

October 2011

INDIAN HEALTH SERVICE

Continued Efforts Needed to Help Strengthen Response to Sexual Assaults and Domestic Violence

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Highlights of [GAO-12-29](#), a report to congressional committees

Why GAO Did This Study

The Justice Department has reported that Indians are at least twice as likely to be raped or sexually assaulted as all other races in the United States. Indians living in remote areas may be days away from health care facilities providing medical forensic exams, which collect evidence related to an assault for use in criminal prosecution. The principal health care provider for Indians, which operates or funds tribes to operate 45 hospitals, is the Department of Health and Human Services' Indian Health Service (IHS).

In response to a Tribal Law and Order Act of 2010 mandate, GAO examined (1) the ability of IHS and tribally operated hospitals to collect and preserve medical forensic evidence involving cases of sexual assault and domestic violence, as needed for criminal prosecution; (2) what challenges, if any, these hospitals face in collecting and preserving such evidence; and (3) what factors besides medical forensic evidence contribute to a decision to prosecute such cases. GAO surveyed all 45 IHS and tribally operated hospitals and interviewed IHS and law enforcement officials and prosecutors.

What GAO Recommends

GAO is making five recommendations aimed at improving IHS's response to sexual assault and domestic violence, including to develop an implementation and monitoring plan for its new sexual assault policy and to modify sections of the policy regarding required training and subpoenas or requests to testify. The Department of Health and Human Services and the state of Alaska generally agreed with GAO's findings and recommendations.

View [GAO-12-29](#) or key components. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

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What GAO Found

GAO's survey of IHS and tribally operated hospitals showed that the ability of these hospitals to collect and preserve medical forensic evidence in cases of sexual assault and domestic violence—that is, to offer medical forensic services—varies from hospital to hospital. Of the 45 hospitals, 26 reported that they are typically able to perform medical forensic exams on site for victims of sexual assault on site, while 19 reported that they choose to refer sexual assault victims to other facilities. The hospitals that provided services began to do so generally in response to an unmet need, not because of direction from IHS headquarters, according to hospital officials. Partly as a result, levels of available services have fluctuated over time. GAO found that the utility of medical forensic evidence in any subsequent criminal prosecution depends on hospital staff's properly preserving an evidentiary chain of custody, which depends largely on coordinating with law enforcement agencies.

IHS has made significant progress since 2010 in developing required policies and procedures on medical forensic services for victims of sexual assault; nevertheless, challenges in standardizing and sustaining the provision of such services remain. In March 2011, IHS took a sound first step in what is planned to be an ongoing effort to standardize medical forensic services by issuing its first agencywide policy on how hospitals should respond to adult and adolescent victims of sexual assault. Remaining challenges include systemic issues such as overcoming long travel distances between Indian reservations or Alaska Native villages and IHS or tribal hospitals and developing staffing models that overcome problems with staff burnout, high turnover, and compensation, so that standardized medical forensic services can be provided over the long term. In addition, other challenges include establishing plans to help ensure that IHS hospitals consistently implement and follow the March 2011 policy, such as with training guidelines, and developing policies on how IHS hospitals should respond to domestic violence incidents and sexual abuse involving children who have not yet reached adolescence—neither of which is included in the March 2011 policy. GAO found that IHS is aware of these challenges and has initiatives under way or under consideration to address them.

Decisions to prosecute sexual assault or domestic violence cases are based on the totality of evidence, one piece of which is medical forensic evidence collected by hospitals. In some cases, medical forensic evidence may be a crucial factor; in other cases, however, it may not be relevant or available. Law enforcement officers and prosecutors said that they also consider several other factors when deciding to refer or accept a case for prosecution. For example, some victims in small reservations or isolated villages may refuse to cooperate or may retract their initial statements because of pressure from community members who may depend on the alleged perpetrator for necessities. As a result, the victim may be unavailable to testify. Several prosecutors also told us that the availability to testify of the providers who perform medical forensic exams is an important factor, because such testimony can help demonstrate that an assault occurred or otherwise support a victim's account. IHS's March 2011 policy, however, does not clearly and comprehensively articulate the agency's processes for responding to subpoenas or requests for employee testimony.

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Abbreviations

FBI	Federal Bureau of Investigation
IHS	Indian Health Service
SANE	sexual assault nurse examiner

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G A O

Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

October 26, 2011

The Honorable Daniel Akaka
Chairman
The Honorable John Barrasso
Vice Chairman
Committee on Indian Affairs
United States Senate

The Honorable Don Young
Chairman
The Honorable Dan Boren
Ranking Member
Subcommittee on Indian and Alaska Native Affairs
Committee on Natural Resources
House of Representatives

The Department of Justice has reported that Indians are at least twice as likely to be raped or sexually assaulted as all other races in the United States and that one in three Indian women have reported being raped at some time in their life.¹ Similarly, over one-third of Indian women and one-eighth of Indian men in the United States will experience domestic violence.² Some Indians who are victims of sexual assault, domestic violence, or child abuse live in urban areas, but many live on rural reservations or in remote, isolated Alaska Native villages. For people in rural or remote areas, it can take hours—and sometimes days—to reach the closest medical provider who can not only treat their injuries, but also perform a medical forensic exam to collect assault-related evidence for use in the criminal justice system.

¹Department of Justice, Bureau of Justice Statistics, *A BJS Statistical Profile, 1992-2002: American Indians and Crime*, NCJ 203097 (Washington, D.C.: 2004), and Department of Justice, Office of Justice Programs, *Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women*, NCJ 183781 (Washington, D.C.: 2000). Justice uses the term *Indian* in these studies to refer to persons who self-identify as American Indian or Alaska Native and does not limit the term to those enrolled in state- or federally recognized tribes.

²Department of Justice, Office of Justice Programs, *Extent, Nature, and Consequences of Intimate Partner Violence*, NCJ 181867 (Washington, D.C.: 2000). Justice uses the term *Indian* in this study to refer to persons who self-identify as American Indian or Alaska Native and does not limit the term to those enrolled in state- or federally recognized tribes.

The Department of Health and Human Services' Indian Health Service (IHS) is the principal federal health care provider for approximately 1.9 million Indians across 35 states.³ IHS headquarters oversees 12 area offices representing the agency's different regions and either directly operates or provides funding to tribes or tribal organizations to operate approximately 1,200 facilities. These facilities include hospitals, clinics, health centers, school health centers, health stations, dental clinics, alcohol substance abuse treatment facilities, behavioral health facilities, and others. Across the United States, IHS provides direct medical care at its facilities, including primary care services and some specialty services, such as treatment and prevention of diabetes, and operates or provides funding to tribes to operate 45 hospitals, providing services to Indians from over 560 tribes.⁴

IHS defines sexual assault as sexual contact without consent, and it defines domestic violence as abusive behavior involving intimate partners or family members or household members that is used to gain or maintain power and control over another intimate partner or family member or household member.⁵ Victims of sexual assault and domestic violence can typically receive a sexual assault medical forensic examination in a hospital.⁶ A 2007 report by the human-rights organization Amnesty International USA called for Congress to increase IHS funding to ensure that victims of sexual assault and domestic violence can receive more timely medical forensic examinations and that proper protocols are followed for collecting and preserving evidence related to these crimes.⁷

³For the remainder of this report, unless noted otherwise, the term *Indian* refers to the American Indian and Alaska Native beneficiaries of the Indian Health Service.

⁴In this report, when referring to entities that operate hospitals, the terms *tribe* and *tribal* refer both to federally recognized tribes and to tribal organizations, such as Alaska Native health corporations operating hospitals in Alaska.

⁵In this report, the terms *sexual assault* and *domestic violence* include cases involving both adult and child victims.

⁶In addition, nonemergency health care facilities, such as community clinics or mobile health clinics, may also provide sexual assault medical forensic exams. Our review focused on hospitals because, according to IHS officials, hospitals are the most likely type of IHS facility to have the necessary infrastructure and expertise to perform these exams.

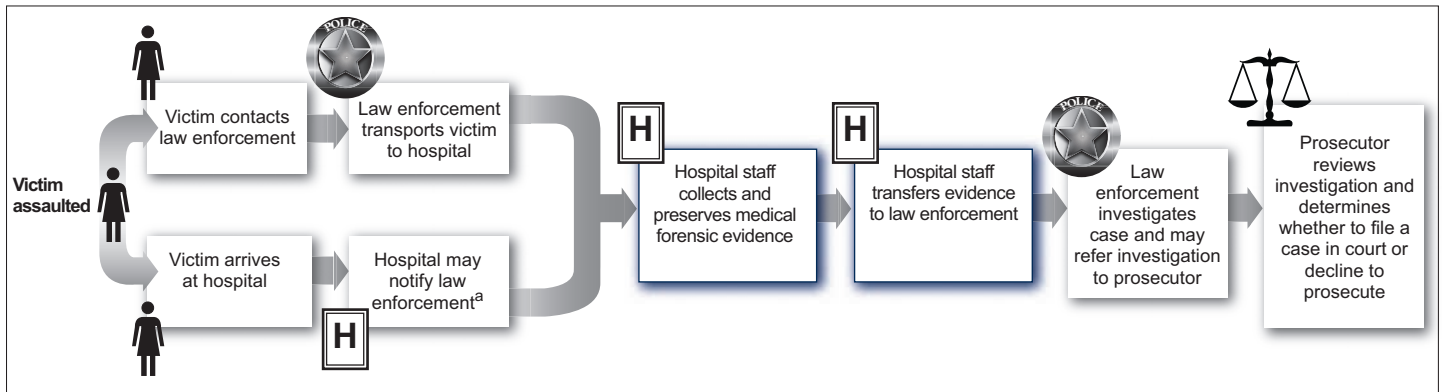
⁷Amnesty International USA, *Maze of Injustice: The Failure to Protect Indigenous Women from Sexual Violence in the USA* (New York: 2007).

Tribal, state, or federal governments may each have jurisdiction to prosecute those who commit crimes in Indian country,⁸ depending on several factors, including the nature of the crime and whether the victim or alleged perpetrator is Indian. For example, the federal government and tribal governments have jurisdiction to prosecute sexual assault crimes committed by Indians in Indian country in almost all states in which IHS has hospitals. For crimes prosecuted by the federal government, investigating agencies include Justice’s Federal Bureau of Investigation (FBI) or the Department of the Interior’s Bureau of Indian Affairs, and the crimes are prosecuted by 1 of the 94 U.S. Attorneys’ Offices.

Victims of sexual assault or domestic violence may arrive at an IHS hospital in various ways: an ambulance may transport them, law enforcement officers may bring them, or they may arrive on their own. They may arrive immediately after an assault (such cases are typically referred to as acute cases) or weeks, months, or years later (delayed or nonacute cases). Thus begins a series of steps that—if proper protocols are followed, and the appropriate “chain of custody” of the evidence is maintained, among other factors—may ultimately lead to a decision to prosecute (see fig. 1).

⁸The term *Indian country* refers to all land within the limits of any Indian reservation under the jurisdiction of the U.S. government; all dependent Indian communities within U.S. borders; and all existing Indian allotments, including any rights-of-way running through an allotment. See 18 U.S.C. § 1151.

Figure 1: General Steps from Assault through Prosecution



Source: GAO.

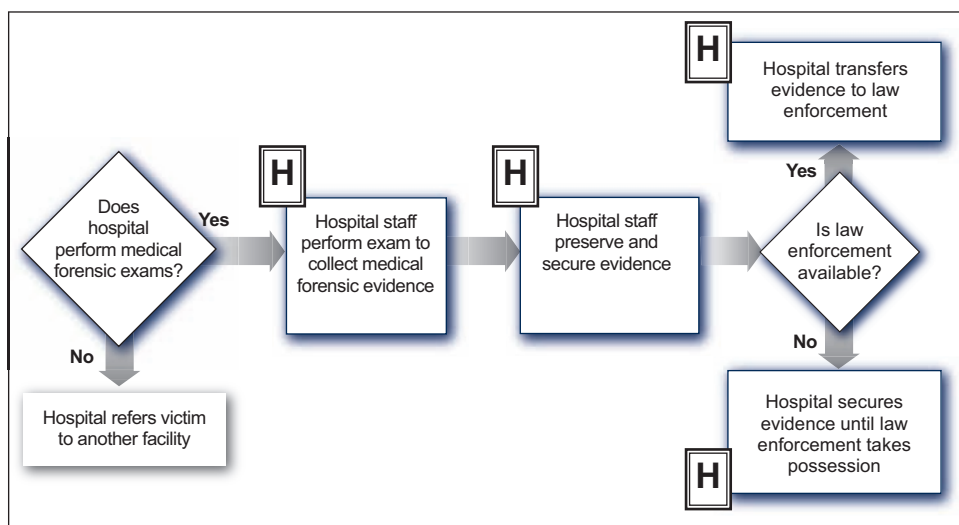
^aHospital notifies law enforcement immediately; later, or, if victim chooses to remain anonymous, not at all. For cases involving children, hospitals may have a legal duty to notify appropriate authorities.

Given consent by the victim, medical providers generally collect medical forensic evidence through a medical forensic examination that may follow steps and use supplies from a sexual assault evidence collection kit; the collected evidence is preserved until law enforcement takes possession of it. Under Justice’s national protocol for sexual assault medical forensic exams,⁹ medical providers may collect a range of physical evidence, including but not limited to clothing, foreign materials on the body, hair (including head and pubic hair samples and combings), body swabs, and a blood or saliva sample for DNA analysis and comparison. In addition, medical forensic exams typically include documenting biological and physical findings such as cuts or bruises, through either writing or photographs, and recording a victim’s medical forensic history such as the time and nature of the assault. This exam can take several hours. Once the exam is completed, medical providers preserve the collected evidence according to jurisdictional policies, which may include procedures for packaging, labeling, and sealing evidence collection kits and storing the kits in a secure location (see fig. 2). For cases of domestic violence, medical providers typically do not perform a sexual assault medical forensic exam unless a sexual assault has also occurred.

⁹Department of Justice, Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*, NCJ 206554 (Washington, D.C.: 2004).

Instead, medical providers, and sometimes law enforcement officers, generally record a victim's statement of the incident and document injuries through writing or photographs.

Figure 2: Steps in Collecting and Preserving Medical Forensic Evidence



Source: GAO analysis of IHS information.

The Tribal Law and Order Act of 2010—whose purpose was, among other things, to combat sexual and domestic violence against American Indian and Alaska Native women—mandated that we study the capability of IHS facilities in remote Indian reservations and Alaska Native villages to collect, maintain, and secure evidence of sexual assaults and domestic violence, as required for criminal prosecution.¹⁰ In response to the mandate and subsequent discussion with offices of the relevant congressional committees of jurisdiction, this report examines (1) the ability of IHS and tribally operated hospitals to collect and preserve medical forensic evidence for use in criminal prosecution in sexual assault and domestic violence cases; (2) what challenges, if any, these

¹⁰Tribal Law and Order Act of 2010, Pub. L. No. 111-211, Title II, § 266, 124 Stat. 2258, 2262 (2010). The act requires that we submit a report describing the results of the study no later than 1 year after the act's enactment. July 29, 2011, marked the 1-year anniversary of the law's enactment. We briefed staff from the Committee on Indian Affairs, U.S. Senate, and the Committee on Natural Resources, House of Representatives, on July 11 and July 14, 2011, respectively.

hospitals face in collecting and preserving such evidence, particularly in remote Indian reservations and Alaska Native villages; and (3) what factors besides medical forensic evidence collected by these hospitals contribute to a decision to prosecute such cases.

For all three objectives, we collected and analyzed laws, regulations, and agency policies relevant to the collection and preservation of medical forensic evidence by IHS and tribally operated hospitals in cases of sexual assault and domestic violence, and we interviewed and gathered relevant documentation from headquarters officials at IHS, the Bureau of Indian Affairs, Justice, and the state of Alaska. In addition, we conducted over 60 semistructured interviews with several groups of stakeholders, including staff from IHS and tribally operated hospitals, victim advocacy groups, prosecutors, and law enforcement. Specifically, we conducted semistructured interviews with stakeholders (1) from hospital staff during site visits to a nonprobability sample of 8 IHS or tribally operated hospitals in Alaska, Arizona, and South Dakota and over the telephone with an additional nonprobability sample of 7 IHS or tribally operated hospitals in Arizona, Minnesota, Montana, New Mexico, North Dakota, and Oklahoma and (2) from victim advocacy groups; federal and state prosecutors; and federal, state, local, and tribal law enforcement agencies that play a role in responding to and prosecuting sexual assault and domestic violence cases in most of the locations these 15 hospitals serve.¹¹ For these semistructured interviews, we spoke with officials about hospitals that (a) are performing medical forensic exams, (b) are developing the ability to perform such exams, and (c) are not performing such exams.¹² In addition, to identify the ability of IHS and tribally operated hospitals to collect and preserve medical forensic evidence, we used a self-administered questionnaire to survey all 45 IHS or tribally operated hospitals. We received a 100 percent response rate. To determine which of these hospitals are located in remote areas, we used rural-urban commuting area codes for isolated and small rural communities

¹¹We selected these 15 hospitals using a series of criteria that included geographic location, remoteness, whether the state or federal government had criminal jurisdiction in Indian country served by the hospital, and whether the hospital was IHS or tribally operated.

¹²Because we used a nonprobability sample to select IHS and tribally operated hospitals to interview, the information we gathered during these semistructured interviews cannot be generalized to all hospitals and instead represents the perspectives only of the interviewed hospital providers and stakeholders.

developed on the basis of U.S. Census tracts by the Department of Agriculture's Economic Research Service. We obtained data from IHS on the location and names of its hospitals, as well as data on hospital visits by IHS beneficiaries from fiscal year 2006 through fiscal year 2010. To assess the reliability of the data, we interviewed knowledgeable IHS officials and performed electronic testing. We determined that the data were sufficiently reliable to meet the objectives of this engagement. Appendix I presents a more detailed description of our scope and methodology.

We conducted this performance audit from October 2010 through October 2011, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

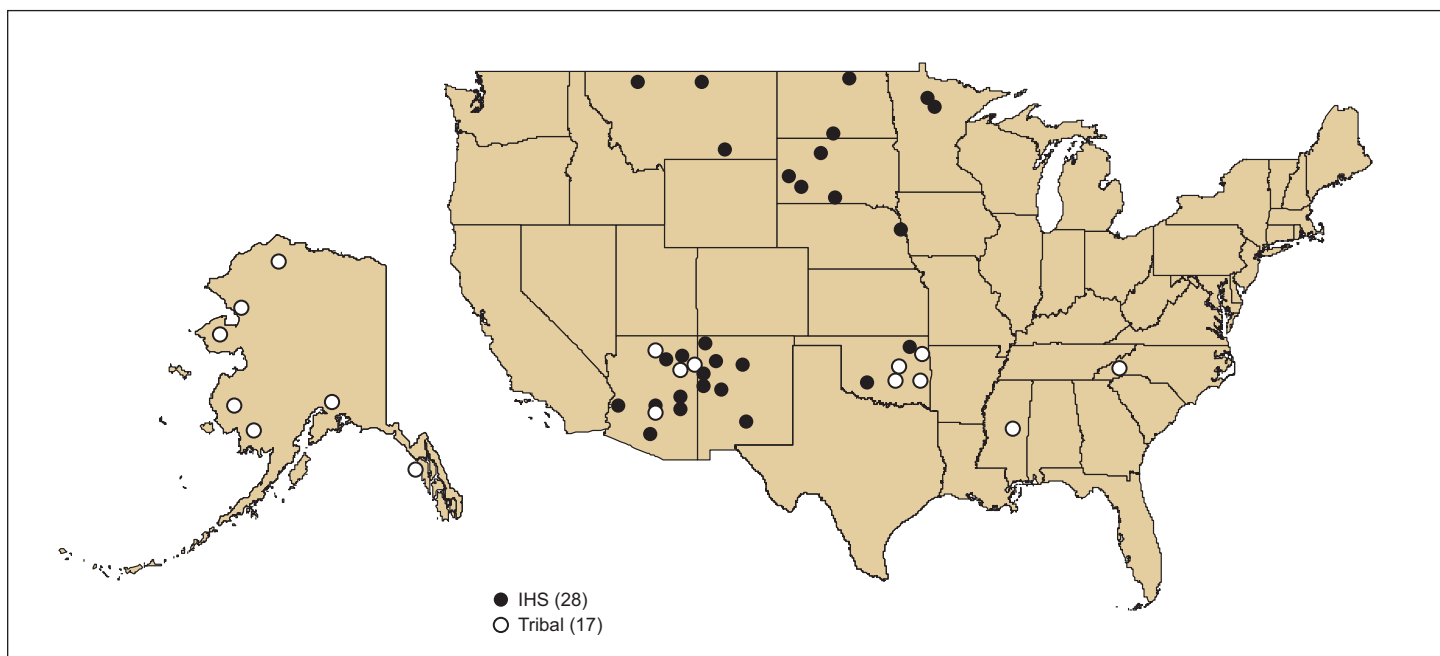
Background

Of the 45 IHS hospitals, 28 are directly operated by IHS, and 17 are operated by tribes through funds provided by IHS (see fig. 3). Specifically, under the Indian Self-Determination and Education Assistance Act, as amended, IHS provides funds to tribes to run their own hospitals through self-determination contracts or self-governance compacts.¹³ For example, the tribes in Alaska operate 7 regional hospitals and 165 village clinics, mainly through a variety of regional health consortiums that provide services to groups of tribes. These self-determination contracts and self-governance compacts implement the act's commitment to effective and meaningful participation by the Indian people in the planning, conduct, and administration of health programs and services. IHS manages its facilities and staff, including the hospitals it directly operates and its direct staff, through the *Indian Health Manual*, among other things. This document serves as the primary reference for IHS employees on IHS-specific policy and procedures. In accordance with the Indian Self-Determination and Education Assistance Act as amended, however, the self-determination contracts and self-governance compacts under which tribes operate hospitals do not generally require compliance with IHS policy. Therefore, IHS policies and procedures—including those laid

¹³Pub. L. No. 93-638 (1975), *codified as amended at* 25 U.S.C. §§ 450 to 458ddd-2.

out in the *Indian Health Manual*—do not generally apply to tribally operated facilities, although they can be used as models on which to base local tribal protocols.

Figure 3: Locations of the 45 IHS and Tribally Operated Hospitals



Source: GAO analysis and Map-Info (map).

With regard to sexual assault, IHS's *Indian Health Manual* states that a person cannot give consent to sexual contact if she or he is forced, threatened, coerced, drugged, inebriated, or unconscious; has certain disabilities; or is a minor. We use the term *sexual assault* to refer to the federal sex abuse felonies and attempts to commit them—that is, sexual abuse and aggravated sexual abuse, abusive sexual contact, or sexual abuse of children. This category includes what is commonly known as molestation and rape, including (1) cases where the alleged perpetrator uses force or threats, renders the victim unconscious, or administers drugs or other intoxicants that substantially impair the victim and (2) cases where the victim is incapable of appraising the nature of the conduct or is physically incapable of declining to participate or of communicating unwillingness to engage in the sexual act. With regard to domestic violence, IHS's *Indian Health Manual* states that domestic violence can involve physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person.

Domestic violence includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone. We use the term *domestic violence* to refer to all major crimes as defined in the Major Crimes Act between intimate partners or family members, including elders and spouses. Domestic violence also includes major crimes against children that are not sexual in nature.

A medical provider specially trained in medical forensic examination may perform such an exam in cases of sexual assault or domestic violence, and law enforcement officers may interview the victim for his or her account of what happened.¹⁴ Medical providers typically perform such exams only for acute cases of sexual assault, where the assault occurred within the previous 72 to 96 hours—when such evidence is considered most viable—because physical and biological evidence on a person’s body or clothes degrades over time, becoming unviable or too contaminated to be used. The standard of practice for how long such evidence is viable changes as scientific advancements are made, with some jurisdictions now performing medical forensic exams up to 7 days after an assault. In terms of sexual assaults, Justice’s protocols describe two types of specially trained medical providers who conduct sexual assault medical forensic exams:

- *Sexual assault nurse examiner (SANE)*: a registered nurse who has received specialized education and has fulfilled clinical requirements to perform sexual assault medical forensic exams.
- *Sexual assault forensic examiner*: a health care provider, including a physician or physician assistant, who has been specially educated and has completed clinical requirements to perform sexual assault medical forensic exams (in the same way a nurse is trained to become a SANE).

The term *SANE* refers to registered nurses, a category including nurse midwives and other advanced practice nurses, among other providers; the term *sexual assault forensic examiner* refers more broadly to medical

¹⁴Medical providers performing medical forensic exams can be specially trained and sometimes certified in performing these exams but may also perform these exams regardless of whether they have undergone such specialized training or received such certification.

providers including registered nurses plus physicians, physician assistants, and nurse practitioners. Justice's protocol encourages certification of SANEs, but certification as a SANE is available only to registered nurses. No such national or international certification exists for sexual assault forensic examiners who are not registered nurses. Registered nurses can be certified as SANEs through the International Association of Forensic Nurses to perform exams for adult and adolescent sexual assault victims or to perform exams in cases of sexual assault of children who have not reached puberty.¹⁵ Nurses can become certified by meeting the association's eligibility requirements; completing a didactic training curriculum; and successfully completing a certification examination covering several topics, such as how to assess sexual assault patients, how to collect and document evidence in a way that protects the evidence's integrity, and how to testify about findings or chain of custody.¹⁶ Beyond cases of sexual assault, medical providers who are specially educated as forensic nurse examiners are able to collect forensic evidence for a variety of crimes other than or in addition to those involving sexual assault, such as in injury associated with domestic violence.

Additionally, for child victims, medical providers may perform medical forensic exams and gather medical history in the hospital, or the child may be interviewed elsewhere at a child-specific facility such as a child advocacy center. Such facilities typically use a multidisciplinary, team approach to minimize the number of times a child is interviewed and to ensure that those individuals involved in the child's life, such as parents or guardians and social services providers, are working together.

Jurisdiction for investigating and prosecuting crimes in Indian country is complex and depends on, among other factors, the nature of the crime and whether the victim or alleged perpetrator is Indian (see table 1). The federal government, rather than the state government, has criminal

¹⁵The Forensic Nursing Certification Board, a functionally autonomous component of the International Association of Forensic Nurses, develops and administers SANE certification.

¹⁶These eligibility requirements, for example, include that nurses (a) complete 40 hours of didactic training in adult and adolescent sexual assault education (or a parallel training curriculum in pediatric sexual assault) and (b) work under an expert, such as a SANE-certified nurse, and perform enough sexual assault exams to demonstrate clinical competency to this expert.

jurisdiction in Indian country in almost all states where IHS or tribes operate hospitals.¹⁷ When the alleged perpetrator of a crime in Indian country is an Indian, tribal governments also have criminal jurisdiction.¹⁸ As a result, the FBI, the Bureau of Indian Affairs, or tribal investigators conduct criminal investigations of sexual assault and domestic violence. Once the investigation or preliminary facts are reviewed, the decision is made as to whether the investigation should be referred to the U.S. Attorneys' Offices, the tribe, or both for possible prosecution. Prosecutors in the U.S. Attorneys' Offices decide whether to accept the matter for criminal prosecution in federal court. We previously reported that receipt of a law enforcement referral does not mean that a prosecutable case exists at the time the referral is made and that, upon further investigation, prosecutors may file the matter for prosecution as a case in court, decline to prosecute the matter, or refer the matter to tribal prosecutors.¹⁹ As we reported in February 2011, because of tribes' limited jurisdiction and sentencing authority, tribes often rely on the federal government to investigate and prosecute serious offenses, since a successful federal prosecution could result in a longer sentence than tribal courts might impose, even where tribal jurisdiction exists.²⁰

¹⁷For reasons explained elsewhere in this report, in Alaska, generally only the state has criminal jurisdiction. In addition, the IHS Cass Lake hospital in Minnesota is located in Indian country subject to state criminal jurisdiction.

¹⁸In July 2011, Justice sent a letter to the President of the Senate and the Speaker of the House of Representatives to consider a proposal to, among other things, extend tribal criminal jurisdiction to non-Indians who commit domestic violence or dating violence in Indian country.

¹⁹GAO, *U.S. Department of Justice Declinations of Indian Country Criminal Matters*, [GAO-11-167R](#) (Washington, D.C.: Dec. 13, 2010). The U.S. Attorneys' Offices call all criminal investigations referred to them by law enforcement *matters*.

²⁰GAO, *Indian Country Criminal Justice: Departments of the Interior and Justice Should Strengthen Coordination to Support Tribal Courts*, [GAO-11-252](#) (Washington, D.C.: Feb. 14, 2011).

Table 1: Jurisdiction over Crimes in Indian Country Where the Federal Government Has Not Conferred Jurisdiction on a State

Involved parties	Federal ^a	Tribal	State
Indian perpetrator and Indian victim	Major crimes ^b	Nonmajor crimes and major crimes (concurrent with federal)	None
Indian perpetrator and non-Indian victim	Major crimes (plus crimes included in the Indian Country Crimes Act ^c and Assimilative Crimes Act ^d)	Nonmajor crimes and major crimes (concurrent with federal)	None
Non-Indian perpetrator and Indian victim	Crimes included in the Indian Country Crimes Act and Assimilative Crimes Act	None	None
Non-Indian perpetrator and non-Indian victim	None	None	Nonmajor crimes and major crimes

Source: Department of Justice, *United States Attorneys' Manual* (Washington, D.C.: 1997), and GAO analysis of relevant statutory provisions.

^aSpecific statutes also grant the federal government criminal jurisdiction over certain sexual assault and domestic violence crimes in Indian country. For example, under 18 U.S.C. § 117, the federal government has criminal jurisdiction over persons who commit domestic assault in Indian country and who have two final convictions in federal, state, or tribal court for assault, sexual abuse, serious violent felony against a spouse or intimate partner, domestic violence, or stalking.

^bThe Major Crimes Act, as amended, provides the federal government with criminal jurisdiction over Indians charged with certain specified crimes regardless of whether the victim is Indian. 18 U.S.C. § 1153(a). Major crimes relevant for this review include murder, manslaughter, kidnapping, maiming, sexual abuse felonies and attempts to commit them, incest, assaults with the intent to murder or with dangerous weapons, assaults resulting in serious bodily injury, assaults against someone younger than 16 years, and felony child abuse.

^c18 U.S.C. § 1152. The Indian Country Crimes Act, also known as the General Crimes Act or Federal Enclaves Crime Act, extends the criminal laws of the federal government into Indian country and establishes federal criminal jurisdiction over crimes committed where either the alleged offender or the victim, but not both, is Indian, unless the alleged offender was punished by the tribal government, or a treaty grants the tribe exclusive jurisdiction over the offense.

^d18 U.S.C. § 13. Under the Assimilative Crimes Act, if a person allegedly commits an offense in an area where the federal government has criminal jurisdiction, such as in certain parts of Indian country, that has not been defined in federal law but has been defined in state law, the federal government can prosecute the alleged offender in federal court as if the state law offense were a federal law offense.

In some states, however, the federal government has conferred criminal jurisdiction over Indian country to the states and renounced federal criminal jurisdiction. In these states, only the state and tribes—if the alleged perpetrator is an Indian—have jurisdiction to investigate and prosecute crimes in Indian country, including sexual assault and domestic violence. For example, Public Law No. 83-280, which was enacted in 1953, gave six states criminal jurisdiction over crimes committed by or

against Indians in Indian country and renounced federal jurisdiction over those crimes.²¹ Two of these so-called mandatory Public Law 280 states—Alaska (which has 225 tribes) and California (which has 105 tribes)—contain over half the Indian tribes (330 out of 565 tribes) in the United States.²² In these six states and certain other states, the state, not the federal government, has jurisdiction over crimes in Indian country, and, except in Alaska, Indian tribes have concurrent jurisdiction over crimes committed by Indians. At the request of a tribe and with consent of the U.S. Attorney General, however, the Tribal Law and Order Act of 2010, among other things, permits the federal government to reassert jurisdiction over certain crimes in Indian country.²³ In such cases, the federal, state, and tribal governments would have concurrent jurisdiction over major crimes committed by Indians against Indians and non-Indians.

In Alaska, generally only the state—not the tribes or federal government—has criminal jurisdiction over Alaska Native villages. As a result of the Alaska Native Claims Settlement Act and a Supreme Court decision finding that Indian country does not generally exist in Alaska, neither the tribes nor the federal government has criminal jurisdiction, except on the Metlakatla Reservation.²⁴ To the extent that Indian country exists beyond the Metlakatla Reservation, the federal government lacks criminal jurisdiction because of Public Law 280, unless the tribe requests

²¹Act of August 15, 1953 (known as Public Law 280), 67 Stat. 588 *codified as amended at* 18 U.S.C. § 1162 and scattered sections of Title 25. Public Law 280 was amended to authorize states to assume criminal jurisdiction over Indian country with tribal consent; states that did so are known as optional Public Law 280 states. Other statutes, such as the Maine Indian Claims Settlement Act, grant states criminal jurisdiction over Indian country or particular tribes or reservations concurrently with the federal government or, in some cases, exclusively. See, e.g., Pub. L. No. 96-240 (1980), *codified as amended at* 25 U.S.C. § 1725.

²²The six mandatory Public Law 280 states are Alaska (except the Metlakatla Reservation), California, Minnesota (except the Red Lake Reservation), Nebraska, Oregon (except the Warm Springs Reservation), and Wisconsin. Of these six states, only Alaska and Minnesota have IHS hospitals.

²³Pub. L. No. 111-211, § 221 (2010), *codified at* 25 U.S.C. § 1132(a)(2); 18 U.S.C. § 1162(d). On May 23, 2011, Justice issued a proposed rule that would establish procedures for an Indian tribe whose Indian country is subject to state criminal jurisdiction under Public Law 280 to request that the United States accept concurrent criminal jurisdiction within the tribe's Indian country and for the Attorney General to approve such a request. 76 Fed. Reg. 29675 (May 23, 2011).

²⁴Pub. L. No. 92-203, 85 Stat. 688 (1971), *codified as amended at* 43 U.S.C. §§ 1601-1629h; *Alaska v. Native Village of Venetie Tribal Govt.*, 522 U.S. 520 (1998).

that the federal government assume criminal jurisdiction according to the Tribal Law and Order Act of 2010. Consequently, the state or municipal government is generally responsible for investigating sexual assault and domestic violence crimes, and the state is generally responsible for prosecuting such crimes. Specifically, Alaska state troopers are generally responsible for investigating sexual assault and domestic violence crimes in Alaska Native villages, although in some cases, municipal police departments are responsible for investigating such crimes within city limits. Alaska's Department of Law is responsible for prosecuting sexual assault and certain domestic violence crimes.²⁵

Regardless of jurisdiction, not all victims of sexual assault or domestic violence report these incidents to law enforcement or opt to receive medical forensic exams. Some stakeholders have identified numerous barriers to reporting sexual assault and domestic violence incidents, including the negative stigmas associated with being sexually assaulted or abused and the potential retribution a victim might endure from the alleged perpetrator or community, especially when the assaults take place in small communities where members are often related or depend on one another for survival. In terms of reports to law enforcement agencies, an average of 30.8 forcible rapes per every 100,000 persons were reported in the United States from 2004 through 2009, according to data from Justice's Uniform Crime Reporting Program.²⁶ Studies indicate, however, that many sexual assaults go unreported nationwide, and the precise number of sexual assaults and incidents of domestic violence remains unknown.

According to data from a Justice study, Indians in 2010 experienced violent crimes at over twice the estimated national rate—42 violent crimes per 1,000 Indians annually, compared with 15 per 1,000 persons nationwide.²⁷ We previously reported that domestic and sexual violence

²⁵In Anchorage and Juneau, the municipal prosecutor's office handles misdemeanor domestic violence cases.

²⁶Federal Bureau of Investigation, *Uniform Crime Reports, Crime in the United States, 2009*, accessed August 22, 2011, <http://www.fbi.gov/about-us/cjis/ucr/ucr>.

²⁷Department of Justice, Bureau of Justice Statistics, *National Crime Victimization Survey: Criminal Victimization, 2010*, NCJ 235508 (Washington, D.C.: 2011). Justice uses the term *Indian* in this study to refer to persons who self-identify as American Indian or Alaska Native and does not limit the term to those enrolled in state- or federally recognized tribes.

against Indian women is among the most critical public safety challenges, and also noted that alcohol and drug use often play a significant role in such violent crimes.²⁸ Specifically, Justice reported that 38 percent of Indian women were subjected to domestic violence during their lives and that Indian victims reported alcohol use by 62 percent of alleged perpetrators, compared with 42 percent for all races.²⁹ These issues are of particular concern to the state of Alaska, where the governor has made ending domestic violence and sexual assault a top priority given that, among other things, 76.2 forcible rapes per every 100,000 persons were reported to law enforcement agencies from 2004 through 2009, according to Uniform Crime Reporting statistics.³⁰ In addition, more than 9 percent of adult women in Alaska reported experiencing domestic violence, and more than 4 percent reported experiencing sexual violence in the past year, according to a state study of victimization.³¹

IHS's Ability to Collect and Preserve Medical Forensic Evidence Varies by Hospital

IHS has limited information on the ability of IHS and tribally operated hospitals to collect and preserve medical forensic evidence in cases of sexual assault and domestic violence, as needed for criminal prosecution—that is, on the hospitals' ability to offer medical forensic services. To collect this information, we surveyed the 45 IHS and tribally operated hospitals and found that the ability to provide these services varies from hospital to hospital, ranging from providing a broad array of on-site services, including performing medical forensic exams to collect physical and biological evidence, to choosing to refer patients to other facilities for such exams. We also found that the services available at a hospital generally developed without direction from IHS headquarters and have fluctuated over time. In addition, the utility of such evidence in any subsequent criminal prosecution depends on hospital staff's properly

²⁸[GAO-11-252](#).

²⁹Department of Justice, *Extent, Nature, and Consequences of Intimate Partner Violence, and A BJS Statistical Profile, 1992-2002*. As already noted, Justice uses the term *Indian* in these studies to refer to persons who self-identify as American Indian or Alaska Native and does not limit the term to those enrolled in state- or federally recognized tribes.

³⁰Federal Bureau of Investigation, *Uniform Crime Reports, Crime in the United States, 2009*.

³¹André B. Rosay et al., "2010 Alaska Victimization Survey" (presentation at the University of Alaska, Anchorage, September 2010).

securing and storing physical evidence, which may in turn depend largely on coordinating with law enforcement agencies.

IHS Had Limited Information on the Ability of Its Facilities to Offer Medical Forensic Services

IHS headquarters had limited information on the ability of its facilities to provide medical forensic services. We found that IHS could not give us comprehensive information about which of its facilities—including hospitals and clinics—provided medical forensic services for victims of sexual assault and domestic violence, although IHS officials identified hospitals as the facilities most likely to provide such services. IHS headquarters also could not identify how many providers at IHS hospitals have had SANE training or certification. In addition, we found that IHS headquarters does not centrally track the number of medical forensic exams performed at its facilities. In analyzing electronic data obtained from IHS headquarters on procedures done at the hospitals, we found that because of the way hospitals record these data, it is not possible to accurately isolate medical forensic exams from other medical activities related to incidents of sexual assault or domestic violence.³² IHS does, however, keep centralized data on where victims of sexual assault and domestic violence were seen and on the primary purpose of these patients' visits.³³

³²Some hospitals may track the number of medical forensic exams their staff perform, but such information may be collected by different hospitals using different methodologies and was not aggregated into IHS's centralized data systems.

³³This information showed that from fiscal year 2006 through fiscal year 2010, IHS and tribally operated hospitals recorded 2,882 visits for services related to adult sexual assault and 3,983 visits for services related to adult domestic violence. For children, during the same time period, 592 visits took place for services related to child sexual abuse and 421 visits for services related to child physical abuse. We do not know how many of these visits led to medical forensic exams, nor do we know how many other visits were not included in these data because they were initially given a primary purpose-of-visit code other than sexual assault or domestic violence: For example, a victim initially might have come in with a broken arm and only later be identified as having been involved in a sexual assault or domestic violence incident. These counts do not include any visits to Sage Memorial Hospital or Norton Sound Regional Hospital because we were unable to assess the reliability of data from these two hospitals.

Hospitals May Perform Medical Forensic Services on Site or Refer Victims to Other Facilities

The results of our survey of all 45 IHS and tribally operated hospitals showed that some hospitals typically provide medical forensic exams on site for both adult and child victims of sexual assault, others typically perform these exams for either adults or children but not both, and still others refer most or all sexual assault victims to other facilities (see table 2).

Table 2: Number of IHS and Tribally Operated Hospitals Performing Sexual Assault Medical Forensic Exams or Referring to Other Facilities, as of June 2011

	IHS	Tribal	Total
Hospitals that typically perform medical forensic exams			
Typically for both adults and children	4	3	7
Typically for adults only	9	8	17
Typically for children only	1	1	2
Subtotal	14	12	26
Refer ^a	14	5	19
Total	28	17	45

Source: GAO survey.

^aThe hospitals in this row generally refer all victims of sexual assault to other facilities. Two hospitals in this category reported sometimes performing medical forensic exams for adults, but they reported that they may still refer some adults and all children to other facilities. The remaining 17 hospitals reported they rarely or never perform medical forensic exams and refer all victims to other facilities.

Specifically, 26 of the 45 hospitals reported that they typically perform sexual assault medical forensic exams for adults, children, or both. Those hospitals reporting that they perform these exams only for adults refer all children to other facilities, and hospitals performing exams only for children refer all adults to other facilities. Additionally, all IHS and tribally operated hospitals reporting that they typically provide exams on site also aim to have staff present or on call so they can offer these services 24 hours a day, 7 days a week. Two hospitals also explained that they use traditional healing practices and objects when treating sexual assault victims (see fig. 4). The remaining 19 hospitals reported that they generally refer all adults and children to other facilities for these exams.

Figure 4: Items Used in Traditional Healing



Source: GAO (April 2011).

Note: Pictured items used in traditional healing (center left) include sweet grass, sage, and a shell used for burning the dried plants.

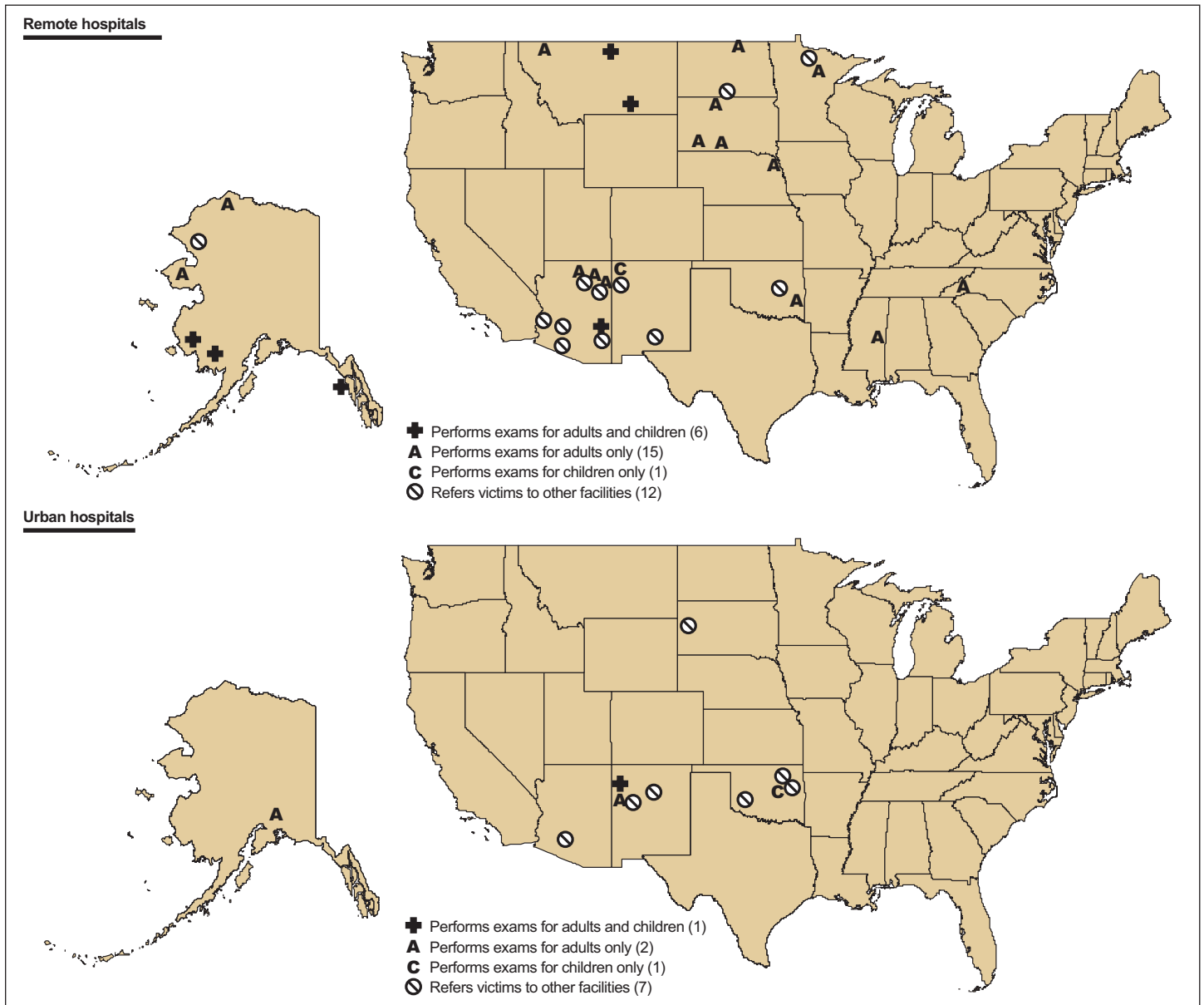
Among the seven hospitals that typically perform medical forensic exams for both adults and children, one tribally operated hospital in Alaska has a dedicated coordinator who has received SANE training and is available to perform exams for both adults and children 24 hours a day, 7 days a week. A victim of sexual assault who arrives at this hospital can typically be examined within a short time and in a room dedicated to sexual assault exams. Similarly, an IHS hospital in Arizona has a group of approximately 14 nurses and doctors who have received specialized training in sexual assault medical forensic exams, as well as a room largely dedicated to these exams. When a sexual assault victim arrives at this hospital, hospital staff contact 1 of the 14 nurses or doctors to perform the exam or, if none of these medical providers is present, a predesignated backup provider is called on. Children requiring an exam generally see a provider, when available, who has undergone specialized training in pediatric medical forensic exams.

A total of 19 of 45 hospitals reported typically performing medical forensic exams for either adult or child victims of sexual assault but not for both. For example, a South Dakota IHS hospital—which offers medical forensic services 24 hours a day, 7 days a week, with providers on 24-hour call—typically performs medical forensic exams for adults but not children. When an adult victim arrives, the emergency room does an initial medical screening and then calls one of three SANE-trained nurses to perform the medical forensic exam. But because this hospital does not have a provider trained to do these exams for children, it refers all child victims to a hospital in Pierre, which is 2 hours away by car, or to a hospital in Sioux Falls, which is 4 hours away. In contrast, an IHS hospital in New Mexico performs exams only for children. The providers at this hospital are available from 8 a.m. to 4:30 p.m. on weekdays and on call during nights and weekends; overall coverage is 24 hours a day, 7 days a week.

Hospitals that we categorized as being in remote areas³⁴ are more likely to perform medical forensic exams and less likely to refer victims elsewhere for service than IHS and tribally operated hospitals taken as a whole. Of the 34 hospitals categorized as remote, 22 hospitals reported that they are able to perform medical forensic exams for adults, children, or both; 12 of the 34 hospitals reported referring victims to other facilities. In contrast, the proportions are reversed among the 11 hospitals we categorized as urban, with 7 of them reporting that they refer all sexual assault victims to other facilities for exams (see fig. 5 for map of hospitals). For example, officials from an IHS hospital in the Phoenix, Arizona, area explained during a site visit that the hospital sees too few sexual assault cases to warrant having its own staff trained in performing medical forensic exams; in the officials' view, it makes more sense for the hospital to leverage existing resources by referring victims to a nearby facility offering medical forensic services.

³⁴Remote areas are those with dispersed and small populations and where travel times are longer because of limitations in transportation infrastructure.

Figure 5: Location of Remote (top) and Urban (bottom) Hospitals Performing Sexual Assault Medical Forensic Exams or Referring to Other Facilities



Source: GAO analysis and Map-Info (maps).

Note: Non-IHS facilities, such as child advocacy centers, also provide specialty services to children. For example, the tribally operated hospital in Anchorage refers children to the Alaska CARES clinic for medical forensic exams.

IHS and tribally operated hospitals vary not only in whether and for whom they can provide medical forensic services but also in the training their providers have received (see table 3). Of the 26 hospitals that typically perform medical forensic exams, 20 reported having providers who received specialized training or certification in sexual assault medical forensic exams. The remaining 6 hospitals reported offering medical forensic exams even if the providers performing the exams have not received this specialized training. In fact, several medical providers told us that traveling doctors and nurses, who temporarily work at an IHS hospital for a few weeks or months, may perform these medical forensic exams on site even if they have not received this specialized training. In discussions with hospital officials, we also found that hospitals referring sexual assault victims—whether adults or children—to other facilities for medical forensic exams may do so because they do not have medical providers on staff with this specialized training.

Table 3: Number of Hospitals That Reported They Typically Perform Sexual Assault Medical Forensic Exams and Level of Training Received by Providers

Level of training received by providers	Hospitals that typically provide medical forensic exams			Total
	Exams for adults and children	Exams for adults only	Exams for children only	
Medical forensic training for adults, children, or both ^a	7	13	0	20
No SANE training	0	4	2	6
Total	7	17	2	26

Source: GAO survey.

^aThis category includes hospitals with providers who have specialized training, including SANE training, in medical forensic exams. Trained staff are more prevalent than SANE-certified staff. Specifically, four hospitals that typically perform exams only for adults have SANE-certified staff, as does one hospital that typically performs exams for adults and children.

Many of the hospitals we surveyed reported that they typically perform medical forensic exams in cases of domestic violence. They may do so only in cases of domestic violence that also include a sexual component or, occasionally, when the injuries sustained from a discrete domestic violence incident without a sexual component are severe. Officials at several hospitals explained that for discrete domestic violence incidents (those that do not include a sexual component), law enforcement officers usually collect evidence, such as photographs of bruises or other injuries, for use in court. For example, officials at two separate hospitals explained that in cases of domestic violence, law enforcement officers take

photographs of physical injuries, and medical providers treat any injuries requiring medical attention.

Medical Forensic Services Have Developed Largely without Central Direction

In general, efforts to provide medical forensic services at the local level have fluctuated over time and have received limited funding from IHS. In discussions with hospital officials, we found that the provision of medical forensic services generally developed at a grassroots level, rather than in response to an explicit requirement from IHS headquarters. Local medical providers chose to provide such exams in response to an unmet need for such services in their area, not because IHS headquarters directed them to do so. For example, a nurse at one hospital explained that she and five other nurses attended SANE training after recognizing that medical providers at the hospital were uncomfortable doing sexual assault medical forensic exams. Additionally, an IHS official at another hospital explained that his staff began providing medical forensic services after the area office requested volunteers to pilot providing such services to better meet the area's needs.

We also found that the ability of an IHS or tribally operated hospital to offer medical forensic services has fluctuated over time. Some hospitals, for example, have been able to sustain or even expand their medical forensic services. In contrast, other hospitals have lost staff who were willing or trained to perform medical forensic exams and ceased offering these exams entirely or waited until new staff could be hired or trained. For example, officials from one hospital explained during a follow-up discussion with us that they recently ceased performing sexual assault medical forensic exams for adults when a shift in staffing resources left the hospital's emergency room without providers specially trained in performing such exams. Consequently, the hospital now performs medical forensic exams only for children and refers adult victims to a private hospital in a nearby city, which helps facilitate more consistent and timely evidence collection, according to a law enforcement official. Similarly, medical providers explained during a site visit that after the sole provider of medical forensic exams in a remote Alaskan community left, the hospital ceased offering medical forensic exams because none of its remaining staff had specialized training. As a result, all adults and children have since been flown several hours away to Anchorage to receive medical forensic exams. Given the importance of providing medical forensic services locally, however, the hospital staff said that they recently sent several staff for training in sexual assault medical forensic exams and hired someone to serve as a coordinator for this effort.

Furthermore, efforts by IHS headquarters to fund medical forensic services have been limited. The agency has provided some funding for training and equipment to hospitals or staff, but this funding has been infrequent or limited, according to IHS officials. Specifically,

- *Pilot program.* In 2002 and 2003, IHS used a grant from Justice to fund two of its hospitals—one in Shiprock, New Mexico, and the other in Pine Ridge, South Dakota—to pilot offering medical forensic exams for adult victims of sexual assault. As part of this pilot program, the hospitals received funding to send their providers to SANE training and to purchase equipment needed for medical forensic exams, such as digital cameras. A hospital official at one of these hospitals explained that it still offers medical forensic exams and, to better meet patients' needs, is expanding its services to also include a clinic more centrally located on the vast reservation, to provide services closer to patients' homes. An IHS official at the other pilot-program hospital explained that it ceased offering medical forensic exams in 2007 after too many of its specially trained medical forensic examiners left. This hospital now sends its patients across state lines to a private provider.
- *Limited funds for training or equipment.* IHS has at times paid for staff at some of its hospitals to receive SANE training, but such funding was not part of a comprehensive effort to develop medical forensic capacity at IHS facilities. From fiscal year 2003 through fiscal year 2011, IHS provided \$45,000 for three training sessions for 60 providers. But agency officials also explained that IHS has provided no additional funding for hospitals to purchase equipment to conduct these exams. According to staff from one IHS hospital, they have had to use a digital camera belonging to the local Bureau of Indian Affairs law enforcement office to photographically document physical injuries as evidence because they did not have funding to purchase their own camera.
- *IHS Domestic Violence Prevention Initiative.* IHS received a \$7.5 million appropriation for its domestic violence prevention initiative in fiscal year 2009 and another \$10 million appropriation in fiscal year 2010. The Domestic Violence Prevention Initiative expands prevention, advocacy, outreach, and medical forensic services in cases of domestic violence and sexual assault. Of this total funding, \$3.5 million funded medical forensic services such as exams, and the remaining funded prevention, advocacy, outreach, and coordination. In fact, of the 65 projects IHS funded through this initiative, 8 projects aimed to use this money for improving medical forensic services at IHS or tribally operated hospitals. Further, seven of these eight projects funded hospitals that

already had some staff on board who were specially trained in providing sexual assault medical forensic exams.

The Preservation of Medical Forensic Evidence Depends in Large Part on Hospital Coordination with Law Enforcement

The specific policies or procedures that IHS has developed to preserve medical forensic evidence vary from hospital to hospital and may depend greatly on coordination with the law enforcement officers who take possession of the evidence for use in the criminal justice system. Improperly securing medical forensic evidence or improperly maintaining its chain of custody—that is, the process that demonstrates the chronological documentation of the collection, custody, control, transfer, analysis, and disposition of the evidence—can undermine the evidence’s usefulness in a criminal investigation or prosecution. Consequently, according to Justice protocols, it is imperative to properly preserve the evidence collected during a medical forensic exam. Proper preservation includes, among other things, securing the physical evidence from contamination or adulteration, as well as properly following and documenting the chain of custody. We found that some hospitals had specific procedures in place for storing and securing physical evidence, and others did not.

In discussions with law enforcement officers and hospital staff, we found that the way a hospital does or does not preserve the medical forensic evidence it collects, such as biological materials or statements from victims, largely depends on the extent or type of coordination with law enforcement. For example, at one hospital, providers and law enforcement officers told us they jointly developed a protocol to store evidence from completed exams in a locked cabinet to which only law enforcement officers have the key. This protocol ensures that if a law enforcement officer cannot immediately take possession of the evidence, it is nevertheless stored in a fashion that properly maintains the chain of custody. Similarly, an official at another hospital explained that medical forensic evidence is stored in a locked filing cabinet in the SANE coordinator’s office until a law enforcement officer signs a release form to take possession of it—an arrangement developed between the hospital and law enforcement to better maintain the chain of custody. In other communities, multidisciplinary groups—such as sexual assault response teams, which coordinate community efforts related to cases of adult sexual assault, or multidisciplinary teams established by prosecutors for cases involving children—provide opportunities for hospital staff to

develop evidence preservation procedures.³⁵ For example, officials from an IHS hospital in a mandatory Public Law 280 state told us that its new sexual assault response team was instrumental in determining the most appropriate law enforcement agency—tribal, local, or county—to call to take possession of medical forensic evidence. Additionally, some hospital officials told us that they do not specifically coordinate with law enforcement or had no specific evidence preservation procedures because they assume that an officer will immediately take possession of any medical forensic evidence collected. Such assumptions do not always hold, however, such as if the law enforcement officer is called away to investigate another crime or cannot wait in the hospital for completion of the multihour medical forensic exam. Differences in how hospitals preserve medical forensic evidence may also stem in part from the type of training received by those who perform medical forensic exams. For example, SANE training covers securing evidence and maintaining its chain of custody. Providers who do not receive such specialized training may be relying on following the instructions contained in an evidence collection kit—a process that some stakeholders told us may miss important steps.

IHS and Tribal Hospitals Face Several Challenges in Standardizing and Sustaining the Provision of Medical Forensic Services

Since enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (on March 23, 2010) and the Tribal Law and Order Act of 2010 (on July 29, 2010), IHS has made significant progress in developing policies and procedures regarding medical forensic services for victims of sexual abuse, as the acts required.³⁶ IHS worked expeditiously to establish its first agencywide sexual assault policy within the 1-year deadline established by the Indian Health Care Improvement Act. The new policy, issued in March 2011, is an important and sound first step in what is planned to be a continuing effort to provide a standardized level of medical forensic services. As part of this effort, IHS has a number of important initiatives under way or under consideration, and events are

³⁵Sexual assault response teams often include, among others, SANEs or sexual assault forensic examiners, representatives from relevant law enforcement, and a victims' advocate. Multidisciplinary teams often include these groups as well as a representative from the federal prosecutor's office.

³⁶Indian Health Care Improvement Reauthorization and Extension Act of 2009, Pub. L. No. 111-148, Title X, § 10221(a) (2010); throughout this report, we refer to this law as the Indian Health Care Improvement Act. Tribal Law and Order Act of 2010, Pub. L. No. 111-211, § 265 (2010).

unfolding rapidly. For example, in partnership with Justice, a new position was created in IHS headquarters for a sexual assault exam and response coordinator, and the position was filled in August 2011.

Still, IHS faces a number of important challenges as it attempts to implement its new policy and continues to respond to incidents of sexual assault and domestic violence. These challenges include systemic issues—such as overcoming long travel distances and developing staffing models that overcome problems with staff burnout, high turnover, and compensation—so that standardized medical forensic services can be provided over the long term. Specifically, we found that hospitals face the following four challenges in standardizing and sustaining the provision of medical forensic services:

- overcoming long travel distances;
- establishing plans to help ensure that hospitals consistently implement and follow the March 2011 policy;
- developing similar policies for domestic violence and child sexual abuse; and
- developing sustainable staffing models that overcome problems with staff burnout, high turnover, and compensation.

In general, our work confirmed that IHS is aware of the challenges that it faces and either has initiatives under way to address them or is trying to formulate such initiatives.

Overcoming Travel Distances

We found that long travel distances between IHS patient populations and hospitals—often across remote terrain with few, if any, roads—pose a barrier to access to a full range of medical services that an IHS beneficiary might need, including medical forensic services. Distances are of particular concern in Alaska, where sexual assault or domestic violence victims from remote Alaska Native villages must travel hundreds of miles to hospitals offering on-site medical forensic exams. Travel is typically possible only by airplane or snow machine; most villages are not accessible by road. (See fig. 6 for a picture of the ambulance used in one of the villages.)

Figure 6: Small Ambulance Serving Remote Alaska Native Village

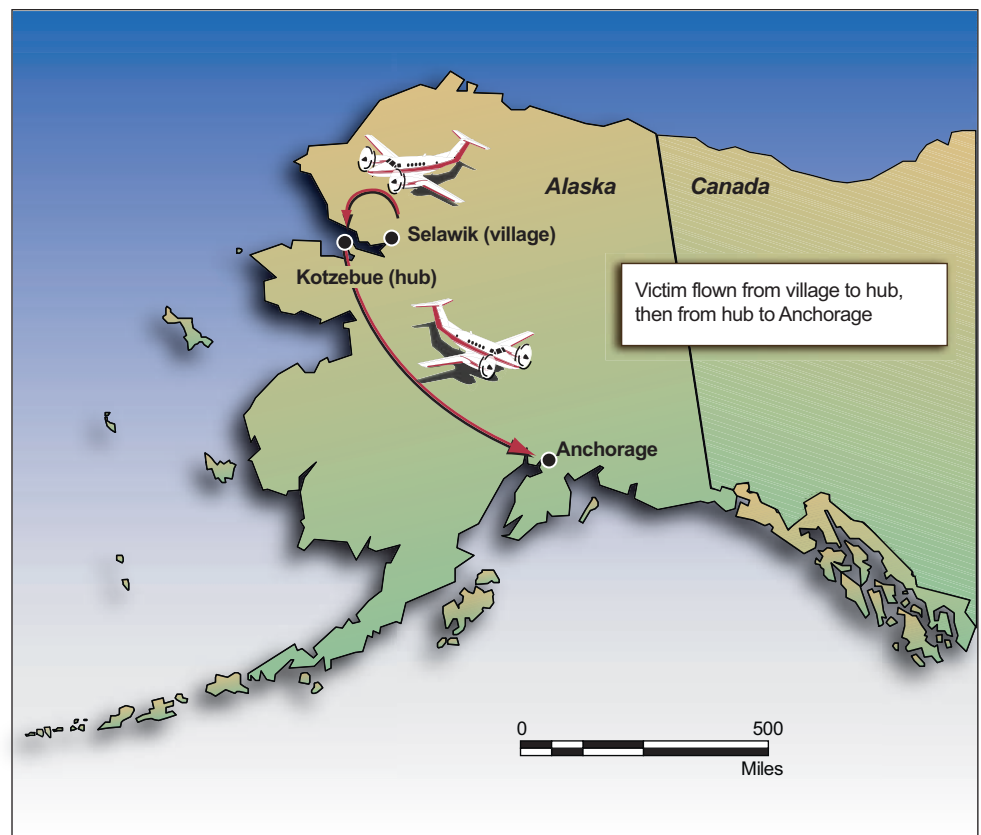


Source: GAO (May 2011).

Further, victims must typically rely on law enforcement to arrange air transportation, and bad weather may delay flights for hours or days, according to stakeholders. Victims living in regions where the nearest hospital does not provide on-site medical forensic services must often undertake multistage trips to find access to these services. For example, medical providers told us that victims from remote villages near Kotzebue, where the hospital does not provide on-site medical forensic services,

must take at least two flights to reach a hospital that does: a first flight from their village to Kotzebue and a second one from Kotzebue to Anchorage (see fig. 7).³⁷

Figure 7: Two-Flight Itinerary from a Remote Alaska Native Village When Victims Need Medical Forensic Services



Source: GAO and Map Art (map).

Great distances may also separate beneficiaries needing medical forensic services from hospitals providing these services in states other than Alaska. For instance, IHS hospitals in Arizona have contracted with an air ambulance provider to transport patients via helicopter or airplane to Phoenix for medical services, including medical forensic exams. Such

³⁷The flight from Kotzebue to Anchorage may have a layover in Nome.

trips can each cost IHS several thousand dollars, according to IHS officials.

Medical providers, law enforcement, and prosecutors expressed concerns that long travel distances may deter victims from reporting sexual assault and domestic violence and delay collection of the medical forensic evidence needed for prosecution. They said that great distances may also discourage victims from reporting assaults to law enforcement and seeking medical forensic exams, particularly for victims from remote villages who may need to take two or more flights to obtain an exam. Also, victims in remote Alaska Native villages who wish to remain anonymous cannot do so because they generally rely on law enforcement for air transportation. Moreover, at least one stakeholder told us that travel delays due to bad weather may make it difficult to collect medical forensic evidence within the 72- to 96-hour time frame in which such evidence is considered most viable. According to stakeholders we spoke with, such long delays are rare, but any delay increases the chance that physical evidence will become contaminated or lost and that victims may forget details of the assault.

To help address long travel distances, some hospitals and other stakeholders, such as law enforcement agencies, told us they are considering or have suggested expanding medical forensic services to clinics, either through telemedicine or by training additional medical providers, and expanding the role of community health aides, the primary medical providers in remote Alaska Native villages.³⁸ Telemedicine technology uses video conference, remote monitoring equipment, and electronic health records to link patients in remote areas to medical providers located elsewhere. Telemedicine connects patients in remote clinics in Alaska to dental, skin, and other health care services and could be expanded to support treating victims of sexual assault, according to some stakeholders. One IHS hospital in Montana, for example, is considering using telemedicine to enable the hospital's specially trained medical forensic examiners to consult on child sexual abuse cases—to determine if a specific injury is consistent with abuse, for example—with medical providers in remote clinics who do not have this specialized training. Before such a plan could be put in place, however, officials from

³⁸Community health aides are trained in basic emergency and primary health care through a statewide training program in Alaska. They are typically selected from village residents and practice under supervision by licensed physicians.

the organization that develops telemedicine technology in Alaska told us, concerns would need to be addressed about how to securely store and transmit medical files to protect victim confidentiality and maintain the evidentiary chain of custody. Rather than use telemedicine, the IHS hospital located on the edge of a vast reservation is seeking to bring medical forensic services closer to its beneficiary populations by developing the capacity to perform medical forensic exams at a centrally located clinic, according to an IHS official. The hospital has identified clinic nurses who are interested in receiving specialized training in conducting the exams.

A few stakeholders also suggested to us that community health aides could play a larger role in collecting and preserving medical forensic evidence. Medical providers and community health aides themselves, however, voiced concerns to us about such a proposal. In cases of sexual assault, health aides' scope of practice and training are currently limited to tasks such as treating victims' injuries and protecting evidence, such as clothing, until law enforcement officers arrive; health aides are not authorized to perform medical forensic exams or to collect evidence themselves. Among the concerns community health aide officials mentioned to us is that expecting health aides to perform such exams, on top of the many tasks already required of them, may increase burnout rates; they said that such an expectation may also put the health aides at risk of retaliation from alleged perpetrators or others in a village. Other suggestions made by stakeholders have included that health aides should receive additional training on the sexual assault response tasks that are already within their scope of practice. For example, medical providers told us that health aides in Alaska's Yukon-Kuskokwim delta area attended training in 2010 designed to help health aides and law enforcement officers understand what health aides should and should not be expected to do when responding to sexual assault cases. The training focused on the actions health aides can already take to assist the response of law enforcement officers and hospitals in such cases, such as asking victims not to wash or change clothes before undergoing a medical forensic exam.

Establishing Plans to Help Ensure That Hospitals Consistently Implement and Follow the March 2011 Sexual Assault Policy

Now that its initial sexual assault policy is in place, IHS faces the challenge of ensuring that its hospitals consistently implement the policy and follow its guidelines. IHS is taking initial steps to help hospitals implement the policy but has not yet developed written, comprehensive plans for implementation and monitoring. For example, IHS officials told us the agency is planning to use funding from the existing Domestic

Violence Prevention Initiative to provide policy training to IHS hospitals and to expand specialized medical forensic training opportunities. IHS has also partnered with Justice's Office for Victims of Crime to fund a national sexual assault exam and response coordinator position within IHS; the position—which was filled in August 2011—may play a role in helping implement and monitor the March 2011 policy. Nevertheless, IHS has not yet developed plans for implementing and monitoring the policy as a whole. Justice officials echoed these concerns, given most hospitals' limited technical expertise in medical forensic exams and general lack of resources for responding to sexual assault.

The Indian Health Care Improvement Act also requires IHS to report to Congress by September 23, 2011, on “the means and extent to which the Secretary has carried out” the act's requirement to establish appropriate policies, among other things, for responding to victims of sexual abuse and domestic violence.³⁹ Agency officials told us that at the time of this report, IHS had not yet identified sufficient resources for implementing the policy as a whole, nor had it developed time frames for implementing major objectives in the policy. Specifically, the agency had not identified resources for purchasing equipment and supplies, such as digital cameras and special forensic evidence-drying cabinets, required under the policy for hospitals providing on-site medical forensic exams. Furthermore, the agency has set December 31, 2012, as the deadline for medical providers to be “credentialed and privileged” as specially trained medical forensic examiners, but it has not identified deadlines IHS hospitals should meet in implementing other parts of the policy, such as providing access to medical forensic exams on site or by referral, or collaborating with the objective of creating sexual assault response teams. The agency has also not made plans to monitor whether IHS hospitals are following the policy, such as whether hospitals located more than 2 hours away from other facilities are developing the capability to provide on-site medical forensic exams or how well hospitals coordinate their activities with law enforcement and prosecutors.

³⁹Indian Health Care Improvement Reauthorization and Extension Act of 2009, Pub. L. No. 111-148, Title X, § 10221(a) (2010). The agency has drafted the required report to Congress, according to an IHS official, but it is currently under review and is thus not available.

Coordination is important because it helps ensure that medical providers collect and preserve evidence in a way that is useful for prosecution. Our review found that hospitals' coordination with law enforcement agencies and prosecutors varied greatly. Hospitals that do not coordinate regularly with law enforcement and prosecutors may unintentionally collect and preserve evidence in a way that hampers the investigation or prosecution of cases. For example, law enforcement officers in one location told us that before a candid meeting between medical providers and the prosecutor took place, providers were unknowingly violating the chain of custody to such a degree that the prosecutor could not reliably use their evidence for prosecution. The officers said that the meeting served as a catalyst for the medical providers to attend SANE training and for law enforcement officers, the prosecutor, and medical providers to develop a collaborative response to collecting and preserving evidence in sexual assault cases. Increased coordination between the hospital and law enforcement also led one hospital to install a locking cabinet (see fig. 8) to securely store collected medical forensic evidence before transferring it to law enforcement. Other medical providers told us they had not received feedback on medical forensic evidence collection and preservation from law enforcement officers or prosecutors. In one location, providers told us they kept completed exam kits with them at all times—even taking the kits home overnight—until law enforcement took possession of the kits, even though Justice officials told us that such practices could undermine the chain of custody. IHS's March 2011 sexual assault policy calls on hospitals to coordinate with law enforcement and prosecutors, but Justice officials expressed concerns that many hospitals do not have working relationships with law enforcement and prosecutors that would enable such coordination. Furthermore, the policy does not specify how IHS headquarters will support its hospitals in building such relationships or initiating a coordinated response to sexual assault.

Figure 8: Locking Storage Cabinet for Medical Forensic Evidence



Source: GAO (December 2010).

According to an agency official, IHS did not have time to develop implementation and monitoring plans before the March 2011 deadline established for issuing a policy under the Indian Health Care Improvement Act. Furthermore, the agency did not seek comments from tribes before issuing the policy and therefore asked the tribes for feedback after releasing the policy. According to IHS officials, comments from tribes were due on May 30, 2011, and the agency was analyzing these comments and intending to issue a revised policy.

One area of IHS's March 2011 policy we found to have caused some confusion deals with guidelines for specialized training and certification for medical providers. The policy stipulates that nurses, physicians, and physician assistants must all complete specialized training in performing

sexual assault medical forensic exams.⁴⁰ The policy is unclear, however, about whether, to perform these exams, medical providers need to obtain documentation of competency beyond this training, especially for physicians and physician assistants. Sections 3.29.1 and 3.29.5 of the policy use the terms “credentialed” and “certified” interchangeably—in defining sexual assault nurse and forensic examiners, in delineating requirements for training and determining competency to perform these exams, and in describing how staff obtain privileges to perform these exams at IHS hospitals.⁴¹ These sections do so even though “credentialing” generally refers to an internal process for allowing medical providers to perform specific services in IHS hospitals, and “certification” is the term used by Justice in its sexual assault protocols and is also typically used by the organization that developed the SANE specialty to denote someone who has demonstrated competency in medical forensic exams and passed a required test. By using these terms interchangeably, the policy leaves unclear whether medical providers such as physicians and physician assistants must obtain specialized training and certification—or just training—before performing sexual assault medical forensic exams. IHS officials we spoke with provided conflicting interpretations of the policy, from interpreting it as calling for certification for sexual assault forensic examiners to calling only for training for these medical providers. IHS officials acknowledged, however, that no third-party certification exists for sexual assault forensic examiners in the same way it exists for nurses, which may imply that IHS would need to develop its own certification of sexual assault forensic examiners more broadly. IHS officials acknowledged to us that the agency has no plans to develop such a certification.

Law enforcement officers and prosecutors told us that variable levels of specialized training among medical providers have sometimes led to inconsistencies in the quality and type of medical forensic evidence collected. Specifically, they said that compared with medical forensic exams performed by medical providers with specialized training, exams

⁴⁰According to IHS officials, community health aides are generally not eligible to perform medical forensic exams under the March 2011 policy because they typically are not registered nurses, physicians, or physician assistants.

⁴¹Sections 3.29.1.E.20 and 24 of the March 2011 policy define sexual assault nurse and forensic examiners, section 3.29.5.A delineates requirements for training and determining competency to perform medical forensic exams, and section 3.29.5.B describes how staff obtain privileges to perform such exams at IHS hospitals.

performed by medical providers without such training have been of lower quality or did not include certain pieces of evidence. A law enforcement officer and prosecutors told us that medical providers with SANE training were more familiar with procedures for collecting evidence and better able to document the intricacies of injuries and identify subtle signs of assault, such as small scratches and bruises, than medical providers who did not have specialized training. A law enforcement officer in one location told us about a child sexual abuse case in which a physician without specialized training found no evidence of abuse after performing a medical forensic exam; in contrast, a SANE-trained medical provider who performed a subsequent exam found internal injuries and other evidence of sexual abuse—evidence the physician without specialized training missed. Stakeholders also told us that because of their specialized training, SANE-trained medical providers understand the importance of identifying and collecting evidence consistent with a victim’s account of an assault, rather than simply following the generic step-by-step instructions in an evidence collection kit. For example, one victims’ advocacy group told us about a case in which a medical provider without specialized training collected only vaginal swabs from a victim when the assault actually involved anal rape—all because the medical provider did not ask the victim to describe the assault. No consensus exists on the specific threshold of specialized training needed to perform adequate exams; law enforcement officers and prosecutors we spoke with, however, generally agreed that some level of specialized training helps improve the quality of evidence collection.

Without clear training and certification guidelines for physicians and physician assistants, medical forensic exams may continue to be performed by medical providers with inconsistent levels of knowledge and expertise. As a result, IHS beneficiaries cannot be assured of uniform quality in medical forensic services received, and law enforcement entities cannot count on uniform quality in the medical forensic evidence collected and preserved, even with IHS’s new sexual assault policy. Furthermore, calling for nurses to be SANE certified or physicians and physician assistants to be certified as sexual assault forensic examiners—if such a certification is developed—may be a difficult standard for hospitals to meet. Very few hospitals currently have nurses certified as SANEs, no comparable certification exists for physicians and physician assistants, and some medical providers we spoke with told us it can be challenging to complete the clinical training needed to be eligible for SANE certification. Some medical providers told us they are planning to complete their clinical training at another facility because their home hospital does not have a certified SANE provider who can validate their

competency or does not see enough sexual assault cases to provide sufficient practical experience in performing medical forensic exams to demonstrate competency. Moreover, hospitals already face considerable challenges in attracting and retaining medical providers who are willing or able to perform the exams; calling for certification may unintentionally exacerbate this challenge, even though several stakeholders told us that it is the SANE training rather than the certification that is most important for performing high-quality medical forensic exams.

In addition to the lack of clarity around training and certification guidelines for physicians and physician assistants under IHS's new sexual assault policy, we have concerns that implementing and monitoring the policy's overall training and certification guidelines may be challenging given IHS headquarters' limited knowledge about how many of its medical providers have such training or certification. Without this baseline information, the agency may be unable to accurately allocate resources for training or identify IHS hospitals with certified SANE providers who can train or validate the competency of providers from other IHS hospitals. The agency also does not have a system in place to track providers' progress toward meeting its training and certification guidelines. As a result, it may be unable to hold hospitals accountable for following this section of the policy.

Developing Policies on Domestic Violence and Child Sexual Abuse

IHS's March 2011 sexual assault policy instructs IHS hospitals to provide a standardized response to adult and adolescent victims of sexual assault.⁴² Specifically, the new policy calls for all IHS-operated hospitals to provide adult and adolescent patients who arrive in need of a medical forensic exam with access to an exam by a medical forensic examiner, either on site or by referral to a nearby facility. The new policy covers adult and adolescent victims of sexual assault, but it does not cover whether or how hospitals should respond to discrete incidents of domestic violence that do not include a sexual component or cover cases of child sexual abuse. Consequently, IHS hospitals do not have specific or recently updated guidance on whether to provide medical forensic services for victims of domestic violence and child sexual abuse; as a

⁴²IHS generally defines an adolescent as an individual who has entered puberty but is below the age of full maturity (18 years of age), according to this policy, and it defines a child as an individual who has not yet reached adolescence.

result, these victims may not have access to the full range of services they need.

Agency officials told us that IHS is deciding how to provide direction on responding to incidents of domestic violence and child sexual abuse—whether through new policies or by updating existing sections of the *Indian Health Manual*—but that the agency does not have concrete plans to develop policies similar in scope and specificity to the March 2011 sexual assault policy. The Indian Health Care Improvement Act requires IHS to establish “appropriate protocols, policies, procedures, [and] standards of practice . . . for victims of domestic violence and sexual abuse” and to develop appropriate victim services, including improvements to forensic examinations and evidence collection.⁴³

According to an IHS official, the agency did not have time to develop a separate domestic violence policy before the Indian Health Care Improvement Act’s March 2011 deadline for establishing such a policy.⁴⁴

In addition, the agency decided to limit the policy’s scope to adults and adolescents because Justice has not yet developed child sexual abuse protocols and recommended against including child sexual assault and adult sexual assault in the same protocol. Moreover, the Tribal Law and Order Act of 2010 directs IHS to base its sexual assault policies and protocols on those established by Justice.⁴⁵ Therefore, the March 2011 policy does not address child sexual abuse.

IHS officials also acknowledged that the sexual assault policy applies only to IHS-operated hospitals,⁴⁶ not tribally operated hospitals. In accordance with the Indian Self-Determination and Education Assistance Act, the self-determination contracts and self-governance compacts under which tribes operate hospitals generally do not require compliance with IHS policy. An objective of the Indian Self-Determination and Education Assistance Act is to assure the maximum Indian participation in the direction of federal

⁴³Indian Health Care Improvement Reauthorization and Extension Act of 2009, Pub. L. No. 111-148, Title X, § 10221(a) (2010).

⁴⁴IHS officials told us they plan to develop additional guidance related to domestic violence, but details were not available during our review about the scope and specificity of this planned guidance.

⁴⁵Tribal Law and Order Act of 2010, Pub. L. No. 111-211, § 265 (2010).

⁴⁶IHS officials also acknowledged that its policies, including the sexual assault policy, apply to all IHS employees even if they work at a tribally operated facility.

services to “Indian communities so as to render such services more responsive to the needs and desires of those communities.”⁴⁷

Accordingly, tribes are accountable for managing day-to-day operations of IHS-funded programs, services, and activities included in their self-determination contract or self-governance compact. Tribes thereby accept the responsibility and accountability to beneficiaries under the contract with respect to use of the funds and the satisfactory performance of IHS programs, functions, services, and activities funded under their contract. At the same time, it is the policy of the Secretary of Health and Human Services to facilitate tribal efforts to plan, conduct, and administer programs, functions, services, and activities under the act. To that end, as requested, IHS may provide technical assistance to tribes in developing their capability to administer quality programs. According to IHS officials, tribally operated hospitals may choose to use IHS’s March 2011 policy as a model for developing their own sexual assault policies.

IHS could negotiate contract or compact provisions requiring tribes to abide by IHS’s sexual assault policy, but the tribes would have to agree to such a provision. IHS officials told us the agency is hesitant to pursue this approach, and has not generally used it, because a multitude of other issues are also up for negotiation. Furthermore, IHS officials indicated that they do not plan to include such a provision in compacts or contracts the agency negotiates.

Developing Sustainable Staffing Models

Hospital officials told us they face challenges in designing staffing models for collecting and preserving medical forensic evidence that can overcome problems with staff burnout, high turnover, and compensation over time. In some hospitals where we conducted interviews, medical forensic services were not organized into a formal program or housed within a specific hospital department. Instead, several officials told us, medical forensic exams are performed by individual medical providers, sometimes from different departments, and often outside the medical providers’ official job duties and beyond their normal working hours. For example, at one hospital, officials told us that nurses from different units received specialized training in performing medical forensic exams and agreed to be on call to perform the exams day or night. Performing these exams was not written into the nurses’ formal job descriptions, however,

⁴⁷25 U.S.C. § 450a.

and the nurses were expected to complete their official job duties, as well as medical forensic activities. Medical providers told us that burnout may occur for several reasons—including stress, lack of supervisor support, and inadequate compensation—stemming from staffing arrangements in which medical providers perform exams in addition to their official job duties.

Potential burnout is a serious concern because it can undermine a hospital's ability to sustain access to medical forensic services. IHS officials acknowledged that turnover rates for medical providers specially trained in performing medical forensic exams are generally very high, with such providers often leaving IHS facilities after only 2 years. Some medical providers told us they find it stressful to balance their normal job duties with providing medical forensic services. For example, in one hospital, several medical providers described the staffing arrangement for medical forensic exams as relying on nurses performing the work of two full-time jobs—their official jobs and their medical forensic exam duties—while receiving compensation only for their official jobs.

In some hospitals, moreover, medical providers told us that their supervisors do not consistently allow them to participate in tasks outside of their normal duties. For example, medical providers told us about instances in which supervisors did not permit them to take time away from their normal duties to attend sexual assault response team meetings; as a result, the medical providers missed the meetings or worked beyond their normal hours to attend. In other cases, because of general hospital understaffing, some medical providers were unable to find backup coverage for their normal duties when called away for several hours to perform medical forensic exams. Consequently, some medical providers had to leave their normal duties unattended or have victims wait to receive exams until the medical providers' normal shifts were over, which is stressful, according to at least one medical provider.

In addition to issues related to understaffing, medical providers performing medical forensic exams over and above their normal duties said that they may not receive enough compensation to prevent attrition. The type and amount of compensation provided for performing medical forensic exams vary across hospitals, with some medical providers receiving overtime pay or compensatory time off and others receiving nothing beyond their normal salaries. Some medical providers told us they had trouble obtaining sufficient compensation. For example, medical providers in one hospital told us they receive compensatory time off for performing medical forensic exams, but they can rarely use the additional

leave hours because the hospital is too short-staffed to approve time off. In another hospital, nurses who provided medical forensic exams in addition to their normal job duties found it difficult to obtain approval from their supervisors for overtime pay when performing the exams made them exceed their normal hours. The overtime rate the nurses said they were paid was commensurate to the nurses' regular hourly rate, not the time and a half usually accorded for overtime. The former SANE coordinator at this hospital told us that such compensation challenges contributed to nurses' burning out over time and ceasing their medical forensic exam duties. When the nurses stopped offering the exams, the hospital was unable to provide exams for victims who needed them and began referring victims to another facility, according to the coordinator.

Concerning staffing, we have issued a guide federal agencies can use in maintaining or implementing effective internal control.⁴⁸ One of the factors this guide states that agencies should consider in determining whether a positive control environment has been achieved⁴⁹ concerns organizational structure and whether the agency has the appropriate number of employees—specifically, so that employees do not have to work outside the ordinary workweek to complete their assigned tasks. Additionally, in its 2006-2011 Strategic Plan, IHS acknowledges the difficulty the agency has long faced in attracting and retaining medical providers across IHS. Attraction and retention is particularly challenging for remote facilities in isolated areas, where medical providers may be offered incentive pay for accepting positions. The agency's strategic plan outlines strategies for recruiting, retaining, and developing employees, stating that the agency will “ensure an ongoing process to identify and

⁴⁸GAO, *Internal Control Management and Evaluation Tool*, [GAO-01-1008G](#) (Washington, D.C.: Aug. 6, 2001). This guide is based on GAO's *Standards for Internal Control in the Federal Government* ([GAO/AIMD-00-21.3.1](#), November 1999). As programs change and agencies strive to improve operational processes and implement new technological developments, management must continually assess and evaluate its internal, or management, control to assure that the control activities being used are effective and updated when necessary. This tool is not required to be used but is intended to help agencies determine how well their internal control is designed and functioning and to help determine what, where, and how improvements, when needed, may be implemented.

⁴⁹One of the five standards for internal control is control environment, which states that management and employees should establish and maintain an environment throughout the organization that sets a positive and supportive attitude toward internal control and conscientious management.

implement the best practices related to staff retention” and “continue to explore options to provide adequate staffing for all facilities.”⁵⁰

Some hospitals have already identified and implemented staffing options for medical forensic services, which aim to address concerns about provider burnout and sustainability. Several hospitals have incorporated medical forensic services into normal job duties for medical providers in a specific hospital department. For example, at one hospital in South Dakota, medical providers told us that most nurse midwives within the hospital’s midwife clinic receive SANE training and perform medical forensic exams as part of their normal clinic duties. In addition, several hospitals in Alaska have hired sexual assault response team coordinators, whose part- or full-time responsibilities are to manage the hospitals’ medical forensic services and perform medical forensic exams, according to hospital officials. An official at one hospital told us the hospital provided retention pay in an effort to adequately compensate medical providers for performing these exams.

Such options may help reduce medical provider stress and burnout, but no single staffing arrangement works for all hospitals or medical providers. For example, medical providers from one hospital told us their hospital considered incorporating the exams into providers’ job descriptions but decided not to because doing so would make it even more difficult to attract candidates for already hard-to-fill positions. In addition, one stakeholder told us many hospitals do not see enough sexual assault cases to warrant a part- or full-time position for a sexual assault response team coordinator. Moreover, according to IHS officials, annual pay caps may limit the amount of bonus or retention pay that medical providers are eligible to receive for performing medical forensic exams. IHS is developing a proposal to separate the salary series of advanced practice nurses—the type of nurse likely to perform medical forensic exams within IHS—from other registered nurses so that advanced practice nurses can receive higher maximum pay. IHS officials told us this proposal may help address the constraints imposed by salary caps, which currently make it impractical for many nurses to be compensated for performing medical forensic exams.

⁵⁰Department of Health and Human Services, Indian Health Service, *Strategic Plan 2006-2011* (Washington, D.C.: 2006), 40.

Factors besides Medical Forensic Evidence also Contribute to Decisions to Prosecute Cases of Sexual Assault and Domestic Violence

Decisions to prosecute sexual assault or domestic violence cases are based on the totality of evidence collected, one piece of which is medical forensic evidence collected by IHS and tribally operated hospitals. Many of the factors contributing to a decision to prosecute are not unique to incidents of sexual assault or domestic violence involving Indians in remote reservations or villages; nevertheless, prosecutors acknowledged, they affect the totality of the available evidence and thus contribute to decisions to prosecute such cases. Specifically, officials from the responsible law enforcement and prosecuting agencies told us they generally base their decisions to refer sexual assault or domestic violence investigations for possible prosecution and to accept these matters for prosecution on the total picture presented by the quality and quantity of available evidence. Prosecutors and law enforcement officials said they consider several factors—including medical forensic evidence collected by hospitals. They also said that the relative importance of these factors can differ from case to case. In some cases, medical forensic evidence may be a crucial factor; in others, however, it may not be relevant or available. For example, photographic evidence or DNA collected during a genital exam may be critical in showing that an alleged perpetrator had sex with the victim, but such medical forensic evidence may not be relevant when the victim and alleged perpetrator admit to having had sex but disagree as to whether the sex was consensual. In many of those cases where consent is the main issue, according to prosecutors and Justice's sexual assault protocols, medical forensic evidence does not reveal physical injuries that readily demonstrate a lack of consent. Also, law enforcement officials and prosecutors told us that medical forensic evidence may be unavailable if a victim reports an assault weeks or months later, as often happens in cases of child sexual abuse, because, for example, DNA evidence or relevant fibers would likely have washed away or become contaminated in the meantime.

In addition to this medical forensic evidence, law enforcement officials told us that when deciding whether to refer an investigation for possible prosecution, they consider several other factors, including quality of the criminal investigation conducted, credibility of witnesses who may have been intoxicated at the time of the assault, and coordination with relevant agencies to obtain supporting evidence. For example, federal prosecutors acknowledged that quality of the criminal investigation is important because evidence in a criminal matter must meet a relatively high threshold to be accepted for prosecution—that is, prosecutors must believe that existing evidence is compelling enough to demonstrate to a jury guilt beyond a reasonable doubt. As a result, prosecutors acknowledged that a law enforcement agency that refers all criminal

investigations involving sexual assault for possible prosecution—regardless of whether the extent or quality of evidence collected during its investigation would warrant such a referral—may find that prosecutors decline to prosecute some of these matters. Law enforcement officials and prosecutors also told us that intoxication of witnesses at the time of an assault can mean these witnesses may be less credible in court because, for example, intoxication adversely affects ability to clearly recall circumstances around the assault or specific statements made by the victim or alleged perpetrator. Additionally, law enforcement officials and prosecutors stated that decisions to refer investigations for possible prosecution are also based on obtaining additional evidence that supports the victim’s account. Availability of coordinated efforts, such as sexual assault response teams, can greatly enhance the quality of a forensic interview with a victim about an assault and facilitate gathering such supporting evidence.

Similarly, prosecutors consider additional factors besides medical forensic evidence when deciding whether to accept a matter for prosecution, including juries’ increased expectation of seeing DNA evidence; perceived credibility of the victim, alleged perpetrator, or other involved party; and availability of involved parties, such as witnesses or hospital providers, to testify. Specifically, several law enforcement officials and prosecutors stated that, in light of popular television series featuring forensic evidence, juries have come to expect prosecutors to regularly present DNA and other forensic evidence before they are willing to convict. As a result, several prosecutors told us they need to factor in such juror expectations when deciding whether they believe they have strong enough evidence to obtain a conviction or plea deal. Additionally, prosecutors told us that decisions to accept matters for prosecution are also based on how believable a witness, victim, or alleged perpetrator seems to be. The credibility of witnesses, including the victim, can be based on a variety of factors, including how well he or she can recall details of the assault. For example, one prosecutor told us her office concluded that the testimony of a particular victim could be persuasive because the woman accurately described the layout of the room where she alleged she was raped, even though the alleged perpetrator told police she had never been inside his house. Prosecutors across the country told us that intoxication of victims at the time of assault is not alone an acceptable reason to decline a matter for prosecution.

With regard to witness testimony, federal and state prosecutors told us that availability of potential witnesses to testify is also an important factor. Some victims in small reservations or isolated villages may refuse to

cooperate or may retract their initial statement, for example, because of pressure exerted on them by family or community members who may depend on the alleged perpetrator for necessities such as food or fuel. As a result, the victim may be unavailable to testify. Additionally, according to several prosecutors with whom we spoke, the availability to testify of medical providers who performed the associated medical forensic exams at IHS or tribally operated hospitals is an important factor because such testimony can help demonstrate that an assault occurred or help otherwise support a victim's account of an assault. Specifically, some prosecutors told us that it may be difficult to locate traveling medical providers who work at these hospitals temporarily; in addition, hospital staffing shortages may keep supervisors from releasing staff from hospital duties to testify. Consequently, some medical forensic examiners at IHS and tribally operated hospitals may not be able to testify in court that evidence obtained from a medical forensic exam belongs to a given victim or attest to a victim's statements made during the exam about the assault—testimony that prosecutors repeatedly stated is critical to using the medical forensic evidence in court. IHS officials noted, however, that the Tribal Law and Order Act of 2010's requirement that state and tribal courts provide employees with 30-day notice of the request for testimony would make it much more likely that a traveling provider could be located and appear or a provider's schedule changed to accommodate a court appearance.

In this context, section 263 of the Tribal Law and Order Act of 2010 contains requirements for IHS regarding approval or disapproval of requests or subpoenas from tribal or state courts for employee testimony. IHS's March 2011 sexual assault policy, however, is not entirely consistent with section 263, and, in some cases, the policy is not clear.

- First, the policy does not state that subpoenas and requests for IHS employee testimony in tribal or state courts not approved or disapproved within 30 days are considered approved. In this regard, the policy appears to contradict section 263 of the act, which states that subpoenas or requests will be considered approved if IHS fails to approve or disapprove a subpoena or request 30 days after receiving notice of it.
- Second, it is unclear whether the prior approval discussed in the policy refers to the agency's approval of the subpoena, as required by the act, or supervisory approval of the employee's release from hospital duties. To the extent that the policy's discussion refers to release from hospital duties, the policy is silent about whether and

under what circumstances supervisors can refuse to release a subpoenaed employee to testify if the subpoena or request is approved or considered approved.

- Third, the policy does not specify criteria to be used to approve a subpoena. Specifically, the policy does not specify that, in accordance with section 263, the IHS Director must approve requests or subpoenas from tribal and state courts if they do not violate the Department of Health and Human Services' policy to maintain impartiality. Explicitly articulating these criteria is important because departmental officials told us requests for IHS employee testimony in these criminal prosecutions would likely always satisfy the criteria and because responding to such requests are in the agency's best interest. In addition, the policy does not discuss legal limitations placed by privacy laws on the production of medical records in response to state or tribal court subpoenas.
- Fourth, the policy does not specify whether it also applies to subpoenas and requests from federal courts—a process currently governed by an unwritten policy—even though IHS officials told us they intended for the policy to cover federal subpoenas and requests as well as those from tribal and state courts.

According to Health and Human Services officials, the department is drafting a more specific and comprehensive description of the subpoena approval process. As of September 2, 2011, however, this document, whose audience is officials involved in the subpoena approval process, had not been completed or disseminated; we have therefore not reviewed it. Moreover, it is unclear how widely it will be disseminated. We received inconsistent accounts from departmental and IHS officials about the extent to which the document will be made available to line staff—the very staff who would be subpoenaed to testify. According to federal standards for internal control, information should be recorded and communicated to management and others within an agency in a form and within a time frame that enables them to carry out their responsibilities.⁵¹ Moreover, the federal standards call for effective communication to flow

⁵¹[GAO/AIMD-00-21.3.1.](#)

down, across, and up the organization.⁵² Therefore, it is still uncertain when and by what processes IHS staff will be able to respond to subpoenas or testify in court about the medical forensic exams they conduct—an ambiguity in the policy that is of great concern, according to several Justice officials with whom we spoke.

Conclusions

Medical providers in IHS and tribally operated hospitals are called upon to fulfill twin purposes when seeing patients who are victims of sexual assault and domestic violence—to treat the victim’s injuries and trauma and to collect medical forensic evidence of high enough quality that it can be used to prosecute crimes. The provision of medical forensic services and collection and preservation of high-quality evidence, however, are highly variable across IHS and tribally operated hospitals, hampered in part by distances victims must travel and the absence, until recently, of central direction from IHS on what, how, and by whom these services are to be provided. IHS has made significant progress in the last 2 years, and its March 2011 sexual assault policy takes a sound first step toward addressing problems like these, but the agency, its hospitals, and medical providers have a long way to go to fulfill the policy’s provisions. Without articulating how it plans to implement the policy and monitor progress toward meeting policy requirements, IHS may not be able to hold individual hospitals accountable to the agency, and the agency may not be able to hold itself accountable to its beneficiaries. The road ahead is likely to be particularly arduous for the more remote hospitals, which have long faced obstacles in attracting and retaining medical providers and are now faced with numerous new demands, such as offering medical forensic exams on site or by referral within 2 hours and making readily available digital cameras and other equipment and supplies needed to collect medical forensic evidence. In addition, responding to incidents of sexual assault and domestic violence requires a multifaceted approach involving not only medical providers but also law enforcement and prosecuting agencies and other stakeholders identified in the policy. The medical forensic evidence needs to be collected and preserved in a way that facilitates its use by law enforcement and prosecuting agencies. Not all IHS hospitals and staff regularly collaborate with these stakeholders or obtain regular feedback from them on evidence collection and

⁵²Our guide for maintaining or implementing these standards states that agencies should consider, among other factors, whether pertinent information is distributed to the right people in sufficient detail, in the right form, and at the appropriate time. [GAO-01-1008G](#).

preservation. Without considerable and concerted investment in the staff and hospitals responsible for providing medical forensic services—and without a detailed implementation plan to clarify how the agency will support its hospitals and staff in meeting the policy’s requirements and by when—the agency is unlikely to meet those requirements.

In addition, IHS’s March 2011 sexual assault policy does not address how its hospitals should respond in cases of discrete domestic violence without a sexual component or in cases of child sexual abuse. IHS is currently considering how its hospitals should respond to such cases, but it has not developed policies that are similar in scope and specificity to its March 2011 sexual assault policy for adolescents and adults. This gap is significant, but IHS is only one of the agencies involved in the multifaceted response to incidents of sexual assault and domestic violence. All the responding federal agencies should present a consistent and coordinated response to these issues. Justice also has not yet developed a policy for responding to child sexual abuse incidents, which is critical, since the Tribal Law and Order Act of 2010 mandates that IHS develop standardized sexual assault policies and protocols based on a similar protocol established by Justice.

IHS’s recent effort to solicit and analyze comments from the tribes and Justice on the March 2011 policy presents an opportunity for the agency to revise areas that, as originally written, are unclear or inconsistent. Specifically, it is unclear whether sections 3.29.1 and 3.29.5 of the policy require both training and certification, or only training, of IHS physicians and physician assistants performing sexual assault medical forensic exams. Also, the policy does not specify how physicians and physician assistants are to attain certification when no such certification by IHS or a third party exists for medical providers other than nurses. IHS’s sexual assault policy is also not consistent with provisions in section 263 of the Tribal Law and Order Act of 2010, which states, among other provisions, that subpoenas and requests for employee testimony or documents from state and tribal courts not approved or disapproved within 30 days are considered approved. To the extent that the policy’s discussion of subpoena and request approvals refers to release from hospital duties, the policy is silent about whether and how IHS plans to approve the release of staff providing medical forensic exams to testify or otherwise comply with subpoena requests. Without greater clarity in the policy’s language—and without giving relevant staff explicit guidance on how to respond when subpoenaed or requested to testify—providers who perform sexual assault medical forensic exams may not understand the

circumstances under which they are allowed or required to testify in court, a serious concern that Justice has echoed.

Some of the prior efforts to provide medical forensic services at individual hospitals failed for various reasons, including staffing problems related to burnout, high turnover, and compensation. The March 2011 sexual assault policy provides the high-level management endorsement that had been missing in the past, but devising appropriate staffing models—so that the provision of standardized medical forensic services being developed under the new policy will continue well into the future—remains a challenge. At some locations, current staffing models present disincentives to the provision of these services, such as supervisory refusal to give medical providers permission to attend sexual assault team meetings or to approve adequate compensation for providing medical forensic services in addition to normal job duties or beyond a unit's official area of responsibility. Given the agency's reliance on temporary medical providers, as well as high burnout and turnover rates among medical providers, unless corrected, such disincentives are likely to undermine IHS's efforts to fulfill the March 2011 policy's goals over the long term.

Finally, IHS also has an opportunity to incorporate comments from tribes that may choose to use the March 2011 policy as a model on which to base their own sexual assault response policies in tribally operated hospitals or clinics. As we discussed earlier, IHS policies and procedures can be used as models on which to base local tribal protocols even though they do not generally apply to its 17 tribally operated facilities. In addition, IHS recognizes that hospital protocols, particularly for complex and sensitive matters like sexual assault, need to reflect each community's individual circumstances. Coordinating with tribes may therefore be especially important to those tribally operated hospitals in Alaska, where the state, rather than the federal government, generally has criminal jurisdiction and where the state has made combating sexual assault and domestic violence a high priority.

Recommendations for Executive Action

To improve or expand medical forensic exams and related activities for the 28 IHS operated hospitals, we recommend that the Secretary of Health and Human Services direct the Director of the Indian Health Service to take the following five actions:

- Develop an implementation plan for the March 2011 IHS sexual assault policy (*Indian Health Manual*, chapter 3.29)—and monitor its progress—to clarify how the agency will support its hospitals and staff in fulfilling the policy, in particular, that the hospitals or staff:
 - obtain training and certification in providing forensic medical exams;
 - obtain equipment like cameras needed to collect evidence;
 - provide medical forensic exams on site or at a referral facility within 2 hours of a patient’s arrival; and
 - collaborate with law enforcement agencies, prosecution, and other stakeholders identified in the policy with the objective of creating sexual assault response teams and obtaining regular feedback from such stakeholders on evidence collection and preservation.
- Develop a policy that details how IHS should respond to discrete incidents of domestic violence without a sexual component and, working with Justice, develop a policy for responding to incidents of child sexual abuse consistent with protocols Justice develops for these incidents; such policies should be similar in scope and specificity to the March 2011 IHS policy on responding to adult and adolescent sexual assaults.
- Clarify whether sections 3.29.1 and 3.29.5 of the March 2011 IHS sexual assault policy call for training and certification, or only training, of IHS physicians and physician assistants performing sexual assault medical forensic exams.
- Modify the March 2011 IHS sexual assault policy so that it comprehensively and clearly outlines (1) the process for approving subpoenas and requests for IHS employees to provide testimony in federal, state, and tribal courts and (2) reflects the provisions in section 263 of the Tribal Law and Order Act of 2010, including that subpoenas and requests not approved or disapproved within 30 days are considered approved.

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- Explore ways to structure medical forensic activities within IHS facilities so that these activities come under an individual's normal duties or unit's official area of responsibility, in part to ensure that providers are compensated for performing medical forensic services.

Agency Comments

We provided a copy of our draft report to the Departments of Health and Human Services, the Interior, and Justice and to the state of Alaska. In its written response, reprinted in appendix IV, the Department of Health and Human Services agreed with our five recommendations and stated that work is now under way to implement each of them. The state of Alaska generally agreed with our conclusions and recommendations, especially the recommendation to develop additional policies specific to child sexual abuse, and expressed its willingness to collaborate with the Indian Health Service in developing sexual assault policies applicable to Alaska (see app. V). The Department of Health and Human Services and the state of Alaska, as well as the Departments of the Interior and Justice, provided technical comments, which we incorporated into the report as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, the Secretary of the Interior, the Attorney General of the United States, the Governor of Alaska, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VI.



Carolyn L. Yocom
Director

Appendix I: Objectives, Scope, and Methodology

Our objectives were to determine (1) the ability of Indian Health Service (IHS) and tribally operated hospitals to collect and preserve medical forensic evidence for use in criminal prosecution in sexual assault and domestic violence cases; (2) what challenges, if any, these hospitals face in collecting and preserving such evidence, particularly in remote Indian reservations and Alaska Native villages; and (3) what factors besides medical forensic evidence collected by these hospitals contribute to a decision to prosecute such cases.

For all three objectives, we collected and analyzed laws, regulations, and agency policies relevant to the collection and preservation of medical forensic evidence by IHS and tribally operated hospitals in cases of sexual assault and domestic violence, and we interviewed and gathered relevant documentation from headquarters officials at IHS, the Bureau of Indian Affairs, the Department of Justice, and the state of Alaska. In addition, we conducted over 60 semistructured interviews with several groups of stakeholders (1) from hospital staff during site visits to a nonprobability sample of 8 IHS or tribally operated hospitals in Alaska, Arizona, and South Dakota and over the telephone with an additional nonprobability sample of 7 IHS or tribally operated hospitals in Arizona, Minnesota, Montana, New Mexico, North Dakota, and Oklahoma and (2) from victim advocacy groups; federal and state prosecutors; and federal, state, local, and tribal law enforcement agencies that play a role in responding to and prosecuting sexual assault and domestic violence cases in most of the locations these 15 hospitals serve. We spoke with officials about hospitals that are performing medical forensic exams, that are developing the ability to perform such exams, and that do not perform these exams.

To determine the ability of IHS and tribally operated hospitals to collect and preserve medical forensic evidence, we surveyed all 45 IHS and tribally operated hospitals on available services, obtained electronic data from IHS on procedures and purpose of visits related to sexual assaults and domestic violence, and determined which hospitals were located in remote areas.

- First, we determined the type of facility within the IHS system that is most likely to provide medical forensic services. From discussions with IHS officials and others, we found that hospitals were the most appropriate type of facility to include in our analysis because of the level of medical expertise and infrastructure available in these facilities relative to other types of health centers or specialized clinics. We then obtained an electronic list of all IHS and tribally operated

hospitals in the United States, including location and contact information for each. We assessed the reliability of this list by validating and cross-checking the data with the IHS official who oversees the information. After eliminating two private hospitals that were erroneously included in the list, we determined that the data were sufficiently reliable for the purpose of this report. Using this list of 45 IHS and tribally operated hospitals, we e-mailed a self-administered questionnaire to survey each of the 45 hospitals. (See app. II for a blank copy of the questionnaire.) The questions were designed to identify the ability of each hospital to collect and preserve medical forensic evidence at the time the questions were answered. To develop the survey questions, we reviewed existing interviews, interviewed IHS officials and providers at several IHS and tribally operated hospitals, and reviewed relevant Justice protocols. We took steps to minimize errors in the survey effort's development and data collection process. For example, the team designed specific questions in consultation with a social science survey specialist and design methodologist. We conducted several pretests with medical providers at three separate hospitals—two IHS-operated hospitals and one tribally operated hospital—to help ensure that the questions were clear, relevant, and unbiased and to ensure that they could be completed quickly. Another survey specialist also reviewed the questionnaire, and suggestions were included where appropriate. We sent the questionnaire to the most knowledgeable hospital official at each location—typically the clinical director and chief executive officer—to be the lead respondent and, if necessary, to confer with other representatives within the hospital to answer questions requiring more detailed knowledge. To maximize our response rate, we sent follow-up e-mails and left reminder telephone messages over a period of approximately 11 weeks—from March 31, 2011, when we started the survey effort, through June 14, 2011, when we closed it. We received responses from 100 percent of the hospitals, and we followed up to clarify specific responses as needed. Accordingly, the responses represent a snapshot in time of each hospital's medical forensic services. We entered the responses into a spreadsheet and analyzed the results. A separate analyst verified the accuracy of data entry and analyses. (See app. III for a summary of key survey results.)

- Second, we obtained electronic data on the reasons for hospital visits by IHS beneficiaries from fiscal year 2006 through fiscal year 2010 for

each of the 45 hospitals that report such data to IHS.¹ To assess the reliability of the data, we interviewed knowledgeable IHS officials and performed electronic testing. Our initial intent was to determine how many medical forensic exams had been performed at each IHS and tribally operated hospital, but we were unable to do so because IHS does not centrally track the number of such exams, and complete data on specific procedures done during each patient visit were not available. We therefore used diagnosis codes established in the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* to determine from patients' "purpose-of-visit" information which hospitals were providing sexual assault and domestic violence services and the primary reason for such visits. We excluded all visits to mental or behavioral health clinics because such services typically take place after an incident and are not part of collecting or preserving medical forensic evidence. To determine how many sexual assault or domestic violence visits each hospital saw from fiscal year 2006 through fiscal year 2010, we analyzed each patient visit by its codes and categorized the codes into four incident types: adult sexual abuse, adult domestic violence, child sexual abuse, and child physical abuse. If a patient had more than one record with a purpose-of-visit code indicating sexual assault or domestic violence, we counted only the first visit to avoid double-counting of visits that may have pertained to the same incident. Thus, we may have undercounted the number of sexual assault or domestic violence incidents in this time frame if one patient had been involved in two or more incidents.

- Third, we identified which hospitals were located in remote areas and those located in urban areas. Given that there are only 45 IHS and tribally operated hospitals in total, we determined that it was reasonable to collect information on all 45 hospitals. We determined which hospitals were located in remote areas by using rural-urban

¹Two hospitals—Sage Memorial Hospital in Ganado, Arizona, and Norton Sound Regional Hospital in Nome, Alaska—do not use IHS's comprehensive health information system, called the Resource Patient Management Information System, but a different electronic health records system. We were therefore unable to assess the reliability of their data or to use their data in any analysis.

commuting area codes²—developed on the basis of U.S. Census tracts by the Department of Agriculture’s Economic Research Service—because IHS has no technical definitions for *remote*. The rural-urban commuting area system defines remote areas as those with dispersed and small populations and where travel times are longer because of limitations in transportation infrastructure, and it defines urban areas as those with large populations and short travel times between cities. We linked a hospital’s zip code to rural-urban commuting area data—also broken out by zip code—to determine if a hospital is located in an isolated, small rural, large rural, or urban area, as classified by the rural-urban commuting area system. We refined these four categories into a two-category classification scheme—collapsing the “isolated” and “small rural” categories into one remote category and collapsing the “urban” and “large rural” categories into one urban category—to aid in analysis and better respond to our objectives.

To determine the challenges faced by these hospitals in collecting and preserving medical forensic evidence, particularly in remote Indian reservations and Alaska Native villages, we also collected and analyzed pertinent laws, regulations, policies, protocols, and reports from IHS, Justice, and other entities. On the basis of initial interviews and responses from our survey of hospitals, we selected a nonprobability sample of IHS and tribally operated hospitals with which to conduct semistructured interviews on challenges they face in collecting and preserving medical forensic evidence. We chose 15 hospitals according to a series of selection criteria that included geographic location, remoteness, whether the state or federal government had criminal jurisdiction in Indian country served by the hospital, and whether the hospital was IHS or tribally operated. Additionally, because we used a nonprobability sample to select these IHS and tribally operated hospitals to interview, the information we gathered in our semistructured interviews cannot be generalized to all hospitals and instead represents the perspectives only of these hospitals’ providers and stakeholders. We also interviewed many victim advocacy groups, federal and state prosecutors, and federal and state and local law enforcement agencies that play a role

²These codes are based on concepts used by the Office of Management and Budget to define county-level metropolitan and micropolitan areas. The Department of Agriculture’s Economic Research Service applied similar criteria to measures of population density, urbanization, and daily commuting to identify urban cores and adjacent territory economically integrated with those cores.

in responding to and prosecuting sexual assault and domestic violence cases in most of the locations these 15 hospitals serve. We reviewed and analyzed our interviews and supporting documentation to identify systemic and regionally specific challenges.

Finally, to identify additional factors that federal prosecutors may consider when determining whether to prosecute cases of sexual assault and domestic violence, we reviewed relevant studies about these crimes and reviewed standards related to decisions by law enforcement to refer, or decisions by prosecutors to accept, a matter for criminal prosecution.

We conducted this performance audit from October 2010 through October 2011, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: GAO Survey of 45 IHS and Tribally Operated Hospitals



United States Government Accountability Office

Indian Health Service Medical Forensic Examination (FE) Program Questionnaire

Introduction

This questionnaire asks for information about medical forensic examinations done in cases of sexual assault or domestic violence for adults and/or children; and information on whether or not your facility has, or ever had, a program offering such medical forensic examination services.

Background

The U.S. Government Accountability Office (GAO) is an agency that assists the U.S. Congress in evaluating federal programs. We have been asked to provide Congress with information about the capability of Indian Health Service (IHS) to collect and preserve evidence in cases of sexual assault/abuse and domestic violence (involving adults or children) for criminal prosecution. The intent of this questionnaire is to determine which IHS and tribal hospitals have medical forensic examiner programs or provide the services of a medical forensic examiner in cases of sexual assault and domestic violence (involving adults and/or children). For the purposes of this questionnaire, the medical forensic examination is the medical treatment of a patient as well as the collection of forensic evidence. Specifically, the forensic component could include performing a forensic evidence collection kit sometimes referred to as a "rape kit", gathering a medical forensic history, conducting an exam, documenting biological and physical findings, and collecting evidence from the patient. We recognize that there is a continuum of forensic evidence collection services that can occur depending on the availability of staff and the medical condition of the victim.

Your facility was selected because it is one of the 47 hospitals operated by IHS, a tribe, consortium, or has a contract to provide services. It should take you about 5 to 10 minutes to complete this questionnaire. The person with the most knowledge of the forensic examination program should complete this questionnaire for the entire facility. If you feel you are not the most knowledgeable person in your facility about these exams, please contact Kyle Stetler (contact information below) and let him know who you feel would be the best person to complete it and we will arrange to send it to that person.

Your cooperation is critical to providing the Congress complete and balanced information about the capability of IHS to collect and preserve evidence in cases of sexual assault/abuse and domestic violence.

Completing and Returning the Questionnaire

Please complete and return this questionnaire as soon as possible, but no later than **Thursday, April 7, 2011**. After receiving your responses, we may also want to follow up with some of you by telephone to better understand your program or how you operate in lieu of a program.

To answer the questions, first open the attached MS Word file and save the file to your computer. Then enter your responses directly to the saved document following the instructions below. Once the questions are completed, please return them by attaching the saved document to an e-mail message to Stetlerk@gao.gov. Or mail to 701 5th Ave., Suite 2700, Seattle WA. 98104.

GAO Contact

If you have any questions, please call or e-mail:

Kyle Stetler
E-mail: StetlerK@gao.gov
Phone: 206-287-4844

Instructions for Completing the Questions Onscreen

- Please use your mouse to navigate, clicking on the field or check box you wish to answer.
- To select a check box or a button, click on the center of the box.
- To change or deselect a check box response, click on the check box and the 'X' will disappear.
- To answer a question that requires that you write a comment, click on the answer box _____ and begin typing. The box will expand to accommodate your answer. You are not limited to the amount of space you see on the screen.
- If you have additional clarifications or comments on any of the questions, please include those in the comment box at the end of this document or in a separate document.

START HERE

Your Contact Information:

Name:	
Title:	
Facility/Program Name:	
Email:	
Phone:	

SECTION A. ADULT VICTIMS OF SEXUAL ASSAULT

1. Currently, if an adult victim of sexual assault comes into your facility, with what frequency does your facility conduct a medical forensic examination, that is, the medical treatment of a patient as well as the collection of forensic evidence?

(Specifically, the forensic component could include such things as performing a forensic evidence collection kit sometime referred to as a "rape kit", gathering a medical forensic history, conducting an exam, documenting biological and physical findings, and collecting evidence from the patient.)

- Typically or always conducts
- Sometimes conducts
- Rarely conducts
- Never conducts

2. If the frequency with which your facility conducts these medical forensic examinations has substantially changed in the last five years, please describe below. The box will expand to fit your answer.

NOTE: If you answered "Never conducts" to Question 1, please skip to Question 7

3. If your facility conducts medical forensic examinations in cases of adult sexual assault, which types of providers typically conduct medical forensic examinations? For each row, please check all that apply.

	Always or Almost Always Conducts	Sometimes Conducts	Rarely Conducts	Never Conducts	Do not have this type of provider
a. Registered Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Physician's Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Nurse Practitioner / Advanced Practice Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Other (Specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. If your facility conducts medical forensic examinations in cases of adult sexual assault, what is the level of training of the providers who typically conduct these examinations? For each row, please check all that apply.

	SANE-A Certified	SANE Trained	Forensic Training	No providers of this type have specific forensic training or do not have this type of provider
a. Registered Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Physician's Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Nurse Practitioner / Advanced Practice Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Other (Specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Has there ever been an extended period of time, during the last 5 years, when there was no one available to conduct the medical forensic examinations for adult victims of sexual assault?

- Yes.....
- No..... → **SKIP TO QUESTION #7**

6. If yes, please describe the circumstances. The boxes will expand to fit your answer.

7. Does your facility (ever) refer adult sexual assault patients someplace else for medical forensic examinations?

- Yes.....
- No..... → **SKIP TO QUESTION #9**

8. If checked “Yes,” please specify where and under what circumstances.

SECTION B. ADULT VICTIMS OF DOMESTIC VIOLENCE
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9. If an adult victim of domestic violence comes into your facility, with what frequency does your facility conduct a medical forensic examination, that is, the medical treatment of a patient as well as the collection of forensic evidence?

- Typically or always conducts
- Sometimes conducts
- Rarely conducts
- Never conducts

10. If the frequency with which your facility conducts these medical forensic examinations has substantially changed in the last five years, please describe below. *The box will expand to fit your answer.*

NOTE: If you answered “Never conducts” to Question 9, please skip to Question 15

11. If your facility conducts medical forensic examinations in cases of adult domestic violence, which types of providers typically conduct medical forensic examinations? *For each row, please check all that apply.*

	Always or Almost Always Conducts	Sometimes Conducts	Rarely Conducts	Never Conducts	Do not have this type of provider
a. Registered Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Physician’s Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Nurse Practitioner / Advanced Practice Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Other (Specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. If your facility conducts medical forensic examinations in cases of adult domestic violence, what is the level of training of the providers who typically conduct these examinations? For each row, please check all that apply.

	SANE-A Certified	SANE Trained	Forensic Training	No providers of this type have specific forensic training <u>or</u> do not have this type of provider
a. Registered Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Physician's Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Nurse Practitioner / Advanced Practice Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Other (Specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Has there ever been an extended period of time, during the last 5 years, when there was no one available to conduct the medical forensic examinations for adult victims of domestic violence?

- Yes.....
- No..... → **SKIP TO QUESTION #15**

14. If yes, please describe the circumstances.

15. Does your facility (ever) refer adult domestic violence patients someplace else for medical forensic examinations?

- Yes.....
- No..... → **SKIP TO QUESTION #17**

16. If you checked "Yes," please specify where and under what circumstances.

SECTION C. CHILD VICTIMS OF SEXUAL ABUSE

17. If a child victim of sexual abuse comes into your facility, with what frequency does your facility conduct a medical forensic examination, that is, the medical treatment of a patient as well as the collection of forensic evidence?

- Typically or always conducts
- Sometimes conducts
- Rarely conducts
- Never conducts

18. If the frequency with which your facility conducts these medical forensic examinations has substantially changed in the last five years, please describe below. *The box will expand to fit your answer.*

NOTE: If you answered “Never conducts” to Question 17, please skip to Question 23

19. If your facility conducts medical forensic examinations in cases of child sexual abuse, which types of providers typically conduct medical forensic examinations? *For each row, please check all that apply.*

	Always or Almost Always Conducts	Sometimes Conducts	Rarely Conducts	Never Conducts	Do not have this type of provider
a. Registered Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Physician’s Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pediatric Nurse Practitioner/ Advanced Practice Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Pediatrician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other (Specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. If your facility conducts medical forensic examinations in cases of child sexual abuse, what is the level of training of the providers who typically conduct these examinations?

For each row, please check all that apply.

	SANE-P Certified	SANE Trained	Forensic Training	No providers of this type have specific forensic training <u>or</u> do not have this type of provider
a. Registered Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Physician's Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pediatric Nurse Practitioner / Advanced Practice Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Pediatrician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other (Specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Has there ever been an extended period of time, during the last 5 years, when there was no one available to conduct the medical forensic examinations for child victims of sexual abuse?

Yes.....

No..... → SKIP TO QUESTION #23

22. If yes, please describe the circumstances.

23. Does your facility (ever) refer child sexual abuse patients someplace else for medical forensic examinations?

Yes.....

No..... → SKIP TO QUESTION #25

24. If you checked "Yes," please specify where and under what circumstances.

SECTION D. CHILD VICTIMS OF PHYSICAL ABUSE

25. If a child victim of physical abuse comes into your facility, with what frequency does your facility conduct a medical forensic examination, that is, the medical treatment of a patient as well as the collection of forensic evidence?

- Typically or always conducts
- Sometimes conducts
- Rarely conducts
- Never conducts

26. If the frequency with which your facility conducts these medical forensic examinations has substantially changed in the last five years, please describe below. The boxes will expand to fit your answer.

NOTE: If you answered “Never conducts” to Question 25, please skip to Question 31

27. If your facility conducts medical forensic examinations in cases of child physical abuse, which types of providers typically conduct medical forensic examinations? For each row, please check all that apply.

	Always or Almost Always Conducts	Sometimes Conducts	Rarely Conducts	Never Conducts	Do not have this type of provider
a. Registered Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Physician’s Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pediatric Nurse Practitioner / Advanced Practice Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Pediatrician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other (Specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. If your facility conducts medical forensic examinations in cases of child physical abuse, what is the level of training of the providers who typically conduct these examinations?

For each row, please check all that apply.

	SANE-P Certified	SANE Trained	Forensic Training	No providers of this type have specific forensic training or do not have this type of provider
a. Registered Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Physician's Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pediatric Nurse Practitioner / Advanced Practice Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Pediatrician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other (Specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. Has there ever been an extended period of time, during the last 5 years, when there was no one available to conduct the medical forensic examinations for child victims of physical abuse?

Yes.....

No..... → **SKIP TO QUESTION #31**

30. If yes, please describe the circumstances.

31. Does your facility (ever) refer child physical abuse patients someplace else for medical forensic examinations?

Yes.....

No..... → **SKIP TO QUESTION #33**

32. If you checked "Yes," please specify where and under what circumstances.

SECTION E. PROGRAM OPERATIONS

33. Does your facility have the capacity to perform medical forensic examinations for adult or child victims of sexual assault and/or domestic violence 24 hours a day, 7 days a week?

- Yes.....
 No.....
 No program..... → Please skip to Question 36

34. What are the current days and hours of operation for your medical forensic examiner staff or program that treats adult or child victims of sexual assault and/or domestic violence? Please describe in the box below if the hours are different for children or adults.

Please indicate time in 24-hour clock format. If you are not open/available during one or more time slots, please type N/A in that time slot.

Regular Hours			On-Call		
Monday		To			To
Tuesday		To			To
Wednesday		To			To
Thursday		To			To
Friday		To			To
Saturday		To			To
Sunday		To			To

35. Please describe, if applicable, other provider/staff availability for children or adults.

36. Are there any (other) IHS or tribal clinics in your service area offering medical forensic examinations to child or adult victims of sexual assault or domestic violence?

- Yes.....
 No..... → Please skip to Question 38
 Don't know..... → Please skip to Question 38

37. If there are other IHS or tribal clinics in your service area to whom you may refer medical forensic examinations for child or adult victims of sexual assault or domestic violence, what are the names of the clinics and their contact information, to the extent it is available (please provide for up to 3 clinics):

	IHS Clinic Name	Contact Name	Contact Phone	Contact Email
1				
2				
3				

38. Is there any additional information that you would like to provide in regards to medical forensic examinations?

Thank you very much for your participation!

Please save your responses before exiting and return the questionnaire by attaching the document to an e-mail message to StetlerK@gao.gov.

Appendix III: Summary of Key Survey Results on Provision of Medical Forensic Services for Sexual Assault Victims

Hospital	Urban or remote	IHS or tribal	Services for adults	Services for children	Training for adult services	Training for child services
Acoma-Canoncito-Laguna Hospital	Urban	IHS	○	○	None	None
Alaska Native Medical Center	Urban	Tribal	■	○	Certified ^a	None
Browning Hospital	Remote	IHS	■	○	None	None
Cass Lake Hospital	Remote	IHS	■	○	Medical forensic training ^b	Medical forensic training
Cherokee Indian Hospital	Remote	Tribal	■	○	Medical forensic training	None
Chickasaw Nation Medical Center	Urban	Tribal	○	■	None	None
Chinle Comprehensive Health Care Facility	Remote	IHS	■	○	Medical forensic training	None
Choctaw Nation Indian Hospital	Remote	Tribal	■	○	Certified	None
Cherokee Nation WW Hastings Hospital	Urban	Tribal	○	○	None	None
Claremore Hospital	Urban	IHS	○	○	None	None
Creek Nation Community Hospital	Remote	Tribal	○	○	None	None
Crow/Northern Cheyenne Hospital	Remote	IHS	■	■	Medical forensic training	Medical forensic training
Crownpoint Healthcare Facility	Remote	IHS	○	○	None	None
Eagle Butte Hospital	Remote	IHS	■	○	None	None
Fort Defiance Indian Hospital	Remote	Tribal	■	○	Certified	None
Fort Yates Hospital	Remote	IHS	○	○	Certified	None
Gallup Indian Medical Center	Urban	IHS	■	■	Medical forensic training	Medical forensic training
Harlem Hospital	Remote	IHS	■	■	Medical forensic training	Medical forensic training
Hopi Health Care Center	Remote	IHS	○	○	None	None
Hu-Hu-Kam Memorial Hospital	Remote	Tribal	○	○	None	None
Kanakanak Hospital	Remote	Tribal	■	■	Medical forensic training	Medical forensic training
Lawton Hospital	Urban	IHS	○	○	None	None
Maniilaq Health Center	Remote	Tribal	○	○	None	None
Mescalero Hospital	Remote	IHS	○	○	None	None
MS Band of Choctaw Hospital	Remote	Tribal	■	○	Certified	None
Mt. Edgecumbe Hospital	Remote	Tribal	■	■	Medical forensic training	Medical forensic training
Northern Navajo Medical Center	Remote	IHS	○	■	None	None
Norton Sound Regional Hospital	Remote	Tribal	■	○	Medical forensic training	Medical forensic training

**Appendix III: Summary of Key Survey Results
on Provision of Medical Forensic Services for
Sexual Assault Victims**

Hospital	Urban or remote	IHS or tribal	Services for adults	Services for children	Training for adult services	Training for child services
Parker Hospital	Remote	IHS	○	○	None	None
Phoenix Indian Medical Center	Urban	IHS	○	○	None	None
Pine Ridge Hospital	Remote	IHS	■	○	Medical forensic training	Medical forensic training
Quentin N. Burdick Hospital	Remote	IHS	■	○	Medical forensic training	None
Rapid City Hospital	Urban	IHS	○	○	Medical forensic training	None
Redlake Hospital	Remote	IHS	○	○	None	None
Rosebud Hospital	Remote	IHS	■	○	Medical forensic training	Medical forensic training
Sage Memorial Hospital	Remote	Tribal	○	○	Medical forensic training	None
Samuel Simmonds Hospital	Remote	Tribal	■	○	None	None
San Carlos Hospital ^c	Remote	IHS	○	○	None	None
Santa Fe Hospital	Urban	IHS	○	○	None	None
Sells Hospital	Remote	IHS	○	○	None	None
Tuba City Indian Medical Center	Remote	Tribal	■	○	Medical forensic training	None
Whiteriver Hospital	Remote	IHS	■	■	Medical forensic training	Certified
Winnebago Hospital	Remote	IHS	■	○	Medical forensic training	None
Yukon-Kuskokwim-Delta Regional Hospital	Remote	Tribal	■	■	Medical forensic training	Medical forensic training
Zuni Hospital	Urban	IHS	■	○	None	None

Legend: ■ = Typically performs; ○ = Does not typically perform (i.e., never, rarely, or sometimes performs medical forensic exams)

Source: GAO.

^aThis category includes nurses that have obtained the sexual assault nurse examiner (adult, SANE-A) or sexual assault nurse examiner (pediatric, SANE-P) certification from the International Association of Forensic Nurses.

^bThis category includes health care providers who have specialized training, including SANE training, in medical forensic exams.

^cOn follow-up with San Carlos Hospital, we found that it does not typically perform medical forensic exams for adults, although its survey response said it did perform such exams. Therefore, the number of hospitals typically performing exams changed from a reported value of 27 to an actual value of 26 in our report.

Appendix IV: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

Carolyn L. Yocom, Director
Natural Resources and Environment
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

OCT 11 2011

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "INDIAN HEALTH SERVICE: Continued Efforts Needed to Help Strengthen Response to Sexual Assaults and Domestic Violence" (GAO-12-29).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "INDIAN HEALTH SERVICE: CONTINUED EFFORTS NEEDED TO HELP STRENGTHEN RESPONSE TO SEXUAL ASSAULTS AND DOMESTIC VIOLENCE" (GAO-12-29)

The Department appreciates the opportunity to review and comment on this draft report. While acknowledging that the Indian Health Service (IHS) is in the early stages of a comprehensive sexual assault and domestic violence response, the IHS is committed to developing and implementing policies and protocols that are responsive to the immediate needs of sexual assault and domestic violence victims in Indian Country. The four challenges described in the GAO's assessment that IHS faces in "standardizing and sustaining the provision of medical forensic services" are areas of vital prioritization for moving forward. The Sexual Assault Policy was established as the first ever policy of its kind in the IHS. Our plan was to develop the initial policy, then consult with Tribes to gather their input and recommendations, then revise/update the policy, and to develop an implementation plan, all of which are currently in progress. IHS will address the recommendations from the report as it continues its implementation of the policy.

In the ongoing effort to meet these challenges, there is a trend toward Tribal management and delivery of health services in American Indian and Alaska Native (AI/AN) communities. Tribes have increasingly contracted or compacted via the Indian Self-Determination and Education Assistance Act, Public Law 93-638, to administer and provide those services. This evolution in health care delivery and management is changing the face of health services in Indian Country.

Where IHS was previously the principal health and behavioral health care delivery system for AI/ANs, there is now a less centralized and more diverse network of care provided by Federal, Tribal, and Urban Indian health programs. The "Indian health system" denotes this larger network of programs and the evolving care delivery system across Indian Country. Meeting the needs of this system requires an evolution in IHS and Tribal collaboration, particularly as Tribal programs take more direct responsibility for services and IHS supports them in doing so.

The IHS has devoted considerable effort to develop and share effective programs throughout the Indian health system. In particular, developing programs that are collaborative, community driven, and nationally supported, offer the most promising potential for long term success and sustainment. IHS regularly relies on Tribal leadership and expertise to collaborate on a range of health and behavioral health problems and programs.

The IHS National Tribal Advisory Committee (NTAC) on Behavioral Health, which is made up of elected Tribal leaders from each IHS Area, provides recommendations and advice on the range of health and behavioral health issues in Indian Country, including sexual assault and domestic violence. From making recommendations on significant funding allocations and service programs, to developing long term strategic plans for Tribal and Federal behavioral health programs for the future, the NTAC is the principal Tribal advisory group for all behavioral health services to IHS. They ensure collaboration among Tribal and Federal health programs, provide Tribal input into the development of programs and services, and also provide the inclusive and transparent development of processes and programs so important to all our communities and programs.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "INDIAN HEALTH SERVICE: CONTINUED EFFORTS NEEDED TO HELP STRENGTHEN RESPONSE TO SEXUAL ASSAULTS AND DOMESTIC VIOLENCE" (GAO-12-29)

The IHS National Behavioral Health Work Group (BHWG) is the technical advisory group to IHS. Comprised of mental health professionals from across the country, the BHWG furthers the agency priorities to strengthen partnerships with Tribes, to reform the IHS, improve quality and access to care for patients, and provide direct collaboration and input for accountable, fair, and inclusive services across the Indian behavioral health system. They provide expert advice and recommendations for services, programs, and intervention models, as well as long term strategic planning and goal development. As the national technical advisory group to the agency, they also work very closely with the elected Tribal leaders on the NTAC to provide collaborative links between the professional community and national Tribal leadership.

With the IHS Domestic Violence Prevention Initiative (DVPI), the numbers of providers receiving medical forensic training is now being tracked. Resources have been allocated to provide Sexual Assault Nurse Examiner (SANE), Sexual Assault Forensic Examiner (SAFE), and Sexual Assault Response Team (SART) training for the remaining Federal and Tribal facilities with 24/7 services and to assist with the purchase of forensic equipment. Collaborative work has begun to address information technology and electronic health record issues to better capture the number of medical forensic exams performed in Federal and Tribal facilities. Areas for remote case consultation, using telemedicine, are being addressed to meet the needs of limited technical expertise in most hospitals, as well as remote locations in need of expert consultation.

Strategies to address domestic violence and sexual assault include collaborations and partnerships with Tribes and Tribal organizations, Urban Indian health programs, Federal, State, and local agencies, as well as public and private organizations. The IHS and the Department of Justice, Office on Victims of Crime (OVC) entered into a partnership involving the Federal Bureau of Investigation and the Department of the Interior. This partnership is the SANE-SART AI/AN Initiative, and is funded through the OVC. Using evidence-based practices involving SANEs, SARTs, and victim-centered law enforcement practices, the initiative will support victim recovery, satisfaction, and cooperation with the Federal criminal justice system, as well as supporting victims' of sexual assault and Tribal communities' need for justice.

GAO Recommendations

To improve or expand medical forensic exams and related activities for the 28 IHS operated hospitals, we recommend that the Secretary of Health and Human Services direct the Director of the Indian Health Service to take the following five actions:

- *Develop an implementation plan for the March 2011 IHS sexual assault policy (Indian Health Manual, chapter 3.29) – and monitor its progress – to clarify how the agency will support its hospitals and staff in fulfilling the policy, in particular, that the hospitals or staff:*
 - *obtain training and certification in providing forensic medical exams,*

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "INDIAN HEALTH SERVICE: CONTINUED EFFORTS NEEDED TO HELP STRENGTHEN RESPONSE TO SEXUAL ASSAULTS AND DOMESTIC VIOLENCE" (GAO-12-29)

- *obtain equipment like cameras needed to collect evidence,*
- *provide medical forensic exams on site or at a referral facility within 2 hours of a patient's arrival, and*
- *collaborate with law enforcement, prosecution, and other stakeholders identified in the policy with the objective of creating sexual assault response teams and obtaining regular feedback from such stakeholders on evidence collection and preservation.*
- *Develop a policy that details how IHS should respond to discrete incidents of domestic violence without a sexual component and, working with Justice, develop a policy for responding to incidents of child sexual abuse consistent with protocols Justice develops for these incidents; such policies should be similar in scope and specificity to the March 2011 IHS policy on responding to adult and adolescent sexual assaults.*
- *Clarify whether sections 3.29.1 and 3.29.5 of the March 2011 IHS sexual assault policy calls for training and certification, or only training, of IHS physicians and physician assistants performing sexual assault medical forensic exams.*
- *Modify the March 2011 IHS sexual assault policy so that it comprehensively and clearly outlines (1) the process for approving subpoenas and requests for IHS employees to provide testimony in federal, state, and tribal courts and (2) reflects the provisions in section 263 of the Tribal Law and Order Act of 2010, including that subpoenas and requests not approved or disapproved within 30 days are considered approved.*
- *Explore ways to structure medical forensic activities with IHS facilities so that these activities come under an individual's normal duties or unit's official area of responsibility, in part, to ensure that providers are compensated for performing medical forensic services.*

IHS Response

In response to the five recommendations, we offer the following comments:

Recommendation 1

To meet the challenge of ensuring that the IHS policy is consistently implemented in IHS operated hospitals and to ensure compliance, an implementation and monitoring plan is now being drafted. The implementation plan will address areas of standardized training and certification, information technology, electronic health records, standardized forensic equipment, telemedicine options for remote case consultation, and set timelines for policy revisions and development. The implementation plan will clarify how IHS will support its facilities in providing medical forensic exams, by referring to an outside facility, or a combination of both services.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "INDIAN HEALTH SERVICE: CONTINUED EFFORTS NEEDED TO HELP STRENGTHEN RESPONSE TO SEXUAL ASSAULTS AND DOMESTIC VIOLENCE" (GAO-12-29)

Recommendation 2

During the Tribal consultation phase of the development of the IHS national sexual assault policy, many Tribal leaders provided recommendations that encouraged establishment of separate IHS-wide guidance addressing operating procedures and protocols for child victims of abuse and neglect through the Indian Health Manual. In response, the IHS created a policy workgroup comprised of IHS professionals with extensive field experience in providing direct services to abused and neglected AI/AN children. The resulting Child Maltreatment Policy Workgroup will collaborate to develop the foundation for local child maltreatment and child sexual abuse policies and procedures for hospitals and clinics managed by the IHS. The IHS's plan is to develop a separate, stand-alone domestic violence policy, without sexual assault components, for its facilities. The policy will be comprehensive and similar in scope and specificity to the sexual assault policy approved by the IHS Director on March 23, 2011.

Recommendations 3 and 4

Clarification of the IHS sexual assault policy on sections 3.29.1 and 3.29.5 on training and certification for IHS physicians and physician assistants performing sexual assault medical forensic exams is part of the revision process for the sexual assault policy. The implementation plan will set timelines for revisions to the sexual assault policy. Tribal leaders have provided recommendations for the sexual assault policy and work has begun to incorporate those recommendations into the revised policy.

Modifying the IHS sexual assault policy to comprehensively and clearly outline the process for approving subpoenas and requests is underway. This modification to the policy will reflect the provisions in section 263 of the Tribal Law and Order Act of 2010, including that subpoenas and requests not approved or disapproved within 30 days of receipt are considered approved.

Recommendation 5

IHS is exploring ways to structure medical forensic activities in IHS facilities and to ensure that providers are compensated for performing medical forensic services. Within the Federal pay systems, (both Title 5 and Title 38) medical forensic duties will fall within providing patient care under the Nursing series. Currently, the IHS is looking at other methods of recognizing the specialized nature of the duties and compensation for performing exams and for call back or standby premiums.

Appendix V: Comments from the State of Alaska



State of Alaska Department of Public Safety

Sean Parnell, Governor
Joseph A. Masters, Commissioner

October 14, 2011

Carolyn Yocom
Director
Natural Resources and Environment
US Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Director Yocom,

Governor Parnell is strongly committed, through his administration's Choose Respect Initiative, to end the epidemic of domestic violence and sexual assault in Alaska. We appreciate you providing the State of Alaska the opportunity to review and comment on the United States Government Accountability Office Report (GAO-12-29): Indian Health Service – Continued Efforts Needed to Help Strengthen Response to Domestic Violence and Sexual Assault.

It was a pleasure working with your team as they planned and executed their travels to Alaska to conduct their investigation and review. We truly appreciate their willingness to travel to the rural and remote regions of our state. This provided them the opportunity to see first-hand the challenges we often face in providing vital services for victims.

After review of the report, we generally concur with the conclusions and recommendations for executive action. However, there are a few significant issues that warrant specific comments.

The first issue is that that the sexual assault policy applies only to Indian Health Service (IHS) operated hospitals, not tribally operated hospitals. As you know, the seven regional hospitals in Alaska and 165 village clinics are not IHS operated hospitals. These hospitals are operated tribally through self-determination contracts or self-governance compacts. This means that IHS policies and procedures do not apply to Alaska. It is our understanding from this document that the policies and procedures may be used as models to base protocols. We may need to rely on the Secretary of Health and Human Services to "facilitate the efforts of tribes to plan, conduct and administer programs, functions, services and activities." Furthermore, if needed, Alaska may decide to call upon IHS for technical assistance in these matters.

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Appendix V: Comments from the State of
Alaska

Director Carolyn Yocom
October 14, 2011
Page 2

The second issue is quite simple and obvious. Alaska does not have the same jurisdictional issues as the Lower 48, and thus the issues with prosecution differ greatly in Alaska. Consequently, much of the first part of this document and the descriptors simply do not apply to Alaska.

The third issue of note is the issue of "certification of providers." The State of Alaska currently does not have a requirement for certification. While we feel strongly that a trained provider is often the best person to conduct the exam (for the reasons outlined in the report), and the use of trained providers is nationally considered to be "best practice," we are concerned that this part of the policy could be potentially limiting to Alaska. This is an issue that we have been discussing at great length during our ongoing statewide meetings on SART sustainability.

Lastly, we strongly agree with your recommendation to develop additional policies specific to child sexual abuse. We have provided your staff some information to help support the need for this within Alaska.

We know that we cannot end this epidemic alone and welcome partnerships, coordination, and collaboration in our efforts on behalf of victims. Again, thank you for the opportunity to provide written comments.

Sincerely,



Joseph A. Masters
Commissioner

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Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov

Staff Acknowledgments

In addition to the individual contact named above, Jeffery D. Malcolm (Assistant Director), Ellen W. Chu, Katherine Killebrew, Ruben Montes de Oca, Kim Raheb, Kelly Rubin, Jeanette M. Soares, Kyle Stetler, Shana B. Wallace, and Tama R. Weinberg made key contributions to this report.

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