Underserved Populations:

A Gap Analysis of Victims of Crime in Maine

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CUTLER INSTITUTE
MUSKIE SCHOOL OF PUBLIC SERVICE

Produced for the Maine Coalition Against Sexual Assault

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Produced for the Maine Coalition Against Sexual Assault

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Executive Summary

This project is a collaboration between the Maine Coalition Against Sexual Assault (MECASA), The University of Southern Maine's Maine Statistical Analysis Center (SAC), and the Maine Department of Health and Human Services (DHHS)/the Victims of Crime Administering Agency (VOCA) administrative agency. The purpose of this project is to better understand the gaps in service for underserved communities (e.g., people of color, people with disabilities, rural residents, etc.) that access services at sexual assault centers throughout Maine. The project is also intended to provide recommendations on current data collection practices to MECASA and sexual assault centers on how these changes could possibly impact future practices and policies among the sexual assault centers.

The Maine SAC analyzed service data that were collected by the Maine sexual assault centers. For the purposes of this project, researchers analyzed data submitted by the Maine sexual assault centers from January 1, 2016 to December 31, 2017.

The following is a summary of key findings:

- A sexual assault forensic exam (SAFE) was reflected as received in 16% of the 3,680 primary victim client records, 24% of the 3,680 primary victim client records reflected that the victim received medical attention, and 32% of the 3,680 primary victim client records reflected that the incident was reported to police.
- Underserved clients under the age of 24 report significantly higher rates of receiving a SAFE, receiving medical attention, and reporting an incident to police than clients aged 24 to 55 and underserved clients aged 56 and older.
- Underserved clients aged 56 and older report significantly lower rates of receiving a SAFE, receiving medical attention, and reporting an incident to police than clients aged 24 to 55 and underserved clients under the age of 24.
- Male clients report significantly lower rates of receiving a SAFE, and significantly lower rates of receiving medical attention, than female clients.
- Clients identified as people of color report significantly lower rates of receiving a SAFE, and significantly lower rates of reporting an incident to police, than clients identified as white.
- Clients who were reported as living in rural Maine reported significantly lower rates of receiving a SAFE than clients not living rurally.
- One to One Support[1] is the highest reported service, which was provided to 3,888 clients (76.87% of the 5,058 total client records).

[1] One to One Support includes individualized services from a center staff or advocate, either in person, through the phone or support line, or any other platform.

Background

In September 2017, the Maine Statistical Analysis Center (SAC), in conjunction with the Maine Coalition Against Sexual Assault (MECASA) and the Maine Department of Health and Human Services (DHHS) submitted a proposal to the Center for Victim Research to analyze victim and victim services data being collected by MECASA. The Center for Victim Research is a collaboration between the Office for Victims of Crime (OVC) and the Justice Research and Statistics Association (JRSA) aimed at enhancing victim and victim services research at the state and local level.

The Center for Victim Research serves as a hub for victim service providers, policymakers, and researchers to share the latest information on victim services research. The Center for Victim Research also promotes approaches for bolstering victim services planning and implementation. This report fulfills one recommendation put forth in OVC's *Vision 21: Transforming Victim Services Final Report*, which spells out that additional victim-related research is integral to determining what services gaps exist and what evidence-based programs are needed.[2]

The Maine Victims of Crime Assistance (VOCA) program, administered by the Maine DHHS, provides assistance to crime victims in Maine and connects them with local community-based providers that are able to support them in their recovery. Maine DHHS distributes funding through subgrants to sexual assault/domestic violence programs throughout the state.

MECASA

For the past 35 years, MECASA has worked to end sexual violence in Maine and to support quality sexual violence prevention and response services within Maine communities. MECASA does this by supporting policy development, public awareness, and communications efforts; funding for sexual violence service providers; and providing training and technical assistance to the sexual assault centers located throughout Maine. The sexual assault centers throughout Maine provide 24-hour services, support groups, medical and legal accompaniment, referrals, education, and more. MECASA serves six traditional full-service sexual assault support centers and one culturally-specific dual sexual assault and domestic violence service provider. Central to MECASA's work is their focus on evaluating these efforts to continually understand more about the populations seeking services and how to better improve those services.

[2] Office for Victims of Crime. (2013). Vision 21: Transforming Victim Services Final Report. Retrieved from https://ovc.ncjrs.gov/vision21/pdfs/Vision21_Report.pdf

Maine's Sexual Assault Support Centers:

- AMHC Sexual Assault Services (AMHC)

  Serving Aroostook, Hancock and Washington Counties

- Sexual Assault Crisis & Support Center (SAC&SC)

  Serving Kennebec and Somerset Counties

- Rape Response Services (RRS)

  Serving Penobscot and Piscataquis Counties

- Sexual Assault Prevention & Response Services (SAPARS)

  Serving Androscoggin, Oxford and Franklin Counties and the Towns of Bridgton and Harrison

- Sexual Assault Support Services of Midcoast Maine (SASSMM)

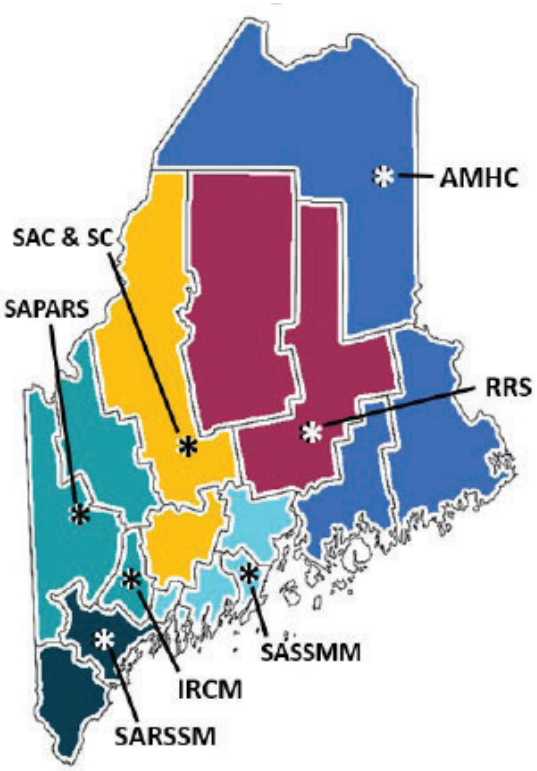
  Serving Eastern Cumberland, Sagadahoc, Knox, Waldo and Lincoln Counties

- Sexual Assault Response Services of Southern Maine (SARSSM)

  Serving Cumberland & York Counties

- Immigrant Resource Center of Maine (IRCM)

  Formally known as United Somali Women of Maine (USWOM). This agency is referred to as USWOM in this report because the name-change is not entirely official, and because the data was submitted at USWOM. IRCM strives to assist refugee and immigrant women living in Maine in a manner which reflects their gender and cultural practices.



Maine SAC

The University of Southern Maine (USM) is one of seven universities that make up the University of Maine System. USM is home to the Muskie School of Public Service (MSPS)[3], which is a highly distinguished public policy school that provides applied research services, training, and technical assistance in conjunction with challenging undergraduate and graduate degree programs.

[3] The Muskie School of Public Service is located on the Portland campus of the University of Southern Maine with an additional site in Augusta, the state capital. The Muskie School's website can be accessed at http://www.muskie.usm.maine.edu.

MSPS is also home to the Cutler Institute for Health and Social Policy, in which the Maine Statistical Analysis Center is located.

The Cutler Institute is also home to the Violence Against Women Act Measuring Effectiveness Initiative (VAWA MEI) team. Since 2001, VAWA MEI has worked with the Office on Violence Against Women (OVW) to document and measure the work of thousands of OVW grantees nationwide that address violence against women, including sexual assault, domestic violence, dating violence, and stalking.

Researcher-Practitioner Partnership

This project bolstered the existent researcher-practitioner relationship that the Maine SAC has with MECASA. Prior to the SAC-VOCA partnership, the Maine SAC worked with MECASA on a couple of very notable projects. As part of its FY 2016 Bureau of Justice Statistics (BJS) State Justice Statistics (SJS) award, the Maine SAC, in partnership with the Maine Department of Public Safety (DPS) (the state administering agency), developed the *2017-2020 Implementation Plan for the STOP (Services*Training*Officers*Prosecutors) Violence Against Women Program*[4]. As part of this planning process, the Maine SAC worked with DPS' Justice Assistance Council, on which MECASA is well represented, and provided data, content, and constructive feedback in the plan's development.

In addition, from 2002 to 2016, the Cutler Institute collaborated with MECASA and other victim service providers in Maine and New Hampshire to develop and produce a Victim Assistance Academy, funded by the VOCA administrative agency, for those working with victims of crime.

Lastly, MECASA's Executive Director is a member of the Maine SAC Advisory Committee, and MECASA worked closely with the Maine SAC to develop the state crime victimization survey to better understand the frequency and characteristics of criminal victimization in Maine, modeled after the National Crime Victimization Survey.[5]

Since being awarded the SAC-VOCA Partnership, MECASA and the Maine SAC have been working together to study how local law enforcement and prosecutors process sexual assault kits. In addition, the Maine SAC and MECASA were just awarded a proposal by the BJS to assess the use and effectiveness of deferred disposition sentences in domestic violence and sexual assault cases.

[4] Morris, J. E., McIntyre, M. State Maine Department of Public Safety Justice Assistance Council. (2017). *2017-2020 Implementation plan for the STOP Violence Against Women Program*. Available from http://muskie.usm.maine.edu/justiceresearch/Publications/Adult/2017_Maine_STOP_Implementation_Plan.pdf

[5] Dumont, R., Shaler, G. (2015). "2015 Maine Crime Victimization Survey: Informing Public Policy for Safer Communities." Muskie School of Public Service, University of Southern Maine. Retrieved from http://muskie.usm.maine.edu/justiceresearch/Publications/Adult/2015_Maine_Crime_Victimization_Survey.pdf

Introduction

Sexual violence (broadly defined as nonconsensual sexual acts such as rape, attempted rape, or threats of sexual violence) is highly prevalent in the United States and has serious health and societal consequences. Recent data from the National Intimate Partner and Sexual Violence Survey (NISVS) showed that nearly one in two women and one in four men are victimized by some form of sexual violence other than rape during their lifetimes.[6,7] Statewide data from the most recent Maine Crime Victimization Survey found that nearly a quarter (23.2%) of respondents reported that they had been raped in their lifetimes.[8] Survivors of sexual violence can experience serious consequences, such as short- and long-term physical injuries, higher rates of adverse and chronic health conditions, depression, PTSD, and shame.[9,10,11]

However, despite the high prevalence rate and adverse health consequences of experiencing sexual violence, reporting rates remain low. Some research shows that only 5 to 20% of rapes are ever reported to law enforcement; other research points to far lower rates of sexual assault reporting.[12] Furthermore, while sexual violence affects all sectors of society, populations that are historically underserved or marginalized may experience disproportionate rates of sexual violence, as well as disproportionate challenges or barriers when seeking services and receiving the care necessary for healing.

For example, research increasingly shows that rates of sexual violence among lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ+) victims are at least as high, if not higher than rates of violence among heterosexual victims. Transgender individuals experience disproportionately higher rates of violence than cisgender individuals.[13,14] This discrepancy in sexual violence victimization between LGBTQ+ and heterosexual populations is also demonstrated through data on Maine high school students. The Maine Integrated Youth Health Survey found that 18.4% of gay or lesbian students, 19.7% of bisexual students, and 14.8% of students who were unsure of their sexual identity reported that they had been physically forced

[6] This violence includes being forced to penetrate a perpetrator, sexual coercion, unwanted contact, or unwanted sexual experiences.
[7] Breiding, M. J., Smith, S. G., Basile, K. C., Walters, M. L., Chen, J., & Merrick, M. T. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization: National Intimate Partner and Sexual Violence Survey, United States, 2011. *Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, 63*(8), 1–18. Retrieved from http://www.cdc.gov/mmwr/pdf/ss/ss6308.pdf
[8] Dumont, R., Shaler, G. (2015). "2015 Maine Crime Victimization Survey: Informing Public Policy for Safer Communities." Muskie School of Public Service, University of Southern Maine. Retrieved from http://muskie.usm.maine.edu/justiceresearch/Publications/Adult/2015_Maine_Crime_Victimization_Survey.pdf
[9] Jordan, C. E., Combs, J. L., & Smith, G. T. (2014). An exploration of sexual victimization and academic performance among college women. *Trauma, Violence, & Abuse, 15*(3), 191–200. http://doi.org/10.1177/1524838014520637
[10] Probst, D. R., Turchik, J. A., Zimak, E. H., & Huckins, J. L. (2011). Assessment of sexual assault in clinical practice: Available screening tools for use with different adult populations. *Journal of Aggression, Maltreatment & Trauma, 20*(2), 199–226. http://doi.org/10.1080/10926771.2011.546754
[11] Linden, J. A. (2011). Care of the adult patient after sexual assault. *New England Journal of Medicine, 365*(9), 834–841. http://doi.org/10.1056/NEJMcp1102869
[12] Bureau of Justice Statistics. (2012). Victimizations not reported to the police, 2006-2010. Retrieved from http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4962
[13] Walters, M. L., Chen J., & Breiding, M. J. (2013). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Findings on victimization by sexual orientation. *Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention*. Retrieved from http://www.cdc.gov/violenceprevention/pdf/nisvs_sofindings.pdf
[14] Jindasurat, C., & Waters, E. (2015). Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-affected intimate partner violence in 2014. *National Coalition of Anti-Violence Programs*. Retrieved from http://www.avp.org/storage/documents/2014_IPV_Report_Final_w-Bookmarks_10_28.pdf

to have sexual intercourse, compared to a rate of 5.4% for heterosexual high school students reporting.[15]

Male victims of sexual violence may not disclose or report the abuse they suffered until significantly after the experience, if ever, due to stigma, reluctance to name their experience as sexual abuse, and other barriers.[16]

These populations as well as other underserved populations (such as those in rural areas, people of color or Native Americans, and those under the age of 24 or over 55) may face cultural, political, or societal barriers to disclosing or reporting the crimes perpetrated against them. They may avoid seeking services due to shame, blame, distrust of authorities, fear of retaliation, or loss of privacy.

While MECASA and sexual assault centers generate a lot of data regarding client contacts, it currently lacks the in-house expertise (and time) to mine this database to assess the needs and understand the gaps in services and outcomes of various potentially underserved populations. This research is the collaborative solution to that obstacle. In collaboration with MECASA and Maine DHHS, the Maine SAC analyzed data collected from sexual assault centers throughout Maine in order to identify gaps in service for underserved communities.

Methods

Data Collection and Management

Since October 2015, MECASA and the sexual assault centers in Maine have been using EmpowerDB, a database specifically designed for sexual assault service providers to track data about victims seeking services, services provided, prevention education, community outreach and training, and outcomes across all services.[17]

The sexual assault centers collect "contact" information (e.g., gender, age, race, and ethnicity), intake and disposition information (e.g., date of initial contact, type of client, referral source, time between assault and report to center, assault type, and relationship of perpetrator to victim), and "optional" abuse questions (e.g., victim received medical attention, victim reported to law enforcement, DHHS involved, and case results).

MECASA provided the Maine SAC with access to the EmpowerDB database so that SAC staff could query the database. Though MECASA's database contains information from all of Maine's local sexual assault support centers, no identifying information is conveyed to MECASA's system; client names, phone numbers, and other identifying information were not available to SAC staff. Maine SAC staff exported its query output to Microsoft Excel spreadsheets, which were then uploaded into SPSS (a statistical software program).

[15] Maine Department of Health and Human Services, Maine Department of Education. (November 20, 2015). "Maine Integrated Youth Health Survey." Retrieved from https://data.mainepublichealth.gov/miyhs/files/HS_Detailed_Reports_MIYHS2015/Maine_High_School_Detailed_Tables.pdf, 66

[16] Easton, S. D. (2013). Disclosure of child sexual abuse among adult male survivors. *Clinical Social Work Journal, 41*(4), 344-355. doi:10.1007/s10615-012-0420-3

[17] Jenkins, S. (2008). EmpowerDB [Software] Boston: Massachusetts. Available from https://www.empowerdb.com/?p=about

The Maine SAC submitted its research protocols to the USM Institutional Review Board for review and was granted approval in December of 2017. All data files were stored in a limited access folder on the University of Southern Maine data compliant network drive as outlined in protocol.

For this project, the Maine SAC analyzed two years' worth of data from January 1, 2016 to December 31, 2017. The Maine SAC opted not to include data from the last quarter of 2015 since the EmpowerDB was still very new at that point.

Analysis

EmpowerDB allows blocks of client record data to be downloaded; one block of variables are tied to the incident date, and another block of variables are tied to the date of service. In order to analyze all of the variables within individual level client records, researchers merged two data sets downloaded from EmpowerDB using Excel and SPSS. Researchers analyzed client record data by running frequencies and crosstabs of select variables.

There were 5,058 client records included in the final analyses. Table 1 depicts the breakdown of client records by agency.

Table 1: Overview of client records by agency

Agency	Number of Client Records*	% of the Total 5,058 Records
SAPARS	1,180	23%
SARSSM	1,123	22%
SACSC	742	15%
SASSMM	698	14%
AMHC	657	13%
RRS	476	9%
USWOM	31	1%
Unassigned*	151	3%
Full Data Set	5,058	100%

* Note that 151 client records are not assigned to an Agency.

Limitations

Time Period

While EmpowerDB was launched in October of 2015, not all sexual assault centers began using EmpowerDB at the exact same time. MECASA trained partner sexual assault service centers on how to use and report client records within EmpowerDB. For this reason, it is possible that total client records reflected in the data for the selected time period might not be entirely reflective of each agency's total client records for the full two-year period.

Missing Data

A significant limitation is that many fields in the database do not require service providers to select an answer when entering a client's information. With some services, notably hotline calls, some demographic information is not collected because doing so might impede service delivery. This can lead to many missing responses, or service providers selecting *unknown* in some cases. Missing data creates a challenge when performing analysis on already small numbers of underserved demographic client records. As shown in *Figure 1: Variables with Missing or "Unknown" Responses*, several variables of interest were missing a large percentages of data. Many clients contact the sexual assault centers through hotline services, which likely accounts for many "unknown" responses or missing responses to variables.

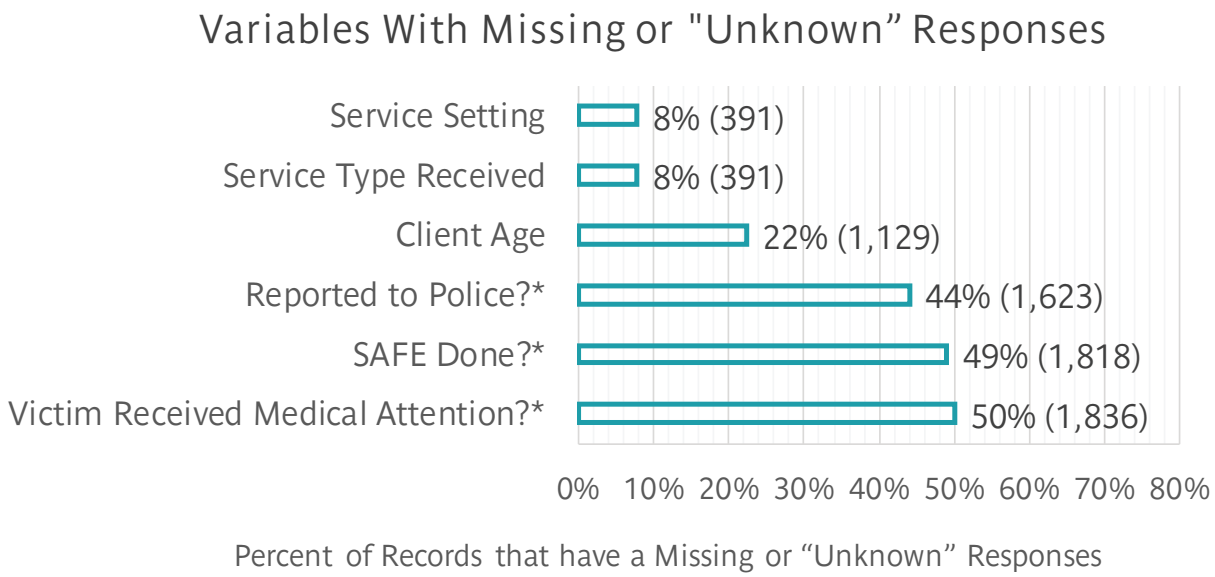


Figure 1: Variables with Missing or "Unknown" Responses

*Note that an asterisk indicates that only primary records (N=3,680) are included for the variables: reported to police, did the victim receive a SAFE, and did the victim receive medical attention. The variables that do not have an asterisk, (service setting, service type received, and client age) include data from all client records (N=5,058).

Variable Changes

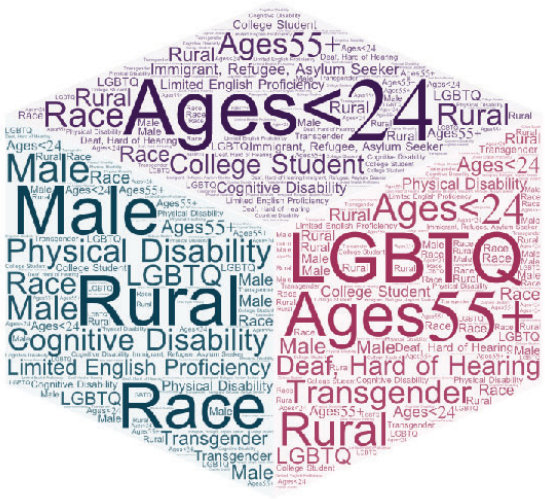
Some data fields that were originally available during the launch of EmpowerDB were later discontinued. This accounts for some variables having large number of missing responses. One known instance of this is the variable *abuse ongoing*, which was marked as either missing or unknown in 2,964 (59%) of the total 5,058 client records.

Findings

Data Regarding Underserved Populations:

Maine SAC researchers and MECASA staff identified of variables of interest, related to underserved populations. Variables that were identified included:

- Cognitive Disability
- College Student
- D/deaf, Hard of Hearing
- Immigrant, Refugee, or Asylum Seeker
- LGBTQ
- Limited English Proficiency
- Male or Transgender
- Race/Ethnicity
- Over 55 Years of Age
- Physical Disability
- Rural
- Under 24 Years of Age



Data were investigated with the intention of identifying strengths and possible gaps in service for these underserved communities.

The data set comprised 5,058 client records. Of those records, 3,680 records indicated the client was a primary victim of a sexual assault incident, and 1,377 records indicated the client was a significant other.[18]

[18] Significant others include relatives, friends or other concerned people who have a personal relationship with a victim/survivor.

Demographics and Descriptives

Age

Approximately 78% of client records indicated the age of the client, while the remaining 22% of client records were missing age data. Of the client records containing age information, Twenty-seven percent (27%) were clients aged 23 and younger, 45% were clients aged 24 through 55, and 6% were clients aged 56 and older.

Figure 2: Percent of Clients in Each Age Cohort

Gender

Nearly all client records (98%) had gender demographic information reported. Eighty-two percent (82%) indicated the client was female, 15% indicated the client was male, and 1% indicated the client was transgender.

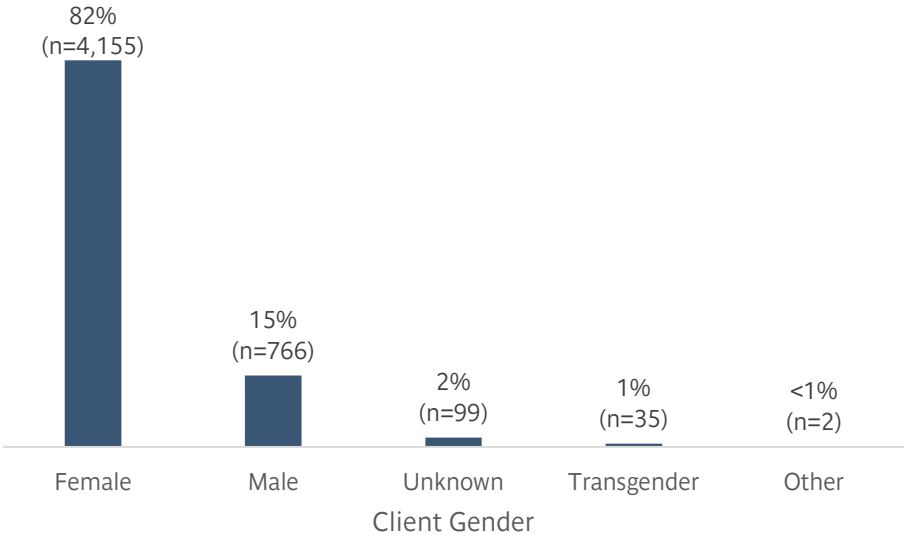


Figure 2: Aggregate Totals of Gender Categories

Race

Slightly more than half of all client records (56%) had race demographic information reported. Figure 4 shows that the majority of client records (50.65%, n=2,562) had a primary race of White. The second highest category selected for primary race of client was "Unknown," (43.61%, n=2,206). As previously mentioned, clients may access hotline services, a scenario that may make it challenging for service providers to collect race data. The two categories of White and Unknown account for 94.26% of total client records.

Note that the primary race demographic variable is a required field for service providers entering client records in EmpowerDB, therefore there were zero client records missing a responses to the primary race variable. There is an "Unknown" category that can be selected in the event that a service provider entering the data does not know the client's primary race.

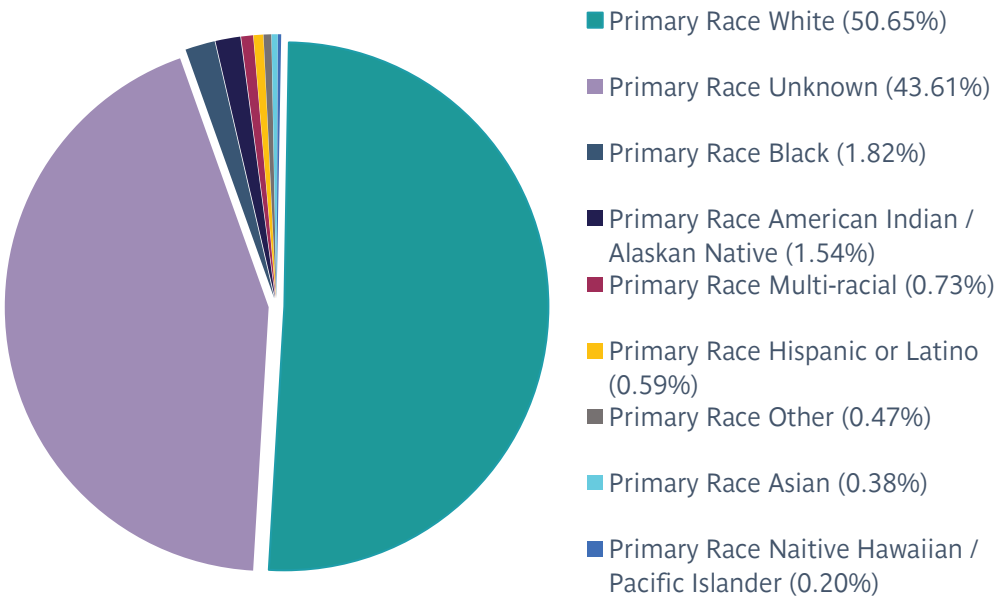


Figure 4: Total Client Race Demographics

Race by Agency

As shown in Table 2, each agency is primarily serving White clients. There were some exceptions to this observation. USWOM served 31 victims/survivors, and all 31 (100%) are identified as Black. For SARSSM, the primary race "Unknown" category was selected for 79% of client records (887 of the 1,123 SARSSM client records). For all but USWOM and SARSSM, the "Unknown" category is the second highest reported primary race. AMHC served the highest number of clients with the primary race American Indian/Alaskan Native, at 6.5% (43 of the 657 AMHC client records). RRS served the second highest number of clients with the primary race American Indian/Alaskan Native, at 4.4% (21 of the 476 RRS client records).

Table 2: Primary race of victims served by agency

	Client Records by Agency						
Primary Race	Client of AMHC	Client of SACSC	Client of SARSSM	Client of SASSMM	Client of RRS	Client of SAPARS	Client of USWOM
American Indian or Alaska Native	**43 (6.5%)**	2 (0.3%)	**5** (0.4%)	2 (0.3%)	**21 (4.4%)**	4 (0.3%)	0 (0.00%)
Asian	**3 (0.5%)**	2 (0.3%)	7 (0.6%)	1 (0.1%)	3 (0.6%)	2 (0.2%)	0 (0.0%)
Black	**12 (1.8%)**	4 (0.5%)	10 (0.9%)	6 (0.9%)	5 (1.1%)	22 (1.9%)	**31 (100.0%)**
Hispanic or Latino	**3 (0.5%)**	3 (0.4%)	17 (1.5%)	4 (0.6%)	3 (0.6%)	0 (0.0%)	0 (0.0%)
Multi-racial	**5 (0.3%)**	9 (0.3%)	3 (0.3%)	8 (0.3%)	3 (0.4%)	9 (0.1%)	0 (0.0%)
Native Hawaiian or Pacific Islander	**2 (0.3%)**	2 (0.3%)	0 (0.0%)	2 (0.3%)	2 (0.4%)	1 (0.1%)	0 (0.0%
Other	**4 (0.6%)**	4 (0.5%)	11 (1.0%)	4 (0.6%)	0 (0.0%)	1 (0.1%)	0 (0.0%)
Unknown	**103 (15.7%)**	**116 (15.6%)**	**887 (79.0%)**	**314 (45.0%)**	**192 (40.3%)**	**448 (38.0%)**	0 (0.0%)
White	**482 (73.4%)**	**600 (80.9%)**	**183 (16.3%)**	**357 (51.1%)**	**247 (51.9%)**	**693 (58.7%)**	0 (0.0%)
Total Client Records	**657**	**742**	**1,123**	**698**	**476**	**1,180**	**31**

Other Demographics

- 18.6% (n=942) of client records indicated the client lives in a rural area.[19]
- 5.3% (n=268) of client records indicated the client has a physical disability.
- 1.3% (n=64) of client records indicated the client identifies as LGBTQ.
- 1.1% (n=58) of client records indicated the client identifies as a college student.
- 1.0% (n=50) of client records indicated the client has a cognitive disability.
- 0.9% (n=45) of client records indicated the client identifies as an immigrant, refugee, or asylum seeker.
- 0.6% (n=32) of client records indicated the client has limited English proficiency.
- 0.2% (n=11) of client records indicated the client is deaf or hard of hearing.

[19] Note that there may not be a universally agreed-upon definition for what is rural between agencies and service providers, which means that this figure may be under-representative.

Service Types Accessed

One to One Support is the highest reported service, which was provided to 76.9% of clients (n=3,888). The second highest service category is Systems Advocacy[20], which was provided to 19.0% of clients (n=963). The third highest service category is Hospital Exam SAFE Accompaniment, which was provided to 9.2% of clients (n=463). As shown below in Figure 5, the categories combined or totaled may exceed 100% due to the fact that clients may receive multiple service types.

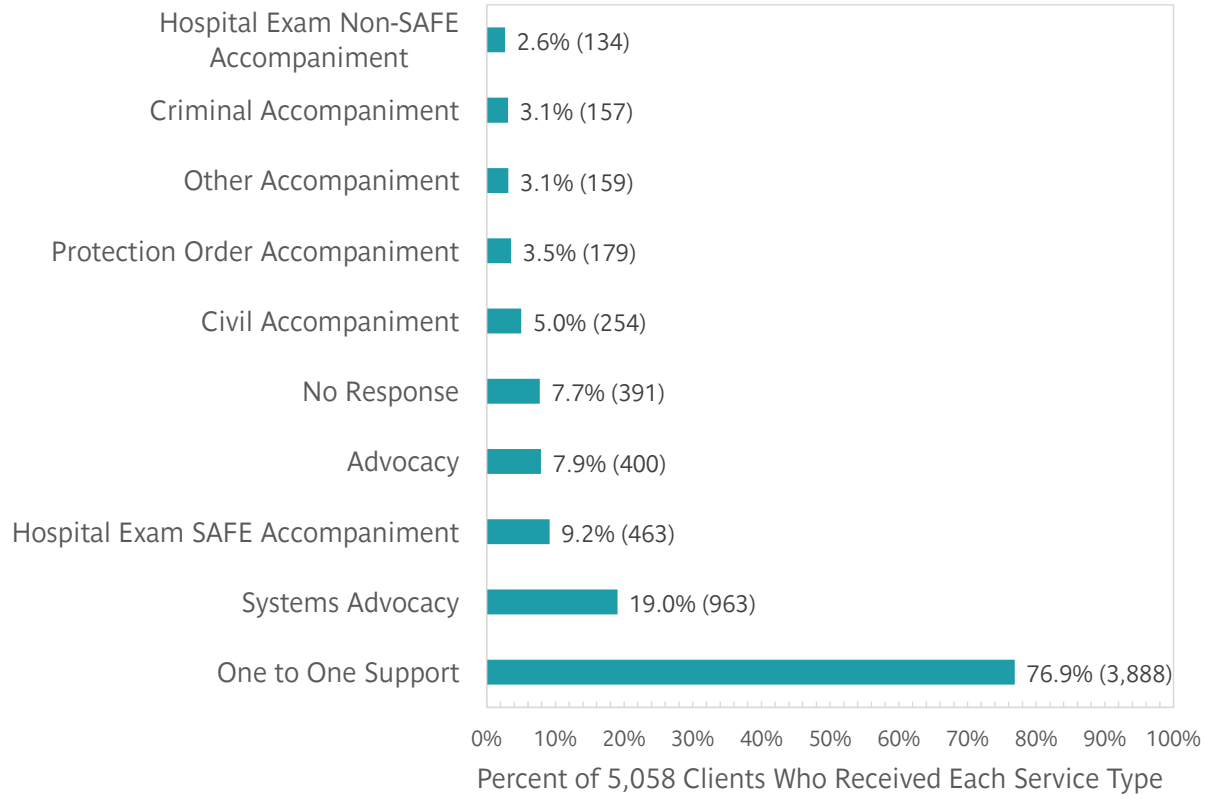


Figure 5: Top Ten Service Types Received

Differences in Access for Underserved Groups

Chi-square tests were performed to examine statistically significant differences in reporting of sexual assault forensic exams, medical attention, and reporting of incidents to police by age cohort, gender, race/ethnicity, sexual identity/orientation, and physical disability. Only client records identified as being a primary victim were included in these analyses (n=3,680). Due to the small numbers in the various non-white race data, all non-white race categories were aggregated for the purposes of running chi-square analyses.

[20] Systems Advocacy includes any service provided to a client that supports him/her through or with a system (services, criminal justice, health, etc.), but which is not an accompaniment (i.e., an in-person companionship at a system-level event), including completing Victims Compensation forms, support with accessing public benefits, support with completing an online Protection Order, etc.

There were not enough data to perform chi-square tests for the following underserved demographics: cognitive disability, college student, deaf or hard of hearing, and limited English proficiency.

Due to the small number of client records identified as transgender, it was not appropriate to investigate statistical differences for this gender subcategory.

There were no statistical differences in reporting rates of receiving a SAFE, receiving medical attention or reporting to police by clients identified as LGBTQ and by clients identified as having a physical disability. There were not enough data to perform analysis for receiving a sexual assault forensic exam by sexual identity/orientation.

Sexual Assault Forensic Exam (SAFE)

Out of the total 3,680 client records identified as primary victim, in 16% (n=584) of the records the client reported that they received a SAFE; in 35% (n=1,862) of the records the client reported that they did not receive a SAFE; in 29% (n=1,072) it was reported that it was unknown if the client received a SAFE; and in 20% (n=746) of the records this information was missing.[21]

Age

The rate at which clients received a SAFE varied by age.[22] At 36%, those younger than 24 were most likely to receive a SAFE, followed by those ages 24 to 55 at 31%, and those 56 and older at 13%. The differences between these three groups were statistically significant.[23]

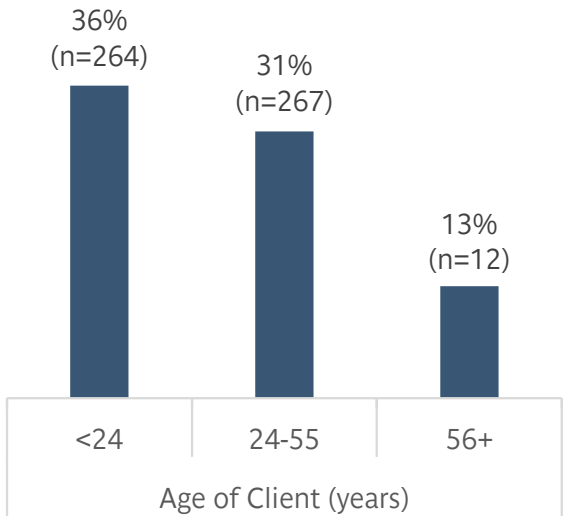


Figure 6: SAFE by Age

[21] Client records may have numerous responses to the client receiving a SAFE as a result of multiple incidents. In order to aggregate the data, if the client record contained any 'yes' response it was classified as a 'yes' response, and if the client record contained the two responses of 'unknown' and 'no', then the client record was classified as a 'no' response.
[22] These statistics only include client records where a known age was reported and the response to the client receiving a SAFE was yes or no. All client records where age was missing or unknown, and where the client receiving a SAFE was missing or unknown, were excluded. N= 1,685.
[23] $X^2(2,1685)=23.789$, $p<.001$, Cramer's V=.119

Gender

While 32% of clients[24] received a SAFE, the rate was higher for females than for males (34% and 12%, respectively). This difference was statistically significant.[25] There were too few cases of clients identified as transgender to perform statistical analysis. This could be possibly remedied by improving data collection for gender or by collecting another year's worth of data.

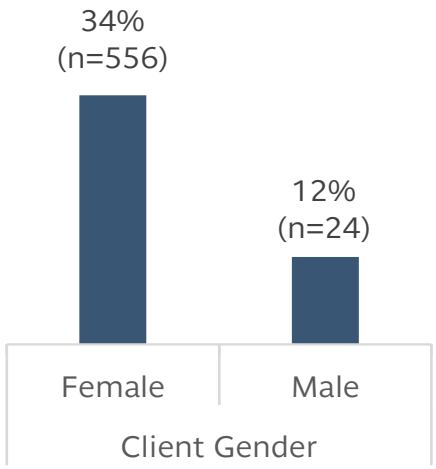


Figure 7: SAFE by Gender

Race/Ethnicity

The rate at which clients received a SAFE varied by Race.[26] White clients received a SAFE at higher rates than non-white clients (35% and 26%, respectively). This difference was statistically significant.[27]

Clients whose race was unknown reported similar rates (26%) or receiving a SAFE as non-white clients. Categorizing the records of clients whose race was unknown may change the outcome of the analysis for white and non-white clients.

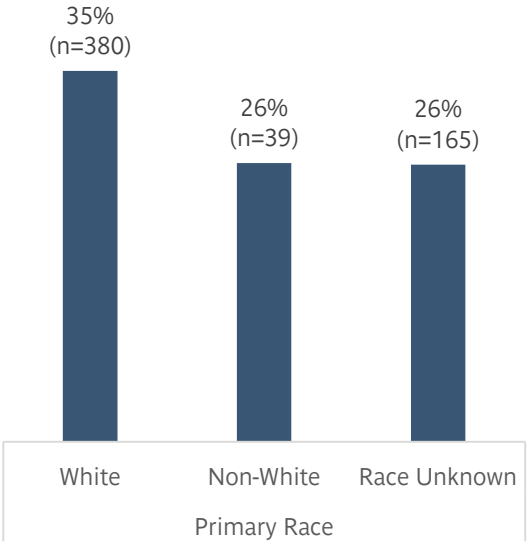


Figure 8: SAFE by Race

[24] These statistics only include client records where gender female or male was reported and the response to the client receiving a SAFE was yes or no. All client records where gender was reported as transgender, or other or unknown were excluded due to the numbers being too small to analyze. Client records in which the client receiving a SAFE was missing or unknown were excluded. N= 1,836.
[25] $X^2(2,1836)=40.328$, $p<.001$, Cramer's V=.148
[26] These statistics only include client records where the client race was reported as white, non-white, or unknown, and the response to the client receiving a SAFE was yes or no. All client records where race was missing, and where the client receiving a SAFE was missing or unknown, were excluded. N=1,862.
[27] $X^2(2,1862)=16.422$, $p<.001$, Cramer's V=.094

Rural

Rates of receiving a SAFE varied by whether or not a client lived in a rural location.[28] Thirty-two percent (32%) of clients who were not reported as living in a rural location received a SAFE. Twenty-seven percent (27%) of clients who were reported as living in a rural location received a SAFE. Although these rates are statistically significantly different,[29] it is notable that there are not clear parameters defining rural, and so this variable was flagged as possibly untrustworthy by MECASA. If all client records were to be categorized under clear guidelines regarding what it means to live in a rural area, this may change the outcome of the analysis for rural and non-rural clients.

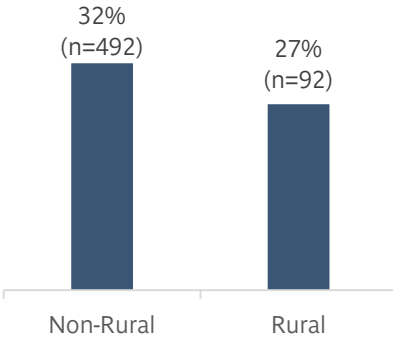


Figure 9: SAFE by Rural

Medical Attention

Out of the total 3,680 client records identified as primary victim, in 24% (n=874) of the records the client reported that they received medical attention; in 26% (n=970) of the records the client reported that they did not receive medical attention; in 30% (n=1,090) it was reported that it was unknown if the client received medical attention; and in 20% (n=746) of the records this information was missing.[30]

Age

The rate at which clients received medical attention varied by age.[31] At 54%, those younger than 24 were most likely receive medical attention, followed by those ages 24 to 55 at 47%, and those 56 and older at 28%. The differences between these three groups were statistically significant.[32]

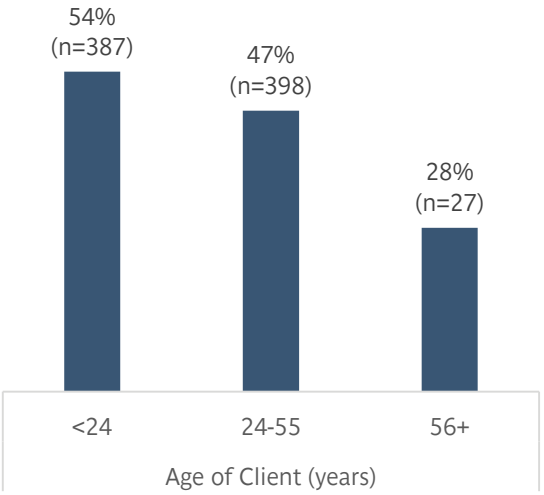


Figure 10: Medical Attention by Age

[28] These statistics only include client records where the response to living rurally was yes or no, and the response to the client receiving a SAFE was yes or no. All client records where a response to living rurally was missing, and where the client receiving a SAFE was missing or unknown, were excluded. N=1,862.
[29] $X^2(1,1862)=4.500$, p=.034, Phi=.049
[30] Client records could have numerous responses to the client receiving medical attention as a result of multiple incidents. In order to aggregate the data, if the client record contained any 'yes' response it was classified as a 'yes' response and if the client record contained the two responses of 'unknown' and 'no', then the client record was classified as a 'no' response.
[31] These statistics only include client records where a known age was reported and the response to medical attention was yes or no. All client records where age was missing or unknown, and where medical attention was missing or unknown, were excluded. N= 1,661.
[32] $X^2(2,1661)=25.614$, p<.001, Cramer's V=.124

Gender

While 48% of clients[33] received medical attention, the rate was higher for females than for males (50% and 24%, respectively). This difference was statistically significant.[34] There were too few cases to perform statistical analysis for transgendered clients. This could possibly be remedied by improving data collection for gender or by collecting another year's worth of data.

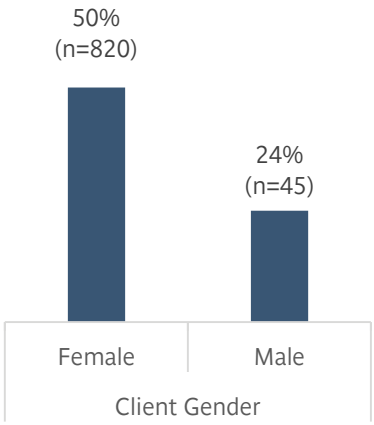


Figure 11: Medical Attention by Gender

Race/Ethnicity

White and non-white clients were just as likely to receive medical attention (52% and 44%, respectively).[35] Clients whose race was unknown, however, were less likely to receive medical attention than white clients, at 41%. The difference between rates reported by clients whose race was white and clients whose race was unknown are statistically significantly different.[36] Categorizing the records of clients whose race was unknown may change the outcome of the analysis for white and non-white clients.

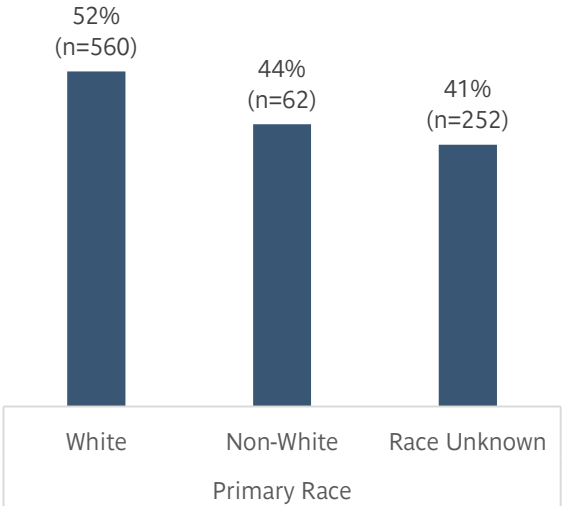


Figure 12: Medical Attention by Race

Rural

Clients who lived in a rural location and clients who did not indicate that they lived in a rural location had similar rates of receiving medical attention (46% and 48%, respectively).[37] It is notable that there are not clear parameters defining rural. If all client records were to be categorized under clear guidelines regarding what it means to live in a rural area, this may change the outcome of the analysis for rural and non-rural clients.

[33] These statistics only include client records where gender female or male was reported and the response to the client receiving medical attention was yes or no. All client records where gender was reported as transgender, or other or unknown were excluded due to the numbers being too small to analyze. Client records in which the client receiving medical attention was missing or unknown were excluded. N= 1,816.

[34] $X^2(1,1816)=47.207$, $p<.001$, Phi=.161

[35] These statistics only include client records where the client race was reported as white, non-white, or unknown, and the response to the client receiving medical attention was yes or no. All client records where race was missing, and where the client receiving medical attention was missing or unknown, were excluded. N= 1,844.

[36] X^2 (2,1844)=21.209, $p<.001$, Cramer's V=.107

[37] These statistics only include client records where the response to the client living rurally was yes or no, and response to the client receiving medical attention was yes or no. All client records where information regarding if the client lives rurally was missing, and where the client receiving medical attention was missing or unknown, were excluded. N=1,84

Reported an Incident to Police

Out of the total 3,680 client records identified as primary victim, in 32% (n=1,190) of the records the client reported an incident to police; in 24% (n=867) of the records the client reported that they did not report an incident to police; in 24% (n=870) it was reported that it was unknown if the client reported an incident to police; and in 20% (n=753) of the records this information was missing.[38]

Age

The rate at which clients reported the incident to police varied by age .[39] Shown in Figure 10, those younger than 24 were most likely (65%) to report to police, followed by those ages 24 to 55 at 59%, and those 56 and older at 48%. The differences between these three groups were statistically significant.[40]

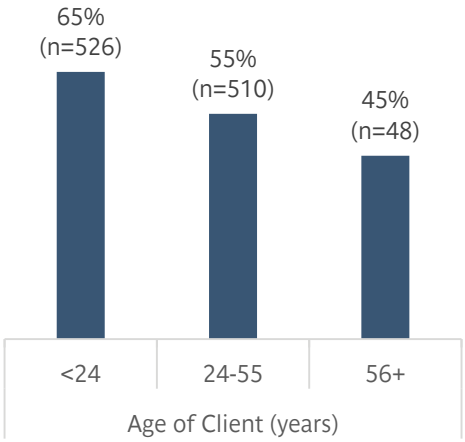


Figure 13: Reported to Police by Age

Gender

The rate at which clients reported an incident to police varied by Race. Female clients reported an incident to police at higher rates than male clients (59% and 51%, respectively). This difference was statistically significant.[41] The rate for transgendered individuals appears to be much lower, but there were too few cases to perform statistical analysis. This could possibly be remedied by improving data collection for gender or by collecting another year's worth of data.

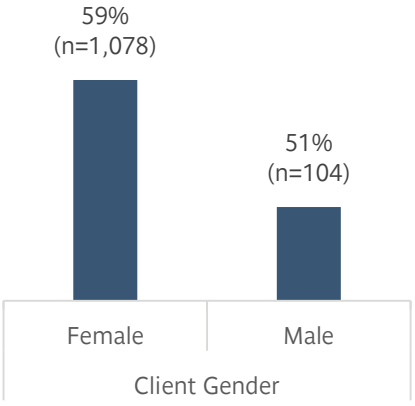


Figure 14: Reported to Police by Gender

[38] Client records could have numerous responses to the client reporting to police as a result of multiple incidents. In order to aggregate the data, if the client record contained any 'yes' response it was classified as a 'yes' response and if the client record contained the two responses of 'unknown' and 'no', then the client record was classified as a 'no' response.
[39] These statistics only include client records where a known age was reported and the response to the client reporting to police was yes or no. All client records where age was missing or unknown, and where the client reporting to police was missing or unknown, were excluded. N= 1,838.
[40] $X^2(2,1838)=28.118$, p<.001, Cramer's V=.124
[41] $X^2(1,2032)=4.118$, p=.042, Phi=.045

Race/Ethnicity

Rates of reporting to police also varied by race.[42] Sixty-four percent (64%) of those who were white reported an incident to police while only 47% of non-white respondents reported doing so. These rates are statistically significantly different.[43] At 50%, clients whose race was unknown had a rate similar to non-white respondents. Categorizing the records of clients whose race was unknown may change the outcome of the analysis for white and non-white clients.

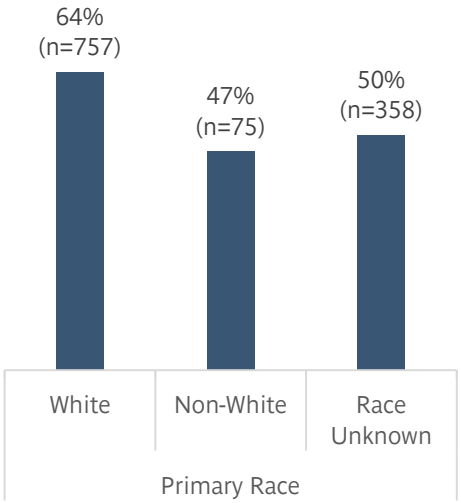


Figure 15: Reported to Police by Race

Rural

Clients who lived in a rural location and clients who did not indicate that they lived in a rural location had similar rates of reporting an incident to police (61% and 57%, respectively).[44] It is notable that there are not clear parameters defining rural. If all client records were to be categorized under clear guidelines regarding what it means to live in a rural area, this may change the outcome of the analysis for rural and non-rural clients.

Agency-Specific Referral Sources

Below are the top five referral sources[45] for each of the sexual assault centers, detailing how clients were made aware of the service provider.

AMHC

As shown in Table 3, *crisis and support line* is the highest reported referral source, followed closely by *therapist/counselor*. This data point suggests that the crisis and support line utilized by AMHC is effectively referring clients seeking services to AMHC for other sexual assault services. Additionally, this data point suggests a strong community connection between AMHC and local therapists and counselors. This may also be a reflection of internal referrals from colleagues at AMHC, which is common practice.

[42] These statistics only include client records where the client race was reported as white, non-white, or unknown, and the response to the client reporting an incident to police was yes or no. All client records where race was missing, and where the client reporting an incident to police was missing or unknown, were excluded. N= 2,057.
[43] $X^2(2,2057)=41.680$, $p<.001$, Cramer's V=.142
[44] These statistics only include client records where the response to the client reporting an incident to police was yes or no and the response to the client living rurally was yes or no. All client records where information regarding if the client lives rurally was missing, and where the client reporting an incident to police was missing or unknown, were excluded. N= 2,057.
[45] Note that there are not definitions for referral sources in the EmpowerDB manual.

Table 3: AMHC Top Five Referral Sources		
	AMHC	
Referral Source	# of Clients	% of Total Clients
Crisis and Support Line	74	11.3%
Therapist/Counselor	71	10.8%
Mental Health Agency/Facility	62	9.4%
Other	61	9.3%
Friend	49	7.5%
Total Number of AMHC Clients	**657**	

RRS

As shown in Table 4, *crisis and support line* is the highest reported referral source, followed by *internet/social media/website*. This data point may highlight that the crisis and support line utilized by RRS is effectively referring clients seeking services to RRS for other sexual assault services.

Table 4: RRS Top Five Referral Sources		
	RRS	
Referral Source	# of Clients	% of Total Clients
Crisis and Support Line	175	36.8%
Internet/Social Media/Website	77	16.2%
Shelter/Safe Home	36	7.6%
Other Hospital/Medical Provider	28	5.9%
Other Victim Services Agency	24	5.0%
Total Number of RRS Clients	**476**	

SACSC

As shown in Table 5, *crisis and support line* is the highest reported referral source for SACSC, followed closely by *DHHS – Child Welfare*. This data point suggests that the crisis and support line utilized by SACSC is effectively referring clients seeking services to SACSC for other sexual assault services. Additionally, this data point suggests a strong community connection between SACSC and DHHS Child Welfare.

Table 5: SACSC Top Five Referral Sources		
	SACSC	
Referral Source	# of Clients	% of Total Clients
Crisis and Support Line	135	18.2%
DHHS - Child Welfare	131	17.7%
Police	122	16.4%
Other Hospital/Medical Provider	113	15.2%
Unknown	35	4.7%
Total Number of SACSC Clients	**742**	

SAPARS

As shown in Table 6, the *unknown* category is the highest (58.4%) of all SAPARS referral sources, followed by *school/school counselor*. SAPARS staff may want to consider exploring ways to better collect this type of information.

Table 6: SAPARS Top Five Referral Sources		
	SAPARS	
Referral Source	# of Clients	% of Total Clients
Unknown	689	58.4%
School/School Counselor	106	9.0%
Other	80	6.8%
Other Hospital/Medical Provider	80	6.8%
Police	74	6.3%
Total Number of SAPARS Clients	**1,180**	

SARSSM

As shown in Table 7, the *unknown* category is the highest (31.2%) of all SARSSM referral sources, followed by *crisis and support line*. This data point suggests that SARSSM staff should consider exploring ways to better collect this type of information.

Table 7: SARSSM Top Five Referral Sources

	SARSSM	
Referral Source	# of Clients	% of Total Clients
Unknown	350	31.2%
Crisis and Support Line	266	23.7%
Internet/Social Media/Website	117	10.4%
Other Hospital/Medical Provider	52	4.6%
Police	36	3.2%
Total Number of SARSSM Clients	**1,123**	

SASSMM

As shown in Table 8, the *unknown* category is the highest (26.6%) of all SASSMM referral sources, followed by *other hospital / medical provider*. This data point suggests that SASSMM staff should consider exploring ways to better collect this type of information.

Table 8: SASSMM Top Five Referral Sources

	SASSMM	
Referral Source	# of Clients	% of Total Clients
Unknown	186	26.6%
Other Hospital/Medical Provider	84	12.0%
Program Outreach	70	10.0%
Other	61	8.7%
Domestic Violence Agency	58	8.3%
Total Number of SASSMM Clients	**698**	

USWOM

As shown in Table 9, the majority (83.9%) of the 31 client records indicate that the clients were referred through program outreach. This data point suggests successful program outreach methods utilized by USWOM.

Table 9: USWOM Top Five Referral Sources

	USWOM	
Referral Source	# of Clients	% of Total Clients
Program Outreach	26	83.9%
Other Victim Services Agency	2	6.5%
Friend	1	3.2%
Other	1	3.2%
Religious/Community Leader	1	3.2%
Total Number of USWOM Clients	**31**	

Implications & Recommendations

At the time of the 2010 Census, 94.7% of Maine's population were reported White, 1.6% were reported Black or African American, 0.7% were reported American Indian and Alaska Native, 1.2% were reported Asian, 1.6% were reported Hispanic or Latino, and 1.8% were reported as two or more races.[46] Most recipients of victim services are reportedly White, urban, English-speaking women without disabilities who are not considered elderly. In contrast, literature has shown that minority women and those with low-socioeconomic status are more likely to be victimized but less likely to report and seek services than European American women.[47]

While the majority (50.7%) of client records were white, 43.6% of the 5,058 total client records were reported as *unknown* race. The proper categorization and inclusion of these records most likely would result in a different racial breakdown of client records. As previously mentioned, asking clients about demographic information during hotline and support line services can be burdensome to the effectiveness of service delivery. Accordingly it is not known what underserved demographics are accessing hotline services.

[46] U.S. Census Bureau. (2018). QuickFacts. Retrieved from https://www.census.gov/quickfacts/fact/table/me,US#viewtop
[47] Koss, M. P., White, J. W., & Lopez, E. C. (2017). Victim voice in reenvisioning responses to sexual and physical violence nationally and internationally. *American Psychologist*, *72*(9), 1019–1030. Retrieved from https://doi-org.ursus-proxy-1.ursus.maine.edu/10.1037/amp0000233

SAPARS had the largest number of records in the EmpowerDB database for the specified time frame of January 2016 to December 2017, totaling 1,180 client records. As shown in *Table 2: Primary Race of Victims Served by Agency,* SAPARS served 58.7% (n=693) clients identified as having a primary race of white. The referral sources for 58.4% (n=689) of the 1,180 client records) had an unknown referral source.

Comparing the agency-specific tables of referral sources in Tables 3 through 9 may shed light on which referral sources are most effective between agencies. Further, it is possible these tables and findings could spark additional inter-agency collaboration and learning about outreach methods and relationships to community referral sources.

As shown in Tables 3 through 9, the *other* referral source category is frequently utilized by service providers entering client records. Investigating the *other* referral source category in all the client records lead to the discovery that there are many duplicate responses in the *other* category. Two examples are the descriptions of family members and the description "CAC." Service providers might consider adding these frequently used referral sources to the choices included database.

As discussed in the section regarding chi-square analyses, missing and unknown data impact the finding of statistical significance between rates. The small number of client records identified as transgender did not allow for statistical differences to be calculated. Additionally, the small numbers in the various non-white race categories did not allow for statistical differences to be calculated. In order to conduct statistical analyses of the data, all non-white race categories were aggregated into the group of client records labeled as non-white race. It must also be noted that the findings reported here could be impacted if missing and unknown information were to be added to client records.

Analyses identified three specific service areas which underserved populations accessed at significantly lower rates than other clients. These three service areas were *receiving a SAFE, rates of receiving medical attention,* and *rates of reporting an incident to police.*

	SAFE	Medical Attention	Reported to Police
< 24	+	+	+
> 55	—	—	—
Male	—	—	
Non-White	—		—
Rural	—		

Analyses showed that people under the age of 24 are most likely to indicate that they received a SAFE, received medical attention, and that they reported an incident to police. Those ages 56 and older are least likely to indicate that they received a SAFE, received medical attention, and that they reported an incident to police.

Additionally, analyses identified differences between males and females. Male clients were significantly less likely to report that they received a SAFE and to report that they received medical attention than female clients.

Analysis showed that clients identified as non-white race were significantly less likely to report that they received a SAFE and to indicate that they reported an incident to police than clients identified as white.

Finally, clients who were reported as living in rural Maine reported lower rates of receiving a SAFE than clients who were reported as not living in a rural location. It is notable that there are not clear parameters defining rural, and so this variable was flagged as possibly being untrustworthy by MECASA. If all client records were to be categorized under clear guidelines regarding what it means to live in a rural location, this may change the outcome of the analysis for rural and non-rural clients.

Possible Variable Suggestions:

Demographics

1. Create variable for "hotline call, no demographics collected" or a way/indicator to keep track of why client records have non-responses to data fields.
2. With the understanding that service providers must be careful not to discourage clients from accessing clients, it might be beneficial to have a conversation with stakeholders from each of the coalitions regarding methods for collecting demographic information. There is a possibility that underserved populations are being served hotline services and that these clients' demographics are being reported as unknown.
    a. An idea to capture clients who have a primary language other than English might be to add a variable that captures if English is the client's second language, or if interpreter services were offered or utilized during a hotline call.

Data Entry Practices

1. Conduct consistent training on the importance of the data/guidelines for filling out EmpowerDB across the agencies to increase the interrater reliability of the data.
    a. Setting stricter guidelines for what is reported as *rural* so that this variable can be used in any future analysis.
    b. Train service providers on definitions of other fields before inputting data in order to increase inter-rater reliability of data being collected/inputted into the database.
    c. Continue to run agency-level reports to see where variables are being skipped/left blank in order to give staff direct examples of where to improve data reporting methods.

2. For practicing within EmpowerDB, compile a list of practice client records so that those records can be removed from aggregated data and reports.

    a. An example of how to label practice records uniformly might be to make the last name of the record always be "Practicerecord" so that future evaluation can quickly remove any records with a last name of "Practicerecord" in order to ensure that only real client data is included with reports or statistics being conducted.

3. Map the data from *Group & Events* part of EmpowerDB to be able to link those activities to the individual client level data. This will enable MECASA to see what underserved demographic groups are accessing those activities and services housed within the data from *Group & Events*.

4. With future use of an Underserved Needs Assessment, consider creating a prospective, longitudinal study design in order to real-time assess the effectiveness of any changes.

    a. For example: Maybe a goal from the UNA would highlight a gap in, or a barrier to, victims seeking services. A change, new service, new protocol, or new method of outreach is implemented with the aim to increase feasibility of seeking services for the target underserved population(s). In order to measure the effectiveness of the new decision, it might help to use a prospective, longitudinal study design.

Service Types

1. Separate out each type of specific service from the "one-to-one support" service variable. As shown in *Figure 4: Top Ten Service Types Received*, 76.9% of clients received the service *one-to-one support*. This service is only selected up to one time per client record, but *one-to-one support* is inclusive of a large array of services. This means that services within that category may be under-reported if a client receives multiple services that are housed under *one-to-one support*.

    a. Assign a definition to each service type, with the aim that a service type is not measuring more than one services/item.

2. Within EmpowerDB make the service type data field a required response if it is not already.

    a. There were 391 (7.7%) client records that did not have a service type selected, and there was no service setting selected for these 391 records.

3. Create separate variables for if SAFE kit was run/destroyed/is in storage/on hold. The status of rape kits is currently a topic of nationwide interest and can knowledge from service providers may help highlight a remaining area of need/support. Additionally, it might be interesting in the future to investigate if underserved populations in Maine experience fewer outcomes from SAFE kits.

    a. In the event that clients may not know this information, create an option to select and explain that the client does not know the status of a SAFE kit.

Referral Types

1. Add frequently used *other referral sources* to the database as unique referral source options that can be selected in order to continue to facilitate a comprehensive list of what is being observed by all the agencies.

    a. Specific examples of potential unique referral categories to add include: *CAC, Family member, 211, Address Confidentiality Program, Preble Street Resource Center, Probation officer, School Guidance Counselor, Victim Services DOC, District Court,* and *Poster in Hospital.*
    b. Adding these options may have the benefit of slightly alleviating the burden of reporting that service providers experience while entering data since it requires less typing.

2. *Other referral source* occasionally contains names that appeared to belong to clients, client's family, and service providers. Since specific names do not are not useful for analysis and pose a privacy issue, it is recommended that data entry training always discourage names from being report as a referral source.

Future Collaborations

Since being awarded the SAC-VOCA Partnership, MECASA and the Maine SAC have started another project, studying how local law enforcement and prosecutors process sexual assault kits. In addition, the Maine SAC and MECASA were just awarded a proposal by the BJS to assess the use and effectiveness of deferred disposition sentences in sexual assault cases.

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Appendices

APPENDIX A: Definitions

Client Type Definitions for EmpowerDB:

Primary Victim: Victims/survivors of sexual violence.

Significant Other: Relatives, friends or other concerned people who have a PERSONAL relationship with a victim/survivor. The assault these callers report should be recorded as you would record an assault if a primary client calls.

Service Category Definitions for EmpowerDB:

Accompaniment Civil (other): The number of clients who are helped through the civil legal process, not including obtaining a protection order, through an in-person presence or companionship during that event.

Accompaniment Hospital Exam SAFE: The number of clients who are helped through the forensic exam process that is completed by a SAFE/SANE through an in-person presence or companionship during that event.

Accompaniment Hospital Exam Non-SAFE: The number of clients who are helped through the forensic exam process that is not completed by a SAFE/SANE through an in-person presence or companionship during that event.

Accompaniment LE: The number of clients who are helped through law enforcement interactions through an in-person presence or companionship during that event.

Accompaniment Other: The number of clients who are helped through any other system that is not covered by one of the above accompaniments through an in-person presence or companionship during that event.

Accompaniment Prosecution: The number of clients who are helped through the criminal justice process through an in-person presence or companionship during that event.

Accompaniment Protection Orders: The number of clients who are helped through obtaining a Protection from Abuse or Protection from Harassment order through an in-person presence or companionship during that event.

Family Advocacy: Services provided at a children's advocacy center that aim to coordinate and provide services to ensure a consistent and comprehensive network of support for the child and family. When a non-offending caregiver receives ongoing one to one support following the CAC services (such as criminal justice accompaniment, etc.), this becomes a sexual assault service and sexual assault client - please refer back to the section on "Referring Clients from CAC to SASC".

Forensic Interview: Service provided at a children's advocacy center to obtain information from a child about abuse allegations in a developmentally and culturally sensitive, unbiased, legally and fact-finding manner that will support accurate and fair decision-making by the multidisciplinary team.

One-to-One Support: The number of people receiving individualized services from a center staff or advocate, either in person, through the phone or support line, or any other platform.

Systems Advocacy: Any service provided to a client that supports them through or with a system (services, criminal justice, health, etc), but which is not an accompaniment (i.e. an in-person companionship at a system-level event), listed above. This may include completing Victims Compensation forms, support with accessing public benefits, and support with completing an online Protection Order, etc.

APPENDIX B: Referral Sources by Gender

The following tables are split out by agency to show what the top ten referral sources are for client records identified as female and male, and all twelve referral sources for client records identified as transgender. The bottom row will always show the total number of clients who were reported with the specified demographic.

Not included in the following tables are the client records identified as gender-other and gender-unknown. There were two client records identified as gender-other. The two reported referral sources for those two client records are SANE and legal services. There were 99 client records who identified as gender-unknown, and for 68 (68.7%) of those client records identified as gender-unknown, the referral sources was reported as unknown. For 8 (8.1%) of those client records identified as gender-unknown, the referral sources was the crisis and support line.

Female Clients

There were a total of 4,155 client records who identified as female. There are nineteen more categories of referral sources that were reported in client records which are not included in the table.

Table 10: Top Ten Referral Sources for Clients Identified as Female

	Female	
Referral Source	# of Clients	% of Total Female Clients
Unknown	1,114	26.8%
Crisis and Support Line	553	13.3%
Other Hospital/Medical Provider	364	8.8%
Police	243	5.8%
Other	215	5.2%
Internet/Social Media/Website	179	4.3%
School/School Counselor	179	4.3%
Other Victim Services Agency	149	3.6%
Program Outreach	132	3.2%
Therapist/Counselor	130	3.1%
Total Number of Female clients	**4,155**	

Male Clients

There were a total of 766 client records who identified as male. There are eighteen more categories of referral sources that were reported in client records which are not included in the table.

Table 11: Top Ten Referral Sources for Clients Identified as Male

	Male	
Referral Source	# of Clients	% of Total Male Clients
Unknown	232	30.3%
Crisis and Support Line	101	13.2%
Internet/Social Media/Website	51	6.7%
Jail/Prison Staff	48	6.3%
Other	45	5.9%
Police	41	5.4%
Other Hospital/Medical Provider	29	3.8%
DHHS - Child Welfare	29	3.8%
Mental Health Agency/Facility	22	2.9%
Program Outreach	21	2.7%
Total Number of Male clients	**766**	

Transgender Clients

There were a total of 35 client records who identified as transgender, and the table below captures all reported referral sources. Roughly one quarter of the client records identified as transgender had an unknown referral source.

Table 12: All Referral Sources for Clients Identified as Transgender

	Transgender	
Referral Source	# of Clients	% of Total Transgender Clients
Unknown	9	25.7%
School/School Counselor	6	17.1%
Crisis and Support Line	5	14.3%
Other	3	8.6%
Shelter/Safe Homes	3	8.6%
Other Hospital/Medical Provider	2	5.7%
Other Victim Services Agency	2	5.7%
Police	1	2.9%
Domestic Violence Agency	1	2.9%
Friend	1	2.9%
Jail/Prison Staff	1	2.9%
Mental Health Agency/Facility	1	2.9%
Total Number of Transgender Clients	**35**	

APPENDIX C: Referral Sources Other Demographics

Rural

The table below shows the top ten highest referral sources for clients classified as rural. The highest reported referral sources was Unknown. Unknown is a referral source option and does not indicate missing data. In twenty-four records, the Other category contained a description of CAC.

Table 13: Top Ten Referral Sources for Clients Identified as Rural

	Rural	
Referral Source	# of Clients	% of Total Rural Clients
Unknown	219	23%
Other	84	9%
Other Hospital/Medical Provider	81	9%
Police	67	7%
Crisis and Support Line	64	7%
School/School Counselor	57	6%
Other Victim Services Agency	47	5%
Domestic Violence Agency	46	5%
Friend	36	4%
District Attorney	35	4%
Total Number of Clients Identified as Rural	**942**	

Other Demographics

The following tables display the top three referral sources for client records that indicated an "other demographic" category, which includes physical disability, LGBTQ, immigrant, refugee or asylum seeker, limited English proficiency, deaf or hard of hearing, and college student.

College Student

There were a total of 58 client records who identified as college students. There are twelve more categories of referral sources that were reported in client records which are not included in the table. The additional categories, in order of most prevalent, are: therapist or counselor, college/university program, friend, mental health agency, police, SANE, brochure, internet or social media or website, the "other" category, other victim services agency, program outreach, and statewide CASL.

Table 14: Top Three Referral Sources for Clients who Identify as Being a College Student

	College Student	
Referral Source	# of Clients	% of Total (58) Clients
Crisis and Support Line	14	24%
Unknown	12	21%
Other Hospital/Medical Provider	6	10%

Deaf, or Hard of Hearing

There were a total of 11 client records who identified deaf or hard of hearing. There are six more categories of referral sources that were reported in client records which are not included in the table. The additional categories, in order of most prevalent, are: domestic violence agency, legal services, police, SANE, unknown, and work colleague.

Table 15: Top Three Referral Sources for Clients who Identify as Deaf or Hard of Hearing

	Deaf, Hard of Hearing	
Referral Source	# of Clients	% of Total (11) Clients
Other	2	18%
Shelter/Safe Home	2	18%
District Attorney	1	9%

Immigrant, Refugee, Asylum Seeker

There were a total of 54 client records who identified as an immigrant, refugee, or asylum seeker. There are seven more categories of referral sources that were reported in client records which are not included in the table. The additional categories, in order of most prevalent, are: friend, other victim services agency, community organization, crisis and support line, internet or social media or website, court or court personnel, legal services, the "other" category, and police.

Table 16: Top Three Referral Sources for Clients who Identify as an Immigrant, Refugee, or Asylum Seeker

	Physical Disability	
Referral Source	# of Clients	% of Total (45) Clients
Crisis and Support Line	21	47%
Unknown	4	9%
Other Hospital/Medical Provider	4	9%

LGBTQ

There were a total of 64 client records who identified as LGBTQ. There are seventeen more categories of referral sources that were reported in client records which are not included in the table. The additional categories, in order of most prevalent, are: other hospital or medical provider, police, school or school counselor, friend, the "other" category, shelter or safe home, domestic violence agency, internet or social media or website, jail or prison staff, other victim services agency, therapist or counselor, brochure, community organization, court or court personnel, legal services and program outreach.

Table 17: Top Three Referral Sources for Clients who Identify as LGBTQ

	LGBTQ	
Referral Source	# of Clients	% of Total (64) Clients
Unknown	10	16%
Crisis and Support Line	8	13%
Mental Health Agency/Facility	7	11%

Limited English Proficiency

There were a total of 32 client records who identified as having limited English proficiency. There are seven more categories of referral sources that were reported in client records which are not included in the table. The additional categories, in order of most prevalent, are: community organization, the "other" category, other hospital or medical provider, legal services, police, and shelter or safe home.

Table 18: Top Three Referral Sources for Clients who have Limited English Proficiency

	Limited English Proficiency	
Referral Source	# of Clients	% of Total (32) Clients
Program Outreach	14	44%
Other Victim Services Agency	4	13%
Unknown	3	9%

Physical Disability

There were a total of 268 client records who identified as having a physical disability. There are twenty-five more categories of referral sources that were reported in client records which are not included in the table. The additional categories, in order of most prevalent, are: shelter or safe home, mental health agency, police, program outreach, the "other" category, other victim services agency, therapist or counselor, court or court personnel, domestic violence agency, community organization, jail or prison staff, friend, SANE, district attorney, internet or social media or website, social services, telephone book, DHHS Child Welfare, legal services, work colleague, brochure, media, school or school counselor, statewide CASL, and substance abuse program.

Table 19: Top Three Referral Sources for Clients with a Physical Disability

	Physical Disability	
Referral Source	# of Clients	% of Total (268) Clients
Crisis and Support Line	56	21%
Unknown	34	13%
Other Hospital/Medical Provider	24	9%

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The Muskie School of Public Service is Maine's distinguished public policy school, combining an extensive applied research and technical assistance portfolio with rigorous undergraduate and graduate degree programs in geography-anthropology; policy, planning, and management (MPPM); and public health (MPH). The school is nationally recognized for applying innovative knowledge to critical issues in the fields of sustainable development and health and human service policy management, and is home to the Cutler Institue for Health and Social Policy.

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The Cutler Institue for Health and Social Policy at the Muskie School of Public Service is dedicated to developing innovative, evidence-informed, and practical approaches to pressing health and social challenges faced by individuals, families, and communities.

Maine Statistical Analysis Center

The Maine Statistical Analysis Center (SAC) informs policy development and improvement of practice in Maine's criminal and juvenile justice systems. A partnership between the University of Southern Maine Muskie School of Public Service and the Maine Department of Corrections, SAC collaborates with numerous community-based and governmental agencies. SAC conducts applied research, evaluates programs and new initiatives, and provides technical assistance, consultation and organizational development services. The Maine Statistical Analysis Center is funded by the Bureau of Justice Statistics and supported by the Justice Research Statistics Association.

Maine SAC Website: http://justiceresearch.usm.maine.edu/

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