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Drug Facilitated Sexual Assault Issues Paper

By

Linda E. Ledray, RN, Ph.D., FAAN
Director, Sexual Assault Resource Service
Minneapolis, Minnesota

Introduction

Drug facilitated sexual assault (DFSA) was first identified as a problem in the United States in the late 1980's and rapidly spread across the country in the 1990's (1). Today it is a crime of epidemic proportions in the US. The introduction of new drugs to facilitate sexual assault has resulted in significant additional challenges in efforts towards prevention, detection, investigation and prosecution. As members of a Sexual Assault Response Team (SART), advocates, law enforcement personnel, prosecutors, Sexual Assault Nurse Examiner's (SANE's) and other professionals must work together to develop new strategies to meet this new challenge.

Members of the SART have shared issues and concerns as well as discipline specific issues surrounding the problem of DFSA. After briefly defining the problem of DFSA, this paper will address these shared and discipline specific issues in an attempt to facilitate further identification of problems and options for a multi-disciplinary, SART, response. The ultimate goal of this response must be to facilitate prosecution and to better meet the needs of the victims of DFSA.

DFSA: The Problem

It is important to begin a discussion of DFSA with a reminder that the number one drug used to facilitate a sexual assault continues to be alcohol. This is not a new

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problem. However, the problem of DFSA today has been greatly magnified. This has resulted from the introduction of inexpensive, readily available, legal and illegal drugs that not only incapacitate a victim as alcohol does, but which can be given to victims without their knowledge, and that cause an anterograde amnesia. Uncertain what has happened, the victim is unlikely to report to law enforcement and when a report is made it is often significantly delayed.

As a result of the challenges in detection and investigation this crime is seldom prosecuted and conviction rates are believed to be substantially lower than for non-DFSA. This is true even though there is often less victim blame than when an excessive amount of alcohol is willingly consumed by the victim of a sexual assault. Because these newer drugs are typically administered without the victim's knowledge, there is actually in some way a bias "in favor" of the victim of a DFSA other than alcohol.

From a public health standpoint the problem is also magnified, and an improved system response is crucial because these new drugs are more likely than alcohol to result in an emergency room admission, and in some cases an overdose which can result in death (2). Mixed with alcohol, other street drugs, or taken in excess, GHB and GBL can induce seizure, coma, and death. Nationally, more than 5,700 people have overdosed on GHB and related compounds such as GBL (3). Unfortunately, the ingredients to make GHB and the directions to do so are readily available over the Internet. To date there have been no convictions for the Internet sale of the ingredients to make GHB. In March, 2000, a Michigan court sentenced three men for manslaughter in one of the nations first trials involving a death linked to the date-rape drug GHB (3).

For the purpose of this paper "drugs" will be used to refer to all drugs other than alcohol, including but not limited to: antihistamines, benzodiazepines; flunitrazepam (Rohypnol), alprazolam (Xanex), diazepam (Valium), midazolam (Versed), clonazepam (Klonipin), and temazepam (Restoril); GHB (gamma hydroxybutyric acid) and its precusors; muscle relaxants (Soma); sedative/hypnotic, zolpidem tartrate (Ambien); GBL (Gamma Butyrolactone) sold as a dietary supplement (Blue Nitro) (Renewtrient); and tranquilizers (Ketamine)(4). We are not referring to street drugs such as crack, cocaine, and marijuana.

While it is acknowledged that men are also victims of DFSA, since women are more often victims of sexual assault, for the purpose of this paper female pronouns will primarily be used. DFSA will refer to the use of drugs or alcohol to facilitate a sexual assault by making the victim physically incapacitated or helpless.

Related Federal Law

In an attempt to facilitate prosecution and limit the continued wide spread, illegal import and abuse of these drugs the Drug-Induced Rape Prevention and Punishment Act of 1996 was passed by Congress. This amendment to the Controlled Substance Act imposes up to a twenty-year prison term for giving any controlled substance to another person without their knowledge, with the intent of committing a sexual assault. It also provides for a sentence of up to twenty years for the distribution and import of flunitrazepam into the US. In addition this law requires the Drug Enforcement Agency (DEA) to study reclassifying Rohypnol from a Schedule IV to a Schedule I drug in order to provide for closer controls, and it instructs the Attorney General to create educational materials for distribution to police departments (H.R. 4137).

Unfortunately, since GHB was not a controlled substance, the use of GHB or its precursors to facilitate a sexual assault did not fall under the guidelines of this law. Many states attempted to rectify this problem by passing state laws making GHB a controlled substance (4). Also disappointing is the fact that there has to date been only one conviction under this law. Jean Graham, Assistant United States Attorney in Minnesota prosecuted the first case under this 1996 federal law in 1999, for the use of prescription zolpidem tartrate (Ambien) to facilitate sexual assault. The defendant was sentenced to nine years in prison in February 2000.

Congress, recognizing the shortcomings of the 1996 law, recently passed another law. On February 18, 2000, President William J. Clinton signed into law H. R. 2130, the "Hillory J. Farias and Samantha Reid Date-rape Drug Prohibition Act of 2000." Among other things, this legislation makes GHB a Schedule 1 controlled substance (5). The first prosecution under this law occurred in Miami, Florida, within two weeks of passage of the law. A man on Florida's sexual predator list was charged with buying enough chemicals over the Internet to make 100,000 doses of the newly outlawed GHB (6).

The Extent of the Problem

In June, 1996, Hoffman LaRoche contracted with ElSohly Laboratory to provide, free of charge, complete toxicology screens to police, medical facilities, and rape crisis centers whenever a drug facilitated sexual assault was suspected. They implemented this testing program in response to concerns about widespread use of one of the drugs they manufacture a benzodiazepam (Rohypnol), being used as a date-rape drug. Alcohol was not initially included in this drug screen, but was added at a later date. They provided this valuable service because they were opposed to the reclassification of Rohypnol and

wanted better data on the problem it and other drugs posed. Payment for this testing by Hoffman LaRoche was discontinued in January, 2000. Unfortunately, not all State Crime Laboratories are able to specifically test for many of these substances, resulting in a lack of testing facilities in many areas.

Between June, 1996, and December, 1998, 1710 samples were tested and the following results reported by ElSohly Laboratories:

- Alcohol 41%
- Marijuana 18%
- Cocaine 9%
- GHB 4%
- Rohypnol 0.4%
- Other Benzodiazepines 14%
- Negative 38%

It is difficult to interpret this data, as the time between possible ingestion and the collection of urine for testing was not provided. Testing was completed for up to 96 hours after possible ingestion. Since alcohol and marijuana, for instance, can be detected in the urine for a significantly longer period of time than Rohypnol, one would expect these substances to be represented at a significantly higher rate at a later point in time (1).

The Miami-Dade County medical examiner's office in Miami, Florida found a much higher rate for Rohypnol. Between the summer of 1996 through the summer of 1997, ten out of fifty-one urine specimens they collected were positive for Rohypnol (7). Once again the time frame is not available, limiting interpretation.

Unfortunately, many state crime laboratories not only do not test for many DFSA substances, but also they are still misinformed about the optimal collection procedures. For example, concern that drugs were being frequently used to facilitate a sexual assault West Virginia recently added a urine container to their sexual assault evidence kit. The new directions that were included with the urine kit, *West Virginia Blood and Urine Collection Procedure* (WVBU 2002) distributed by the West Virginia State Crime Laboratory, directs medical professionals collecting a specimen to do as follows:

> "The individual giving a urine specimen will empty his/her bladder and **discard the specimen**. The attending physician/nurse will observe the individual for twenty minutes to verify that no food or drink has been ingested during the observation time. After twenty minutes of observation, the individual shall void a urine sample into a clean dry container...Return both sex crime collection kit box and urine/blood collection kit box to the outer box for transport to the biochemistry section of the lab".

When asked the rationale for discarding the first voided sample they responded that the committee followed the procedure used when a urine is collected for suspected alcohol use.

We believe that the number of suspected cases is continuing to climb dramatically. We also believe that in most parts of the U S these cases are not being prosecuted. Unfortunately, as a result of significant under reporting, as well as long delays when a DFSA is reported, and multiple problems with drug testing, it is difficult to confirm most cases, and we do not have an accurate picture of the true extent of this problem. In an attempt to more accurately identify the number of suspected and

confirmed DFSA cases nationally this data is now being collected on the SANE-SART web site funded by OVC DOJ. This web site www.sane-sart.com is collecting the following information related to DFSA :

- Is DFSA suspected?
- Was urine collected for toxicology?
- Hours between ingestion and urine collection?
- Was blood collected for toxicology?
- Hours between ingestion and blood collection?
- ETOH level?
- Rohypnol level?
- Other benzodiazepine levels?
- GHB level?
- GBL level?
- Marijuana level?
- Cocaine level?

This data will then be compared to the following data also being requested on each case:

- Victim's age?
- Victim's gender?
- Was a police report filed?
- Was the case charged?
- Was the offender convicted?
- Sentence?

It is hoped that this data being collected from SANE-SART programs across the U S will eventually provide a more accurate picture of the problem of DFSA.

DFSA Shared Issues and Concerns

There are several issued related to DFSA that need to be jointly addressed by the Sexual Assault Response Team. These include the following.

Who should decide when to test?

- Victim?
- Family of a minor?
- Law enforcement?
- SANE/medical professionals?
- Advocate?
- Prosecutor?

Because ElSohly has in the past paid for complete alcohol and drug screens whenever requested by law enforcement, rape crisis advocates, or medical personnel, these have been the individuals who have been making that determination. Without this testing option, new problems arise for which guidelines must be developed.

Unfortunately, in many cases of possible DFSA it is unclear if the symptoms described are the results of alcohol consumption or of a drug. It is often not even clear if the individual has been sexually assaulted. Should alcohol and/or drug toxicity screening be completed for any victim who is concerned that he or she has possibly been drugged and sexually assaulted? Or should someone else make that determination, and if so, who should decide?

Under what circumstances should testing occur?

When to test is of particular concern, because testing is very expensive and unnecessary testing will result in a substantial drain on limited system resources. In most cases of suspected DFSA the victim has also knowingly consumed alcohol. In fact, often the alcoholic beverage is the beverage of choice for the assailant to administer other drugs without the victim's knowledge. Often, not only is the victim unsure if she has been given a drug without her knowledge, but she is also unsure if she has been sexually assaulted, and if so, by whom. These cases bring significant new challenges for all aspects of the SART response.

- Should cases be treated differently when the victim willingly took a drug, or if it was or was not a legal substance?
- Should a complete screen, including alcohol and other drugs, be routinely completed in all suspected DFSA without concern for the symptom picture?
- Should symptom patterns be identified that will allow for differential testing for alcohol, separately from other drugs, in a suspected DFSA?

The criteria used by those making the decision to test or not to test are often not available, and have not been implemented systematically. Some have decided arbitrarily on a case-by-case basis.

The SANE Development and Operation Guide (1) recommends that specific criteria be considered when deciding to complete a drug screen. They include the following:

- A history of being out drinking with friends, having just one or two drinks (too few to account for the high level of "intoxication"). A moment where she

recognized feeling suddenly "very drunk", even if she still looked "normal" and was able to walk out with her assailant.

- Becoming very "intoxicated", very rapidly, within a matter of 5 to 15 minutes, especially after accepting a drink from someone, or drinking a drink she left unattended.
- "Waking up" eight or more hours later, uncertain if she had been raped, but believing she was because she is experiencing vaginal soreness, or because she has no clothes on, or waking up with a strange man, with no memory, or a very spotty memory of what happened.
- Being told she was given "Roaches", "Roofies", "Mexican Valium", "R-2", "Special K", "Ecstasy", etc.
- History of feeling or being told she suddenly appeared drunk, drowsy, dizzy, confused, with impaired motor skills, impaired judgement, or amnesia.
- History of "cameo appearances" in which she remembers waking up, possibly seeing the assailant with her, but being unable to move, and passing out once again

For what time period should testing occur and what source should be used?

Information indicating the length of time that various substances can be detected in the blood, urine, or hair is also very limited. When Hoffman LaRoche initially began testing they recommended collecting urine for up to 96 hours. The recommended time for collection today is typically the same as that for a complete evidentiary examination,

72 hours. Unfortunately, most DFSA cases are delayed reports beyond 72 hours, significantly limiting the usefulness of testing.

Urine is currently the preferred source of analysis because metabolites of these drugs can be detected for a longer period of time in the urine than they can be in blood. However, many SANE programs also routinely collect a blood specimen (1).

Few medical professionals collect hair specimens for drug screening at the time of the assault, but perhaps it would be helpful to develop protocols to collect hair specimens at a later point in time.

Who should pay for drug and alcohol testing?

Hoffman LaRoche generously paid for complete urine drug and alcohol toxicity screens from June 1996, through December 1999, at ElSohly Laboratories in suspected DFSA cases. They abruptly terminated payment in January 2000. While ElSohly Laboratories will continue to do the urine screens, they must now bill the requesting agency for that service. A complete drug toxicity screen will typically cost over $800. This is more than the total amount available to most SANE programs or medical facilities as reimbursement for the complete evidentiary exam, including personnel costs, laboratory testing, and medications. Even a test for a single substance, such as GHB or flunitrazepam, can cost $80.

As responsible professionals working with limited resources it is our responsibility to decide when to test and for what to test. Cost and payment sources must be a consideration. Should the decision to test be based upon ability to pay or availability of resources? Even if insurance or government funding is available to pay for a drug

screen, we must also consider that unnecessary testing will further burden health care and government costs.

Options for payment include:

- Whoever requests the tests assumes responsibility for payment
- The victim or the victim's insurance, if available
- Law enforcement
- Prosecutor's office
- Advocacy
- SANE/medical programs should include it as part of the evidentiary exam fee, when possible

To a great extent the payment issue is dependent upon how extensive the testing will be, what substances will be tested for, and who will be doing the testing.

What drugs should be included in the drug screen?

The urine screens completed by ElSohly Laboratories and paid for by Hoffman LaRoche included:

- alcohol
- flunitrazepam
- other benzodiazepines
- marijuana
- GHB
- cocaine
- amphetamines
- opiates

- barbiturates

As a result of the focus on Rohypnol and GHB as "the" date-rape drugs, when a DFSA is suspected these are often the only tests requested by law enforcement.

Issues that must be considered include the following:

- Should illegal but commonly used street drugs such as marijuana, cocaine, and amphetamines be included in the DFSA drug screen?
- Should alcohol be routinely included for testing?
- Should there be different time guidelines for specific substances?

Alcohol and marijuana can be detected much longer than GHB or flunitrazepam. If only alcohol or marijuana is detected, an unsophisticated detective, prosecutor, or jury may assume they are the sole problem. This may bias the investigation or prosecution process. Not understanding the detection limitations which occur with time delays between ingestion and specimen collection is different for each drug, further investigation into other drug use may not occur as a result of the positive urine for marijuana or cocaine. Victims may loose credibility and cases may not be charged as a result. If the case does go to trial the defense attorney may use this in an attempt to "prove" there was no DFSA.

Where should tests be conducted?

Most hospital medical laboratories are still unable to test for specific substances such as flunitrazepam. As a result, when medical personnel send suspected DFSA tests to their laboratory for a toxicology screen the results are often less than adequate. Chain-of-custody is also typically not maintained.

Even state crime laboratories and private toxicology facilities are just beginning to develop this capability. It is a costly process to develop the testing capacity and it can take several years.

Options for testing include the following:

- Local state crime laboratory
- All specimens nationally sent to government crime laboratory
- Local private laboratory
- All specimens nationally sent to one private laboratory

What informed consent options should be made available to the DFSA victim?

It is important to consider victim consent and confidentiality issues in DFSA testing.

- What type of informed consent and testing options does the victim have?
- Should she be able to specifically request or deny testing for a specific substance, such as marijuana?
- What impact may this have on the legal case?
- Should limited consent from the victim, e.g. for a partial drug screen only, have implications for payment?

Who will get the results of the DFSA drug screen?

It is also important to consider who will have access to the results and how this information will be reported to the victim, and who should tell the victim. To a great extent this may depend upon who is ordering the tests and where they are conducted.

- Who initially should get the results of the drug screens?

- Who will have access to the results?
- How will the victim be informed?

Discipline Specific Issues

In addition to the above issues there are shared concerns of the SART. The following are issues that are of specific concern to a particular SART member or the DFSA victims and their family. There is of course some overlap.

DFSA Victim/Victim Family Issues

The following are issues and concerns that impact DFSA victims and their families, but may not be issues for sexual assault investigation or prosecution. However, in order to meet the victims' needs we must address these concerns. The following represent the victim specific issues:

- How can a drug screen be obtained when a clinical symptom picture is used to determine if DFSA is suspected, and the criteria are not met, but the victim wants a drug screen anyway for her own knowledge?
- Who pays in these cases?
- Do only those who can pay get the test?
- Should health insurance cover the cost?
- What if the results are positive?
- Long delays awaiting test results are difficult. Can this be shortened?
- It is difficult getting the results of drug testing. How can this be resolved?
- What do negative results really mean?
- How should the results be interpreted and by whom?

- What can be done when drug testing is negative, but the case fits the clinical picture of DFSA?
- What can be done to deal with the psychological trauma that results from not knowing what happened, or from "knowing" but not having enough proof to get the system to "do something"?
- How can the victim deal with the guilt/anger when their lack of memory is "why" there is not a good criminal case?
- What options do they have when no criminal investigation or charge results?
- Is a civil case an option?

Medical Forensic Examiner/ SANE

Most medical professionals who do not routinely deal with DFSA do not know when to test, what to test for, or how to go about testing if they decide it is necessary. The following are concerns that are specific to the medical professional/ SANE to whom the suspected DFSA victim goes to for care.

- Is there anything else we can do to increase the likelihood of getting a positive biological specimen when a DFSA did occur?
- Should blood, urine, hair, other (?) always be collected?
- Since there are no national guidelines for when DFSA testing should be done, what symptom picture should be followed?
- When should drug screens be completed?
- Who will decide?
- Who will pay for the testing when it is ordered?
- Where should the specimen be sent?

- If the specimen is sent to the state crime lab, how will the SANE get results, and when?
- Who will determine what will be tested (blood, urine, hair, other), when, and for what substances?
- How and by whom will the results be communicated and interpreted to the victim?
- How will chain-of-custody be maintained (Courier services/FEDEX) and how will this be communicated to medical professionals who do not routinely conduct these exams?
- What type of informed consent should the patient get?
- How can confidentiality be maintained when transporting specimens?
- What should the medical professional do when the patient clearly does not fit the DFSA pattern but the patient/family/police insist on testing?
- What medical/legal responsibilities do they have?
- Who will pay for testing if it is done in cases that do not fit the criteria?
- Who will deal with the victim's concerns (psychological impact)?

Law Enforcement

It is indeed difficult to investigate a DFSA case when the victim, the primary witness, has little or no memory of the crime and may even be uncertain that a crime occurred. The American Prosecutors Research Institute (APRI), recognizes this in their manual *The Prosecution of Rohypnol and GHB Related Sexual Assaults,* which attempts to provide prosecutors and law enforcement officers with the necessary information to successfully investigate and prosecute these cases (4).

Because of the focus in the media on Rohypnol and GHB use in DFSA, many law enforcement officers also tend to focus on these substances whenever a DFSA is suspected. When they are asked to determine the drugs for which they want the specimen tested, they are likely to request only Rohypnol or GHB. Is this appropriate? If so, when should a complete screen be done?

As a result of the lack of certainty that a crime was committed in the DFSA case, law enforcement officers may delay investigation of these cases awaiting the results of a drug screen, which can take weeks. If a positive test is not obtained the case may be considered unfounded. This is particularly problematic in areas where law enforcement must "certify" that a crime was committed before a medical-forensic examination is authorized for payment.

- In addition to the information provided by APRI, what guidelines can be made available to guide early investigation procedures so valuable crime scene evidence is not lost?
- Is additional information or training needed to guide law enforcement investigations?
- How should law enforcement deal with alcohol vs. drug intoxication during the early investigation of a suspected DFSA?
- Should they be treated the same or differently?
- Should a symptom pattern checklist be developed for law enforcement or should all cases be referred to a medical facility for this determination?
- How should law enforcement decide where to refer a suspected DFSA victim for testing?

- During what time frame should the suspected DFSA victim be taken to a medical facility (72 hours)?
- Will law enforcement pay for testing requested?
- What should law enforcement do if the suspected DFSA victim cannot wait until she gets to a medical facility to void? Should this first voided specimen still be kept? By whom? How will chain-of-custody be maintained?
- When should a full drug screen be requested vs. specific substances

Prosecutor

As APRI recognizes in their manual it is indeed very challenging to charge or prosecute a DFSA with the minimal evidence available in most cases (4). The solution, which they also address, is to evaluate what additional evidence is possibly available but not identified or not properly obtained, or which is being underutilized. It may also be that prosecutors are unaware of how to interpret the information that is available, and how to use this information to its full advantage in the courtroom. Prosecution issues include:

- What evidence to expect in a suspected DFSA and how to best utilize the evidence provided?
- How to interpret and present negative drug testing evidence?
- How can negative drug testing, the clinical symptom picture, or other evidence available be most effectively presented to a jury?
- Would national guidelines be useful to help determine when to charge?
- Would additional education be helpful to interpret drug screen evidence or the clinical symptom picture, even without a positive drug screen?

- Would identification of expert witnesses in this area be helpful?
- Would expert witness training be helpful?
- When should a case be tried under the Federal law vs. state laws?
- How can the Internet sale of ingredients to make GHB be charged and prosecuted?
- Is it possible to develop guidelines to assist with jury selection?
- Are negative results better than not testing, or would it be better to further limit testing when it is extremely unlikely that a positive drug test will be obtained?
- Should street drugs and alcohol be routinely included in the drug screen?
- What type of informed consent and ability to refuse all or specific testing should the victim be given?
- How could this affect prosecution?
- Is there any additional evidence that would facilitate charging or prosecution that is not being collected?
- Are prosecutors being too conservative in decisions to charge DFSA cases?
- Would it be better to charge more "marginal" cases? If so, under what circumstances?

Advocacy

Not only does advocacy assist the suspected DFSA victim with the initial report and medical evidentiary issues, but they also assist with the long-term impact. The initial reporting decision, criminal prosecution involvement, and psychological recovery can be very difficult for the victim of a suspected DFSA. The range of psychological distress

varies greatly. Some victims recover very rapidly because they have no memory of an assault, and others have great difficulty and may even become totally dysfunctional as a result. The unknowns and the uncertainty can raise serious doubts and result in blame or disbelief by others, self-blame, and shame.

It is the advocate to whom the DFSA victim will likely turn for support and answers to questions. This is especially likely when it does not appear she is being taken seriously or believed by the legal system, her case is not being actively investigated, or when her case is not charged or prosecuted.

Advocacy issues include the following:

- When should a suspected DFSA victim be encouraged to get a drug screen? What guidelines should be used to make this decision?
- Where should the victim who calls be directed for medical examination?
- Should all DFSA victims be encouraged to make a police report?
- What should they be told when the make the initial call to the rape crisis center?
- What additional public education would be useful for prevention and early detection and to who should the education be directed?
- Is the current education adequate, or would additional education be useful for advocates who respond to medical facilities?
- Would the victim be better served to have experienced, paid staff available on call instead of volunteers?
- Should the advocacy center have access to the drug test results? If so, how will they obtain these? When and what consent should be obtained?

- What role or responsibility does the advocate have to ensure that the victim is fully informed about drug testing?
- Should advocacy be able to send a specimen for testing when the victim does not want to report and does not want a medical exam? If so, what, where, and how? Is so, who is responsible to pay for testing that the advocate requests?
- Should the advocate inform the victim of the drug screen results?
- If testing guidelines are used, what should the advocate tell the victim whose symptom picture falls outside these guidelines?
- What should the advocate tell the victim who insists on testing but the symptom picture falls outside the guidelines? Who will do these tests and who will be responsible for payment?

The initial crisis response after a sexual assault is clearly a very critical period when advocacy is important to the progress of the case and the recovery of the victim. Advocates, like other professionals responding, have a wide range of experience and training related to DFSA. It may be problematic, however, that in most rape crisis centers the advocate who responds to the medical facility is usually a volunteer, not a staff person, and as a result often has the least training and experience.

One Typical Suspected DFSA Scenario

A suspected DFSA today would typically proceed as follows:

- The victim awakens groggy late in the day after a night of partying at a local college fraternity. She is experiencing some vaginal soreness and is surprised when she notices blood on her panties, as her period is not due for a week.

She has never had sex in the past. She washes her panties so the blood does not stain them.

- A little later she becomes suspicious that she may have been sexually assaulted.
- Uncertain but increasingly fearful, late that evening she talks with her roommate who is concerned about her somewhat unusual behavior.
- Her roommate calls the local rape crisis center the next morning.
- They recommend she go to the local SANE center for an exam.
- The victim goes to a medical facility that afternoon concerned that she has been drugged and sexually assaulted. She is now approximately forty hours post suspected DFSA.
- She agrees to make a police report and have an evidentiary exam.
- The SANE informs the victim about testing protocol and decides to do a complete toxicology screen based on the symptom picture presented.
- The next voided urine and blood specimens are collected.
- The police are called and the urine and blood are given to law enforcement with the rape kit and any available additional evidence.
- Law enforcement decides where to send the specimen, what to test for, and they pay for testing.
- If the victim decides not to report, the medical staff may send the specimen to the hospital laboratory and the victim is billed for testing.
- Drug testing and the rape kit are negative, no suspect is identified, and the case is dropped.

- The victim continues to believe she was sexually assaulted.
- Afraid that any man on campus could be the assailant, she drops out of college and moves back home.
- The next Friday the same fraternity has another party and another woman wakes up late Saturday morning, confused and experiencing vaginal soreness.

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