Improving Recovery Infrastructure for Survivors of Sexual Assault through a Nationwide Lobbying Strategy

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May 2022

Acknowledgments

Professor Lucy Bassett—thank you for your guidance and feedback from start to finish with this report. I truly could not have done it without your help.

My mother, father, and sister—I'm beyond grateful for your constant support throughout my academic career.

Dedication

I dedicate this report to the survivors of sexual assault across the United States, who have been left with a collection of inadequate choices for recovery and whose voices have often been ignored, forgotten, and silenced in the policymaking process.

Disclaimer

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

Honor Pledge

On my honor as a student, I have neither given nor received aid on this assignment.

“Our job is not to deny the story, but to defy the ending—to rise strong, recognize our story, and rumble with the truth until we get to a place where we think, ‘Yes, this is what happened, this is my truth, and I will choose how this story ends.’”

—Brené Brown

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Acronyms & Definitions

Early evidence kit (EEK): the term used to describe kits that are provided to survivors through private sector actors

Forensic examination: the evidence collection process that is administered by a forensic nurse following an incidence of rape

International Association of Forensic Nurses (IAFN): the organization responsible for training and certifying sexual assault nurse examiners

Personal evidence collection: the collection of evidence by the survivor (with the use of an at-home early evidence kit (EEK))

Rape: the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the individual assaulted[1]

'Rape kit': the colloquial term for the kit used for evidence collection following an incidence of rape (traditionally administered by medical personnel)

Recovery infrastructure: the support resources that are provided to a survivor following an incidence of rape or sexual assault

Sexual Assault Nurse Examiner (SANE): nurses that are trained and certified in forensic examination

[1] This is a modified version of the 2012 DOJ definition of rape—removing the language of 'victim'

Executive Summary

By the time you've read onto the next page of this document, an individual will be sexually assaulted in the United States. Although a prevalent issue, there have not been major modifications to the evidence collection component of the sexual assault recovery process since the 1970s (with the vast majority of hospitals and legal bodies using the same design of kit from that era) and those in place have often failed to be survivor-centered.

Innovation is greatly needed to provide survivors with the recovery infrastructure that they deserve and governments with the tools they need to better recovery infrastructure. Leda (as a private company) has the opportunity to innovate in ways that governments cannot, however, it is relatively restricted in its policy toolkit—relying on lobbying to allow for its operations across the country.

This report first outlines the background of the issue area and its context within the United States. Lacking recovery infrastructure, in combination with a lackluster criminal justice system, has led to no noticeable improvements in rates of sexual assault along with a lack of reporting. The pitfalls of the current system can be illustrated in the procedure, personnel, and maintenance of evidence components within the system.

Next, it analyzes relevant evidence related to sexual assault recovery infrastructure and early evidence collection; finding that there have been some promising small-scale innovations tested by governments at the local and state level but that these have failed to scale and problems still remain. Additionally, there are large gaps in the research related to sexual assault evidence collection (in general) and especially related to private sector provision of services.

It then outlines the methodological framework for sorting states into three tiers for Leda based upon sexual assault statistics (rate of rape and ratio of forensic nurses to survivors) and evaluates these tiers based upon the criteria of projected impact, political feasibility, and estimated cost per state. This methodology was chosen as Leda seeks a nationwide strategy and this allows for grouping which can aid in strategy and planning.

Lastly, it provides a recommendation for Leda and a plan for implementation. The analysis within this report recommends that the client focuses their lobbying efforts on Tier One states. States in Tier One, after sorting and evaluation, were projected to allow for the most impact, had the highest political feasibility, *but* were the lowest in cost range for lobbying—making them ideal for the client.

Client Overview

Leda Health Co. is a startup company operating in Texas, California, and Florida that provides survivors of sexual assault with at-home early evidence kits (EEKs) and other post-incident support (including sexually transmitted infection (STI) tests, emergency contraceptive (Plan B), and therapy groups). The kit comes with instructions on how to collect DNA from different parts of the body and upon receipt, the results come back within 72 hours. They utilize blockchain technology (a digital ledger that is verified through Ethereum) to ensure chain of custody with evidence and to notify survivors of the status of their EEK. In some states, kits like Leda's are admissible in criminal court with the permission of the judge, while in others they can solely be used in a civil proceeding. Even before their launch, they experienced significant pushback from state governments across the United States with 14 State Attorneys General sending them cease & desist letters—alleging false advertising.

Problem Statement

Following the occurrence of sexual assault, survivors are left with a set of inadequate choices; they can go to a hospital within 72 hours of the incident where they receive a forensic examination (an extremely invasive process that often lasts hours and requires one to not shower nor use the restroom) *or* they can choose not to and may never be able to seek legal action against the perpetrator—some may even choose to go to a hospital but find that there are no forensic nurses to complete the exam. **Current state policies related to recovery and support following sexual assault—specifically those governing evidence collection—vary widely across the United States and often hinder a survivor's recovery.**

Background

Sexual Assault in the United States

Sexual assault is defined as an illegal sexual contact that usually involves force upon a person without consent or is inflicted upon a person who is incapable of giving consent (as because of age or physical or mental incapacity) or who places the assailant (such as a doctor) in a position of trust or authority (*Sexual Assault Definition & Meaning - Merriam-Webster*, n.d.). In 2019, there were approximately 459,310 incidents of sexual assault in the United States (Morgan, 2018). With only an estimated 60% of sexual assaults reported, the actual number is likely higher (Lonsway & Archambault, 2012). And on the economic side, it's projected that sexual assault will cost the United States economy $3.1 trillion across the lifetimes of all current survivors (including healthcare costs, lost work/productivity, etc.) (DeGue, n.d.). On the whole, women and LGBTQ+ individuals (specifically those who hold intersectional identities such as trans women of color) face disproportionate rates of sexual assault (at almost twice the rate) (Messinger & Koon-Magnin, 2019). These statistics convey the broad scope of this issue but it's important to remember that each incidence represents a dramatic impact on each survivor's life.

The responses and legal frameworks related to sexual assault vary greatly from state to state and often amplify issues surrounding recovery infrastructure and evidence collection. One such legal framework is simply the *definition* of sexual assault and rape. In some states (such as Alabama and Mississippi), rape is solely defined as something that can occur to a woman. And although federal guidelines sought to overhaul outdated definitions, many states remain resistant to adoption of these more inclusive frameworks (DeLaHunta & Baram, 1997). These varying definitions affect the outcomes of the justice system while also affecting recovery support—if an individual who has just experienced sexual assault does not conceptualize the incidence as assault or if the legal definition invalidates their experience, then they may not feel comfortable seeking out a forensic examination or other recovery resources. Furthermore, those with mental health concerns prior to an incidence of sexual assault—social anxiety, depression, etc. can deter some from seeking help following a traumatic event and conditions could be exacerbated by a lack of substantial legal language support (Walsh & Bruce, 2014).

Conception of Recovery Infrastructure

Recovery infrastructure, for the purpose of this paper, encompasses the support and resources that a survivor interacts with following an incident of sexual assault—this includes evidence collection, physical healthcare, etc. The last major overhaul of recovery processes for survivors of sexual assault was in the 1970s with the introduction of sexual assault nurse examiner (SANE) programs and the advent of the 'rape kit' used by health systems and police. The creator of the kit, Martha 'Matty' Goddard, was a survivor advocate and first created it for the Chicago police department

(Kennedy, 2020). The kit was funded by the Playboy Foundation and was eventually adopted by the FBI. Care for survivors—from the standpoint of this innovation—was a *criminal justice* response rather than a *health* response. In this, the process was evidence-centered rather than survivor-centered, and support for survivors remained (and remains) an afterthought. This conception of recovery by governments at the local, state, and federal level allows for a focused analysis on the failures of *evidence collection* in the recovery process.

Below, Figure 1 illustrates the current process that survivors find themselves in. Governments are hesitant to give up autonomy regarding evidence collection while, at the same time, failing to adapt the justice system to adequately support survivor support & recovery. There is a cycle of harm that is perpetuated by lacking policy interventions (and a lack of willingness from the government to allow for more innovative options). Cultural indifference regarding sexual assault also plays an important role in furthering the cycle of sexual violence by empowering perpetrators rather than survivors and further weakening the validity of the current 'justice system'.

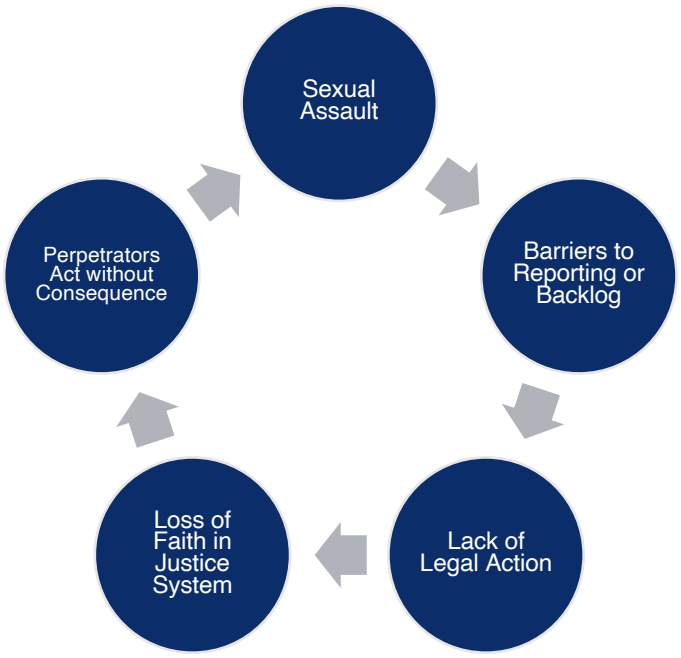

Figure 1: The Cycle of Sexual Violence

The Pitfalls of Current Evidence Collection

Current evidence collection frameworks that are used across the United States can be broken down into three components:

1. Procedure
2. Personnel
3. Maintenance of Evidence

Procedure

With current evidence collection procedures, a survivor of sexual assault is advised not to shower, change their clothes, nor use the restroom following the incident of assault—for those who have just lost control of an intimate aspect of their life, this can be especially damaging. They also may not be informed that the clothes they were in will be held as evidence. In addition to being damaging, many survivors may not know about these suggestions nor where they can go to receive a forensic examination.

During the forensic examination process at a hospital or medical center, a forensic nurse examiner will collect evidence with swabs from the skin and orifices of the survivor. This process can take up to 6 hours and often leads to the re-traumatization of survivors—re-traumatization is a conscious or unconscious reminder of past trauma that results in a re-experiencing of the initial trauma event (Corrigan, 2013). The examination also serves as a time for the forensic nurse to distribute vital medical information to the survivor, including the provision of emergency contraceptives, STI testing, and post-exposure prophylaxis[2]. Although programs have consistently been effective in provision of emergency contraceptives and testing for syphilis, hepatitis, gonorrhea, and chlamydia, a survey of national SANE programs conveyed that less than half offer HIV testing or post-exposure prophylaxis (Ciancone et al., 2000). This is a substantial failure and disproportionately affects gay men who have been sexually assaulted.

Many survivors will have to pay large sums 'out of pocket' as the service provided by a forensic nurse is 'specialized'—while some insurance companies will only cover the exam if it is administered by a certified SANE. On average, survivors of sexual assault face $466 in cost-shares for a forensic examination (Ramaswamy et al., 2022). In some cases, survivors had to pay as much as $3,000 (Andrews, 2019). Secondary costs may also be incurred due to mental healthcare needs following an incident of sexual assault; recovery resources like therapy are rarely advertised by SANEs or the hospitals that they serve.

[2] Medication that can be taken to prevent HIV infection after a possible exposure

Personnel

The personnel infrastructure that governments on the state and federal level have permitted and perpetuated also plays a part in denying survivors effective support through evidence collection. The individuals that are responsible in the central parts of the recovery process are police and forensic nurse examiners. Various communities (predominantly BIPOC & LGBTQ+) may not feel comfortable approaching the police due to historical mistreatment at their hand *and* due to trends of sexual misconduct perpetrated by police officers. Forensic nurse examiners are the second formalized component of current sexual assault recovery infrastructure and receive substantial training (although there have been recent concerns regarding their conception of trauma-informed care). However, this training comes from one specific organization, the International Association of Forensic Nurses (IAFN), and there has been some lagging in the update of their training regarding trauma-informed care and diversity & inclusion. On top of all of this, there is a nationwide shortage of forensic nurse examiners, meaning some survivors will go to hospitals only to be told they cannot receive a forensic examination (Kaplan et al., 2020).

Maintenance of Evidence

State action following sexual assault has been riddled with longstanding issues that further disincentivize survivors from seeking justice. As of 2020, approximately 200,000 rape kits remain in a backlog where they sit on a shelf—some due to cost, some negligence, and others due to lack of testing infrastructure (Bradley Hagerty, 2019). And, although some states have eliminated their backlogs, wait times for evidence and an actual court date span from months to years—a survivor in North Carolina had to wait 18 months for the results of her rape kit to be released (Maxwell, 2015). Survivors are not in control of their own evidence which can also increase anxiety following such a traumatic event.

Barriers to Personal Evidence Collection

Like with any government failure, the private sector has begun to innovate in this space. The first direct-to-consumer at-home early evidence kit (EEK) was created in 2016 by Preserve Kit. Preserve Kit shut down operations shortly after starting due to a large amount of government intervention. More recently Leda Health Co. (previously MeToo Kit) launched earlier this year, providing EEKs, additional medical support, and recovery resources (including different therapy options and support groups) to survivors. Leda not only gives the survivor more agency in the actual evidence collection procedure but also has innovated in the maintenance of evidence as they utilize blockchain technology to make a survivor aware of where their kit is at all times and provide completed testing in less than a week.

Some states have chosen to embark on a mission to restrict these private companies from operating through cease-and-desist letters—with Leda Health Co receiving 14 before even launching. Despite this pushback from government bodies, Leda Health Co

has begun operations in Florida, Texas, and California (with California previously piloting government-run at-home kits during the COVID-19 pandemic) (Sernoffsky, 2020).

Evidence Review

Procedure

The current 'procedure' facet of evidence collection combines two previous innovations in sexual assault recovery: the use of trained Sexual Assault Nurse Examiners (SANEs) and a rape kit. During the forensic examination process at a hospital or medical center, a forensic nurse examiner will collect evidence with swabs (using a rape kit) from the skin and orifices of the survivor. Adaptations to the 'kit' component have not been made since its inception in the 1970s, however, this remains the primary government-sponsored evidence collection procedure. The use of a trained SANE with the aforementioned kit has been shown to provide more effective evidence (in terms of amount of DNA collected and completed swabs) when compared to both an exam administered by a non-SANE trained nurse and an at-home kit administered by the survivor (Sievers et al., 2003). However, there have only been limited evaluated uses of at-home kits, so evaluative studies rely on lab-replicated evidence collection samples.

The actual construction of the kit and the subsequent procedure stemming from its creation has been criticized due to its lack of focus on LGBTQ+ survivors *and* the dichotomy it creates in survivor narratives. Ultimately it begs the question, should the narratives of survivors who choose not to submit to a forensic exam hold less weight in a court of law? However, these critiques were not considered during the original popularization of the kit and their absence "served to naturalize and sediment the perceived benefits of the kit as a techno- scientific witness of assault among victim advocates, law enforcement, and legislators" (Shelby, 2020). The evaluation of the origins of the kit and its implications for care today are demonstrated through a discourse analysis utilizing archival materials from the years encompassing the creation of the kit (1973 to 1987) (Shelby, 2020). This research process involves collecting newspaper passages, public discourse, and other narratives from the time period to analyze patterns and trends. Although a qualitative tool, this analysis provides valuable insights into the thoughts of policymakers in forming the system we confront today.

To alleviate ambiguity regarding kit status (where a survivor's kit is at a given moment) there have been some efforts to improve notification systems for survivors surrounding the evidence collection process. A program implemented in the Detroit Metro area found that notification (both after a regular forensic exam and of a backlogged kit) generally did not retraumatize survivors (Campbell et al., 2018). This survey of survivors was extremely limited, with only 41 participating. In Washington and Idaho, there are legal requirements set by the state regarding tracking and so there has been widespread adoption of a notification system (using anonymized call and text systems) for survivors, but no comprehensive analysis of its effect or implications. One framework for notification system adoption and evaluation has been created by the Houston Sexual Assault Kit Action Research Working Group but it solely relies on survivor surveys (that gauge measures such as feelings of ease of access and satisfaction) in its

recommendations and does not create quantitative metrics for future evaluation of implementation (which is a partial step in the right direction of including survivor voices, but there also needs to be concrete quantifiers for success)(Busch-Armendariz & Sulley, n.d.).

Solutions have been devised to lessen deterrent factors (those that prevent or limit a survivor from reporting) related to the current procedure in place. Factors of cost and choice still disincentivize many survivors from seeking out a forensic exam or support following an incidence of sexual assault. On the 'cost' side, the stipulation that survivors file a police report in order for their forensic examination to be subsidized by the state government has been widely eliminated as a product of the Violence Against Women Act (VAWA), however, some states still choose to keep this stipulation in place and face federal fines & restriction of funding support. Even in states that require insurance covers the exam, survivors may still face costs of up to $900 in additional fees (Crist, 2017). On the 'choice' side (there will be elaboration on this aspect in the 'Maintenance of Evidence' section below), once survivors have completed a forensic examination, they rarely have autonomy over what is done with the evidence kit. Some may face a seemingly unsurmountable backlog while others may want to keep the option of the use of the kit in a civil suit but lack the ability to do so. A lack of choice in the evidence collection procedure, remains the significant barrier to moving sexual assault recovery infrastructure toward being survivor-centered.

Personnel

The specialization of forensic nurse examiners was widely seen as a welcomed innovation in survivor advocacy. Survivors of sexual assault could not only receive a form of trauma-informed care but could also collect evidence that may be helpful in future criminal cases. However, there have been pitfalls in service provision. The use of SANEs has been criticized as their accreditation comes from one organization and training has often not remained up to date with best practice for trauma-informed care (as prescribed by the National Institute for Trauma-Informed Care) (Corrigan, 2013). Small-sample surveys (many consisting of 100-200 respondents) of survivors have conveyed that, on the whole, experiences with SANEs have been "positive and humanizing", but assessments of programs across the country raised serious questions regarding provision of care (Fehler-Cabral et al., 2011). One such assessment of US SANE-administered programs found that less than half of the evaluated SANE programs across the country provided HIV testing or Post-Exposure Prophylaxis (PEP)—illustrating the prevailing bias related to LGBTQ+ survivors amongst forensic nurses (Draughon et al., 2014).

Maintenance of Evidence

A number of solutions have been explored to improve maintenance of evidence[3], specifically related to the rape kit backlog. In Cuyahoga County, Florida, a cross-site comparative study evaluated effective practice for eliminating backlog and identified three causes: lack of DNA forensic lab resources in the locale, the cost of mass testing, and police department culture (Lovell et al., 2018). Another method of elimination has simply been public pressure and advocacy. Following the MeToo movement and the creation of several nonprofits related to the backlog, a large number of locales and states accelerated and/or began their efforts to eliminate it.

There still remains one concern that has not been solved in a comprehensive manner: destruction policies. Some states, in an effort to lessen backlog, have created policies in which if a survivor does not pursue a criminal case within 30-60 days then their evidence kit will be destroyed. In New York, the legislature recently improved destruction policies for police and crime units, but this did not apply to hospitals—where the vast majority of evidence kits are held (Nason, 2017).

Limitations to Evidence & Concluding Analysis

With this subject area specifically, it's difficult to solicit population feedback that's valuable in research (with a personal traumatic event, one may not feel comfortable replying to a request for survey). There have even been meta-analyses of what would motivate survivors to participate in research—altruism was a primary motivating factor (Campbell & Adams, 2009). Women of color and LGBTQ+ individuals have been reported to be less likely to seek out a forensic examination following an incidence of sexual assault and so reported data is likely to lack marginalized perspectives (that often experience sexual assault at a higher rate). Another limitation lies in the localized geographic nature of many of the studies cited. As sexual assault policy greatly varies across the United States, the findings regarding implementation and results may not be generalizable.

[3] The way in which evidence kits are stored

Methodology

Sorting Through Tiers

As the client—Leda Health Co.—is a private company, their toolkit in the policy arena is relatively constrained to lobbying. To present Leda with practical and manageable options that mesh with their current strategies, a tier system will be employed to divide states into three core groups—each will be evaluated and then tied to a specific plan of action. Using the decision matrices below, any state can be given a scored point value. By taking the average of each state's point values, they can then be sorted into a specific tier. States with an average score between 1 and 1.5 are part of Tier One, states with an average score between 1.6 and 2.4 are part of Tier Two, and states with an average score between 2.5 and 3 are part of Tier Three.

The scoring will be based upon state sexual assault profiles, including the rate of rape (Figure 2) and the ratio of forensic nurses to rape survivors (Figure 3). The rate(s) of rape will be drawn directly from the FBI 2020 report on violent crime. The ratio of forensic nurse to rape survivors is derived from the number of sexual assaults in a state in 2020 divided by the estimated number of forensic nurses in the state (the number of forensic nurses is drawn from the IAFN database of registered SANE-certified nurses).[4]

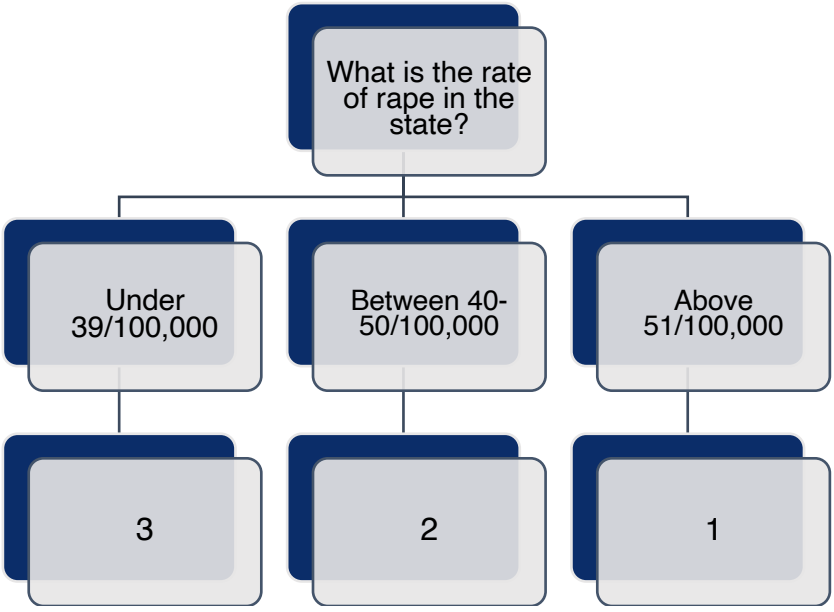

Figure 2: Rate of Rape Scoring Matrix

[4] A table with the data of each state (related to its characteristic scoring) can be found in the Appendix.

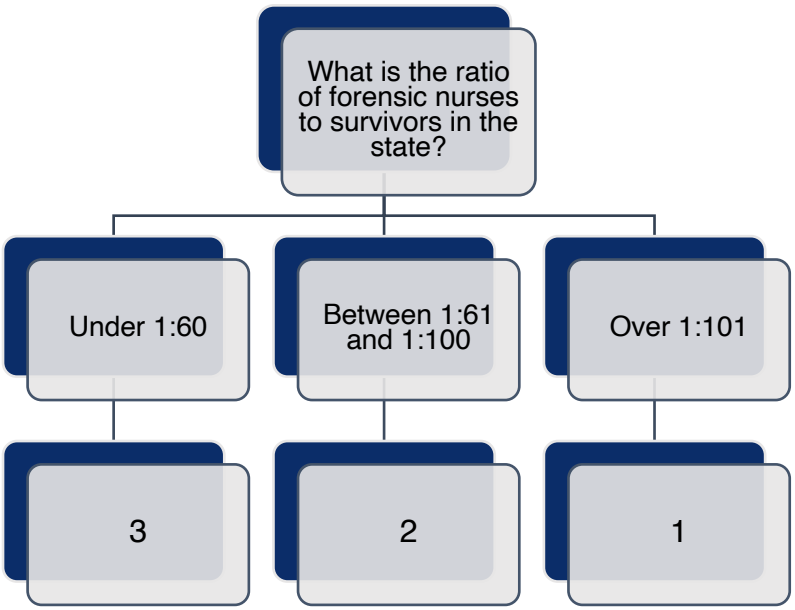

Figure 3: Ratio of Forensic Nurses to Survivors Scoring Matrix

Use of Case Studies

For each tier, there will be a case study on a "representative state" to showcase a more detailed profile of the tier and allow for greater analysis for the client. The case studies explore recent developments in the administration of sexual assault (or lack thereof) and an overview of the states' data related to rape.

Tier Designation

Tier	States	Representative State
One	Arkansas, Hawaii, Illinois, Michigan, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, South Carolina, South Dakota, Texas, Utah, West Virginia, Wyoming	Nevada
Two	Alabama, Alaska, Arizona, California, Colorado, Florida, Georgia, Idaho, Kansas, Louisiana, Massachusetts, Mississippi, New Jersey, New York, Ohio, Rhode Island	New York
Three	Connecticut, Delaware, DC, Indiana, Iowa, Kentucky, Maine, Maryland, Minnesota, New Hampshire, North Carolina, Oregon, Pennsylvania, Tennessee, Vermont, Virginia, Washington, Wisconsin	Virginia

Evaluation

Evaluative Criteria

To best inform the client of the opportunities for success in each tier, each will be evaluated as alternatives using the following three criteria:

1. Projected Impact
2. Political Feasibility
3. Estimated Cost

It is important to remain cognizant of the ways that conditions in states could change over time—states may move between tiers and the evaluation that follows is within our current context. Additionally, the three criteria are somewhat interrelated. If there will be more impact from the client's operation in a state, then there is a high likelihood that Leda's kits and recovery support will be more feasible, and therein it will be less costly to lobby—and the parallel of this is likely also true.

Projected Impact
The projected impact will be evaluated upon the probability of the number of individuals that could benefit from the client's services if their lobbying is successful (and they are able to operate in a state). Leda's mission focuses on the impact on the greatest number of survivors that they can support. This criterion will be scored Low, Medium, or High with High being the desired outcome for the client.

Political Feasibility
The political feasibility of each tier will be evaluated through a broad analysis of the conditions of sexual assault within the tiers (as derived through the tier sorting). States where sexual assault conditions are less pressing will, in general, be less likely to adopt private provision, while states that experience worse conditions related to sexual assault will likely have a larger Overton window on private reforms. The case study within each tier will highlight a broad level of the political discourse within a representative state. This criterion will be scored Low, Medium, or High, with High being the desired outcome for the client.

Estimated Cost Per State
Estimated cost is gauged as a numerical range for the lobbying cost that will be incurred with each tier (for one year of lobbying efforts). These numbers are based upon publicly available lobbying spending in related issue areas and also based upon the amount that Leda has spent in states they are currently operating in. The desired outcome for this criterion for the client would be the lowest cost range as they are an early-stage startup with a limited budget.

Alternatives

Tier One

The first tier of states includes those that have—on average—higher rates of sexual assault and a higher ratio of survivors to forensic nurses. States in this tier include Arkansas, Hawaii, Illinois, Michigan, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, South Carolina, South Dakota, Texas, Utah, West Virginia, and Wyoming. The case study of this tier will focus on Nevada. Nevada was chosen as they experience one of the worst forensic nursing shortages in the country, despite recent legislation passed to better support survivors.

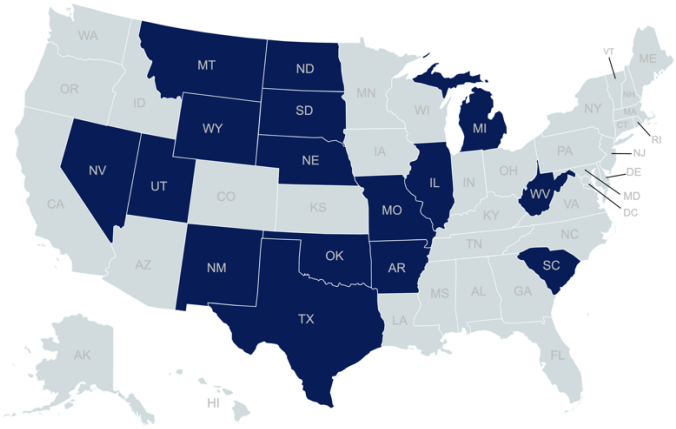

Figure 4: Map of Tier One States

Nevada

The state of Nevada experiences a relatively high rate of rape when compared to the rest of the United States *and* an extreme shortage of forensic nurses—with one forensic nurse for every 540 survivors in the state. In 2019, following the nationwide MeToo movement, the Nevada state legislature instituted a number of reforms including a 'Sexual Assault Survivors Bill of Rights' (Avery, 2019). These reforms saw widespread bipartisan support but there remained questions regarding their implementation. For example, the legislation stipulated that survivors were allowed a third-party advocate during the evidence collection process but some questioned if there were enough advocates available in the state. The rate of rape and/or the number of forensic nurses in Nevada have not been observed to improve following the passage of these reforms. The Governor and members of the legislature have signaled that they are open to new methods of support for survivors.

Tier Two

The second tier of states are those that may have a high rate of sexual assault but also a high number of forensic nurses *or* a moderate rate of sexual assault and a low number of forensic nurses. States in this tier include Alabama, Alaska, Arizona, California, Colorado, Florida, Georgia, Idaho, Kansas, Louisiana, Massachusetts, Mississippi, New Jersey, New York, Ohio, and Rhode Island. The case study of this tier will focus on New York. New York was chosen as it has had several pieces of legislation in recent years related to rape policy; however, it still ranks in the middle range for the rate and ratio.

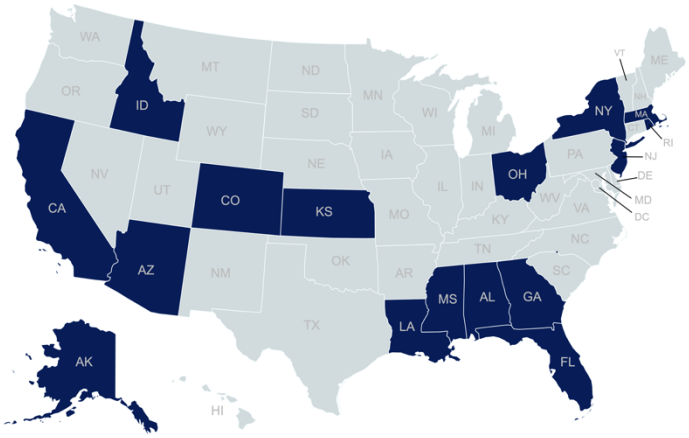

Figure 5: Map of Tier Two States

New York

The state of New York is recorded to have had a moderate rate of rape in recent years and a lackluster ratio of forensic nurses to survivors (1:122). There have been recent legislative developments related to protecting survivors, however none have been directly tied to improving evidence collection. One piece of legislation from February of this year, sought to protect survivors' DNA in rape kits from being tested in unrelated criminal cases (Farrell, 2022). The micro-detailed focus of this legislation fails to adequately support survivors, *especially* since this practice is already outside barred in New York. There has been no effort from the government to increase the number of forensic nurses in the state and there *has* been documentation of harmful activity from some hospitals—destroying evidence kits (in their custody) within 30 days if the evidence is not requested from legal authorities (Nason, 2017). The New York legislature seems to lack focus on significant reform measures and has repeatedly transitioned components of recovery and support to nonprofits.

Tier Three

The third tier of states are those with low rates of sexual assault and high numbers of forensic nurses. States in this tier include Connecticut, Delaware, DC, Indiana, Iowa, Kentucky, Maine, Maryland Minnesota, New Hampshire, North Carolina, Oregon, Pennsylvania, Tennessee, Vermont, Virginia, Washington, and Wisconsin. The case study for this tier will focus on Virginia as the rates of rape are low and it has a relatively high number of forensic nurses.

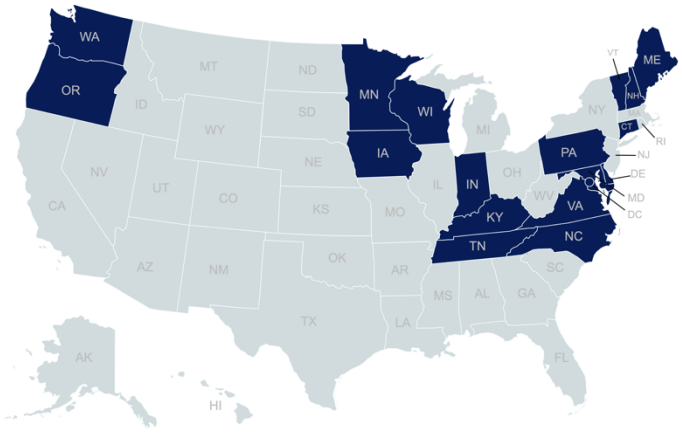

Figure 6: Map of Tier Three States

Virginia

The commonwealth of Virginia experiences both a low rate of rape and a sufficient ratio of forensic nurses to survivors. Prior to the client's launch of operations, Virginia Attorney General Mark Herring was one of the Attorneys General that sent Leda Health Co. a cease-and-desist letter to disincentivize their operation within the commonwealth. In 2020, the Virginia legislature passed HB 475, a bill to establish a statewide coordination program for sexual assault forensic examiners, fund the creation of bolstered forensic nurse recruiting programs, and a number of other measures that would increase and retain the number of forensic nurses in the state. Virginia has also consistently updated its criminal statutes related to rape and frameworks for acceptable evidence collection. The actions of the previous Attorney General and the current situation regarding recovery infrastructure in the Commonwealth would make it difficult for private providers to operate.

Federal Option
With the reauthorization of the Violence Against Women Act (VAWA), Leda should place some focus on federal options for lobbying. Federal provisions for a survivor's right to early evidence collection could be stipulated through lobbying efforts or there could be greater focus on the provision of Leda's kits in areas where there is federal jurisdiction. This could include in the military through the Department of Defense or on Native American reservations through the Bureau of Indian Health.

Findings

Evaluation Matrix[5]

Tier	Projected Level of Impact	Political Feasibility	Estimated Cost Per State
One	High	High	$21,000-$120,000[6]
Two	Medium	Medium	$32,000-$240,000
Three	Medium	Low	$50,000-$160,000
Federal	High	Low	$60,000-$450,000

Tier One
Tier One is **High** in its **Projected Level of Impact**. As the states that make up Tier One have high rates of sexual assault and a general unavailability of forensic nurses for survivors, lobbying by the client and therein the distribution of Leda's kits could impact a large number of individuals.

It is also **High** in its **Political Feasibility**. As states in Tier One have rates of rape that are not being addressed (or responding to legislative actions) and also a lack of forensic nurses, legislative stakeholders will be more likely to accept new, innovative options for recovery infrastructure.

Lastly, it has the **lowest cost** of all of the tiers with a range of **$21,000 to $120,000** per state per year. The upper limit of this range was somewhat influenced by Texas which was significantly larger and has a more competitive lobbying ecosystem than other states in the tier.

[5] The matrix is color coded to illustrate the desired outcome for each criterion. Green conveys that the outcome is the closest to the desire of the client, while yellow is moderately close to the desire of the client, and red is the least desired outcome for the client.
[6] Texas was an outlier that caused an increased upper end of cost range.

Tier Two

Tier Two is **Medium** in its **Projected Level of Impact**. Some of the states that are part of Tier Two have high rates of sexual assault and high availability of forensic nurses, while others have moderate rates and a moderate availability of forensic nurses. The client's operations, if allowed, could build upon and amplify existing efforts by these states.

It is also **Medium** in its **Political Feasibility**. Some of the state legislative stakeholders may be open to Leda as a supplemental strategy to the current frameworks surrounding early evidence collection while others may be hesitant to cede government participation in a part of the process.

Lastly, it has a **higher cost** (second only to the federal option) at a range of **$32,000 to $240,000** per state per year. As many large states are included in Tier Two, they generally have larger bureaucracies and legislatures—leading to more stakeholders and an increased cost of lobbying.

Tier Three

Tier Three is **Medium** in its **Projected Level of Impact**. Although the states in this tier do have low rates of sexual assault and/or high availability of forensic nurses for survivors, Leda's product has the ability to have moderate impact due to the nationwide lack of reporting that was highlighted in the background section.

It is **Low** in its **Political Feasibility**. As rates are low and there are seldom forensic nurse shortages, legislative stakeholders have little incentive to allow for Leda to operate in their state. Additionally, many of the states in this tier have had discourse present by political stakeholders that is against the use of at-home EEKs.

Lastly, it has a **mid-range cost** at a value of **$50,000-160,000**. These states would require more consistent lobbying, however, their lobbying environments (on average) are not very competitive and so the costs would only be slightly higher than those seen in Tier One states.

Federal

The federal option is **High** in **Projected Level of Impact** as, if lobbying is effective, it has the ability to allow Leda's operation across the country *or* in the military and American Indian reservations—which are two communities that are disproportionately impacted by rape.

It is **Low** in **Political Feasibility** as the client would be interacting with other lobbying factions that have longstanding relationships with federal stakeholders and due to the vast number of stakeholders that Leda would have to take into account.

Lastly, it has the **highest cost** with a range of **$60,000-$450,000** per year. This is a conservative estimate and lobbying costs at the federal level could easily balloon into the millions if a more robust strategy is necessary.

Recommendation

At the current stage of the company, Leda should pursue those states that fall in the Tier One category. These states would allow for Leda to maximize impact while saving on cost and lobbying effort. They could also serve as a 'lobbying lab' where Leda could experiment with messaging and strategy. Prolonged lobbying efforts that Leda has taken on in states where they operate convey that constant, strategic lobbying is necessary for the success of their mission. For example, a DNA collection law that was recently passed in Florida affected their operation but was targeted toward online genealogical service companies. Based on the context that Leda finds itself in and the preceding evaluation, lobbying in Tier Two, Tier Three, or at the federal level would likely require an internal lobbying team and would be resource intensive.

Implementation

In order to provide the client with future flexibility in their lobbying strategy, this section provides a plan of action for the recommendation (Tier One). As mentioned previously in the evaluation section, Leda should consistently use the scoring matrices and criteria provided to adjust the position of each state within the tiers as states' positions may fluctuate over time if conditions and characteristics in the states change.

The plan of action for Tier One would be consistent lobbying that focuses on the dire situation in the state. The client could highlight stories of survivors who have not received adequate support and identify policy stakeholders that are open to private provision of at-home EEKs (while also having significant authority within their political factions and state institutions). As Leda has already been successful with lobbying in a few states across Tier One and Tier Two (California, Florida, and Texas) it may be helpful to incorporate past lessons that Leda gained. In these states they learned that it was effective to lobby within both major political factions and mainly focus on significant decision makers (such as the speaker of the state House or Senate). Lastly, for Tier One, Leda can maintain their operations strategy of limited in-house and majority third-party contract lobbyists; however, it may be efficacious to build a more robust internal lobbying division in preparation for engagement in Tier Two and Tier Three.

Leda (or their lobbying proxy) should engage in preparation that includes these steps in each state they plan to lobby in:

1. Outline key objectives for lobbying. What type of outcome is Leda attempting to achieve?
2. Identify the major legislative stakeholders. This could include the speakers of the state house or senate, major party leaders, and/or legislators that have been outspoken regarding their support of sexual assault survivors.
3. Document the start and end date of the annual legislative session for the state.
4. Devise a messaging strategy that builds upon the current situation in the state *and* previous lobbying attempts by similar advocacy organizations.
5. Collaborate with advocacy organizations that have been vocal regarding policies that support sexual assault survivors.

Conclusion

Sexual assault has a profound impact on survivors across the United States, however, their voices have often been forgotten or ignored in the construction of support and recovery infrastructure. From the way that personnel are trained *to* how care is delivered *to* how evidence is collected, there is substantial room for improvement. Private sector options may be valuable in offering survivors greater flexibility in care and support, however, in order to implement these options, lobbying is necessary at the state level. By creating tiers of states based upon conditions related to sexual assault, Leda can engage in an effective and dynamic lobbying strategy. In the context that Leda currently finds itself in, lobbying in Tier One states will allow for the greatest impact while being politically feasible and cost effective.

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Appendix

Raw Data—Scoring Characteristics

State	Rate of Rape (# per 100k)	Ratio of Forensic Nurses to Survivors	Score for Rate	Score for Ratio	Average
Alabama	38.4	1:103	3	1	2
Alaska	154.8	1:35	1	3	2
Arizona	44	1:92	2	2	2
Arkansas	73.5	1:333	1	1	1
California	38.4	1:215	3	1	2
Colorado	62.9	1:60	1	3	2
Connecticut	38.4	1:70	3	2	2.5
Delaware	38.4	1:24	3	3	3
District of Columbia	43.6	1:39	2	3	2.5
Florida	35.4	1:197	3	1	2
Georgia	31.9	1:85	3	1	2
Hawaii	40.4	1:153	2	1	1.5
Idaho	45.5	1:67	2	2	2
Illinois	40.4	1:152	2	1	1.5
Indiana	34.8	1:64	3	2	2.5
Iowa	40.7	1:9	2	3	2.5
Kansas	43.3	1:77	2	2	2
Kentucky	30.6	1:72	3	2	2.5
Louisiana	46	1:67	2	2	2
Maine	36	1:47	3	3	3
Maryland	28.6	1:50	3	3	3
Massachusetts	26.9	1:315	3	1	2
Michigan	60.9	1:110	1	1	1
Minnesota	39.1	1:54	3	2	2.5
Mississippi	38.7	1:125	3	1	2
Missouri	43.3	1:112	2	1	1.5
Montana	55.3	1:78	1	2	1.5
Nebraska	60	1:78	1	2	1.5
Nevada	59	1:540	1	1	1
New Hampshire	39.7	1:84	3	2	2.5
New Jersey	14.4	1:139	3	1	2
New Mexico	55.5	1:129	1	1	1
New York	28.3	1:122	3	1	2
North Carolina	27.6	1:52	3	2	2.5

North Dakota	51.7	1:437	1	1	1
Ohio	43.2	1:82	2	2	2
Oklahoma	52.8	1:162	1	1	1
Oregon	36.9	1:94	3	2	2.5
Pennsylvania	33.1	1:69	3	2	2.5
Rhode Island	38.5	1:491	3	1	2
South Carolina	40	1:107	2	1	1.5
South Dakota	67.1	1:80	1	2	1.5
Tennessee	38.9	1:85	3	2	2.5
Texas	46	1:147	2	1	1.5
Utah	55.7	1:107	1	1	1
Vermont	34.2	1:70	3	2	2.5
Virginia	26.5	1:48	3	3	3
Washington	34.8	1:17	3	3	3
West Virginia	46.6	1:151	2	1	1.5
Wisconsin	34.6	1:78	3	2	2.5
Wyoming	57.2	1:54	1	2	1.5