special Issue

VAWA 2005 Forensic Compliance

by Kimberly A. Lonsway, Ph.D.

The 2005 reauthorization of the Violence Against Women Act (often referred to as "VAWA 2005") specified that states and territories may not "require a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam, reimbursed for charges incurred on account of such an exam, or both." See 42 U.S.C. § 3796gg-4(d). In the past, states were required to offer such exams to victims free of charge or with full reimbursement, but victims could be required to cooperate with the criminal justice process. VAWA 2005 was designed to change that, by offering all victims of sexual assault free access to a forensic exam, regardless of whether they report the crime to law enforcement or participate in an investigation and criminal prosecution. (This issue is often referred to as "forensic compliance.")

Yet achieving forensic compliance requires addressing many complex issues with respect to evidence collection, storage, anonymous reporting, medical mandated reporting, records retention, and collaboration with hospitals and other community agencies. For many states and territories, the changes that are required have been described as "monumental" (Maryland Coalition Against Sexual Assault, 2009, p. 4).

In this issue, we feature two articles describing the efforts that have been undertaken by multidisciplinary professionals in two

See SPECIAL ISSUE, page 14

U.S. Supreme Court Decisions: Post-Sentence Civil Commitments and Habeas Corpus Relief

by Annie Perry, Esq.

I. Court Upholds Power to Confine "Sexually Dangerous" Prisoners Beyond Sentencing Terms

The U.S. Supreme Court upheld the federal law that allows the US government to hold inmates who have served their prison time but who are deemed "sexually dangerous." *United States v. Comstock*, No. 08-1224 (May 17, 2010). The Court majority held that the Necessary and Proper Clause granted Congress the authority to extend the civil commitment of sex offenders after completion of their criminal sentences.

The 7-2 vote, authored by Justice Breyer, endorsed broad federal authority to legislate in furtherance of powers bestowed by the Constitution. Justice Breyer was joined by Justices Roberts, Stevens, Ginsburg, Sotomayor, Kennedy, and Alito. Justices Kennedy and Alito also filed concurring opinions. Justice Thomas wrote a dissenting opinion in which Justice Scalia joined.

The Federal Commitment Statute

Under 18 U.S.C. § 4248, the Department of Justice is authorized to detain a mentally ill, sexually dangerous prisoner beyond

the date the prisoner would otherwise be released. The Government must prove by "clear and convincing evidence" that the prisoner has engaged in sexually violent activity or child molestation in the past and that the prisoner suffers from a mental illness that makes him dangerous to others. Upon such a showing, the Attorney General must return the offender to the care and custody of the state where the offender was tried or the state where he was domiciled. Alternatively, the offender can be placed in a suitable federal facility for treatment, if neither state is willing to assume such responsibility. Confinement in a federal facility then lasts until the offender's mental condition improves to the point where he is no longer considered dangerous, or when a state assumes responsibility for his care and custody.

Five federal prisoners brought the case against the U.S. following their civil confinement under § 4248. Lead challenger Graydon Comstock's case was typical of the five. Comstock was certified as "sexually dangerous" six days before the end of his prison term in November 2006 for possession

See U.S. SUPREME COURT, next page

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Fulfilling the Spirit of VAWA 2005: Multidisciplinary Strategies

Sara G. Thome, J.D.*

The Sexual Violence Justice Institute (SVJI) is a special project of the Minnesota Coalition Against Sexual Assault, which has been formally working on forensic compliance within the state since August 2009. While SVJI has always worked to increase victim access to a quality medical forensic exam, it was only recently that we had the opportunity to focus on all aspects related to forensic compliance.

Part of the mission of SVJI is to encourage victim-centered investigation and prosecution of sexual assault cases by increasing multidisciplinary collaboration and providing multidisciplinary teams with training and resources. SVJI also provides intensive technical assistance to 11 teams within Minnesota, as well as several national teams. Because of this, we at SVJI are in a unique position to see how these teams have tackled the complex issues associated with forensic compliance, as well as the benefits and challenges that multidisciplinary collaboration presents.

Background: Forensic Compliance in Minnesota

While Minnesota is technically in compliance with VAWA 2005 through statute (Minn. Stat. 609.35(2003)), we are aware that things could be working better on the ground. We have found that jurisdictions need education, practical examples and technical assistance to maintain or improve compliance. Of particular importance to us is the continued movement toward fulfillment of the *spirit* of compliance—that is, ensuring that exams which begin as unreported cases and are later converted to standard reports are being actively investigated and prosecuted. While Minnesota jurisdictions clearly meet the letter of the law by offering victims access to an exam regardless of their decision to report, few jurisdictions have written policies in place and few jurisdictions are seeing converted cases prosecuted.

*Sara G. Thome works as Project Attorney and Collaboration Specialist with the Sexual Violence Justice Institute at the Minnesota Coalition Against Sexual Assault. She can be reached at sthome@mnccasa.org.

Our forensic compliance project therefore has three primary goals. First, we hope to improve the current county-based exam payment system. In Minnesota, the law specifies that counties have the responsibility to pay for any medical forensic examination that is conducted without a report to law enforcement. The state has 87 counties, so a county-by-county payment structure is difficult to navigate for victims and professionals alike. Second, we plan to develop model policies regarding victims' reporting options, evidentiary kit storage location and duration, and

on where evidentiary kits from unreported cases will be stored or whether/how victims will be notified of kit destruction requires compromise, cooperation and conversation among diverse team members.

In our experience, strong multidisciplinary teams with active participants are able to communicate openly and honestly with one another; they are therefore better able to adapt protocols to reflect changes associated with forensic compliance. Because all disciplines have a part in discussions with strong multidisciplinary teams, all of the disciplines

The complex issues associated with forensic compliance either can help a multidisciplinary team move to the next level of collaboration or create tensions that ultimately weaken the team.

case conversion. Third, we hope to foster the competence and confidence of medical professionals who treat victims of sexual violence by providing low-cost opportunities for professional networking and training.

With these goals in mind, we have reached out to the teams we support as they strive to achieve the spirit of VAWA 2005. Some of the strategies that they have found effective are highlighted here. Our hope is that the lessons learned in Minnesota can be helpful in other states as well.

The Benefits of a Multidisciplinary Approach

Forensic compliance topics cross all of the disciplines involved in the criminal justice and community response to sexual assault. Therefore, representatives from all of the disciplines must be engaged in the process of reform for compliance mandates to be met. For example, setting policy to ensure victims are offered the medical forensic exam regardless of their decision to report requires cooperation among medical personnel, advocates and law enforcement. Professionals within each of these disciplines must have a good understanding of each others' roles in order to be successful. Likewise, setting policy

have a greater degree of "buy-in" and a better understanding of the goals associated with compliance. Such increased understanding and buy-in thus has the potential to lead to a more victim-centered approach.

The Challenges of a Multidisciplinary Response

Despite its benefits, multidisciplinary collaboration is not always easy or fun! With true multidisciplinary collaboration, professionals—who are striving to be better at what they do—come together to dissect how the system is (or is not) working. This process obviously subjects their own individual performances to criticism. Strong teams can learn how to benefit from this diversity, and establish good communication patterns and mutual respect. While a strong team might thrive under the challenges presented by forensic compliance, the same challenges could strain a newer or weaker team. This is true for several reasons.

First, differing perspectives held by team members have the potential to create tension. For example, by ensuring that all victims have access to a medical forensic exam without cooperating with law enforcement,

See FULFILLING THE SPIRIT, page 15

FULLFILLING THE SPIRIT, from page 3

officers may feel like they are being prevented from doing what they do best—investigating crime. Law enforcement professionals may also believe that advocates or medical professionals should be doing more to encourage victims to report. In particular, officers who have worked hard to establish victim rapport and investigative skills may feel their efforts have been wasted.

Second, time is often a challenge for teams tackling compliance issues. Given the complexity of the issues, it is clear that multidisciplinary teams need to devote more than one meeting to discussing compliance requirements. For instance, if the team agrees that local law enforcement agencies will store the evidentiary kits from unreported cases, there are many follow-up questions that must be asked: How will the kits be transported to the law enforcement facility? How will the kits be identified? How will victims who decide to convert their case later on accomplish this task? Working through all of these details takes time and attention to detail, something that may not be possible in a monthly meeting format.

In our experience, the complex issues associated with forensic compliance either can help a multidisciplinary team move to the next level of collaboration or create tensions that ultimately weaken the team. To move forward, we encourage team members to be honest about their concerns, and redirect difficult conversations back to what the team's overall goal should be, namely, providing victim-centered care.

Encourage Consistent, Victim-Centered Language

We have made a conscious effort to influence how teams talk about forensic compliance. As we all know, our choice of language matters a great deal when it comes to sexual assault, so we should not underestimate the potential impact of the language we use to describe the tools associated with forensic compliance. For years we have been encouraging police officers and prosecutors to use language that effectively articulates the seriousness of sexual assault, both in written reports and in the courtroom. We now have the same opportunity with forensic compliance. We have thus modeled positive language to our teams and watched as this language has caught on.

For example, we noticed that team members struggled to put a label on cases that began as unreported cases where the victim later decided to report to law enforcement.

Some teams called these cases "delayed," while others labeled them as "deferred" or "change-over" cases. We began by modeling the term "converted" instead. The use of that term is intentional, keeping in mind the effect the term may ultimately have on juries. Aware that jurors distrust "delayed" reports, we thought it best to use a more neutral term to convey that process.

Another example is our use of the phrase "reporting options" to classify all non-traditional reporting mechanisms such as anonymous, blind, third party, or Jane Doe reporting. We originally noticed that some team members meant different things by the term "anonymous" reporting. Thus, some teams were debating the advantages and disadvantages of anonymous reporting without first clarifying that they had a consistent understanding of what was meant by that term. By using the umbrella term "reporting options," we have found that teams can better appreciate the "bigger picture" of the issues involved and discuss what features they would like to employ in an alternative reporting structure—rather than getting hung up on what the individual terms might mean.

Foster Innovation

In general, we have not set out to direct individual jurisdictions what to do to implement or maintain forensic compliance, but rather to create an environment that fosters innovative solutions to the challenges that are involved. Thus, we have provided teams with educational materials, examples of compliant systems, and tools

such as *Ensuring Forensic Medical Exams for All Sexual Assault Victims: A Toolkit for States and Territories* (developed by the U.S. Department of Justice, Office on Violence Against Women and the Maryland Coalition Against Sexual Assault) and the webinars and resource materials provided by End Violence Against Women (EVAW) International. We have also made ourselves available for further questions or meetings and monitored the results.

The results have been heartening. For example, in one rural Minnesota county where there are several small police departments, evidence kit storage presented a problem. Specifically, team members representing the police departments were concerned that their evidence rooms would have to purchase new refrigerators in order to store the kits from unreported cases. Team members were also concerned that victims might not remember the specific town where they had been assaulted, if they chose to convert their case to a standard report at a later date. As a result of these conversations, the county sheriff offered to store all evidentiary kits collected in the county, no matter which police department might have jurisdiction over the crime if it was later investigated. This offer was made for several reasons. The sheriff's office is the county entity designated to pay for the exam under Minnesota law. It also has a larger evidence room and more refrigerators than any other agency, as well as a full-time evidence technician. One central storage location ensures that victims have only one

See *FULLFILLING THE SPIRIT*, next page

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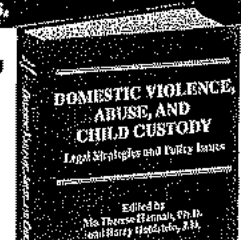
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Sexual Assault Report

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APPENDIX A

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Sexual Assault Report

September/October 2010

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Sexual Assault Report is published six times annually. A basic one-year subscription is \$165 plus \$14.95 postage and handling. Non-exempt New Jersey and New York residents please add appropriate sales tax.

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FULFILLING THE SPIRIT, from page 15

point of contact if they decide to convert their case later on. The sheriff's office generally has an officer in the area and will therefore be able to respond to all of the medical facilities in the county within a reasonable period of time, to transport and store the kit. Finally, the sheriff's office has a history of offering assistance to the smaller police departments within the county. This type of creative, guided innovation is what we were after. As a result, this jurisdiction is closer to fulfilling the spirit of the law with forensic compliance, because it instituted a policy that takes advantage of the unique features and resources of their community. It is also clearly a credit to the collaborative leadership of this particular sheriff's office.¹

Encourage Written Policies

Another prominent feature of our response at SVJI has been to encourage teams to incorporate compliance principles into their written protocols, no matter how basic they might be. Sometimes teams are reluctant to change existing protocols because of the time it takes to edit and re-print them, or because team members feel that they work well together and therefore do not need a formal protocol.

Yet written policies benefit team members and victims alike. By articulating each discipline's responsibilities in a step-by-step format, all team members can better understand each others' roles. Written policies

also help explain to others how the system works. For example, having a written protocol for case conversion lends legitimacy to those cases by showing jurors that the conversion process is an accepted option that was developed by professionals and routinely offered to victims.

Written policies also survive the loss of team members and address the constant challenge of turnover among agency staff. For example, when the specific details of how emergency department personnel should interact with victim advocates are formalized in writing, it is more likely that this interaction will be consistent even when a new emergency department manager is hired.

Conclusion

While we are barely one year into our forensic compliance project, we have already seen how these strategies have moved Minnesota closer to compliance with the overall spirit of the law for VAWA 2005 forensic compliance. In future articles, we hope to continue to share how the multidisciplinary teams we support have tackled forensic compliance issues and produced innovative reforms for victims.

Endnote

1. Credit for leading this collaborative effort must be given to Captain Pat Thompson, Goodhue County Sheriff's Office, Red Wing, Minnesota, and all members of the Goodhue County Sexual Assault Multidisciplinary Action Response Team (SMART).

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To: All Staff

From: Schirmers

Date: 4-9-2010

RE: "Jane Doe" Sexual Assault Kits

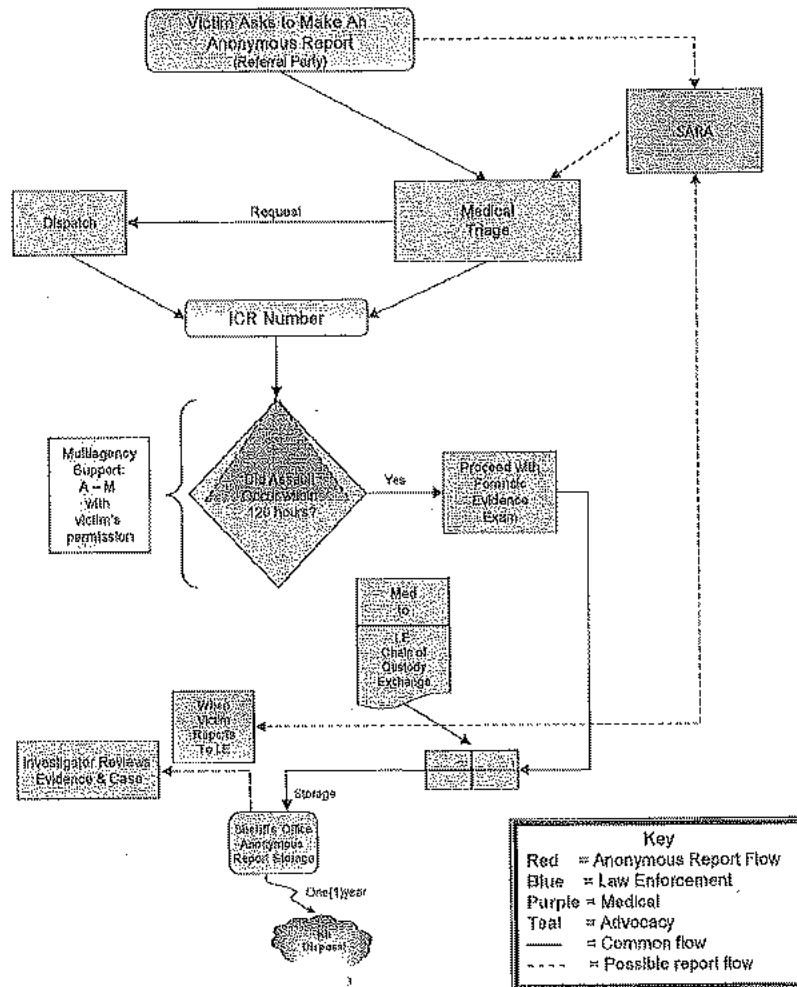
I recently met with Jane Smalley from St. Gabriel's Hospital and Lt. Motes regarding creating a procedure to identify collect and retain Sexual Assault Evidence Kits when the victim wishes to remain anonymous at the time the physical exam is completed. If and when this would occur:

1. An officer will need to respond to the emergency room, collect the physical evidence and retain the evidence in an appropriate manner,
2. The hospital will assign and identify the kit with a reference number and retain all information related to the victim,
3. The police department will guarantee St Gabriel's Hospital that we will retain the evidence for a minimum period of one year,
4. A case file titled, "Information" will be created and St Gabriel's Hospital will be listed as the Complainant. The evidence collected and reference number also need to be listed in the file.

The intent of this process is to allow for the immediate collection of any physical evidence and allow the victim time to get into an environment he/she feels is safe. The victim can then make contact with the police to report the incident if they wish.

Let me know if you have any questions.

Anonymous Reports





Program for Aid to Victims of Sexual Assault
Southern St. Louis County SMART

Anonymous 3rd Party Reporting Process
The collection and storage of evidence from SANE exams
Revised 4-26-2011

Purpose:

The purpose of developing an anonymous reporting process is to allow DNA and other evidence to be stored indefinitely in the event a victim decides to report at a later time. Evidence may include BCA kits (including toxicology kit and BAL kit), clothing or other items collected, Sexual Assault Exam Report Form completed by SANE, and photo disc.

Process for release and storage of evidence:

The patient/victim will sign the authorization for release of evidence checking the box designating that they are making an anonymous report.

The patient will be given the following details in writing, via the Anonymous 3rd Party Report Form:

- Possible length of time the evidence will be stored anonymously
- Where evidence will be stored
- How to change an anonymous report to a standard report
- How to have clothing returned
- How and when patient will be notified by the SANE program
- Where to call with questions

The SANE will contact 911 to obtain an ICR number and attach that number to the case.

The Sexual Assault Exam Report form will have the victim's name, other identifying information and the ICR number. The original of this form and a copy of the photo disc will be kept in the standard, confidential manner by the SANE program.

The sealed BCA kit(s), clothing, and photo disc will be marked with the anonymous report number and will be transferred to the appropriate law enforcement agency.

Additional medical documentation by hospital personnel will follow the standard hospital protocols and will not be released without signed authorization from by the patient.

911 Dispatch

See Attachment A

Shield Documentation

The anonymous reporting code for shield will be 9833. When entering information into shield the following information will be used: address will be the address of the law enforcement agency having jurisdiction over the report, SANE as reporting party and the anonymous reporting code 9833.

Accessing Evidence for Future Reporting

Patients will be advised that should they decide to report the crime to law enforcement, they should contact the SANE Program to avoid multiple ICR numbers being assigned. The patient's evidence and documentation will be accessed using the anonymous reporting number through the SANE Program. An updated authorization form signed by the patient will be required for the transfer of evidence held by the SANE program.

Law enforcement may contact the SANE Coordinator to obtain authorization forms and coordinate evidence transfer. If a victim reports to law enforcement, the officer will ask if they have had a SANE exam to reduce the number of cases where multiple ICR numbers may be issued.

The SANE Coordinator will track names of reported assailants. Patients/victims opting to report anonymously will have the choice of being contacted if the same assailant is reported by another victim.

Permanent Evidence Destruction

Before a law enforcement agency destroys any evidence attached to an anonymous report, they will contact the SANE Program. The SANE Coordinator will notify the victim of the pending evidence destruction.

If a victim notifies the SANE Program that they do not wish to have the evidence held any longer, the SANE Coordinator will notify the appropriate law enforcement agency.

SANE personnel will contact every patient who has not either relinquished evidence for a standard report or destruction 18 months from the date of the exam to determine patient wishes about continued storage of the evidence.

Participating Law Enforcement Agencies

Duluth Police Department
 Hermantown Police Department
 Proctor Police Department
 St. Louis County Sheriff's Department and 9-1-1 Dispatch
 University of Minnesota- Duluth Police Department
 Douglas County Sheriff's Department and 9-1-1 Dispatch
 Superior Police Department

Additional Participating Agencies:

Program for Aid to Victims of Sexual Assault
 St. Louis County Attorney Office
 St. Louis County Initial Intervention Services
 St. Luke's Hospital
 Essentia Health Care St. Mary's Medical Center

Attachment A

**9-1-1 PROCEDURE FOR PROCESSING
SANE (3rd PARTY)/CSC ANONYMOUS REPORTS**

(9/16/2008) rev. (2/11/2009), (9/21/2009)

Southern St. Louis County is offering a secondary reporting option for victims of sexual assault. This option, called Anonymous Reporting has been developed by PAVSA (Program for Aid to Victims of Sexual Assault) in collaboration with St. Louis County Law Enforcement Agencies. It allows a SANE (Sexual Assault Nurse Examiner) to make a sexual assault report on behalf of a victim and receive an Incident Criminal Report number (ICR) without divulging the identity of the victim. The report will be made by calling 9-1-1.

The SANE who examines the victim will call 9-1-1 and provide the location at which the assault occurred in order to establish jurisdiction (see note below re: location). The SANE will also provide the date and time the assault occurred and will request an ICR for an Anonymous CSC Report. An officer should not be dispatched at this time. The SANE will call back for an officer to respond after the exam has been completed to pick up the evidence kit and place it into property. On call back, the SANE will provide the ICR so the original call may be reopened and assigned to a jurisdictional squad.

At the time of the initial call, the 9-1-1 call taker will enter an ADVISED/MOR call in CAD and provide an ICR to the SANE. Each of the fields identified below must be completed.

From the Command Line: OV (generic unit) <Tab>

OV Unit: Use Generic Unit for LE agency in jurisdiction which the assault occurred. See list on page 2.

Location: Use Common Name Address for LE agency in which the assault occurred, NOT location of incident or location of hospital reporting.

Type: Use CSCA (Criminal Sexual Conduct Anonymous)

Comment: Enter ANON RPT – OCCURRED (date/time)
SANE CALLED FROM (hospital name)

Group: Enter 1P or 1DPD based on jurisdiction location

Info: Enter PAVSA/SANE report

Dispo: Use MOR

Service: Use P

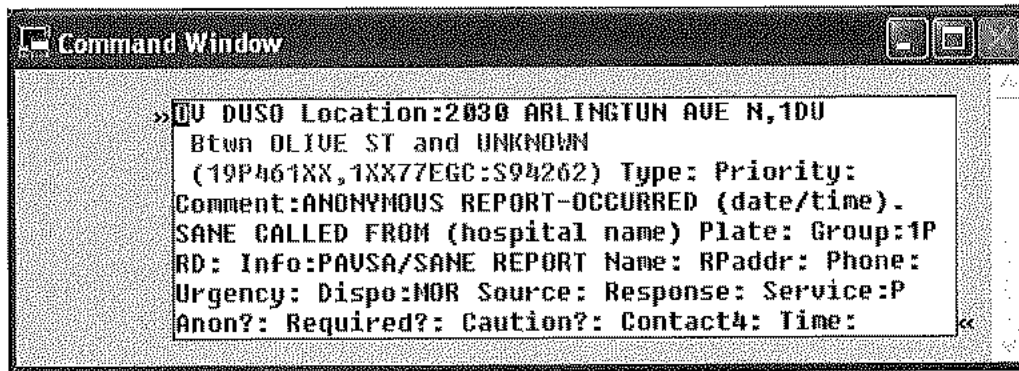
Generic Unit Options:	City of Duluth:	DUPD
	Duluth Sheriff's Office:	DUSO
	City of Hermantown:	HEPD
	City of Proctor:	PRPD
	City of Floodwood:	FLPD

Fond du Lac Police:
UMD Police:

FDLPD
UMDPD

At this time the call will enter directly into history with an ICR, will transfer to Shield, and will appear in previous events in CAD.

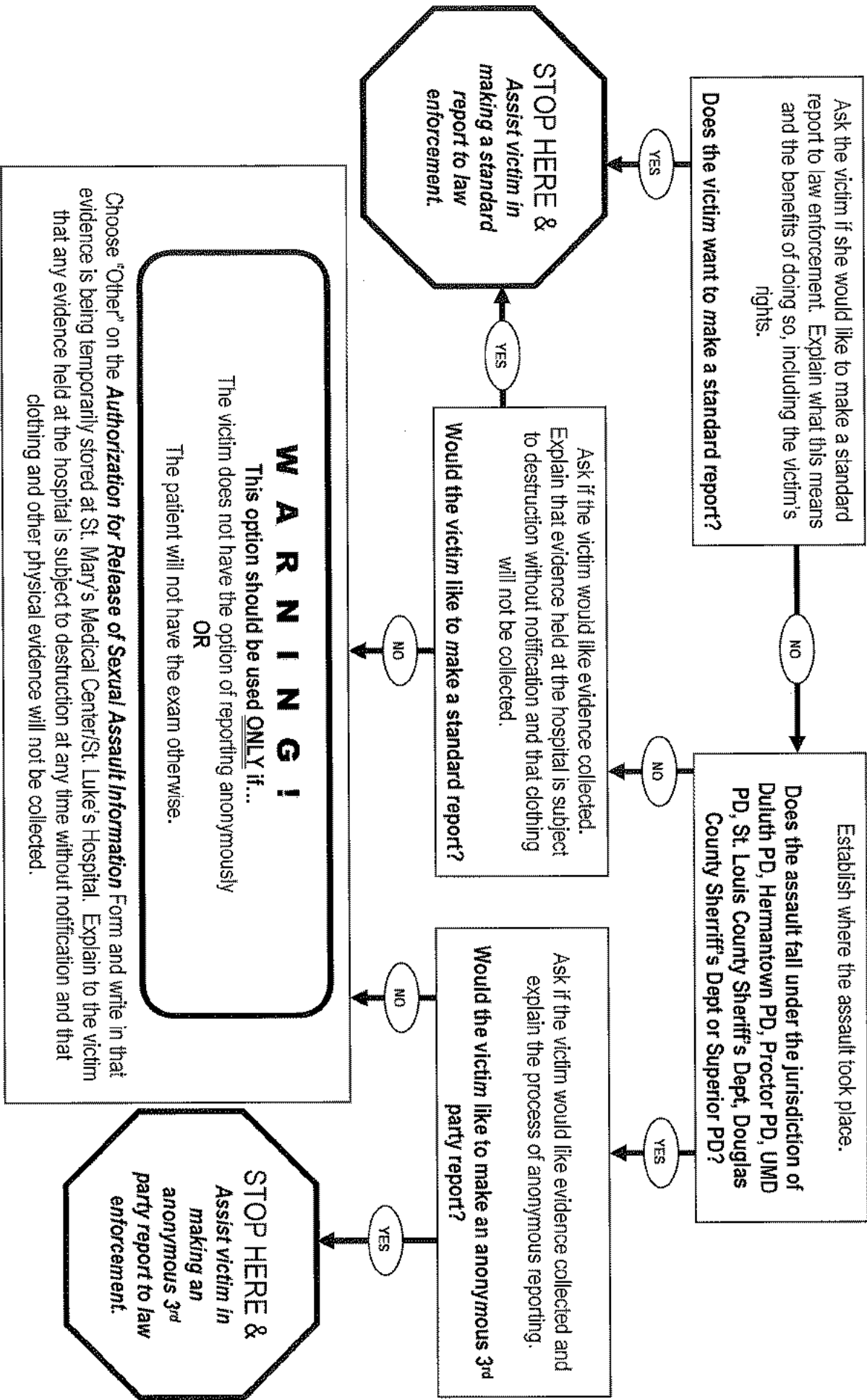
SAMPLE: For incident occurring in the county. Type: CSCA



The MOR report now exists in the event the victim chooses, at a later date to make a formal report to law enforcement.

When calling back to request an officer to respond to pick up the evidence kit and take to property, the SANE will provide the ICR from the original report to the call taker. At this time, the call will be reopened and a jurisdictional officer will be assigned to respond to the appropriate hospital to collect and store evidence. The officer will enter comments and disposition when this process is complete.

ASSISTING VICTIMS IN REPORTING TO LAW ENFORCEMENT





APPENDIX B

Program for Aid to Victims of Sexual Assault
Sexual Assault Nurse Examiner Program
PAVSA Office – 218/726-1442
PAVSA 24-Hour Crisis Line – 218/726-1931

Check Indicates authorization

Reporting Options (Please Choose One)

Standard Report

- ☐ I am choosing to make a standard report to law enforcement. I give permission to the SANE Program to provide evidence collected and information documented during my sexual assault exam to law enforcement agencies involved in investigating this assault or prosecuting the assailant. This includes the release of my name and contact information.

Anonymous 3rd Party Report

- ☐ I am choosing to anonymously report. I have read and understand the terms of anonymous reporting on the form "Anonymous 3rd Party Report."

Other

- ☐ (Please Explain): _____

Reporting Information (If applicable)

Law Enforcement Agency: _____ Incident Criminal Report Number: _____

Release to Physician (If applicable)

- ☐ I authorize the SANE Program to release all information obtained in my sexual assault exam and all other information relevant to my ongoing treatment to my primary care physician for continuing care purposes, upon request.

Physician: _____ Clinic: _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner. **
(Date)
- I understand that I may revoke this authorization at any time by notifying the SANE Program in writing. It will become effective on the date notified, but will not apply to any actions already taken.
- I understand I will receive a copy of this form after I have signed it.
- I understand a photocopy or fax of this form is the same as the original.

** One year expiration of authorization does not apply to those choosing to anonymously report.

Patient Signature Date

If I am signing as Authorized Representative of the patient, I am:

- ☐ Parent of minor ☐ Court appointed guardian/conservator

Print Name Signature of Authorized Person Relationship to Patient

AUTHORIZATION FOR RELEASE OF SEXUAL ASSAULT EXAM INFORMATION

PATIENT LABEL



APPENDIX B

Program for Aid to Victims of Sexual Assault
Sexual Assault Nurse Examiner Program
PAVSA Office – 218/726-1442
PAVSA 24-Hour Crisis Line – 218/726-1931

If you choose to make an Anonymous 3rd Party Report:

- The SANE Program will turn over any physical evidence (BCA Kit, clothing, photo disc, etc.) collected during your sexual assault exam to the law enforcement agency with jurisdiction over the location of the assault.
- Evidence turned over to law enforcement will include your case number but **will not include your name or contact information.**
- The SANE Program will hold other evidence and information collected during your sexual assault exam (exam report and other SANE forms)
- Evidence held by the SANE Program **will include your name, contact information, and case number.**
- Law enforcement has the right to share information with the SANE Program about the physical evidence collected.
- If you decide you would like to make a standard report to law enforcement, you should call the SANE Program at 218-726-1442. You will need to sign a release allowing the SANE program to provide identifying information and other documentation and evidence from your exam to law enforcement. Upon request an advocate is available to be present at any law enforcement interview.
- Would you like the SANE Program to attempt to notify you if any further evidence or information regarding your assault or perpetrator comes to our attention?
☐ Yes ☐ No
- If you decide you do not wish to go forward and would like the physical evidence collected to be destroyed or returned to you (i.e. clothing), you should call the SANE Program at 218-726-1442.
- Physical evidence will be held for an indefinite length of time to be determined by law enforcement. Before destroying any evidence, law enforcement will contact the SANE Program and reasonable attempts to notify you will be made. **For this reason, it is your responsibility to update your contact information with the SANE Program. The SANE Program is not responsible for loss or destruction of evidence held by law enforcement.**

Preferred Method of Contact – Please complete all that apply

<p style="text-align: center;">Landline Phone</p> <p><input type="checkbox"/> Caller can leave me a message</p>	<p style="text-align: center;">Cell Phone</p> <p><input type="checkbox"/> Caller can leave me a message</p>
<p>E-mail</p> <p>Please make sure you e-mail account allows you to receive messages from the address – sane@pavsa.org</p>	
<p>Standard Mail</p> <p>Street Address, City, State, Zip Code</p>	

Questions, concerns, change of contact information?
Please contact the SANE Program at 218/726-1442 ext. 20

ANONYMOUS 3rd PARTY REPORT

PATIENT LABEL



APPENDIX B

Program for Aid to Victims of Sexual Assault
Sexual Assault Nurse Examiner Program
PAVSA Office – 218/726-1442
PAVSA 24-Hour Crisis Line – 218/726-1931

SANE Follow-up Call

Date of Follow-Up Call:	Conducted by:
Notes if no response:	

- Introduce yourself as PAVSA staff - *During your exam you and your SANE Nurse discussed me calling you to check in. I am calling to see how you are doing since your exam and to see how you felt about the services you received. Are you still willing to answer some questions?*

No	<i>Do you have any questions for me at this time? Do you have PAVSA's contact information? Thank you for your time.</i> Notes:
Yes	<i>Continue... Thank you! This will only take a few minutes. This is a confidential survey – we appreciate your feedback and are always trying to improve our services. Please feel free to be honest with me.</i>

- Have you seen or made an appointment to see (follow-up clinic/doctor discussed during exam – see above)?*

No	<i>Is there any particular reason you have not? Would you like any assistance setting up an appointment?</i>
Yes	<i>How did you feel that went?</i>

- Did you receive support from a PAVSA advocate at the hospital?*

No	<i>Was an advocate offered to you? Was there any particular reason you did not choose to see that advocate?</i>				
Yes	<i>How would you rate the support you received from your advocate?</i>				
	Excellent 5	Very Good 4	Good 3	Fair 2	Poor 1
	Notes:				
	<i>What could your advocate have done differently to better support you?</i>				

- Did the hospital advocate:*

	Yes/No	Additional Comments
Treat you with respect & sensitivity		
Respect your privacy & personal choices		
Clearly explain your rights		
Clearly explain who they were & their role		
Explain what they were doing & why		
Give you contact information & resources		
Answer your questions		
Appear judgmental in any way		

- Are you currently receiving support from a PAVSA advocate(s)?

No	Did you know an advocate is available to you? Is there any particular reason you have not? Would you like an advocate to contact you? (Best way to contact)				
Yes	How would you rate the support you are receiving from your advocate?				
	Excellent 5	Very Good 4	Good 3	Fair 2	Poor 1
	Notes:				
	Is there anything your current advocate could be doing differently to better support you?				

- A) I see you made a standard report with **law enforcement**
• B) I see you made an anonymous report with law enforcement
• C) I see you did not make a report at the time.

No	A) Have you been in contact with law enforcement since you made your report? B) Do you understand what an anonymous report is? (explain) Are you interested in making a standard report? C) Have you made a report since then? Is there any particular reason you chose not to report? Would you like to report now?				
Yes	How do you feel you were treated by the law enforcement officers who responded?				
	Excellent 5	Very Good 4	Good 3	Fair 2	Poor 1
	Notes:				
	What could law enforcement have done differently that would have been helpful to you?				

- Did the responding **law enforcement officer**:

	Yes/No	Additional Comments
Treat you with respect & sensitivity		
Respect your privacy & personal choices		
Clearly explain your rights		
Clearly explain who they were & their role		
Explain what they were doing & why		
Give you contact information & resources		
Answer your questions		
Appear judgmental in any way		



APPENDIX B

Program for Aid to Victims of Sexual Assault
Sexual Assault Nurse Examiner Program
PAVSA Office – 218/726-1442
PAVSA 24-Hour Crisis Line – 218/726-1931

- Now I would like to ask you a few questions specifically related to the Sexual Assault Nurse Examiner you saw.

How do you feel you were treated by the SANE Nurse who responded?				
Excellent 5	Very Good 4	Good 3	Fair 2	Poor 1
Notes:				
What could your SANE Nurse have done differently to better support or help you?				
If you had a friend in a similar situation, would you recommend s/he see a SANE Nurse?				

- What took the longest during your time in the emergency room?

Notes:

- Did the **SANE Nurse**:

	Yes/No	Additional Comments
Treat you with respect & sensitivity		
Respect your privacy & personal choices		
Clearly explain your rights		
Clearly explain who they were & their role		
Explain what they were doing & why		
Give you contact information & resources		
Answer your questions		
Appear judgmental in any way		

- Did the **emergency room personal**:

	Yes/No	Additional Comments
Treat you with respect & sensitivity		
Respect your privacy & personal choices		
Clearly explain your rights		
Clearly explain who they were & their role		
Explain what they were doing & why		
Give you contact information & resources		
Answer your questions		
Appear judgmental in any way		



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- Would you be willing to be contacted in the future for focus groups or surveys related to your experiences with these professionals?

☐ YES

☐ NO

- Do you have any other comments or questions for me?

Notes:

Thank you very much for your time. Your input is very valuable to us and will be used to improve our services. If at any time you have any questions please call PAVSA at 218/726-1442.

Sexual Assault Exam Payments – Contact List

Alkin County Sheriff's Department ATTN: Sue Coffman 217 2nd Street NW Alkin, MN 56431	Tel: (218) 927-7430 Fax: (218) 927-7359 Email: sue.coffman@co.alkin.mn.us
Anoka County Sheriff's Department ATTN: Bryon Fuerst 13301 Hanson Blvd. Andover, MN 55304	Tel: (763) 323-5042 Fax: (763) 323-5165 Email: bryon.fuerst@co.anoka.mn.us
Becker County Sheriff's Department ATTN: Cindy Steling PO Box 702 Detroit Lakes, MN 56601	Tel: (218) 847-6682 Fax: (218) 847-1604 Email: imgordo@co.becker.mn.us
Beltrami County Investigating agency pays	Tel: Fax: Email:
Benton County Attorney's Office Victim Witness Assistance Program ATTN: Mary Radunz 615 Hwy. 23 PO Box 189 Foley, MN 56329	Tel: (320) 958-5182 Fax: (320) 958-6346 Email: mary.radunz@co.benton.mn.us
Big Stone County Attorney's Office ATTN: William J. Watson 37 NW 2nd St Ortonville, MN 56276	Tel: (320) 839-6197 Fax: (320) 839-6154 Email: bwatson@waisonlawoffice.net
Blue Earth County Dept. of Human Services ATTN: Anne Broskoff 410 S 5 th St Mankato, MN 56002	Tel: (507) 304-4292 Fax: (507) 304-4367 Email: anne.broskoff@co.blue-earth.mn.us
Brown County Sheriff's Department ATTN: Chief Deputy Jason Seldi 15 S Washington St PO Box 877 New Ulm, MN 56073	Tel: (507) 233-6713 Fax: (507) 359-1524 Email: chiefdpp@co.brown.mn.us
Carlton County Auditor's Office ATTN: Todd Milosevich PO Box 300 Carlton, MN 56718	Tel: (218) 384-9170 Fax: (218) 384-9161 Email: todd.milosevich@co.carlton.mn.us
Carver County Sheriff's Office ATTN: Sergeant Dewitt Meler 606 East 4th St. PO Box 12 Chaska, MN 55318	Tel: (952) 477-7327 Fax: (952) 361-1413 Email: DeWittMeler@co.carver.mn.us
Cass County Sheriff's Department ATTN: Tom Burch, Sheriff 300 Minnesota Ave PO Box 1110 Walker, MN 56484	Tel: (218) 647-7309 Fax: (218) 647-3394 Email: tom.burch@co.cass.mn.us
Chippewa County Sheriff's Department ATTN: Tim Bergeland 629 N 11th St Montevideo, MN 56265	Tel: (320) 269-2620 Fax: (320) 269-8583 Email: STuffio@co.chippewa.mn.us
Chisago County Sheriff's Department ATTN: Tracy Armistead 313 N Main St #100 Center City, MN 55012	Tel: (651) 213-6322 Fax: (651) 213-6331 Email: sheriff@co.chisago.mn.us
Clay County Sheriff's Department ATTN: Matt Silro, Chief Deputy 915 9 th Ave. N PO Box 280 Moorhead, MN 56560	Tel: (218) 299-5151 Fax: (218) 299-5228 Email: matt.silro@co.clay.mn.us

Sexual Assault Exam Payments - Contact List

Clearwater County Sheriff's Department ATTN: Michael Erickson, Sheriff 213 Main Ave N, Dept 102 Bagley, MN 56621	Tel: (218) 694-6226 Fax: (218) 694-6964 Email: mike.erickson@co.clearwater.mn.us
Cook County Sheriff's Department ATTN: Don Phillips 143 Gunflint Trail Grand Marais, MN 55604	Tel: (218) 387-3030 Fax: (218) 387-3032 Email: don.phillips@co.cook.state.mn.us
Cottonwood County Sheriff's Department ATTN: Kristen Porath 902 5 th Ave Windom, MN 56101	Tel: (507) 831-1376 Fax: (507) 831-1957 Email: kristen.porath@co.cottonwood.state.mn.us Note: the investigating agency pays
Crow Wing County Attorney's Office ATTN: Lydla Marohn 213 Laurel Street, Suite 31 Brainerd, MN 56401	Tel: (218) 824-1026 Fax: (218) 824-1026 Email: Lydla.marohn@co.crow-wing.mn.us
Dakota County Sheriff's Department ATTN: Fran Bakke 1580 W. Highway 55 Hastings, MN 55033	Tel: (651) 438-4711 Fax: (651) 438-4709 Email: fran.bakke@co.dakota.mn.us
Dodge County Dodge Fillmore Olmsted Victim Services ATTN: Jeanne Martin Government Center 151 4th St SE Rochester, MN 55904-5960	Tel: (507) 328-7271 Fax: (507) 328-7954 Email: victim.services@co.olmsted.mn.us
Douglas County Attorney's Office ATTN: Christopher Karpan, County Attorney 305 9 th Ave W Alexandria, MN 56308	Tel: (320) 762-3856 Fax: (320) 762-3880 Email: chris.karpan@mail.co.douglas.mn.us
Fairbault County Sheriff's Office ATTN: Sharon Determan Government Center 320 Dr. H. Russ St Blue Earth, MN 56013	Tel: (507) 526-5148, Ext #2005 Fax: (507) 526-3051 Email: sharond@frcsd.org
Fillmore County Dodge Fillmore Olmsted Victim Services ATTN: Jeanne Martin Government Center 151 4th St SE Rochester, MN 55904-5960	Tel: (507) 328-7271 Fax: (507) 328-7954 Email: victim.services@co.olmsted.mn.us
Freeborn County Attorney's Office ATTN: Sara Rehdal PO Box 1246 Albert Lea, MN 56007	Tel: (507) 377-5192 Fax: (507) 377-5196 Email: sara.rehdal@co.freeborn.mn.us
Goodhue County Attorney's Office Victim Services Goodhue County Justice Center ATTN: Kathy Hendrickson 154 W 6th St Red Wing, MN 55066	Tel: (651) 267-4965 Fax: (651) 267-4972 Email: kathy.hendrickson@co.goodhue.mn.us
Grant County Sheriff's Department ATTN: Troy Langille, Chief Deputy PO Box 58 Elbow Lake, MN 56531	Tel: (218) 685-5303 Fax: (218) 685-5319 Email: troy.langille@co.grant.mn.us
Hennepin County Sexual Assault Resource Service ATTN: Barbara Kern-Pich, Director OR Jessica Cheney, Office Specialist 701 Park Ave. S # Orange Bldg 2.220 Minneapolis, MN 55416	Tel: (612) 873-5832 Fax: (612) 904-4677 Email: barbara.kern-pich@hcned.org or_jessica.cheney@hcned.org

Sexual Assault Exam Payments - Contact List

Houston County Mediation & Victims Services ATTN: Michelle Herman Houston County Courthouse 304 S Marshall St Rm 210 Caledonia, MN 55921	Tel: (507) 725-5831 Fax: (507) 725-5550 Email: victim.service@co.houston.mn.us
Hubbard County Sheriff's Department ATTN: Accounts Payable 301 Court Ave Park Rapids, MN 56470	Tel: (218) 732-2518 Fax: (218) 732-2550 Email: leischens@co.hubbard.mn.us
Isanti County Sheriff's Department ATTN: Investigator Lisa Lovering 509 18 th Ave SW Cambridge, MN 55008	Tel: (763) 691-2416 Fax: (763) 689-3891 Email: lisa.lovering@sheriff.co.isanti.mn.us
Itasca County Health and Human Services ATTN: Roxanne Merles 1209 SE 2 nd Ave Grand Rapids, MN 55744-3983	Tel: (218) 327-6167 Fax: (218) 327-6647 Email: roxanne.merles@co.itasca.mn.us
Jackson County Sheriff's Department ATTN: Sheriff Roger Hawkinson PO Box 229 Jackson, MN 56143	Tel: (507) 847-4420 Fax: (507) 847-4308 Email: Unknown
Kanabec County Sheriff's Department ATTN: Trisha Grayling 18 N Vine Street, Suite 143 Mora, MN 55051	Tel: (320) 678-8400 Fax: (320) 678-8422 Email: sheriff@co.kanabec.mn.us
Kandiyohi County Sheriff's Department ATTN: Sheriff Dan Harlog PO Box 738 2201 23 rd St NE, Suite 101 Willmar, MN 56201	Tel: (320) 235-1260 Fax: (320) 231-6289 Email: dan.harlog@co.kandiyohi.mn.us
Kittson County Sheriff's Department ATTN: LoAnn Dalzell 410 S. 5 th St., Suite 102 Hallock, MN 56728	Tel: (218) 843-3535 Fax: (218) 843-2020 Email: ldalzell@co.kittson.mn.us
Koochiching County Attorney's Office ATTN: Susan Schnick 715 4th St International Falls, MN 56649	Tel: (218) 283-1131 Fax: (218) 283-1162 Email: susan.schnick@co.koochiching.mn.us
Lac Qui Parle County Tri-County Victim Witness Program ATTN: Denise Loy 629 N 11th St, #1 Montevideo, MN 56265	Tel: (320) 269-3095 Fax: (320) 269-7733 Email: denise.loy@co.vw.mn.gov
Lake County Human Services ATTN: Dennis Henkel, Director 816 3rd Ave Two Harbors, MN 55616	Tel: (218) 834-8415 Fax: (218) 834-8412 Email: dennis.henkel@co.lake.mn.us
Lake of the Woods County Sheriff's Department ATTN: Dallas Block, Sheriff 206 8 th Ave SE, Suite 300 Baudette, MN 56623	Tel: (218) 634-1143 (sheriff) (218) 634-2642 (social services) Fax: 218-634-1144 (fax-sheriff) 218-634-4520 (fax-social services)
Lake of the Woods County Social Services Department ATTN: Nancy Wendler 206 8 th Ave SE, Suite 200 Baudette, MN 56623	Email: dallas_b@co.lake-of-the-woods.mn.us nancy_w@co.lake-of-the-woods.mn.us
Le Sueur County Attorney's Office Victim Witness Program ATTN: Vicki Walechka 88 S Park Ave Le Center, MN 56057-5977	Tel: (507) 357-8512 Fax: (507) 357-6375 Email: vwalechka@co.le-sueur.mn.us

Sexual Assault Exam Payments – Contact List

Lincoln County Sheriff's Department ATTN: Linda 322 N. Wallace St. P.O. Box 166 Ivanhoe, MN 56142	Tel: (507) 694-1664 Fax: (507) 694-1325 Email: sheriff@co.lincoln.mn.us
Lyon County Sheriff's Department ATTN: Sgt. Todd Roellsema 811 W. Main St. PO Box 28 Marshall, MN 56258	Tel: (507) 637-7666 Fax: (507) 637-7428 Email: toddroellsema@co.lyon.mn.us
Mahnomen County Sheriff's Department ATTN: Sheriff Doug Krier Courthouse PO Box 440 Mahnomen, MN 56557	Tel: (218) 935-2255 Fax: (218) 935-6946 Email: doug.krier@co.mahnomen.mn.us
Marshall County Sheriff's Department ATTN: Sheriff John Novacek 208 E. Colvin, Suite 1 Warren, MN 56762	Tel: (218) 745-5411 Fax: (218) 745-9203 Email: john.novacek@co.marshall.mn.us
Marlin County Sheriff's Department ATTN: Diane Larson 201 Lake Ave #188 Fairmont, MN 56031	Tel: (507) 238-3148 Fax: (507) 238-4093 Email: diane.larson@co.marlin.mn.us
McLeod County Sheriff's Department ATTN: Rhonda Zajcek 801 E. 10 th St. Glencoe, MN 56336	Tel: (320) 864-3134 Fax: (320) 864-5920 Email: rhonda.zajcek@co.mcleod.mn.us
Meeker County Sheriff's Office ATTN: Jeanne Sellen, Admin Assistant 326 N Ramsey Ave Litchfield, MN 55355	Tel: (320) 693-5400 Fax: (320) 693-4664 Email: jeanne.sellen@co.meeker.mn.us
Millie Lacs County Sheriff's Department ATTN: Sheriff Brent Lindgren 840 3 rd St. SE Milaca, MN 56353	Tel: (320) 983-8250 Fax: (320) 983-8343 Email: brent.lindgren@co.mille-lacs.mn.us
Morrison County Sheriff's Department ATTN: Michel Wetzel 213 SE First Avenue PO Box 312 Little Falls, MN 56345	Tel: (320) 832-9233 Fax: (320) 632-6179 Email: michelw@co.morrison.mn.us
Mower County Attorney's Office ATTN: LeeAnn Schafer 201 1st St NE Austin, MN 55912	Tel: (507) 437-9428 Fax: (507) 437-9471 Email: lschafer@co.mower.mn.us
Murray County Sheriff's Department Murray County Courthouse ATTN: Donna Mollerma 2500 28 th St. PO Box 57 Stacy, MN 56172	Tel: (507) 836-6168 Ext 173 Fax: (507) 836-8704 Email: dmollerma@co.murray.mn.us
Nicollet County Social Services ATTN: Cindy McCabe 2070 Howard Drive North Mankato, MN 56003	Tel: (507) 387-4510 Fax: (507) 387-2918 Email: cmccabe@co.nicollet.mn.us or JTesdahl@co.nicollet.mn.us
Nobles County Sheriff's Department ATTN: Sheriff Kent Wilkening 1530 Airport Road, Suite 100 Worthington, MN 56187	Tel: (507) 372-2136 Fax: (507) 372-5977 Email: chelnrichs@co.nobles.mn.us
Norman County Sheriff's Department ATTN: Sheriff Jeremy Thornton 15 2 nd Ave E. Ada, MN 56516	Tel: (218) 784-7114 Fax: (218) 784-7117 Email: jeremy.thornton@co.norman.mn.us

Sexual Assault Exam Payments – Contact List

Olmsted County Dodge Fillmore Olmsted Victim Services ATTN: Joanne Marlin Government Center 151 4th St SE Rochester, MN 55904-5960	Tel: (507) 328-7271 Fax: (507) 328-7954 Email: victim.services@co.olmsted.mn.us
Otter Tail County Auditor's Department ATTN: Wayne Sieln, County Auditor 510 Flr Ave. W. Fergus Falls, MN 56637	Tel: (218) 998-8030 Fax: (218) 98-8042 Email: wsieln@co.ottertail.mn.us
Pennington County Attorney's Office ATTN: Karla Stavnes PO Box 610 101 Main Ave N Thief River Falls, MN 56701	Tel: (218) 681-0861 Fax: (218) 681-0765 Email: kstavnes@co.pennington.mn.us
Pine County Sheriff's Department ATTN: Chief Deputy Steve Ovick 635 Northridge Drive NW, #100 Pine City, MN 55063	Tel: (320) 591-1419 Fax: (320) 629-8392 Email: srovick@co.pine.mn.us
Pipestone County Sheriff's Department ATTN: Sheriff Dan Delaney 416 S. Hiawatha Ave PO Box 220 Pipestone, MN 56154	Tel: (507) 825-6700 Fax: (507) 825-6708 Email: dan.delaney@co.pipestone.mn.us
Polk County Attorney's Office Coordinated Victim Services ATTN: Dana Johnson or Stephanie Pry 816 Marin Ave Suite 125 Crookston, MN 56718-6502	Tel: (218) 281-1554 Fax: (218) 281-7556 Email: dana.johnson@co.polk.mn.us stephanie.pry@co.polk.mn.us
Pope County Sheriff's Department ATTN: Kim Joos 130 E. Minnesota Ave Olenwood, MN 56334	Tel: (320) 634-6411 Fax: (320) 634-6457 Email: kim.joos@co.pope.mn.us
Ramsey County Budget and Accounting ATTN: Kathy Kapoun, Budget Mgr. (policy questions) ATTN: Diane Hollinger (payments) 270 Courthouse 16 W Kellogg Blvd St Paul, MN 56102	Tel: (651) 266-8059 Fax: (651) 266-8068 Email: kathleen.kapoun@co.ramsey.mn.us diane.hollinger@co.ramsey.mn.us
Red Lake County Sheriff's Department ATTN: Sheriff Mitch Bernstein 124 North Main PO Box 306 Red Lake Falls, MN 56750	Tel: (218) 253-2596 Fax: (218) 251-2656 Email: unknown
Redwood County Sheriff's Department ATTN: Sheriff Randy Hanson 303 East 3rd St PO Box 47 Redwood Falls, MN 56283	Tel: (507) 637-4036 Fax: (507) 637-4007 Email: randy_h@co.redwood.mn.us
Renville County Sheriff's Department ATTN: Janace Kern 105 6th Street South, Ste 210 Olivia, MN 56277	Tel: (320) 523-3770 Fax: (320) 523-3787 Email: janace_k@co.renville.mn.us
Rice County Attorney's Office Paul Beaumaster, County Attorney ATTN: Dan Carlson, Office Mgr. 218 NW 3rd St Faribault, MN 55021	Tel: (507) 332-0103 (507) 333-3758 (Dan Carlson) Fax: (507) 332-6175 Email: pbeaumaster@co.rice.mn.us dcarlson@co.rice.mn.us
Rock County Sheriff's Department ATTN: Sheriff Evan Verbrugge PO Box 613 Luverne, MN 56156	Tel: (507) 283-5000 Fax: (507) 283-5003 Email: evan.verbrugge@co.rock.mn.us

Sexual Assault Exam Payments – Contact List

Roseau County Sheriff's Department ATTN: Terry Bandemer, Chief Deputy 604 5 th Ave SW Roseau, MN 56751	Tel: (218) 463-1421 Fax: (218) 463-1455 Email: terry.bandemer@co.roseau.mn.us
St. Louis County Public Health and Human Services ATTN: Cathy Beaver 320 West 2 nd St., Room 410 Duluth, MN 55802	Tel: (218) 726-6163 Fax: (218) 733-2970 Email: beaverc@co.st-louis.mn.us
Scott County Attorney's Office ATTN: Tera Portinga, Victim/Witness Coordinator Government Center JC340 200 4th Ave W Shakopee, MN 55379-5425	Tel: (952) 496-8242 Fax: (952) 496-8775 Email: tera.portinga@co.scott.mn.us
Sherburne County Attorney's Office Kathleen Heaney, County Attorney ATTN: Office Manager 13880 Business Center Drive Elk River, MN 55330-4601	Tel: (763) 241-2695 Fax: (763) 241-2576 (County does not accept bills by fax.) Email: kathleen.heaney@co.sherburne.mn.us
Sibley County Sheriff's Department ATTN: Gail Estensen, Admin Assistant 419 Harrison St. PO Box 102 Gaylord, MN 55334	Tel: (507) 237-4330 Fax: (507) 237-4334 Email: bruce@co.sibley.mn.us
Stearns County Attorney's Office ATTN: Jenny Thels 705 Courthouse Square Admin Center Rm 448 St Cloud, MN 56303-7204	Tel: (320) 656-3880 Fax: (320) 656-6695 Email: jenny.thels@co.stearns.mn.us
Steele County Attorney's Office Victim Services Program ATTN: Teresa Dudley 303 S Cedar St. Owatonna, MN 55060	Tel: (507) 444-7783 Fax: (507) 444-7790 Email: teresa.dudley@co.steele.mn.us
Stevens County Sheriff's Department ATTN: Ann Vipond 400 Colorado Ave Morris, MN 56267	Tel: (320) 689-2141 Fax: (320) 589-1157 Email: ann.vipond@co.stevens.mn.us
Swift County Sheriff's Department ATTN: Sheriff John Holz PO Box 266 Benson, MN 58215	Tel: (320) 843-3133 Fax: (320) 843-2299 Email: john.holz@co.swift.mn.us
Todd County Sheriff's Department ATTN: Bryan Tebben 115 3rd Ave S Long Prairie, MN 56347	Tel: (320) 732-2157 Fax: (320) 732-3867 Email: bryan.tebben@co.todd.mn.us
Traverse County Sheriff's Department ATTN: Brenda Pederson PO Box 826 Wheaton, MN 56296	Tel: (320) 563-4244 Fax: (320) 563-8700 Email: brenda.pederson@co.traverse.mn.us
Wabasha County Sheriff's Department ATTN: Barb Brommer 618 Broadway Ave Wabasha, MN 56981	Tel: (651) 665-8361 Fax: (651) 365-3843 Email: rbartech@co.wabasha.mn.us
Wadena County Sheriff's Department ATTN: Jean Birch 415 Jefferson St. E. Wadena, MN 56402	Tel: (218) 631-7600 Fax: (218) 631-7699 Email: jean.birch@co.wadena.mn.us
Waseca County Sheriff's Department ATTN: Sheriff Brad Milbrath PO Box 226 122 3 rd Ave NW Waseca, MN 56093	Tel: (507) 835-0510 Fax: (507) 835-0537 Email: brad.milbrath@co.waseca.mn.us

Sexual Assault Exam Payments – Contact List

Washington County Sheriff's Department ATTN: Sue Kaufman 15015 62nd St N PO Box 3601 Stillwater, MN 55082	Tel: (651) 430-7601 Fax: (651) 430-7603 Email: sue.kaufman@co.washington.mn.us
Watsonwan County Sheriff's Department ATTN: Chief Deputy Lea Bouma PO Box 168 St James, MN 56081	Tel: (507) 875-3121 Fax: (507) 875-1246 Email: lea.bouma@co.watonwan.mn.us
Wilkin County Sheriff's Department ATTN: Sheriff Rick Fledler PO Box 30 Breckenridge, MN 56520	Tel: (218) 643-8544 Fax: (218) 643-9115 Email: sheriff@co.wilkin.mn.us
Winona County Auditor's Office ATTN: Susan Rivers 177 Main St Winona, MN 55987	Tel: (507) 467-6349 Fax: (507) 454-9368 Email: srivers@co.winona.mn.us
Wright County Sheriff's Department ATTN: Sheriff Joe Hagerly 3800 Braddock Ave NE Buffalo, MN 55313	Tel: (763) 682-7600 Fax: (763) 682-7610 Email: todd.hoffman@co.wright.mn.us
Yellow Medicine County Sheriff's Department ATTN: Sheriff Bill Flaten 930 - 4 th Street, Suite 1 Granite Falls, MN 58241	Tel: (320) 564-2130 Fax: (320) 564-2369 Email: bill.flaten@co.yvm.mn.gov

Selected STD Testing and Treatment Clinics

The following clinics provide confidential counseling and testing for HIV and other STDs. Clinic staff are trained to answer questions about HIV and STDs and to provide medical and mental health referrals to knowledgeable and concerned providers.

MINNEAPOLIS ST. PAUL

Hennepin County Public Health Clinic (Formerly Red Door) 525 Portland Avenue Minneapolis, MN 55415 (612) 543-5555 (612) 348-4729 TTY www.co.hennepin.mn.us	St. Paul Ramsey County Department of Public Health Room 111 555 Cedar Street St. Paul, MN 55101 (651) 266-1352 www.co.ramsey.mn.us/en
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There are many other HIV and STD testing sites throughout Minnesota. There isn't enough room to list each site individually on this brochure. Contact MAP AIDSline for HIV testing sites and the Minnesota Family Planning and STD Hotline for STD testing sites (see below).

Minnesota AIDS Project AIDSline

Metro Area
(612) 373-AIDS
(612) 373-2465 TTY

Statewide
1-800-240-AIDS
1-888-820-2437 TTY
<http://www.mnaisdproject.org>

Minnesota Family Planning and STD Hotline

1-800-783-2287 voice/TTY
(651) 645-8360 (Metro area)
<http://www.sexualhealthmn.org>

For More Information

If you have questions or concerns about STDs, ask your physician, hospital staff, or your local health department. For more information about testing, contact one of the STD clinics listed on the preceding column or other information resources listed below.

If you have special concerns about sexual assault, contact your local sexual assault center. They can provide information, referrals, and support.

Always seek expert medical advice if you believe that you have contracted an STD.

For information about STDs, call the: Minnesota Family Planning and STD Hotline

1-800-783-2287 voice/TTY
(651) 645-8360 (Metro area)
<http://www.sexualhealthmn.org>

Minnesota AIDS Project AIDSline

Metro Area
(612) 373-AIDS
(612) 373-2465 TTY

Statewide
1-800-240-AIDS
1-888-820-2437 TTY
<http://www.mnaisdproject.org>

Minnesota Department of Health
Infectious Disease Epidemiology,
Prevention and Control Division
STD and HIV Section
(651) 201-5414
<http://www.health.state.mn.us/std/>

Minnesota Coalition Against Sexual Assault

Metro: (651) 209-9993
Statewide: 1-800-964-8847
<http://www.mnoca.org>

If you require this document in another format, such as large print, Braille or cassette tape, call:
(651) 201-5414
(651) 201-5797 TTY

IC #741-0650

4/11

For Persons Who Have Been Sexually Assaulted

Information You Should Know
About Sexually Transmitted
Diseases



Infectious Disease Epidemiology, Prevention and Control Division
STD and HIV Section

Introduction

People who have been sexually assaulted often have concerns and questions about many subjects. This brochure is intended to provide you with information about sexually transmitted diseases or "STDs".

If you do not understand this information, or would like additional information, ask your physician or health care provider to assist you.

Sexually Transmitted Diseases (STDs)

You can get an STD through vaginal, oral or rectal sexual contact with someone who is infected. The most common bacterial STDs are chlamydia, gonorrhea and syphilis. The most serious viral STDs are human immunodeficiency virus (HIV), the virus that causes AIDS, hepatitis B, genital herpes, and genital warts.

Some of these STDs can cause serious complications. For example, untreated gonorrhea and chlamydia can damage the reproductive organs, leading to miscarriage or infertility in women and sterility in men. Some viral STDs like HIV infection can lead to serious life threatening conditions. Certain STDs can also be transmitted from a pregnant woman to her unborn child.

Risk of Getting an STD from a Sexual Assault

The STDs that are diagnosed most frequently after sexual assault include gonorrhea or chlamydia. The risk of acquiring gonorrhea or chlamydia from sexual assault is low. The chances of acquiring syphilis or genital herpes are even lower. The risk of becoming infected with HIV is extremely low, and even lower if only oral sex was involved with the assault.

If an STD is diagnosed after a sexual assault, it does not always mean that the infection was acquired during the assault. However, a post-assault examination provides an important opportunity to identify and treat undetected STDs. For example, a person may have an STD (without knowing it) before being sexually assaulted. This could be the case when infected with chlamydia as about 3 out of 4 women and 1 out of 2 men will not have symptoms. Early treatment can prevent lasting harm.

STD Signs and Symptoms

Some STDs cause symptoms such as itching, pain, discharge, bleeding, genital sores, or lower abdominal pain. These symptoms may develop days, weeks, or even longer after a person becomes infected. But you can't depend on these symptoms to know if you are infected. Many people with an STD will not have any symptoms. Therefore, it is very important that you see a physician for an examination and STD tests to find out if you have been infected after a sexual assault, even if you don't have any symptoms.

STD Testing and Treatment after Assault

After being sexually assaulted it is important that you get a sexual assault evidentiary examination as soon as possible. If you seek medical care within 72 hours of the assault, the physician who sees you may give you medications for certain STDs in case you were exposed to the diseases during the assault. Because these medications are not 100% effective in preventing disease, it is still important that you are aware of what to look for and return to your physician in two or three weeks to assure that you have been effectively treated. For HIV risk, post-exposure prophylaxis (PEP) of antiretroviral drugs may be offered if the assault took place within 72 hours of your medical evaluation.

If you do not have a physician, there are several public health clinics listed on the back of this brochure that can provide confidential testing for HIV and other STDs for victims of sexual assault, or anyone else who may have an infection.

Safe, effective treatment is available to cure gonorrhea, chlamydia, and syphilis. Antibiotic treatment usually is based on the results of STD tests. However, your physician may decide to treat you while waiting for the test results.

Preventing STD Transmission to Sexual Partners

You can spread an STD to your own partner if you were infected during a sexual assault. Therefore, we recommend that you do not have sex until after you have had follow-up tests two to three weeks after the assault and you have received the results.

If you do have oral, anal, or vaginal sex, it is important to use latex condoms or other barrier methods. Latex condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV. In addition, correct use of latex condoms can reduce the risk of other STDs.

HIV/AIDS and Sexual Assault

It is not easy to get HIV infection. The risk of becoming infected from a single sexual contact is very small. Penetration of the vagina or anus by a penis, or contact with blood, is the most likely way HIV would be transmitted during a sexual assault. There is a lower, but not zero, risk of transmission from oral sex.

HIV infection is diagnosed by a blood test. Immediately after a sexual assault, contact a physician and get tested. The physician will repeat the test at different intervals up to six (6) months. If the test is still negative after six (6) months, you can be assured that you do not have HIV infection.

Testing Offenders

Minnesota Law (Minnesota Statute 67 1A.19) allows the court to require HIV antibody testing after conviction of an offender. A sexual assault victim can request that a convicted offender be tested. Because conviction—if it occurs at all—does not take place immediately, testing the offender may not occur until months after the possible exposure. Therefore, finding out information about the individual who sexually assaulted you is not the best way of determining whether you are infected. The nature of the assault, the stage of any disease, your own immunity, and other factors make your own test result more important than the test results of an offender.

Discussing your concerns with your local sexual assault program may be helpful.

Minnesota Coalition Against Sexual Assault
161 St Anthony Avenue, Suite 1001
St. Paul, MN 55103
(651) 209-9993
1-800-964-8847 toll free
<http://www.mncasa.org>

Clinicas seleccionadas para pruebas y tratamiento de enfermedades transmitidas sexualmente (STD)

Las siguientes clinicas ofrecen asesoramiento confidencial y pruebas de VIH y otras enfermedades transmitidas sexualmente (STDs, por sus siglas en inglés). El personal de las clinicas está capacitado para responder preguntas acerca del VIH y las STDs y proporcionar referencias médicas y de salud mental a proveedores con conocimiento e intereses.

MINNEAPOLIS

ST. PAUL

Hennepin County Public Health Clinic (Formerly Red Door) 525 Portland Avenue Minneapolis, MN 55415 (612) 543-5555 (612) 348-4729 TTY www.co.hennepin.mn.us	St. Paul-Ramsey County Department of Public Health Room 111 555 Cedar Street St. Paul, MN 55101 (651) 286-1352 www.co.ramsey.mn.us/ph
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Hay muchos otros lugares para pruebas de VIH y STD en todo Minnesota. En este folleto no hay suficiente espacio para proveer una lista de cada lugar individual. Llame a la Línea SIDA de MAP para los lugares de pruebas de VIH y a la Línea Directa de Planificación Familiar y STD de Minnesota para los lugares de pruebas de STD (véase a continuación).

Línea de SIDA del Proyecto SIDA de Minnesota (Minnesota AIDS Project AIDSline)

Área metropolitana
(612) 373-AIDS
(612) 373-2465 TTY

Todo el estado
1-800-248-AIDS
1-888-820-2437 TTY
<http://www.mn.aidsproject.org>

Línea Directa de Planificación Familiar y STD de Minnesota (Minnesota Family Planning and STD Hotline)

1-800-783-2287 voz/TTY
(651) 645-9360 (área metropolitana)
<http://www.sexualhealthmn.org>

Para obtener más información

Si tiene preguntas o inquietudes respecto a las STDs, pregunte a su médico, al personal del hospital o a su departamento de salud local. Para obtener más información sobre las pruebas, comuníquese con una de las clinicas de STD indicadas en la columna anterior o con otro de los recursos de información indicados a continuación.

Si le preocupa especialmente el asalto sexual, comuníquese con el centro de asalto sexual de su localidad, donde pueden proporcionarle información, referencias y apoyo.

Si cree que ha contraído una STD, obtenga siempre el consejo médico experto.

Para obtener información sobre STDs, llame a: Línea Directa de Planificación Familiar y STD de Minnesota (Minnesota Family Planning and STD Hotline)

1-800-783-2287 voz/TTY
(Dispositivos de telecomunicación para sordos)
(651) 645-9360 (Área metropolitana)
<http://www.sexualhealthmn.org>

Línea de SIDA del Proyecto SIDA de Minnesota (Minnesota AIDS Project AIDSline)

Área metropolitana
(612) 373-AIDS
(612) 373-2465 TTY

En todo el estado
1-800-248-AIDS
1-888-820-2437 TTY
<http://www.mn.aidsproject.org>

Departamento de Salud de Minnesota (Minnesota Department of Health)

División de Epidemiología, Prevención y Control de
Enfermedades Infecciosas
Sección de STD y VIH
(651) 201-5414
<http://www.health.state.mn.us/std>

Coalición Contra el Asalto Sexual de Minnesota (Minnesota Coalition Against Sexual Assault)

Área metropolitana: (651) 209-9993
En todo el estado: 1-800-964-8847
<http://www.mn.casa.org>

Si necesita este documento en otro formato, tal como en letras grandes,
Braille o cinta en cassette, llame al:

(651) 201-5414
(651) 201-5797 TTY

IC #44-A650
For Persons Who Have Been Sexually Assaulted - Spanish

4/11

Para personas que han sido asaltadas sexualmente

*Información que debe conocer
sobre las enfermedades
transmitidas sexualmente*



División de Epidemiología, Prevención y Control de Enfermedades Infecciosas
Sección de STD y VIH

Introducción

Las personas que han sido asaltadas sexualmente con frecuencia tienen preocupaciones y preguntas sobre muchos temas. El propósito de este folleto es proporcionar información sobre las enfermedades transmitidas sexualmente o "STDs".

Si no entiende esta información, o desea información adicional, pida a su médico o proveedor de atención médica que lo ayude.

Enfermedades transmitidas sexualmente (STDs)

Usted puede contraer una STD mediante el contacto sexual vaginal, oral o rectal con alguien que esté infectado. Las STD's bacterianas más comunes son la clamidia, la gonorrea y la sífilis. Las STDs virales más graves son el virus de inmunodeficiencia humano (VIH), el virus que causa el SIDA), la hepatitis B, el herpes genital y las verrugas genitales.

Algunas de estas STDs pueden causar complicaciones graves. Por ejemplo, la gonorrea y la clamidia sin tratar pueden dañar los órganos reproductivos, lo cual puede causar abortos espontáneos o infertilidad en las mujeres y esterilidad en los hombres. Algunas STDs virales, como la infección del VIH, pueden causar condiciones graves que amenazan la vida. Algunas STDs también pueden ser transmitidas de una mujer embarazada a su bebé sin nacer.

El riesgo de contraer una STD debido a un asalto sexual

Las STDs que se diagnostican con más frecuencia después de un asalto sexual incluyen gonorrea o clamidia. El riesgo de contraer gonorrea o clamidia por un asalto sexual es bajo. Las posibilidades de contraer sífilis o herpes genital son aún más bajas. El riesgo de ser infectado con VIH es sumamente bajo, y es aún más bajo si el asalto sólo implicó sexo oral.

Si se diagnostica una STD después de un asalto sexual, esto no siempre significa que la infección se cortó durante el asalto. No obstante, un examen posterior al asalto proporciona una oportunidad importante para identificar y tratar las STDs no detectadas. Por ejemplo, una persona puede tener una STD (sin saberlo) antes de ser asaltada sexualmente. Esto podría ser el caso cuando está infectada con clamidia, ya que 3 de cada 4 mujeres y 1 de cada 2 hombres no tendrán síntomas. El tratamiento temprano puede prevenir un perjuicio duradero.

Las señales y los síntomas de STD

Algunas STDs causan síntomas tales como picazón, dolor, secreción, sangrado, llagas genitales o dolor en la parte baja del abdomen. Estos síntomas pueden comenzar días, semanas e incluso mucho tiempo después de que la persona quede infectada. Pero usted no puede depender de estos síntomas para saber si está infectado. Muchas personas con una STD no tendrán ningún síntoma. Por lo tanto, aunque no tenga ningún síntoma, es muy importante que vea a un médico para hacerse un examen y pruebas de STD para saber si ha sido infectado después de un asalto sexual.

Pruebas y tratamiento para STD después de un asalto

Después de haber sido asaltado sexualmente, es importante que se haga un examen para probar el asalto sexual tan pronto como sea posible. Si busca atención médica dentro de las 72 horas de ocurrir el asalto, el médico que lo vea puede darle medicamentos para ciertas STDs en caso de que haya estado expuesto a las enfermedades durante el asalto. Debido a que estos medicamentos no son eficaces en un 100% para prevenir la enfermedad, es aún importante que sepa qué esperar y regrese a su médico dos o tres semanas después para asegurar que haya sido tratado eficazmente. En el caso de riesgo del VIH, se le pueden ofrecer drogas antirretrovirales para profilaxis posterior a la exposición (PEP, por sus siglas en inglés) si el asalto tuvo lugar dentro de las 72 horas de su evaluación médica.

Si no tiene un médico, hay varias clínicas de salud pública listadas al dorso de este folleto que pueden proporcionar pruebas confidenciales para el VIH y otras STDs para víctimas de asalto sexual o cualquier otra persona que pueda tener una infección.

Hay disponible un tratamiento seguro y eficaz para curar la gonorrea, la clamidia y la sífilis. El tratamiento con antibióticos normalmente se basa en los resultados de las pruebas para STD. No obstante, su médico puede decidir darle tratamiento mientras espera por los resultados de las pruebas.

Cómo prevenir la transmisión de STD a las parejas sexuales

Usted puede contagiar a su propia pareja con una STD si quedó infectado durante un asalto sexual. Por lo tanto, le recomendamos que no tenga relaciones sexuales hasta que se haya hecho pruebas de seguimiento dos o tres semanas después del asalto y haya recibido los resultados.

Si tiene relaciones sexuales orales, anales o vaginales, es importante usar condones de látex u otros métodos de barrera. Los condones de látex, cuando se usan consistentemente y correctamente, son sumamente eficaces para prevenir la transmisión del VIH. Además, el uso correcto de condones de látex puede reducir el riesgo de contraer otras STDs.

VIH/SIDA y el asalto sexual

No es fácil contraer la infección del VIH. El riesgo de quedar infectado por un solo contacto sexual es muy bajo. La penetración de la vagina o el ano por un pene, o el contacto con semen, es la manera más probable de que el VIH se transmita durante un asalto sexual. Existe un riesgo menor, pero no cero riesgo, de la transmisión por medio del sexo oral.

La infección del VIH se diagnostica por medio de un análisis de sangre. Inmediatamente después de un asalto sexual, vea a un médico y hágase una prueba. El médico repetirá la prueba en diferentes intervalos hasta los seis (6) meses. Si la prueba todavía da un resultado negativo después de los seis (6) meses, puede estar seguro que no está infectado con el VIH.

Pruebas de delincuentes

La Ley de Minnesota (Estatuto 611A, 19 de Minnesota) permite que el tribunal exija que se realice una prueba de anticuerpos de VIH después de la condena de un delincuente. Una víctima de asalto sexual puede solicitar que un delincuente condenado se someta a una prueba. Debido a que la condena — si de hecho ocurre — no tiene lugar inmediatamente, es posible que la prueba del delincuente no ocurra, hasta que hayan transcurrido meses después de la posible exposición. Por lo tanto, encontrar información sobre el individuo que lo asaltó sexualmente puede que no sea la mejor manera de determinar si usted está infectado. La naturaleza del asalto, la etapa de cualquier enfermedad, su propia inmunidad y otros factores hacen que el resultado de su propia prueba sea más importante que los resultados de las pruebas de un delincuente.

Hablar de su preocupación con el programa de asalto sexual de su localidad puede ser de ayuda.

Minnesota Coalition Against Sexual Assault

161 St. Anthony Avenue, Suite 1001
St. Paul, MN 55103
(651) 209-9993
1-800-964-8847 sin cargo
<http://www.mncaasa.org>

Диагностика отделенных заболеваний, передающихся половым путем

В следующих клиниках проводится конфиденциальное консультирование и диагностика ВИЧ-инфекции и других заболеваний, передающихся половым путем (ЗППП). Квалифицированный персонал клиник ответит на вопросы о ВИЧ и ЗППП, а также предоставит направления к компетентным и внимательным поставщикам медицинских и психиатрических услуг.

МИННЕАПОЛИС

СЕНТ-ПОЛ

Hennepin County
 Public Health Clinic
 (Formerly Red Door)
 525 Portland Avenue
 Minneapolis, MN 55415
 (612) 543-5535
 (612) 348-4729 TTY
www.co.hennepin.mn.us

St. Paul-Ramsey County
 Department of Public Health
 Room 111
 555 Cedar Street
 St. Paul, MN 55101
 (651) 266-1362
www.co.ramsey.mn.us/dh

В штате Миннесота существует много других центров, где можно пройти обследование на ВИЧ-инфекцию и ЗППП. В данной брошюре не хватает места для того, чтобы перечислить все центры. Чтобы узнать о центрах, где можно пройти диагностику ВИЧ, позвоните на горячую линию AIDSline Проекта штата Миннесота по борьбе со СПИДом (MAP AIDSline); чтобы узнать о центрах, где можно пройти обследование на выявление ЗППП, позвоните на горячую линию штата Миннесота по вопросам планирования семьи и ЗППП (см. ниже).

Горячая линия Проекта штата Миннесота по борьбе со СПИДом (Minnesota AIDS Project AIDSline)

Для жителей муниципального района:

(612) 373-AIDS

Линия TTY: (612) 373-2465

Для жителей штата:

1-800-248-AIDS

Линия TTY: 1-888-820-2437

<http://www.mn.aidsproject.org>

Горячая линия штата Миннесота по вопросам планирования семьи и ЗППП (Minnesota Family Planning and STD Hotline)

Голосовая линия/линия TTY: 1-800-783-2287

Для жителей муниципального района:

(651) 645-9360

<http://www.sexualhealthmn.org>

Дополнительная информация

Если у вас возникнут проблемы или вопросы, касающиеся ЗППП, вы можете обратиться к своему врачу, сотрудникам больницы или в местный отдел здравоохранения. Для получения дополнительной информации об обследовании обратитесь в одну из клиник, указанных в предыдущей колонке, или к другим источникам информации, приведенным ниже. Если у вас есть особые проблемы, связанные с сексуальным насилием, обратитесь в местный центр помощи жертвам сексуального насилия. Сотрудники центра предоставят вам информацию, направления к специалистам и поддержку.

Обязательно обратиться к квалифицированному специалисту за медицинской консультацией, если вы подозреваете, что у вас был контакт с больным ЗППП.

Для получения информации о ЗППП звоните на горячую линию штата Миннесота по вопросам планирования семьи и ЗППП (Minnesota Family Planning and STD Hotline)

Голосовая линия/линия TTY (для лиц с нарушением слуха): 1-800-783-2287

Для жителей муниципального района: (651) 645-9360

<http://www.sexualhealthmn.org>

Горячая линия Проекта штата Миннесота по борьбе со СПИДом (Minnesota AIDS Project AIDSline)

Для жителей муниципального района:

(612) 373-AIDS

Линия TTY: (612) 373-2465

Для жителей штата:

1-800-248-AIDS

Линия TTY: 1-888-820-2437

<http://www.mn.aidsproject.org>

Департамент здравоохранения штата Миннесота (Minnesota Department of Health)

Служба эпидемиологии, профилактики и контроля инфекционных заболеваний

Отдел профилактики ЗППП и ВИЧ

(651) 201-5414

<http://www.health.state.mn.us/std>

Коалиция противодействия сексуальному насилию штата Миннесота (Minnesota Coalition Against Sexual Assault)

Для жителей муниципального района: (651) 209-9993

Для жителей штата: 1-800-964-8647

<http://www.mncasa.org>

Если вы хотите получить настоящий документ в другом формате (напечатанный крупным шрифтом, шрифтом Брайля или записанный на пленку), позвоните по тел.:

(651) 201-5414

Линия TTY: (651) 201-5797

IC #141-0650
For Persons Who Have Been Sexually Assaulted - Russian

4/11

Для лиц, подвергшихся сексуальному насилию, информацию о заболеваниях, передающихся половым путем, которую следует знать



Служба эпидемиологии, профилактики и контроля инфекционных заболеваний
Отдел профилактики ЗППП и ВИЧ

Введение

У людей, подвергшихся сексуальному насилию, возникают различные проблемы и вопросы. В настоящей брошюре представлена информация о заболеваниях, передающихся половым путем, или ЗППП.

Если данная информация вам непонятна или вы хотели бы получить дополнительную информацию, обратитесь к своему врачу или поставщику медицинских услуг.

Заболевания, передающиеся половым путем (ЗППП)

ЗППП можно заразиться при вагинальном, оральном или ректальном контакте с инфицированным лицом. Наиболее распространенными бактерияльными ЗППП являются хламидиоз, гонорея и сифилис. Самыми серьезными вирусными ЗППП являются вирус иммунодефицита человека (ВИЧ-вирус, вызывающий СПИД), гепатит В, генитальный герпес и остроконечные кондиломы.

Некоторые из этих ЗППП вызывают серьезные осложнения. Например, при отсутствии лечения гонорея и хламидиоз могут привести к повреждению репродуктивных органов и, как следствие, к выкидышу или бесплодию, как женскому, так и мужскому. Некоторые вирусные ЗППП, например ВИЧ-инфекция, могут привести к серьезным, угрожающим жизни состояниям. Некоторые ЗППП также могут передаваться от беременной женщины плоду.

Риск заражения ЗППП

Риск заражения сексуального насилия к ЗППП, которые чаще всего диагностируются после сексуального насилия, относится гонорея и хламидиоз. Риск заразиться гонореей или хламидиозом в результате сексуального насилия невысок. Вероятность заражения сифилисом или генитальным герпесом еще меньше. Риск заражения ВИЧ ничтожно мал, а при сексуальном насилии, связанном только с оральным сексом, он еще ниже.

Если ЗППП было диагностировано после сексуального насилия, это не всегда означает, что инфицирование произошло во время сексуального насилия. Однако обследование после насилия позволяет обнаружить не выявленные ранее ЗППП и назначить лечение. Например, человек может иметь ЗППП (не зная об этом) до сексуального насилия. Это происходит, потому что хламидиоз протекает бессимптомно у 3 из 4 женщин и у 1 из 2 мужчин. Раннее лечение может предотвратить длительное расстройство здоровья.

Признаки и симптомы ЗППП

Некоторые ЗППП вызывают такие симптомы, как зуд, боль, выделения, кровотечение, генитальные язвы или боль в нижней части живота. Эти симптомы могут развиваться в течение нескольких дней, недель и более длительного срока после заражения. Однако нельзя полагаться на данные симптомы для определения факта заражения. Многие люди с ЗППП не имеют никаких симптомов. Поэтому очень важно обратиться к врачу и пройти обследование для выявления ЗППП, чтобы узнать, заразились ли вы в результате сексуального насилия, даже если у вас нет никаких симптомов.

Диагностика и лечение ЗППП после сексуального насилия

После того как вы подверглись сексуальному насилию, важно как можно быстрее пройти обследование, подтверждающее факт сексуального насилия. Если вы обратитесь за медицинской помощью в течение 72 часов после насилия, врач, к которому вы обратитесь, может назначить вам лекарства для лечения определенных ЗППП в случае опасности заражения во время сексуального насилия. В связи с тем, что данные препараты не действуют на 100 % эффективны для профилактики заболеваний, важно, чтобы вы знали, какие симптомы могут появиться, и пришли на прием к врачу через две-три недели, чтобы убедиться, что лечение является эффективным. Для предотвращения риска заражения ВИЧ-инфекцией вам может быть предложена постконтактная профилактика (ПКП), которая подразумевает прием антиретровирусных препаратов, если насилие имело место в течение 72 часов до медицинского обследования.

Если у вас нет врача, на обороте данной брошюры перечислены несколько государственных клиник, в которых на условиях конфиденциальности проводится диагностика ВИЧ-инфекции и других ЗППП у жертв сексуального насилия, а также всех, кто может быть инфицирован.

Для лечения гонореи, хламидиоза и сифилиса существуют безопасные эффективные средства. Лечение антибиотиками обычно проводится на основании результатов обследования на наличие ЗППП. Однако ваш врач может принять решение начать лечение до получения результатов обследования.

Предотвращение передачи ЗППП половым партнерам

Если вы были заражены во время сексуального насилия, вы можете передать ЗППП своему партнеру, поэтому мы рекомендуем вам не иметь сексуальных контактов до получения результатов контрольных анализов спустя две-три недели после того, как вы подверглись насилию.

Если вы все-таки занимаетесь оральными, анальными или вагинальным сексом, важно использовать латексные презервативы или другие барьерные методы контрацепции. Латексные презервативы, используемые постоянно и правильно, являются высокоэффективным методом предотвращения передачи ВИЧ-инфекции. Кроме того, использование латексных презервативов может уменьшить риск заражения другими ЗППП.

ВИЧ/СПИД и сексуальное насилие

Заразиться ВИЧ нелегко. Риск заражения при единичном сексуальном контакте очень небольшой. Проникновение полового члена в вагину или анус или контакт с кровью — наиболее вероятные способы передачи ВИЧ-инфекции во время сексуального насилия. Во время орального секса риск заражения незначителен, но он существует.

Диагностика ВИЧ-инфекции проводится с помощью анализа крови. Сразу после сексуального насилия обратитесь к врачу и сдайте анализы. Вам будут назначены повторные анализы с различными интервалами в течение 6 (шесть) месяцев. Если анализ будет отрицательным спустя 6 (шесть) месяцев, можете быть уверены, что заражение ВИЧ-инфекцией не произошло.

Обследование лиц, совершивших насилие

Согласно законодательству штата Миннесота (закон штата Миннесота 61A.19) суд может потребовать проведения обследования на антигена к ВИЧ после признания лица виновным в изнасиловании. Жертва сексуального насилия может потребовать проведения обследования признанного виновным насильника. В связи с тем, что признание насильника виновным — если оно вообще имеет место — не происходит немедленно, обследование насильника может быть проведено спустя несколько месяцев после возможного заражения. Поэтому поиск информации о лице, совершившем изнасилование, — не лучший способ определить, заразились ли вы. Характер насилия, стадия заболевания, ваш собственный иммунитет и другие факторы делают результаты вашего собственного обследования более важными, чем результаты обследования насильника.

Вам может помочь обсуждение ваших проблем с сотрудниками местной программы по борьбе с сексуальным насилием.

Коалиция противодействия сексуальному насилию штата Миннесота (Minnesota Coalition Against Sexual Assault)

161 St. Anthony Avenue, Suite 1001

St. Paul, MN 55103

(651) 209-9993

1-800-964-8847 (авонок бесплатный)

<http://www.mnpsa.org>

Cov Chaw Soj Ntsuam Tej Co Kab Mob STD thiab Chaw Kho Mob

Cov chaw kho mob nam gab no muaj kev tawm tsaw yim thiab kev soj ntsuam HIV thiab lwv cov kab mob STD uas tsis pub lwv tus neeg paub. Cov neeg ua hauj lwv hauv chaw kho mob muaj kev cob qhia los tes cov lus nug txog kab mob HIV thiab kab mob STD thiab los muab kev xa mus cuag cov chaw muab kev pab uas paub txog thiab muaj kev txhawj txog los kho mob thiab kho kev puas thwm.

MINNEAPOLIS

ST. PAUL

Hennepin County
Public Health Clinic
(Formerly Red Door)
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Minneapolis, MN 55415
(612) 643-5555
(612) 348-4729 TTY
www.co.hennepin.mn.us

St. Paul Ramsey County
Department of Public Health
Room 111
555 Cedar Street
St. Paul, MN 55101
(651) 268-1352
www.co.ramsey.mn.us/ph

Muaj ntau cov chaw soj ntsuam kab mob HIV thiab kab mob STD thoob plaws hauv xeev Minnesota. Tsis muaj chaw traus los sau txiav qhov chaw rau hauv daim ntauv qhia no. Nug sau rau ntawm MAP AIDSline hais txog cov chaw soj ntsuam kab mob HIV thiab Minnesota Kev Npej Tub Ki thiab Tus Xov Tooj Qhia Txog STD (Minnesota Family Planning and STD Hotline) rau cov chaw soj ntsuam kab mob STD (sab hauv gab).

Minnesota AIDS Project AIDSline

Cheeb Tsam Hauv Zos
(612) 373-AIDS
(612) 373-2465 TTY

Thooob Hauv Lub Xeev
1-800-248-AIDS
1-888-820-2437 TTY
<http://www.mnidsproject.org>

Minnesota Kev Npej Tub Ki thiab Tus Xov Tooj Qhia
Txog STD (Minnesota Family Planning and STD
Hotline)

1-800-783-2287 suab/TTY
(651) 645-9360 (Cheeb tsam hauv zos)
<http://www.sexualhealthmn.org>

Yog Xav Paub Ntxav

Yog tias koj muaj lus nug los yog cov kev txhawj xeeb txog kab mob STD, nug koj tus kws kho mob, cov neeg ua hauj lwv hauv tsev kho mob, tus kws kho mob hauv lub tsev kho mob, los yog lub tuam tsev xyuas txog kev noj gab haus huv ntawm cev hauv koj lub zos. Yog xav paub ntxiv txog kev soj ntsuam, nug tau rau ntawm STD ib lub chaw kho mob uas muaj nyob rau seem lawv gab hov los yog lwv cov chaw muab lus qhia uas muaj nyob hauv gab no.

Yog hais tias koj muaj ib co kev txhawj xeeb tsawj xeeb txog kev yuam deev, nug tau koj qhov chaw pab txog kev yuam deev. Lawv yuav muab tau cov lus qhia, cov kev xa mus cuag, thiab kev txhawj nqa.

Yuav tsum tau nthav tsaw yim txog kev kho mob los ntawm ib tug kws txawj yog koj nteeg hais tias koj kis tau kab mob STD lawm.

Yog xav tau cov lus qhia txog kab mob STD, hu rau:
Minnesota Kev Npej Tub Ki thiab Tus Xov Tooj Qhia Txog
STD (Minnesota Family Planning and STD Hotline)

1-800-783-2287 voice/TTY
(Lub xov tooj rau cov neeg tsis hnov lus)
(651) 645-9360 (Cheeb tsam hauv zos)
<http://www.sexualhealthmn.org>

Minnesota AIDS Project AIDSline

Cheeb Tsam Hauv Zos
(612) 373-AIDS
(612) 373-2465 TTY

Thooob Hauv Lub Xeev
1-800-248-AIDS
1-888-820-2437 TTY
<http://www.mnidsproject.org>

Minnesota Tuam Tsev Xyuas Txog Kev Noj Gab Hais Huv
(Minnesota Department of Health)

Kab Mob Uas Kis Tau,
Ceg Tiv Thiav Thiab Tswj
Seem Hais Txog Kab Mob STD thiab Kab Mob HIV
(651) 201-5414
<http://www.health.state.mn.us/std>

Minnesota Lub Koom haum Tiv Kev Yuam Moc Deev
(Minnesota Coalition Against Sexual Assault)

Hauv zos: (651) 209-9993
Thooob Hauv Lub Xeev: 1-800-964-9847
<http://www.mnccsa.org>

Yog tias koj xav tau daim ntawv no ua horn yam ntawv, xws li ua cov ntawv
hoj, cov ntawv txawj rau cov neeg tias pohn kev,
los yog kev xaav kab xav, hu rau:

(651) 267-5414
(651) 267-5737 TTY

IC #441-0550
For Persons Who Have Been Sexually Assaulted - Hmong

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Rau Cov Neeg Uas Tau Raug Yuam Deev

Cov Lus Qhia Uas Koj Yuav Tsum
Tau Paub Txog Cov Kab Mob Kis
Los Ntawm Kev Sib Deev



Kab Mob Uas Kis Tau, Ceg Tiv Thiav Thiab Tswj
Seem Hais Txog Kab Mob STD thiab Kab Mob HIV

Nthuv Lus

Cov neeg uas rau raug yuam deev feem ntau muaj kev thawj xeeb thiab tus nung xog ntau yam. Daim ntawm no yog los muab cov lus qhia rau koj xog cov kab mob kis los ntawm kev sib deev los yog "STD".

Yog hais tias koj tias nkag sib xog cov lus qhia no, los yog xav tau ib co lus qhia ntaw, nung koj tus kws kho mob los yog tus neeg muab kev pab kho mob kom pab koj.

Cov Kab Mob Kis Los Ntawm Kev Sib Deev (STDs)

Koj yuav kis tau kab mob STD los ntawm kev sib deev ntawm chaw mos, ntawm qhov ncauj los yog ntawm qhov quav nrog ib tug neeg uas muaj tus kab mob. Tus kab mob STD uas nuag muaj tshaj yog chlamydia, gonorrhea thiab syphilis. Tus kab mob STD uas txuas ntxhais tshaj yog tus kab mob human immunodeficiency virus (HIV), tus kab mob uas ua rau kab mob AIDS. Kab mob sib B, sawv hlav ntawm chaw mos (genital herpes), thiab ua pob ntawm chaw mos (genital warts).

Tej co kab mob STD no ua tau kom muaj teeb meem loj. Piv dww il, cov kab mob gonorrhea thiab chlamydia yog tias tseeb kho yuav ua rau cov chaw xeeb me nyuam ntawd puas, uas yuav rau nchuv me nyuam los yog cov poj nyam yuav muaj tias tsaus me nyuam los yog ua rau cov kab me nyuam tsis qoos rau cov dxiv neej. Tej co kab mob STD xws li HIV yuav ua tau teeb meem loj uas thiag tsaus thiab. Tej co kab mob STD tseem yuav kis tau ntawm: ib tug poj nyam uas cav xeeb tub mus rau nws tus me nyuam hauv plab.

Txoj Kev Pheej Hmoo uas Yuav Tau Kab Mob STD los ntawm Kev Yuam Deev

Cov kab mob STD uas nuag porm muaj tshaj tom qab yuam deev muaj xws li gonorrhea los yog chlamydia. Txoj kev pheej hmoo tias yuav tau gonorrhea los yog chlamydia los ntawm kev yuam deev mas nws tsawg. Txoj kev pheej hmoo yuav tau syphilis los yog sawv hlav ntawm chaw mos mas nws tseem hai yam tsawg. Txoj kev pheej hmoo yuav kis tau HIV mas nws tsawg heev, thiab tseem tsawg dua yog hais tias tsaus deev ntawm qhov ncauj thaum mos deev ntawd.

Yog hais tias pom tias kis tau kab mob STD tom qab ib qho kev yuam deev, nws tias txhais tau tias li tias kis tau tus kab mob thaum yuam deev ntawd. Tiam sis, kev soj ntsuam tom qab ib qho kev yuam deev yuav muab ib lub sij hawm los xhieb xyuas thiab kho cov kab mob STD uas txhom tseeb tau ntawd. Piv txwv il, ib tug neeg tej zaum muaj tus kab mob STD (yam uas tsis pab) ua tej raug yuam deev. Tej zaum muaj li no thaum uas kis tau chlamydia vim tias kws yees li ntawm 3 tug hauv 4 tug poj nyam thiab 1 tug hauv 2 tug poj nyam yuav tias muaj cov tsaus mob. Kev kho thaum ntxov yuav tiv thaiv tau kev puas uas kav mus ntev.

Cov Cim thiab Tsos Mob Ntawm Kab Mob STD

Tej co kab mob STD ua rau muaj tsos mob xws li khaus, mob, muaj kua discharge, los ntshav, ua hlav ntawm: chaw mos, los yog mob plab mog. Cov tsos mob no tej zaum yuav muaj li ntawm ntau hnub, ntau av thiv, los yog ntev dua ntawd tom qab ib tug neeg kis tau. Tiam sis koj yuav tso sib tias tau rau cov tsos mob los qhia seb koj puas kis tau mob. Coob tus neeg uas tau tus kab mob STD yuav tias muaj cov tsos mob. Li no, nws yog ib qho tseem ceeb heev uas koj mus cuag ib tug kws kho mob kom soj ntsuam thiab soj ntsuam kab mob STD los xyuas seb koj puas kis tau kab mob tom qab ib qho kev yuam deev, txawm tias koj tias muaj tsos mob il.

Kev Soj Ntsuam Kab Mob STD thiab Kho Mob Tom qab Yuam Deev

Tom qab raug yuam deev tias nws yog ib qho tseem ceeb uas koj mus soj ntsuam tias tau raug yuam deev kom sai li sai tau. Yog tias koj nthav kev kho mob li ntawm 72 teev tom qab raug yuam deev, tus kws kho mob uas saib xyuas koj ntawd yuav muab tau tshaj rau koj noj rau tej co kab mob STD tsam koj ho raug rau cov kab mob thaum lub sij hawm yuam deev. Vim hais tias cov tshaj no nws tias tiv thaiv kab mob 100%, nws tseem yog ib qho tseem ceeb uas koj pab tias yuav xyuas ntsoov seb puas muaj dab tsu thiab rov qab mus cuag koj tus kws kho mob li ntawm ob mus rau pab as thiv kom pab tseeb tias tau kho koj zoo lawm. Rau kev pheej hmoo tias ho raug kab mob HIV, tej zaum yuav muab cov tshaj post-exposure prophylaxis (PEP) ntawm cov tshaj antiretroviral yog hais tias qhov kev yuam deev nws tshwm sim li ntawm 72 teev ua ntej qhov kev soj ntsuam koj.

Yog hais tias koj tias muaj ib tug kws kho mob, muaj ntau qhov chaw kho mob pab pei xeeb nyob rau sab nraum qab ntawm daim ntaw no uas yuav muab tau kev soj ntsuam kab mob HIV thiab lwm cov kab mob STD yam uas tias pud qhia rau tej twg pab rau cov neeg uas raug yuam deev, los yog lwm tus neeg uas tej zaum kis tau tus kab mob.

Muaj kev kho mob uas muaj kev ruaj ntseeg thiab kho tau los kho gonorrhea, chlamydia, thiab syphilis. Cov tshaj tias kab mob feem ntau yog raws qhov kev tshaj porm, tau los ntawm qhov kev soj ntsuam kab mob STD. Tiam sis, koj tus kws kho mob tej zaum yuav txawv txim koj thaum uas koj tos seb tshaj porm tau dab tsi.

Tiv Thaiv Kev Kis Kab Mob STD mus rau Cov Neeg Uas Deev Nrog

Koj yuav kis tau kab mob STD mus rau koj tus khub yog hais tias koj kis tau thaum yuam deev. Li no, pab xav kom koj tias txhob rawm sib deev kom bog thaum uas koj tau rov qab mus soj ntsuam dua li ntawm ob mus rau pab as thiv tom qab raug yuam deev thiab koj tau txais cov kev tshawb porm tau lawm tso.

Yog tias koj deev ntawm qhov ncauj, qhov quav, los yog ntawm chaw mos, nws yog ib qho tseem ceeb uas yuav tau siv cov hnab loj latex los yog lwm yam kev thaiv. Cov hnab loj latex, thaum uas siv xwm yeam thiab siv yog, mas nws pab tau zoo, heev xog kev tiv thaiv qhov kis kab mob HIV. Ntxiv thiab, kev siv cov hnab loj latex kom yuav pab tau koj kev pheej hmoo ntawm lwm cov kab mob STD.

Kab Mob HIV/AIDS thiab Kev Yuam Deev

Kev kis kab mob HIV nws tias xog yim. Txoj kev pheej hmoo uas yuav kis tau los ntawm kev sib chaw, ib zaug mas nws tsawg heev. Kev siv tus qau mus chaw qhov chaw mos los yog lub qhov quav, los yog chaw cov ntshav, mas faem ntau yog xoj kev uas yuav kis tau kab mob HIV thaum yuam deev. Muaj xoj kev pheej hmoo tsawg, tiam sis tias yog tias yuav tias muaj li, ntawm kev kis los ntawm kev deev hauv qhov ncauj.

Kev kis kab mob HIV yog pab tau los ntawm kev soj ntsuam ntshav. Tom qab ib qho kev yuam deev tias, mus cuag ib tug kws kho mob thiab mus soj ntsuam tam: sim ntawd. Tus kws kho mob yuav rov qab ua qhov kev soj ntsuam rau cov sij hawm txawv kom xog li rau (6) lub nts. Yog hais tias qhov kev soj ntsuam tseem yog nyob rau qhov tias muaj tom qab rau (6) lub nts, koj yuav tso sib tau tias koj tias kis tus kab mob HIV.

Soj Ntsuam Cov Neeg ua Txhauwm

Minnesota Txoj Cai (Minnesota Statute 61A.19) cia lub tsav hais plaub txhob kom cia li mus soj ntsuam kab mob HIV tom qab txhawv txim tias tus neeg tau ua txhauwm cai lawm. Tus neeg raug yuam deev yuav thov tau kom tus neeg ua txhauwm ntawd cia li mus soj ntsuam. Vim hais tias kev muab txim txhauwm rau—yog hais tias muaj—tias ua tam sim ntawd, kev soj ntsuam tus neeg ua txhauwm tej zaum yuav tias tau ua kom xog ntau hli tom qab tej zaum uas raug. Li no, kev tshawb xyuas cov lus qhia xog tus neeg uas tau yuam deev koj ntawd tias yog xoj kev zoo tshaj los xyuas seb koj puas kis mob. Txoj kev nws yuam deev koj, seb tus kab mob, thiab lwm yam ua rau koj xoj kev tiv thaiv kab mob, thiab lwm yam ua rau koj xoj kev soj ntsuam tseem ceeb dua qhov kev soj ntsuam tshawb porm tau los ntawm tus neeg ua txhauwm.

Kev tham koj cov kev thawj xeeb nrog ib qho kev pab cuam xog kev yuam deev tej zaum yuav pab tau:

Minnesota Coalition Against Sexual Assault
161 St. Anthony Avenue, Suite 1001
St. Paul, MN 55103
(651) 209-9923
1-800-964-8647 hu dawb
<http://www.mnacaasa.org>

Information required by Emergency Care to Sexual Assault Victims Act

(S.F. 1266/Ch. 42)

Background

A law was passed during the 2007 legislative session requiring the Minnesota Department of Health to provide Minnesota hospitals with information about emergency contraception from the American College of Obstetricians and Gynecologists (ACOG). Minnesota hospitals are required to provide this information to victims of sexual assault. The information in this fact sheet comes directly from the ACOG Web site, at http://www.acog.org/departments/dept_notice.cfm?recno=18&bulletin=1084.

Frequently asked questions about hormonal approaches to emergency contraception

1. What is emergency contraception?

Emergency contraception (EC) is a term that describes the use of contraceptive methods to prevent pregnancy after unprotected or incompletely protected intercourse. The approach most often used is the ingestion of combined oral contraceptives (COC) or progestin-only pills (POP) within 72 hours of unprotected intercourse. Several regimens of different formulations can be used for EC:

Yuzpe regimen: Two tablets of Ovral (50 mcg ethinyl estradiol plus 0.5 mg norgestrel) followed in 12 hours by 2 additional tablets.

Formulations of sub-50 mcg COCs.

"Preven": The equivalent of the 2 Ovral doses of 2 tablets each).

"Plan B": One tablet of 0.75 mg levonorgestrel followed in 12 hours by 1 additional tablet.

As an alternative to the hormonal approach, an intrauterine device can be very effective for EC when it is inserted within 5 days of unprotected intercourse. IUDs must be inserted and removed by a physician. This method may be appropriate for women seeking long-term

contraception; however, it is not advisable for women at high risk for sexually transmitted diseases or for adolescents. Furthermore, insertion of an IUD is not recommended for EC in cases of rape.

2. What is meant by "incompletely protected" intercourse?

Approximately half of unintended pregnancies in the U.S. result from a contraceptive method failure. Commonly experienced examples of such failure are condom slippage or breakage or multiple missed pills in a cycle of pill use. (http://www.acog.org/departments/dept_notice.cfm?recno=18&bulletin=1077)

3. What is the mechanism of action of COCs or POPs in providing emergency contraception?

Before ovulation, treatment with EC is believed to disrupt follicular maturation and consequently inhibit or delay of ovulation. After ovulation, treatment appears to have no effect on ovarian hormone levels. Thus, prevention of implantation may be a secondary mechanism of action. In addition, POPs alter tubal motility.

4. Does this mean that emergency contraception can cause an abortion?

Emergency contraception will not disrupt an established pregnancy. Women often are exposed to exogenous hormones in early pregnancy without adverse outcome. Some women undergoing assisted reproductive technology procedures to achieve pregnancy are routinely prescribed progesterone to support the pregnancy. It is also a common occurrence to interview patients in early pregnancy who were not aware that their missed pills had resulted in contraceptive failure and who thus had continued taking their pills.

Emergency Care to Sexual Assault Victims Act

5. How effective is emergency contraception?

Effectiveness is determined by comparing the number of pregnancies observed with treatment to the number that would have been expected without treatment. Women who utilize emergency contraception in the most fertile segment of the menstrual cycle (6 days preceding ovulation to the day after ovulation) will have a higher failure rate than women who utilize the method during another part of the cycle. The proportion of pregnancies prevented with the Yuzpe regimen has been calculated to be between 57-75%. The effectiveness of the levonorgestrel regimen is reported to be 85%. The effectiveness of all regimens decreases after the first 12-24 hours after unprotected or incompletely protected intercourse.

6. Is there any point in using EC after 24 hours?

Although the reduction in the risk of pregnancy is most striking in the first 12-24 hours, EC can be effective for up to 72 hours. Based on combined COC and POP method use, the World Health Organization (WHO) has reported pregnancy rates of 0.5%-1.5% in the first 12-24 hours compared to approximately 2.6% at 48 hours and 4.1% at 72 hours. To reduce unintended pregnancies it is critical to find ways to make EC as readily available as possible to women as soon as the need is recognized.

7. What about having emergency contraception available in advance?

The correlation of low pregnancy rates with early utilization of emergency contraception supports advance prescribing of the dedicated products along with detailed instructions for their use. In addition, it is well known that users of barrier methods and OCPs would benefit from this kind of intervention. Users of OCPs are routinely advised to take a missed pill along with the current pill. Studies have shown that women can identify their risks and needs quickly, will utilize the regimen appropriately when it is provided in advance,

and are not inclined toward repetitive use patterns for EC.

8. What are the side effects associated with EC use?

The most common side effects of EC use are nausea and vomiting. At least 50% of the COC regimen users will experience nausea and 18-20% will have vomiting. The Plan B (levonorgestrel) regimen is associated with less than 25% frequency of nausea and about 5% vomiting. An antiemetic should be offered in conjunction with the EC prescription. Products such as those used for motion sickness are generally sufficient. The dose may need to be repeated if an EC user vomits within 1 hour of taking the medication. An episode of vomiting after 2 hours does not require a replacement

9. In addition to temporary side effects, are there any serious complications of EC?

The short-term nature of the regimen makes any vascular complications such as thrombosis highly unlikely. Menstrual cycle changes such as heavier bleeding, headache, dizziness, and breast tenderness may be experienced by as many 16 % of EC users. Because of the presumed effects on tubal motility with POP regimens, caution should be exercised in evaluating the possibility of ectopic pregnancy in users who experience abnormal bleeding for. There are very few contraindications to using EC: women should not use EC who are already pregnant or who have genital bleeding of unknown cause.

10. What if a woman is already pregnant or if EC fails to prevent pregnancy? What problems may occur?

The use of EC is contraindicated during pregnancy. A woman with a problem pregnancy needs evaluation, counseling, and advice. A woman with an unplanned but desired pregnancy needs exactly the same care from her physician. Menses may be delayed after EC use, and a follow-up visit should be scheduled within 1-3 weeks to check for possible pregnancy. Based on studies of

Emergency Care to Sexual Assault Victims Act

pregnancies where EC failed to prevent pregnancy, there is no (finding) that there is any increased risk of birth defects or other problems for the ongoing pregnancy. This finding is consistent with the knowledge that early exposure to estrogen or progestin formulations does not produce adverse embryonic or fetal effects.

11. Should a pregnancy test be performed before using EC?

A pregnancy test is not a prerequisite to the use of EC. It can be useful in determining the need for EC if the woman has experienced more than one episode of unprotected or incompletely protected intercourse in the cycle and at least one episode was greater than 72 hours preceding evaluation. A positive test will allow the woman or her physician to begin the appropriate care for early pregnancy.

12. When should the regular method of contraception be resumed after EC use?

Since EC (both the COC and the POP methods) can delay ovulation, it is important for a woman who is at continued risk for pregnancy to use an effective method of contraception for the remainder of the current cycle. Barrier methods and spermicide can be used immediately. A woman who is using OCPs can start a new pack after beginning the next menstrual cycle or she could even begin with one pill a day of her regular OC on the day after completing the EC treatment regimen.

13. Do EC users become less effective contraceptive users?

Most couples would like to increase their ability to effectively prevent and plan pregnancy. Many EC users are currently using a contraceptive method the best way they can under the circumstances of their lives. Identifying the need for EC and providing it gives a woman an opportunity to enhance personal decision-making for ongoing effective contraception.



MINOR CONSENT FOR MEDICAL AND MENTAL HEALTH TREATMENT

This fact sheet will address two main issues:

1. When may a sexual assault advocate or medical professional provide services to a minor without consent from the minor's parent?
2. When is the advocate or medical professional required to keep the services confidential, even from the minor's parent?

1. General rule: Parent's consent required	In Minnesota as with most other states, the general rule is that a parent must be informed about and give consent for medical treatment for her child.
Exceptions to general rule:	In the following situations, a minor (an individual under 18 years of age) may consent to medical or mental health treatment by herself without separate permission from a parent or guardian:
Pregnancy/STD	<p>Any minor may consent to medical or mental health services to diagnose either pregnancy or STD's. Minn. Stat. §144.343 subd. 1</p> <p>A minor (whether sexually assaulted or not) may obtain a medical examination to diagnose or treat these conditions. Her parents need not give consent.</p> <p>See also SVJI fact sheet on emergency contraception and compassionate care for sexual assault victims.</p>
Contraceptive care	Providing contraceptive care to a minor without consent of her parents is not a criminal act, and thus medical personnel may not be punished criminally for treating a minor seeking contraceptive services, including after a sexual assault.
Emergency care	A minor may seek medical treatment without parental consent if her life or health is at such risk that treatment should be given without delay associated with contacting parents. Minn. Stat. §144.344. Thus, a minor who was sexually assaulted and received injuries which risk her life or health need not obtain parental consent for the medical treatment.
Abortion	The set of procedures for abortion services for minors are outside the scope of this fact sheet.
Drug/alcohol counseling	A minor may seek medical or mental health services to diagnose and treat drug or alcohol dependency issues without the consent of a parent.

Emancipated minor	While no formal system exists in Minnesota for a judge to legally emancipate a minor, a minor living separate from parents or guardians, and managing her own financial affairs, may seek medical treatment without the consent of a parent or guardian. Minn. Stat. §144.341
Married/borne child	A minor who has been married (even if not currently), or who has given birth to a child, may give consent for medical or mental health procedures for herself or her child. Minn. Stat. §144.342
2. General Rule: Parent must be informed and is responsible for the bill.	Generally, a parent must be informed about medical or mental health procedures regarding their minor children, must be given copies of medical records, and is responsible to pay for the services.
Two Exceptions to General Rule:	In certain circumstances, the rule that parents are to be informed about treatment of a minor does not apply:
Confidentiality of consenting minor must be maintained	If a minor properly consented to a medical or mental health procedure under the situations described in issue 1 above (for pregnancy/STD, emergency, etc.), then the medical or mental health personnel may not release medical information or records even to the parent or guardian. See the Minnesota Health Records Act at Minn. Stat. §144.291(g) for requirements and exceptions.
Payment for medical or mental health services is responsibility of consenting minor	When a minor properly consents to medical or mental health care as in issue 1 above, the bill for those services becomes the financial responsibility of the minor alone. Minn. Stat. §144.347
Other confidentiality requirements:	<ul style="list-style-type: none"> • The statutes discussed above probably apply to sexual assault victim advocates, as they are arguably mental health treatment providers. • However, most non-profit advocacy programs also have own by-laws setting out policies and procedures regarding confidentiality. Advocates must follow the program policies as well as the statute. • Further, many programs contract with the State of Minnesota, especially if they provide "per diem" shelter services. If that is the case, Minnesota Chapter 13, the Data Privacy statute, also applies to provide privacy/confidentiality requirements for advocates. • See the SVJI fact sheets on advocate confidentiality. • If you are unsure about your program's confidentiality requirements, the Minnesota Council of Non-Profits or a local attorney may be of help.
Q&A	<p>Q. A 14 year old adolescent contacts our program and wants to know what to do. She says her boyfriend "went too far" and had sex with her when she didn't want to. She does not want to tell her parents, but wants help. If she has a medical exam and speaks to my program, will either the hospital or our program need to discuss the matter with her parents? Who will pay the bill?</p> <p>A. She can have a medical/forensic exam and have advocacy throughout the process, and both the medical and victim advocacy information are confidential from anyone else – including her parents. Because she properly consented to the treatment, the financial responsibility for the bill belongs to the 14 year old.</p>

Q. A 16 year old contacts our program and says she left her home last year because of abuse. She has been living on her own, staying with friends and relatives, and working a job to support herself. She wants to talk to our program about sexual abuse that has happened since she was a kid, but she wants to know if we have to tell her parents?

A. No. She is emancipated since she is supporting herself and living away from parents, and may therefore talk to your program confidentially without parents having access to the information.

Q. What about mandatory reporting? Don't I *have* to report some abuse of minors?

A. Yes. Please refer to SVJI's separate Fact Sheet on Mandatory Reporting, outlining the situations when confidentiality must be broken to report abuse to authorities.

Sexual Violence Justice Institute
Minnesota Coalition Against Sexual Assault
161 St. Anthony Avenue, Suite 1001
St. Paul, MN 55103
651.209.9993 or 800.964.8847
www.mncasa.org

Updated May 2010



EMERGENCY CONTRACEPTION: COMPASSIONATE CARE FOR SEXUAL ASSAULT VICTIMS

In 2007, the Minnesota legislature enacted Minnesota Statute §§145.4711 and 145.4713 which requires all Minnesota hospitals to provide information about and access to Emergency Contraception (EC) and prophylaxis for sexually transmitted infections (STI) during an emergency department visit after sexual assault. This measure passed overwhelmingly with bipartisan support and became effective August 1, 2007. For many victims, fear of pregnancy and/or contracting an STI are the most pressing concerns after an assault. This statute effectively removes those barriers for victims. This fact sheet primarily addresses emergency contraception.

What is emergency contraception?	Emergency contraception is a term used to describe a contraceptive method to prevent pregnancy after unprotected or incompletely protected intercourse. The most commonly used medication is referred to as Plan B. Plan B is available at the emergency department or over the counter without prescription in pharmacies. The terms EC and Plan B are used interchangeably.
When is the optimum time to take EC?	120 hours after a sexual assault is the maximum amount of time that the medication can be effective. The more time that elapses from the time of intercourse or assault, the less effective this medication is. The patient does not have to prove she was assaulted in order to receive treatment.
What does EC do?	EC prevents or delays ovulation (egg release.) It also changes a woman's reproductive environment so that sperm cannot fertilize the egg and rearranges the chemical balance seen in pregnancy. Plan B/EC is not the same as RU 487 ("abortion pill") and does not cause the abortion of a viable pregnancy. For the patient who is not already pregnant, the menstrual cycle will start on time or within a week of its normal date.
How is Plan B administered?	Plan B is given in two tablets. These two may be given as a single dose while in the emergency department setting or one tablet may be given in the emergency department and the second taken 12 hours later. Taking the tablets singularly is the preferred method but there are no significant ill effects documented by taking both tablets at once. It is becoming the preferred practice in cases of sexual assault for the victim to be given both tablets in the emergency department. Again, the medication must be administered within 72 hours of the assault to be the most effective.
Are there side effects?	The most common side effect is nausea and/or vomiting. If the victim/survivor vomits within one hour of taking the medication, a call should be made back to the medical provider so that a repeat dose may be initiated. Nausea increases

	when the victim is also taking prophylaxis for gonorrhea and/or chlamydia.
Are there restrictions on who can access EC?	EC has been the focus of some political concern. In 2009 a federal judge ordered the Food and Drug Administration (FDA) to make EC available without prescription to women as young as 17. Under the former administration, EC had been limited only to women over the age of 18. Other restrictions may also be changing, such as the FDA rule that EC be stocked behind pharmacy counters (in contrast to other over the counter contraceptives like condoms. MNCASA will keep advocates informed of changing rules.
What if the victim is or may be pregnant?	The hospital may give a pregnancy test to confirm this. If the test is positive, the hospital has the right by statute to refuse to give EC under these circumstances. However, Plan B will not do anything to a fertilized egg already attached to the uterus. There have been no documented cases of fetal development impacted by EC.
What does the state law require of hospitals?	<p>The hospital must:</p> <ul style="list-style-type: none"> • Give each female survivor medically and factually accurate and unbiased information about EC. • Use language provided by the American College of Obstetricians and Gynecologists when writing the notice. • Orally inform each female victims of the option of receiving EC at that hospital. • Immediately provide EC to each sexual assault victim who requests it. <p><i>(Similar to the response to EC, this law also requires hospitals to provide factual and accurate information about prophylactic antibiotics for sexually transmitted infections; orally inform patients about the option of receiving antibiotics at that hospital; immediately provide the antibiotics to the patient who requests it.)</i></p>
Can hospitals refuse to comply?	No. All hospitals, faith-based or not, must comply with this statute. Hospitals can require a pregnancy test prior to administering EC. However, once a negative pregnancy test result returns, the hospital cannot refuse to administer EC. Complaints of non-compliance can be reported to the Minnesota Department of Health which is responsible for enforcing this law. The Office of Health Facility Complaints is the office which takes reports. The phone number is 651-201-4201 or 1-800-369-7994.
Can a doctor refuse to supply EC?	Yes, but the hospital must find another doctor to immediately provide it. This law is a mandate on hospitals, not doctors. So, while an individual physician can refuse to provide the medication, the hospital must supply it immediately when a victim requests EC.
Advocacy issues:	<ul style="list-style-type: none"> • Every advocacy program should write and/or review their policies for assisting sexual assault victims with accessing emergency contraception and prophylaxis for STIs. • Because payment for EC is not addressed in the statute and could be argued

to be treatment related, advocates should work with local providers to clarify how billing for exams will be handled. Payments for EC and prophylaxis are often assumed by the county or written off by the medical provider.

- Remember and help your community partners understand that EC is not an abortion pill; it is completely legal and available over the counter.
- Advocates should advise victims of their right to request and receive EC.
- If medical personnel neglect to inform the victim of EC or prophylaxis, the advocate can advise the victim of that right.
- A victim can refuse to take a pregnancy test. By doing so, however, a hospital can legally refuse to give that victim EC.
- Victims do not have to agree to an entire evidentiary exam in order to have access to EC in the emergency department.
- If a victim does not wish to be seen at the emergency department they can receive EC at a free clinic or family planning center.
- If a victim, for reasons of privacy, does not want to visit either the ED or another clinic, advocacy programs are providing a central victim service by helping the victim access EC at a local pharmacy. No prescription is required. Some programs maintain a small supply of prepaid gift cards for victims who need this assistance. In some instances, advocates have protected the victim's privacy by making the purchase themselves.
- Engage in dialogue with your local emergency department personnel to ascertain if they are having difficulty complying with the state laws. Offer to assist them in evaluating the procedures and working toward victim-centeredness.
- Contact MNCASA if you have questions, are encountering barriers with local providers, or seek model policies.

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SEXUAL ASSAULT EVIDENTIARY EXAM PAYMENT

In Minnesota, victims of sexual assault who have an evidentiary exam done for the purpose of gathering evidence of sexual assault need not pay for that service. Minnesota Statute § 609.35. See also SVJI fact sheet on Payment for Evidentiary Exam Across State Lines.

What is an evidentiary exam?

Many hospitals in Minnesota are trained and equipped to conduct sexual assault evidentiary exams. The exams are designed to capture any physical evidence, such as hair, fibers, bodily fluids from the assailant, as well as to note any observable injury or trauma. The goal of the evidentiary exam is to locate and preserve anything that will prove an assault occurred and identify a suspect. The kit may be processed by the Bureau of Criminal Apprehension (BCA) at the time the victim decides to make a report to law enforcement. At the time of an evidentiary exam, medical personnel will also screen for and provide treatment for medical conditions that may require treatment, such as sexually transmitted infections, pregnancy, and physical trauma. The statute is specific to costs of evidence collection but not treatment of injury.

Who pays for the exam?

- In Minnesota, the county in which the assault occurred is responsible for covering the cost of the exam. **The victim does not have to report the assault to law enforcement in order for the county to pay.**
- The statute does not identify which county agency is responsible for administration. It may be the sheriff's office, county attorney's office, or county financial office. The agency designate should protect a victim's identity.
- The covered costs include, but are not limited to: full cost of the rape kit examination, associated tests relating to the complainant's sexually transmitted disease status, and pregnancy status.
- Victims can visit the hospital of their choice. They do not need to consult a hospital in the county in which the assault occurred. They do not need to be referred by the prosecutor or law enforcement officer.

What if the victim does not want the county to pay?

A victim may be concerned about her/his privacy and may not want the county to pay for the exam. In that case, the county can inform the victim that they may submit the cost to their insurance company for payment. In order to ensure that victims are not pressured to bill insurance, this option may not be addressed until the exam is completed. Victims must be informed that if they do not want their insurance billed, the county is obligated to pay. This will not negatively affect how the county proceeds with the case or the victim.

When should an evidentiary exam be done?

Most agree that the sooner an exam is conducted, the more likely it is that evidence can be collected. In most cases, hospitals will conduct exams within 72 hours of an assault. In some instances, exams can be conducted after that time. For example, some hospitals in Minnesota will conduct an exam within 120 hours of an assault.

Does a rape victim have to consent to the exam?

The exam is only done with the consent of the victim. The victim will also be asked to sign a release to share the results of the exam with law enforcement, if the victim has decided to report the assault.

Can a victim take time

Yes. However, most hospitals will hold the evidence kit only a limited time (two weeks to

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deciding whether or not to report the assault to law enforcement?	six months.) Check with your hospital to determine if they have a time limit. Victims should be advised that, while they can always make a report, a delay in reporting can make a case more difficult to prosecute.
What exact costs are covered by the county?	What is considered evidentiary in nature depends upon the specifics of the assault. Costs that are considered primarily related to medical treatment are the responsibility of the victim. For crime victims, some costs can be submitted to the Crime Victims Reparations Board for reimbursement in those instances when the victim is working with law enforcement. Other costs may be recouped from an offender as a part of sentencing via a restitution claim. Also, many counties have crime victim emergency funds that may assist a victim with uncovered costs.
Is this a special service just for victims of sexual assault?	The reasons these charges are covered is that they are the result of "processing the crime scene" for the local jurisdiction. This is not a special service for rape victims – but a criminal justice investigative procedure that may occur after any type of crime. The goal is to ensure that physical evidence is gathered if there is any potential of future criminal charges.
FAQs for advocates	<p>Won't this lead to a dramatic increase of women who have not really been assaulted accessing exams – perhaps for free STD/STI checks?</p> <p>Probably not. The process of a full rape exam is quite involved, lengthy and intrusive. There are a variety of other ways free STD/STI testing can be accessed in most communities. Additionally, professionals in hospitals and advocacy are in the position to discuss with patients the reasons to have a rape exam conducted. Counties who have routinely paid for all exams have not experienced a large number of victims who have not chosen to report to law enforcement.</p> <p>Why should the county be responsible for the costs of these exams if the victim is unsure about reporting the assault?</p> <p>The purpose is to avoid forcing a victim to decide, at the time of crisis, whether or not to have the evidentiary exam done based on their ability to pay if they choose to not report the incident to law enforcement. Forcing such a decision effectively limits the victim's choices. Furthermore, victims who choose to not have the exam done rather than risk having to cover the cost may destroy their chances of prosecution should they choose later to report the assault. Without the prompt collection of physical evidence, prosecution may not be able to go forward.</p> <p>How do local jurisdictions find out about changes in the law?</p> <p>Often, they don't hear about new legislation such as the one mentioned above. We encourage local professionals who work with sexual assault victims to work together toward effective implementation. For help, contact SVJI at the number below.</p>

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PAYMENT FOR SEXUAL ASSAULT EXAMS WHEN THE ASSAULT OCCURS IN ONE STATE BUT THE EXAM OCCURS IN A DIFFERENT STATE

This fact sheet explains who pays for a sexual assault exam when the victim is assaulted while visiting one state but undergoes a sexual assault exam in her/his home state of Minnesota.

In **Minnesota**, who pays for a sexual assault exam if the sexual assault occurs and the exam is performed in **Minnesota**?

- Under Minnesota law, the costs incurred for a sexual assault exam are paid for by the county where the assault occurred. See Minnesota Statute § 609.35.
- The county can seek reimbursement from the victim's insurance only if authorized to do so by the victim.
- Authorization to contact the victim's insurance company can only be sought after the exam is performed.
- When seeking authorization, the county must inform the victim that if s/he does not authorize insurance coverage, the county is required by law to cover the costs of the examination.

What costs does the Minnesota county cover?

Costs covered by the county include, but are not limited to:

- Full costs of the rape kit exam
- Pregnancy tests
- Tests related to the complainant's sexually transmitted disease or infection (STD/STI) status

If a victim is sexually assaulted while visiting another state, but does not undergo a sexual assault exam until returning to **Minnesota**, who pays for the exam?

- Under Minnesota law, Minnesota will only pay for a sexual assault exam if the assault occurred in Minnesota.
- Thus, if a Minnesota resident is assaulted in another state but the sexual assault exam takes place in Minnesota, the victim must still apply in the state where the assault occurred for compensation.
- See below for examples of who pays for rape kit exams under the laws of different states.

If the assault occurred in **Iowa**, does **Iowa** pay for a sexual assault exam performed in **Minnesota**?

- Yes, in Iowa the cost of a sexual assault exam to gather evidence and prevent STD/STIs is paid for through Iowa's Victim Compensation Fund (VCF).
- The Victim's Compensation Fund provides compensation (1) to victims of crimes that occur in Iowa and (2) to victims of out-of-state crimes committed against Iowa residents if the state where the crime was committed does not have similar provisions.
- www.iowa.gov/government/ag/helping-victims/services/compensation-program.html

Is a sexual assault victim who is not a resident of **Iowa**, a "victim" for the purposes of Iowa's VCF?

- Yes, a "victim" is defined by the VCF as a petitioner or person who is the victim of a sexual assault occurring in Iowa.
- There is no differentiation made between victims who are residents and nonresidents of Iowa.

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What requirements must a sexual assault victim meet to apply for Iowa's VCF?	<ul style="list-style-type: none"> The sexual assault must occur in Iowa.
If the assault occurred in North Dakota, who pays for a sexual assault exam in Minnesota?	<ul style="list-style-type: none"> In North Dakota, the cost of a sexual assault exam for an assault that occurred in North Dakota is paid for through North Dakota's Crime Victim's Compensation fund (CVC). www.ndcrimevictims.org
Is a sexual assault victim who is not a resident of North Dakota, a "victim" for the purposes of the CVC?	<ul style="list-style-type: none"> Yes. "Victim" is defined as a "person who suffers bodily injury of death as a result of criminally injurious conduct, the good faith effort of any person to prevent criminally injurious conduct, or the good faith effort of any person to apprehend a person suspected of engaging in criminally injurious conduct." NDCC 54-23.4-01.
Are there requirements the victim of a sexual assault that occurred in North Dakota must meet in order to receive CVC compensation?	<ul style="list-style-type: none"> A victim is only eligible for compensation from North Dakota if the assault is reported to a law enforcement officer within 72 hours after its occurrence or good cause is found for the victim's delayed reporting. It is recognized that sexual assault victims often take longer than 72 hours to report an assault and are encouraged to apply for CVC regardless.
If the assault occurred in South Dakota, who pays for a sexual assault exam in Minnesota?	<ul style="list-style-type: none"> In South Dakota, if a hospital, physician or clinic examines a victim of sexual assault to gather evidence or information, the examination is paid for by the county where the assault occurred. If the alleged offender is later convicted, the county is reimbursed by the offender. www.sdvictims.com
Are there requirements a victim of sexual assault that occurred in South Dakota must meet for the county to pay for the exam?	<ul style="list-style-type: none"> The assault must be reported to the state. The crime must be reported to law enforcement within five days of its occurrence or when a report could reasonably have been made. The claim for compensation must be filed within one year of the crime unless good cause is shown for the delay. The victim and claimant must reasonably cooperate in the investigation and prosecution. Compensation cannot be paid to a claimant if it would unjustly benefit the offender or an accomplice. The victim cannot contribute to the crime. It is recognized that sexual assault victims often take longer than five days to report an assault and are encouraged to apply for compensation regardless.
If the assault occurred in Wisconsin, who pays for a sexual assault exam performed in Minnesota?	<ul style="list-style-type: none"> In Wisconsin, sexual assault exams are paid by Wisconsin's Crime Victim Compensation Fund (CVC). www.doj.state.wi.us/CVC/cvcompensation/compensation-brochure.asp or see Wisconsin Coalition Against Sexual Assault Fact sheet at www.wcasa.org.
Is a sexual assault victim who is not a resident of	<ul style="list-style-type: none"> Yes, a "victim" is defined by the CVC as a person who is injured or killed during

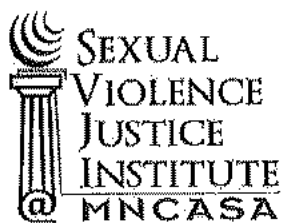
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Wisconsin, a "victim" for the purposes of the CVC?	<p>an act occurring within the state of Wisconsin.</p> <ul style="list-style-type: none"> No differentiation is made between resident and nonresident victims.
Are there requirements the victim of a sexual assault that occurred in Wisconsin must meet in order to receive CVC compensation?	<ul style="list-style-type: none"> The victim must: <ul style="list-style-type: none"> Report the crime within 5 days of its occurrence or within 5 days of when the crime could reasonably have been reported. Incur actual, out-of-pocket expenses. Utilize all other sources of payment (example: restitution, private insurance) Apply for CVC within one year of the crime's occurrence. Cooperate with the law enforcement investigation. Cooperate with the Office of Crime Victim Services as they process the CVC application. If a victim does not meet all of the above requirements, they are still encouraged to apply for CVC in the interest of justice. It is recognized that sexual assault victims often take longer than 5 days to report an assault and therefore are encouraged to apply for CVC regardless.
If a Wisconsin victim does not want to bill their insurance for a sexual assault exam, are they still eligible for CVC?	<ul style="list-style-type: none"> No. To receive CVC funds, the victim must utilize all other sources of payment for expenses resulting from the crime, including insurance. However, If a victim chooses not to bill their insurance they may be eligible for Wisconsin's SAFE (Sexual Assault Forensic Exam) fund. SAFE only pays for the sexual assault exam. Victims may not apply for both SAFE funds and CVC funds.

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LIMITATIONS ON THE USE OF POLYGRAPH EXAMS IN CRIMINAL SEXUAL CONDUCT CASES

The purpose of this fact sheet is to explain the limitations on polygraph use by law enforcement in criminal sexual conduct cases. According to the STOP Violence Against Women Formula Grant Program administered by the United States Department of Justice, all states, Indian tribal governments, territorial governments, and units of local governments receiving funds must comply with a **prohibition on requiring victims of sexual violence to submit to a polygraph examination as a condition for proceeding with a criminal investigation**. The law went into effect in Minnesota on July 1, 2008 as Minn. Stat. §611A.26.

Definition of a Polygraph Examination	A mechanical or electrical instrument or device used, or allegedly used, to examine, test or question individuals for the purpose of determining truthfulness.
Prohibition Against Requirement of Polygraph in Investigation, Charging or Prosecution	No law enforcement agency or prosecutor shall require that a victim/survivor of a criminal sexual conduct offense submit to a polygraph examination as part of or a condition for proceeding with the investigation, charging, or prosecution of an offense.
Required Referral to Sexual Assault Counseling	No law enforcement agency or prosecutor may ask the victim/survivor to submit to a polygraph examination as part of the investigation, charging, or prosecution of an offense without referring the victim/survivor, and ensuring the victim/survivor has had an opportunity to consult with, a sexual assault counselor (see below for legal definition of a sexual assault counselor).
Informed Consent to Take a Polygraph Examination	Law enforcement may conduct a polygraph examination with the victim/survivor's written, informed consent, meaning: <ul style="list-style-type: none"> • The exam is voluntary and solely at victim/survivor's request • The law enforcement agency or prosecutor may not ask or require the victim/survivor to submit to the polygraph examination • The results of the examination are not admissible in court • The victim/survivor's refusal to take a polygraph examination may not be used as the basis for law enforcement or the prosecutor not to investigate, charge or prosecute the offender.
No Consequences for Refusal to Take Polygraph Examination	The victim/survivor's refusal to take a polygraph examination <u>shall not</u> prevent the investigation, charging or prosecution of the offense.

Advocacy Issues

Because the statute directs law enforcement to engage an advocate if asking the victim to submit to a polygraph, it is important that advocates understand their role and the assistance they can offer to a victim. The following are suggestions for responding to this new law.

- Meet with your local law enforcement agencies to ensure they know about this prohibition in the law.
- Let them know that your advocacy center will be happy to meet with a victim should the potential of a polygraph arise.
- Help victims understand that if they are asked they can respectfully decline to participate in the polygraph. By statute, the case should go forward.
- Inform yourself about polygraphs— the benefits and liabilities—so that you can assist a victim in making an informed decision.
- Stay in touch with MNCASA if you feel there are problems with implementing this law in your area. If victims are routinely being asked to take polygraph exams, please let MNCASA know.
- If a victim becomes a suspect in a case, this does not prevent law enforcement from asking the now suspect to take a polygraph.
- Note that polygraph issues may come up on rare occasion in other settings such as child protection or family law cases. A victim should always consult with an advocate and preferably a lawyer before deciding to submit to a polygraph under these circumstances.

Who is a Sexual Assault Counselor?

Under Minn. Stat. §595.02 subd. (k), a sexual assault counselor must meet the following requirements:

- have undergone at least 40 hours of crisis counseling training
- work under the direction of a supervisor in a crisis center
- the crisis center's primary purpose must be to render advice, counseling or assistance to victims of sexual assault

For more information about the victim/survivor and a sexual assault counselor relationship, please see our fact sheet entitled "Communication Between an Advocate and a Victim/Survivor is Not Always Confidential."

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