UTAH SEXUAL ASSAULT NEEDS ASSESSMENT

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Executive Summary

Sexual violence is a serious worldwide threat to public health and human rights that results in significant short- and long-term physical and mental health issues to its victims. Although sexual violence in the United States has been trending downward over many years, it remains a significant problem affecting every demographic group. The National Institute of Justice reports 1 out of every 6 American women has been the victim of an *attempted or completed* rape in her lifetime. These crimes are also a serious problem in Utah where rape has been the only violent crime in the state that is higher than the national average.

Supporting Utah victims of rape and sexual assault has been a priority for the Office for Victims of Crime (OVC), who assist with crime reparations to individuals and ensure statewide service provision through its grant programs. In an effort to ensure grant support addresses the needs of crime victims and those that provide those services, OVC contracted with the University of Utah Social Research Institute (SRI) to conduct a sexual assault needs assessment. The purpose of the needs assessment was to better understand rape and sexual assault in Utah, including sexual violence service provision, survivor needs, and service gaps and make recommendations for service needs and best practice approaches. The methodology adopted by SRI included conducting a literature review, surveying crime victim service provides, and conducting interviews with service providers. A total of 129 responses were received to the online survey and 37 in-depth interviews were conducted with geographically diverse stakeholders statewide.

By integrating the results of the literature review with the quantitative and qualitative findings of the survey and interviews, four recommendations are offered:

1. Develop and implement trauma and sexual assault training for providers.
2. Increase public awareness of sexual assault and the services available to survivors.
3. Increase access to trauma-informed, mental health services.
4. Expand SANE services.

Introduction

Sexual violence is a serious public health and human rights problem with both short- and long-term consequences on the survivors physical, mental, and sexual and reproductive (women's) health. Whether sexual violence occurs in the context of an intimate partnership, within the larger family or community structure it is a deeply violating and painful experience for the survivor.

The World Health Organization (2013) has attempted to assess the scale of the problem of sexual violence at the international, regional and national levels. At the international level, WHO estimates that over a third (35 %) of women worldwide have experienced physical and/or sexual violence by an intimate partner or sexual violence by a non-partner at some point in their lives. A recent United Nations study on men and violence in Asia and the Pacific found that nearly half of the more than 8,000 men interviewed reported using physical and/or sexual violence against a female partner, with the proportion of men reporting such violence ranging from 26 to 80 percent across sites. In all six countries included in the study, the majority (between 65 and 85%) of men who reported using physical or sexual violence against a partner had committed such violence more than once.

The Centers for Disease Control (CDC, 2014) define sexual violence is any sexual activity where consent is not freely given. This includes completed or attempted sex acts that are against the victim's will or involve a victim who is unable to consent through use of force or alcohol/drug facilitation (See Appendix 1). Other forms of sexual violence are:

- Non-physically pressured unwanted sex
- Unwanted sexual contact (intentional sexual touching), or
- Non-contact, unwanted sexual experiences (such as verbal sexual harassment). In general, the prevalence of sexual violence when measured in surveys is lower than that of physical violence. However, in the case of intimate partner violence, sexual violence is often experienced along with physical violence.

Sexual violence can be perpetrated by women's intimate partners or non-partners. In general, data availability is higher for sexual violence perpetrated by an intimate partner. However, available data suggest that, at the global level, an estimated 7 percent of women have experienced sexual violence perpetrated by someone other than an intimate partner in their lifetime.

Sexual Violence in the U.S. Although sexual violence in the United States has been trending downward over the past 25 years (Dept. of Justice, 2015) it remains a significant problem. For example, some of the most recent federal reports show there were 321, 500 citizens 12 years and older that were sexually assaulted, 60,000 children were victims of "substantiated or indicated" sexual abuse, 80, 600 inmates sexually assaulted and nearly 19,000 military personnel experiencing unwanted sexual contact.

Sexual violence is also perpetrated on every demographic group. The National Institute of Justice reports 1 out of every 6 American women has been the victim of an *attempted or completed* rape in her lifetime (14.8% completed, 2.8% attempted). Approximately 3 percent of American men have experienced an attempted or completed rape in their lifetime. The Department of Justice has also reported that of the 60,000- plus children who have been victims of sexual assault, 34% of victims are under age 12, and 66% of victims of sexual assault and rape are age 12-17.

Further, it has been established that the majority of sexual assaults take place *at or near* the victim's home. Specifically, nearly half (48%) took place while the victims was sleeping or performing another activity at home. Twenty-nine percent were traveling to and from work or school, or traveling to shop or run errands, while 12% were working, and 7% were attending school and 5% were doing an unknown or other activity.

Those at highest risk of Sexual Violence. The evidence is clear that younger people are at highest risk for become a victim of sexual violence. Specifically, those 12-34 years of age are at greatest risk. While those age

65 and older are 92% less likely and females ages 16-19 are 4 times more likely than the general population to be victims of rape, attempted rape, or sexual assault. Men are also victims of attempted or completed rape, with approximately 3% experiencing an attempted or completed rape in their lifetime. Cantor et al. (2015) reports that 21% of LGBTQ (Lesbian, gay, bisexual, transgender, genderqueer, nonconforming) college students have been sexually assaulted, compared to 18% of non- LGBTQ females, and 4% of non- LGBTQ males. The group with the greatest likelihood to experience sexual assault are Native Americans. The high levels of violence were first highlighted in 1999, when the Department of Justice released its initial report. Since then, multiple studies on the topic have confirmed that Native Americans are 2.5 times more likely to experience sexual assault and rape than any other ethnic group in the United States.

Utahns at increased risk for sexual violence. For a number of years, rape has been the only violent crime in Utah that is higher than the national average. While this unwanted trend continues, the above headline highlighted a 2016 report from the Utah Department of Health (UDOH) indicating those who identify as a sexual minority, are from a low-income household, or do not have a college degree are at increased risk for sexual violence. For example, 45.5 percent of Utahns who report being bisexual and 33.6 percent of Utahns who report being lesbian or gay experienced sexual violence at some point in their lives compared to only 8.7 percent of Utahns who report being straight.

Other findings showed that:

- Sexual violence affected 16.4 percent of Utah adult females and 3.1 percent of Utah adult males in Utah in 2016.
- Nearly one in 10 Utah adults (9.7%) reported that someone had sex, or attempted to have sex with them *without their consent*.
- Adults who are divorced, separated, or unemployed have higher rates of sexual violence.
- Utahns who experienced sexual violence demonstrated the traumatic impacts in that they had more difficulty doing errands alone (12.5% vs. 3.3%) and concentrating or remembering (19.4% vs. 7.9%) than those who did not experience sexual violence.

In a previous study (UDOH, 2015) the economic impacts resulting from sexual violence totaled nearly $5 billion, almost $1,700 per Utah resident.

Project Goals

Goal of the 2017-18 rape and sexual assault needs assessment is two-fold. First, to better understand the scope of rape and sexual assault in Utah, including sexual violence service provision, survivor needs, and service gaps. Second, to make recommendations for service needs and best practice approaches to the Officer for Victims of Crime.

The gender-specific language used in this report is not intended to minimize the experience of male victims of sexual assault as there are many men of all ages experiencing sexual assault. However, most victims of sexual assault are women and girls, and most offenders are men so the use of those pronouns reflects that reality.

Methodology

The methodology adopted by SRI to conduct the needs assessment includes multiple steps to ensure the data collected in Utah adequately describes the scope of the problem, the current rape and sexual assault services provided in the state, and the existing service needs and gaps. The specific activities conducted by SRI staff include the following:

1. Conduct a literature review to identify the best practice service models for crime victims of rape / sexual assault. Find best practice approaches used, including those internationally that may be recommended.

2. Obtain the most current rape / sexual assault data to assess status and trends with a primary focus on Utah.

3. Conduct an online survey of the current capacity of crime victim service providers statewide to provide rape and sexual assault services. Describe statewide service availability and perceived service needs and gaps for the future.

4. Conduct face-to-face in depth interviews with rape and sexual assault service providers including law enforcement and attorneys to gain insight into organization culture and existing barriers / factors influencing rape / sexual assault prosecution. Seek qualitative insights and perception of service responsiveness and effectiveness in addressing local community needs.

Literature Review

An initial list of search strings based on appropriate key words was drawn up. The initial list included 40 search strings such as “best practice AND education AND sexual assault”, “services AND training AND sexual abuse”, and “trauma-informed AND training AND sexual assault AND services”. Search strings and key words were modified as necessary. For instance, the term “best practice” would often return results in grey literature but not in peer-reviewed research literature, however the key word “effective” or “evidence” would return results in peer-reviewed literature but not in grey literature. The main keywords initially used to build the search strings were:

“best practice”, “education”, “prevention”, “sexual assault”, “sexual violence”, “child sexual abuse”, “policy”, “victim”, “response”, “policing”, “services”, “training” and “meta-analysis”.

Numerous databases were searched for relevant peer-reviewed articles including EBSCO Social Science database, ProQuest, InformIT, and PubMed. Grey literature, policy documents, and the names of services and programs were sourced via Google and Google Scholar searches using the search strings and key words.

Sexual violence can have long-term effects. The health impact on a victim of sexual violence spans a wide range of severity. Not all women who are sexually assaulted experience physical injuries or have medical problems. However, the physical injuries and health consequences usually result from the more violent type of assaults. Injuries can be sustained as a direct result of the assault itself, from later complications, or from its long term psychological impact.

Physical Health

Impacts on physical health from a sexual assault can include damage such as bruising, tears, and contusions to the genitourinary system including the urethra, vagina and anus which may lead to gastrointestinal, sexual and reproductive health problems; increased risk of contracting sexually transmissible infections, including HIV/AIDS (Astbury, 2006); unwanted pregnancy and decisions regarding abortion (Wasco, 2003); and pelvic pain (Stein & Barrett-Connor, 2000). Additionally individuals with a sexual abuse history tend to self-rate their overall wellbeing as lower than those with no sexual abuse history (Stein & Barrett-Connor, 2000); sexual assault is associated with an increased dependence on alcohol (Ullman, Filipas, Townsend, & Starzynski, 2005), prescription medication (Sturza & Campbell, 2005) and other drugs as way of coping. Smith and Brieding (2011) found that people who had experienced rape were more likely to have higher cholesterol, stroke, heart disease, problems with their immune system, and report that they smoked or drank excessively in comparison to people who had not been raped. Kapur and colleagues (2011) identified that victims of sexual assault were significantly less likely to attend routine health checks, more likely to report that they could not afford to see a doctor, and more likely to be a current smoker. I a study by Banyard (2011) of sexual victimization, indicated women who had been victimized were likely to report problems with employment including ability to work and job satisfaction.

Mental health problems can contribute to the onset of physical health problems including those related to stress, substance use, and risk taking (Public Health Agency of Canada, 2012). Sexual violence can also negatively affect intimate, familial, peer and service provider relationships, resulting in a reduction of social support and increased isolation. Women who experience negative reactions and discrimination from health professionals and police have a harder time engaging in recovery supports and experience more negative mental health symptoms (Benoit 2015).

Psychological Health

Both short- and long-term psychological and emotional impacts have been associated with sexual assault.

Immediate and short-term impacts. During the attack itself, it is common to experience reactions such as an intense fear of death and dissociation. These are natural physical responses. Being paralyzed by fear does not mean the victim/ survivor wanted the assault to happen. Even if the victim/survivor "decides" that it is safest not to physically resist in the situation, this does not mean she wanted it to happen or gave consent.

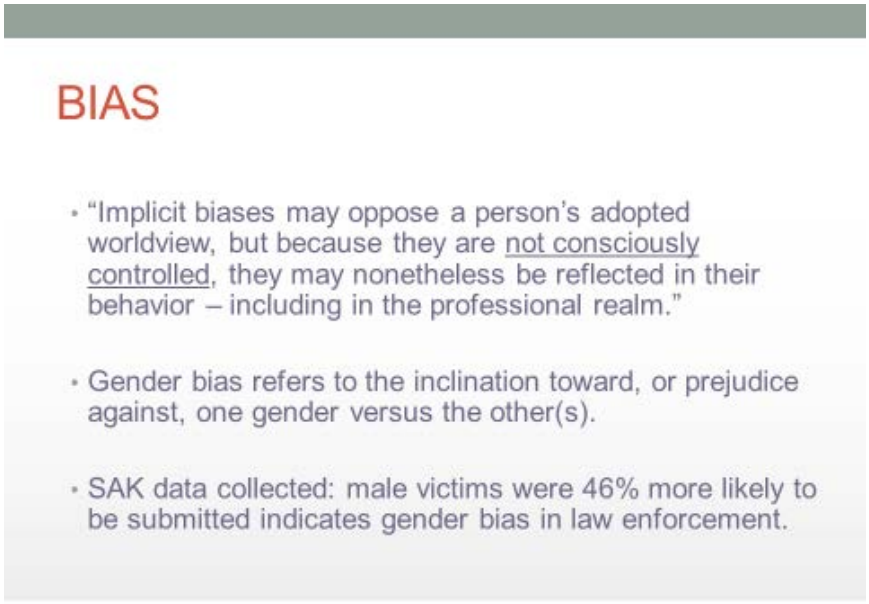
Research indicates that fear is a common immediate and short-term impact on sexual assault victims. Anxiety and intense fear are the primary responses following rape. Some research has found that this peaks at around three weeks after the rape (Petrak, 2002), however, it can last for more than a year for a significant number of survivors. Ongoing fears can be related to reminders of the attack (e.g., legal proceedings or medical examinations, being with men, or being in a location that reminds the person of the assault). Fears of future attacks and other harm can follow sexual assault. If the victim/survivor had previously experienced the world as basically a safe place, this assumption is shattered. She may now experience the world as inherently untrustworthy and unsafe. This can lead to the restriction of social activities, including work and community involvement. This may be particularly profound when the perpetrator is an intimate partner (Crome & McCabe, 1995).

For some women, particularly those from marginalized communities, sexual assault can reaffirm assumptions about themselves as devalued persons ("insidious trauma"), and about the world being unsafe and dangerous (Wasco, 2003).

Medium-to-long-term impacts. Evidence demonstrates victim/survivors may experience a range of medium-to-long-term impacts such as feelings of low self-esteem, self-blame and guilt which can endure for months and years after the assault. It is common for survivors to forget or deny aspects of their experience. This can be a defense against overwhelming feelings of confusion, shock and bewilderment. This may be especially powerful in partner rape (Crome & McCabe, 1995). The likelihood that a person suffers suicidal or depressive thoughts increases after sexual violence. A third of all women who are raped contemplate suicide and 13% of those attempt suicide, while approximately 70% of rape or sexual assault victims experience moderate to severe distress, a larger percentage than for any other violent crime (DOJ, 2014). Ninety-four percent of women who are raped experience symptoms of post-traumatic stress disorder (PTSD) during the two weeks following the rape (Riggs, D.S. et al. 1992).

Providing Services to Victims / Survivors: Care and Handling

Rape and sexual assault is a very complex crime that challenges the capacity of individuals, families, victim-serving agencies, and communities to respond in a helpful and supportive way. In order to be sensitive to the needs of those who have experienced sexual victimization, there are a number of other important related factors that must be considered. These include bias, rape myths, victim blaming, reporting, and trauma care.



Bias

What is bias and how does bias relate to sexual crimes? Bias is defined as "prejudice in favor of or against one thing, person, or group compared with another, usually in a way considered to be unfair" (Webster). For decades the FBI's Uniform Crime Report (UCR) have indicated rates for sexual assault are among the lowest for all violent crimes. At the same time, there has been significant attrition rates for sexual assault crimes from the time the crime occurs through prosecution. The figure below illustrates the findings by Lonsway and Archambault (2012) describing what has been labeled the a "justice gap," (Temkin and Krahé, 2008) with research findings of only 5-20% of sexual assaults are reported, 0.4 to 5.4% are prosecuted, and 0.2 to 5.2% result in a conviction of any kind.

This phenomenon may be due in part to biases and the resulting stereotypes and attitudes that influence professional response to, and investigation and prosecution of sexual assault. Generally, sexual assault perpetrators are not held accountable within the justice system of the US and in most other countries. There are many reasons, but one may be the difficulty of proving the legal elements beyond a reasonable doubt. Another is the existence of implicit gender bias.

Implicit bias is the automatic and unconscious process of assigning a stereotype and/or linking negative or positive attitudes to a particular group, or to an individual associated with a group. The brain automatically and unconsciously identifies, categorizes, differentiates and labels the world around us, in a process referred to as implicit cognition. This automatic response functions to identify and differentiate things thousands of times each day (Kang, 2009).For example, there is no need to think about the difference between a car, a motorcycle, and a truck. This is not a bad thing; it is an example of the efficiency of the human brain.

However, when we use these processes to unconsciously identify and differentiate people in social categories, such as age, gender, and race, this can create problems. In fact, decades of neuroscientific, cognitive, and social psychological research demonstrate that the assignment of people into such categories is generally consistent with prevailing social hierarchies (Kang, 2009). For example, these social hierarchies include grouping men over women, white over black, young over old, and straight over gay. Research demonstrates the connection between implicit bias and attitudes, which can translate into actual discriminatory behavior.

> *"Implicit … attitudes and stereotypes operate automatically, without awareness, intent, or conscious control. Because they are automatic, working behind-the-scenes, they can influence or bias decisions and behaviors, both positively and negatively, without an individual's awareness. This phenomenon leaves open the possibility that even those dedicated to the principles of a fair justice system may, at times,*

> *unknowingly make crucial decisions and act in ways that are unintentionally unfair"* (Casey et al., 2012).

These automatic and unconscious processes of categorizing, assigning and differentiating the world around us do not result in discrimination. The evidence is clear, however, among human beings it is nearly impossible to avoid drawing on stereotypes and attitudes toward individuals and groups that can and do result in real-world discrimination.

The other factor is that implicit bias operates at the unconscious level, so "people may not even be consciously aware that they hold biased attitudes" (Casey et al., 2012). Further, Halilović & Huhtanen (2014) have stated "implicit biases may oppose a person's adopted worldview, but because they are not consciously controlled, they may nonetheless be reflected in their behavior – including in the professional realm".

This happens because the development of implicit bias begins early in life, during childhood, when we absorb information about the world around us, from family, friends, school, and socio-cultural messaging in the media. During this process, children learn to "ascribe certain characteristics to members of distinct ethnic and social groups" and with age, these stereotypes become more ingrained, and they remain largely unchanged – and thus become implicit (Levinson & Young, 2010).

Additionally, societal norms often dictate the extent to which gender roles define how men and women (and boys and girls) are expected to behave and operate in the world. This then relates directly to the stereotypes or attitudes that are consciously endorsed, as well as those that operate without our awareness (unconscious). Then in the context of sexual victimization these stereotypes and attitudes can interfere with the interactions between and among all of those involved in the case. This interference can result from either or both explicit and/or implicit biases.

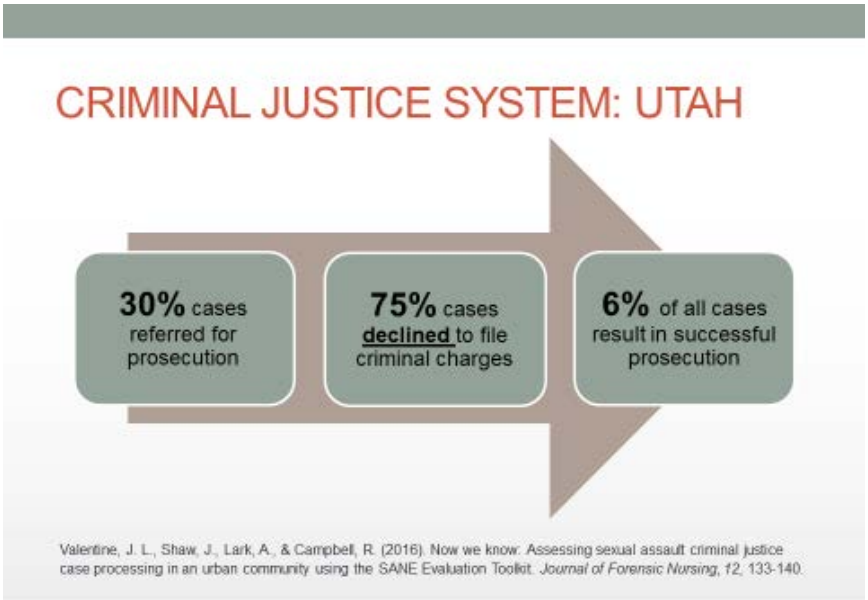
Given this widespread understanding, US Department of Justice (DOJ) published new guidance for law enforcement in 2015, entitled, Identifying and Preventing Gender Bias in Law Enforcement Response to Sexual Assault and Domestic Violence. This DOJ guidance calls on law enforcement to acknowledge the presence of gender bias and introduce specific practices during the initial response and investigation process, to mitigate its impact.

Gender bias in policing practices is a form of discrimination that may result in LEAs [law enforcement agencies] providing less protection to certain victims on the basis of gender, failing to respond to crimes that disproportionately harm people of a particular gender, or offering reduced or less robust services due to a reliance on gender stereotypes.

Gender bias, whether explicit or implicit, conscious or unconscious, may include lead to police officers misclassifying or underreporting sexual assault or domestic violence cases, or inappropriately concluding that sexual assault cases are unfounded; failing to test sexual assault kits; interrogating rather than interviewing victims and witnesses; treating domestic violence as a family matter rather than a crime; failing to enforce protection orders; or failing to treat same-sex domestic violence as a crime.

If gender bias influences the initial response to or investigation of the alleged crime, it may compromise law enforcement's ability to ascertain the facts, determine whether the incident is a crime, and develop a case that supports effective prosecution and holds the perpetrator accountable (US Department of Justice, 2015, p. 3).

Data from the Utah justice system based on research conducted by Valentine and colleagues (2016) are detailed in the figure below. Their findings indicate a similar pattern of sexual assault prosecution with only 6% resulting in a successful outcome. In this study "success" was defined as "a plea bargain or trial with a conviction". In another study (Valentine et al. 2016) the researchers



found differences between rape sexual assault kit submission for crime lab analysis between women and men, with male victims being 46% more likely to have their results submitted than female victims. This, according to the authors constituted a significant gender bias.

Rape myths

Rape myths were first recognized in the 1970s as cultural beliefs supporting male sexual violence against women (Brownmiller, 1975; Schwendinger & Schwendinger, 1974), thereby trivializing rape. Rape myths have also been defined in as “prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists” (Burt, 1980) and as “attitudes and beliefs that are generally false, but are widely and persistently held, and that serve to justify male sexual aggression again women” (Lonsway & Fitzgerald, 1994). Rape myths serve many purposes, including blaming the victim while exonerating the perpetrator from responsibility, implying that the victim is lying about the offense (Grubb & Turner, 2012) or is to blame, and providing justifications for acquaintance rape. These researchers also claim this justification has a significant impact on: 1) how victims of rape are perceived, 2) how victims of rape are treated, and 3) the dissemination of a cultural acceptance of rape and a rape-supportive society.

Male Rape Myths and Victim Blaming. By holding to the view of males as perpetrators and females as victims, rape myths could be seen as denying the possibility of males also being victims of rape (Newburn & Stanko, 1994). Ignorance and disbelief about male sexual assault has perpetuated myths about this phenomenon for many years. Male rape myths — prejudicial and false beliefs about male sexual assault victims and the perpetrators of such assaults come from the traditional view of masculinity, which dictates that men should be strong, assertive, sexually dominant, and heterosexual. According to Davies (2002) myths, such as ‘‘men cannot be raped’’ or ‘‘sexual assault is not as severe for a man as it is for a woman’’ minimize the impact of sexual assault on male victims and serve to blame the victim for his assault. Male victims use male rape myths as a way to blame themselves for their assault. For example, victims may feel that they did something to provoke the assault, or did not do enough to prevent it.

Rape myths within the police service. Over the past three decades there has been limited research into police officers' rape myths (Sleath & Bull, 2015). With attrition rates being greatest at the investigative stage of a sexual assault case, it needs to be recognized that police officers are actively involved in the legal decision-making process and ultimately, officers' identity, social position, and past experiences may be influential in the decisions made in processing a rape case (Alderden & Ullman, 2012).

The first systematic review of police officers' rape myths was conducted by Parratt and Pina (2017). They reviewed 18 individual studies and examined the literature on police officers rape myth beliefs and examined the specific components of that research, including decision-making, victim credibility, police training and experiences, and police gender. Their findings demonstrated that

stereotypes appeared to be highly influential in officers' beliefs of rape, where in most, but not all cases, officers had pre-conceived ideas of what a genuine rape victim presents as, and when victims do not fit such stereotypes, they are believed to be less credible than those that do.

These studies highlighted a variety of beliefs/attitudes relating to rape. Some found that traditional beliefs and sexist attitudes are related to rape myth endorsement. This is logical considering that rape myths serve to support sexual violence against women by men which supports the notion that women should be subordinate to male domination (Lee et al., 2012). Others confirmed the role of personal characteristics of police officers in relation to their beliefs of rape. For example, gender played a significant role in how it relates to officers' beliefs of rape. Gender was influential, in that female officers appear to have more positive perceptions of rape victims compared to their male colleagues.

Other characteristics studied, focused on the profession of being a police officer, such as training, experience (years of service, and yeas processing rape cases), education, resources, and police subculture. Training had mixed results. Training was found to be associated with possible benefits such as an increased likelihood of including victim advocates when taking rape complaints, and advanced interviewing skills. However, in terms of beliefs of rape, even though training appeared to influence behavior, it failed to alter officers' attitudes and had no eventual influence on victim blaming. Additionally, training had no effect on rape myth acceptance rates regarding the victim.

Lastly, the review examined the influence of resources, police culture and questioning style in relation to officers' beliefs. For example, in one study the majority of police officers felt that resources had no influence on their decision to pursue a rape case. The type of agency was also influential in officers' beliefs of rape, specifically that officers from larger agencies endorsed a lower amount of rape myths than officers in smaller and more rural agencies. The size of the agency, however, did not seem to influence officers' interviewing skills (Rich & Seffrin, 2012). Another review of 37 studies gives support to the notion that rape myth acceptance is associated with negative attitudes towards women and is more prevalent in men (Suarez & Gadalla, 2010), which accounts rape victim blaming (van der Bruggen and Grubb, 2014).

Victim Blaming

Further, it has been demonstrated that 'rape myths' influence the decision-making process and guilt assessment of lay people as well as jurors (Bohner et al., 2009; Temkin & Krahé, 2008; Ward, 1995). It is generally believed that these myths determine the degree to which a victim is blamed and the perpetrator is

exonerated for the rape (Gerger, Kley, Bohner, & Siebler, 2007; Ward, 1995). Other research indicates that victims are consistently blamed more when it concerns date and acquaintance scenarios, compared to stranger scenarios (Bell et al., 1994; Kelly, 2009; Sleath & Bull, 2010; White & Yamawaki, 2009; Yamawaki, 2009).

Reporting

There is also a growing body of literature on the differences between victims who choose to report and non-reporters of sexual violence. Generally speaking, victims who were intoxicated at the time of the assault were less likely to report to the police. In contrast, sexual violence is more likely to be reported, when there was a weapon involved or when the assailant is a stranger (Fisher, Daigle, Cullen, & Turner, 2003; Wolitzky-Taylor et al., 2011).

Various reasons for non-reporting and regret about non-reporting. Studies examining reasons why victims do not report the crime to the police have compiled a lengthy set of reasons, including (a) did not occur to me, (b) solved it on my own, (c) no proof or witness, (d) belief the police can or will not act, (e) fear of retaliation, (f) feeling of shame, (g) fear the violence will worsen, (h) did not feel the violence was severe enough, (i) fear no one will believe me, (j) bad previous experience with the police, (k) would disrupt my life too much, (l) feelings of guilt about own behavior prior to violence, (m) fear of losing my job, (n) fear of losing help or care, (o) fear of the physical examination in case of rape or the occurrence of injuries, (p) no physical injuries had occurred, and (q) other reasons.

Regret about non-reporting / potential reporting. Non-reporting victims have indicated they may have reported the rape (and become a potential reporter) had they known that (a) I could talk to the police before deciding whether or not to report; (b) I'd be ensured of sufficient privacy during the reporting process; (c) I could speak with a specialized investigator of the vice squad; (d) I was allowed to bring someone for support; (e) I could receive professional support from victim assistance during the reporting process; (f) I could be examined by a specialized (forensic) physician, who can collect evidence to support my case; (g) possible injuries I suffered during the incident could serve as evidence; (h) there are techniques that can tell when injuries were inflicted, which can serve as evidence; and (i) how much of a burden the violence still is today.

Post-decision attitude. Almost 40% of non-reporters expressed regrets about not having reported the crime to the police. In addition, 65% of non-reporting victims indicated to have considered reporting the crime and 47% agreed with the statement that they would have reported the crime if they had known, then, how much of a burden the violence would still be today. These studies suggest that proper education about the reporting process may increase victims' willingness

to report to the police, thereby increasing opportunities to ensure the prosecution of perpetrators of sexual violence (Ceelen et al. 2016)

Rape and sexual assault crimes are a particularly difficult challenge within each component of the criminal justice system, due to factors such as bias, rape myths, and victim blaming, and reporting. Each of these must be considered by policy officers, defense and prosecuting attorneys, jury panels, the media, and judges as well. The playing field for prosecutors, who already have a substantial burden of proof, is not level when defense attorneys unfairly characterize normal victim behaviors as credibility problems. It is incumbent upon all who are involved in the criminal justice system to acknowledge the presence of biases and myths and learn about the research that refutes them.

Trauma

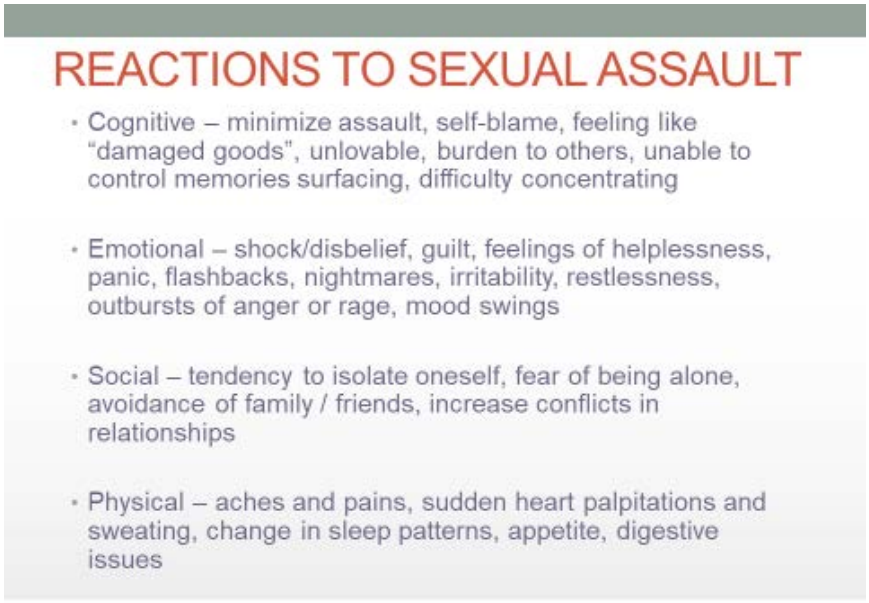
The science of trauma can refute the assumptions, inferences, and conclusions that are made about victim behavior. Psychological trauma is a disruption of equilibrium that severely affects a person's ability to cope in response to an experience that is emotionally painful, distressing, or shocking. Although psychological trauma is a normal human response to an extreme event, it may leave lasting mental and physical effects.

Frequently, individuals use the word "traumatic" to describe stressful life events. However, the American Psychiatric Association (2015) defines it in a very specific way. The criterion must involve both of the following:

> *"The person experienced, witnessed, or was confronted with an event where there was the threat of or actual death or serious injury. The event may also have involved a threat to the person's physical well-being or the physical well-being of another person; and*
>
> *The person responded to the event with strong feelings of fear, helplessness or horror".*

Traumatic events are usually differentiated from stressful events and crises by the nature and severity of the event. Based on this definition, a sexual assault would always be categorized as a traumatic event. A person who experiences a traumatic event always has a reaction to the event, although their reaction may not be apparent or logical to others. Reactions to traumatic events involve conscious and unconscious uses of coping strategies in the attempt to return the person to equilibrium. Although these attempts to cope may seem strange, counterproductive or counterintuitive to others, there are a wide range of reactions that are normal and even expected.

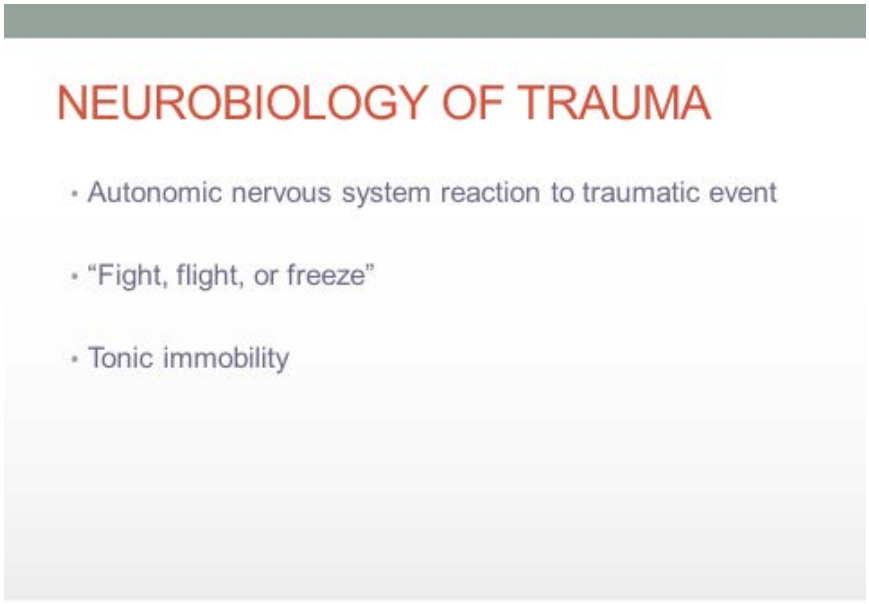
All traumatic events evoke cognitive, emotional, physical and social responses. Often they include avoidance of reminders of the event, re-experiencing the event through intrusive memories, flashbacks and nightmares and hyper arousal displayed as anxiety, heightened startle response, irritability, or insomnia. However, the victims typically experience a wide reactions to a sexual assault.



Neurobiology of Trauma

When a person experiences a traumatic event, there is a cascade of neurological and biological responses that occur during and after the event. These reactions influence physical and psychological responses to the event and may continue for weeks, months or years following the experience. The neurobiological response is controlled by the autonomic nervous system (ANS) that is a reactionary, survival system. The ANS bypasses the "thinking" brain to provide speedy response when needed to insure safety and survival and commonly referred to as the "fight or flight" response.

The neurobiological response to trauma is a physical reaction to the perception of threat and is not influenced by conscious thought. For example, it is illustrated in the common experience of pulling one's hand away from a hot surface. This reaction involves the release of chemicals in the body that control respiration, blood flow, heart rate, muscle control, speech, as well as cognition and memory. These involuntary neurochemical responses have a significant effect not only on the behavioral response during a traumatic event like a sexual assault, but also on the memories and perceptions the victim may have and be able to communicate or recall following the event.



Fight, Flight, or Freeze

One's reaction to threat depends on two factors: 1) the level of fear and 2) the proximity of the threat. The initial response to threat is to freeze. When a threat appears distant (spatially, temporally, or perceived likelihood) and the fear is low, freeze is the involuntary, momentary reaction. This happens similarly with both humans and animals. With animals, the freeze response allows the organism to assess the situation, and avoid detection in the hopes that the threat may pass without incident. For example, the mouse freezes when it hears movement in the brush. This reaction allows it to assess whether a predator is present, and if it is, the stillness may protect the mouse from being detected. With humans involved in a sexual assault, "freezing" may happen when an offender first crosses a boundary initiating an assault. This may be a factor leading offenders to take advantage of this momentary lack of response to move forward with their goal of sexual assault.

In the "fight or flight" response where the danger is determined to be present and fear is increasing, the chemicals released encourage the fight or flight response. In the example of the mouse, if a predator has found the mouse and is moving closer, the mouse can choose to make a run for cover, or bare its teeth and claws to fight. In the sexual assault situation, the process is more complicated as can involve a range of behaviors a victim may employ from non-verbal (turning away or non-responsiveness) resistance to verbal resistance (saying no or pleading to stop) to direct physical resistance (hitting, punching, biting). There may also be psychological defenses such as dissociation in which the victim may have the sensation of leaving her body – and detaching from the horror of the

assault. This can be a form of flight. See Lisak (2015) for a thorough and detailed explanation of the neurobiology of trauma as it relates specifically to sexual assault

Tonic Immobility

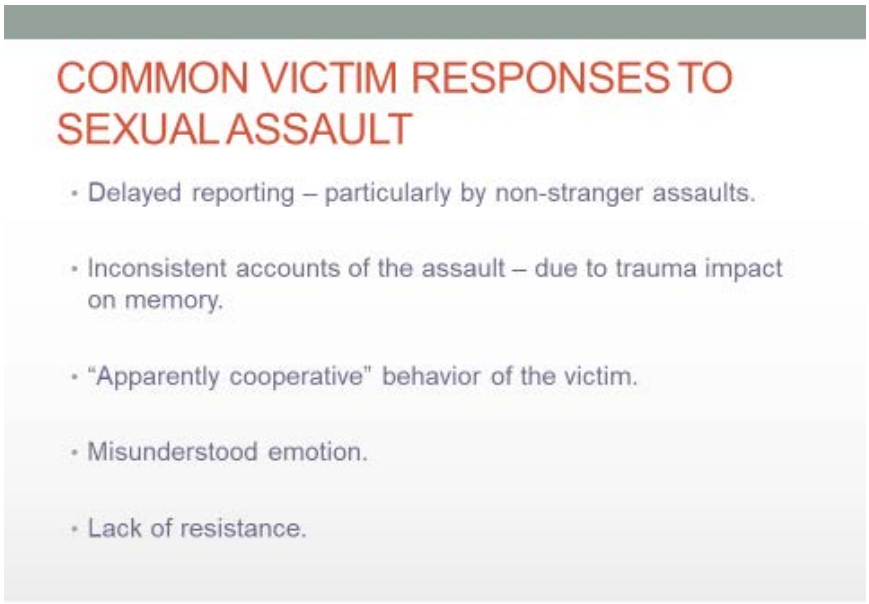
A less well-known and understood response that is critical for understanding sexual assault is tonic immobility. Research indicates (Moller et al. 2017) that 12-70% of rape victims experience tonic immobility. This neurobiological response happens when the threat is imminent and fear is high and the victim's central nervous system feels there is no escape. Here the brain releases neurotransmitters leading to a type of paralysis. Here the victim is physically incapable of moving or responding, and the ability to speak is sometimes lost. Tonic immobility may serve to reduce the amount of pain and suffering the victim may experience as well as distorting cognitive functions such as memory, a physiological attempt to lessen emotional pain (Marx, 2008).

Understanding common victim responses. Another challenge influencing the successful prosecution of sexual assault crimes due to the impact of victim trauma, is that most of the normal human responses to the trauma appear to run counter to the ingrained societal views as to how a victim of sexual assault should respond (Missoula County Attorney's Office, 2014). As a result, victim responses often are termed "counterintuitive" or "paradoxical," in that victim responses are not what would intuitively be expect. These terms describe the perceptions of others that a "real" victim should act in a certain manner. A "real" victim would do everything in her power to fight off the offender. A "real" victim would look and act like a victim; she would be hysterical and report right away to the police. A "real" victim wouldn't have put herself in that position to begin with.

Research has verified that sexual assault victim responses are anything but counterintuitive. Victim responses are clearly indicative of how the human brain responds to trauma. According to Fanflik (2007) "the presence of "counterintuitive" responses should support the presence of a real trauma, not negate it." According to the Office for Victims of Crime (2012), there are common victim responses to traumatic sexual assault.

Delayed reporting. Delayed reporting of sexual assault, particularly in non-stranger sexual assaults, is the norm rather than the exception. It can be directly attributed to the consequences of trauma described above – including the neurobiological response to and the inhibition of memory. Additionally, victims who are sexually assaulted by someone they know may not report right away for many reasons. For example, one reason may be because an acquaintance rape does not fit the stereotype that most people are sexually assaulted by strangers. As a result, the victim may not even recognize that what happened to them fits the legal definition of sexual assault. A second reason may be fears about

potential safety concerns that may arise from reporting a sexual assault by someone the victim knows (a family friend, co-worker, or former intimate partner).



Delayed reporting of sexual assault is seen as counterintuitive because jurors expect that a victim of sexual assault will report immediately to law enforcement. As a result, the presence of a delayed report creates a perceived credibility issue for the prosecution. In reality however, delayed reporting should be viewed as a natural and expected reaction to trauma.

Inconsistent accounts of the assault / trauma and memory. The neurobiological response to a traumatic event also impairs the normal process retaining memories. This can affect a victim's memory immediately after the assault as well as over the long-term. According to Lisak (2015) the sexual assault may be remembered over a period of days, weeks, months or even in some cases years. However, the specific chronology of the event may be disrupted so that it is difficult for a victim to give a clear, linear story. For example, specific parts of the assault may be remembered in vivid detail, while other aspects of the event (that may seem critical to law enforcement or prosecutors) are not remembered at all by the victim.

Additionally, memories of the traumatic event may be fragmented and surface in pieces over time. As a result, the victim's report naturally may evolve over time, but is then perceived by others as "inconsistent." The impact of trauma on memory has major implications as to when and how a victim reports the sexual assault. A sexual assault victim may not report the assault right away because she has no memory, or unclear memories, of the assault. Additionally, the fact that memories come in pieces may lead to ongoing disclosure of certain facts

related to the assault, which some term “layered reporting.” Layered reporting may create credibility problems as a case makes its way through the criminal justice system

Apparently cooperative behavior of the victim. One of the immediate psychological reactions to trauma is the feeling of intense fear, helplessness and horror. Sexual assault victims commonly report fearing for their lives during an assault, whether or not weapons, violence, or threats were used by the offender. Another in the list of counterintuitive examples is that in an effort to survive the situation, a victim may engage in some cooperative behavior with the offender, both during and after the assault. This is normal. The victim may be in shock and not making what others would see as rational choices. The victim may be doing what she needs to do to get the offender away, or to ensure she survives the assault. The victim may be in denial and trying to normalize the assault. Another example of cooperative behavior would be where the victim gives the offender a ride home or have contact with the offender after the assault. At first glance this type of behavior may be seen as evidence of consensual sexual activity rather than sexual assault, and defense attorneys will definitely try to use this as part of a consent defense (Missoula, 2014). However, prosecutors should anticipate these defense strategies in a sexual assault case, and educate juries to view these cases through a trauma-informed perspective, usually through the use of expert testimony.

Misunderstood emotional response. Societal stereotypes hold that a “real” victim of sexual assault should be hysterical. But the stereotypes also suggest that a victim should move on after “enough” time has passed. However, there is ample evidence suggesting victims of trauma respond in a variety of ways, depending on the stage of healing they are experiencing. One common psychological reaction to sexual trauma is for a victim to withdraw or shut down which may manifest itself as “flat affect”. This is manifest in the victim displaying little to no emotion, which may be wrongly perceived as evidence of a false report. Reactions to trauma can also include anger or irritability, especially in later stages of healing. Although these reactions may make the victim more difficult to work with and less sympathetic to a jury, these emotions may be positive signs of healing. Any service provider should anticipate a range of emotions from sexual assault victims they encounter. They should also understand that these emotions should not be considered evidence of deception, but rather as evidence of a traumatic response.

Lack of resistance by the victim. Another reaction not well understood by people without an understanding of trauma is the expectation that victims will fight vigorously against a sexual assault. There are reasons a victim does not resist

during a sexual assault. First a victim may choose not to act, being passive or even cooperating with the assailant, in an attempt to survive the event. As mentioned previously, most sexual assault victims perceive that their life is in danger, regardless whether a weapon is present, even if doing so seems irrational to an outsider. Passivity or apparent cooperation may be the best way to survive the assault, or to survive without serious physical injury. Passivity or apparent cooperation do not imply consent.

Another normal response previously discussed to traumatic events is *tonic immobility*. This response is one in which the human body enters a state of paralysis. What is important to understand about this response is that it is an automatic response, not a choice a person makes. Tonic immobility differs from choosing not to act; it also differs from "freezing," in that the freeze response in a momentary response and tonic immobility is an ongoing physical paralysis that may occur during and immediately after the assault. Both tonic immobility and making the conscious choice not to resist or otherwise act – both of which are perfectly normal and adaptive responses to sexual assault.

Recovery from the trauma of sexual assault. Recovery from sexual assault begins immediately after the assault occurs and continues for days, weeks, months and years after the assault. Research shows that the initial responses a victim receives when she discloses the assault affect the trajectory of her recovery. A victim who is believed, supported and encouraged to regain a sense of control may move more quickly to the later stages than victims who are met with disbelief or criticism. Many survivors who engage in the criminal justice system experience re-victimization. Even if a victim is met with uniform support and a victim-centered response from sensitive and understanding law enforcement and prosecutors, the criminal justice process is designed to "prove or disprove" her experience. This requires repeated retelling of the story, and facing those seeking to undermine the victim's credibility, including the offender and his counsel. Often it involves many procedures, interactions and situations that the survivor is unable to control. Additionally, neurologic responses to trauma may cause a victim to respond to certain stimuli related to the assault as if it were occurring again. These "triggers" are unconscious and often connected to the senses; for example, the sound of the assailant's voice or the smell of his aftershave. This has major implications for victims of sexual assault who are going through the criminal justice system. David Lisak (2015) states that

> "to participate in that process – to endlessly recount their trauma, to appear in the court room where the offender sits – is equivalent to the zebra choosing to return to the water hole where the lion attacked."

This analogy speaks volumes about how important it is to institute a victim-centered response that focuses on minimizing re-traumatization by the criminal justice system. In working with victims in the criminal justice system, it is

important to understand the stages of trauma and recovery and how the stage the survivor is experiencing will affect her thoughts, emotions, and behavior.

Best Practice Review

Defining "'best practice"

Currently there is no consensus about "what works" or what constitutes "best practice" in sexual violence and child sexual abuse prevention or response. What the research literature and other evidence presents as successful in preventing or responding to adult, youth and child victimization and perpetration of sexual violence will be covered in the following sections. There is no uniform definition for "best practice" in the child and adult sexual assault field, although the term has been used in a number of sexual assault policy and guideline publications (see, National Association of Services Against Sexual Violence [NASASV], 2015; Government of South Australia, 2013; Quixley, 2010).

Although there are some basic concepts that provide guidance for developing an appropriate definition of "best practice" in this field, it remains a complex issue. The term "best practice" has its recent origins in the Cochrane Collaboration from the early 1990s in the United Kingdom, which inform research and policy due to the systematic reviews that are undertaken to search for and find "gold standard" evidence (Breckenridge & Hamer, 2014). While the work undertaken by experts creating the Cochrane Reviews is extensive and systematic, evidence that is quantitative, clinical or methodologically similar to health and medical research is promoted over qualitative, practitioner experience or evidence informed by the lived experiences of individuals. As Webb (2001) noted, the idea of applying outcomes from rigorous, scientific (not social-science) method-based research projects is appealing. Practices that are based on research evidence can be presented as a cure to costly and difficult social issues. However, in areas of human services these research practices have often not been appropriately critiqued and a scientific application of them in practice settings has rarely been conducted. Researchers have also indicated that they dislike the term "best practice" because it implies that the application of evidence-based research will lead to the problems being solved without evaluation, individualization or change (Bowen & Zwi, 2005; Breckenridge & Hamer, 2014). Services dealing with sexual assault usually operate under a variety of political, philosophical or methodologically diverse systems, which can lead to a disagreement about what constitutes "best practice" (Breckenridge & Hamer, 2014).

One recent approach in Australia (NASASV, 2015) notes that practice informed purely by research evidence is not necessarily guaranteed to work because "it cannot be assumed that an intervention clinically proven to be successful with

one client group experiencing a certain set of 'symptoms' will achieve the same results with a different client group". Further they argued that effectiveness of programs and practices should come from client-based review and feedback, research literature, reflective practice and "outcome evaluation methods that are client focused". Their model blends both evaluations of programs as well as client review and feedback leading to a more balanced practice models in sexual assault and other violence against women services (Carmody, Evans, Krogh, Flood, Heenan & Ovenden, 2009).

General criteria for what would be considered best practice in rape prevention, treatment and support for female victims was offered by the European Union's Directorate-General for Internal Policies (Walby et al., 2013). Criteria included:

> "being victim-survivor centered; being gender expert and gender sensitive; including the participation of survivors; having trained personnel; having 'skilled specialized centers that act as beacons to good practice in the mainstream'; having monitoring and evaluation built into the services and programs in order to continuously update practice; inter-agency collaboration; and being part of a broader package of policies to combat violence against women. Practices that are innovative, proven to have made a difference, and models for development elsewhere can be classed as being part of the best practice, whereas others should be classified as 'promising practices' ".

Sexual assault services that are informed by similar criteria have been referred to as "practice-informed" (Plath, 2006), or "evidence-influenced" (Bowen & Zwi, 2005) rather than "best practice". Other reviews have also highlighted that while international evidence-informed or influenced models for public health services may be promising, they may be difficult to translate in other locations where, where different laws exist, and where policies may be highly regulated defining the types of practice models that are permissible and who may deliver them (Breckenridge & Hamer, 2014). In another review based in Australia, the authors pointed out that victim advocacy and support programs had mixed results at best and that the programs have not been rigorously evaluated; however, these are the programs that continue to receive ongoing funding from state and territory governments based on internal, practice-informed criteria (Quadara et al., 2015).

Grey literature

In addition to the published literature review, SRI staff also collected a wide variety of "grey literature", documents that are comprised of published government reports, topical monographs, policy documents, issue papers, and conference proceedings. A number of other helpful resource documents were

also compiled from credible organizations such as the United Nations and the World Health Organization.

SRI collected a total of 63 documents including documents from 26 states. Additional documents from foreign countries such as Australia (2), Austria, Canada, EU Parliament, India, Ireland (2), New Zealand, Scotland, & UK (2) were also obtained. Other documents were also gathered from the Berkley Human Rights Center, the Centers for Disease Control, US Department of Justice, International Association of Chiefs of Police, United Nations, the White House, and the World Health Organization (2).

Core services identified

During the early stages of compiling and reviewing these documents, staff found a review document from Iowa (Core Services and Characteristics, 2013) that consisted of a qualitative study of state service programs and standards for victim advocates providing rape and sexual assault services. This review article summarized findings of victim services involving 20 states and compiled the similarities and differences in sexual assault service provision. The authors detailed the services and methods widely seen as core services and what services may be considered supplemental to those core services or recommended practices. The findings noted that core and recommended practices look slightly different in each state, but were strikingly consistent across the states. The table below shows the participating states with corresponding "core" and "recommended" services.

	CA	CT	FL	HI	IA	IL	KY	MA	MI	MO	NC	NE	NH	NY	OR	PA	TN	VT	WA	WV
Crisis interven.																				
Info. & referral																				
General advoc.																				
Medical advoc.																				
Legal advoc.																				
Couns/ therapy																				
Support groups																				
Preven.																				
Com. aware																				
Proferaining																				
Systems advoc.																				

Core
Recommended

In addition to these core service practices, the review also pointed to the need of having these services delivered in the context of several important philosophical principals. The common philosophies that were highlighted include:

- Confidential services
- Free
- Social Justice Approach – victim-centered, anti-oppression, empowerment
- Specifically trained workers
- Maintain community presence
- Support survivors' choice
- Provide services to ALL survivors

Analysis of documents

Given the widely recognized findings from the comprehensive review and identification of core practices, SRI staff began examining the grey literature documents using the core practice list as a template. SRI's larger review of state, country, and other organization documents using the core standards found similar results as the vast majority of the standards were also highlighted and discussed in these documents. For example, of the 26 state documents examined for each of the 11 core services previously identified in the 2013 review, legal advocacy was offered in 24 states (92%), followed by medical

advocacy in 23 states (88%), and crisis intervention in 21 states (81%). These were followed by counseling/therapy in 17 states (63%), support groups in 14 (54%) states, and information and referral in 14 states (54%). The average number of core services cited in each state was 6.85 out of 11. Even among the group of 20 foreign country/organizational documents reviewed, this pattern repeated itself. The average number of core services found in the 20 documents examined was also 6.85 out of 11. Crisis intervention and legal advocacy were the most frequently cited service, listed in 17 (85%) of the documents reviewed. Counseling/therapy services was second with references in 16 (64%) documents, followed by medical advocacy and professional training found in 15 (60%) of the documents. See Appendix 2 for a complete summary of core service findings.

The SRI document review also identified other commonly implemented programs, polices, or practices, which, based on the frequency of inclusion and discussion merit consideration.

- 24-hour hotline
- Staff who are culturally and linguistically diverse
- Staff who receive “caring for the caregivers” (self-care) training
- Staff workforce development
- Coordinated community response teams (CCR) such as SART
- Service provision capacity for special population groups: persons with disabilities, LGTBQ, trafficked victims, indigenous groups, and refugees

Title IX

Title IX is a federal civil rights law originally passed in 1972 that says “no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.” Although the law applies to all educational programs, a common application of the law is found with students in higher education. Title IX ensures that both women and men be provided equitable opportunities to participate in sports, received scholarships and other benefits. Title IX also addresses sexual harassment, sexual violence, or any other gender-based discrimination that may deny a person access to educational benefits and opportunities.

Under this law schools must proactively try to prevent and respond to claims of sexual harassment, sexual violence, and other forms of gender-based violence, retaliation, or discrimination. Schools must also have an impartial and prompt process for investigating and adjudicating reported cases. Most schools try to approach this first on an informal basis by offering services such as mediation.

This may be an appropriate process for some cases of sexual harassment, but in cases involving allegations of sexual assault, mediation is not appropriate even on a voluntary basis. If the survivor is resolving a case informally, they must be notified of the right to end the informal process at any time and begin the formal process. Retaliation from either the school, the faculty, or your peers is also prohibited. Furthermore, regardless of whether a report has been filed to the school or police, an institution must provide the survivor with living or academic accommodations and the right to notify law enforcement. Schools must also notify survivors of options for interim measures, such as no contact orders and changes to transportation, dining, and working situations.

Another federal law that intersects with Title IX is called the Clery Act. This act provides a bill of rights for survivors of campus sexual assault and specifies colleges and universities to do the following:

- Notify survivors of counseling resources.
- Notify survivors of the option to report a case to either the school, law enforcement, or both.
- Provide academic or living accommodations, such as changing dorms, classes, etc. Schools are discouraged from burdening the survivor, instead of the perpetrator, with the responsibility to change their circumstances.
- To be notified of the final outcome of a disciplinary proceeding.

This is an important law because university and college women are disproportionately affected by sexual assault, impeding their safety, comfort, access to education, and ability to participate in campus life. The law is designed to protect students from sexual harassment and violence that occur in the course of a school's education programs and activities. Once a school knows of or reasonably should have known about sexual harassment or sexual assault on campus, Title IX requires the school to promptly investigate the complaint and take steps to protect its students.

In Utah, there have been 5 colleges to come under Title IX investigation (Brigham Young University, Dixie State University, Utah Valley University, University of Utah, and Westminster College). In each of these cases, the issue focuses on whether the colleges have violated the law in providing a path of recourse for students who believe administrators have mishandled their reports of sexual assault. Nationally, there have been 429 Office of Civil Rights investigations, of which 78 (18%) have been resolved.

Online Survey Results

The online survey was emailed to 211 valid addresses representing all organizations in Utah with a contract (72) for services with the Office for Victims of Crime, as well as all county sheriffs (29) and city police chiefs (110). The survey consisted of approximately 16 questions, including 3 related to demographic variables such as gender, age, and occupational status. There were also 3 questions that contained 32 sub-items related to rape and sexual assault service provision. The objective of the survey was to collect opinion data regarding a complete range of crime victim services and to have survey respondents prioritize service needs. The survey also asked people to identify barriers to effective service delivery.

SURVEY RESPONDENTS BY AGE & EDUCATION

Age	N =129
Age: Range	21 - 66
Age: Mean	45.4
Highest level of education	
Some High School	0.8% (1)
High School Diploma/GED	4.7% (6)
Some College	17.8% (23)
Two-Year Degree	5.4% (7)
Four-Year Degree	37.3% (48)
Graduate Level Degree	33.3% (43)
None of the Above	0.8% (1)
Years of Experience: Range	<1 – 31
Years of Experience: Mean	8.61

The survey was sent by email and included a copy of a letter of endorsement from the Director of the Office for Victims of Crime. Multiple email follow-up reminders were sent to potential respondents. Following six weeks of follow up 129 surveys were submitted for analysis, which represents a 61% response rate. Of those responding, 73% were female and 27% were male. The average respondent was 45 years old and the age range of those completing the survey was 21 to 66 years of age. Respondents to the online needs assessment survey were well educated. When asked about their educational attainment, 37% reported they had a 4-year degree, 33% reported they had a graduate degree, while 18% indicated they had completed “some college”. Further, 5% had completed a 2-year degree and 55 had a high school diploma or GED. Survey respondents also represented a wide variety of occupational categories, with the most being system-based advocates (23%), followed by police/law enforcement (18%) and agency executive directors (16%). When asked how long they had been employed in their current position, respondents reported from 1 to 31 years, with the average being 8.6 years.

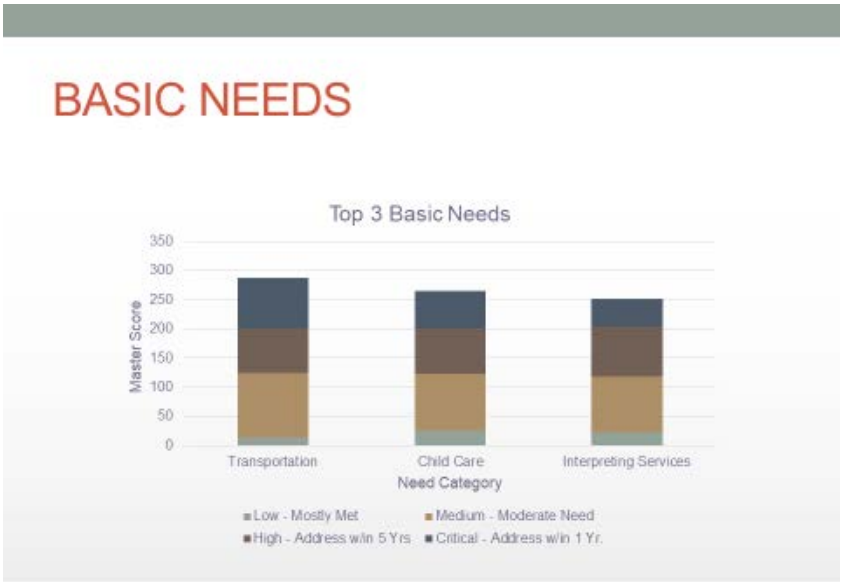
SURVEY RESPONDENTS BY OCCUPATION

What category best describes your current position?	n = 129
Attorney	5 (3.9%)
Children's Justice Center or Family Justice Center Employee	7 (5.4%)
Detective	3 (2.3%)
Executive Director	20 (15.5%)
Police/ Law Enforcement	23 (17.8)
Program Manager	5 (3.9%)
Therapist	7 (5.4%)
Individual Victim Advocate	11 (8.5%)
System-Based Victim Advocate	29 (22.5%)
Other	19 (14.7%)

Next survey respondents were asked to identify the primary location (by county) where their agency or programs focused its service delivery. Sixty percent of the respondents indicated they only provided services in one county, while 40% reported that they provided services in more than one county.

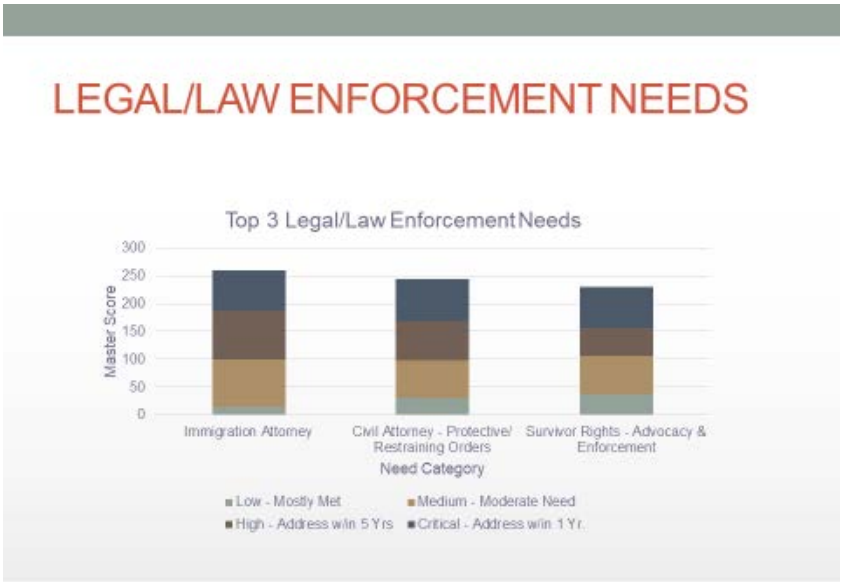
Following these demographic items the survey respondents were asked to prioritize and rate sexual assault victim needs for the balance of the survey. First, there were three categories of services: a) basic service needs, b) survivor-centered service needs, and c) legal / law enforcement service needs. In rating the priority level of service needs, respondents were asked to use the following definitions: low did not mean the priority was low, it meant the service was mostly being met at this time; moderate meant there was only a moderate need; high indicated the need must be addressed within 5 years; and critical meant the need must be addressed within 1 year. By using this 4-point Likert-scale, values were assigned to each of the four ratings and a "master score" was created based on each survey respondents rating.

Basic Service Needs. Respondents identified and rated the top three basic service needs as: 1) transportation, 2) childcare, and 3) interpreting services. The stacked bar chart figure below illustrates how the higher weighted ranking (critical) need is at the top (darkest) followed by the next highest ranking (high) followed by the other rankings. The only other basic service need ranked by respondents was medical care. Transportation is viewed as the highest basic priority need for victims by survey respondents. Transportation is a necessary service for many who have been victimized in order for them to receive the array of services they need to help them deal with the trauma they have experienced.



Survivor-Centered Service Needs. The second grouping of services to be prioritized were those focusing on survivor-centered needs. The top three survivor-centered needs were: 1) therapy, 2) support groups, and 3) intervention with a creditor / employer / landlord or academic institution. Other needs ranked by respondents were: 4) case management, 5) confidential reporting, 6) individual advocacy (e.g. assistance applying for repartitions or accessing services), 7) sexual nurse examiners, 8) information and referral, 9) safety planning, and 10) accompaniment to forensic/medical examination. Given what is known from the literature and "best practice" core services, this finding that the need for victim therapy and support groups is not surprising.

Legal / Law Enforcement Service Needs. The third and final grouping of services to be prioritized were those related to legal and law enforcement needs. Master scores of respondent ratings produced a list of priorities. The top three were: 1) immigration attorney assistance, 2) civil attorney assistance, and 3) survivor rights advocacy and enforcement. These were followed by a number of other identified priority services such as: 4) survivor impact statement preparation, 5) prosecution interview accompaniment, 6) notification of court proceedings, 7) assistance with restitution, 8) accompaniment to meet with law enforcement, and 9) accompaniment to court proceedings.



Barriers to Accessing Resources. After prioritizing the most needed services, survey respondents were asked to identify, based on their experience working with rape and sexual assault survivors, barriers that prevented access to needed service supports. This question used a 5-point Likert scale ranging from "strongly disagree" to "strongly agree". The top three barriers that were identified based on being rated more highly (agree and strongly agree), were: 1) feeling victim blamed by authorities, 2) potential loss of confidentiality if they seek help, and 3) survivors not wanting to be labeled a "victim". Other barriers that we also identified included: 4) survivors do not understand the process of obtaining assistance, 5) survivors believe applying for assistance will require them to be involved in the system longer than they desire, 6) survivors believe the crime is a private matter, and 7) survivors want to deal with it on their own terms.

BARRIERS TO ACCESSING SUPPORT

	Strongly Agree or Agree
Survivors believe if they report the crime, they will be blamed or not believed by authorities.	79.6%
Survivors are concerned their confidentiality may not be preserved.	68.8%
Survivors do not want to be labeled as a victim.	60.2%

In-depth Interview Results

In order to explore some of the qualitative aspects of rape and sexual needs in Utah, SRI staff designed a series of open-ended questions related to service delivery, service needs, and factors related to improving services. Staff wanted to ensure geographic representation in the selection of stakeholders that would be asked to participate in the interviews so a matrix of interview locations was developed to maximize the diversity of interviewees. A total of 50 individuals were identified and invited to participate by introductory email. Follow up telephone contact was then conducted and interviews were scheduled to be help

in the stakeholder's office. A total of 37 interviews were conducted involving a total of 45 individuals. The interview consisted of 11 questions (3 demographic, agency-specific questions followed by 8 open ended questions). The stakeholders who participated were geographically balanced across the state and included agency directors, direct service staff, legal and law enforcement representatives, and state-level service providers. Each stakeholder was assured his or her anonymity would be preserved.

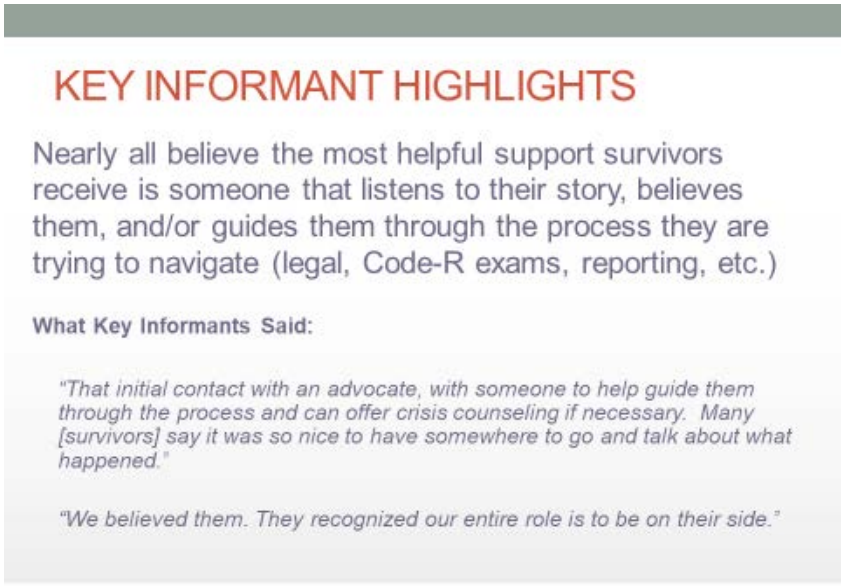
Each open-ended question that follows was given to participants during the interview. SRI staff took notes throughout the interview and transposed the findings to a spreadsheet for analysis. Analysis consisted of sorting comments by question to isolate specific themes. Each question of the interview is followed by a brief summary. The number following each question is the number of interviews that had the particular response in the summary.

Interview Questions:

"What are the successes your agency has had with providing rape and sexual assault services? What has made them successful?" (N=37)

Respondents most frequently identified their agency's successes on that of survivors (24). Many stated success is defined by the survivor and looks different for each person they work with (12). Many respondents felt their greatest successes were providing a listening ear, allied response, or affirming presence to survivors (12). Others highlighted specific services they were able to provide at their agency that are valued by their community (11), including specialized programs, community outreach, or services that fill a service gap, for example mental health counseling.

In addition to services, respondents were proud of internal improvements and expansion of services that allow the agency or organization to better meet the needs of clients (9), and collaborative efforts with other providers (6). A small number explicitly expressed concerns about the gap that existed between service providers and the challenges inherent in the criminal justice system that impact success in serving clients (4).



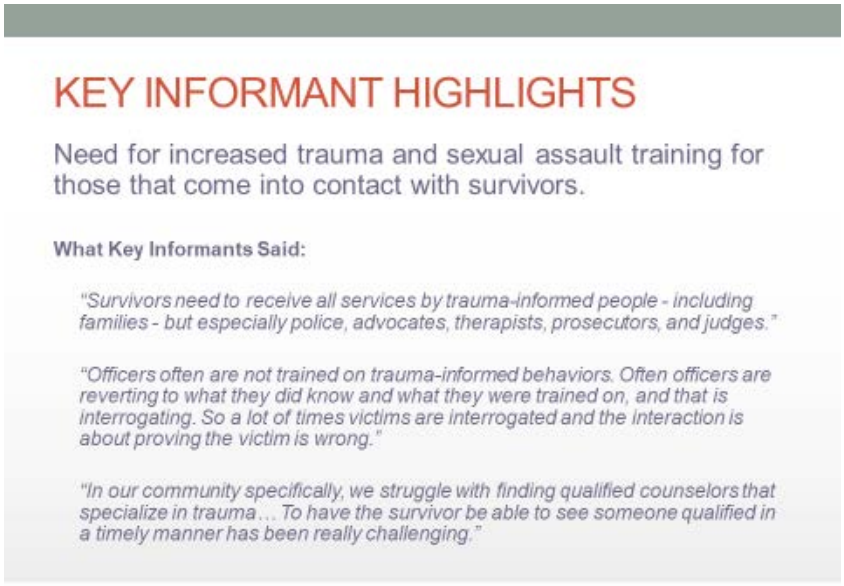
"What are the most challenging aspects of trying to implement these services in the community? What made it challenging?" (N = 37)

While the most common response was a gap in services for a specific need, such as housing, access to SANE nurses, or mental health counseling (19), respondents also discussed a difficult dynamic with the criminal justice system and serving survivors of sexual assault (16). Challenges spanned across the system, including law enforcement's response to reports of sexual assault, challenges within the court system, and the prosecution process itself. Many stakeholders discussed a lack of education and awareness among the community and service providers of sexual assault, trauma, and available services (15). Several respondents stated inter-agency collaboration is challenging and needed to improve to better serve survivors (7).

"If you could establish a standard set of services that all survivors of rape and sexual assault would have access to, what core services would you include and why?" (N = 37)

The single most common reported service was mental health counseling (30). Therapy services should be available immediately, by clinicians well trained in

trauma and sexual assault. Respondents emphasized a need for long-term and affordable free services. Support to meet basic needs such as food, housing, and transportation and childcare to alleviate barriers to accessing services, were also frequently identified (17), as well as well-trained professionals providing the various services to meet basic needs and survivor specific services. Specifically, respondents expressed a need for well trained professionals so survivors experience trauma-informed care across services and within the criminal justice system (14). Advocacy (14), medical care (Code-R exams, and follow up care) (12), prevention and awareness education (11), crisis responders (8) and legal assistance (7) were also identified by those interviewed.



"From the ideas that you shared, what needs among rape and sexual assault survivors have you noticed are often left unmet? Are there often secondary impacts to family members?" (N = 35)

Unmet needs included mental health services (16), psychoeducation related to sexual assault for the community and those impacted by sexual assault (12), accountability for the perpetrator (9), advocacy services, medical or hospital responses, and support for those that experience sexual assault with language barriers (2).

"Please share any thoughts on what might be contributing to the unmet needs you described?"(N = 33)

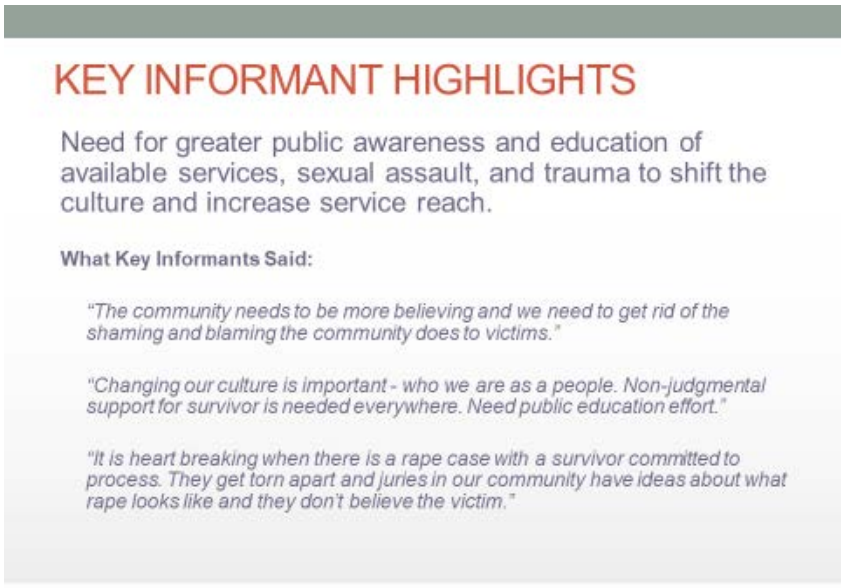
Contributing factors for unmet needs include a general lack of awareness of the issue, and need for services among communities (15), a lack of funding (11), and a lack of trauma-informed services for survivors of sexual assault (7).

"If you could improve one service, assistance or support in your community to better meet the needs of survivors, what would it be and why?" (N = 34)

Training (6) and education about sexual assault and trauma (6) were areas identified as needing improvement by respondents. Additionally, respondents stated there is a need to improve collaboration between agencies and service providers (7). Sexual Assault Response Teams (SARTs) were mentioned as a specific way this could be addressed. Quicker, and wider-reaching initial contact with survivors (5) was discussed to reduce the number of survivors that fall through the cracks for being connected with desired services. Others also identified a need for better access to Sexual Assault Nurse Examiners (SANEs) (4).

"What would survivors identity as the most helpful support they received as a rape / sexual assault survivor?" (N = 37)

Nearly all respondents (32) expressed that the most helpful support survivors receive is someone that listens to their story, believes them, or guides them through the process they are trying to navigate in that interaction (legal, Code-R exams, reporting, etc.). Also mentioned were therapy and counseling services (4).



"Based on your experience working with survivors of rape and sexual assault, what are some of the reasons why someone would chose not to report the crime?" (N = 35)

Respondents reported many reasons why someone may choose not to report a sexual assault. Some believe going through the process of reporting will not be worth it (25). This could be due to the emotional toll, lack of perpetrator accountability when reported, and that the process is too hard on the survivor, or takes a long time. Others have a general distrust that police will help them, and thus a lack of desire to engage with the police to make a report.

Other common barriers to reporting are fear of not being believed or blamed for the incident (21), feeling guilty, at fault, ashamed or embarrassed about what happened (19), not wanting other people to find out they were assaulted (18), cultural barriers (rape myths, viewed perception and judgement from community, conservative culture, etc.) (14), perpetrator retaliation (12), trauma as a result of reporting (11), not wanting to get others in trouble (10), just wanting to move on and forget about it (9), not knowing if what they experienced was sexual assault (7), and knowing the perpetrator (6).

Of the thirty-five respondents that provided a primary reason someone chooses not to sexual assault, the most common reasons were fear of being blamed or not believed (7), feeling guilty, ashamed or embarrassed about what happened (7) and just wanting to move on (7). Findings from this interview question mirror the findings of the online survey related to barriers preventing victims from seeking access to service. Further, both the online survey and interview results reflect the findings in the literature cited on page 18.

Recommendations

Based on the review of the literature and evidence-based practices for rape and sexual assault services, along with the online survey findings and in-depth interviews, the following recommendations are offered.

First, the Office for Victims of Crime together with all of its partner organizations should develop and implement a comprehensive trauma and sexual assault training for service providers in Utah. Second, there is a significant need to increase public awareness of sexual assault and the availability of sexual assault services to survivors. Third, there is a need to increase access to trauma-informed, mental health services statewide. Finally, in order to provide an array of comprehensive trauma-informed sexual assault services in Utah, there is a need for expanded sexual assault nurse examiner services.

RECOMMENDATIONS

1. Develop and implement trauma and sexual assault training for providers.
2. Increase public awareness of sexual assault and services available to survivors.
3. Increase access to trauma-informed, mental health services.
4. Expand SANE services.

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APPENDIX 1 - CDC DEFINITIONS

Sexual violence is defined as a sexual act committed against someone without that person's freely given consent. Sexual violence includes:

- **Completed or attempted forced penetration of a victim**
  Includes unwanted vaginal, oral, or anal insertion through use of physical force or threats to bring physical harm toward or against the victim.
- **Completed or attempted alcohol or drug-facilitated penetration of a victim**
  Includes unwanted vaginal, oral, or anal insertion when the victim was unable to consent because he or she was too intoxicated (e.g., unconscious, or lack of awareness) through voluntary or involuntary use of alcohol or drugs.
- **Completed or attempted forced acts in which a victim is made to penetrate someone**
  Includes situations when the victim was made, or there was an attempt to make the victim, sexually penetrate a perpetrator or someone else without the victim's consent because the victim was physically forced or threatened with physical harm.
- **Completed or attempted alcohol or drug-facilitated acts in which a victim is made to penetrate someone**
  Includes situations when the victim was made, or there was an attempt to make the victim, sexually penetrate a perpetrator or someone else without the victim's consent because the victim was too intoxicated (e.g., unconscious, or lack of awareness) through voluntary or involuntary use of alcohol or drugs.
- **Nonphysically forced penetration which occurs after a person is pressured to consent or submit to being penetrated**
  Includes being worn down by someone who repeatedly asked for sex or showed they were unhappy; having someone threaten to end a relationship or spread rumors; and sexual pressure by misuse of influence or authority.
- **Unwanted sexual contact**
  Includes intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, or of a person who is unable to consent. Unwanted sexual

contact also includes making a victim touch the perpetrator. Unwanted sexual contact can be referred to as “sexual harassment” in some contexts, such as a school or workplace.

- **Noncontact unwanted sexual experiences**
  Includes unwanted sexual attention that does not involve physical contact. Some examples are verbal sexual harassment (e.g., making sexual comments) or unwanted exposure to pornography. This occurs without a person’s consent and sometimes, without the victim’s knowledge. This type of sexual violence can occur in many different settings, such as school, the workplace, in public, or through technology.

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APPENDIX 2 - BEST PRACTICE DOCUMENT ANALYSIS

CORE SERVICES* / STATE or COUNTRY (YR)	CA 1999	FL 2017	GA 2016	HI 2005	IA* 2013	IL 2015	KY 2014	MA 2017	MI 2015	MO 2013	MN 2010	MT 2014	NC 2011	ND 2014	NE 2015-2020	NH 2018	NV 2012-2016	NY 2016	OH 2013	OR 2004	PA 2002	TN 2014	VT 2017	WA 2016	WI 2018	WV 2016
Crisis Intervention	X	X	X	X	X	X		X	X	X	X	X			X	X			X	X	X	X	X	X	X	X
Information & referral	X	X	X	X	X	X	X	X	X	X	X	X			X	X			X	X	X	X	X	X	X	X
General Advocacy	X		X	X	X	X		X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X
Medical Advocacy	X	X	X	X	X	X		X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X
Legal Advocacy	X	X		X	X	X	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X
Counseling / therapy	X		X	X	X	X		X		X		X	X		X				X	X	X	X	X	X	X	X
Support Groups	X		X		X	X	X			X		X	X	X	X	X			X	X	X	X	X	X		X
Prevention			X	X	X	X					X		X				X	X	X				X	X		
Community awareness			X		X	X					X		X	X	X		X	X	X			X		X	X	X
Professional training	X	X	X		X	X	X			X				X		X		X	X					X	X	X
Systems Advocacy	X		X		X	X				X		X			X			X	X	X	X	X		X	X	X

* Core services intentified in 2013 review of 20 states

CORE SERVICES* / STATE or COUNTRY (YR)	Australia 2014	Australia 2015	Austria 2005	Alberta (CAN) 2013	B.C. (CAN) 2007	B.C. (CAN) 2009	EU Parliament 2013	India 2014	Ireland 2010	Ireland 2006	New Zealand 2009	Scotland 2012	UK 2013	UK 2016	Berkley 2011	IACP 2017	White House 2014	UN 2012	WHO 2004	WHO 2013
Crisis Intervention	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X		
Information & referral	X	X		X	X	X	X		X	X	X	X	X	X	X	X				
General Advocacy	X			X	X	X	X	X	X	X	X	X	X	X	X					
Medical Advocacy		X	X		X	X	X	X	X	X	X	X	X		X	X	X	X		X
Legal Advocacy	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
Counseling / therapy	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Support Groups	X	X	X	X	X	X	X		X	X	X	X	X		X	X		X	X	X
Prevention			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Community awareness											X									
Professional training	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Systems Advocacy	X			X	X	X	X	X	X	X	X		X	X	X	X			X	

APPENDIX 3 - ONLINE SURVEY RESPONSES

Quantitative Survey Data N = 129

Which best describes your gender?	Responses n = 128
Female	93 (72.7%)
Male	34 (26.6%)
Other	1 (0.8%)

Do you provide services to sexual assault survivors in more than one county?	n = 129
Yes	52 (40.3%)
No	77 (59.7%)

What is the highest level of school that you have completed?	N = 129
Some high school but no diploma	1 (0.8%)
High School Diploma or GED	6 (4.7%)
Some college	23 (17.8%)
2-Year college degree	7 (5.4%)
4-Year college degree	48 (37.3%)
Graduate-level degree	43 (33.3%)
None of the above	1 (0.8%)

What category best describes your current position?	n = 129
Attorney	5 (3.9%)
Children's Justice Center or Family Justice Center Employee	7 (5.4%)
Detective	3 (2.3%)
Executive Director	20 (15.5%)
Police/ Law Enforcement	23 (17.8%)
Program Manager	5 (3.9%)
Therapist	7 (5.4%)
Individual Victim Advocate	11 (8.5%)
System-Based Victim Advocate	29 (22.5%)
Other	19 (14.7%)

Years of Experience Range	<1 – 31 years
Years of Experience Mean	8.61

Of those that serve MULTIPLE COUNTIES, select all counties served:	n = 52
Beaver	2 (3.8%)
Box Elder	5 (9.6%)
Cache	8 (15.4)
Carbon	5 (9.6%)
Daggett	3 (5.8%)
Davis	2 (3.8%)
Duchesne	3 (5.8%)
Emery	4 (7.7%)
Garfield	1 (1.9%)
Grand	2 (3.8%)
Iron	2 (3.8%)
Juab	6 (11.5%)
Kane	4 (7.7%)
Millard	4 (7.7%)
Morgan	3 (5.8%)
Piute	2 (3.8%)
Rich	6 (11.5%)
Salt Lake	5 (9.6)
San Juan	2 (3.8%)
Sanpete	3 (5.8%)
Sevier	3 (5.8%)
Summit	1 (1.9%)
Tooele	2 (3.8%)
Uintah	6 (11.5%)
Utah	9 (17.3%)
Wasatch	3 (5.8%)
Washington	7 (13.5%)
Wayne	2 (3.8%)
Weber	4 (7.7%)
All Counties (State Level Provider)	20 (38.5%)

Of those that serve MULTIPLE COUNTIES, the primary county selected to answer the survey questions to	N = 49
Box Elder	1 (2.0%)
Cache	6 (12.2%)
Carbon	2 (4.1%)
Davis	1 (2.0%)
Duchesne	1 (2.0%)
Grand	2 (4.1%)

Salt Lake	12 (24.5%)
Sevier	1 (2.0%)
Uintah	3 (6.1%)
Utah	10 (20.4%)
Washington	6 (12.2%)
Weber	4 (8.2%)

Of those that serve ONE county, the county they serve:	N = 77
Beaver	2 (2.6%)
Box Elder	2 (2.6%)
Cache	1 (1.3%)
Carbon	1 (1.3%)
Daggett	2 (2.6%)
Davis	16 (20.8%)
Duchesne	2 (2.6%)
Emery	-
Garfield	-
Grand	-
Iron	2 (2.6%)
Juab	-
Kane	1 (1.3%)
Millard	-
Morgan	-
Piute	-
Rich	-
Salt Lake	22 (28.6%)
San Juan	-
Sanpete	1 (1.3%)
Sevier	-
Summit	-
Tooele	5 (6.5%)
Uintah	4 (5.2%)
Utah	8 (10.4%)
Wasatch	-
Washington	1 (1.3%)
Wayne	-
Weber	7 (9.1%)

County representation for survey (narrowed down from all counties served to primary or only counties served).	N = 124
Beaver	2 (1.6%)
Box Elder	3 (2.4%)
Cache	6 (4.8%)
Carbon	3 (2.4%)
Daggett	2 (1.6%)
Davis	17 (13.7%)
Duchesne	3 (2.4%)
Emery	-
Garfield	-
Grand	2 (1.6%)
Iron	2 (1.6%)
Juab	-
Kane	1 (0.8%)
Millard	-
Morgan	-
Piute	-
Rich	-
Salt Lake	34 (27.4%)
San Juan	-
Sanpete	1 (0.8%)
Sevier	1 (0.8%)
Summit	-
Tooele	5 (4.0%)
Uintah	7 (5.6%)
Utah	18 (14.5%)
Wasatch	-
Washington	7 (5.6%)
Wayne	-
Weber	10 (8.1%)

Basic Services: Please indicate the level of need for survivors of sexual assault, for each item listed below. N = 116	**Ranking** (Based on Master Score)	Master Score	**Low – Need** Mostly Met	**Medium – Moderate Need**	**High –** Address Within 5 Years	**Critical** – Address Within 1 Year
Transportation n = 116	1	288	13 (11.2%)	56 (48.3%)	25 (21.6%)	22 (19.0%)
Childcare n = 116	2	265	25 (21.6%)	49 (42.2%)	26 (22.4%)	16 (13.8%)
Interpreting Services n = 115	3	251	23 (20.0%)	48 (41.7%)	28 (24.3%)	16 (13.9%)
Medical Care n = 115	4	243	34 (29.6%)	34 (29.6%)	26 (22.6%)	21 (18.3%)
Other (Please Specify) n = 33	5	108	3 (9.1%)	3 (9.1%)	9 (27.3%)	18 (54.5%)

Survivor-Centered Services: Please indicate the level of need for survivors of sexual assault, for each item listed below.	**Ranking** (Based on Master Score)	Master Score	**Low – Need** Mostly Met	**Medium** – Moderate Need	**High** – Address Within 5 Years	**Critical** – Address Within 1 Year
Therapy n = 106	1	258	23 (21.7%)	38 (35.8%)	21 (19.8%)	24 (22.6%)
Support Groups n = 105	2	238	23 (21.9%)	43 (41.0%)	27 (25.7%)	12 (11.4%)
Intervention with Creditor, Employer, Landlord, or Academic Institution n = 105	3	227	30 (28.6%)	40 (38.1%)	23 (21.9%)	12 (11.4%)
Case Management – Linking to Resources n = 108	4	220	30 (27.8%)	44 (40.7%)	20 (18.5%)	14 (13.0%)
Confidential Reporting of Assault or Rape n = 106	5	212	50 (47.2%)	23 (21.7%)	16 (15.1%)	17 (16.0%)
Individual Advocacy (e.g. assistance applying for reparations or accessing services) n = 108	6	208	54 (50.0%)	25 (23.1%)	12 (11.1%)	17 (15.7%)
Sexual Assault Nurse Examiners (SANEs) n = 107	7	203	55 (51.6%)	23 (21.5%)	14 (13.1%)	15 (14.0%)
Information and Referral (e.g. survivor rights, reporting options) n = 107	8	200	52 (48.6%)	30 (28.0%)	12 (11.2%)	13 (12.1%)
Safety Planning n = 108	9	198	53 (49.1%)	32 (29.6%)	11 (10.2%)	12 (11.1%)

Survivor Accompaniment to Forensic/ Medical Examinations n = 106	10	187	55 (51.9%)	31 (29.2%)	10 (9.4%)	10 (9.4%)

Legal / Law Enforcement Services: Please indicate the level of need for survivors of sexual assault, for each item listed below.	**Ranking** (Based on Master Score)	Master Score	**Low – Need** Mostly Met	**Medium** – Moderate Need	**High** – Address Within 5 Years	**Critica**l – Address Within 1 Year
Immigration attorney assistance (e.g. visas, continued presence application, etc.) n = 105	1	259	16 (15.2%)	42 (40.0%)	29 (27.6%)	18 (17.1%)
Civil attorney assistance – protection/ restraining orders n = 107	2	244	31 (29.0%)	34 (31.8%)	23 (21.5%)	19 (17.8%)
Survivor rights – advocacy and enforcement n = 107	3	229	38 (35.5%)	34 (31.8%)	17 (15.9%)	18 (16.8%)
Survivor impact statement preparation assistance n = 106	4	215	39 (30.2%)	40 (37.7%)	12 (11.3%)	15 (14.2%)
Prosecution interview accompaniment (e.g. with prosecuting attorney, survivors, etc.) n = 108	5	211	43 (40.2%)	36 (33.6%)	16 (15.0%)	12 (11.2%)
Notification of court proceedings (e.g. arrest, case status, court proceeding disposition, release, etc.) n = 107	6	208	41 (38.3%)	42 (39.3%)	13 (12.1%)	11 (10.3%)
Assistance with restitution (e.g. requesting and collecting) n = 107	7	207	41 (38.3%)	39 (36.4%)	20 (18.7%)	7 (6.5%)
Accompaniment to meet with law enforcement n = 107	8	204	43 (40.2%)	41 (38.3%)	12 (11.2%)	11 (10.3%)
Accompaniment to court proceedings n = 106	8	204	46 (43.4%)	35 (33.0%)	12 (11.3%)	13 (12.3%)

Barriers to Accessing Services: Please indicate how much you agree or disagree with the following statements.	**Strongly Disagree**	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
There is a limited awareness of services and resources available to sexual assault survivors in my community. n = 108	6 (5.6%)	16 (14.8%)	27 (25.0%)	44 (40.7%)	15 (13.9%)
Survivors do not understand the process of obtaining assistance. n = 108	2 (1.9%)	8 (7.4%)	25 (23.1%)	59 (54.6%)	14 (13.0%)
The process for seeking assistance is overly burdensome for survivors. n = 108	4 (3.7%)	18 (16.7%)	45 (41.7%)	28 (25.9%)	13 (12.0%)
Survivors believe applying for assistance will require them to be involved with a system for longer than they desire. n = 108	-0-	7 (6.5%)	32 (29.6%)	52 (48.1%)	17 (15.7%)
Survivors do not apply for assistance because they believe they will not be eligible. n = 108	-0-	23 (21.3%)	45 (41.7%)	31 (28.7%)	9 (8.3%)
Survivors are concerned their confidentiality may not be preserved. n = 108	-0-	7 (6.4%)	31 (28.7%)	46 (42.6%)	24 (22.2%)
Survivors do not want to be labeled as a victim. n = 108	-0-	9 (8.3%)	34 (31.5%)	41 (38.0%)	24 (22.2%)
Survivors believe the crime is not serious enough to justify reporting. n = 108	1 (0.9%)	22 (20.4%)	54 (50.0%)	22 (20.4%)	9 (8.3%)
Survivors believe the crime is a private matter n = 108	3 (2.8%)	14 (13.0%)	25 (23.1%)	49 (45.4%)	17 (15.7%)
Survivors do not think the local service/advocacy program will help them. n = 108	1 (0.9%)	22 (20.4%)	54 (50.0%)	22 (20.4%)	9 (8.3%)
Survivors believe if they report the crime, they will be blamed or not believed by authorities. n = 108	1 (0.9%)	7 (6.5%)	14 (13.0%)	54 (50.0%)	32 (29.6%)
Survivors want to deal with it on their own terms. n = 107	3 (2.8%)	7 (6.5%)	38 (35.5%)	46 (43.0%)	13 (12.1%)

Population priority of need: Please rank the top five populations in your county, by priority need. Note: You will only be able to select five populations from the list below.	Ranking (Based on Master Score)	Master Score	Frequency Per Population				
			1st Highest Priority	2nd	3rd	4th	5th Lowest Priority
Persons assaulted by an intimate partner n = 90	1	358	43 (47.8%)	21 (23.3%)	14 (15.6%)	5 (5.6%)	7 (7.8%)
Children/teens n = 81	2	352	50 (61.7%)	15 (11.6%)	12 (14.8%)	2 (2.5%)	2 (2.5%)
Persons with limited English proficiency or interpreting needs n = 75	3	230	12 (16.0%)	20 (26.7%)	17 (22.7%)	13 (17.3%)	13 (17.3%)
Persons experiencing homelessness n = 71	4	225	20 (28.2%)	11 (15.5%)	15 (21.1%)	11 (15.5%)	14 (19.7%)
LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning) n = 59	5	174	11 (18.6%)	11 (18.6%)	10 (16.9%)	18 (30.5%)	9 (15.3%)
Immigrants, refugees, asylum seekers n = 52	6	149	10 (19.2%)	11 (21.2%)	4 (7.7%)	16 (30.8%)	11 (21.2%)
University students n = 48	7	144	10 (20.8%)	10 (20.8%)	10 (20.8%)	6 (12.5%)	12 (25.0%)
Persons with disabilities n = 59	8	142	10 (16.9%)	11 (18.6%)	13 (22.0%)	16 (27.1%)	9 (15.3%)
Elder population n = 48	9	141	9 (18.8%)	9 (18.8%)	8 (16.7%)	14 (29.2%)	8 (16.7%)
Native Americans n = 34	10	104	6 (17.6%)	8 (23.5%)	7 (20.6%)	8 (23.5%)	5 (14.7%)
Veterans n = 28	11	80	3 (10.7%)	7 (25.0%)	7 (25.0%)	5 (17.9%)	6 (21.4%)
Polygamous Communities n = 33	12	78	4 (12.1%)	3 (9.1%)	6 (18.2%)	8 (24.2%)	12 (36.4%)
Deaf/hearing impaired n = 26	13	64	2 (7.7%)	3 (11.5%)	7 (26.9%)	7 (26.9%)	7 (26.9%)