ORIGINAL RESEARCH

Giving Sexual Assault Survivors Time to Decide:

An Exploration of the Use and Effects of the Nonreport Option

Findings show that the nonreport option has had considerable positive impact, but challenges remain.

Forensic nurses, sexual assault nurse examiners (SANEs), and victim advocates have long recognized the trauma of sexual assault crimes and the significance of survivors' decisions around reporting these crimes to law enforcement agencies. The original Violence Against Women Act of 1994 focused on establishing new penalties for these crimes and creating a program to address domestic violence and sexual assault (the STOP Violence Against Women Formula Grant Program). But until recently, survivors of sexual assault were not entitled to a free medical forensic examination unless they reported the assault to law enforcement. Because these crimes are physically and emotionally traumatic, and because there may be complicating factors (for example, the perpetrator may be a family member, or the survivor may have been using illicit drugs at the time of the assault), survivors often aren't immediately ready to report such assaults. And this has meant that many survivors also haven't received the medical care they urgently need.

In a significant policy shift, the Violence Against Women and Department of Justice Reauthorization Act of 2005 provided an additional decision option with regard to the medical forensic examination for survivors of sexual assault. This provision, referred to here as the nonreport option, was established to offer survivors a full range of reporting options and to ensure exemplary health care, with evidence collection as an important secondary goal.[1,2] Specifically, it mandates that survivors of sexual assault be afforded medical forensic examinations even if they choose not to cooperate with law enforcement or participate in the criminal justice system, and that states must pay for these examinations regardless. The Violence Against Women Reauthorization Act of 2013 preserves the nonreport option.

This provision recognizes the complex nature of crimes of sexual assault, as well as the competing needs and requirements of survivors and those who provide response services to survivors and prosecute offenders. For all those involved—survivors, rape crisis center advocates, forensic nurses and SANEs, law enforcement officers, and prosecutors—the nonreport option continues to present a major shift from past policy and practice, even though some programs and facilities have recommended and used delayed or anonymous reporting (or both) for many years.[3] Also, although we use the terms *nonreport option* and *nonreport case*, it should be noted that some experts call for more precise language intended to avoid misperceptions about the purpose of medical forensic examinations.[1,2] For example, Lonsway and Archambault specifically recommend the term "victims who have not yet made their decision to report to police or [to] participate in the investigation."[1]

In order to receive STOP program funds, states were required to comply with the nonreport option by January 2009. Five years have passed since then, and researchers and practitioners are now examining and trying to understand the effects of the new provision. A sexual assault medical forensic examination must be offered regardless of whether the survivor decides to involve law enforcement. States have

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ABSTRACT

Background: Forensic nurses, sexual assault nurse examiners (SANEs), and victim advocates have long recognized the trauma of sexual assault crimes and the significance of survivors' decisions around reporting these crimes to law enforcement agencies. Until recently, survivors who didn't report the crime were not entitled to a free medical forensic examination. In a significant policy shift, the Violence Against Women and Department of Justice Reauthorization Act of 2005 provided an additional decision option with regard to the medical examination for survivors of sexual assault. This provision, referred to here as the nonreport option, was established to offer survivors a full range of reporting options and to ensure exemplary health care, with evidence collection as an important secondary goal.

Objectives: This study sought to examine the implementation of the nonreport option in Texas; explore its impact on SANEs, survivors, and the criminal justice system; and identify strengths and challenges of the nonreport process.

Methods: A mixed-method approach was used that included qualitative interviews with 79 professionals who regularly respond to sexual assault crimes, a Web-based survey questionnaire of such professionals that yielded 131 completed surveys, and a review of existing data.

Results: The step-by-step process involved in a nonreport case was described, and findings in three descriptive areas emerged: confidentiality processes, storage and shipment of evidence, and the use of the nonreport option. Beneficial effects of the nonreport option were identified in five areas: the role of SANEs, the impact on survivors, collaborative relationships, collateral crimes, and anonymous reporting strategies. Seven areas of remaining dilemmas were also identified.

Conclusions: Findings indicate that the nonreport option has had a considerable positive impact on SANEs, survivors of sexual assault, and the criminal justice system. But challenges remain if this option is to be fully utilized in the future; further research is warranted. The authors also present recommendations to improve health care delivery.

Keywords: forensic compliance, forensic nurse, nonreport option, rape, sexual assault, sexual assault nurse examiner

responded to the nonreport option in a variety of ways. The three main models of compliance that have emerged are as follows.[4]

- A sexual assault medical forensic examination is offered. Law enforcement is not involved at all; if an examination is conducted, the evidence is stored in a medical facility.
- A sexual assault medical forensic examination is offered. Law enforcement is involved, but only for the purpose of storing evidence at a law enforcement facility.
- A sexual assault medical forensic examination is offered. Law enforcement takes an anonymous report and stores evidence in a law enforcement facility.

The importance of evaluating the impact of this new provision cannot be understated. The shift in policy was intended to positively affect the health care needs of survivors of sexual assault, while recognizing the complex issues involved in reporting such an assault to law enforcement and the critical element of time in forensic evidence collection. The goals of our study were threefold: to examine the implementation of the nonreport option in Texas and its impact on SANEs, survivors, and the criminal justice system; to identify strengths and challenges of the nonreport process; and to offer recommendations to improve health care delivery. (Although a comparative analysis of other states' policies and procedures would be useful, this was beyond the scope of our research.)

BACKGROUND

The nonreport option in Texas. In July 2009, following a year of stakeholder workgroup meetings coordinated by the Texas Association Against Sexual Assault (TAASA), Texas House Bill 2626 was passed by the state legislature and the nonreport option became law in Texas. Specifically, the law provides adult survivors with the option of having a medical forensic examination conducted within 96 hours of a sexual assault without reporting the assault to law enforcement. Evidence in such cases is held anonymously and confidentially by the Texas Department of Public Safety (DPS) for two years. At any point during those two years, a survivor can "convert" her or his nonreport case by reporting the sexual assault to law enforcement.

Literature review. According to the 2010 National Intimate Partner and Sexual Violence Survey, 18%

of women and 1% of men reported having been raped at some point in their lifetimes.[5] In research conducted in Texas, Busch-Armendariz and colleagues found that about 20% of women and 5% of men had experienced sexual assault during their lives.[6,7] The same investigation also found that only 18% of all survivors (20% of female survivors and 12% of male survivors) had reported the assault to law enforcement. Indeed, experts agree that crimes of sexual assault are underreported.[5]

As with other crimes of interpersonal sexual violence, sexual assault is plagued with terminological and definitional challenges. Some of these challenges are historical and related to how our understanding of the crime developed (for example, early definitions of rape focused solely on vaginal penetration by a penis). Other challenges stem from the context in which terms and definitions are being used (for example, law enforcement versus victim advocacy perspectives). That said, currently the term *sexual violence* is generally understood to mean any nonconsensual sexual act, whether completed or attempted, and includes rape, sexual abuse, and verbal sexual harassment.[8] *Sexual assault* has been defined by the U.S. Department of Justice as "any type of sexual contact or behavior that occurs without the explicit consent of the recipient."[9] The legal definition of sexual assault outlined in Section 22.011 of the Texas Penal Code includes rape, sodomy, and penetration, touching, or oral sex in which the victim is unwilling or unable to give consent, for reasons that include being under 17 years of age, drugged, or unconscious.[10] Sexual assault and rape may be defined differently from state to state.

Our findings suggest that new processes for tracking nonreport sexual assault evidence are needed.

The definition of rape given in the Department of Justice's Uniform Crime Reporting Program, which gathers data on reported crimes and arrests from local police departments, was recently broadened and now reads, "the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim."[11] The revised definition includes cases in which the victim has a temporary or permanent mental or physical incapacity, including those related to the impact of drugs or alcohol. Although it still leaves out cases that don't involve penetration, the revised definition will likely improve our ability to measure and understand sexual assault crimes that are reported to law enforcement agencies.

Sexual assault medical forensic examinations. Intentional, organized medical responses to survivors of sexual assault aren't new. The nation's first SANE programs were created in Memphis, Tennessee; Minneapolis; and Amarillo, Texas, in the 1970s.[12] SANEs are trained in the collection of forensic evidence that may later assist in successful prosecution of offenders. SANEs provide what Campbell and colleagues term "empowering care," which emphasizes understanding the impact of trauma, helping survivors to regain a sense of control and choice, and respecting survivors' decisions.[13] SANEs may sometimes serve as buffers between survivors who don't want to report a sexual assault and law enforcement or community personnel who might pressure survivors to report, by helping to provide clear communication and clarification of expectations.[14]

Reporting and underreporting of sexual assault. The large gap between the prevalence of sexual assaults and the number that are reported to law enforcement is concerning. Sexual assault is traumatic, with serious consequences that can include profound psychological and emotional damage, physical injuries, sexually transmitted diseases, unwanted pregnancies, and reduced work productivity.[15-17] Such crimes can instill an intense fear of retaliation and extreme feelings of shame, anger, and hopelessness that may deter survivors from seeking help or reporting to law enforcement.[5,17]

There is evidence that survivors of sexual assault who report the assault to law enforcement may be more likely to seek and receive medical care afterward. A Bureau of Justice Statistics report found that 37% of injured survivors who reported the assault received medical treatment, compared with 18% of those who did not report the assault.[18] And there is evidence that the delayed reporting option and access to SANEs improves the rate of reporting and aids prosecution efforts, although SANEs adopt a neutral position with regard to both. In one study, 38% of sexual assault survivors entering a hospital ED were uncertain about whether they were going to report the assault; of those, 12% decided to report to law enforcement after meeting with a SANE.[3] Another recent study concluded that providing survivors with information about longer-term advocacy and counseling services can ease their fears about participating in prosecution.[14]

METHODS

Three broad questions guided this exploratory research:

- How is the nonreport option currently being used in Texas?
- How does this option affect SANEs, survivors, and the criminal justice system?

Table 1. Description of Participants by Professional Representation

Participant professional representation	In-depth interviews	Web-based surveys
SANE or other health care professional	24	42
Rape crisis center advocate	42	74
Law enforcement investigator	9	8
Prosecutor	3	7
State agency personnel	1	0
Total	**79**	**131**

SANE = sexual assault nurse examiner.

- What are the strengths and challenges of the nonreport option?

We used a mixed-method approach that included qualitative interviews, a survey questionnaire, and a review of existing data. Ethical approval was obtained from the institutional review board at the University of Texas at Austin. Informed consent was obtained from all participants.

Qualitative interviews. From August 2010 through February 2011, we conducted in-depth, face-to-face interviews with 79 professionals who respond to sexual assault crimes on a regular basis. The participants were recruited, using purposive and snowball methods, from 14 Texas sites selected to represent the state's urban, rural, and border communities. Initially, SANEs and rape crisis center advocates from these communities were contacted about the study, and were then asked to recommend other professionals in their communities. Participants included SANEs and other health care personnel (including SANE and forensic program coordinators and a hospital chaplain), rape crisis center advocates, law enforcement officers, prosecutors, and state agency personnel.

To guide interviews, we used a semistructured questionnaire that was developed in close collaboration with experts in the field of sexual assault. This included both closed- and open-ended questions about participants' experiences and challenges faced with regard to the nonreport option. Data were analyzed using thematic and content analyses, iterative processes in which the interview transcripts were read, discussed, and reread by members of the research team before initial codes were assigned. Each transcript was analyzed using a line-by-line process, and existing codes were refined and additional codes were developed as needed. Codes were then grouped into broader themes and compared within and across transcripts for accuracy. Transcript quotes that best illustrated themes were also identified. The research team met regularly to discuss, debate, and refine the collective understanding of the data and the context of interview responses.

Survey questionnaire. We also disseminated a Web-based survey to SANEs and other health care personnel (including staff nurses, SANE and forensic program coordinators, a nurse administrator, a hospital administrator, and a risk manager), rape crisis center advocates, law enforcement officers, and prosecutors. Survey participants were recruited using purposive and snowball methods. Links to the survey were sent via e-mail by TAASA and the Texas Office of the Attorney General to their lists of stakeholders working in the field of sexual assault response statewide. These lists included more than 200 stakeholders (including all certified SANEs in Texas, leadership at all Texas rape crisis centers, and sexual assault response teams). We were unable to document the number of respondents who received the survey link through snowballing efforts by the original recipient, so the response rate is unknown. Initial recruitment and launch of data collection happened simultaneously in early December 2010. Surveys were collected between December 2010 and February 2011. A total of 131 professionals responded.

Like the interview questionnaire, the survey questionnaire was designed in close collaboration with experts in the field of sexual assault. It included both closed- and open-ended questions about participants' experiences and challenges faced with regard to the nonreport option. Data from closed-ended questions were analyzed using descriptive statistics. Data from open-ended questions were analyzed using the processes of thematic and content analyses described above. (See Tables 1 and 2 for demographic data on interview and survey questionnaire participants.)

Review of existing data. We also conducted a retrospective review of publicly available data on the nonreport option from the Texas DPS for the period from July 2009 through May 2011. Reviewed data were limited to the following: the number of nonreport cases received by the central DPS storage facility; the number of converted cases subsequently transferred to local law enforcement (initiated by survivors' decisions to report the assault); and the length of time data from converted cases were stored (from date of

receipt at the central storage facility to date of transfer to local law enforcement).

FINDINGS

After considering various options, we decided to analyze the three types of data qualitatively. Findings are categorized in three broad areas: a description of the nonreport option and its use to date based on data from the interviews, survey, and review of existing data; consideration of the positive impact of the nonreport option as reported by interview participants; and remaining dilemmas identified by interview and survey participants.

Description and use of the nonreport option includes four subthemes: the step-by-step process involved in a nonreport case, confidentiality processes, storage and shipment of evidence, and the use of the nonreport option. Figure 1 illustrates the general step-by-step process used in the nonreport option, from the time of assault to storage of evidence in the central DPS storage facility, as identified by interview participants.

Confidentiality processes. Interview data revealed that, in most cases, a unique identifier is created by the SANE or a medical record number is used as such. This identifier serves as a confidentiality shield and is used to track the evidence kit if and when a survivor reports the assault.

Storage and shipment of evidence. Survey participants reported various timelines concerning storage of the forensic evidence before its shipment to the central DPS facility. Forensic evidence was retained at hospitals for periods of from one day to three weeks. The rationales offered for these variations included a desire to ship evidence kits within 24 hours of collection; a policy of batching kits for shipment; and intentionally storing evidence kits in-house, based on an assumption that the survivor is likely to report to law enforcement within a few weeks. Some SANEs reported that all nonreport evidence is stored in-house.

Use of nonreport option. The review of existing data revealed that during the first 23 months of the nonreport option, the Texas DPS received 228 nonreport evidence kits for storage in the central facility. During the same period, 11 of those kits were subsequently transferred from the DPS to local law enforcement agencies (initiated by survivors' decisions to report the assault). For those converted cases, the length of evidence storage time at the DPS ranged from one week to eight months.

The qualitative interviews revealed that some hospitals store all nonreport evidence kits in-house, rather than shipping them to the central storage facility. Because these kits are not tracked by the state, it's difficult to assess their number accurately.

Considerations of positive impact of the nonreport option. Qualitative interview participants reported beneficial effects of the nonreport option in five areas: the role of SANEs, the impact on survivors, collaborative relationships, collateral crimes, and anonymous reporting strategies.

Role of SANEs. SANE interview participants reported that the nonreport option has helped them to better understand their role as nursing and forensic experts in sexual assault crimes in assisting survivors. They also reported feeling that the nonreport option has gained the role of SANEs more legitimacy. One SANE stated, "The nonreport program has helped nurses understand their role, their *medical* forensic role, and to make the leap towards making our place as a nursing *practice*." (*Editor's note:* In all quotes from the study, italics represent the participant's emphasis.)

Impact on survivors. SANEs' interview responses supported the notion that some survivors may not be emotionally or physically ready to report a sexual assault, given the trauma experienced or the survivor's relationship to the perpetrator (or both). For example, one participant reported that survivors "might want to go and do that first step and get the exam" without having to make a decision about reporting.

Another SANE respondent explained:

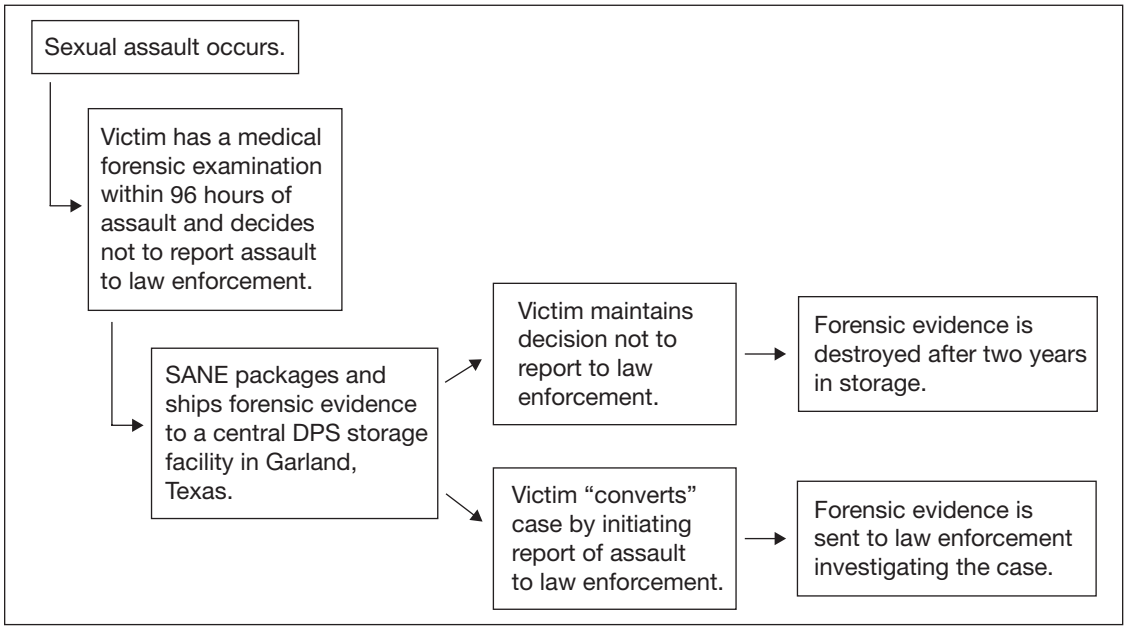
> If you can go in and get your physical well-being taken care of and get the evidence collected, then you can think about what you want to do with the rest, instead of waiting so long that you end up being pregnant, that you

Table 2. Participants' Years of Experience in the Field

Participant professional representation	Number of Web-based survey respondents	Number of respondents to this query	Average years of experience
SANE or other health care professional	42	42	7.7
Rape crisis center advocate	74	74	12.1
Law enforcement investigator	8	8	7.6
Prosecutor	7	NA	NA

NA = not applicable, because prosecutors were not asked this question; SANE = sexual assault nurse examiner.
Note: Data are reported for Web-based survey participants only; we did not ask qualitative interview participants how many years of experience they had.

Figure 1. Process in the Nonreport Option



DPS = Department of Public Safety; SANE = sexual assault nurse examiner.

> end up having [a sexually transmitted disease] that can't be treated, [or] that you end up having things that could've been taken care of if you had gone [to the hospital]. You get a resource in us. You get your medical well-being taken care of and someone to listen to you and someone who believes you.

SANEs and other survivor advocates also noted that survivors are often worried about the legal, familial, or social repercussions of reporting crimes of sexual assault. One respondent stated, "One woman was on parole and was afraid the report would cause her problems." Several respondents noted that the nonreport option is helpful when the perpetrator is a family member or acquaintance:

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

Some survivors fear they will not be believed by law enforcement, because they were using alcohol or drugs at the time of the assault. SANEs were aware that some survivors have little faith that the criminal justice system will seriously address the crime. One survivor advocate relayed concerns from groups that work with people with disabilities: "A lot of deaf people refuse to report the situation, because they don't think anyone is going to take them seriously because they are deaf."

Collaboration among health care professionals, rape crisis centers and survivor advocacy groups, and law enforcement and legal personnel is critical to effective responses to sexual assault crimes. This is particularly true in nonreport cases and for the development of nonreport procedures and protocols. Interview participants reported that collaborative relationships improve the efficiency of medical forensic examinations in nonreport cases and increase the potential for nonreport evidence to inform open investigations.

Collateral crimes. Interview participants suggested that the nonreport option can potentially improve the criminal justice system's response to sexual assault crimes by ensuring the collection and secure storage of evidence that later assists prosecution efforts in collateral crimes, such as domestic violence or serial rapes. One SANE participant whose hospital began offering medical forensic examinations in nonreport cases before the state law went into effect described such a scenario:

> Before the nonreporting [law], we had had 14 cases that flipped [converted], and some of them were within a few days, and some of them were within months. So they had come here for one of the events that had happened to them. And then months later, they had had another event that really wasn't a sexual assault. It was more of a physical assault, a kind of domestic violence incident. They made a

> report to law enforcement, and law enforcement asked if that ever happened before, and they were like, "Yeah, and that one time he also did this to me, and I had to go to the hospital." Then that becomes important for them because this isn't going to give them any DNA, the physical assault, but this [the sexual assault] will.

Anonymous reporting. Good communication and collaboration between law enforcement personnel and SANEs can foster the compiling of information about sexual assault crimes in a particular community, without breaching patient confidentiality. The nonreport option has led some communities to develop creative, anonymous reporting strategies. For example, one interview participant described the following:

> [Law enforcement officers] were feeling very left out of the whole [nonreport] process, and they came up with a great idea. "Here is what we want to do: If the survivor does not want to report, offer to them [the option] to talk to a cop off the record; you can use your personal cell phone and not theirs, so we don't even know who we're talking to. And they can ask us any questions without any commitment to report whatsoever."

Remaining dilemmas. Qualitative interview and survey participants noted several remaining dilemmas associated with the nonreport option to date. There were seven areas of concern: financial costs to survivors, billing confidentiality, toxicologic challenges, process efficiency, delayed reporting, incomplete or absent evidence, and awareness.

Financial costs to survivors constituted the most frequently discussed challenge associated with the nonreport option. The initial sexual assault examination is performed at no charge to survivors, whether they choose to report the crime or not. But only those who report the crime can receive compensation for additional medical costs and for counseling through a state-run crime victim compensation program; survivors who choose the nonreport option are ineligible. Hospitals are reimbursed for a portion of the costs of collecting a forensic evidence kit in both reported and nonreported cases. But any additional costs for treatment, which may include laboratory tests, care for injuries, and medications, are billed to the survivor. (Those costs might be covered retroactively if the survivor later decides to report the assault.)

Confidentiality in billing. Because the nonreport option is inherently confidential, very little data are collected and connected to each evidence kit. For each kit, the DPS storage facility collects the name of the hospital that sent the kit, the date the kit was received at the DPS, and the survivor's date of birth. A unique identifier is associated with each nonreport case and is used to track the kit, so that it can be retrieved if the survivor later decides to report the assault. Some SANEs create unique identifiers that are not related to other information; but sometimes the medical record number—which is associated with billing documents—is used as the identifier.

While the latter practice helps hospitals to correctly apply DPS reimbursement funds, participants reported that billing processes sometimes compromised patient confidentiality. For example, patients' names may be included on billing forms submitted to the DPS. Bills are often generated from separate billing departments, and SANEs may not have access to billing processes. Currently invoices are manually redacted after arrival at the DPS. Participants reported that if the nonreport option becomes more widely used, manual redaction will not be viable. Finally, some SANEs reported that becoming involved in billing processes diverted them from patient care.

Toxicologic challenges. The central storage facility does not have the capacity to store liquids that need refrigeration, including urine, which is usually collected for toxicologic screening. Thus, nonreport evidence kits lack this piece of potential evidence. Participants expressed concern about this omission and its potential impact on patients who might benefit medically from toxicologic screening. One participant felt that survivors of drug-facilitated sexual assault (DFSA) might be most likely to use the nonreport option. Participants also noted that survivors of DFSA already face evidentiary challenges, given the short half-life of many drugs used by sexual predators, making prosecution of nonreport cases even more difficult.

A comprehensive medical examination is precisely what some survivors are seeking following a sexual assault, with forensic evidence a secondary concern.

Many SANEs have initiated solutions to address these challenges. For example, some SANEs indicated that they collect and store urine and blood samples

from both reported and nonreport cases in-house. As one SANE explained, "A majority of places don't do their own drug testing. That is all part of what they consider evidentiary [need]. For us, we consider it part of medical need. It does have an evidentiary value, but it is all part of [survivors'] health care."

Process efficiency. Participants indicated that the new forms required to process nonreport cases in Texas are clear and user-friendly (to see these forms, visit www.txdps.state.tx.us/CrimeLaboratory/NRSA.htm). But they noted that additional time and care may be required from the SANE or other health care professional completing these forms. Participants also suggested that the need to de-identify a nonreport case and add a unique identifier adds to the process time. Estimates of additional time needed ranged from 0 to 100 extra minutes. One SANE described the value of taking that extra time: "It is a lot of extra work for one person, but I feel in all fairness that's the way it has to be until we're 100% sure of the complete process and all the pieces of the puzzle."

Concerns about delayed reporting. While participants affirmed the benefits of the nonreport option for the criminal justice system, many still harbored concerns. In particular, participants reported that delays in reporting by survivors can create further challenges for the prosecution. (For example, grand jurors often ask why a survivor did not report the crime immediately after it happened.) In describing why timely reporting is important, one participant said:

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

Incomplete or absent evidence. Another concern participants had was that certain types of evidence relevant in sexual assault crimes—such as bedding and clothing, as well as toxicologic evidence mentioned above—are not collected in nonreport cases. One respondent stated, "That's the only reason I don't like it—I just want the case to be complete. I think honestly it's hard enough for people to believe it happened [when all the evidence is presented]." Especially in cases of acquaintance rape or incest, the extra evidence can be important:

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

Raising awareness. Participants identified a need to raise awareness about the nonreport option among health care personnel, rape crisis center advocates, law enforcement and legal personnel, and the community at large. In Texas, the Sexual Assault Legal Services and Assistance project (www.hopelaws.org)—created jointly by TAASA and Texas Legal Services Center—has sought to increase such awareness, and one participant commented on its efforts:

> The brochure from TAASA has been a *great* piece of information, crank it out! It is clear for patients, rape crisis centers, the public, law enforcement, and relevant to all audiences. We need more.

The nonreport option has been frequently discussed at statewide SANE coordinator meetings, and SANE interview participants reported providing continuing education on this option for hospital colleagues and during sexual assault response team meetings. One SANE emphasized the importance of educating hospital staff:

> We are only as good as our first contact [with survivors] at the hospital, because [survivors] are not calling 911. They are going directly to their doctors or the ER and saying, "I think I've been sexually assaulted; I think I've been raped, and I don't want to report to the police." Well, [what] if that triage nurse is there and says, "I think you have to tell the police," or "What do you want us to do about it?" Wrong!

DISCUSSION

Study findings confirm that one state's response to the nonreport option, while still in its infancy, is working relatively well. During the first two years of its availability, the nonreport option positively affected services to survivors and SANEs' experiences with survivors, and enhanced both the role of SANEs and survivors' decision making about reporting to law enforcement.

In general, law enforcement officers have focused heavily on the evidence collected during a sexual assault examination, but have overlooked the examination's importance for survivors' well-being. Yet a comprehensive medical examination is precisely what some survivors are seeking following a sexual assault, with forensic evidence a secondary concern. Study

findings also indicate that the nonreport option relieves the time pressure survivors feel about deciding whether to report a sexual assault to law enforcement. And both interview and survey participants agreed that more public awareness would help improve access to and increase use of the nonreport option. These factors in turn could mean that more survivors present for immediate medical attention. And, as more SANEs and other health care professionals become more familiar with nonreport processes, it's likely that the need for extra time to complete forms will lessen.

Nurses must understand the applicable protocols for providing care to survivors.

Nursing practice implications. Findings of this study will be important to the practices of forensic nurses, SANEs, and other nursing staff, despite state-to-state differences in policy. First, it's imperative that nursing staff be aware that the new nonreport option neither requires nor assumes that sexual assault survivors will report to, be involved with, or cooperate with law enforcement agencies. Given that policies and practices may vary from state to state and facility to facility, nurses must understand the applicable protocols for providing care to survivors and those regarding when and how to contact law enforcement. Hospitals and medical clinics must develop system-wide processes to educate staff from all disciplines regarding appropriate responses to survivors of sexual assault. The second edition of the Department of Justice's *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents* includes information on victim-centered reporting procedures and provides a useful resource for health care professionals.[19]

Nurses, and SANEs in particular, have the expertise needed to fine-tune the nonreport option. It's important that SANEs initiate and direct future dialogue about standardizing evidence storage, collecting toxicologic evidence, and reaching marginalized populations. SANEs and other nurses are adept at developing effective collaborative relationships and advocating on behalf of sexual assault survivors. SANEs are especially well-positioned to raise awareness about the nonreport option by educating other SANEs, ED staff, and other health care professionals.

In partnership with survivor advocates, SANEs can help to educate criminal justice system personnel about the trauma of sexual assault and the importance of offering survivors unpressured time in which to decide whether to report such crimes. It is also vital that SANEs continue their own professional development and training in terms of providing expert testimony to the court. Particularly in converted cases, their testimony may be crucial.

Other implications. Our findings suggest that new processes for tracking nonreport sexual assault evidence and safeguarding confidentiality are needed. Improved and standardized data collection will allow for a more accurate understanding of the nonreport option's utilization and better planning and implementation. Moreover, experts have noted that, in some states and in certain situations, if law enforcement agencies want to identify nonreport-case survivors, they might be able to do so without survivor consent.[1] Although we did not find evidence of this, it suggests that protocols for and expectations of confidentiality need refinement. Strategies for addressing these issues merit both organizational and national debate and attention.

There is some concern that, nationwide, many hospitals may lack the facilities to provide and maintain adequate evidence storage. The challenges of collecting toxicologic evidence in general, and the impact of the nonreport option on DFSA cases in particular, warrant further investigation.

This study's findings also leave us with questions about the underutilization of the nonreport option by some survivors. Male survivors are already thought to underreport sexual assaults to law enforcement, and little is known about their experiences with sexual assault examinations. One SANE shared her theory on why men may not be using the nonreport option: "Once they have made this huge, huge step to go, they are going to go all the way [and report]." More research is needed to clarify how different populations may be responding to the nonreport option.

Very few Texas nonreport cases have subsequently been converted, and little is known about the impact of the nonreport option on prosecution efforts. That said, we believe that more education is needed for people working within the criminal justice system—including law enforcement personnel, prosecutors, and juries—about the effects of trauma and why some survivors might not immediately report a sexual assault. In-depth analyses of cases that began as nonreport cases and were later converted to reported cases and prosecuted would be useful in determining the impact of differences in evidence collection. Longitudinal methods should be considered. It would also be useful to explore further the impact of absent evidence (particularly toxicologic evidence) on prosecution efforts in converted cases, as well as the feasibility of including toxicologic evidence in nonreport evidence kits.

Limitations. The methodologic design of this study means that our findings are not generalizable to other states. And our literature review suggests that few other states have as yet conducted in-depth empirical analyses of their nonreport processes, which are

still in their infancy. So it's difficult to know how Texas's processes might compare with those elsewhere.

CONCLUSIONS

This study was exploratory, and it leaves us with many unanswered questions and concerns about the implementation and use of the nonreport option in Texas. These questions and concerns are highly relevant to health care professionals, hospitals, survivor advocates, legal personnel, and law enforcement agencies nationwide.

The process for a nonreport option implemented by Texas represents one state's approach to providing care for survivors of sexual assault without necessarily involving law enforcement. In addition to insight and support by rape crisis center advocates, the input and expertise of nurses have been critical to its development and progress. We hope that our findings will help to inform further improvements to Texas's nonreport option process, as well as to foster and inform dialogue about comparable and dissimilar efforts in other states. The dissemination of information based on the experiences of all involved will be critical to this national discussion. Further research to explore the impact of the nonreport option on survivor decision making and well-being is essential. ▼

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