Inventory of Statewide Data Sources on Sexual Violence in California

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CDC Grant VF1/CCV919942-04

June 2006

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Table of Contents

Introduction 2
How to Use this Report 3
SV Case Definitions 3
Using Existing Data 4
Problems with SV Data Sources 5
Findings 6
Surveys 6
California Women's Health Survey (CWHS) 6
Maternal Infant Health Assessment (MIHA) 7
California Health Interview Survey (CHIS) 8
The California Student Survey (CSS) 9
Rape Crisis Centers 10
Medical Information Reporting 11
ED Treatment 11
Hospitalizations 12
Death Records 13
Emergency Medical Services 14
Crime Investigation and Reporting 16
Sexual Assault Evidence Kits 16
The Homicide File 17
The Linked File 18
Other Crime Data 18
California Crime Index 19
Monthly Arrest and Citation Register 19
Violent Crimes Committed Against Senior Citizens 20
Social Services 20
Child Sexual Abuse 20
Sexual Abuse of Elders and Dependent Adults 21
Sexual Abuse in Long-term Care Facilities 23
Data Needs: What We Did Not Find 23
SV among Adolescents 23
SV in College Settings 23
Human Trafficking 24
SV Incidence and Perpetration 24
Local data collection 25
Conclusion 26
Glossary of Acronyms 28

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Introduction

Public health relies heavily on health data to identify and prioritize public health problems and to develop, implement, and evaluate interventions. Health data includes information about health events, such as communicable diseases and injuries, and health-related behaviors, such as smoking cigarettes and using seatbelts. *Public health surveillance is the ongoing and systematic collection, analysis, and interpretation of population health data for the purpose of tracking public health issues.*

Because public health surveillance ("surveillance") systems are expensive to establish, we often rely on data that are collected for other purposes, such as hospital billing, for injury surveillance. For example, reports from coroners and doctors provide useful surveillance of many public health issues: communicable diseases, chronic diseases, and the full range of injuries--including assault injuries. Until recently, sexual violence (SV) was considered mostly an issue of law enforcement and criminal justice, with little thought to how we might seek to understand, and ultimately prevent, SV in the population. This data inventory extends traditional public health surveillance to SV and describes California statewide data sources that provide information about SV. We describe these very different sources from a single point of view—that of public health surveillance.

As a first step toward developing surveillance of SV in California, we searched for all statewide information on SV. With this data inventory, we attempt to provide pertinent information on all potential statewide sources of SV data for people wishing to study SV in California.

The foundation work for this report was done by the Crime and Violence Prevention Center (CVPC) of the California Attorney General's Office, as an inventory of domestic violence (DV) data collection systems. CVPC staff contacted 18 departments within state government and conducted 34 interviews with staff in those departments about their data. The inventory included Departments of Justice (DOJ), Health Services (DHS), Alcohol and Drug Programs, Social Services (DSS), Mental Health, Developmental Services, Aging, Corrections, and Child Support Services, Community Services and Development, and Housing and Community Development; Office of Statewide Health Planning and Development (OSHPD); Emergency Medical Services Authority (EMSA); Managed Risk Medical Insurance Board; Secretary of State; Office of Criminal Justice Planning (OCJP); California Youth Authority; and Victim Compensation and Government Claims Board.[1] The comprehensive DV data inventory was completed

[1]Amanda Noble, Ph.D., Research Program Specialist at CVPC, is the primary author of the CVPC report.

in 2003.

SV is often a component of domestic or intimate partner violence (IPV). However, many perpetrators of SV are not intimate partners. In compiling this SV data inventory, DHS, Epidemiology and Prevention for Injury Control (EPIC) Branch expanded CVPC's DV inventory to include all possible victims of SV, regardless of age, sex, or relationship between the perpetrator and victim, and contacted many of the same entities for information.

How to Use this Report

This report provides some basic information on statewide data for those interested in studying SV in California. For each data source, this document describes the data collected, whether the data are individual level or aggregated, and how requesters can obtain the data for legitimate purposes. Where possible, limitations of the data sources with respect to SV are also noted. Each description includes the entity responsible for data maintenance and provides contact information for those wishing to obtain the data.

This report is organized roughly by how helpful we think data sources will be for the purpose of learning about SV in California, with the most useful data first. The table of contents and glossary of acronyms may be helpful to readers who wish to read only about selected data sources, rather than the entire report.

Readers are cautioned not to underestimate the time and skill needed to analyze most data sets. "Data sets" or "data files" here refers to computerized data bases, often in formats not easily analyzed on basic desktop computer systems. Analysis of these data sets typically requires the skills of a person trained in such work. Those with no access to a skilled analyst are advised to rely on printed reports or web-based analysis systems, such as the DHS EPICenter (http://www.dhs.ca.gov/EPICenter).

SV Case Definitions

In deciding what to include, we considered SV in broad terms, including violence that does not result in physical injury or arrest by law enforcement officials. We do not use a single definition of SV in this document because various systems define cases differently and for different purposes (e.g., incidents or victims of rape, sexual assault, or harassment). For example, some systems record crimes, whereas other systems record medical treatments. Because of these differences in what is considered a case of SV, it would be impossible to fit the various sources into one comprehensive definition. To illustrate, consider how the following data sources might define a case of SV:

- Police reports— *incidents of forcible rape* that are reported to a law enforcement agency. The Uniform Crime Reporting (UCR) Program of the Federal Bureau of Investigation (FBI) defines *forcible rape* as "the carnal knowledge of a female forcibly

and against her will. Assaults or attempts to commit rape by force are also included; however, statutory rape (without force) and other sex offenses are excluded."[2]

- Death certificates—*all deaths caused immediately by sexual assaults*, described in a legal document. Through 1999, causes of death were coded on death certificates using the International Classification of Diseases, Ninth Revision (ICD-9). Deaths after 1999 are coded using the International Classification of Diseases, Tenth Revision (ICD-10). The ICD-9 code for rape as an external cause of injury is **E960.1**. Under ICD-10, the code **Y05** indicates a sexual assault using bodily force, including rape, sodomy, and attempts to commit these acts.

- Hospitalizations—*all intentionally inflicted injuries resulting from a sexual assault and requiring an in-patient stay*, documented in a type of billing record.

- Surveys—usually, survivors of violence reporting their own experiences in response to structured interview questions. Survey results depend on the population interviewed, the structure of the surveys, the wording of the questions, and the specific behaviors

Using Existing Data

Because data systems are expensive, many health and safety problems are studied by using existing data. For example, hospital inpatient data are used to study population patterns of serious gunshot injuries. The most useful sources have the following traits:

- Established—they are ongoing information systems rather than one-time studies. Additionally, the data have been analyzed so that data collection problems are caught and remedied;

- Sensitive—they capture a high proportion of the incidents in a population;

- Generalizable—they cover a large, easily described general population such as "all women residents of California" rather than cases in a client data base or in only one local area;

- Informative—they include enough pertinent data to be of interest (for example, "crisis call received by police" does not include enough information to be very informative); and

- Available—information is reasonably easy to get in a useful form (e.g., web site, regular reports).

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[2] FBI, Crime in the United States, 2002. Retrieved 3/11/05 from http://www.fbi.gov/ucr/cius_02/html/web/offreported/02-nforciblerape04.html

Unfortunately, no single data system meets all these standards for SV in California.

Problems with SV Data Sources

Injuries, including many that result from violence, have a severity pattern shaped like a pyramid. The top of the pyramid consists of a small number of the most severe injuries—those resulting in death. These fatal injuries would be recorded in the vital statistics death records. The layer just below includes a larger number of injuries that are severe but not fatal. For example, for physical assaults in California, this second layer, represented by hospitalizations, is nearly five times larger than the number of deaths from assaults. The next layer down—ED visits—would be larger yet. Currently, statewide data on assault injuries is only available for the top two layers of the pyramid. The majority of violent injuries, especially those of modest severity, may never come to the attention of physicians or police, and would never be recorded in the currently available health (vital statistics and hospitalizations) or law enforcement data.

As a subset of violent injury, SV is even more difficult to track. Although survey data consistently indicate that many people, especially women, experience SV at some point in their lives, very few such incidents appear in the data sources we describe in this report. Two important reasons for this are that most sexual assaults do not result in serious *physical* injury, and many victims are reluctant to report sexual assaults to law enforcement. Reluctance to report may be due to victims not wanting people to know, not realizing that the incident was a crime or serious enough to report, fear of not being believed, fear of being blamed, and fear of reprisal or other negative consequences for reporting.

Findings

Surveys

The first data sources described in this report are from large surveys which permit, or could permit, with the addition of a few questions, estimates of the prevalence of SV victimization. One advantage to surveys as data sources is that they do not depend on the victim actually seeking medical care or reporting the victimization to police, and may therefore better represent the magnitude of the problem. Another very important advantage is that surveys also include demographic information, such as age, sex or gender, race and ethnicity, income level, and education.

California Women's Health Survey (CWHS)

The Public Health Institute's Survey Research Group (SRG) coordinates CWHS in collaboration with DHS' Office of Women's Health (OWH) and various State programs. CWHS is an annual statewide telephone survey of approximately 4,000 women. The survey began in 1997 and provides a representative sample of women aged 18 years and older living in households with telephones in California. CWHS provides only statewide data—analyses for smaller areas such as regions or counties are not possible. The sample size is not large enough to permit detailed comparisons among race/ethnic categories.

Respondents answer a wide variety of questions on health and health-related behaviors, such as cigarette smoking, alcohol use, physical activity, and use of medical services. The survey also asks questions about demographics (such as age, race, and income) and the respondents' households (such as the number of adults and the ages of children living in the home).

In June 1998, the survey added a module of questions about respondents' personal experiences with IPV ("DV module"). Respondents were told that they were going to be asked questions about how couples resolve problems and conflicts, and that "couple" referred to the respondent and a current or former husband, partner, boyfriend, or girlfriend. The CWHS DV module asks a series of questions to find out what kinds of violent acts the respondent may have experienced at the hands of an intimate partner. The original DV module is a modified form of the Conflict Tactics Scale, a validated and widely used series of questions developed to measure the prevalence and severity of family violence. In 2002, as an example, the respondent was asked whether her intimate partner had forced her to have sex in the past 12 months. Although CWHS data on individual years are available, because the wording of the questions changed several times after 1999, it is not possible to assess changes over time using this survey.

In addition to the DV module, California Department of Social Services (CDSS) added questions concerning traumatic stress symptoms in 2001. These questions asked

whether the respondent had ever been sexually assaulted as an adult, and during childhood. The questions have been used through 2005. Additionally, the 2005 survey asks whether the respondent experienced SV in the past 12 months.

Numerous Data Points, which are very brief reports based on the CWHS data, are available at http://www.dhs.ca.gov/director/owh/survey.htm. Information on the dataset and how to obtain it is available at www.surveyresearchgroup.com. A user identification and password, required to view some documents, can be obtained by calling (916) 779-0338. The data are available as a public use dataset by contacting SRG, housed in the California Cancer Registry. CWHS allows collaborating programs exclusive access to data that they have sponsored for one year. After one year, all data are made available to the public.

To obtain the CWHS data, indicate the years of data desired, briefly describe what information you need, and specify the topics you plan to analyze. Print your request on organizational letterhead and address it to:

Marta Induni, M.A., Ph.D.
Interim Chief, Survey Research Group
Public Health Institute
1700 Tribute Road, Suite 100
Sacramento, CA 95815-4402
Phone (916) 779-0331
MInduni@SurveyResearchGroup.com

Recent research shows that there are important race/ethnic differences in women's experience of violence.[3] As mentioned above, CWHS will not permit detailed analysis of SV by specific groupings, such as race/ethnicity, language, age, education level, or locality, because the sample size is too small and it was designed to yield statewide (rather than local) estimates.

Maternal Infant Health Assessment (MIHA)

MIHA is a collaborative project between DHS', Maternal, Child and Adolescent Health Branch (MCAH) and researchers in the Department of Family and Community Medicine at the University of California, San Francisco. First conducted in 1999, MIHA is an annual, population-based survey of about 3,500 women who are at least 15 years old and recently gave birth to a live infant in California. The survey is a written questionnaire with English and Spanish versions, mailed eight to ten weeks post-partum, with telephone follow up to non-responders. The response rate is over 70

[3] Lund, Laura E. Incidence of Non-Fatal Intimate Partner Violence Against Women in California, 1998-1999. EPICgram Report No. 4, May 2002. California DHS, EPIC Branch, Sacramento.

percent. The sampling design is random stratified, based on race/ethnicity (African Americans are over-sampled), education level, and region within California.

MIHA is designed to provide data for developing, targeting, implementing, and evaluating maternal and infant health policies and programs, to monitor progress in decreasing modifiable risk factors to improve outcomes, and to monitor progress toward reducing disparities. In order to address emerging issues some questions change from year to year.

In 1999 and 2000, MIHA included questions about screening by health care providers for physical and sexual abuse during the respondents' most recent pregnancy, whether they had experienced physical or sexual abuse in the past two years, and whether they sought medical care for the abuse. Because the physical and sexual abuse were combined in the questions, they cannot be distinguished from each other. No DV questions were asked in MIHA 2001. Since 2002, questions have again been asked about IPV. However, sexual abuse was no longer included in the survey. MIHA also collects demographic, socioeconomic, and substance use information.

For more information on MIHA, contact:

Moreen Libet, Ph.D.
Epidemiology and Evaluation Section
Maternal, Child, and Adolescent Health Branch
California Department of Health Services
1615 Capitol Avenue, MS 8304
P.O. Box 997413
Sacramento, CA 95899-7413
Phone (916) 650-0393, Fax (916) 650-0308
mlibet@dhs.ca.gov

California Health Interview Survey (CHIS)
CHIS is a collaborative effort of DHS; the University of California, Los Angeles; and the Public Health Institute. It is a biannual survey and one of the largest health surveys conducted in the United States. In 2001, its first year, CHIS collected information from over 55,000 California households. In 2003, the sample was about 42,000 households. As a household survey, CHIS permits linkage of data for adults, children, and adolescents in the same household. CHIS is conducted in several languages, so major ethnic groups that other surveys could not reach (such as Vietnamese) are included. CHIS' administration in different languages, in addition to its large sample size makes possible fairly specific analyses using race/ethnicity or county.

A multidisciplinary, multi-agency workgroup, led by the Attorney General's Crime and Violence Prevention Center, designed a set of violent victimization questions, based on

national research, to add to the 2005 CHIS. The workgroup was unable to secure funds to support the questions on CHIS, however, so CHIS is not currently a source of data on SV. The workgroup intends to seek funding to add the violent victimization questions for the 2007 CHIS.

Public use data are available by registering at *Ask*CHIS, which can be reached through the main CHIS website, at http://www.chis.ucla.edu. For more information on CHIS, send an email to: CHIS@ucla.edu. Reports using the 2001 CHIS data, on topics ranging from health care access disparities to asthma, have been published. Many of these can be found at the CHIS website or at DHS' website:

http://www.dhs.ca.gov/org/hisp/chs/OHIR/Publication/publicationindex.htm.

The California Student Survey (CSS)

CSS is administered to a representative statewide sample of students in public schools, and was first administered in 1985. CSS is administered in grades 7 through 11 in selected districts that agree to participate. CSS is coordinated with the California Healthy Kids Survey, which is largely the same survey, but administered to a different, non-representative sample. WestEd™ collects these data for the California Attorney General's Crime and Violence Prevention Center. Due to a state mandate, the surveys collect data on students' use of alcohol, tobacco, and other drugs. Contingent on funding, data concerning other behaviors may also be collected and analyzed.

The 2001-02 and 2003-04 CSS each had a question concerning sexual jokes, comments, or gestures; one question on relationship violence (by boyfriend or girlfriend); and questions about other forms of violence or threats, including bullying, in the past 12 months. Demographics, usual grades (e.g., "mostly Bs"), resilience assets such as a caring relationship with an adult, and some information on physical and behavioral health were recorded. Most of the questions and analyses on these surveys, however, concern substance use (including alcohol and tobacco).

Reports for the 1999-2000 survey reveal that among 11th grade students who had a boy/girlfriend, 10.4 percent reported having been hit, slapped, or physically hurt on purpose by that person in the past 12 months. There was little difference by gender for 9th graders, but by 11th grade, girls were 1.3 times as likely as 11th grade boys to report experiencing such behavior.[4] The 2003-04 survey revealed that about 9 percent of 9th graders and 13 percent of 11th graders who had a boy/girlfriend reported having been hit, slapped, or physically hurt by that person.[5] Reports have not included analyses of the sexual harassment data.

[4] WestEd, "2001-2002 California Student Survey: Violence and Safety" Fact sheet
[5] WestEd, "Teen Dating Violence: 2003-2004 California Student Survey Brief 4"

Examples of reports published from CSS include: "Violence and Safety Among California Youth," and "Continuation Schools Report," both published winter 2002; and "Teen Dating Violence: 2003-2004 California Student Survey Brief 4." Researchers at UC Davis, University of Texas, and the Los Angeles Commission on Assaults Against Women have acquired CSS data. The reports are available at: http://safestate.org/index.cfm?navid=254. Other researchers may acquire CSS data by sending, on letterhead stationery, a request describing the nature of the research to:

Ms. Daphne Hom, CSS Project Manager
Crime and Violence Prevention Center
Attorney General's Office
1300 I Street, Suite 1150
Sacramento, CA 95814.
(916) 324-7863
Daphne.Hom@doj.ca.gov

On receiving a request, Ms. Hom obtains permission from co-sponsors, California Departments of Education and Alcohol and Drug Programs, and forwards the request to contractor WestEd. WestEd provides the data, without charge or for a nominal fee, but requires a Memorandum of Understanding with the requestor. If the requestor is with a state agency, permission from the co-sponsors is not needed, but the request must still be on letterhead.

Further information on data DOJ maintains can be found at:

http://caag.state.ca.us/cjsc/statisticsdatatabs/dtabscrims.htm

Rape Crisis Centers

In California, 84 rape crisis centers (RCCs) or programs receive state and federal funds to provide a wide variety of services, such as crisis intervention, counseling, and advocacy to victim/survivors of SV. RCCs also provide prevention education in school and other settings, and training to professionals who interact with victims of SV, such as law enforcement officers, mental health workers, and sexual assault forensic examiners. Victim/survivors obtain services from RCCs by calling crisis lines for assistance, visiting RCCs in person, or when RCC staff or volunteers assist victims at other locations, such as medical centers where forensic medical examinations are conducted.

When RCC staff or volunteers provide services to victims of SV, they document and submit some aggregated information about these services to the California Office of Emergency Services (OES). Reports to OES include the following information about the victim/survivors served: counts by age group (0-17, 18-24, 25-50, 51+ years), ethnicity, disabilities, referral source, and types of services provided. In order to provide an unduplicated count of victims served, RCCs count only the first contact with a victim

in a given year. Information concerning the sexual assault incidents or perpetrators is not included in the reports to OES.

California's RCCs do not share a single, standardized form for collecting intake information, and they do not report information about individual victims to OES. Therefore, a state-level source for individual-level victim data does not exist.

For the 12-month reporting year 2004-05, RCCs reported providing services to 26,188 victims of SV throughout California. Of these victims, 1,693 were reported to have disabilities.

Although the RCC data have not been formally analyzed, EPIC has begun descriptive analyses using these data. For more information about the data, contact Linda Bowen at OES, (916) 324-9210.

Medical Information Reporting

The Medical Information Reporting for California (MIRCal) online system was developed in response to legislation requiring online reporting of patient data. The system currently collects inpatient discharge (i.e., hospitalization) data and is currently implementing ED and ambulatory surgery data collection. [6,7] These data are described in the following sections.

ED Treatment

The California Health and Safety Code mandates the development of a system for electronically reporting all visits to nonfederal EDs and ambulatory surgical (AS) clinics in California.[8] The law essentially extends the current inpatient hospital discharge data reporting (described below) to include ED and AS patients. The information collected includes description of the type of injury (diagnosis) and how it occurred, outcome (e.g., hospitalized, treated and released), and the patient's age, race/ethnicity, and county of residence. Injuries are classified according to external causes of injury codes, or E-codes, which are assigned by a specially trained coder (nosologist) using information in the patient record. These codes allow data users to identify injuries that were documented and coded as being caused by violence. Data collection began in early 2005. The first data are expected to be available soon.

ED reporting, when fully implemented, may be the best option for describing and tracking SV and related injuries in California. The number of injuries reported from EDs will likely be much larger than the number of inpatient hospitalizations and represent a much greater segment of assault-related injuries. These less severe injuries will

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[6] http://www.oshpd.ca.gov/MIRCal/index.htm
[7] Candace Diamond, Electronic communication, 10/19/04
[8] California Health and Safety Code, Section 128736

probably also show different patterns: for example, weapon involvement in SV may be more common among hospitalized sexual assault victim/survivors than among those treated in the ED only.

Although likely to improve on hospitalization data for purposes of SV surveillance, ED data will still probably capture only a fraction of sexual assault resulting in injury. According to the National Crime Victimization Survey (NCVS) study on rape reporting, only 14-15 percent of rape and attempted rape victims received care in hospitals and EDs.[9] In other words, even ED data are likely to represent only the minority of victims. Nevertheless, ED data may provide useful information on treatment for victims of SV.

When the ED data are ready for release, they will be available by contacting:

Candace L. Diamond, Manager
Patient Data Section
Healthcare Information Division
Office of Statewide Health Planning and Development
818 K Street, Suite 100
Sacramento, CA 95814
Phone (916) 324-2712, Fax (916) 327-1262
cdiamond@oshpd.ca.gov, hirc@oshpd.ca.gov, or mircal@oshpd.ca.gov.

Hospitalizations

OSHPD maintains data on fatal and nonfatal hospitalized violent injuries in the Patient Discharge Data. California hospitals must report external causes of injuries, coded using E-codes, for all hospitalized injuries. As with the ED data, these codes allow data users to identify injuries that were documented as being caused by violence. Because an E-code is required only for the hospitalization during which the injury was first diagnosed and treated, E-coded discharge records contain unduplicated hospitalized injury incidence data.

The data set includes all hospital admissions in California. Information in this data set includes description of the type of injury (diagnosis) and how it occurred, any other illnesses or conditions that contributed to the cost or duration of the hospital stay, as well as procedures performed (coded according to ICD-9). It also includes demographic information, such as age, race, and sex; and information about the hospital stay, such as number of days, payer, amount billed for care, and disposition (destination) of the

[9] Rennison, C.M. 2002. Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Washington, D.C.

discharged patient.[10]

Hospitalizations represent a very small fraction of sexual assault incidence or prevalence. According to data from NCVS, about five percent of victims of completed rapes suffered serious injuries. Only about 31 percent of physically injured women who survived SV (including completed and attempted rapes and other sexual assaults) sought *any* medical treatment and only about two percent were hospitalized.[11] We would only expect to find these two percent in the hospitalization data. In California, for the years 1991 through 2002, there were 924 hospitalizations for rape, for an average of about 77 per year.[12] Although more inclusive than the death certificate data, this figure is much too small to be a credible representation of the incidence of SV. If these 77 victims are two percent of all sexual assaults, then about 3,850 others would not have been hospitalized. Furthermore, as with most injuries, the vast majority of medical treatments for sexual assaults likely takes place in EDs and does not result in admission to the hospital.

Hospitalization data are used for reports produced by DHS staff. The data, without patient identifiers, are available as a public use dataset by contacting:

Candace L. Diamond, Manager
Patient Data Section
Healthcare Information Division
Office of Statewide Health Planning and Development
818 K Street, Suite 100
Sacramento, CA 95814
Phone (916) 324-2712, Fax (916) 327-1262
cdiamond@oshpd.ca.gov, hirc@oshpd.ca.gov, or mircal@oshpd.ca.gov.

Custom tables can be created from the hospitalization data for 1991-2003 by visiting EPIC's data website, the EPICenter, at: http://www.dhs.ca.gov/EPICenter.

Death Records

DHS' Center for Health Statistics maintains death certificate data in their electronic death data files. These data are available for the years 1960 through 2004. They include deaths from natural (internal) causes and from injuries (external causes). The injury deaths are identified by external cause of injury codes. A specially trained coder

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10 Candace Diamond, Electronic communication 10/19/04

11 Rennison, C.M. 2002. Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Washington, D.C.

12 OSHPD, Hospital Inpatient Discharge Data. Retrieved 7/5/04 from EPICenter: http://www.applications.dhs.ca.gov/epicdata/content/TB_nonfatal.htm

(nosologist) assigns these codes using information on the death certificate. Injuries are classified according to what caused them. For example, violent deaths are identified by several codes for assault injuries.

For injury deaths, including fatal assaults, data come from death certificates filed by either a county coroner or medical examiner and forwarded by each of the 61 California Registration Districts to DHS. Non-residents who die in California and California residents who die elsewhere are included.

This data source is most valuable for demographic information on the victim, such as age, sex, race, education level, and marital status. Beyond the external cause of death codes indicating that the death resulted from an assault, there is little information on the circumstances of the death in the electronic record. Lacking this information on circumstances, death certificate data are not useful for examining SV.

In the years 1991-2003, a total of five deaths of California residents were listed as caused by "rape" or "rape by bodily force."[13] Given the high incidence of SV documented in other sources, death records appear to be an extremely poor source of statewide data on this problem. We think this is due to the fact that although rape and other forms of SV are very common, they rarely lead directly to the victim's death. Even in the event of a lethal sexual assault, the death record would be coded according to the method used to kill the victim, such as assault by blunt object, rather than rape.

The data files are available from the Center for Health Statistics for a fee varying from $100 to $300 per file. For further information regarding the electronic death data files, contact Jan Christensen or Karl Halfman at:

Jchrist1@dhs.ca.gov or Khalfman@dhs.ca.gov
California Department of Health Services
Office of Health Information and Research
P.O. Box 997410, MS 5103
Sacramento, CA 95899-7410
(916) 552-8095

Custom tables for 1991-2003 can also be created from the death records data by visiting EPIC's data website, the EPICenter, at: http://www.dhs.ca.gov/EPICenter.

Emergency Medical Services
When a 911 call causes a first responder (fire company or ambulance service) to be

[13] California Department of Health Services, Death Statistical Master File. Retrieved 12/22/05 from EPICenter:
http://www.applications.dhs.ca.gov/epicdata/content/TB_fatal.htm

dispatched, a record is created. This "run sheet" documents the dispatch, the nature of the medical emergency, and what was done with the injured person. Run sheets are another way to learn about injuries such as assaults, because they provide information about the scene and circumstances not usually found in ED or hospital records. In California, unlike some other states, operation of emergency medical services, including run sheet information, is a local responsibility. As a result, California does not yet have a single source of data on patients who are transported by first responders, and mandated state reporting is not likely in the near future.

The California Emergency Medical Services Authority (EMSA) is creating a statewide data system that will gather patient data. A pilot project began in Marin and Los Angeles Counties in March 2004. Providers will have two to five years to learn to use the system and report consistently. Emergency medical service providers will provide these reports voluntarily. When reports become consistent, they may provide new information on SV-related injuries.

This system will allow coding for injuries from violence against women, including distinguishing DV and SV from other forms. A “primary impression” field describes a medical condition that is most important in determining the type of care administered, e.g., blunt trauma. A “secondary impression” field requires information on the type and anatomic location of traumatic injuries. The “cause of injury” field includes E-codes. Multiple entries per patient record are permitted and encouraged, to provide detail. There are also fields for reporting factors that contributed to the injury, preexisting conditions, and suspected alcohol or drug use by the patient.

Other data fields include information about the providers, dispatch, procedures, transport destination, location of incident, trauma severity indicators, pain, and special diagnostic studies. However, EMSA has not yet determined which data fields will be available to researchers outside EMSA. Patient-level analyses are not possible.

If detailed information does become available, we expect these data to be a very rich source of information on serious unintentional injuries, but less informative for violence against women and SV, because we expect that only a very small proportion of SV incidents will result in emergency medical service calls. Moreover, the data may not be available for use by researchers in the near future.

For more information about these data, contact:

Ed Armitage, Chief Information Officer
Emergency Medical Services Authority
1930 Ninth Street
Sacramento, CA 95814
(916) 322-4336, extension 422
ed.armitage@emsa.ca.gov

Crime Investigation and Reporting

Sexual Assault Evidence Kits

When a sexual assault is reported to law enforcement soon (typically within about 72 hours) after the incident, the law enforcement agency (LEA) usually asks the victim to submit to an evidentiary examination. This examination is conducted by a specially trained sexual assault nurse examiner (SANE) or sexual assault forensic examiner (SAFE), or by emergency medical personnel. These examiners document injuries and collect evidence such as hair, clothing, and semen, using a sexual assault evidence kit. Results of laboratory analysis of sexual assault evidence kits can be used by the LEA in the investigation and prosecution of criminal cases.

In California, sexual assault evidence kits are purchased or assembled by either a local LEA's crime laboratory, or by one of DOJ's crime laboratories for the law enforcement agencies in the 46 counties that do not have their own crime labs. After the evidence is collected, the sexual assault evidence kits are sent to the local LEA, which forwards the kit to its crime lab or to a DOJ crime lab for analysis if necessary. Distribution of sexual evidence assault kits is not centralized, so there is *no systematic, statewide information on the distribution, use, or analysis of sexual assault evidence kits*. Consequently, we do not know how many kits are administered statewide, nor do we know the characteristics of the victims, perpetrators, or circumstances of the reported sexual assaults.

Although all sexual assault evidence kits conform to protocol set forth in the California Penal Code, there are currently minor differences among kits that local LEAs use. In response to a request for standard sexual assault evidence kits from the California Medical Training Center (CMTC), which trains SANE/SAFEs, the California Association of Crime Laboratory Directors (CACLD) formed a committee to standardize sexual assault evidence kits. This committee developed a prototype standard sexual assault evidence kit in 2004. LEAs are not mandated to adopt the standard sexual assault evidence kit, but the majority of LEAs, including DOJ, are expected to adopt the proposed standard.

For more information about sexual assault evidence kits, contact:

Karen Sheldon, Chief of Forensic Services
Contra Costa County Office of the Sheriff, and
Chair, Sexual Assault Evidence Kit Standardization Committee, California Association of Crime Laboratory Directors
Phone (925) 313-2800
kshel@so.cccounty.us

For information about training SAFE/SANEs, contact:

Dr. William M. Green
Medical Director, Sexual Assault Forensic Exam Team
University of California, Davis Medical Center
Director, Sexual Assault Education
California Medical Training Center
Phone (916) 734-4760, (530) 676-8452
wmgreen@jps.net

The Homicide File

The Homicide File is compiled annually by the Criminal Justice Statistics Center in DOJ. These data provide detailed information about the circumstances of each homicide in California and the demographics of the victim. These data are used by federal, state, and local agencies; researchers and planners; and others interested in the administration of criminal justice in California.

Supplementary Homicide Reports (SHR) are received monthly from all local California LEAs as part of the federal Uniform Crime Reporting (UCR) program when a homicide is believed to have occurred. SHRs provide basic information for the Homicide database for all homicides investigated by LEAs in California. Additional information is obtained from local agency crime reports and newspaper clippings of homicides occurring in California.

This data source is most valuable for information on the circumstances of the event. For instance, it contains information on precipitating event and victim-offender relationship, as well as demographic information on both the victim and the suspects. Because rape is rarely listed as the cause of death, rather than other injuries inflicted during the assault, this file does not document all homicides in which a sexual assault occurred. However, because the Homicide File can accommodate both the sexual assault as the precipitating event, e.g., circumstances, *and* a separate manner (e.g., use of a weapon) of the killing, it is probably a better source for describing fatal sexual assaults than are the death certificates. Moreover, multiple precipitating events may be recorded for a single homicide. For 1990-2002, 251 rape-related homicides are

recorded in the Homicide File. We do not know of any SV studies using the Homicide File.

The Homicide File is available to the public back to 1987 from the Criminal Justice Statistics Center. To obtain these data, contact:

California Department of Justice
Criminal Justice Statistics Center
Attn: Special Requests Unit
P. O. Box 903427
Sacramento, CA 94203-4270

The Linked File
The Linked File is maintained by the EPIC Branch of DHS. The file consists of records from the Death Statistical Master File linked with records from DOJ's Homicide File. The current file contains 34,542 records from 1990-99.

The purpose of this file is to combine the strengths of the death records (victim demographic information) with strengths of the Homicide database (information on circumstances) to create a more useful dataset for criminal justice and public health researchers. For example, the Linked File makes it possible to look at the victim's average education level (determined from death certificates) among women killed by intimate partners (determined from the Homicide database).

For simplicity, the file can be thought of as the Homicide database with additional data. It was created by using probabilistic linkage software to match injury deaths in the death file to all records in the DOJ Homicide database. More than 90 percent of homicide records are linked to a corresponding death certificate.

Anyone can obtain this data file for research purposes by contacting Jason Van Court, M.P.H., at jvancour@dhs.ca.gov or (916) 552-9849. Custom tables can be created from the Linked File by visiting http://www.dhs.ca.gov/EPICenter. However, SV as a precipitating factor in the homicide cannot be ascertained from the EPICenter website.

Other Crime Data
Law enforcement and criminal justice data are likely to seriously underestimate the incidence of SV to the extent that sexual assaults are not reported to law enforcement officials by victims. First, most rape survivors do not report the incident to the police. Data from the NCVS suggest that in 1992-2000, 63 percent of completed rapes are not reported to police nationally,[14] though reporting of sexual assault to law enforcement

[14] Rennison, C.M. 2002. Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000. U.S. Department of Justice, Office of Justice Programs, Bureau

appears to have improved substantially in 2002, when data from the NCVS suggest that more than one-half of sexual assault victims reported the crime to law enforcement.[15]

Even if reporting to law enforcement is improving, these data sources will likely miss many incidents of SV that do not meet the law enforcement definition of forcible rape or attempted forcible rape. Finally, sources that require arrest of a suspect will result in further underestimating the magnitude of SV in California, because even reported incidents often do not result in arrest of a suspect.

California Crime Index

The California Crime Index data represent crimes reported to LEAs, and are summarized regularly in the series *Crime in California*, published by the California Attorney General's Office. California statewide statistics on "forcible rape" are available for 1952 forward. The FBI defines forcible rape as "the carnal knowledge of a female forcibly and against her will." Assaults or attempts to commit rape by force or threat of force are included, but other types of sexual assault are not. DOJ does not receive information on individual incidents of rape from LEAs, so reports have not focused on SV and provide limited detail on rape. DOJ's *Preliminary Reports* include summary forcible rape and attempted rape statistics for selected jurisdictions. In 2003, DOJ recorded 9,918 rape crimes, including 1,457 attempted rapes.[16]

Monthly Arrest and Citation Register

In addition to the Homicide File and UCR, California DOJ has additional databases that could help track SV. The Monthly Arrest and Citation Register (MACR) consists of felony and misdemeanor arrests and citations reported to DOJ by all California law enforcement agencies. MACR lists the arrestee, age, gender, race/ethnicity, the most serious arrest offense, and law enforcement disposition. In 2003, the there were 2,456 arrests for rape in MACR. About 12 percent of those arrested for rape were juveniles.[17] MACR could be used to monitor perpetration of SV if LEAs reliably receive and record reports of SV, and subsequently identify, apprehend, and arrest perpetrators.

The Offender-Based Transaction Statistics (OBTS) consist of adult felony arrests and

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of Justice Statistics. Washington, D.C.

[15] Rennison, C.M. and Rand, M.R. 2003. Criminal Victimization, 2002. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Washington, D.C.

[16] California Office of the Attorney General, California Department of Justice, Division of Criminal Justice Information Services, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center. Crime in California, 2003.

[17] California Office of the Attorney General, California Department of Justice, Division of Criminal Justice Information Services, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center. Crime in California 2003.

final dispositions from 1982 to present. Some examples of final dispositions are: released by law enforcement, not convicted, fine, and probation with jail. The OBTS file include: date of event; arresting agency and booking number; most serious charged offense; most serious disposition; disposition offense; and sentence. The adult felony dispositions represent about 65-75 percent of the total adult felony arrests in a given year.[18] OBTS data are published in *Crime in California* (formerly *Crime and Delinquency in California*) and *Homicide in California.*[19]

Violent Crimes Committed Against Senior Citizens
The Violent Crimes Committed Against Senior Citizens data consists of monthly summaries of victims of forcible rape and other violent crimes who were at least 60 years of age. These data, which are available for 1983 to the present, are reported by LEAs.[20]

These and other reports can be found at http://caag.state.ca.us/cjsc/pubs.htm.
Arrest statistics for forcible rape can also be found in the *Criminal Justice Profile*. These arrest statistics are available disaggregated by county, jurisdiction, gender, race, or age of the arrestee, but not as individual-level data.

The data files (individual level but without personal identifiers) are available by contacting:

California Department of Justice
Criminal Justice Statistics Center
Attn: Special Requests Unit
P. O. Box 903427
Sacramento, CA 94203-4270
(916) 227-3509

Social Services

Child Sexual Abuse
When a county child protection services (CPS) agency receives a report of child maltreatment, an emergency response worker screens the referral to determine whether a response is needed, and if appropriate, initiates an investigation. Upon investigation,

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[18] California Office of the Attorney General, California Department of Justice, Division of Criminal Justice Information Services, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center. Crime in California 2003.
[19] Office of the Attorney General. CJSC Databases. Retrieved 12/23/04 at: http://caag.state.ca.us/cjsc/statisticsdatatabs/databss.htm
[20] Office of the Attorney General. CJSC Databases. Retrieved 12/23/04 at: http://caag.state.ca.us/cjsc/statisticsdatatabs/databss.htm

a CPS worker determines the report to be substantiated, inconclusive, or unfounded (false). Case data, including demographic information about the child and family, case disposition (e.g., case opened, closed, transfer to family maintenance), services provided (e.g., psychological assessments, child counseling, parenting classes), and type of allegation (e.g., sexual abuse, physical abuse, severe neglect) are entered into the state Child Welfare Services (CWS)/Case Management System (CMS).

CDSS, the mandated state child welfare agency, maintains the CWS/CMS as a management tool to collect and manage data for all children receiving child welfare services in California. Generally, CWS/CMS data are not readily available except through published reports. CDSS supports use of CWS/CMS data by funding the Child Welfare Research Center at the University of California at Berkeley Center for Social Services Research (CSSR). Reports of the CWS/CMS data are available at: http://cssr.berkeley.edu/CWSCMSreports/Referrals/referrals.asp. Users can select report criteria, including year, county, and "demographic," which includes type of abuse, age group, race/ethnicity, and gender. Similar reports for first entries to foster care are available at: http://cssr.berkeley.edu/CWSCMSreports/cohorts/firstentries/. To obtain reports showing the number of children entering foster care as a result of sexual abuse, use the drop-down menu for "Category" and select "by Removal Reason." These reports count each child once per year, even if multiple allegations and investigations occur in one year. Only the most serious allegation is counted; sexual abuse is considered more serious than any other type of allegation.

Summaries of CWS/CMS data with allegation types and demographic characteristics are also available at CDSS' website, at: http://www.dss.cahwnet.gov/research/CWS-CMS4-C_721.htm. For more information about CWS/CMS data, contact the CDSS Child Welfare Data Analysis Bureau at (916) 653-3850.

For the period July 1, 2004 through June 30, 2005, CPS received and substantiated child abuse for 109,324 children in California. Sexual abuse was alleged for 7,241 (6.6 percent) of these. CPS investigations were inconclusive for another 100,392 children referred; 6,233 (6.2 percent) of these referrals were for allegations of sexual abuse.[21]

Sexual Abuse of Elders and Dependent Adults

CDSS' Adult Protective Services (APS) Program provides assistance to dependent adults (i.e., adults between 18 and 64 years of age, with physical or mental limitations which restrict their ability to carry out normal activities or protect their rights) and elderly adults (i.e., 65 years and older) who are abused, neglected, or exploited in settings

[21] Needell, B., *et al*. Child Welfare Services Reports for California. Retrieved 12/09/05, from University of California at Berkeley Center for Social Services Research website. URL: http://cssr.berkeley.edu/CWSCMSreports/Referrals/referrals.asp

other than long-term care facilities.[22] For the purposes of APS, self-neglect comprises physical (e.g., hygiene, shelter), financial, and medical neglect, as well as malnutrition/dehydration and health and safety hazards. Abuse perpetrated by others includes sexual, physical, psychological/mental, and financial abuse, as well as neglect, abandonment, isolation, and abduction.[23]

County APS agencies are responsible for investigating reports of elder and dependent adult abuse and neglect. Upon investigation, cases are judged to be confirmed, inconclusive, or unfounded, and temporary services are provided as appropriate. The county APS agency completes a monthly statistical report and submits this report to the DSS, APS program. The statistical report summarizes caseload flow, case reports and investigation findings, types of abuse, and services provided. Data for elderly and dependent adults are summarized separately.[26] Currently, no demographic information is included in this report. The county-level data are available in summary tables at:

http://www.dss.cahwnet.gov/research/SOC242-Adu_436.htm

For more information on the APS data, contact:

Mr. Joseph Smith
Program Analyst
California Department of Social Services
(916) 229-4763 or joseph.smith@dss.ca.gov

or

Ms. Shirley Washington
Public Information Officer
California Department of Social Services
(916) 667-2268.

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[22] DSS, Research and Development Division, Adult Programs Analysis Team, "Early Impact of SB 2199 on the Adult Protective Services Program," May 2000. Retrieved 3/11/2005 from: http://www.dss.cahwnet.gov/research/res/pdf/APSWeb.pdf

[23] Adult Protective Services and County Services Block Grant Monthly Statistical Report, November 2004 (Version1). Retrieved 3/11/2005 from: http://www.dss.cahwnet.gov/research/res/pdf/soc242/2004/SOC242Nov04.pdf

Sexual Abuse in Long-term Care Facilities
The California Department of Aging tracks numbers of complaints of seven different categories of abuse and neglect, including sexual abuse, for residents of long-term care facilities. These residents include elderly adults and dependent adults with disabilities. Data on numbers of complaints are available to researchers, but no details on the incidents, victims, or perpetrators are included. To learn more about this data source, contact:

Ms. Jana Matal
Office of the Long-Term Care Ombudsman
California Department of Aging
1600 K Street
Sacramento, CA 95814
Telephone: (916) 323-6681
E-mail: jmatal@aging.ca.gov

Data Needs: What We Did Not Find

SV among Adolescents
Even though half of women who experience SV report that their first victimization occurred before age 18,[24] we lack statewide data that specifically address SV in this young population. Health risk behavior surveys that are regularly administered in schools throughout the state have not specifically addressed SV, although dating violence, bullying, and weapon carrying are addressed. The Youth Risk Behavior Surveillance System (YRBSS) monitors high priority health behaviors, including violence, nationally and in participating cities and states. The State of California does not participate, but the Cities of San Bernardino, San Diego, San Francisco, and Los Angeles participate in the YRBSS. The 2003 YRBSS included questions about dating violence and "forced sexual intercourse," and revealed that nationally, nearly 12 percent of high school girls and about 6 percent of high school boys reported ever having been physically forced to have sexual intercourse. The results for two of the California sites were similar.

SV in College Settings
The Clery Act, codified in 1998, requires all institutions of higher education (IHE) participating in federal student aid programs to maintain and publish statistics on sexual

[24] Tjaden, P. and Thoennes, N. Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey. U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, and Centers for Disease Control and Prevention. Research in Brief, November 1998.

assault and other crimes that occur within a defined campus area.[25] Less than half of the national sample of IHEs responding to a survey reported SV.[26] Although colleges do not represent the general population, they do represent a high-risk population and may be excellent sites for monitoring trends and developing, implementing, and evaluating prevention strategies.

Human Trafficking

The Victims of Trafficking and Violence Prevention Act of 2000 was signed into federal law in October 2000, and was reauthorized in 2003. The U.S. Attorney General announced in 2001 that trafficking in persons would be a top civil rights priority for the DOJ. In 2002 the President established a Cabinet-level Task Force to address human trafficking, chaired by the Office to Monitor and Combat Trafficking in Persons, under the U.S. Department of State. Further federal legislation to address trafficking of youth was also enacted in 2003, and the "Trafficking in Persons Report" is published annually. Despite recognition that human trafficking is a serious global problem and a concern of numerous federal agencies, this clandestine trade is extremely difficult to track systematically. Existing data appear to be limited to client service data collected by agencies that provide services to victims of trafficking, such as the Coalition to Abolish Slavery and Trafficking (CAST), or data collected for legal investigations.

SV Incidence and Perpetration

Some of the available survey data address the prevalence of SV victimization, that is, how many people have *ever* been sexually assaulted. However, existing data do not adequately address incidence, or how many new incidents occur *in a given period*, for California. RCCs serve far more survivors of SV than is represented by either law enforcement or health services data. We hope that emergency medical services and ED data will fill some of this gap sufficiently to reveal some trends. CWHS recently began collecting data about SV within a specific time frame (previous 12 months). However, we will probably need multiple years' data collection to obtain reliable estimates of the incidence rate of SV among California women.

Although DOJ maintains numerous crime data sets, incident-level information is not available for crimes other than homicides in California. The FBI's National Incident-Based Reporting System (NIBRS) has been implemented in numerous states, but not yet in California. NIBRS includes much more detailed information about specific crimes, including forcible rape, that criminal justice data sources currently available in California do not provide.

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[25] Security on Campus, Inc. The Jeanne Clery Act. Retrieved 4/4/2005 from: http://www.securityoncampus.org/schools/cleryact/cleryact.html

[26] Karjane, H.M., Fisher, N.S..., and Cullen, F.T. Campus Sexual Assault: How America's Institutions of Higher Education Respond. Final Report, NIJ Grant # 1999-WA-VX-0008. Newton, MA: Education Development Center, Inc. 2002.

Data sources mentioned in this report generally rely on victims to tell someone, such as an interviewer, health professional, or law enforcement officer, about SV victimization. Even when a victim reports SV to law enforcement or seeks medical or crisis intervention services, victims might know very little, if anything, about the perpetrators, and little information about the perpetrator is typically collected and recorded. However, understanding and preventing SV must address *perpetration*.

Local data collection

This project focused on statewide data sources and did not include a systematic assessment of the existence of local-level data. Although RCCs serve local populations and count the number of SV victims who obtain RCC services for reports to OES, we did not learn of any local efforts to analyze and disseminate the RCC data. Local LEAs also report statistics for rape to DOJ, but we did not encounter analyses of rape data from local LEAs. There are a few data collection efforts based in medical centers, and local health departments or other local entities may have ongoing and systematic SV data collection efforts that we did not find.

Conclusion

Public health surveillance can help elevate SV on the public agenda by highlighting the magnitude and breadth of the problem. Knowing who is at greatest risk can help mobilize people and resources to focus SV prevention efforts. Surveillance data can help us develop and evaluate prevention programs, and reliable surveillance data are essential for monitoring progress towards meeting our prevention goals.

Any effort at public health surveillance of SV will be affected by changing knowledge and attitudes about SV. The ways in which SV is perceived and handled have indeed changed rapidly. In the past 30 years, advocates have:

- established the first RCCs and statewide coalitions of RCCs,
- secured government recognition and funding for services and prevention,
- introduced and changed laws pertaining to SV,
- trained health, law enforcement, legal, and social service professionals about SV,
- strengthened the prosecution of SV cases,
- educated the public about SV,
- worked to change the public's attitudes and behaviors concerning SV, and
- increased public awareness of resources for victims of SV.

We hope these activities have prevented some SV, and we expect them to increase help-seeking and reporting of SV to law enforcement, independent of any changes in the actual incidence of SV. While more reporting of SV is important and welcome, it does add to the challenge of disentangling changes in reporting from actual changes in the incidence of SV. Comparing data across time and localities is also likely to be difficult for some of the same reasons.

Nevertheless, with the advent of ED data, we expect significant progress in our ability to conduct public health surveillance of violence-related injuries that require medical attention but not inpatient hospitalization. Because SV incidents are far more likely to result in ED visits than inpatient stays, ED data may provide the first statewide surveillance with individual-level data and some information about the incidents.

The accuracy and completeness of ED data will depend on many factors, including victims reporting SV to local LEAs, LEAs authorizing the evidentiary examinations, and the victims' willingness to undergo the evidentiary examination. The ED data will also depend on hospital staff properly recording the victim's reason for seeking medical care, especially in the cases where victims do not report to LEAs and undergo evidentiary exams. Moreover, it may take additional effort, time, and experience for the ED data to uniformly include sexual assault-related care.

Telephone surveys of the general population in California have recently begun to include questions concerning SV, and analyses of these data will guide the collection and development of further information to help us understand and prevent SV. Among the many concerns with any data collection effort is the extent to which reported incidents represent all incidents. This problem is especially important in the study of SV because of the paucity of other useful data sources. Therefore, surveys that address SV in some detail and that permit complex analysis, including victims' help-seeking and reporting behaviors, are especially valuable.

RCCs appear to be the resource most commonly used by victims of SV, and may, therefore, hold the greatest potential for surveillance of SV. Unfortunately, California RCCs do not share a standard protocol for collecting victim- or incident-level information (although they do report standard, aggregated information to funding agencies). Consequently, a single set of data from California's 84 RCCs does not exist. Confidentiality concerns also pose a barrier to RCC reporting.

Despite the great potential in ED and RCC data, their necessary focus on victim care results in much less potential for surveillance of SV perpetration. Although we believe that a minority of sexual assaults are reported to LEAs, further development of crime data could be very helpful in efforts to address SV. For example, standardization and tracking sexual assault evidence kits and collection of a few key data elements from the law enforcement and medical interviews might provide very useful data about SV perpetration.

Because no single source currently provides the information needed to guide prevention, we must rely on a mosaic constructed of information from various sources, with each source providing one part of the overall picture. Thus, for the present and near future, our knowledge about sexual violence in California will come from multiple data sources, including criminal, medical, and survey data systems. We hope that eventually RCC data will provide a more comprehensive, detailed, and timely picture of SV in California.

Glossary of Acronyms

APS	Adult Protective Services
AS	Ambulatory surgery
BRFSS	Behavioral Risk Factor Surveillance System
CALCASA	California Coalition Against Sexual Assault
CDC	U.S. Centers for Disease Control and Prevention
CDSS	California Department of Social Services
CHIS	California Health Interview Survey
CHKS	California Healthy Kids Survey
CJSC	Criminal Justice Statistics Center (California Department of Justice)
CMS	Caseload Management System (California Department of Social Services, Child Welfare Services)
CPS	Child Protection Services
CSS	California Student Survey
CSSR	Center for Social Services Research (University of California, Berkeley)
CWHS	California Women's Health Survey
CWS	Child Welfare Services (California Department of Social Services)
CVPC	Crime and Violence Prevention Center of the California Attorney General's Office
DHS	California Department of Health Services
DOJ	California Department of Justice
DV	Domestic violence
ED	Emergency department
EMSA	Emergency Medical Services Authority
EPIC	Epidemiology and Prevention for Injury Control Branch (California Department of Health Services)
FBI	Federal Bureau of Investigation
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
IHE	Institution of higher (postsecondary) education
LEA	Law enforcement agency
MACR	DOJ's Monthly Arrest and Citation Register
MCH	Maternal, Child, and Adolescent Health Branch (California Department of Health Services)
MIHA	Maternal and Infant Health Assessment
MIRCal	Medical Information Reporting for California
NCVS	National Criminal Victimization Survey
OBTS	Offender-Based Transaction Statistics
OCJP	Governor's Office of Criminal Justice Planning (now part of the Office of Emergency Services)
OES	California Office of Emergency Services
OSHPD	Office of Statewide health Planning and Development

RCC	Rape crisis center
SRG	Survey Research Group
SHR	Supplementary Homicide Reports
SV	Sexual violence
UCR	Uniform Crime Reports (FBI and DOJ)
YRBSS	Youth Risk Behavior Surveillance System (national)