Understanding Sexual Victimization

Using Medical Provider Data to Describe the Nature and Context of Sexual Crime in Massachusetts, 2001-2006

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Highlights

This report presents findings from the Provider Sexual Crime Reports (PSCR) between 2001 and 2006 on many aspects of the nature and context of sexual crime in Massachusetts. The following are highlights of these findings:

- Victims of PSCR sexual assaults tended to be young (the average victim age was 24 years) and female (95% of victims were female).

- Over two-thirds of all assailants (68%) were known to the victim and almost all were male (98%).

- As victim age increased for victims ages 12 and up, the share of assaults perpetrated by assailants known to the victim decreased while the share of assaults perpetrated by strangers increased.

- At the time of PSCR filing, very few victims had restraining orders against their assailant(s) in place before the assault (1.5%) or after the assault (5.4%).

- Two hundred and eighty-four Massachusetts communities had PSCR sexual assaults between 2001 and 2006.

- The majority of assaults occurred in a house or apartment (60%).

- The majority of assaults occurred between 10:00pm and 6:00am (59%) with the most commonly reported time being 2:00am.

- Assaults increased during the spring months and peaked in July and August.

- 45% of victims sought medical treatment within 12 hours of the assault, 70% sought treatment within 24 hours, and 98% sought treatment within 5 days (120 hours).

- Verbal threats were the most commonly reported type of force used by the assailants (25%). The use of knives (6%), guns (3%), and blunt objects (2%) were relatively uncommon.

- Victims age 12 to 17 and 65 and older were the most likely to report the assault to the police (both reporting in 83% of cases within these age groups).

- Victims assaulted by a date, friend, or acquaintance were the least likely to report the crime to police. Victims assaulted by a parent's live-in partner, spouse, or ex-spouse were the most likely to report the crime to police.

- For victims under the age of 18, 51A child abuse reports were filed in 48% of cases.

Introduction

Victimization surveys, police reports, public health surveys, and rape crisis center data all contribute to a better understanding of the incidence and prevalence of sexual assault and rape, but no single source of information can provide a complete and comprehensive picture. Most of this information contains limited details on the specific nature and context of sexual assaults and fails to address many important questions. For example, what are the most common victim-assailant relationships? Does reporting to the police vary by relationship to the assailant? What types of force are most frequently used against victims during an assault? Understanding the answers to these and other questions can help further the state of knowledge about contextual aspects of sexual assault in Massachusetts.

Under Massachusetts law, all medical professionals who examine a victim of sexual assault are required to fill out a Provider Sexual Crime Report (PSCR) and forward the report to the Massachusetts Executive Office of Public Safety and Security (EOPSS), where each case is stored electronically (see Appendix for a sample report).

This report, an update of a previous report titled "Understanding Sexual Victimization: Using Medical Provider Data to Describe the Nature and Context of Sexual Crime in Massachusetts, 2001-2004," presents information on sexual victimizations in the Commonwealth of Massachusetts based on an analysis of PSCR data. A total of 6,098 sexual assaults were collected through the PSCR between 2001 and 2006.

The results presented in this report should not be considered a representative sample of sexual assault in Massachusetts, but merely a reflection of the cases in which *a victim sought medical attention* and a medical professional forwarded the information to EOPSS.[1] Although PSCR compliance has improved over the years, there still exists a need to improve medical providers understanding regarding the completion and submission of the PSCR to EOPSS. This report does not present information on the incidence or prevalence of sexual victimization in Massachusetts, as the PSCR does not capture sexual assaults where the victims did not seek medical attention, regardless of whether they reported the crime to the police.

The report first provides contextual information on sexual victimization from both a national and a state perspective. Next, the report provides background on the PSCR and an overview of the dataset. Finally, analyses are presented in four sections:

- *Victim characteristics*, such as the age, gender, and race of the victim
- *Assailant characteristics*, such as the gender of the assailant, relationship (if any) between the assailant and victim, and the number of assailants
- *Nature and specifics of the crime*, including the city of the assault, the time of assault, the surroundings at the time of the assault, and the types of force used by the assailant
- *Reporting the crime*, such as the percent of crimes resulting in a police report, child abuse report, elder abuse report, disabled persons report, or weapon report

[1] For more information on the dataset see "Data Overview" section.

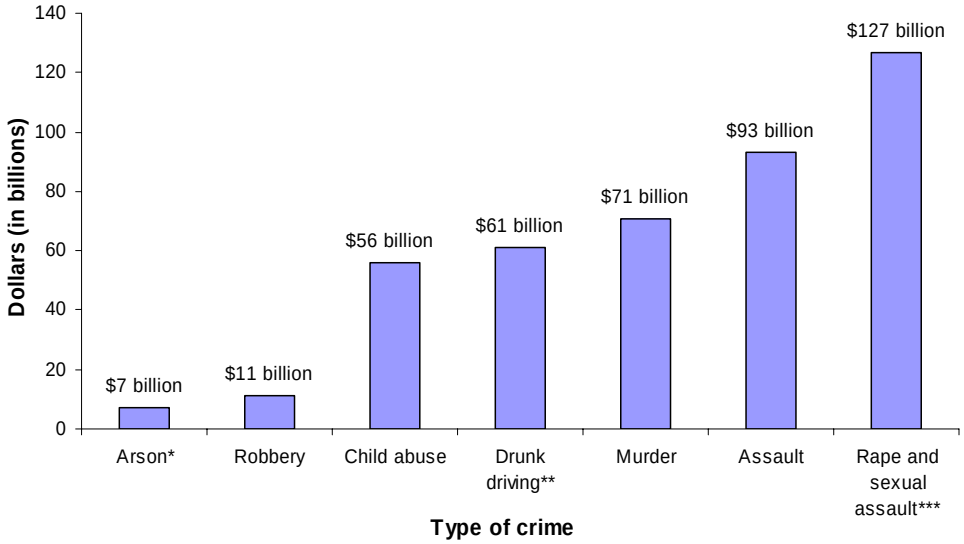
Sexual Victimization: A Key Public Safety Issue

Rape and sexual assault are heinous crimes that have significant, pervasive, and damaging effects. Sexual victimizations are associated with a myriad of economic and societal consequences, such as mental illness, debilitating physical injury, sexually transmitted disease, drug use, and increased risk for other types of crime.[2]

Sexual crime has significant, negative economic costs for both victims and society. A frequently referenced study by the National Institute of Justice (NIJ) found that rape/sexual assault has the highest annual total costs to society of any crime. NIJ estimated the total annual societal costs for rape/sexual assault to be $127 billion, at a rate of $87,000 per victimization.[3] The costs to society associated with rape/sexual assault are more than assault ($93 billion), murder ($71 billion), and child abuse ($56 billion) (see Figure 1).[4]

Figure 1.

Annual societal costs due to crime, 1993



* Includes arson deaths.
** Includes drunk driving deaths.
*** Excludes child abuse.

More recently, data from the 2005 Bureau of Justice Statistics' (BJS) National Crime Victimization Survey (NCVS) found that the total economic loss to victims of rape/sexual assault (which includes costs of medical care, theft, damages, and time lost from work) was $26 million dollars annually, an average of approximately $136 per victim per year.[5] On a state level, a study conducted the Minnesota Department of Health found that sexual assault in Minnesota cost almost $8 billion in 2005, or $1,540

[2] National Center for Injury Prevention and Control website. *Understanding Sexual Violence Fact Sheet*. http://www.cdc.gov/ncipc/factsheets/svfacts.htm. Accessed 01/17/08.
[3] Miller, T.R., Cohen, M.A. & Wiersema, B. (1996). *Victim Costs and Consequences: A New Look.* Washington, DC: U.S. Department of Justice, National Institute of Justice.
[4] Figure 1 is taken substantially from Miller, Cohen, & Wiersema, (1996): pg 17.
[5] Bureau of Justice Statistics. (2006). *Criminal Victimization, 2005*. Washington, DC: US Department of Justice.

per resident. The largest cost was due to the pain, suffering, and quality of life losses of victims and their families. Of the $8 billion, medical care, mental health care, victim work loss, sexually transmitted diseases, unplanned pregnancy, suicidal acts, substance abuse, and victim services cost $1.3 billion. Criminal justice and perpetrator treatment cost approximately $131 million.[6]

Additionally, victims of sexual assault are at increased risk for engaging in a number of negative health behaviors including cigarette smoking, drug use, alcohol abuse, and early sexual experiences.[7] Medical providers consistently note a number of long-term and short-term physical and psychological problems that victims may experience post-assault. Physical effects include bodily injury, chronic pain, headaches, stomach problems, genital trauma, sexually transmitted disease, and unwanted pregnancy.[8] Psychological effects include increased risk of mental illness or psychological disorders such as depression, suicidal thoughts, Post-Traumatic Stress Disorder (PTSD) and Acute Stress Reduction Disorder.[9] Specifically, victims of rape are about six times more likely to suffer from Post-Traumatic Stress Disorder than non-victims (31% vs. 5%) and about three times more likely to suffer from major depression (30% vs. 10%).[10] Other impacts may include strained family and social ties, sleep disturbance, attempted or completed suicide, and high-risk sexual behavior.[11]

In addition to the negative consequences experienced by victims and society, the criminal justice system is significantly impacted by sexual offenders. Offenders of sexual crimes pose a risk both for committing future violent crime and for recidivism of sexual assault. A 1997 Department of Justice (DOJ) report found that within three years of release from incarceration nearly 28% of rapists were re-arrested for another violent crime and about 8% of rapists were re-arrested for another charge of rape.[12] A 2003 Department of Justice (DOJ) report found that sex offenders released from State prisons in 1994 were four times more likely than other releasees to be subsequently arrested for a sex crime (5.3% of sex offenders versus 1.3% of non-sex offenders). Within the first 3 years following their release from prison, 3.5% of released sex offenders were reconvicted for a sex crime. During this same time period, nearly 40% of released sex offenders were returned to prison (either for a new crime or a technical violation of their parole).[13]

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[6] Miller, T.R., Taylor, D.M., & Sheppard, M.A. (2007). *Costs of Sexual Violence in Minnesota*. St. Paul, MN: Minnesota Department of Health, Sexual Violence Prevention Program.
[7] Centers for Disease Control and Prevention website. *Sexual Violence Prevention: Consequences.* http://www.cdc.gov/ncipc/dvp/SV/svp-consequences.htm. Accessed 04/18/08.
[8] National Center for Injury Prevention and Control website. Accessed 01/17/08.
[9] American Medical Association. (1995). *Strategies for the Treatment and Prevention of Sexual Assault.* Chicago, IL: American Medical Association.
[10] Kilpatrick, D.G. & Ruggiero, K.J. (2003). *Rape in Massachusetts: A Report to the Commonwealth*. Charleston, SC: National Violence Against Women Prevention Research Center.
[11] National Center for Injury Prevention and Control website. Accessed 01/17/08.
[12] Greenfeld, L.A. (1997). *Sex Offenses and Offenders: An Analysis of Data on Rape and Sexual Assault.* Washington, DC: US Department of Justice, Bureau of Justice Statistics.
[13] Langan, P.A., Schmitt, E.L., & Durose, M.R. (2003). *Recidivism of Sex Offenders Released from Prison in 1994*. Washington, DC: US Department of Justice, Bureau of Justice Statistics.

Sexual Victimization in the United States

Sexual victimization is one of the most pervasive social problems currently facing society. However, despite substantial progress in relevant research over the last 25 years, gaps still exist in the overall understanding of sexual crime.[14] Therefore, data that furthers our knowledge of the nature of sexual assault is very valuable.

The Federal Bureau of Investigation (FBI) produces an annual publication "Crime in the United States" that compiles volume and rates of crime offenses for the nation. According to "Crime in the United States, 2006", 92,455 forcible rapes were reported to the police at a rate of 30.9 crimes per 100,000 residents.[15] These statistics only reflect crimes where the victim reported the assault to the police and therefore significantly underestimate sexual assault by excluding crimes that are not reported to the police.

Victimization surveys, such as the National Crime Victimization Survey (NCVS), National Women's Study (NWS) and National Violence Against Women Study (NVAWS), track sexual victimization through random, representative, and confidential samples. Survey questions often include whether the respondent had been raped or assaulted during the survey period or during their lifetime, regardless of whether or not the crime was reported to police. In this sense, victimization surveys cast a wider net when quantifying sexual crime and suggest that sexual crime is much more prevalent than police data suggest.

Data from the Bureau of Justice Statistics' (BJS) National Crime Victimization Survey (NCVS) found that in 2006 there were 272,350 victims of sexual assault, a rate of 1.1 per 1,000 people age 12 or older or per 1,000 households. However, of those 272,350 sexual assault victims, only 41.4% reported the assault to the police, making sexual assaults the least likely violent crime to be reported to the police - compared to robbery (56.9%), aggravated assault (59.2%), and simple assault (44.3%).[16]

According to the 1992 *Rape in America* study, which evaluated data from the NWS survey, 13% of all women (approximately one in eight) experienced at least one attempted or completed rape in their lifetime.[17] An NIJ report summarizing results from the NVAWS survey found that 0.3% of all women and 0.1% of all men experienced rape within the year preceding the survey, equating to roughly 395,000 women and men in the United States raped during a 12-month period. The study also found that nearly 18% of women (approximately one in six) and 3% of men (approximately one in thirty-three) had been raped at some time in their life. Thus, based on the U.S. Census estimates of the number of men and women aged 18 and older in the United States during the year of the

[14] Tjaden, P. & Thoennes, N. (2006). *Extent, Nature, and Consequences of Rape Victimization: Findings From the National Violence Against Women Survey*. Washington, DC: US Department of Justice, National Institute of Justice.
[15] Federal Bureau of Investigation. (2007). *Crime in the United States, 2006*. Washington, DC: US Department of Justice.
[16] Bureau of Justice Statistics. (2007). *Criminal Victimization, 2006*. Washington, DC: US Department of Justice.
[17] Kilpatrick, D.G., Edmonds, C.N. & Seymour, A. (1992). *Rape in America: A Report to the Nation.* Arlington, VA: National Victim Center and Medical University of South Carolina.

study, nearly 18 million women and nearly 3 million men in the United States had been raped at some time in their life.[18] It is worth noting that these studies present statistics on the *prevalence* of rape, which reflects the number of individuals who experienced attempted or completed rape. Since many victims are raped more than once in their lifetime, the *incidence* of rape is higher.[19]

Data on sexual victimizations suggest that, in most cases, the assailant is known to the victim. Findings from the 2005 NCVS indicate that victims knew their assailant in 67% of sexual victimizations.[20,21] The 1992 *Rape in America* study estimates that 80% of rape victims knew their assailant.[22] More specifically, the NVAWS study found that female victims knew their assailant in over 83% of cases, and male victims knew their assailant in approximately 77% of cases.[23] Statistics further indicate that sexual victimization usually takes place in a context or location familiar to the victim.[24]

While victimization surveys provide good tools for estimating the prevalence of sexual victimization in the general population, they are by no means perfect. Most surveys are limited to individuals 18 years and older and therefore do not include child victims. Additionally, since most surveys are conducted by phone, survey statistics largely reflect individuals with a phone and by extension, a home.[25]

Importantly, there are very few national statistics that provide contextual detail on the nature of sexual crime. For the most part, researchers are limited to statistics that estimate the prevalence or incidence of sexual assaults. Because data on the context and nature of these crimes are not commonly collected, carrying out analyses is considerably more challenging and, thus, a rare opportunity presented by the PSCR.

Sexual Victimization in Massachusetts

The majority of Massachusetts' data is gathered from police reports and from agencies that provide services to victims, such as rape crisis centers. The FBI's "Crime in the United States, 2006" indicates a total of 1,742 forcible rapes were reported to law enforcement in Massachusetts, at a rate of 27.1 rapes per 100,000 citizens.[26] This is slightly below the national average of 30.9 forcible rapes per 100,000 citizens.

Massachusetts does not currently employ a broad-based victimization survey akin to the NCVS, NWS, or NVAWS that specifically focuses on sexual assault. Limited

[18] Tjaden & Thoennes. (2006).
[19] Kilpatrick, D.G. & Ruggiero, K.J. (2004). *Making Sense of Rape in America: Where Do the Numbers Come From and What Do They Mean?* Charleston, SC: National Crime Victims Research and Treatment Center, Medical University of South Carolina.
[20] Bureau of Justice Statistics. (2006). *Criminal Victimization, 2005*. Washington, DC: US Department of Justice.
[21] The Bureau of Justice Statistics reconfigured their NCVS reports after the 2005 analysis. Reports after this period do not include this calculation.
[22] Kilpatrick et al. (1992).
[23] Tjaden & Thoennes. (2006).
[24] Greenfeld. (1997).
[25] Kilpatrick & Ruggiero. (2004).
[26] Federal Bureau of Investigation. (2007).

information has been available to develop a descriptive analysis of the specific nature or context of sexual victimization in the State. The Massachusetts Department of Public Health's Behavioral Risk Factor Surveillance System (BRFSS) is an annual survey that provides a profile of adult health in Massachusetts. The survey includes questions relating to unwanted sexual contact. Survey data for 2006 indicate that about 15% of women and 7% of men in Massachusetts age 18 to 74 have experienced unwanted sexual contact.[27] These results are echoed by Kilpatrick and Ruggiero's 2003 *Rape in Massachusetts* study, which estimated that 13% of women in Massachusetts, or approximately one in seven, have been, or will be, victims of one or more completed rapes in their lifetime.[28]

The Massachusetts Department of Elementary and Secondary Education, in collaboration with the Centers for Disease Control and Prevention, conducts the Youth Risk Behavior Survey (YRBS) every other year in randomly selected high schools around the Commonwealth. The YRBS polls high school students on the major risk behaviors jeopardizing the health and safety of young people. According to the 2005 YRBS, 10% of Massachusetts high school students reported ever experiencing sexual contact against their will. Females were significantly more likely to report unwanted sexual contact than males (15% vs. 5%). Sexual minority youth (i.e. students who either identify as gay, lesbian, or bisexual) were significantly more likely than other students to report having experienced sexual violence against their will.[29]

Seventeen Rape Crisis Centers (RCCs) as well as Llamanos, the statewide Spanish-language helpline, collect data on individuals using their services. RCC data indicate a total of 2,582 unduplicated reports of sexual assault for the period July 1, 2005 through June 30, 2006; 93% of which involved female victims. The majority of crimes were perpetrated by someone who was known to the victim (84%) with the most common perpetrators being friends and acquaintances (34% of all assaults).[30] Of particular interest for this report is that only 51% of victims who sought help through the RCCs or Llamanos also sought medical attention for the assault (of the 75% who provided information on medical attention). This parallels NCVS data, which indicates that most injured rape, attempted rape, and sexual assault victims do not receive treatment for their injuries. Furthermore, this reaffirms that PSCR data may only capture a portion of all sexual assaults in Massachusetts.

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[27] Wooley, L., Hawk, H., Kang, E., Keyes, S., Mouradian, V., & Zhang, Z. (2008). *A Profile of Health Among Massachusetts Adults, 2006*. Boston, MA: Massachusetts Executive Office of Health and Human Services, Department of Public Health.

[28] Kilpatrick & Ruggiero. (2003).

[29] Massachusetts Department of Elementary and Secondary Education. (2006). *2005 Youth Risk Behavior Survey*. Boston, MA: Massachusetts Department of Elementary and Secondary Education.

[30] Massachusetts Department of Public Health website. *Rape and Sexual Assault in Massachusetts, 2005-2006*. http://www.mass.gov/Eeohhs2/docs/dph/com_health/violence/survivor_factsheet_05_06.pdf. Accessed 02/07/08.

Dataset Overview

This report analyzes data from the Provider Sexual Crime Report (PSCR). Developed by a multidisciplinary committee in 2000, the PSCR data tracking form collects information from cases where an individual sought medical treatment for a sexual assault. Massachusetts law requires medical providers who treat sexual assault victims to report details about the crime to the Executive Office of Public Safety and Security (EOPSS) and to local law enforcement. This is done in order to alert law enforcement of possible unreported crimes in their jurisdiction.[31, 32]

PSCR forms are distributed to all hospitals in the State along with evidence collection kits, appropriated by an annual line item in the Massachusetts budget. Upon examining a victim and collecting information based on the victim self-report, medical professionals fax or mail the completed form to the EOPSS. Information from the form is manually entered into an SPSS database for analysis. The data elements in this dataset are unique, as they include information reported by medical professionals and they provide information on some cases that are not reported to the police. Data collected on the PSCR do not include victim name, address, or any other identifying information.

It is important to note that PSCR forms were developed specifically for adolescent and adult victims (age 12 years and over) and were only completed for victims under the age of 12 when a medical professional chose to use an adolescent/adult evidence collection kit on a young child. Therefore, youth victims under the age of 12 will be underrepresented in this report. In 2005, it was decided that PSCR data should be tracked for *all* sexual assaults committed on youth under the age of 12, and a separate form was specially designed for this population (called a Pediatric Provider Sexual Crime Report form). The Pediatric PSCR was specifically designed with more limited data fields to discourage medical professionals from obtaining detailed information about the abuse/assault from a child because this information is best obtained by a specially trained forensic interviewer. The Pediatric PSCR collects data on all youth victims under the age of 12 who are examined by a medial professional (including those who had an evidence collection kit and those that did not). These cases will be excluded from analysis in particular data sections, where indicated, as such data is not collected on the Pediatric PSCR.[33]

[31] MGLC 112§ 12 ½. Massachusetts General Court website. http://www.mass.gov/legis/laws/mgl/112-12a.5.htm. Accessed 6/10/06.

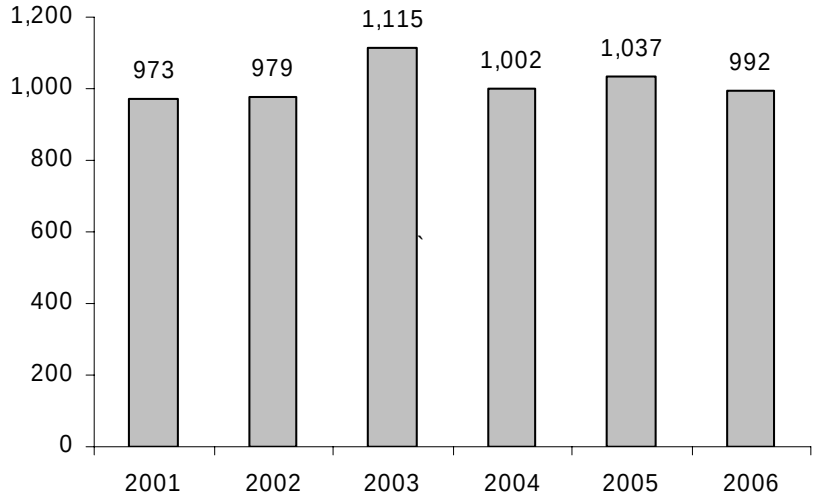
[32] The Massachusetts Executive Office of Public Safety mandated that all forms be centralized at the EOPSS offices instead of the Criminal History Systems Board, which is an EOPSS agency. Currently, the Research and Policy Analysis Division at EOPSS compiles all PSCR forms.

[33] For a more in-depth analysis on youth victims, please see the Executive Office of Public Safety and Security's report titled "Youth Victims of Sexual Assault: Using Medical Provider Data to Describe the Nature and Context of Sexual Crime Perpetrated on Youth Victims".

The analyses presented in this report reflect 6,098 individual cases of sexual assault between January 2001 and December 2006 (see Figure 2).[34] Each case reflects one individual seeking medical treatment for a sexual assault. For purposes of this report only, all sexual assaults collected through the PSCR form will be referred to as "PSCR sexual assaults".

Figure 2.

Number of PSCR sexual assaults by year, 2001-2006



[34] Includes only those cases where the victim reported the date of assault.

Victim Characteristics

The PSCR captures several demographic characteristics of the victim including gender, age, and race.

Gender

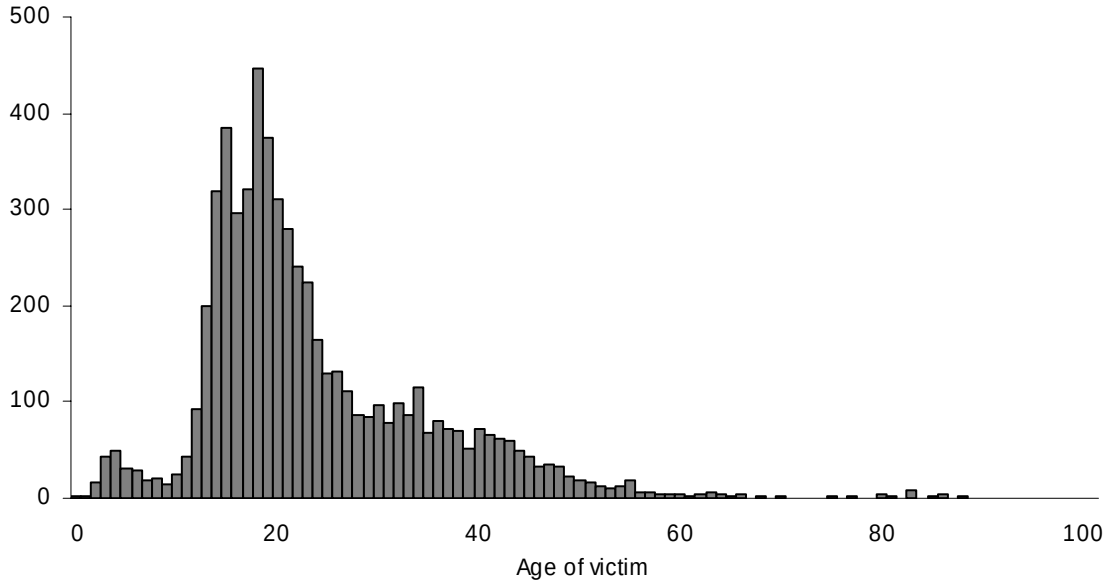
The majority of victims were female (95%). Approximately 4% of victims were male and less than 1% reported being transgender. Gender was unknown in approximately 1% of cases.

Age

There is significant variation in the age of victims of sexual assault. As shown in Figure 3, victim age ranged from less than one year to 101 years of age.[35] The median age was 20 years, indicating that 50% of all victims in the PSCR database were under the age of 20. The average victim age was 24 years and the modal age (the most commonly reported age) was 18 years. Approximately 31% of victims were 17 years or younger; about 5% were 11 or younger. Male victims were slightly younger than female victims; the mean age of male victims was 23 years, while the mean age of female victims was 24 years. It is important to note that prior to June 2006, data were not collected on all PSCR victims under the age of 12 and, as such, victims under the age of 12 may be underrepresented in this analysis.[36]

Figure 3.

Age of victim, 2001-2006



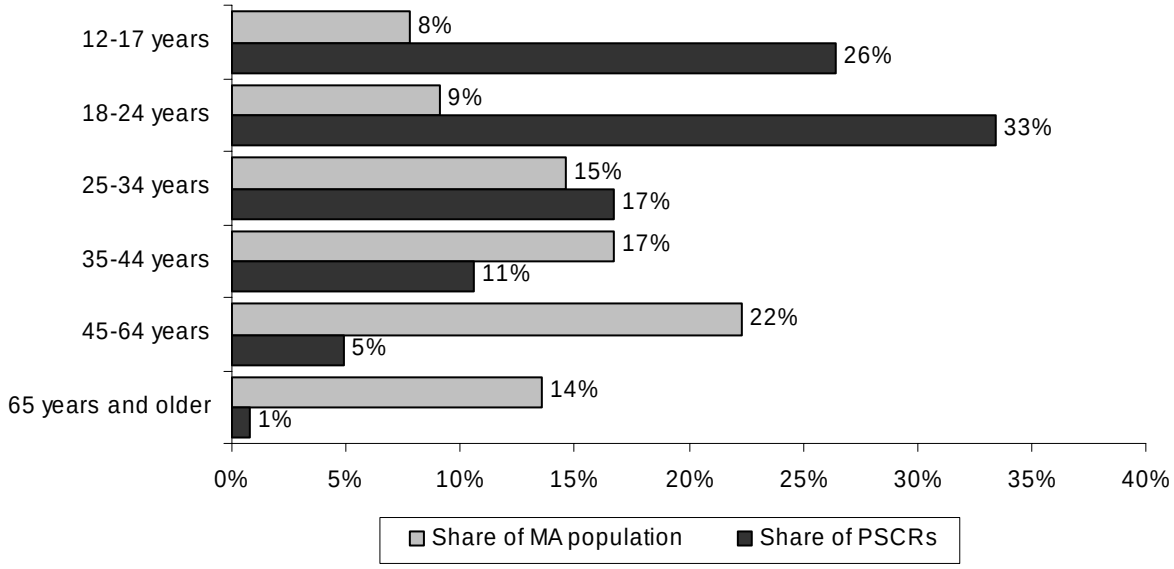
[35] Includes only those cases where the age of victim is indicated.
[36] See the data overview section for a more detailed explanation.

In order to further explore the relationship between victim age and sexual assault, PSCR assaults for selected age groups were compared to the Massachusetts population based on data from U.S. Census 2000 (Figure 4).[37] As data were not collected on all PSCR sexual assault victims under the age of 12 prior to June 2006, any comparisons to the Massachusetts population for this age group will be misleading. As such, we have left victims under the age of 12 out of this analysis.

For the age groups 12-17 and 18-24, there was a disproportionate share of sexual assaults compared to the general population.[38] For example, 12-17 year olds accounted for 8% of the population, but 26% of PSCR sexual assaults. Conversely, the share of victims 45 years and older is smaller compared to the general population. For example, 45-64 year olds accounted for 22% of the population but only 5% of PSCR sexual assaults.

Figure 4.

Share of PSCR sexual assaults and Massachusetts population by age, 2001-2006



[37] Population figures from U.S. Census Bureau website. *U.S. Census 2000, Summary File 1*. http://www.census.gov/Press-Release/www/2001/sumfile1.html. Accessed 12/01/08

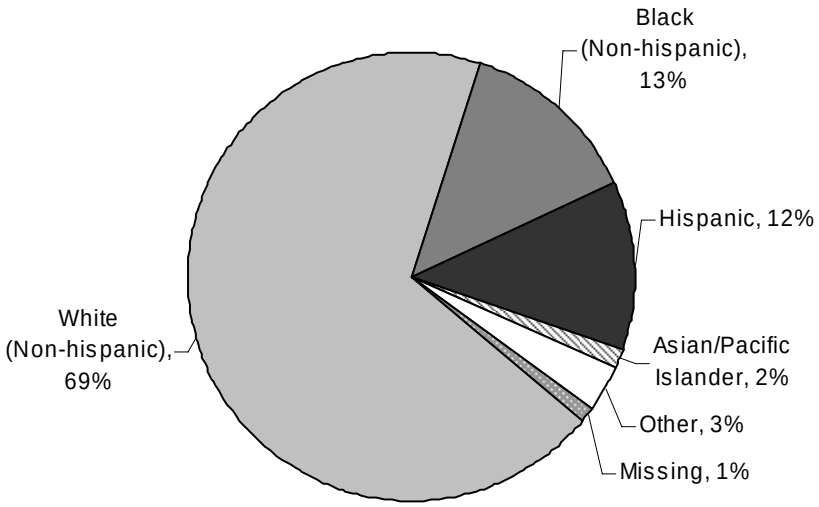
[38] Includes only those cases where the age of victim is indicated.

Race

The majority of victims in the PSCR database (69%) self-reported as White (non-Hispanic). Black (non-Hispanic) victims made up 13% of all victimizations and Hispanic victims made up 12% of the total (Figure 5). Comparisons of the race of the victim to the general population are not possible due to differences in categories on the PSCR form and those collected by the U.S. Census.

Figure 5.

Race of victim, 2001-2006



Assailant Characteristics

The PSCR form includes several data fields regarding sexual assailants, such as gender, the number of assailants involved in the assault, victim-assailant relationship, and whether a restraining order existed before and/or after the assault.

Gender

Almost all assailants were male (98%) and a small share of assailants were female (2%) (Table 1).[39,40] Six percent of male victims were assaulted by a female assailant and two percent of female victims were assaulted by a female assailant.

Table 1.

Gender of assailant, by victim gender, 2001-2006

	Male assailant	Female assailant
ALL VICTIMS	98%	2%
Female victims	98% (n=5,125)	2% (n=89)
Male victims	94% (n=219)	6% (n=13)

[39] Includes only those cases where the gender of both the victim and assailant are indicated.
[40] The table does not include 3 cases where the victim identified their gender as "transgender".

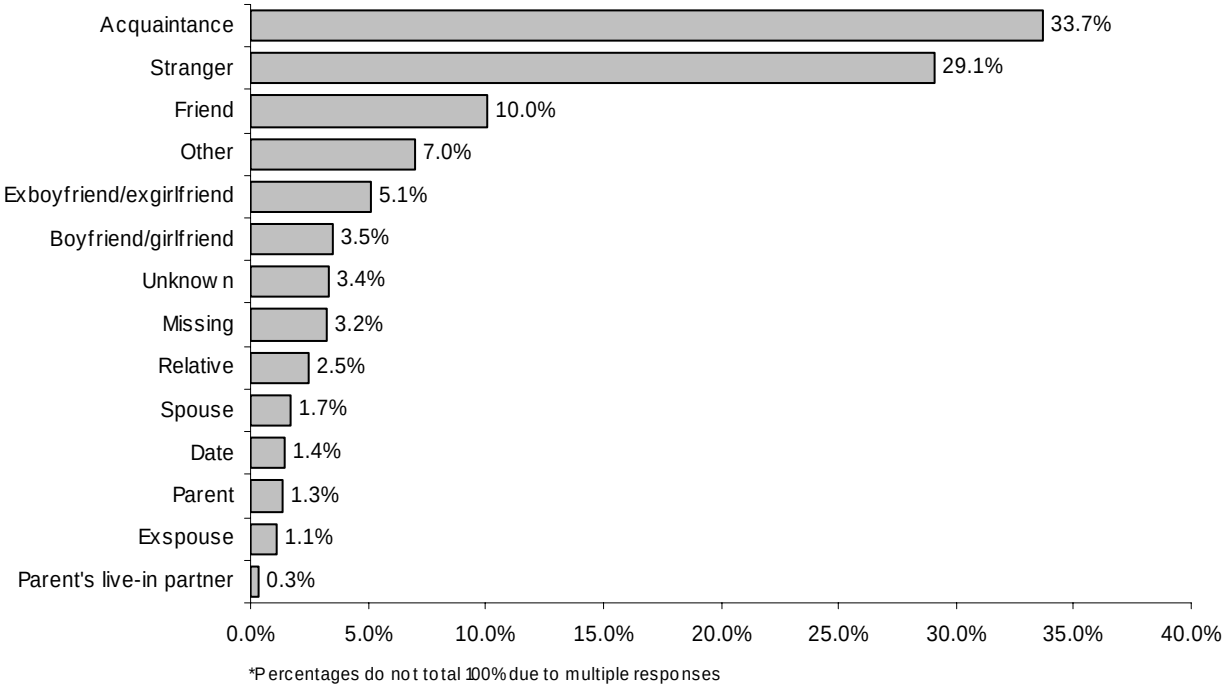
Victim-Assailant Relationship

Victims are asked about their relationship to the assailant(s) during medical exams. Data were analyzed to determine the most commonly reported relationship types (Figure 6).[41] It is important to note that the relationship types listed below are not mutually exclusive as a number of cases involving multiple assailants included more than one relationship type (i.e. two assailants: one "stranger", one "friend").

The most commonly reported relationship type was "acquaintance" (33.7%). The least commonly reported relationship type was "parent's live-in partner" (0.3%). Approximately 30% of assaults were reported to be perpetrated by a "stranger" or "unknown assailant".[42] Another way to summarize the information in Figure 6 is to say that in more than two-thirds of incidents (67.6%) the assailant was known to the victim.[43]

Figure 6.

Victim-assailant relationship, 2001-2006*



*Percentages do not total 100% due to multiple responses

[41] The 58 pediatric PSCRs were removed from analysis because questions regarding victim-assailant relationship are not included on the form.

[42] The "unknown" category refers to assailants that the victim was unable to identify. Thus, this term does not necessarily refer to a "stranger."

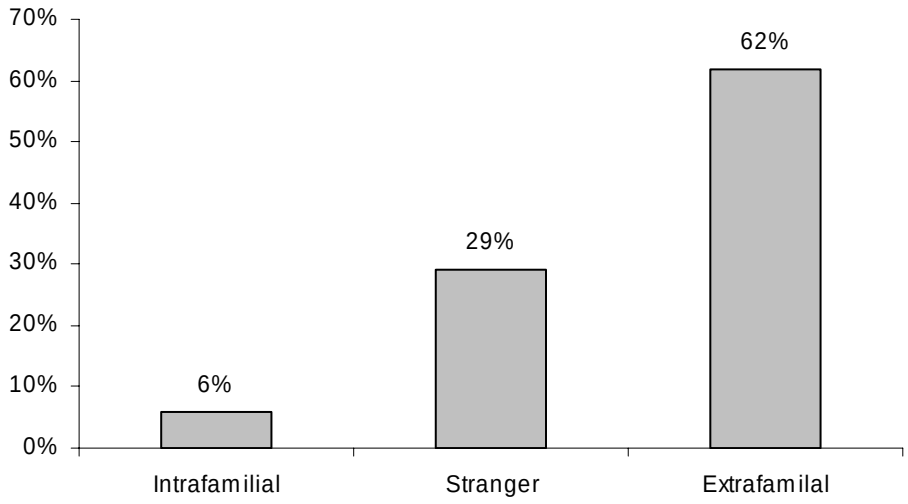
[43] The "other" category refers to assailants known to the victim, and captures relationship types not listed on the PSCR form. Examples of "other assailants" include: teacher, inmate, babysitter, neighbor, and co-worker.

In order to understand the nature of victim-assailant relationships more generally, relationship types were collapsed into three general categories - "intrafamilial," "extrafamilial," and "stranger." The intrafamilial category includes parents, relatives, spouses, and parent's live-in partners. The extrafamilial category includes ex-spouses, boyfriends/girlfriends, ex-boyfriends/girlfriends, friends, acquaintances, and dates. The stranger category includes only strangers.[44,45]

Figure 7 shows that the most common victim-assailant relationship category was extrafamilial (62%), followed by stranger (29%). Assaults by intrafamilial assailants were relatively uncommon (6%).[46]

Figure 7.

Victim-assailant relationship categories, 2001-2006*



*Percentages do not toatal 100% due to multiple responses and cases where the victim-offender relationship type was missing or unknown

[44] The three relationship categories do not include cases where the victim did not identify an assailant relationship type ("missing") or those cases where the victim-assailant relationship type was unknown ("unknown").

[45] The three relationship categories are not mutually exclusive as a number of cases involving multiple assailants included more than one relationship type.

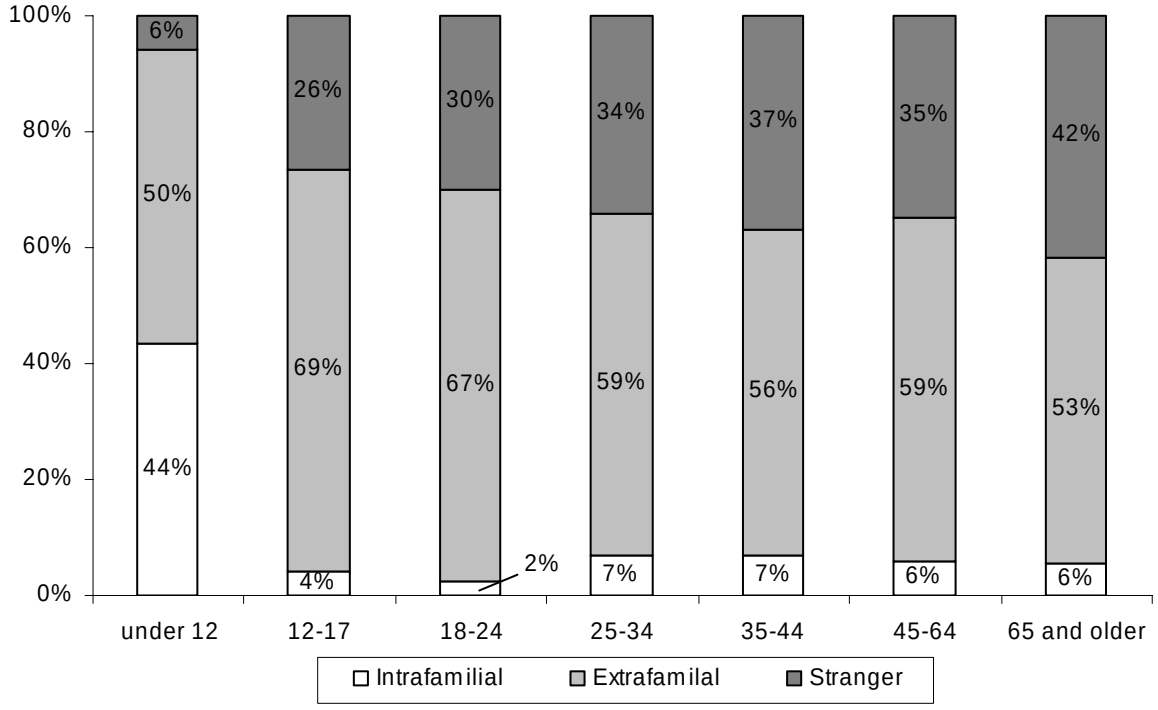
[46] The 58 pediatric PSCRs were removed from analysis because questions regarding victim-assailant relationship are not included on the form.

The data were analyzed to determine the most common relationship type for victim age groups, as it is possible that victim age affects victim-assailant relationships.[47] As Figure 8 shows, victims under the age of 12 were almost as likely to be assaulted by a family member as they were by an extrafamilial assailant (44% vs. 50% of all victims under the age of 12).[48] For the remaining age groups, sexual assaults by family members were much less frequent, ranging from 2% to 7%.

Victims in all age groups were most commonly assaulted by extrafamilial assailants (ranging from 50% to 69% for all victims). However, as victim age increased for victims ages 12 and older, the share of assaults perpetrated by extrafamilial assailants decreased. Conversely, as victim age increased, the share of assaults perpetrated by strangers increased. For example, only 6% of assaults where the victim was under the age of 12 were perpetrated by a stranger, compared to 42% of assaults where the victim was 65 years or older.

Figure 8.

Victim-assailant relationship categories by age group, 2001-2006*



*Percentages do not total 100% due to rounding.

[47] Includes only those cases where both the victim age and victim-assailant relationship are identified.
[48] Prior to June 2006 data were not collected on all PSCR victims under the age of 12 and, as such, victims under the age of 12 may be underrepresented in this analysis.

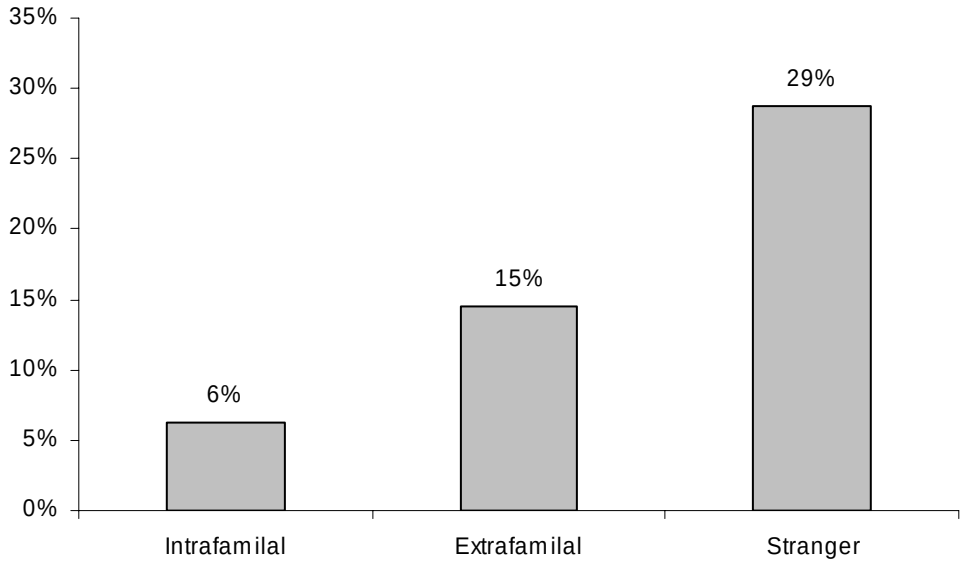
Number of Assailants per Assault

The number of assailants involved in an assault is another piece of information collected by the PSCR.[49] In cases where victims identified the assailant(s), the number of assailants ranged from one to 35. While the majority of cases involved only one assailant per incident (84%), a significant share of cases (16%) involved more than one assailant.

The number of assailants varied by victim-assailant relationship (Figure 9).[50] Twenty-nine percent of PSCR sexual assaults that involved more than one assailant involved a stranger. Assaults where the assailant was a family member were the least likely to involve more than one assailant (6%).

Figure 9.

Victim-assailant relationship categories by assaults involving more than one assailant, 2001-2006



Restraining Orders

A very small percent of victims had restraining orders against the assailant prior to the assault (1.5%). The share of restraining orders against the assailant filed after an assault (at the time of PSCR filing) more than tripled compared to those filed before an assault (5.4%).[51]

[49] The 58 pediatric PSCRs were removed from analysis because questions regarding the number of assailants are not included on the form.

[50] As previously mentioned, the three relationship categories are not mutually exclusive as a number of the cases involving multiple assailants included more than one relationship type.

[51] The 58 pediatric PSCRs were removed from analysis because questions regarding restraining orders are not included on the form.

Geographic and Other Characteristics

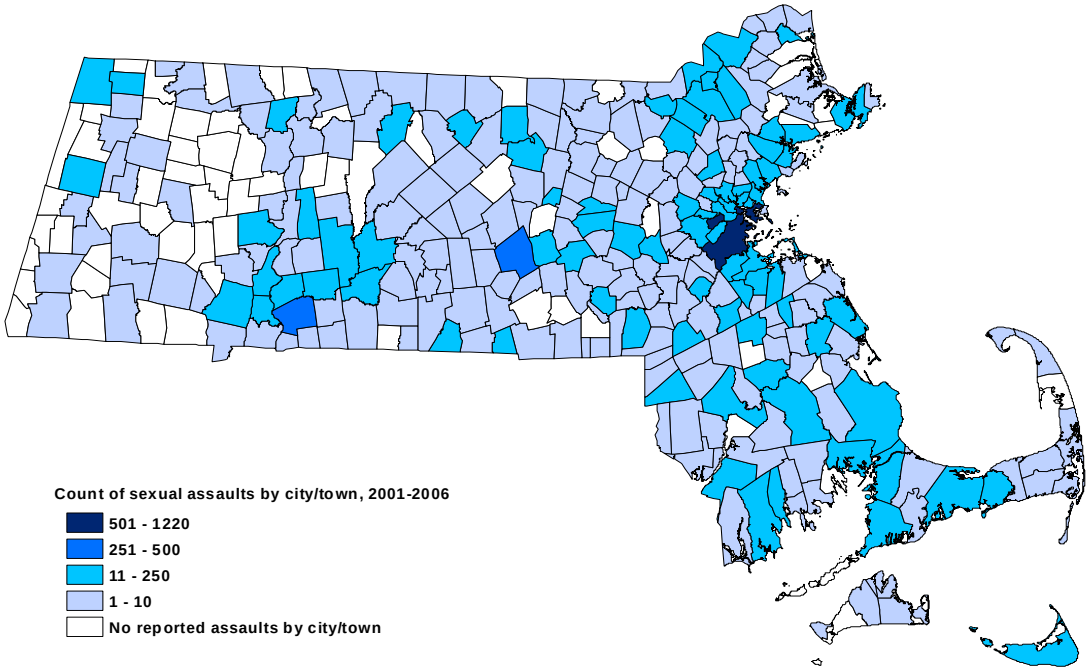
The PSCR data is different from many other data sources because it provides detailed information on geographic and other sexual assault characteristics (such as time of day and month of assault, types of force used during assault, and injuries sustained).

City/Town of Assault

Two hundred and eighty-four Massachusetts cities/towns had PSCR sexual assaults between 2001 and 2006 (or 81% of Massachusetts cities/towns). A total of 5,723 assaults are shown on the map below.[52] The map displays the distribution of PSCR sexual assaults in Massachusetts between 2001 and 2006.

Map 1.

Count of Sexual Assaults by Massachusetts City/Town, 2001-2006



[52] Only assaults that occurred in Massachusetts cities/towns are displayed on the map. Not included on the map are 97 assaults where the city/town was unknown and 63 assaults where the city/town was located outside of Massachusetts.

Table 2 shows the ten communities with the highest number of sexual assaults collected through the PSCR between 2001 and 2006. As one would expect, the most populous cities had the highest number of PSCR sexual assaults between 2001 and 2006, with Boston experiencing the greatest number PSCR sexual assaults (1,220).[53] The PSCR form includes a field for victims to identify the specific Boston neighborhood in which the assault took place. Many of the cases did not identify a Boston neighborhood (459). Of those cases where a Boston neighborhood was identified, Dorchester had the largest number of assaults (263), followed by Roxbury (90), and Jamaica Plain (54).

Table 2.

Top ten communities by count of PSCR sexual assaults, 2001-2006

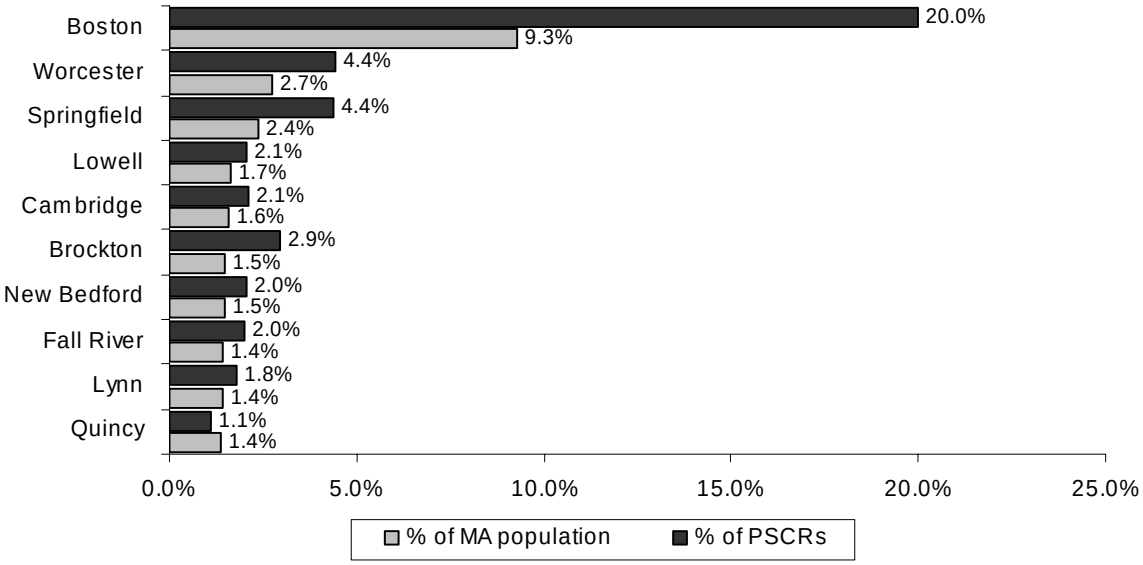
	Population	PSCR sexual assaults 2001-2006
Boston	590,763	1,220
Worcester	175,454	270
Springfield	151,176	268
Brockton	94,191	179
Lawrence	70,662	168
Cambridge	101,365	129
Lowell	103,229	127
New Bedford	92,538	125
Fall River	91,474	123
Lynn	87,991	108

[53] Population figures from U.S. Census Bureau website. Accessed 12/01/08.

After controlling for population, Massachusetts' most populous cities accounted for a disproportionate share of sexual assaults (Figure 10). Boston is the most dramatic example accounting for approximately 20% of reported sexual assaults, but only 9.3% of the State's population.[54] The reasons behind these disproportions are unknown and could be the result of several factors such as ease of access to medical care, the share of young people in the population, or training of medical professionals.

Figure 10.

Ten largest cities in Massachusetts and share of PSCR sexual assaults, 2001-2006



Massachusetts cities account for a disproportionate share of other types of violent crime in addition to sexual assaults. However, this effect appears to be less pronounced for sexual assaults compared to other violent crimes. Table 3 presents the total share of violent crime in the ten largest Massachusetts cities, according to the 2006 Uniform Crime Report (UCR). The table also contains each city's share of the total state population according to the 2000 U.S. Census. For example, Boston accounted for 9% of the State population, but 16% of forcible rape, 21% of aggravated assault, 35% of robbery, and 41% of murder.

Table 3.
Ten largest cities and share of UCR violent crime, 2006[55]

	Share of population	Forcible rape	Aggravated Assault	Robbery	Murder/Non-negligent homicide
Boston	9%	16%	21%	35%	41%
Worcester	3%	7%	5%	5%	3%
Springfield	2%	7%	7%	9%	8%
Lowell	2%	2%	3%	3%	7%
Cambridge	2%	1%	1%	3%	1%
Brockton	1%	3%	5%	3%	4%
New Bedford	1%	3%	4%	4%	4%
Fall River	1%	3%	4%	4%	2%
Lynn	1%	2%	3%	3%	2%
Quincy	1%	1%	1%	1%	2%

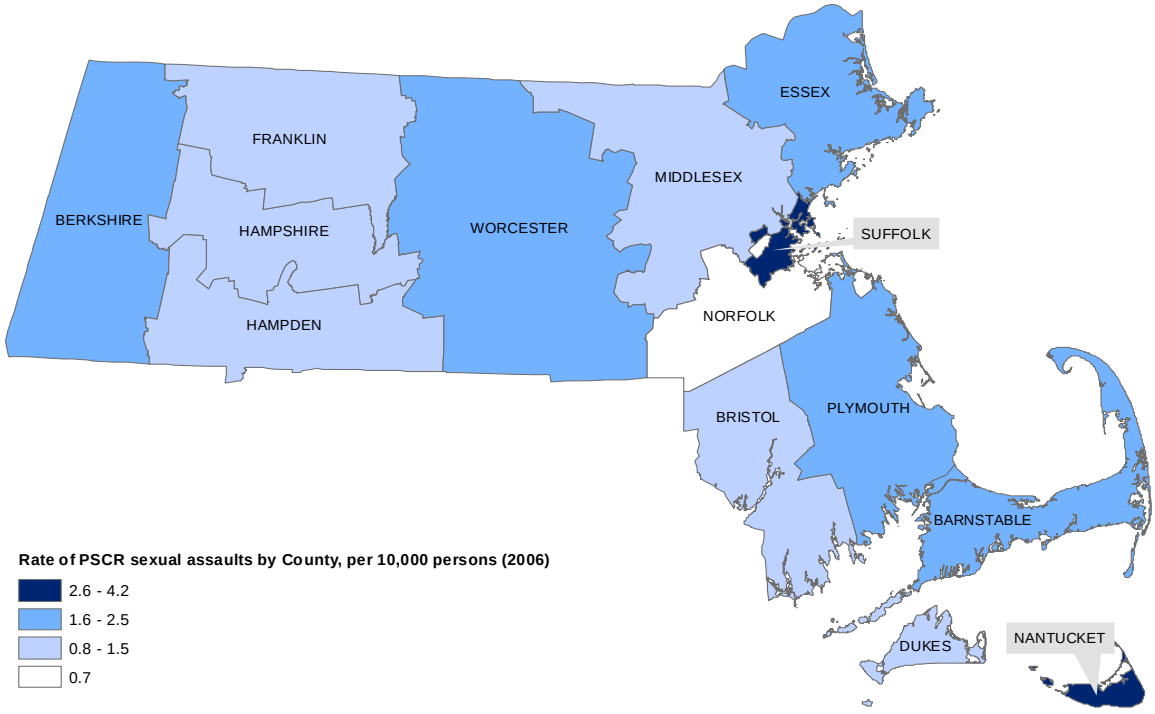
[54] Population figures from U.S. Census Bureau website. Accessed 12/01/08
[55] Massachusetts State Police, Crime Reporting Unit. (2007).

The previous analyses show counts of PSCR sexual assaults. The following maps show PSCR sexual assault rates. Rates were only calculated for the most recent year of data (2006) using U.S. Census 2000 population figures.[56] Rates are used to make comparisons among different cities and counties. However, very small counts of assaults coupled with small community populations can inflate rates and thus be very deceiving.

Map 2 indicates that, in 2006, Nantucket and Suffolk Counties experienced the highest sexual assault rates per 10,000 persons (rates of 4.2 and 3.4 per 10,000 persons, respectively). It should be noted that Nantucket County had 4 PSCR sexual assaults in 2006, but because of their small population (9,520) had a very high rate.[57] By comparison, Suffolk County had a total population of 689,807 residents and had 232 PSCR sexual assaults.

Map 2.

Rate of PSCR Sexual Assaults by Massachusetts County (2006)



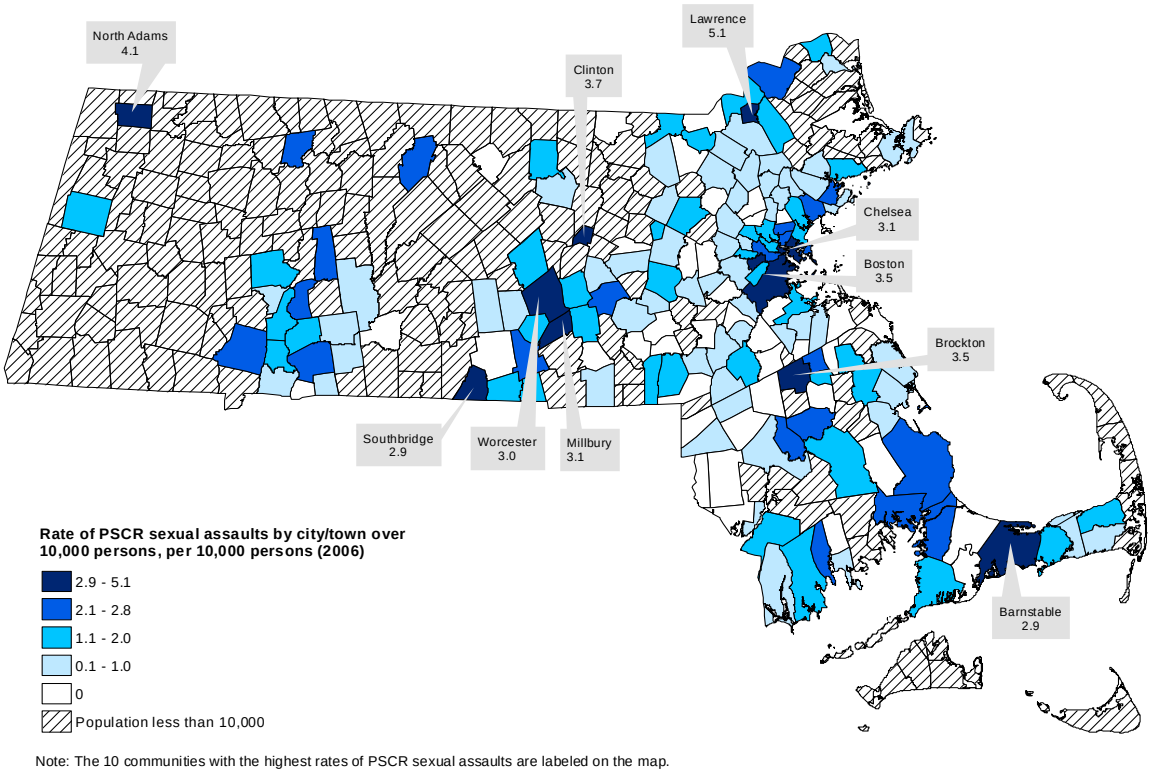
[56] Total number of PSCR sexual assaults in 2006 was 940.

[57] As discussed in the previous paragraph, very small counts of assaults combined with small community populations can inflate rates and thus be very deceiving.

In an effort to diminish the impact of very small city/town populations with very small counts of sexual assaults, map 3 only shows the distribution of 2006 PSCR sexual assault rates in cities/towns with populations over 10,000 persons. The 10 communities with the highest PSCR sexual assault rates are labeled on the map. Lawrence experienced the highest rate of PSCR sexual assault (5.1), followed by North Adams (4.1), and Clinton (3.7).

Map 3.

Rate of PSCR Sexual Assaults by Massachusetts City/Town with populations over 10,000 (2006)



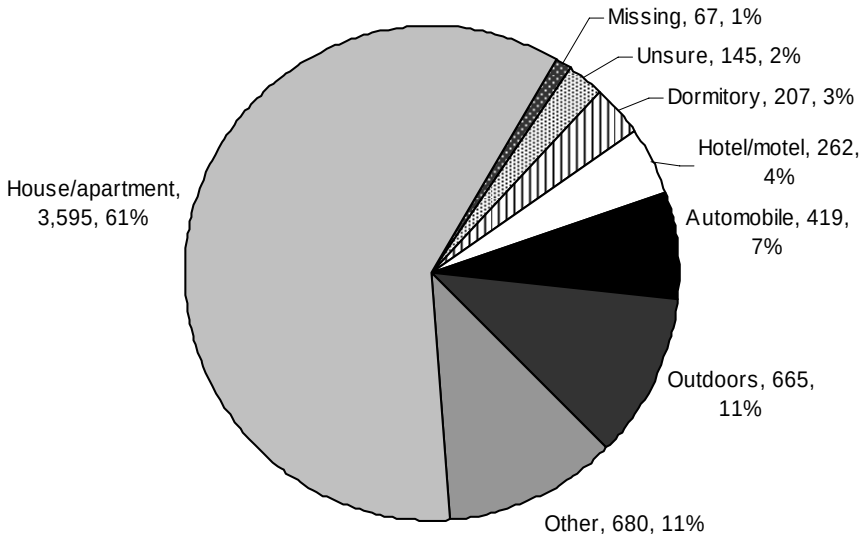
Note: The 10 communities with the highest rates of PSCR sexual assaults are labeled on the map.

Assault Surroundings

PSCR forms ask victims about the surroundings at the time of the assault. As shown in Figure 11, the majority of victims indicated that the assault took place in a house or apartment (61%). Outdoors (11%) and automobiles (7%) were also frequently reported surroundings at the time of assault. Victims identified other surroundings in 11% of cases, which include places such as hospitals, jails, nursing homes, and schools.

Figure 11.

Surroundings at time of assault, 2001-2006

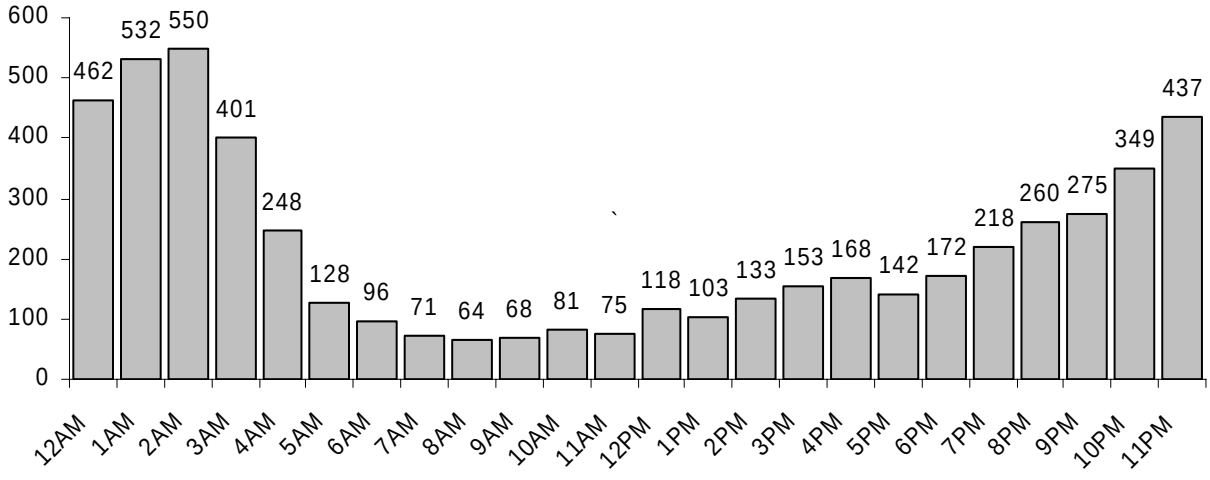


Time of Assault

The PSCR also includes data on the time of the assault. An analysis of the time of assault indicates that most sexual assaults occurred during the late evening or early morning hours. The most commonly reported time of assault was between 2:00AM and 3:00AM. As shown in Figure 12, assaults peaked between 12AM and 2AM, decreased during the early morning and afternoon, and began to increase again during late evening hours.

Figure 12.

Time of assault, 2001-2006



Data from the PSCR allow us to calculate the time between assault and the time of exam (Table 4).[58] The median time between assault and exam was 14.3 hours. Forty-five percent of victims were examined within 12 hours of the assault and 70% within 24 hours. Approximately 98% of exams were administered within 120 hours.

Table 4.

Hours between assault and exam, 2001-2006

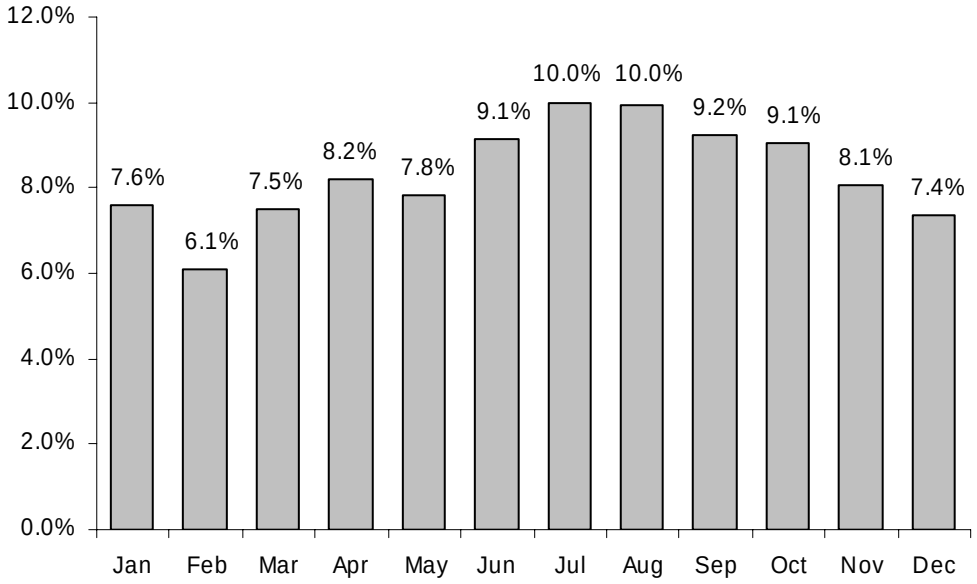
Number of hours	Percent of total exams administered
12 hours	45%
24 hours	70%
36 hours	79%
48 hours	85%
72 hours	93%
120 hours	98%

Month of Assault

Figure 13 suggests that there is a seasonal effect on PSCR sexual assaults. Assaults began to increase in June and peaked in July and August. Forty-seven percent of reported sexual assaults occurred between the months of June and October.

Figure 13.

Month of assault, 2001-2006

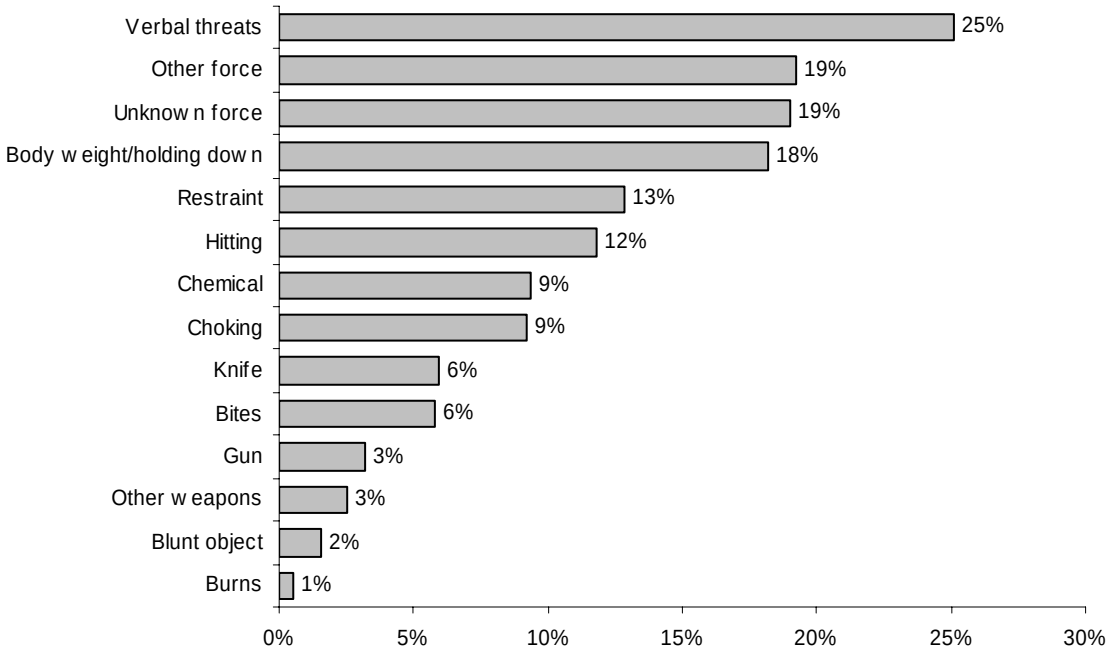


[58] Includes only those cases with a finite assault date, assault time, exam date, and exam time.

Types of Force

The PSCR dataset provides detailed data on the type of force used against the victim.[59] Verbal threats were the most commonly reported type of force, reported in 25% of the cases (Figure 14). Other force (19%)[60], threats of an unknown weapon (19%), and the use of body weight/holding down (19%), were the next most frequently reported types of force used. The use of weapons such as knives (6%), guns (3%), other weapons (3%), and blunt objects (2%) was rare relative to the above mentioned types of force. Chemical force, such as Rohypnol or other "date rape" drugs, was reported in 9% of sexual assaults. It is important to note that the types of force listed below are not mutually exclusive as a number of cases involved multiple types of force.

Figure 14.
Type of force used, 2001-2006*



* Percentages total more than 100% due to multiple responses

Injuries Sustained

The PSCR form asks whether the victim received any injuries that resulted in bleeding or if the victim inflicted any injuries upon the assailant that resulted in bleeding.[61] In 21% of cases, the victim received injuries that resulted in bleeding and in 13% of cases the victim was unsure of injuries received. Victims reported inflicting injury upon the assailant in 3% of assaults and were unsure of whether they inflicted injury in 30% of assaults. In only 1.4% of cases did victims report injuries that resulted in bleeding both to themselves and the assailant.

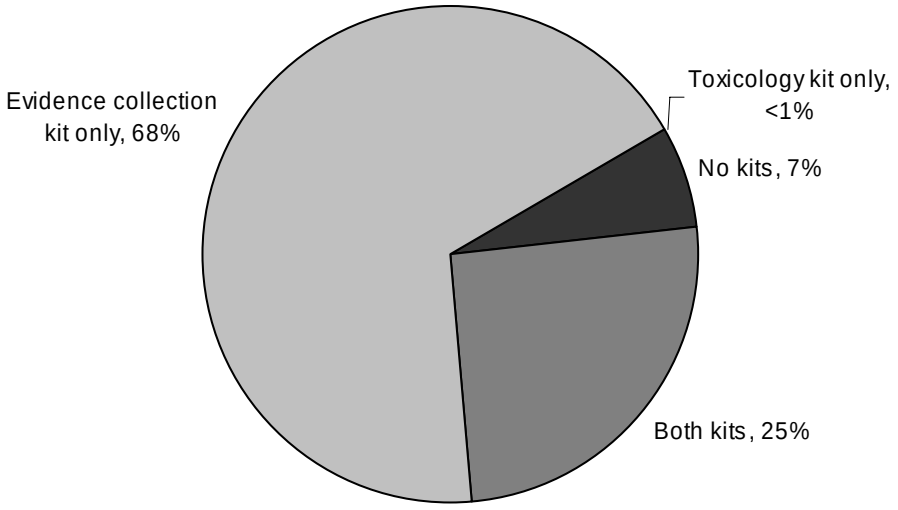
[59] The 58 pediatric PSCRs were removed from analysis because questions regarding type of force are not included on the form.
[60] Examples of "other force" include hair pulling, pushing, kicking, and dragging.
[61] The 58 pediatric PSCRs were removed from analysis because questions regarding injuries sustained are not included on the form.

Evidence Collection

Upon seeking medical treatment, the health care provider may gather evidence from the victim (with consent) that can be used for prosecutorial purposes. Evidence collection may include gathering hair and/or bodily fluid samples, photography of wounds, toxicology, and blood samples. Two methods of evidence gathering can be used, separately or in tandem: evidence collection kits and toxicology kits. Evidence collection kits gather forensic evidence for prosecutorial purposes. Toxicology kits investigate if there is any indication that the assault was facilitated by drugs or other chemicals.

Figure 15 shows the frequency of kits used during exams from 2001-2006.[62] A kit was used to gather evidence in approximately 93% of cases. Approximately 68% of exams included evidence collection kits only, 25% of exams included both an evidence collection kit and toxicology kit, 7% of exams did not include either kit, and less than one percent of exams included a toxicology kit only (.3%).

Figure 15.
Percent of PSCR sexual assaults by evidence collection and toxicology kits, 2001-2006



[62] Includes only those cases where an answer to "evidence collection kit completed" and "toxicology kit completed" was indicated.

Sexual Assault Nurse Examiner (SANE)

The Sexual Assault Nurse Examiner (SANE) program provides coordinated and expert forensic services to victims of sexual assault of all ages. Available 24-hours per day, SANE nurses are intensively trained in medical-legal examinations and forensic evidence collection that serve to increase the likelihood of prosecution of assailants. SANE nurses provide care to victims of sexual assaults in the critical hours following the assault and are responsible for examinations, treatment, evidence collection, and referrals. In addition, the SANE program provides outreach and training to both SANE sites and non SANE sites on evidence collection protocols and treatment options for patients.

The SANE program is currently implemented in 25 hospital-based emergency departments and urgent care centers and 8 pediatric sites in Massachusetts. SANE nurses examined 36% of PSCR sexual assault victims (approximately 1 in 3).[63]

[63] Seventeen hundred and five cases were removed from analysis because questions regarding examination by SANE staff were not included on older versions of the PSCR form. The PSCR program began collecting this data in 2002.

Reporting the Assault

The PSCR form collects data on whether the assault was reported to the police, and whether several mandatory reports including child and elder abuse reports, disabled persons reports, and weapon reports were completed. In the case of youth victims, the decision to report to the police is usually made by the parent or legal guardian. In cases where teen victims seek medical treatment without parental involvement, they decide whether or not to report the assault to the police.

Reporting to Police

Not all PSCR sexual assault victims report the assault to the police. Between 2001 and 2006, an average of 72% of PSCR victims indicated that they reported their assault to the police.[64]

Table 5.

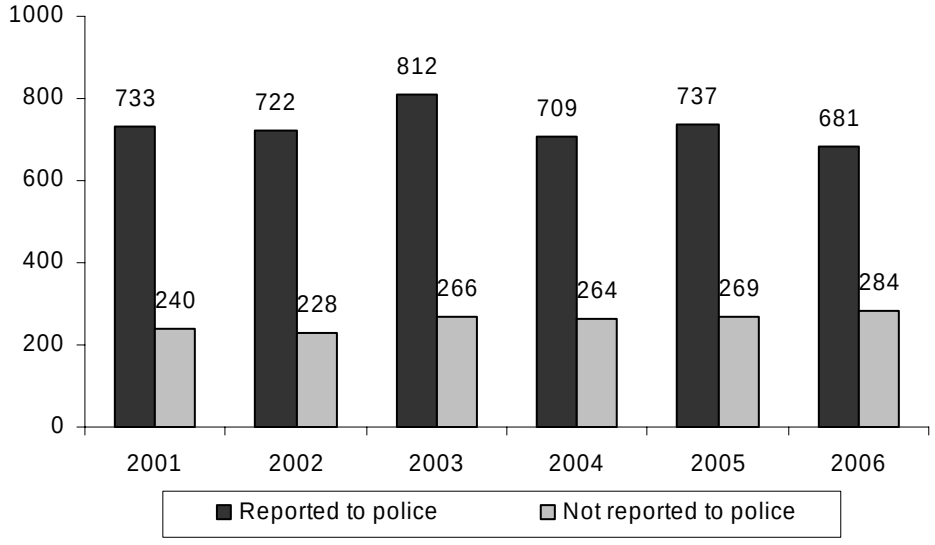
Annual share of PSCR sexual assaults reported to police, 2001-2006*

Year	Percent reported
2001	75.3%
2002	73.8%
2003	72.8%
2004	70.8%
2005	71.1%
2006	68.7%

*Includes cases with valid date of assault and response to police reporting

Figure 16.

Number of PSCR sexual assaults reported to the police, 2001-2006



[64] EOPSS does not report incidents in the PSCR database to police departments, nor does EOPSS cross-check data to determine if self-reports to the police by victims have been completed.

PSCR data indicate that the share of victims who reported the assault to the police (69% - 75%) is higher than those indicated by national survey data, which estimate that between 16% and 32% of all sexual assault victims report the crime to the police.[65] Specifically, the Bureau of Justice Statistics found that among female victims 63% of completed rapes, 65% of attempted rapes, and 74% of completed and attempted sexual assaults were not reported to the police.[66] The NVAWS study conducted by NIJ found that only one in five adult women report their rape to the police.[67]

These differences may be due to several factors. It is possible that victims who seek medical treatment may have experienced a high degree of physical or emotional trauma, which may correlate with increased police reporting. In addition, individual characteristics of victims in the PSCR sample may differ from those of respondents in national survey samples, leading to differences in police reporting. Regional effects may also result in increased police reporting if, for example, individuals in Massachusetts have greater trust in or stronger relationships with police and the justice system. Individuals who seek medical treatment may also be more likely to seek police intervention.

In order to further investigate reporting to police, analyses were run to determine if a relationship exists between police reporting and the following variables: victim-assailant relationship, victim and assailant gender, victim age, victim race, whether the victim was injured, and type of force.

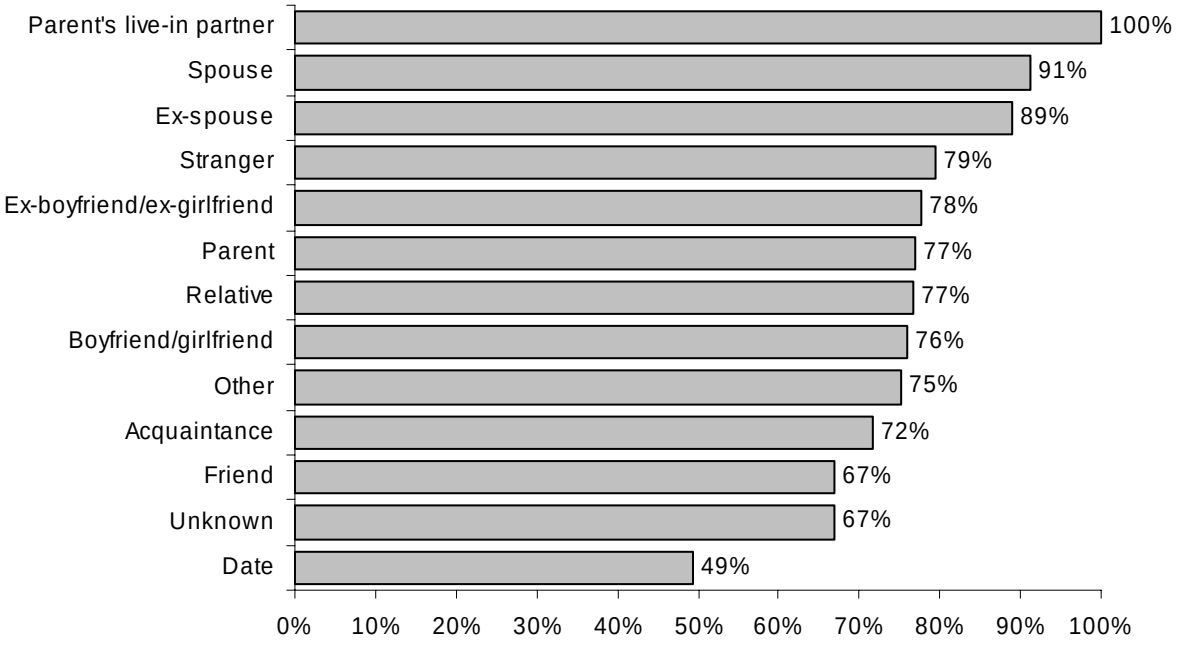
[65] Kilpatrick et al. (1992).
[66] Rennison, C.M. (2002). *Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000*. Washington, DC: US Department of Justice, Bureau of Justice Statistics.
[67] Tjaden & Thoennes. (2006).

Reporting to Police and Victim-Assailant Relationship

The extent of police reporting varied by the victim-assailant relationship (Figure 17).[68] Victims were most likely to report to the police if the assailant was a parent's live-in partner (100% of assaults involving live-in partners reported the assault to the police), spouse (91%), or ex-spouse (89%). Victims were least likely to report to the police if the assailant was a date (49%).

Figure 17.

Percent of victims reporting to police by victim-assailant relationship, 2001-2006



[68] As previously mentioned, the relationship types listed above are not mutually exclusive as a number of cases involving multiple assailants included more than one relationship type.

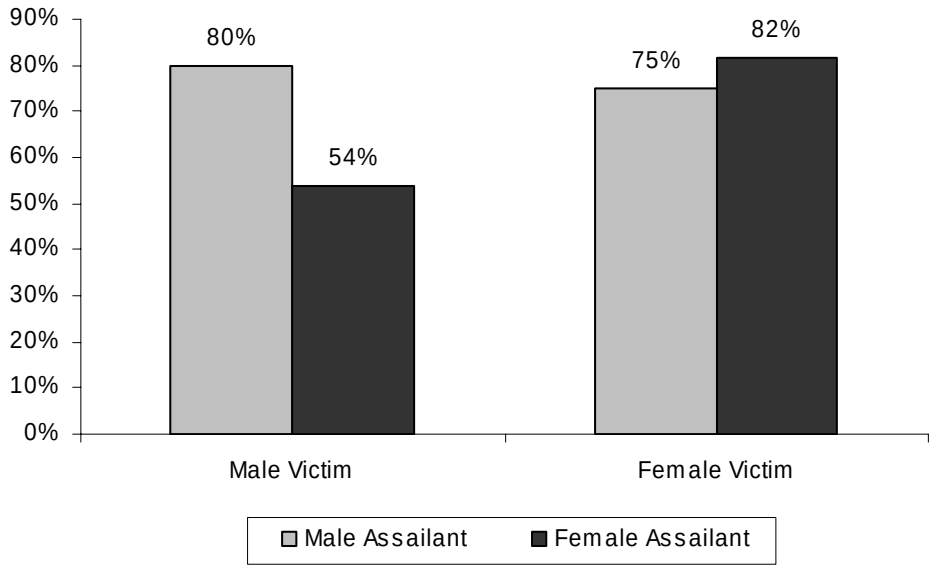
Reporting to Police and Gender of Victim and Assailant

The gender of the victim had little effect on police reporting rates. Males were slightly more likely to report the assault to the police than were females (77% of male victims and 74% of female victims).

An analysis was done to assess whether there was any interaction between victim gender and assailant gender on police reporting. Assaults that involved at least one male assailant were compared to assaults that involved at least one female assailant for both male and female victims (Figure 18). Of the four possible victim-assailant gender pairs (male-male, female-male, male-female, and female-female), the assaults most likely to result in a police report involved female victims with at least one female assailant; 82% of female victims with a female assailant reported the assault to the police.[69] The assaults least likely to result in a police report involved male victims with at least one female assailant - 54% of male victims with a female assailant reported the assault to the police.

Figure 18.

Police reporting by genders of victims and assailant, 2001-2006



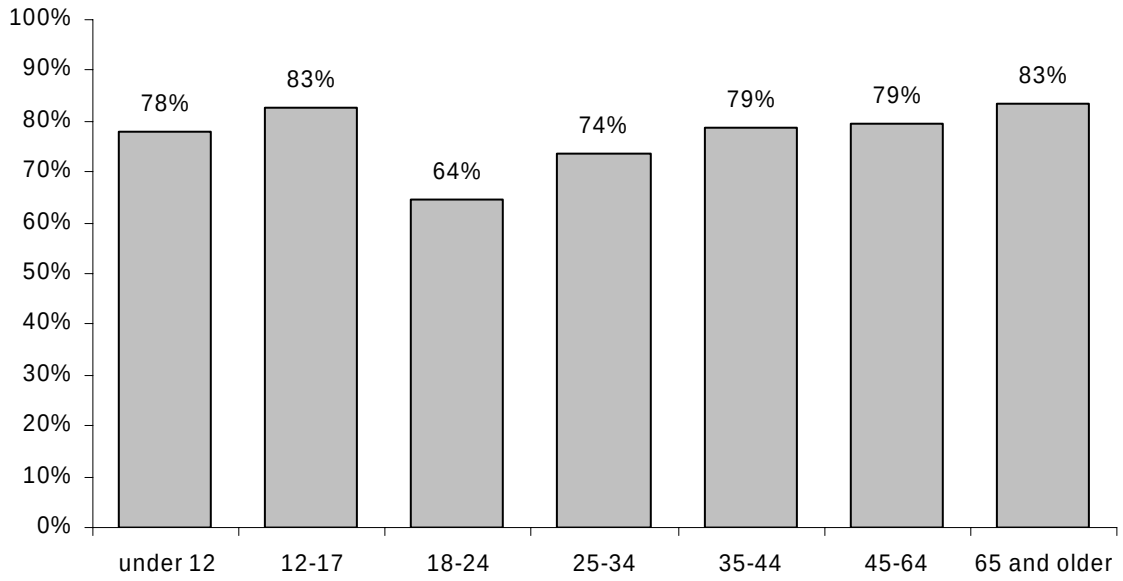
[69] It is important to note that crimes involving female assailants were rare in the PSCR dataset. Female assailants accounted for only 2% of all cases. Therefore, the number of cases in the male victim - female assailant and female victim - female assailant categories are low (n=13 and n=82, respectively). The small sample size should be considered when evaluating the results presented in this section.

Reporting to Police and Victim Age

Police reporting also varied by the age of the victim (Figure 19). Victims between the ages of 18 and 24 were the least likely to report the assault to the police, doing so in only 64% of PSCR cases involving victims in this age group. Victims between the ages of 12 and 17 and 65 and older were the most likely to report the assault to the police (both reporting in 83% of cases within these age groups).[70]

Figure 19.

Police reporting by age of victim, 2001-2006



Reporting to Police and Victim Race

Police reporting rates also varied by victim race (Table 7). Asian-Americans/Pacific Islanders were the least likely race to report the assault to the police (68% within this racial category). Hispanic and Black (non-Hispanic) victims were the most likely to report the assault to the police (80% and 79%, respectively).

Table 7.

Police reporting by race of victim, 2001-2006

	Reported to police
Hispanic	80% (n=588)
Black (non-Hispanic)	79% (n=624)
White (non-Hispanic)	72% (n=2,939)
Other	70% (n=129)
Asian/Pacific Islander	68% (n=65)

[70] As mentioned previously, in the case of youth victims, the decision to report to the police is usually made by the parent or legal guardian. In cases where teen victims seek medical treatment without parental involvement, they decide whether or not to report the assault to the police.

Reporting to Police and Injury to Victim

The police reporting rates for victims who received injuries that resulted in bleeding were compared to the reporting rates for victims who did not receive injuries that resulted in bleeding. The infliction of an injury did not appear to have a considerable impact on the likelihood of reporting the assault to the police (Table 8). Victims who were injured during the assault were only slightly more likely to report the assault than were victims who received no injury or who were unsure of an injury.

Table 8.
Police reporting by nature of injury, 2001-2006

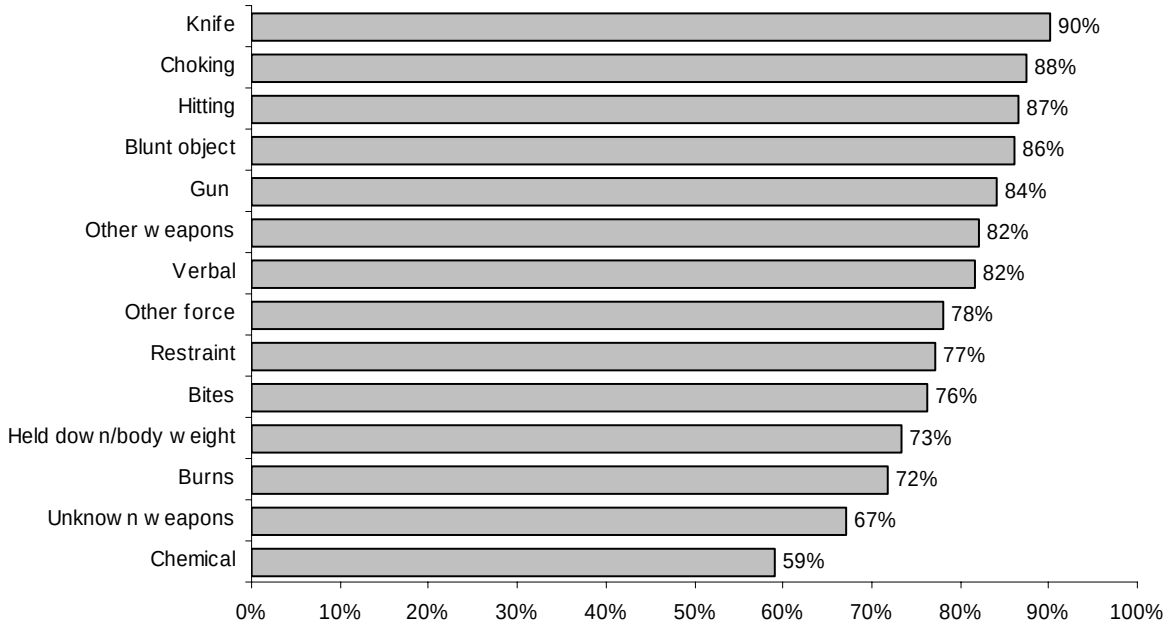
	Reported to police
Injured	76%
Not Injured	74%
Unsure	71%

Reporting to Police and Use of Force

Some variation in police reporting was found when looking at different types of force used during the assault (Figure 20). Due to the possibility of multiple types of force being used in a single assault, it is difficult to isolate any single type of force as more or less likely to result in a police report. However, assault involving certain types of force, either alone or in combination with other types of force, may be more or less likely to result in a police report.

Sexual assaults involving knives were reported to the police 90% of the time, making assaults involving knives the most likely to be reported to the police. Choking, blunt objects, and hitting were the next most commonly reported types of force (reported 88%, 87%, and 86% of time, respectively). Assaults involving chemicals were the least likely to be reported to police (59%).

Figure 20.
Police reporting by type of force, 2001-2006



Mandatory Reports

Child Abuse Reports

According to M.G.L. Chapter 119, Section 51A, certain professionals (including physicians and nurses) are required to report cases of suspected child abuse or neglect to the Massachusetts Department of Social Services. For victims under the age of 18, 51A child abuse reports were filed in only 48% of cases.[71] However, there are various reasons that a 51A might not have been filed, such as the youth already having an open DSS case.

Elder Abuse Reports

According to M.G.L. Chapter 19A, Section 15, certain professionals (including physicians and nurses) are required to report cases of suspected elder abuse or neglect. For victims 65 years and older, 19A elder abuse reports were filed in 70% of cases.[72]

Disabled Persons Reports

According to M.G.L. Chapter 19C, Section 10, certain professionals (including physicians and nurses) are required to report any serious physical or emotional injury resulting from the abuse of a disabled person, including nonconsensual sexual activity. A 19C disabled persons report was filed in 2% of cases.

Weapon Reports

According to M.G.L. Chapter 112, Section 12A, every physician attending to a bullet or gunshot wound, any injury resulting from the discharge of a gun, or certain burn injuries, is required to report the case to the State Police and to the local law enforcement agency where the hospital is located. Weapon reports were filed in 2% of cases.

Table 9.

Mandatory reporting summary table, 2001-2006

	Percent of cases reported
Child abuse report	48%*
Elder abuse report	70%**
Disabled persons report	2%
Weapon report	2%

* Based on cases involving victims age 17 and under.
** Based on cases involving victims age 65 and above.

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[71] In 14% of cases where the victim was under the age of 18, the response to 51A filed was missing.
[72] The Massachusetts statute does not cite a specific age whereupon an elder abuse report must be filed. This analysis uses the age range of 65 years and older to approximate the "elder" population of PSCR victims.

Comparisons to Previous Research

Some of the findings in this report, including victim-assailant relationship and reporting to the police, were compared to findings from previous research.

Victim-Assailant Relationship

The findings from these analyses show that for those victims seeking medical treatment, some victim-assailant relationships are more common than others. The most frequently reported victim-assailant relationship in the PSCR dataset was "acquaintance," reported in 34% of assaults; another 10% of victims characterized the assailant as a "friend." In total, approximately 68% of all assaults were perpetrated by someone known to the victim.

These findings do not deviate from previous research, which show that assailants are known to victims in the majority of crimes. For example, results from the 2005 NCVS indicate that in 73% of sexual assaults the assailant was known to the victim, either as an intimate partner, other relative, or friend/acquaintance.[73] Similarly, the National College Women Sexual Victimization study reports that nine out of ten assailants are known to female victims of sexual crimes.[74] This suggests that education and prevention strategies should continue to stress the realities of acquaintance rape and sexual crime when promoting awareness on sexual victimization.

However, the findings from these analyses depart from previous research in two ways. First, the percent of sexual assaults perpetrated by a stranger (29%) in the PSCR dataset is higher than other research suggests. For example, the Massachusetts Department of Public Health reports that 16% of victims seeking assistance at rape crisis centers indicated that the assailant was a stranger.[75]

Second, the proportion of assaults perpetrated by an intimate partner (13%) in the PSCR dataset is lower than other research findings; the Massachusetts Department of Public Health indicates that 24% of victims were assaulted by intimate partners.[76] An examination of how relationship types influence the decision to seek medical treatment would help to better clarify reasons for these differences. It may be the case that stranger-perpetrated sexual assaults are more likely to lead to the seeking of medical treatment and, conversely, that intimate partner-perpetrated assaults are less likely to lead to the seeking of medical treatment.

[73] Bureau of Justice Statistics. (2006).
[74] Fisher, B.S., Cullen, F.T., & Turner, M.G. (2000). *The Sexual Victimization of College Women.* Washington, DC: US Department of Justice, National Institute of Justice.
[75] Massachusetts Department of Public Health website. Accessed 02/07/08.
[76] Ibid. This publication defines an "intimate partner" as a current or former spouse, current or former partner, date, or boyfriend/girlfriend.

Police Reports

Findings from this report indicate that 72% of victims reported or intended to report the assault to the police. This percentage is much higher than estimates of police reporting for both sexual assaults in general and sexual assaults where the victim sought medical treatment.[77,78] The high percent of reported offenses could be due to several factors, each of which warrants further investigation.

The use of self-reports to measure police reporting could inflate the proportion of victims who have, or who intend to, report the assault to the police. Since the PSCR data are based on self-reports, it is not possible to determine whether all victims accurately responded to this item, or whether contextual effects such as perceived social desirability or nonverbal interviewer cues led some victims to respond affirmatively when asked about reporting to police.

As noted in previous literature, higher police reporting rates are associated with medical treatment.[79] It may be the case that sexual assaults where victims seek medical treatment differ from sexual assaults where victims do not seek medical treatment. It is possible that the nature of sexual assaults that lead to medical treatment also result in increased police reporting.

Another possibility is that victims who seek medical treatment differ from victims who do not seek medical treatment. In other words, individuals who seek medical treatment may also be more likely to file a police report than an individual who does not seek medical treatment.

[77] Kilpatrick et al. (1992).
[78] Rennison. (2002).
[79] Ibid.

Appendix

PROVIDER SEXUAL CRIME REPORT

K

Per MGL C.112, S. 12A 1/2

A. PATIENT/VICTIM INFORMATION *Name, address and other identifying information should not be written on this anonymous form.*

1. Age:_____ **2. Gender:** ☐ Female ☐ Male
3. Race: ☐ White (non-Hisp.) ☐ Hispanic ☐ Black (non-Hisp.) ☐ Asian/Pac. Isl. ☐ Other: _____
4. Date of Assault (e.g., 01/01/2000): _____ **5. Approx. Time of Assault:** _____ ☐ AM ☐ PM
6. City/Town of assault: _____ **State:**_____ **Neighborhood:**_____
7. Specific surroundings at time of assault:
☐ House/Apartment ☐ Outdoors ☐ Dormitory ☐ Hotel/Motel ☐ Other _____ ☐ Unsure
8. Date of hospital exam (e.g., 01/01/2000): _____ **9. Time of hospital exam:** _____ ☐ AM ☐ PM
10. Hospital providing service: _____
11. Exam Completed by a Sexual Assault Nurse Examiner (SANE)? ☐ Yes ☐ No
12. Interpreter used? ☐ Yes ☐ No **Language:** _____

B. ASSAILANT(S) INFORMATION *Did the patient/victim voluntarily report any of the following relationships with the assailant(s)?*

13. Total number of assailants: _____
14. Assailant(s) relationship to patient/victim and gender of assailant (m/f) *(If >1 assailant, designate relationship of each).*

	# Male	# Female		# Male	# Female
☐ Parent/ Step-parent			☐ Boy/ girlfriend		
☐ Spouse/ live-in partner			☐ Ex-boy/ girlfriend		
☐ Ex-Spouse/ live-in partner			☐ Date		
☐ Parent's live-in partner			☐ Acquaintance		
☐ Other relative			☐ Friend		
☐ Stranger			☐ Unknown		
			☐ Other (specify): _____		

C. 15. WEAPONS/ FORCE USED *Document as per the victim's voluntary report of threats or weapons used and/or your physical findings.*

☐ Unknown ☐ Bites ☐ Gun ☐ Restraints
☐ Verbal threats ☐ Hitting ☐ Knife ☐ Chemical(s)
☐ Choking ☐ Burns ☐ Blunt Object ☐ Other weapons Describe: _____
☐ Other physical force Describe: _____

D. ACTS DESCRIBED BY THE PATIENT/VICTIM:

Was there penetration, however slight, of:

16. Vagina ☐ No ☐ Unsure ☐ Attempt ☐ Yes *BY* ☐ Penis ☐ Finger ☐ Tongue ☐ Object/Other: _____
17. Anus ☐ No ☐ Unsure ☐ Attempt ☐ Yes *BY* ☐ Penis ☐ Finger ☐ Tongue ☐ Object/Other: _____
18. Mouth ☐ No ☐ Unsure ☐ Attempt ☐ Yes *BY* ☐ Penis ☐ Finger ☐ Tongue ☐ Object/Other: _____
19. During the assault, were acts performed by the patient/victim upon the assailant(s)? ☐ YES ☐ NO ☐ UNSURE
If yes, specify: _____
20. Did ejaculation occur? ☐ YES ☐ NO ☐ UNSURE 21. Did assailant(s) use a condom? ☐ YES ☐ NO ☐ UNSURE
22. Did assailant(s) use any substance as lubrication (saliva is considered lubrication)? ☐ YES ☐ NO ☐ UNSURE
If yes, specify: _____
23. Did assailant(s) kiss, lick, spit or make other oral contact with the patient/victim? ☐ YES ☐ NO ☐ UNSURE
If yes, describe location: _____
24. Did assailant(s) touch the patient/victim with bare hands or fingers? ☐ YES ☐ NO ☐ UNSURE
If yes, describe location: _____
25. Any injuries to patient/victim resulting in bleeding? ☐ YES ☐ NO ☐ UNSURE
If yes, specify: _____
26. Any injuries to assailant(s) resulting in bleeding? ☐ YES ☐ NO ☐ UNSURE
If yes, specify: _____

E. CASE STATUS AT TIME OF THE EXAM

27a. Evidence Collection Kit completed? ☐ Yes ☐ No 27b. Toxicology Kit completed? ☐ Yes ☐ No
28. Reported to police? ☐ Yes ☐ No *If yes, specify police dept.:* _____
29. DSS Involved? ☐ Yes ☐ No *If yes, describe status:* _____
30. Restraining order in place before assault? ☐ Yes ☐ No *If yes, date and court location:* _____
31. Restraining order filed after assault? ☐ Yes ☐ No *If yes, date and court location:* _____

F. MANDATORY REPORTING (Check all that apply):

32. 19A Elder Abuse Report ☐ Yes ☐ No 35. 12A Weapon Report ☐ Yes ☐ No
33. 51A Child Abuse Report ☐ Yes ☐ No 36. 70E Emergency Contraception Administered ☐ Yes ☐ No
34. 19C Disabled Persons Report ☐ Yes ☐ No

Mail or FAX this report to: **Massachusetts Executive Office of Public Safety-Statistical Analysis Center**
10 Park Plaza, Suite 3720
Boston, MA 02116
AND: Local public safety authority ***FAX (617) 725-0260 or (617) 725-0261***

RE2MA: PSCR1.6 11/05

PROVIDER SEXUAL CRIME REPORT

Overview

The Provider Sexual Crime Report (PSCR) was created as a mechanism for determining the volume and characteristics of rape and sexual assault crimes occurring in Massachusetts. These crimes are often not reported to police and are, as a result, not recorded or tracked. Medical providers can be of great assistance to law enforcement by reporting their cases to the State Police and local police department via the Provider Sexual Crime Report, thus enabling these crimes to be counted and cases of serial offending to be identified. Massachusetts General Law requires the Provider Sexual Crime Report to be completed by medical providers for every victim of rape or sexual assault. Specifically, *Chapter 112, Section 12½* requires:

"Every physician attending, treating, or examining a victim of rape or sexual assault, or, whenever any such case is treated in a hospital, sanatorium or other institution, the manager, superintendent or other person in charge thereof, shall report such case at once to the criminal history systems board and to the police of the town where the rape or sexual assault occurred but shall not include the victim's name, address, or any other identifying information. The report shall describe the general area where the attack occurred. Whoever violates any provision of this section shall be punished by a fine of not less than fifty dollars nor more than one hundred dollars." M.G.L.C. 112§ 12½

Instructions and Definitions

- DO NOT write a patient's name, address, or any other identifying information on the PSCR. To ensure patient safety, the Report is anonymous.
- Question 21: Check "YES" only if all assailants used a condom. If one or more assailants did not use a condom, check "NO."
- Question 30 & 31: These questions pertain to restraining orders in place or filed for assailant(s) involved in this attack only.

Rape: "Whoever has sexual intercourse or unnatural sexual intercourse with a person, and compels such person to submit by force and against his will, or compels such person to submit by threat of bodily injury and if either such sexual intercourse or unnatural sexual intercourse results in or is committed with acts resulting in serious bodily injury, or is committed by a joint enterprise, or is committed during the commission or attempted commission of an offense..." M.G.L.C. 265 § 22.

Unnatural sexual intercourse: "Any penetration of the mouth, vagina, or anus by any foreign object or extremity; or, any penetration not understood to be what is collectively referred to as "sexual intercourse." M.G.L.C. 265 § 22.

19A Elder Abuse Report: M.G.L. Chapter 19A, Section 15 requires certain professionals (including physicians, physician assistants, medical interns, and nurses) to report suspected occurrences of elder abuse, neglect and financial exploitation.

51A Child Abuse Report: M.G.L. Chapter 119, Section 51A requires certain professionals (including physicians, physician assistants, hospital personnel engaged in the examination, care or treatment of persons, medical interns, and nurses), who, in their professional capacity shall have reasonable cause to believe that a child under the age of eighteen years is suffering physical or emotional injury resulting from abuse inflicted upon him which causes harm or substantial risk of harm to the child's health or welfare including sexual abuse, or from neglect, including malnutrition, or who is determined to be physically dependent upon an addictive drug at birth, shall immediately report such condition.

19C Disabled Persons Report: M.G.L. Chapter 19C, Section 10 requires certain professionals (including physicians, medical interns, hospital personnel engaged in the examination, care or treatment of persons, nurses) to report a serious physical or emotional injury resulting from the abuse of a disabled person including nonconsensual sexual activity.

Weapon Report: M.G.L. Chapter 112, Section 12A requires every physician attending or treating a case of bullet wound, gunshot wound, powder burn or any other injury arising from or caused by the discharge of a gun, pistol, BB gun, or other air rifle or firearm, or examining or treating a person with a burn injury affecting five percent or more of the surface area of his body, or, whenever any such case is treated in a hospital, sanatorium or other institution, the manager, superintended or other person in charge thereof, shall report such case at once to the colonel of the state police and to the police of the town where such physician, hospital sanatorium or institution is located or, in the case of burn injuries, notification shall be made at once to the state fire marshal and to the police of the town where the burn injury occurred.

Emergency Contraception Report: M.G.L. Chapter 111 Section 70E requires hospitals to report the dispensing of emergency contraception to a victim of rape.

Submission Requirements:

• Upon completion, please mail or FAX the PSCR to:

Massachusetts Executive Office of Public Safety-Statistical Analysis Center
10 Park Plaza, Suite 3720
Boston, MA 02116
FAX (617) 725-0260 or (617) 725-0261

• In addition, please mail a copy of the PSCR to the local public safety authority where the rape or sexual assault occurred.

Additional Information: Should you have any questions regarding the PSCR, please call the Massachusetts Statistical Analysis Center at (617) 725-3301.

RE2MA: PSCR2.4 11/05

MASSACHUSETTS PROVIDER SEXUAL CRIME REPORT
FOR PEDIATRIC ASSAULTS/ABUSE (<12 Years of Age)

Per MGL C.112, S. 12A 1/2

A. PATIENT/VICTIM INFORMATION

Patient's name, address and/or other identifying information should not be written on this form.

1. Date of Birth: _____/ _____/ _____
2. Gender: ☐ Female ☐ Male
3. Race: ☐ White (non-Hisp.) ☐ Black (non-Hisp.) ☐ Hispanic ☐ Asian/Pac. Isl. ☐ Other: _____
4. Date of Assault (e.g., 01/01/2004): _____/ _____/ _____
5. Approx. Time of Assault: _____ ☐ AM ☐ PM ☐ Unknown
6. City/Town of assault: _____
7. State: _____
8. Neighborhood: _____
9. Facility where exam was performed: _____
10. Date and time of exam: _____/ _____/ _____ _____ ☐ AM ☐ PM

B. CASE STATUS/MANDATORY REPORTING AT TIME OF EXAM (Check all that apply):

11. Evidence Collection Kit completed? ☐ YES ☐ NO
12. Toxicology testing completed? ☐ YES ☐ NO
13. Reported to police? ☐ YES ☐ NO
14. 51A filed? ☐ YES Date and Time of filing: _____
15. Weapon Report? ☐ YES ☐ NO

Mail or FAX this report to: Massachusetts Executive Office of Public Safety
Statistical Analysis Center
One Ashburton Place, Suite 2110
Boston, MA 02108
FAX (617) 727-5356

RE0MA(P): PSCR1.1 4/04

PROVIDER SEXUAL CRIME REPORT FOR PEDIATRIC SEXUAL ASSAULTS/ABUSE (<12 Years of Age)

Overview

The Provider Sexual Crime Report for Pediatric Sexual Assaults/Abuse was created as a mechanism for determining the volume and characteristics of pediatric sexual assault and abuse crimes occurring in Massachusetts. These crimes are often not reported to police and are, as a result, not recorded or tracked. Medical providers can be of great assistance to law enforcement by reporting their cases to the State Police and local police department via the Provider Sexual Crime Report, thus enabling these crimes to be counted and cases of serial offenders to be identified. Massachusetts General Law requires the Provider Sexual Crime Report to be completed for every victim of sexual abuse or sexual assault. Specifically, *Chapter 112, Section 12½* requires:

"Every physician attending, treating, or examining a victim of rape or sexual assault, or, whenever any such case is treated in a hospital, sanatorium or other institution, the manager, superintendent or other person in charge thereof, shall report such case at once to the criminal history systems board and to the police of the town where the rape or sexual assault occurred but shall not include the victim's name, address, or any other identifying information. The report shall describe the general area where the attack occurred. Whoever violates any provision of this section shall be punished by a fine of not less than fifty dollars nor more than one hundred dollars." M.G.L.C. 112§ 12½

Instructions and Definitions

- DO NOT write the patient's name, address, or any other identifying information on the PSCR. To ensure patient safety, the Report is anonymous.

Sexual abuse is sexual contact or activity between a child and a person who is significantly older. In cases involving a child offender, a developmental asymmetry between the participants exists. Sexual abuse most commonly involves bribery, coercion and/or threats. Sexual activities encompassed in the term sexual abuse include all forms of oral-genital, genital, or anal contact by or to the child, or non-touching abuse, such as exhibitionism, voyeurism, or using the child in the production of pornography.

Sexual assault is a broad term used to refer to any unwanted genital contact that involves the use of force or coercion. In the pediatric population, this term is used to describe an acute episode of sexual abuse.

Rape is a legal term used to describe a sexual assault in which the following criterion are met:

a. Any vaginal, anal or oral penetration *(no matter how slight)* by a penis, or other body part, or object
b. Lack of consent

- May be communicated by any verbal or physical sign of resistance
- Is present when the victim is unable to consent due to age (the legal age of consent in MA is 16 years), mental status (i.e. incapacitation resulting from drug or alcohol intoxication, unconsciousness or severe mental handicap)

c. Threat or actual use of force

51A Child Abuse Report: M.G.L. Chapter 119, Section 51A requires mandated reporters to complete a report to the Massachusetts Department of Social Services when there is concern that a child < 18 years of age has been sexually abused/ assaulted.

Weapon Report: M.G.L. Chapter 112, section 12A requires every physician attending or treating a case of bullet wound, gunshot wound, powder burn or any other injury arising from or caused by the discharge of a gun, pistol, BB gun, or other air rifle or firearm, or examining or treating a person with a burn injury affecting five percent or more of the surface area of his body, or, whenever any such case is treated in a hospital, sanatorium or other institution, the manager, superintendent or other person in charge thereof, shall report such case at once to the colonel of the state police and to the police of the town where such physician, hospital, sanatorium or institution is located or, in the case of burn injuries, notification shall be made at once to the state fire marshal and to the police of the town where the burn injury occurred.

Submission Requirements:

- Upon completion, please mail or FAX the PSCR to:

Massachusetts Executive Office of Public Safety-Statistical Analysis Center
One Ashburton Place, Suite 2110
Boston, MA 02108
FAX (617) 727-5356

- In addition, please mail a copy of the PSCR to the local public safety authority where the rape or sexual assault or sexual abuse occurred.

Additional Information: Should you have any questions regarding the PSCR, please call the Massachusetts Statistical Analysis Center at (617) 727-6900, x25553.

FE0MA(P): PSCR2.1 4/04