U.S. Department of Justice
Office of Justice Programs
Office for Victims of Crime

Sexual Assault Nurse Examiner

SANE

Development & Operation Guide

Sexual Assault Resource Service
Minneapolis, Minnesota

Office for Victims of Crime
OVC
Advocating for the Fair Treatment of Crime Victims

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SUGGESTIONS FOR USING THIS GUIDE

A multidisciplinary response is needed to serve victims of sexual assault, and OVC anticipates that individuals from many disciplines, not just forensic nursing, will use this guide to aid their efforts in establishing and operating a SANE program. Indeed, the impetus driving the development of several SANE programs has come from law enforcement, sexual assault victim advocates, and others. Therefore, this guide was written from the perspective that not everyone who reads it will have a forensic nursing or even a clinical background. At the same time, there are a few clinical issues addressed in this guide that cannot adequately be addressed in "layman's terms." We hope that this guide strikes a reasoned balance. As the effort to develop a SANE program should be a multidisciplinary one, we suggest that nonclinicians refer to the nursing and medical members of the organizing team for clarification or further discussion of clinical topics. To aid the nonmedical reader, a glossary of acronyms used throughout the guide is located after the appendixes.

An important issue is the rapid development of State policies and procedures governing the processes and protocols of SANE programs that occurred during the writing and review of this guide. ***Users of this guide should understand that State statutes and policies always take precedence over the recommendations described in this manual.***

This guide was designed to be read in its entirety, with each chapter building on information presented in the previous chapter. Treating each chapter independently would have required much duplication of basic information, greatly increasing the length of the guide. Constant duplication of the same information in each chapter would also be annoying and distracting to most readers. In a few instances, information is repeated for clarity and to preclude frequent referral back to previous chapters. Readers who are unable to read the manual in its entirety are advised that:

- The use of female pronouns for victims was a deliberate choice and the rationale is explained in Chapter 1, page 2, in the section "Terminology."
- Female pronouns were also used to refer to SANE practitioners, as the overwhelming majority of them are female.
- Throughout the guide, references are made to "the survey." This refers to a survey conducted of existing SANE programs at the beginning of the project and is described in Chapter 1, page 2, in the section "Scientific Basis of This Guide."

A MESSAGE FROM THE OVC ACTING DIRECTOR

OVC believes that an informed, effective response to violence in America transcends the criminal justice system, and builds on many disciplines, including the health care sector. We know that victims of sexual assault suffer psychological trauma and, all too frequently, long-term health consequences as a result of their victimization. Therefore, providing sensitive health care to victims is critically important in the aftermath of a sexual assault. Unfortunately, the traditional model for sexual assault medical evidentiary exams frequently compounds the traumatization of victims. Medical personnel in the emergency room setting often regard the needs of most sexual assault victims as less urgent than other patients in the emergency room. As a result, rape victims may endure long hours of waiting in the public areas of busy emergency rooms. They are not allowed to eat, drink, or even urinate while they wait for a physician to conduct the medical evidentiary exam. Frequently, the physicians or nurses who perform the exams have not been trained in medical evidence collection procedures or do not perform these procedures frequently enough to maintain their proficiency. Some physicians are reluctant even to perform the medical evidentiary exam, knowing that they might be called away to spend a day or more in court testifying or that their qualifications to testify might be questioned due to their lack of training and experience. In response to these issues, the first Sexual Assault Nurse Examiner (SANE) program was developed in 1976, offering a multidisciplinary, victim-centered way of responding to sexual assault victims. There are now more than 100 SANE programs throughout the U.S., but these programs are not enough to serve the hundreds of thousands of children and adults who are victims of sexual assault every year.

The services of trained, experienced SANE practitioners help to preserve the victim's dignity, enhance medical evidence collection for better prosecution, and promote community involvement and concern with crime victims and their families. OVC has a strong interest in promoting the replication of programs such as SANE. This *SANE Development and Operation Guide* is the result of that interest and we anticipate that it will serve as a blueprint for nurses and other community leaders who wish to establish a similar program in their own community. OVC commends Dr. Linda Ledray and her colleagues in forensic nursing across the nation for their strong, visible leadership in developing and supporting programs that help sexual assault victims take the first steps toward healing.

Kathryn M. Turman
Acting Director
Office for Victims of Crime

ACKNOWLEDGMENT

When Dr. Linda Ledray started the Sexual Assault Resource Service (SARS) at Hennepin County Medical Center in Minneapolis in 1977, she did so with the intent of developing a nursing focused service delivery model that could one day be implemented in rural Minnesota. At that time, according to Dr. Ledray, she did not understand the impact that this model, now known as SANE, would have across the country, and that 20 years later it would be considered a "new," innovative treatment model for sexual assault victims.

Dr. Ledray was excited to discover in the mid 1980's that nurses in Amarillo, Texas; Memphis, Tennessee; and Tampa, Florida were also focusing on responsive treatment for sexual assault victims. These nursing pioneers realized that by pooling their resources of creativity, energy, and enthusiasm, progress in developing a treatment model for this victim population would happen more quickly. With the publication of this SANE *Guide*, Dr. Ledray has now identified 116 functioning SANE programs, and her organization has contacted many more SANE programs nearing operation in behalf of rape victims.

The magnitude of effort required to develop the SANE program cannot be accomplished in a vacuum. It takes the combined efforts of many individuals with vision, commitment, and tenacity. It takes the efforts of those who know what they want to do is right and who are persistent in overcoming the roadblocks that might prevent the implementation of this vision for their community. As Dr. Ledray helped others to initiate SANE programs in their communities over the past 20 years, she noticed the same struggles that she had initially encountered in Minneapolis were occurring in these communities. The need for a SANE *Guide* became apparent.

The Office for Victims of Crime at the Department of Justice also recognized the need for this *SANE Development and Operation Guide* in order to provide others the ability to efficiently and knowledgeably start SANE programs using the wisdom of those who have been operating SANE programs. With this *Guide*, others can learn from the trials and errors of those who went before, and they can move ahead more rapidly to improve services for sexual assault victims in their communities.

This *Guide* has taken the combined effort and expertise of many individuals. Kathy Simmelink, MA, RN and Maggie Dexheimer Pharris, MPH, MS, RN together wrote the chapter on the pediatric examination pulling together information provided by SANEs across the country with a significant contribution from Pat Speck, MSN, RN, CS, FNP and Colleen O'Brien, MS, RN, who are both advisory committee members of this project. Based on the sage advice of Judge Isobel Gomez, also an advisory committee member, Maggie Dexheimer Pharris, MPH, MS, RN, rewrote the section on special populations to better focus on meeting the unique needs of individuals rather than perpetuating stereotypes. Patricia Moen, JD; Thomas Kiresuk, Ph.D.; Lee Barry, JD; Carolyn Levitt, MD; and Kit Mauer, BSN, RN, also on the advisory committee, contributed by reviewing the manuscript and making suggestions for additions and revisions. Pat Speck and Colleen O'Brien were gracious enough to carefully reread the revised manuscript numerous times without complaint and edit extensively as they did so. Susan Valentine from SARS offered sound advice, careful manuscript reviews, and good judgment to keep the project on track. This project also benefited greatly from the contributions of Joye Whatley, the project monitor at OVC, Olga Trujillo, Legal Counsel, OVC; Timothy Johnson,

Program Specialist, OVC; Kristen Gremmell, Program Manager, Violence Against Women Grants Office, U.S. Department of Justice; and Ronald C. Laney, Director, Missing Children's Program, Office of Juvenile Justice and Delinquency Prevention, U. S. Department of Justice. Thanks also goes to Grace Coleman, the OVC editor, who spent many hours ensuring that the final product was one of quality and Chris Naylor, the SARS secretary, as always, also pitched in and stayed late when necessary to ensure that the project was completed.

This *Guide* is the result of the efforts of these individuals and the many SANEs across the country who shared their materials and experience with Dr. Ledray and SARS. OVC hopes that it will assist others in developing and operating a SANE program so that communities across the nation can better meet the needs of sexual assault victims. If we cannot stop rape, at least we can work together to reduce the suffering of its victims and improve the system that responds to it.

CHAPTER 1 INTRODUCTION

In 1991, when the *Journal of Emergency Nursing* published the first list of SANE programs, there were only 20 programs listed (ENA: 91). In a 1996 update, 86 SANE programs were identified (Ledray: 96a). This updated list was used as the basis of a survey of SANE programs conducted by the Sexual Assault Resource Service (SARS) at Hennepin County Medical Center in Minneapolis in order to obtain information about current SANE program structure and practice. Fifty-nine (68%) of the 86 programs surveyed responded. Of these 59 programs responding, 3 were established between 1976 and 1979; 10 between 1980 and 1989; and 46 between 1990 and 1996. Although the initial SANE development was slow with only three programs in existence at the end of the 1970's, program development today is progressing rapidly. During the progress of writing this manual, 117 SANE programs were identified and are listed in Appendix B. It is anticipated that their number has already changed significantly. This list of existing SANE programs will be updated on a SANE Web site <*www.sane-sart.com*> that has been funded by the Office for Victims of Crime, Office of Justice Programs, Department of Justice, which began functioning in January 1999.

This current flurry of interest in SANE is to a great extent a result of the media attention created by the 1994 recognition of the Tulsa SANE program when it received the Innovations in State and Local Government Award from the Ford Foundation and John F. Kennedy School of Government at Harvard University (Yorker: 96). While Tulsa was certainly not the first community to develop a SANE program, the Tulsa program has taken an active role in promoting the concept. As a result, individuals and private and public institutions across the country became aware of the potential benefits of the SANE model for their own community, and they became eager to explore the possibility of starting a SANE program in their area.

As a result, existing SANE programs have been inundated with requests for information about the development and operation of the SANE model. While those experienced in this field have been willing to do whatever possible to assist individuals and groups in developing new programs, this help has primarily been verbal assistance in answering questions and offering advice to help individuals anticipate and overcome obstacles. With each phone call from a new area, the process was repeated once again. The caller, while highly motivated, was often unsure where to start or even what questions to ask. The advice given was typically based on personal experience in one program and did not necessarily meet the needs of other communities.

Project Goals and Objectives

The Office for Victims of Crime (OVC), Office of Justice Programs (OJP), U. S. Department of Justice (DOJ), recognized the need for additional information and technical assistance when they funded this project. OVC's goal, and the goal of this project, is to facilitate SANE program development by providing information about existing SANE program operation and development in a systematic and comprehensive format. This manual is intended for those who want to develop a SANE program and for those already operating a SANE program who want to ensure that they are utilizing the most current information and standards.

The goal of this manual is to provide the necessary information to develop and operate a SANE program in an easily understood format. It includes references for or samples of many essential

forms, policies, procedures, protocols, training options, and program evaluation tools. Standards of Practice are provided when there is a recognized standard. When program options are a choice, advantages and disadvantages for each option are discussed.

The distinguished project staff and advisory committee working on this project recognize that different communities have different needs and resources. Whenever possible, these differences are addressed and options provided with rationale for inclusion and selection.

Scientific Basis of This Guide

Work on this guide includes a complete review of the SANE literature. The information available is included in this guide, with references, for your use. In addition, this guide is based on information from the 59 (68%) programs who responded to the survey of the 86 programs identified in the 1996 *JEN* survey (Ledray: 96b). Followup phone calls were made to several programs to obtain additional information for clarification. Since not every question was answered on every survey, the information and numbers included are based on the answered questions only and do not always add up to 59.

Since national certification or standardization of SANE programs and training has not yet been implemented, this manual reflects the experience and judgment of the project staff, advisory committee, and the programs who responded to our request for information (See Appendix A: Project Staff and Advisory Committee; and Appendix B: List of Participating SANE Programs), as well as the current SANE literature.

Terminology

She or He?

While SANE programs deal with both male and female sexual assault and abuse victims, for the most part female pronouns will be used in this guide to refer to the victim population. This decision reflects the fact that the majority of victims within this victim population are female. No intent was made to exclude application to male victims. When it is established that there are different needs based on the sex of the victim, these are distinguished.

Rape, Sexual Assault, or Abuse?

Since the legal definitions of rape, sexual assault, and abuse vary from State to State, in this guide the terms will be used interchangeably to refer to any unwanted contact of one person's sexual organs by another, regardless of sex, with or without penetration, and with or without resulting physical injury.

Victim or Survivor?

The decision was made to refer to the **victim** of rape in this guide rather than the **survivor**. This decision was made because of the request of many victims to recognize the fact that they were victimized, and in the emergency department (ED) they feel like a victim, not a survivor. In the ED or SANE clinic during the initial period of crisis, few victims have moved to survivor status.

SANE Guide Evaluation

A questionnaire is included at the back of this guide to assist in evaluating its completeness and utility. The questionnaire consists of two pages which are designed to be pulled from the manual, folded in half with the address visible, stapled, and mailed.

Your comments and suggestions will help to update and improve this guide in the future so that it will be even more useful. **We truly want and need your assistance. Please complete the evaluation questionnaire and return it once you have reviewed the information in this guide.**

CHAPTER 2

HISTORY AND DEVELOPMENT OF SANE PROGRAMS

Even though rape has likely occurred for as long as humankind has existed (Brownmiller: 75), there only has been a concerted effort to better understand the issue and better meet the needs of survivors has developed only since the early 1970's. One of the first researchers to systematically study the impact on and needs of this population was Ann Burgess who holds both a nursing degree and an Ed.D. (Burgess & Holmstrom: 74a). Burgess identified a pattern of psychological response which she referred to as Rape Trauma Syndrome (Burgess & Holmstrom: 74b), and she continues to be actively involved in furthering the scientific understanding of rape.

Rape in the United States

The 1996 Uniform Crime Report indicates that 97,464 women were forcibly raped in the United States in 1995. This represents a 5-percent decrease in reported rapes from 1994, and a 9-percent decrease from 1991. Even though the numbers reported in the survey are declining, this figure still indicates that in 1995, 72 of every 100,000 women in the United States were the victims of a forcible rape and reported the crime to the police. More rapes occurred in large metropolitan areas, where the rate was 76 victims per 100,000 population, compared with 49 per 100,000 in rural communities (Uniform Crime Report: 96).

Geographically, 39 percent of the 1995 forcible rapes occurred in the most heavily populated Southern States, 25 percent in the Midwestern States, 23 percent in the Western States, and 13 percent in the Northeastern States. The 2-year trend indicates there was a decline in all regions of the country, especially in large metropolitan areas. During the 10-year period that the rate of reported forcible rapes declined 10 percent in large metropolitan areas, the rate actually increased 70 percent in smaller suburban cities and 40 percent in rural areas. The Northeastern and Midwestern States experienced a 6-percent decline, the Southern States a 5-percent decline, and the Western States a 2-percent decline in reported forcible rapes. In 1995, the highest reporting rate occurred in August, and the lowest reported rate was in December (Uniform Crime Report: 96).

Despite these reported statistics, the actual rate of rape remains unknown. We can only speculate that this increased reporting rate outside of metropolitan areas represents an actual increase in crime. An increase in reported rapes may also be the result of better community education, increased service availability, and improved reporting of crime. Estimates of the number of women who are actually raped range from an additional four to an additional nine victims for every one woman who reports. In one SANE program, while approximately 20 percent of victims are uncertain about reporting when they first came to the ED, working through their fears and concerns with a knowledgeable SANE has empowered 95 percent of these survivors to report (Ledray: 92a).

As with all Crime Index offenses, reports of forcible rape are sometimes considered "unfounded" by law enforcement, and they are then excluded from the crime count. The rate of "unfounded" cases is notably higher for rape than for any other index crime. In 1995, 8 percent of forcible rapes were determined by law enforcement to be "unfounded," compared with 2 percent of all other index crimes (Uniform Crime Report: 96). Some individuals in the criminal justice system may assume that all "unfounded" cases are false reports, deceitfully reported and baseless. However, this is not necessarily the case. Reported rape cases

are actually classified by police as "unfounded" for a variety of reasons. These reasons for classifying a rape case as "unfounded" vary greatly from one community to another, but the following are the most common reasons:

- The police are unable to locate the victim.
- The victim decides not to follow through with prosecution.
- The victim repeatedly changes the account of the rape.
- The victim recants.
- No assailant can be identified.
- The police believe no rape occurred.

There are also a variety of other situations that impede or prevent completion of the investigation and in which the case may be classified as "unfounded" (Aiken: 93). Unfortunately, not everyone distinguishes between "changing the story" and recalling additional data, or telling different aspects of the same story, or distinguishing between an untrue allegation and a victim who is so fearful of the assailant that she recants her story out of fear for her life or the life of her family. The number one reason victims give for not wanting to report is fear of the assailant, whose parting words in 76 percent of the cases were, "If you tell anyone... (or report to the police), I'll come back and kill you...rape you again...rape your child" (Ledray: 96a).

Unfortunately, only 4 percent of rapists go to jail either as the result of guilty pleas or guilty verdicts (Minneapolis Police Chief's Report: 89). This is true even though 51 percent of reported forcible rapes in metropolitan areas are cleared by arrest and 52 percent in rural and suburban areas. The arrest rate for forcible rapes declined in 1995 by 4 percent in metropolitan areas, 6 percent in suburban areas, and 14 percent in rural areas (Uniform Crime Report: 96). The results were slightly better in an earlier Detroit report which indicated out of 372 reported rapes, convictions resulted in 13 percent of these cases (Tintinalli & Hoelzer: 85).

Violence has a significant impact on the physical and psychosocial health of millions of Americans every year. Since women are so often the victims of violence, it is essential that women who present to emergency departments for even minor trauma be thoroughly evaluated. ED staff must be aware of the types of injuries most likely resulting from violence, and the victim must be asked about the cause of the trauma to determine if it is the result of violence and further evaluation is required (Sheridan: 93). When violence such as rape is identified, trained staff need to be available to provide services. Only in 1992 did the guidelines of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) first require emergency and ambulatory care facilities to have protocols on rape, sexual molestation, and domestic abuse (Bobak: 92).

Fortunately, women's groups have been working to provide services to victims of violence, such as rape and domestic abuse, before large sums of money were available to support these grassroots programs. Rape centers began to be established across the country in the early 1970's, primarily utilizing volunteer staff. While the sexual assault recovery movement and most rape centers continue to depend upon volunteer labor, more money is becoming available to pay staff. Goodyear (1989) suggests that staff must be paid for their work with rape victims. Women working as volunteer workers help perpetuate the tradition of women as unpaid caregivers and allows society to avoid responsibility.

The landmark Violence Against Women Act (VAWA) of 1994 was introduced by Senator Biden and signed into law on September 13, 1994, as Title IV of the Violent Crime Control and Law Enforcement Act of 1994. In addition to doubling the Federal penalties for repeat offenders and requiring date rape to be treated the same as stranger rape, this Act made $800 million available for training and program development over a 6-year period. This was an important recognition of the need for specialized services for female crime victims of violent crime.

Demonstrating the Need for SANE Programs

The impetus to develop SANE programs began with nurses, other medical professionals, counselors, and advocates working with rape victims in hospitals, clinics, and other settings. These individuals recognized that services to sexual assault victims were inadequate and not at the same high standard of care as for other ED clients (Holloway & Swan: 93; O'Brien: 96). When rape victims came to the ED for care, they often had to wait as long as 4 to 12 hours in a busy, public area; their wounds were seen as less serious than the other trauma victims; and rape victims competed unsuccessfully for staff time alongside the critically ill (Holloway & Swan: 93; Sandrick: 96; Speck & Aiken: 95). They were often not allowed to eat, drink, or urinate while they waited, for fear of destroying evidence (Thomas & Zachritz: 93). Doctors and nurses were often not sufficiently trained to do medical-legal exams, and many were also lacking in their ability to provide expert witness testimony (Lynch: 93). Even when they had been trained, staff often did not complete a sufficient number of exams to maintain their level of proficiency (Lenehan: 91; Yorker; 96; Tobias: 90). Even when the victim's medical needs were met, their emotional needs all too often were overlooked (Speck & Aiken: 95), or even worse, the victim was blamed for the rape by the ED staff (Kiffe: 96).

Typically, the rape victim faced a time-consuming, cumbersome succession of examiners for one exam, some with only a few hours of orientation and little experience. ED services were inconsistent and problematic. Often the only physician available to do the vaginal exam after the rape was male (Lenehan: 91). While approximately half of rape victims in one study were unconcerned with the gender of the examiner, for the other half this was extremely problematic. Even male victims often prefer to be examined by a woman, as they too are most often raped by a man and experience the same generalized fear and anger towards men that female victims experience (Ledray: 96a).

There are also many anecdotal and published reports of physicians being reluctant to do the exam. This was due to many factors including their lack of experience and training in forensic evidence collection (Bell: 95; Lynch: 93; Speck & Aiken: 95), the time-consuming nature of the evidentiary exam in a busy ED with many other medically urgent patients (DiNitto et al.: 86; Frank: 96), and the potential that if they completed the exam they were then vulnerable to being subpoenaed and taken away from their work in the ED to testify in court and be questioned by a sometimes hostile defense attorney (Thomas & Zachritz: 93; DiNitto et al.: 86; Speck & Aiken: 95; Frank: 96). This often resulted in documentation of evidence that was rushed, inadequate, or incomplete (Frank: 96). Many physicians even refused to do the exam (DiNitto et al.: 86). In one case, it was reported that a rape victim was sent home from a hospital without having an evidentiary exam completed because no physician could be found to do the exam (Kettelson: 95).

As research became more readily available on the complex needs and appropriate followup of rape victims, nurses and other professionals realized the importance of providing the best ED care possible (Lenehan: 91). For 75 percent of these victims the initial ED contact was the only known contact they had with medical or professional support staff (Ledray: 92a). Nurses also were very aware that while they were credited with only "assisting the physician with the exam," in reality they were already doing everything except the pelvic exam (DiNitto et al.: 86; Ledray: 92a). It was clear to these nurses that it was time to re-evaluate the system and consider a new approach that would better meet the needs of sexual assault victims.

History of SANE Program Development

To better meet the needs of this underserved population, the first SANE programs were established in Memphis, TN in 1976 (Speck & Aiken: 95); Minneapolis, MN in 1977 (Ledray & Chaignot: 80; Ledray: 93b); and Amarillo, TX in

1979 (Antognoli-Toland: 85). Unfortunately, these nurses worked in isolation until the late 1980's. In 1991, Gail Lenehan, editor of the *Journal of Emergency Nursing (JEN),* recognized the importance of this new role for nurses and published the first list of 20 SANE programs (ENA: 91).

In 1992, 72 individuals from 31 programs across the United States and Canada came together at a meeting hosted by the Sexual Assault Resource Service and the University of Minnesota School of Nursing in Minneapolis. At that meeting, the **International Association of Forensic Nurses (IAFN)** was formed (Ledray & Simmelink: 97). The IAFN is an international professional organization of registered nurses formed to develop, promote, and disseminate information about the science of forensic nursing nationally and internationally. Membership in **IAFN** surpassed the 1,000 mark in 1996 and continues to grow (Lynch: 96).

While the initial SANE development was slow, with only three programs operating by the end of the 1970's, development today is progressing much more rapidly. We are now aware of 10 new programs that were established between 1980 and 1989, and 73 additional SANE programs established between 1990 and 1996. Eighty-six SANE programs were identified and included in the October 1996, listing of SANE programs published in *JEN* (Ledray: 96b). This number is likely to grow much more rapidly in the years to come.

After years of effort on the part of SANEs and other forensic nurses, the American Nurses Association (ANA) officially recognized Forensic Nursing as a new specialty of nursing in 1995 (Lynch: 96). SANE is the largest subspecialty of forensic nursing. At the 1996 IAFN meeting in Kansas City, Geri Marullo, Executive Director of ANA, predicted that within 10 years the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) would require every hospital to have a forensic nurse available (Marullo: 96).

Statewide networks of SANE programs have recognized the need to develop State policies, procedures, and guidelines to direct SANE program operations in their area. State guidelines and procedures always take precedence over the recommendations in this guide.

CHAPTER 3

SANE PROGRAM MODEL

Before deciding to start a SANE program, it is important to understand what a SANE program does and does not do, the scope of nursing practice, and how a typical SANE program operates. This chapter defines the terms typically used in relation to SANE programs. An example of SANE program values statement, mission statement, goals, and scope of practice are presented. The chapter concludes with a discussion of the operation of a model SANE program and its impact on the community.

What Is a SANE? SANC? SAFE? FNE?

Since forensic nurse examiner programs began independently and functioned independently until the first meeting held in Minneapolis in 1992, different terminology has been used across the country to define the new role. The Minneapolis program used the term Sexual Assault Nurse Clinician (SANC) to denote a clinical nursing role that went beyond examination of the sexual assault victim. The SANC role in Minneapolis broadened the continuum of services provided to sexual assault victims, emphasizing crisis intervention and supportive counseling in the ER setting, and continuing with followup counseling by specially trained nurse counselors. To avoid a conflict in roles, the nurse counselor who provides followup services is a separate clinician from the SANC who provides services to the victim in the ER. The Memphis program, like many others, preferred the acronym SANE—Sexual Assault Nurse Examiner.

Some newer programs have chosen to use the more generic term of Sexual Assault/ Forensic Examiner (SAFE) or Forensic Nurse Examiner (FNE). A program in Minnesota has chosen the SAFE terminology because they hope to move beyond examination of only sexual assault victims to the completion of evidentiary exams on domestic abuse victims, accident victims, and other populations where forensic evidence collection may be useful. Forensic evidence is all too often overlooked in busy medical facilities where the focus is on clinical treatment.

At the October 1996 IAFN annual meeting held in Kansas City, the SANE Council voted on the terminology it wanted to use in the standards to define this new position. While there were some dissenting votes, the overwhelming decision was to use the title SANE, Sexual Assault Nurse Examiner.

A Sexual Assault Nurse Examiner (SANE) is a registered nurse, R.N., who has advanced education in forensic examination of sexual assault victims. In some areas, the SANE is still referred to by other names, including Sexual Assault Nurse Clinician (SANC), and Sexual Assault Forensic Examiner (SAFE). While the preference for particular terminology may vary, for the purpose of this manual the term SANE is used**.**

SANE Program Values, Mission, and Goals

According to Peter Drucker there are five questions that must be answered to effectively assess the values, mission, and goals of a nonprofit organization (Rossum: 93). A mission statement should clearly and succinctly describe an organization's reason for being. To develop a mission statement begin by asking the following:

1. What is our business (mission)? What are we trying to achieve? What specific results are we seeking? What are our major strengths? What are our major weaknesses?

After addressing the above question, focus on the following questions:

2. Who is our customer or client? Who is the primary customer (service users)? Who are our supporting customers (Board, volunteers, staff, law enforcement, prosecutor, other agencies)? Will our customers change?

3. What does the customer or client value? What do our primary customers value? What do our supporting customers value? How are we providing what our customers or clients value?

4. What have been our results? How do we define results? To what extent have we achieved these results? How are we using our resources?

5. What is our plan? What have we learned and what do we recommend? Where should we focus our efforts? What, if anything, should we do differently? What is our plan to achieve results?

Answering these questions is a critical step in ensuring that an organization focuses on the activities that will achieve the desired results. The following are examples of SANE program values, mission statement, and goals.

Values Statement

The basis of a SANE program operation is the belief that sexual assault victims have the right to immediate, compassionate, and comprehensive medical-legal evaluation and treatment by a specially trained professional who has the experience to anticipate their needs during this time of crisis. As health care providers, the SANE has an ethical responsibility to provide victims with complete information about choices so victims can make informed decisions about the care they want to receive.

A SANE program is also based on a belief that all sexual assault victims have a right (and responsibility) to report the crime of rape. While every victim may not choose to report to law enforcement, she has a right to know what her options are and what to expect if she does or does not decide to report. Those who do report also have a right to sensitive and knowledgeable support without bias during this often difficult process through the criminal justice system. Those who do not report still have a right to expert health care.

In addition, a SANE program is based on the belief that providing a higher standard of evidence collection and care can speed the victim's recovery to a higher level of functioning, prevent secondary injury or illness, and ultimately increase the prosecution of sex offenders and reduce the incidence of rape.

Mission Statement

The primary mission of a SANE program is to meet the needs of the sexual assault victim by providing immediate, compassionate, culturally sensitive, and comprehensive forensic evaluation and treatment by trained, professional nurse experts within the parameters of the individual's State Nurse Practice Act, the SANE standards of the IAFN, and the individual agency policies.

Program Goals

This next step involves the development of specific goals and objectives. The following are examples of SANE program goals:

- To protect the sexual assault victim from further harm.
- To provide crisis intervention.
- To provide timely, thorough, and professional forensic evidence collection, documentation, and preservation of evidence.
- To evaluate and treat prophylactically for sexually transmitted diseases (STDs).
- To evaluate pregnancy risk and offer prevention.
- To assess, document, and seek care for injuries.
- To appropriately refer victims for immediate and followup medical care and followup counseling.

- To enhance the ability of law enforcement agencies to obtain evidence and successfully prosecute sexual assault cases.

Based on the above values, mission statements, and program goals, each SANE program should develop a community-specific strategic plan or developmental plan of action. This process involves translating the values and mission statements into action. Where are we now? What do we have to do to get to where we want to be? This plan of action is the blueprint for obtaining financial support (See Chapter 6: A Look at Funding).

SANE Scope of Practice

A SANE program provides 24-hour on call services for all male and female victims of sexual assault or abuse.

Medical Care

The purpose of the SANE examination of the sexual assault victim is specifically to assess, document, and collect forensic evidence. In addition, prophylactic treatment of STDs and prevention of pregnancy are provided by the SANE following a pre-established medical protocol or with the approval of a consulting physician. While the SANE may treat minor injuries, such as washing and bandaging minor cuts or abrasions, further evaluation and care of any major physical trauma is referred to the ED or a designated medical facility.

The SANE conducts a limited medical examination, not a routine physical examination, and clearly explaining this difference to the client is important. Obvious pathology or suspicious findings that may be observed are reported to the client with a suggestion for followup care and referral. Evaluation and diagnosis of pathology is beyond the scope of the SANE examination.

Reporting and Victim Support

While the SANE is not a legal advocate, she does provide the rape victim with information to assist her in anticipating what may happen next in making choices about reporting and deciding who to tell and to ensure that she gets the support she will need after she leaves the SANE facility. This usually includes a discussion between the victim and the SANE about reporting to law enforcement. If the victim has made a choice not to report, she needs to discuss why she may be hesitant to report. In most cases, the SANE encourages the victim to report the crime and makes referrals to legal advocacy agencies that can provide the support necessary to help the victim through the criminal justice process.

The SANE also provides emotional support and crisis intervention. The SANE makes an initial assessment of the victim's psychological functioning sufficient to determine if she is suicidal, oriented to person, place, and time; or if she is in need of referral for followup support, evaluation, counseling, or treatment.

Education, Training, Research, and Program Evaluation

In addition, the SANE is active in training personnel from other health care and community agencies who provide services to sexual assault victims. Each SANE program also conducts ongoing program evaluation and periodic research studies to evaluate the impact, treatment needs, client outcomes and services provided to sexual assault victims. This should include a variety of program output, process, and outcome evaluation research activities.

SANE Standards of Practice

At the 1996 annual meeting of IAFN, the SANE Council voted and adopted the first SANE Standards of Practice. The standards incorporate the following:

- Goals of Sexual Assault Nurse Examiners.
- Definition of the practice area.
- Conceptual framework of SANE practice.
- Components of evaluation and documentation.

- Forensic evaluation components.
- SANE minimum qualifications.

For a nominal fee, a copy of the *SANE Standards of Practice* may be obtained by telephoning IAFN at 609–848–8356 or writing to IAFN 6900 Grove Road Thorofare, NJ 08086-9447.

While this guide was being developed, many State policies, protocols, or regulations have emerged. For example, based on the IAFN SANE Standards of Practice, the Virginia State Council of Forensic Nurses published their own *Standards of Practice for Sexual Assault Nurse Examiners* (1997). Always determine if there are State policies and standards relevant to the operation of SANE programs within your own State before implementing a SANE program in you area. You may request a copy of the Virginia Standards by contacting Kim Wieczorek, RN, BSN, FNE at telephone number 804-281-8574 or writing to: St. Mary's Hospital Emergency Department, Forensic Nurse Examiners, 5801 Bremo Road, Richmond, VA 23226.

How a Model SANE Program Operates

A SANE is usually available on call, off premises, 24 hours a day, 7 days a week. The on call SANE is paged immediately whenever a sexual assault or abuse victim enters the community's response system. If the protocol indicates a rape advocate should be called, the staff or SANE also will page the advocate on call.

Hospital-Based SANE Programs

If the SANE program is hospital-based, victims may enter the system in the following ways:

- Calling local law enforcement who will transport them to the hospital emergency department or SANE exam clinic.
- Going directly to the hospital emergency department or hospital clinic
- Calling the designated crisis line for assistance.

During the time it takes for the SANE to respond (usually no more than 1 hour), the ED or clinic staff will evaluate and treat any urgent or life-threatening injuries. If treatment is medically necessary, the ED staff will treat the client, always considering and documenting thoroughly the forensic ramifications of the lifesaving and stabilizing medical procedures. If clothes or objects are removed from the victim by the ED staff, care should be taken utilizing forensic principles for handling and storage of the physical evidence. If medical necessity dictates treatment prior to the arrival of the SANE, ED staff will take photographs following established forensic procedures. However, it is preferable that the SANE take all forensic photographs.

When the ED staff determines that the victim does not require immediate medical care, the victim is made comfortable in a private room near the ED. This area should enhance the victim's sense of safety and security and provide comfort and quiet in a sound-proof room with comfortable furniture, preferably a sofa that she can lie down on while she waits, a telephone, and a locked door. Family members who accompany the victim, with the victim's permission, should be allowed to stay with the victim while she waits. If there was no oral sex, she is offered something to eat or drink while she waits.

If she has not yet filed a police report and she knows she wants to do so, the triage nurse will call the police to take the initial report at the hospital. If the victim is upset, and a hospital chaplain or social worker is available on site, with her permission, they will be called to wait with her until the SANE, advocate, or counselor arrives.

Community-Based SANE Programs

If the SANE program is community-based, victims may enter the system in the following ways:

- Calling the local law enforcement where they will be triaged for injuries and, if only minor injuries or no injuries are present, they will be transported to the

community-based SANE facility by law enforcement.

- Going to the ED of a local hospital on their own, where they will be triaged for injuries, and if there are only minor injuries or no injury present, they will be transported to the community-based SANE program.
- Going directly to the community-based SANE program during office hours.
- Calling the designated crisis line for assistance and receiving a referral to the community-based SANE program.

Community Response and Responsibilities

In response to a sexual assault victim in the community, law enforcement is charged with initiating the investigation of the crime and determining if the client has serious injuries necessitating ED evaluation or care. If moderate to severe injury is detected, the victim is evaluated by paramedics and referred to the hospital ED. This occurs with less than 4 percent of rape victims, as rape seldom involves serious injury (Tucker, Ledray & Werner: 90).

Life-threatening injuries indicate whether the client needs to go to the hospital ED first rather than to a SANE facility. When no injuries are suspected, the client is transported from the crime scene to the community SANE facility where she is met by the SANE within 1 hour. If the victim goes directly to a hospital ED, the staff will evaluate the victim for life-threatening injuries requiring immediate treatment. When these are present, the ED staff will admit the victim to the ED and notify the on call SANE to come to the hospital ED. The ED staff will evaluate and treat the injuries, always considering the forensic implications of the lifesaving and stabilizing medical procedures. Clothing or objects removed from the client are handled and labeled to maintain the proper chain-of-evidence. Photographs are taken of the injuries for forensic purposes by the ED staff. After the patient is stabilized medically, the SANE will collect the forensic evidence in the designated ED area.

When the ED staff determines that the patient does not require urgent or lifesaving medical care, the victim is not admitted to the hospital. She is instead transported by law enforcement to the community-based SANE program facility.

SANE Responsibilities

Once the SANE arrives, she is responsible for completing the entire sexual assault evidentiary exam including crisis intervention, STD prevention, pregnancy risk evaluation and interception, collection of forensic evidence, and referrals for additional support and care.

When the victim is uncertain about reporting. If the victim has not yet decided if she wants to report, the SANE will discuss the victim's fears and concerns with her and provide her with the information necessary to make an informed decision.

If the victim does not want to report at this time, but is unsure if she will report at a future date, the SANE will make sure the victim is aware of her options and the limitations of reporting at a later date. The SANE will also offer to complete an evidentiary exam kit that can be held in a locked refrigerator for a specified time (usually 1 month or an appropriate period of time as mandated by State statutes if any exist) in case she chooses to report later.

Mandatory reporting. In States with mandatory reporting laws for felony crimes or child abuse, the SANE will follow established protocol for reporting after explaining the process and her responsibilities to the victim or the victim's family when a child is involved and a parent is present. (NOTE: This is different from statutory rape laws which are discussed in Chapter 13: Policies and Procedures.)

When the victim does not want to report. If the victim decides not to report and an evidentiary exam is not completed, the SANE can still offer her medications to prevent STDs, evaluate her risk of pregnancy, and offer pregnancy prevention for up to 72 hours post-rape. The SANE also will

make referrals for followup medical care and counseling and provide the victim with written followup information.

When a report is made. When a report is made or the victim is certain she will be reporting, a complete evidentiary exam is conducted following the SANE agency protocol. In most agencies, the complete exam is conducted within 36 hours of the sexual assault, and an abbreviated exam is completed between 36 and 72 hours post-rape (up to 96 hours in some States). (NOTE: Please see the Section on seminal fluid evidence in Chapter 11: SANE Program Operation, which describes the rationale for use of the complete versus the abbreviated exam.)

After obtaining a signed consent, the SANE will conduct a complete exam including the collection of evidence in a rape kit, further assessment and documentation of injuries, prophylactic care for STDs, evaluation of pregnancy risk and preventive care, crisis intervention, and referral for followup medical and psychological care.

Discharge. If the victim is alone, the SANE will talk with her about whom she would like to call and where she will go from the hospital. Every effort will be made to find a place for her to go where she will feel safe and will not be alone. When necessary, arrangements may be made for shelter placement. If she is intoxicated or does not want to leave until morning, arrangements may be made for her to sleep in a specified area of the hospital when this type of space is available. In many facilities, this will be an ED holding room or crisis center. If necessary, a community referral can be made to better meet her long-term housing needs.

Community Impact and Benefit

A SANE program cannot operate in isolation and be effective. Developing good community relationships must begin with the decision to consider developing a SANE program. When cooperating agencies are informed about the SANE model of care, they are more likely to see the benefits of collaborating with the SANE program to help victims. Working closely with community resources from the very beginning will encourage collaboration in the future. As a collaborative effort, the community can decide the type of SANE program which best meets the community needs.

Change is often threatening because the results are unknown. It is common to have some resistance to any change including the implementation of a SANE program. Just because one may encounter resistance, even strong resistance, it does not follow that the idea is a bad one, or that it won't succeed. Chapter Five: Assessing the Feasibility of a SANE Program addresses the types of resistance others have encountered, along with information on how they were able to resolve these obstacles.

The next chapter on developing a sexual assault response or resource team concentrates on developing and maintaining strong working community relationships.

CHAPTER 4

SART: A COMMUNITY APPROACH

No SANE program can operate in isolation. To be optimally effective and provide the best service possible to victims of sexual assault, the SANE must function as a part of a team of individuals from community organizations. They can be either formally organized as a Sexual Assault Response/ Resource Team or as informal collaborators.

Communities that have chosen to organize formally into a team have developed different concepts of a Sexual Assault Response/Resource Team (SART). One way is to work as a team of individuals who respond together to jointly interview the victim at the time of the sexual assault exam. Another way is to work independently on a day-to-day basis but communicate with each other regularly (possibly daily, and meet weekly or monthly) to discuss mutual cases and solve mutual problems thus making the system function more smoothly.

Who Is on a SART?

SART team members typically include the SANE, police or sheriff, detective, prosecutor, rape crisis center advocate or counselor, and emergency department medical personnel. The makeup of the SART team will vary from area to area, depending upon the community needs and resources. Ideally the team will include representatives from the community who can best help the victims. In some areas, it may include the SANE and the police. The SART team may also include an expanded range of professionals who work with specific victims populations: a school counselor, a battered women's advocate, a counselor who works with prostitutes, and any combination of representatives of programs in the community who are concerned about the problem of sexual assault. The team membership may change over time depending on the needs of the clients and the goals of the SART team.

The Sexual Assault RESPONSE Team Model

The original SART model, developed in California, involves a coordinated response. This SART concept is based on the belief that a team response helps prevent the victim from reporting the account of the assault repeatedly. It also helps prevent confusion among professionals trying to meet the needs of the rape victim as she progresses through the health care and criminal justice systems.

In communities using the California SART model where multiple members of the SART respond to the emergency department together to conduct the sexual assault exam, the team usually includes law enforcement, the SANE, and a rape advocate. They are all present when the victim makes her initial statement so she only needs to tell the account once.

How a Sexual Assault RESPONSE Team Operates

When law enforcement is called to the scene of a sexual assault, they will protect the client from further harm, protect the crime scene evidence, and take a limited statement from the victim to determine if a sex crime was committed. They will then call the hospital ED triage who will page the SANE on call and the rape advocate on call. When the police and victim arrive at the hospital, the SANE will decide if the victim should be directed to the ED for medical evaluation by a physician, or directed immediately to the SANE area for forensic examination. The SANE will stay with the victim during any necessary medical evaluation and until

she is cleared medically and transferred to the SANE examination area.

If a client presents to the ED initially, law enforcement is called immediately to determine if a crime has been committed. The SANE and advocate may also be called to help facilitate the victim's admission to the SART system. In a limited number of communities, a prosecuting attorney also responds to the hospital as a member of the SART. *The police are called initially in many areas to certify that a crime has been committed, because in these locales, the hospital is compensated for the medical evidentiary exam only if there is an accompanying police statement certifying that there was a crime.* For a more comprehensive discussion of issues related to compensation, please refer to the section on SANE Program Funding Options in Chapter Six of this manual.

With the advocate present to provide support, the SANE and police conduct an indepth interview of the victim after briefly conferring to coordinate questioning and reduce repetition. In California, the penal code gives the victim a right to have any two individuals of her choice present for support during police questioning. The advocate may be one of these two. Once the interview is completed, the police officer will wait outside the exam room while the SANE collects the evidence which is then turned over to law enforcement or locked in a secured area for law enforcement to pick up at a later time. With the victim's permission, the advocate will remain in the exam room to provide support during the exam as well.

When the exam is completed, the SANE will make any necessary arrangements for followup medical care, and the advocate will make arrangements to contact the victim for followup supportive counseling and legal advocacy.

Members of the SART may also meet regularly to discuss cases, or they may communicate informally after the initial ED experience.

Sexual Assault RESPONSE Team Model Limitations

While the coordinated effort of a SART certainly has some advantage, there are also some limitations to this approach. If the victim is uncertain about reporting, she may feel pressured to report when protocol requires law enforcement personnel to interview the victim before the SANE becomes involved. The advocate will support the victim in whatever decision she makes, even if the decision is not to prosecute. If the victim decides not to report, this also may result in a victim who cannot access health care for STD and pregnancy risk evaluation and prevention.

If the victim decides not to report, the hospital care is then typically not paid by the crime victims compensation fund. When the police authorize reimbursement, they are more likely to require that a police report be made. In areas where payment is authorized through another agency, reporting is not necessarily a requirement for payment. Detailed information on compensation issues is provided in Chapter Six: A Look at Funding.

In addition, while repetition of the account of the sexual assault is certainly an unpleasant experience that most victims want to avoid, the assumption that they will be better off if they do not have to do so is only a presumption. Research of treatment efficacy has in fact shown that repetition of the account of the assault in detail has a beneficial, desensitizing, healing effect (Foa: 97).

The Sexual Assault RESOURCE Team Model

Other parts of the country have modified the initial SART model to better meet the needs of their community while trying to maintain the team concept that the SART model fosters. In many of these other areas, while the team members meet regularly and communicate routinely about cases,

they do not actually respond at the same time. They function cooperatively, not conjointly, which is why some choose to refer to themselves as a **resource team,** rather than a **response team.**

In these areas, the police respond to the crime scene and take the initial report and then transport the rape victim to the hospital or SANE clinic. The SANE assumes responsibility for the care of the rape victim at the hospital or SANE clinic and completes the evidentiary exam. The police officer is not present during the exam and may not even wait at the hospital. Rather, the SANE will call the police when the exam is completed, and they will return for the victim. After discussing the exam findings with the SANE, the police may also take possession of the evidence and provide the victim with a safe ride home.

If the victim comes to the hospital before contacting the police, with the victim's permission, the SANE may call the police to come to the hospital to take the initial report. The police may complete the report at the hospital, and the SANE may then be present during the interview.

The rape center advocate may bring a victim to the hospital or be paged at the same time the SANE is paged. The advocate may also be contacted at a later point in time to provide followup advocacy and counseling. The advocate will likely go with the sexual assault victim when meeting with the sex crimes detective and prosecutor at a later point in time.

Most areas also have a standing SART meeting to discuss broader concerns and to communicate informally about specific cases. The goal of this type of meeting is to gather the primary decision-makers, such as the directors or managers of the involved agencies, and resolve problems that affect the group as a whole. At this meeting, the nature of the SART's work is usually broader policy issues, rather than specific case issues.

The Sexual Assault Resource Team needs to be aware of how the victim's testimony can jeopardize her case should she want to prosecute. For example, when the victim tells her account of the assault to the police, the SANE, the prosecutor, and the advocate at different times, her memory and the completeness of each account may vary somewhat. When present, these discrepancies must be addressed if the case goes to court. Therefore, all team members need to meet or communicate over the phone to discuss cases, issues, and concerns. While in many States, sexual assault advocates who have completed the required training cannot be subpoenaed to testify in court, both the SANE and law enforcement personnel will be called, and they need to have consistent facts about each case.

Summary

For a SANE program to be successful, all involved agencies must work together. It takes a coordinated community approach to deal with the multiple needs of the rape victim and to prosecute the offender. However the SART model operates, whomever is included on the team, whatever name is used to describe the team, the important concern is ensuring a coordinated community response with the needs of the victim as the primary focus.

CHAPTER 5

ASSESSING THE FEASIBILITY OF A SANE PROGRAM

The first step in determining the feasibility of developing a SANE program is to determine a community's need. If the need is there, then obstacles to SANE program development must be identified, and adequate support or resources to overcome these obstacles must be obtained.

Needs Assessment

A community needs assessment must be completed before making the decision that a SANE/SART program is appropriate for the community. Potential funders will ask for this information before they consider financially supporting the concept. Keeping an open mind during this initial assessment phase is important because a simpler change may be sufficient to provide adequate community services for sexual assault victims. On the other hand, it may be that, while there is need for implementing a SANE/SART program, sufficient community support may not exist. Perhaps all that can be accomplished initially is to plant the first seed of the idea that may take several years to germinate.

Many communities have agencies who conduct needs assessments. If possible, identify such a local resource to work with because a properly done needs assessment can be very time-consuming and expensive. Even though a needs assessment may be a source of additional work, it is extremely beneficial, adding credibility to pleas to establish a SANE program.

Identifying Allies

Begin by talking to people in the community who work with rape victims or who are concerned about the problem of rape, such as personnel in law enforcement, hospitals, teen medical clinics, district attorneys' offices, and victim assistance organizations. Explain the SANE/SART concept to them and look for potential allies in program development and membership on a community resource team.

Determining the Extent of the Community Problem of Rape

While meeting with community players, determine the number of rapes that occur in the community each year. Getting a count of the actual number of rapes may be more difficult to determine than anticipated. At a minimum, talk with people from the local police department, rape crisis center, medical facility, and prosecuting attorney's office. Ask these people about who else should be contacted.

Provide information about the SANE/SART concept to individuals who are interested in improving services to victims of rape. Use this information to identify one individual in each agency who is involved in providing care to sexual assault victims, who is knowledgeable about the current system, and who may be willing to work to try to improve those services. Offer to send them some information describing the SANE/SART concept and how it works, prior to the initial visit. The articles "Sexual Assault Nurse Clinician: A fifteen-year experience in Minneapolis" and "The Sexual Assault Examination: Overview and lessons learned in one program," in the *Journal of Emergency Nursing,* June 1992 (Ledray: 92a & 92b), are good choices because they are concise and easy to read and because they contain discussions about and demonstrate the advantages of the SANE concept for other agencies. They also summarize the most common obstacles and resistance to the development of a SANE program and provide accurate information to counter these concerns. Follow up these contacts with a personal visit to each agency.

Assessing Community Services and Developing Community Support

Law Enforcement

Start by contacting the local police department. Ask if they have a special unit that investigates rape cases. If one exists, get the name and phone number of the police officer in charge of this unit. Call that person and obtain the following information:

- What are the number of reported sexual assaults the unit receives each year? Ask for detailed clarification of the numbers. For example, some police departments include the number of indecent exposures in their sex crimes statistics; others may just include stranger rapes or only rapes that involve vaginal/penile penetration. Ask about the numbers of adult, adolescent, and child sexual assault victims. Remember, the literature suggests that the actual rate for sexual assaults is 5 to 10 times the number of rapes reported.
- What percentage of rape reports do the police consider unfounded and how do they determine that a rape report is unfounded?
- How efficient and effective do the police consider the current medical response?
- Do officers have long waits after they take a rape victim to the hospital?
- Where do they usually take the rape victims they see, and why do they go to that particular medical facility?
- Is the medical evidence collected complete and is the proper chain-of-evidence maintained?
- Is the medical staff cooperative in sharing information with them and helping them gain access to the medical records and maintaining contact with the victims?
- Are the police familiar with the SANE/SART concept, and if so, do they think it could improve victim services in the community?

Rape Crisis Center

The local rape crisis center should be asked the following:

- How many rape victims do staff see each year?
- How many crisis calls does the center receive?
- What are the victims saying about medical services?
- What percentage of the victims have reported the rape to law enforcement?
- What is the staff's assessment of the effectiveness of the current medical response?
- What does staff believe are the strengths and weaknesses of the current health care response?
- What percentage of rape victims, do staff believe, have rape exams completed?
- Are staff familiar with the SANE/SART concept, and if so, how do they think it could improve community victim services?

Medical Facility

The next step is to identify which medical facilities in the community see most of the rape victims. Begin by calling the ED nurse managers and asking how many rape victims their facility sees each month and year. Try to identify a staff person, probably a doctor or nurse in the ED or women's clinic who works with the rape victims at each facility and who is particularly concerned about their care, and ask that person for the following information:

- *How many rape exams does the clinic (or ED) do each year*? An estimate may be all that is available as hospitals often do not record the sexual assault as a primary diagnosis and if they do, they may include both victim and perpetrator exams. Consequently, the number of sexual assault victims seen may not be retrievable, and when cases are identified, the numbers may not be accurate.
- *How are exams done, and by whom*? Ask for a copy of their protocol and ask if the doctors

or nurses currently doing the rape exams are satisfied with the system.

- *Are they familiar with the SANE/SART concept*, and if so, do they think it could improve services for victims at their facility?

Prosecuting Attorney

Talk to the prosecuting attorney who is most active prosecuting sexual assault cases. Larger jurisdictions often have a special sex crimes prosecuting unit. When available, the lead attorney in that unit will be the best person to provide the following information:

- What are the number of rapes the prosecutor's office reviews each year?
- What number do they charge, plea bargain, and take to trial?
- What is their experience with the rape kit evidence?
- Is the kind of evidence they need from the local medical facilities provided?
- Do they work together with the medical staff to improve the evidence collection process?
- Do they encounter problems in getting medical staff to testify?
- What are the advantages of working together with the medical staff?
- Are they familiar with the SANE/SART concept, and if so, how could it improve evidence collection?

Other Agencies

Ask the above contacts to identify additional agencies or individuals who they believe are key community players working with sexual assault victims. This could be a program in the school system, a pediatric clinic, a domestic violence program, a local women's group, or a church group. Be sure to include them in the assessment phase.

Meeting with these agencies should provide a more accurate idea of the services available for rape victims in the area, the problems with the local system, the support for change that currently exists, and the resistance or obstacles to implementing a SANE/SART program that might be encountered.

Identifying and Overcoming Obstacles

Obstacles identified in the literature that SANE programs have had to overcome include the following:

- The fear of physicians that the SANE would miss injuries in the initial exam (Ledray: 96a; O'Brien: 96a).
- The concern of physicians that they will still be called to testify in court even though they did not complete the exam (Ledray & Simmelink: 97).
- The belief of prosecutors that a physician must conduct the exam in order for the physical evidence to stand up in the court room (DiNitto et al.: 86).
- The belief of prosecutors that the SANE will not be as credible a witness in court as the physician (Ledray: 92a; Antognoli-Toland: 85).
- Inadequate funding (O'Brien: 96a).
- Narrow interpretation of old laws requiring a physician to collect the evidence for it to be used in court and for the cost of the exam to be reimbursable (Speck & Aiken: 95).

Unfortunately, little hard data is available about the efficacy of the SANE model. Most of what is available is testimonial or anecdotal. On the other hand, no published data even suggests that the SANE model is ineffective or not preferable to the former model which involves a nurse and physician jointly completing the evidentiary exam.

Concerns About Cost

Starting and operating a SANE program costs money. Chapter 6: A Look at Funding deals with cost and funding issues more specifically. The amount of additional costs can vary greatly,

depending upon how the program is structured. The treatment of rape victims by hospitals today is not free, but the costs are usually hidden.

Having a SANE available on call may actually be more cost effective to the facility because it frees both the ED physician and nurse, saving an estimated 20 minutes of physician time and 3.5 hours of ED nursing time (Rambow et al.: 92). The costs for SANE programs are more modest than the costs in facilities with physicians completing even a portion of the exam (DiNitto: 86). Actual costs for the physician fee, use of the ED, laboratory fees, and medication costs often exceed the amounts reimbursed by the State. If there are no legal restrictions on billing the victim, or no special arrangements are made with the hospital, victims may be charged these additional expenses (DiNitto et al.: 86). Please see Chapter 6, under the section "VOCA Funding" for an expanded discussion of the reimbursement and billing of expenses. Having the nurses work on call has greatly reduced program costs, as has the ability to successfully train and utilize nurses without advanced degrees (Ledray: 96a).

Fear of Interference

There are numerous ways in which the SANE assists the police and the prosecutor. SANEs can ensure that the police get records of exams in a more timely fashion. They can interpret the findings for the police and prosecutor when necessary. Some SANEs routinely ask for the name, address, and phone number of friends or relatives with whom the victim might decide to stay, and through whom they may later be contacted. This information is often very helpful to the police (Ledray: 92a). Police generally prefer to work with a few forensically trained nurses, as opposed to dozens of different nurses and physicians in a busy ED because these nurses know what evidence to collect and how to maintain the proper chain-of-evidence, which makes the police officer's job easier (Yorker: 96).

In EDs without a SANE program, victims sometimes encounter busy, insensitive staff, and as a consequence, victims may decide it is not worth the effort to report. However, with a SANE's support, more victims make a police report and follow through with prosecution (Arndt: 88). By providing the rape victim with additional assistance, resources, and support, SANEs facilitate the victim's followthrough with the legal process (Frank: 96; Ledray: 92a). This support results in more victims filing police reports (Arndt: 88). One program had an additional 15 percent of rape victims who reported after talking with a SANE even though the victims were initially hesitant to make a police report. The SANE is aware of the usual fears that keep victims from reporting and is thus able to give victims the needed information to make more informed decisions (Ledray: 92a).

SANEs provide continuity of care from reporting to conviction (Ledray & Arndt: 94). SANEs also shorten the time a victim must spend in the ED (DiNitto et al.: 86). Unlike the ED physician who may be called away during the rape exam to see a more urgent ED case, the SANE is able to stay with the victim until the entire exam is completed (Frank: 96). In a client satisfaction questionnaire mailed to 201 victims 2 weeks after they were seen by a SANE for an exam, 93 percent of those returning the questionnaire were satisfied with the care they received. Unfortunately, only 33 (16%) returned the questionnaire (Speck & Aiken: 95). In most communities, having a SANE respond guarantees the availability of a female examiner which is important to many victims (Arndt: 88).

Concern the SANE Will Not Do the Exam as well as the Physician

The reliability of the evidence collected from a rape victim has been a prime concern in determining who would conduct the sexual assault exam. Until recently in England, only police surgeons, usually men, were allowed to collect evidence from rape victims. When a group of female general practice physicians decided they wanted to make their services available, their ability to develop the necessary forensic skills to collect evidence was challenged by the police surgeons. They have,

however, proven their abilities and are now accepted (Wright, Duke, Fraser & Sviland: 89). This was a necessary first step before the police were willing to train nurses for this role in England (Holloway & Swan: 93).

The real issue is one of training and experience, not professional background. Just as with any other specialized clinical skill, competency in the collection of forensic evidence and the completion of a sexual assault evidentiary exam entails training and experience. It does not necessarily require an advanced medical degree. Unfortunately, most medical and nursing schools do not teach forensic principles. Few physicians or nurses have the opportunity to complete a sufficient number of rape exams to develop or maintain proficiency, even if they have completed the training. A primary advantage of the SANE program is that a dedicated, limited number of nurses complete all of the evidentiary exams in a given hospital or clinic, which enables them to complete an adequate number of exams to develop and maintain proficiency (DiNitto et al.: 86).

The SANE evidence collection process has evolved over the years because SANEs have historically met periodically with the prosecuting attorneys about the use of evidence in the courtroom. As a result of this history, today the evidence that is collected is more complete and useful in obtaining a conviction. For example, one program now routinely collects an extra tube of blood that can be held and run for drug or alcohol analysis if the assailant claims the victim was so drunk she doesn't remember giving consent or if he claims the sex was consensual because she exchanged sex for drugs (Ledray: 92a).

Because SANE programs follow a case from the initial evidence collection through to prosecution, they have collected valuable data on the results of the evidence collected. These data have included information such as the likelihood of finding sperm at a specific site, at a specific point in time, and the likelihood of a rape victim being injured during the assault. This information has also been helpful to county attorneys who need to explain that the lack of injuries or the absence of sperm does not mean that the woman was not raped (Ledray: 92a).

In a study comparing 24 sexual assault evidence kits collected by SANEs to 73 collected by non-SANEs, the SANE kits were overall better documented and more complete, and the SANEs always maintained proper chain-of-evidence, whereas the others did not. Thirteen (18%) of the kits completed by non-SANEs either had no indication of who had collected the evidence or the records were illegible thus making the available evidence useless. Overall, 48 percent of the non-SANE kits had some break in the chain-of-evidence compared to none of the rape kits collected by SANEs (Ledray & Simmelink: 97).

Concern the SANE Will Not Be a Credible Witness in Court

Concerns about SANE credibility are unfounded. In fact, there are several reports of prosecutors, who were initially concerned, later finding that the SANE is an extremely credible witness in court as a result of her extensive experience and expertise in conducting the sexual assault exam (Ledray & Barry: in press). SANEs are also more accessible and more willing to adjust their schedules to testify because it is an expected part of their chosen position (Ledray: 92a; Antognoli-Toland: 85). Prosecuting attorneys who have worked with SANEs know they can rely upon the competence of the SANE as a witness if the case goes to trial (Yorker: 96). The testimony of the SANE is backed up by solid credentials and impressive numbers of victims seen (Lenehan: 91). As a result of this solid SANE education, training, and experience, Tennessee more broadly interpreted its State laws to allow the SANE to testify in court (Speck & Aiken: 95).

A common concern of physicians is that the physician will still be called to testify in court. In one community where thousands of rape cases have been completed by SANEs, not one case in which the testimony was given by the SANE alone ever required the prosecutor to subpoena the ED physician to testify about the evidence collected

(Ledray & Simmelink: 97). When the physician is called to testify, it has always been about injuries that were treated.

The Santa Cruz County Attorney believes that having the SANE collect evidence and be available to testify in court has resulted in more guilty pleas (Arndt: 88). In other communities, the SANE model is credited with an increase in conviction rates (Solola & Severs: 83). To date, two programs in operation for more than 10 years continue to have an impressive 96-percent conviction rate in cases in which the SANE did the exam (O'Brien: 96a; Smith: 96). In other communities, at the very least, there has not been the feared decline in convictions (DiNitto et al.: 86).

Deciding to Proceed

Based on the initial assessment, one of the following conclusions is likely:

- The community system may be efficient and effective, and it may not need a major change to a SANE/SART system.
- The problems in the system won't be fixed with the implementation of a SANE/SART program, but some other approach may be more helpful.
- While the system is in drastic need of the type of restructuring a SANE/SART program could provide, there is currently too little support and too many obstacles to make the commitment to take on the project.
- The community could indeed benefit from the implementation of a SANE/SART program, and there is at least enough support to take the next step toward overcoming any existing obstacles in the community in the hope of implementing a SANE program.

Starting a Formal Task Force

The next step is bringing together a group of interested individuals from the previously mentioned agencies to meet and discuss the possibility of implementing a SANE program. Be prepared to present the following:

- A summary of the findings collected, including the best estimates available of the number of reported rapes and actual rapes in the community each year.
- The positive and negative aspects of the current response to rape.
- A brief description of how a SANE program operates.
- The benefits of a SANE program for rape victims and each agency involved. If possible, list and respond to each concern presented by community agencies and solicit additional issues and concerns.

To establish a SANE program, two primary task force goals must be achieved. The first primary goal is to establish an initial meeting with community leaders for an open discussion of the SANE concept and identification of additional concerns and information that will be needed.

An additional goal is to get a commitment from each agency to meet again to explore further the possibility of starting a SANE/ SART program in the community or region. Getting community leaders to this first meeting is a big step. Getting them to come back again is even bigger. Respect their time by starting when scheduled and stopping on time. Have an agenda and stick to it.

When meeting with the community, provide comprehensive information about the SANE program. When you do not have information, make a sincere effort to obtain it but do not promise information for the next meeting that is likely not available. Be honest about what is not known and not available. When unsuccessful in obtaining requested information, explain what efforts were made to obtain it and ask for suggestions or help getting the additional facts.

To get community leaders to commit to meetings, be accommodating. For example, be flexible and creative in finding a convenient meeting time and place. If possible, get your agency to provide coffee and bagels or cookies. If individuals miss a meeting, send them a summary of what was discussed with the time and location for the next meeting. It is also important to call individuals who are unable to attend to let them know that they were missed and that you really hope they will be able to attend the next meeting. If possible, tell them what type of input would be helpful from them. If they don't attend, keep sending them minutes of the meetings so they are at least informed about the progress. Periodically reassess who should be included on the initial task force.

Developing a SART

Once a working committee is established, discuss becoming a SART even if developing a SANE program at the present time may not be possible. In all likelihood, the group of individuals brought together to discuss starting a SANE program are at least a major portion of a SART team membership (See Chapter 4: SART: A Community Approach). If the group decides to continue meeting as a SART, ask who else should be invited to the meetings. Continued communication among interested agencies may result in the development of a SANE program in the future or it may at least result in the improvement of victim services in other ways.

CHAPTER 6 A LOOK AT FUNDING

Funding is a vital issue often overlooked in the early stages of SANE program development. The inability to obtain needed funding for program startup costs has thwarted the past efforts of numerous nurses who wanted to develop a local SANE program. Many of these nurses were employed at medical centers and expected their medical center to incur the initial costs of SANE program development. While some were successful in making their case, many others were not. More often, these nurses were good clinicians who wanted to start SANE programs because they realized they were not providing victims of sexual assault with state-of-the-art clinical care in their institution. They were aware that there was a better way, the SANE way. Unfortunately, because their focus was on the clinical aspects of care, funding was an afterthought. To a great extent, the ability to obtain program funding is the test of program feasibility. If the necessary funding cannot be obtained, it will not be possible to develop a SANE program.

The reality of the health care climate today is that it has become cost driven, and to a great extent, limited by cost. Most hospitals already provide services which do not produce revenues sufficient to cover costs. Understandably, hospital administrators are reluctant to develop an additional program that they perceive will increase costs and decrease profits. Hospital administrators may not understand that hospitals already assume many indirect and overhead costs associated with examining and treating sexual assault victims, such as physician and nursing time, supplies, and staff training. Furthermore, because the ED staff does not conduct these exams routinely, it takes these clinicians longer than a SANE. In addition, while ED staff is involved with a sexual assault exam, the ED may need additional staff to cover other cases in the ED and overtime may be required because staff cannot leave until the exam is completed. The ED must supply both a physician and a nurse to conduct the sexual assault exam so consequently both may be required to testify in court. If there is a delay in court cases, scheduling problems will arise in the ED. When promoting the establishment of a SANE program with hospital administrators, provide a cost-benefit analysis to administrators, demonstrating how a SANE program can provide some services in a more cost-effective manner.

Less tangible, but equally important benefits should also be included in the discussion. Even though cost considerations drive many decisions in health care, intensifying competition in the ambulatory health care sector also focuses on the provision of quality, patient-centered care. Point out that the provision of SANE services would enhance the medical facility's reputation with the community, allowing the hospital to stand out among its competitors. Finally, hospitals and medical centers are increasingly interested in and involved with community wellness efforts. Explain how a SANE program, with its cadre of educated, experienced forensic nurse specialists, provides an invaluable resource for a hospital's community outreach and education initiatives. For example, the SANE can educate law enforcement and county attorneys about evidence collection and use of evidence. For the community, the SANE can raise the community's awareness about how secondary trauma is caused by sexual assault.

However, even with the most favorable cost-benefit analysis, one cannot assume that a hospital will fund all the costs associated with an ideal SANE program. This is why SANE program costs and funding options must be an initial consideration, starting with the goal of developing a realistic and fundable program, not necessarily the ideal program.

This chapter addresses both the cost of program development and program operation, including options when minimal funds are available as well as ideal options when funds are more readily available. (Many SANE programs start with minimal funds and are able to improve staff pay and benefits as well as extend program services after they have established themselves in the community and demonstrated the service need and benefit. It is essential to realistically anticipate all initial costs in order to obtain adequate startup and program operational funding.) This chapter also reviews the funding of SANE programs currently in operation. Lastly, it considers potential funding sources for program development and operation.

Program Development and Operation Costs

Program development and operation costs vary greatly. Surveyed programs indicated that initial startup costs ranged from $6,000 to over $50,000, and averaged $30,000 to $40,000. Much can be done to control and lower these costs when necessary (See Chapter 7: Starting Your SANE Program). Depending on the resources available, this section provides cost-saving options for consideration. It provides information on the minimum, unavoidable costs for those working with strict limitations, as well as options when more financial resources are available. The costs of program development are not all monetary; in fact, many of the costs are time commitments from personnel.

Important Startup Costs of Developing a SANE Program:

- Community and institutional needs assessment.
- Facilities and utilities.
- Supplies and equipment.
- Staff advertising and selection.
- Staff training (See Chapter 9: SANE Training).
- Program media promotion.
- Staff salaries for the first year (See Chapter 8: SANE Program Staff).

Needs Assessment

In most cases, the cost of the community and institutional needs assessment involves the time of a committed individual. In the early days, this was most often institutional employees who were aware of the inadequate services to sexual assault victims. The employees were typically nurses working in the ED or a clinic that saw rape victims, and they wanted to improve services for these victims. With the increased awareness of the SANE model, the needs assessment is now often provided by someone working with rape victims outside the hospital, such as the police, an advocate from the local rape crisis center, or staff at the prosecutor's office. Many State attorneys general and governors are now even taking leadership roles in promoting the SANE concept on a statewide level.

While an interested institution may be willing to donate staff time, the hundreds of hours of needed time may have to be spread out over a full year or more. If there is an intense amount of interest, it is more likely that an agency or organization will provide a substantial amount of paid, experienced, professional staff time to determine program feasibility and startup activities.

If an individual, rather than an institution, is the interested party, then a time commitment must be negotiated. While this person may be able to perform some of the tasks involved with the initial needs assessment and feasibility studies on institutional time, most efforts will be uncompensated, off-duty hours. If the interested individual's supervisor does not support compensated work hours for the development of a SANE program, the alternative is to find someone in the institution who does support the SANE project. Another possibility is to find support outside the institution, but this is not an optimal solution if the institution's support is vital to the SANE project. At this point, the feasibility of developing a SANE program needs to be carefully reconsidered. Another strategy may need to be developed, including postponing the development of the SANE program until more support can be generated.

Facilities and Utilities

Office space for the program director, secretary, and staff meetings are almost always located in space donated to the program. The only exceptions to this across the country are programs operated independently for profit. When the program is hospital-based, the hospital donates the space. Community-based programs are usually housed administratively with the sponsoring community agency. Office space should be negotiated either with the hospital where the services will be provided or with the sponsoring community agency. A SANE program provides the hospital or community agency with a valuable resource and a lot of community goodwill. Take advantage of the negotiating power this provides to avoid expensive office overhead.

Supplies and Equipment

Both office and exam supplies and equipment need to be included in the initial budget. Much like office space, however, it is often possible to get the sponsoring institution to donate supplies, at least for the first year of operation. It will be especially important during this first year to keep an accurate account of the actual supply costs. These cost records will be useful to negotiate for continued donation by the institution or to know the actual expenses if the program needs to assume them.

Office equipment. In addition to the usual office equipment, a SANE program needs a computer with access to the Internet and facsimile (FAX) capabilities. The FAX capabilities can be part of the computer or a separate piece of equipment. The FAX equipment should have the capability of displaying the name and phone number of the receiving agency prior to pushing the send key. This allows staff the chance to double check that sensitive or confidential data are sent to the correct agency. To ensure data security, store client data in a computer separate from the computer linked to the Internet.

Each SANE needs a long-range pager. Always try to get this cost donated, possibly by a paging company or a community agency, before adding it to the budget. Even $10 per month adds up when it is multiplied by 10 nurses and 12 months.

Exam equipment. The hospital ED or clinic where the exams are being completed is often willing to donate exam supplies. In many States, the rape exam kits are provided by law enforcement at no charge. Standardized kits can also be purchased when they are not available free from law enforcement. Consult with the local State crime laboratory that will be analyzing the evidence collected before purchasing the kits. Since the price and contents of "standardized" kits vary greatly from manufacturer to manufacturer, ask to have a sample sent for review before making a decision to purchase a particular kit. The crime laboratory may know where to purchase standardized kits. They are available from a number of sources. (See Appendix C: Rape Kit Supply Resources). Law enforcement agencies often pay for this cost because use of standardized kits benefits law enforcement by promoting better evidence collection. Emphasize this benefit to the law enforcement agency when negotiating with them to provide these kits.

A Polaroid camera and/or a 35mm camera will also be needed. Before making the purchase, check to see if the ED or clinic where the exams will be completed already has one available that SANE staff could access. Small 35mm cameras with automatic focus that are easy to operate and will take adequate pictures of injuries are available for as little as $100. A camera with a macro lens attachment will produce higher quality, closeup photos. Later, when the budget allows, the camera equipment can be upgraded. Don't be tempted to get camera equipment that is so sophisticated that the staff will have trouble using it effectively. Also, ensure that the cost of film and film development is covered in the budget if these costs, which can be considerable, are not reimbursed by law enforcement or the prosecutor's office.

If the budget allows, consider purchasing a digital camera that can transmit photo evidence directly to the police department, if it is utilizing this

technology. The police department may even be willing to provide the SANE program this equipment. One Minnesota police department offered to do so, recognizing the value to the investigative efforts of its department. Another consideration is photographic equipment which captures ultraviolet images. While more sophisticated, it is very effective in identifying and highlighting bruising, especially in women of color. While this technology was once controversial and its accuracy challenged in the courtroom, its scientific value is now widely accepted. The use of a digital camera, however, must be discussed with the local prosecuting attorney's office because digital imagery can be altered easily and, consequently, it may not be accepted by that office.

Common Examination Supplies

- Rape kits.
- Clean-catch urine specimen containers.
- Wet preparation tubes.
- Roll of white paper (e.g., butcher paper)
- Fingernail file or Q-tip (to scrape under the nail.
- Tourniquets.
- Syringes.
- Blood tubes for bloodtype, pregnancy, alcohol, and drugs.
- Disposable towels.
- Barrier drapes.
- Speculums of various sizes.
- Lubricant (for bi-manual exam).
- Fixative (depending on lab protocol).
- Slides.
- Paper bags.
- Labels.
- Fingernail clippers.
- Envelopes.
- Swabs.
- Gauze.
- Needles.
- Plastic combs.
- Gloves.
- Gowns.
- Normal saline.
- Pencils and pens.
- Film.
- Biological and sharps waste receptacles.

An alternate light source will also be needed. Much like the camera, these light sources are typically available in the ED or clinic for eye exams. If the budget is tight, arrange to have access to the equipment rather than to purchase it.

If the SANE program is located in a separate clinic, a pelvic examination table also must be acquired. A microscope may be necessary to observe wet mounts for motile sperm.

Additional equipment that will soon become a standard, but which is still not available to many SANE programs because of the cost, are the colposcope ($10,000 to $15,000 for the colposcope alone); light staining microscope ($1,000 to $1,500); digital camera systems with direct computer links; and video equipment with print capabilities. Because of the excessive cost of the colposcope, some programs, especially those working with children, have chosen instead to purchase MedScope ($3,500; $11,500 including camera, internal lens, camera holder, monitor, printer, foot switch, VCR, and cart). It is currently being evaluated in a trial study funded by OVC.

Exam paperwork. At a minimum, the SANE staff will need the following exam forms:

- Sexual Assault Exam Report (with chain-of-custody).
- Evidentiary Exam Consent which includes consent to release evidence to and communicate with law enforcement.
- Pregnancy Prevention Consent.
- Laboratory forms including a specimen chain-of-custody.
- Program brochures.
- Followup materials.

Additional forms may include the following:

- Medical and other referral forms.
- Nursing Care Plan.
- Medical History Forms.

To avoid expensive printing of these forms, including the brochure, all can be produced on a computer. Several low cost computer printing programs are available from which to choose.

Staff Advertising and Selection

Advertising costs to recruit nurses for a SANE position can be reduced by posting the new SANE positions in local hospital EDs and clinics such as the obstetrics and gynecology clinic. Advertising in the local newspaper may also be necessary. This can cost hundreds of dollars. Ask the sponsoring institution if it will assume this cost; if not, advertising must be included in the budget. Media publicity associated with the development of the SANE program will not only alert the community of the program but may provide free advertising for interested nursing personnel. Sending flyers to the local nurses' associations, schools of nursing, and other local institutions is another less expensive mechanism for locating interested and talented nurses. Recruitment strategies should include recruiting for nurses who are sensitive and knowledgeable of diverse community populations and the issues involving sexual assault.

Staff Training

If the new SANE staff is sent to an established SANE training program the cost will run approximately $250 to $500 per person, plus travel expenses (See Appendix D: SANE Training Programs). If a trainer is brought in to provide training, the cost will be $1,000 to $1,200 per day, per trainer, for 5 or 6 days of training, plus travel expenses (See Appendix E: SANE Trainers).

Program Media Promotion

Media attention spotlighting the plight of rape victims can generate considerable public response. Use this community interest and support to elicit improvement of services to rape victims. Media attention is particularly effective if an individual victim is highlighted. Many victims are willing and even anxious to tell their story to the media when they do not believe their needs were properly addressed at the time of the rape. This can offer an opportunity to constructively focus their desire to effect a change in the system for future victims. Before a rape victim goes public, however, staff should discuss with the victim the potential responses, both negative and positive, that might follow public disclosure.

Once the new SANE program is in operation, media attention can also be helpful in alerting potential clients to the availability of the service and how it can be accessed. The focus of this media coverage would include magazine articles, newspaper editorials, and television spots about general services and awards given to the program or a particular staff member. A testimonial from a rape victim would also be appropriate in this message.

Staff Salaries

Many variables influence the determination of staff salaries. Some variables are location of the SANE program not only geographically but also whether hospital-based or community-based. The number of sexual assault cases and the jurisdiction—urban or rural—affect the pay schedule. Please refer to Chapter 8: SANE Program Staff for a detailed discussion of SANE salaries.

Current SANE Program Funding

The survey of existing SANE programs found the following. Thirty programs were public nonprofit agencies, either associated with a nonprofit hospital, a nonprofit community program, or a government agency. Six were private, for profit, and one program characterized itself as a coalition. The yearly budgets ranged from $6,000 to $825,000 with an average of $122,000. It is rare to have all program funding from one source. Most programs rely on a variety of funding sources.

Many SANE programs (N=20) are directly reimbursed for services by Federal money that is administered by a State or county agency. The rationale is that, since the exam is being completed to collect evidence, the State, not the victim or her insurance, should pay for the cost of the evidence collection. This money may be provided directly from a State agency, however, it is usually disbursed to the

county and reimbursed on a per-case basis. Bills for each case are submitted by the SANE program for payment to a designated office, usually the law enforcement agency or the prosecutor's office. This reimbursement may be limited to a set maximum dollar amount that will be paid for each exam completed, ranging from as little as $75 per exam to $500 per exam. The reimbursement may also be payment of the actual charges for the evidentiary exam, without a set dollar limit. This reimbursement was found to cover a continuum of program costs ranging from 33 percent to as much as 80 percent of ongoing SANE program operating costs.

Additional funding is provided through government agencies, at the State level (N=18), at the county level (N=5), or at the city level (N=2). State money is often received as a grant through the State Department of Corrections or through a State Crime Victims Assistance or Crime Victims Compensation Fund. An additional 11 SANE programs receive Federal grant money.

SANE programs (N=44) also rely on donations from a variety of sources, including local foundations, corporations, businesses, churches, hospital foundations, women's groups, the United Way, universities, and individuals. Donations may support a specific clinical service, for equipment such as a colposcope or light staining microscope, or for ongoing operating expenses.

Most hospital-based programs (N=47), or 94 percent of the total of 50 hospital-based programs, are fortunate to have the hospital assume responsibility for the remainder of their costs not covered by grants, donations, or reimbursement for services. Two additional SANE programs have a consortium of agencies that share the additional, nonreimbursed expenses. Two of the 9 nonhospital SANE programs, have similar relationships with their sponsoring agencies, the YWCA and a Violence Against Women's program.

SANE Program Funding Options

The literature indicates SANE programs have been started using Federal research grant funding (Ledray & Chaignot: 80), local community foundation grants, community fund-raising (Frank: 96; O'Brien: 96a), and fee-for-service reimbursement from the hospitals served, police, and/or the county attorney's office (O'Brien: 96a). Some hospitals have an in-house SANE programs because they serve large numbers of sexual assault victims. Other SANE programs are independent nursing programs or agencies that contract with the hospital to provide services on an on-call basis and bill the hospital on a per case basis for the exam (Burgess & Fawcett: 96; O'Brien: 96a).

Where to Look for SANE Program Funding

The best funding strategy includes approaching a variety of resources including local private foundations, State agencies, and Federal resources. The U.S. Department of Justice Response Center will place interested fund-seekers on a mailing list to receive updated information on funding resources for violence against women programs. Call 800–421–6770 to be added to the list.

VOCA funding. The Victims of Crime Act (VOCA) of 1984 established the Crime Victims Fund, which is derived from fines and special assessments collected from Federal criminal offenders—not from tax dollars. The Crime Victims Fund is administered by the Office for Victims of Crime (OVC). Each year, OVC distributes approximately 90 percent of the Fund by **formula** to States to support victim assistance and compensation programs that provide services to Federal and State crime victims. All States and territories receive annual VOCA funding and, in turn, the States award VOCA Victim Assistance grant funds to local community-based organizations to provide services directly to victims of crime.

A limited amount of VOCA funds is also awarded directly by OVC each year in the form of **discretionary** grants to improve and enhance the availability of victim services. These discretionary grant funds support a variety of nationwide initiatives, such as developing training curricula, training victim service providers and criminal justice professionals, and identifying and disseminating information about promising practices in victims services. OVC discretionary funds do not provide operational funding for victim services organizations.

Community programs interested in obtaining a VOCA grant for operational funding should apply to the State agency designated by the Governor of their State to administer the State VOCA victim assistance grant monies. Appendix F contains a list of the State agencies that administer the VOCA Victim Assistance Funding. Each State has discretion to determine which organizations will receive funding based upon the VOCA victim assistance guidelines and the needs of crime victims within each State. Most States make awards on a competitive basis. Although many programs compete for this money, this is an excellent source of funding for sexual assault programs.

States also receive VOCA funding for their victim compensation programs that may be used to pay for evidentiary exams given to victims of sexual assault. States may disburse funds to a variety of State or county agencies that conduct the exams—very often a police or sheriff's department. Law enforcement agencies are more likely to mandate that crime victims report their victimization and cooperate with the prosecution in order for the examination expenses to be reimbursed. Victim advocates should understand that States have some discretion in defining the nature and extent of "victims' cooperation with law enforcement." OVC's most recent VOCA Victim Compensation Final Program Guidelines recognize that there may be cultural or psychological factors that undermine a victim's willingness to report sexual assault or to report the crime in a timely fashion. Thus, the VOCA Guidelines allow States to "accept proof of the completion of a medical evidentiary examination such as a report, x-rays, medical photographs, and other clinical assessments as evidence of cooperation with law enforcement in cases involving sexual assault or abuse" (Final Program Guidelines, Victims of Crime Act FFY 1997 Victim Compensation Program, *The Federal Register,* 14 February 1997).

To determine which agency is responsible for billing locally, contact an area hospital and ask whom they bill for the sexual assault evidentiary exam. Since the specific amount reimbursed and the services for which the SANE can be reimbursed typically vary from county to county, the SANE will need to contact the appropriate agency in her county and ask for a copy of the policy. If rape victims are examined from more than one county, a copy of the evidentiary exam reimbursement policy will be needed for each county. Reimbursement generally comes from the county in which the rape occurred, which will not necessarily be the county where the exam is completed.

More information on VOCA formula and discretionary grant funding, as well as OVC, can be obtained via the OVC Homepage on the World Wide Web at the following address: http://www.ojp.usdoj.gov/ovc/.

Reimbursement of costs associated with the forensic exam is a complex issue. According to a 1997 report by The Urban Institute prepared for the National Institute of Justice, "Medical costs and cumbersome restitution mechanisms in sexual assault cases continue to be a barrier for victims and discourage many women from seeking needed medical care and undergoing examinations to collect evidence needed for prosecution" (The Urban Institute: 97). In 1996, The Urban Institute conducted site visits to 12 States as part of its study of the S-T-O-P (Services, Training, Officers, and Prosecutors) grant implementation process. Most of the 12 States visited had long-standing State legislation that covered the waiver of charges for forensic examinations of sexual assault

victims; others passed similar legislation during final congressional consideration of the Violence Against Women Act (VAWA), which was sponsored by Senator Joseph Biden and passed by Congress in 1994.

The Urban Institute reported that hospitals incur substantial costs in conducting forensic examinations. Costs are around $800 if a physician conducts the exam; and substantially lower (between $200 and $300) if a trained nurse such as a SANE conducts the exam. The report continues as follows:

> State laws vary in the mechanism they specify for reimbursing hospitals and relieving victims of the burden of payment. Most of the 12 States visited by the State Institute had no State appropriation for covering these costs, and those that did usually did not appropriate enough funds to cover the need. One State had a backup fund that could pay for examination costs if other mechanisms failed. The various payment mechanisms, or lack of them, still leave victims with a financial burden in quite a number of States.... Most of the payment mechanisms established by the site visit States still leave some victims with either primary or secondary responsibility for payment because either they or the hospital have to apply for compensation to cover the cost of the exam. If the victim must apply, she must pay the hospital first and then seek reimbursement. Situations where hospitals may, and do, seek payment from victims include the following:
>
> - Low levels of reimbursement by counties do not cover most of the hospital's cost.
> - The victim has medical insurance that will cover the cost of emergency care.
> - Crime Victim Compensation Boards take years to pay claims, although they send an award letter relatively quickly.
> - Crime Victim Compensation Boards or county agencies reject victim claims for reimbursement because police reports indicate that a case is "unfounded" or because the victim "fails to cooperate with prosecution."

Another reimbursement issue is that only part of the procedure is forensic; the rest is medical. Many women, according to The Urban Institute Report, seek medical care in emergency rooms after a sexual assault with no intention of reporting the crime to police. In at least two States, States paid for "evidence collection" but not "followup services." Hospitals then either covered the cost or attempted to bill the victim for these "additional services."

VAWA funding. VAWA authorized a 6-year funding cycle for formula grants similar to the OVC victims assistance formula grants to the States. The VAWA funds are available to States to distribute to victim service agencies as well as prosecution, law enforcement, and the courts. Like the VOCA programs, most of the VAWA funding is distributed directly to the States through formula grants. The Violence Against Women Grants Office (VAWGO) is the Federal agency that administers the S-T-O-P Violence Against Women Formula Grant Program. Each State must allocate a minimum of 25 percent of S-T-O-P funds to nonprofit, nongovernmental victim services agencies. The State agency that administers the S-T-O-P grant determines the process for awarding subgrants. State are not required to competitively select recipient organizations. To be eligible for S-T-O-P funds, States must certify that they incur the full out-of-pocket cost of forensic medical examinations for sexual assault victims either by providing or arranging for free examinations, or by reimbursing the victim for the full cost of the examination. As discussed previously in this chapter in the section regarding VOCA funding, States utilize differing interpretations of what actions constitute victim cooperation with law enforcement to establish reimbursement eligibility.

Twenty-five percent of each State's S-T-O-P falls into a discretionary category, and the purpose of this funding need not be strictly law enforcement, prosecution, or victim services, but must conform to the broad guidelines of VAWA. Discretionary funded projects must still fulfill at least 1 of the 7 purpose areas of this program. More information

on VAWGO funding can be obtained via the VAWGO Homepage on the World Wide Web at the following address: http://www.ojp.usdoj.gov/VAWGO. The telephone number for VAWGO is 202–307–6026. Appendix F also contains a list of the State agencies that administer the S-T-O-P grant funds.

Byrne funding. The Edward Byrne Formula Grant Program, administered by the Bureau of Justice Assistance of the U.S. Department of Justice, awards funds to States for use by States and units of local government to improve the functioning of the criminal justice system. As one of the 26 legislatively authorized purpose areas, government units may make awards to subgrantees to provide assistance to jurors and witnesses and assistance, other than compensation, to victims of crime. The Edward Byrne Formula Grant Program may be a potential source of funding for some services designed to assist sexual assault victims. Appendix F contains a listing of the State agencies that administer the Edward Byrne Formula Grant Program.

Other Federal and private funding. There are other potential resources for SANE program funding beyond the U.S. Department of Justice. These include other Federal agencies such as the U.S. Department of Health and Human Services, private foundations, community foundations, grant making public charities, individual donors, and fundraising campaigns. The Foundation Center is an excellent source of information on the many grant funding resources. The Foundation Center does not make grants, rather, it provides information on those entities that do. In addition to maintaining libraries in Atlanta, Cleveland, New York City, San Francisco, and Washington, D.C., the Foundation Center has a nationwide network of affiliated libraries and nonprofit resource centers called Cooperating Collections. According to information provided by the Foundation Center on its Internet site, "These collections provide a core group of Center publications for public reference and some level of instruction on how to do funding research.... Every State has at least one Cooperating Collection, and many States have collections in more than one city" ("A Message to Grant-seekers" 1997, http://fdncenter.org/2onlib/2ufgall.html).

The Foundation Center also publishes many useful reference directories. One of the most useful is *The Foundation Directory* (Renz, Baker & Read: 96). It is frequently updated and lists all of the private foundations by State. It provides information on trends in foundation giving, how much grant money each foundation has available, to what geographical area, and for what purposes. This is a valuable resource when applying for private foundation funding.

Many Cooperating Collections of the Foundation Center also make available for public use a searchable database of funding resources called *FC Search: The Foundation Center's Database on CD-ROM*. The Foundation Center's main libraries and Cooperating Collections offer grant-seekers a myriad of services on site and on line, including access to publications, periodicals, training workshops, online tutorials on grant-funding research and proposal writing, online responses via e-mail to reference questions, and computerized databases. The Foundation Center is one of many resources available online and has links to other resources for grant-seekers on its Web site at: http://fdncenter.org/. A tremendous number of grant funding organizations now maintain their own site or homepage on the Internet including most agencies of the Federal Government.

Fundraising Process

The following processes are suggested for effective and efficient fundraising:

- Make sure the type of funds needed is an integral part of the developmental plan: startup funds, capital expenditures, general operating expenses, special project funds, funds to increase organizational capabilities.
- Gather information about potential program funding sources and support, including government, foundation, and local private

donors; fundraising activities; professional organizations with grant opportunities; and in-kind gifts and services.

- Analyze and synthesize the above information.
- Decide which prospects are most promising. Match the organization's interests with those of potential funders.
- Develop a time-line of proposal writing based on application deadlines, funding cycles, and program needs.
- Cultivate potential donors in the private sector: rely heavily on professional contacts and personal networking, relationships of the Advisory Board, community stakeholders, etc.
- Keep track of initial contacts made and potential donors' interests; invite potential donors to any and all events such as open houses, press conferences, exhibits, educational initiatives, public interest events.
- Keep donors and potential donors informed of program progress through letters, memos, a newsletter, telephone contacts, or one-on-one meetings and informal lunches.
- Focus on a distinctive characteristic of your project that sets it apart from other similar projects and that will appeal to and motivate a funding entity to support your program. The appeal might vary from one donor to the next. For government funding, a program might serve as a model; for a local business or organization, it could generate good will and promote the donor's community visibility, or provide an opportunity for unique collaboration.
- Follow up with donors who provide support with thank you letters. Always respond to requests for information and don't forget to ask for additional support.

Looking to the Future as You Begin

Clearly SANE program affiliations have a significant impact on program funding. Fifty of the 59 programs surveyed are hospital-based. Survey respondents indicated that program costs that exceed the program income are paid by the sponsoring institution in 88 percent of the programs which are hospital-based, compared to only 22 percent of the programs that are nonhospital-based. This is probably due to more limited resources and budgets in community programs as compared to hospital organizations. It appears that the decision to affiliate a SANE program with a large institution, such as a hospital, may be an effective choice in ensuring ongoing program funding.

Providing effective crisis intervention and preventive care for sexual assault victims is an important component in promoting health maintenance and preventing secondary injuries. Although the provision of these services may initially increase costs of the health care facility, research and careful accounting of direct and indirect costs can convincingly demonstrate that in the long term, overall costs can be reduced.

Summary

It is imperative to develop a funding strategy before establishing a program to ensure long-term financial solvency and continuation of the program. It may be possible to negotiate with the local hospital or a government or community agency to assume financial responsibility for the ongoing SANE program costs. Initial startup costs typically represent a large portion of the non-reimbursable costs of a SANE program. A local hospital may be willing to assume the future costs that exceed reimbursement, especially if the hospital administration understands that it is already assuming many hidden costs associated with treating sexual assault victims in a less cost efficient manner.

Obtaining ongoing grants and donations is a full-time job. A SANE program manager cannot do full-time fundraising and manage the day-to-day clinical program responsibilities. It is essential to plan ahead when establishing a new SANE program in order to reduce the amount of time and attention that the SANE program manager must place on ensuring the financial viability of the program.

CHAPTER 7

STARTING YOUR SANE PROGRAM

Once the decision has been made to develop a SANE program, the SART team will need to work together to create a vision of how the SANE program will be implemented. The strategic plan will be based on the SANE vision and mission statements. Developing a strategic plan not only involves a basic startup plan of operation but also anticipates obstacles encountered later on during the operation of the SANE program. Consequently, this chapter provides information about how existing SANE programs have approached many of the organizational decisions that need to be made (see Appendix G: Startup Checklist).

How Long Can It Really Take?

While every community is different, the average SANE program startup time is 1 to 2 years. It can take longer. This includes the time from the initial concept to actual service delivery. It will, of course, take longer in areas where there is more resistance and where fewer resources exist. Even in an area where the SANE concept is well understood and accepted and where there are ample resources, it will take at least 6 months for the necessary team building, strategizing, staff selection, and training.

Hours of Operation

The majority of existing SANE programs provide services 24 hours per day, 7 days a week, including holidays and weekends (Antognoli-Toland: 85; Ledray: 92a). One program indicated that in the initial stage, the SANEs completed exams during evenings, nights, holidays, and weekends with the ob-gyn residents completing the exams during the day Monday through Friday (Thomas & Zachritz: 93). After a few years of operation, this SANE program proved to be so effective that the SANEs assumed the caseload 24 hours a day. While there may be times when the SANE is not available for unavoidable reasons such as severe weather warnings with travel restrictions, it is important to plan to provide complete coverage 24 hours a day, 7 days a week.

Population Served

All programs that report client gender in the literature see both females and males. Some programs see adults, adolescents, and children (O'Brien: 96a; Speck & Aiken: 95); others see only adults and adolescents (Arndt: 88; Ledray: 96a). Some programs started with a more limited patient population and then expanded the age bracket served (Ledray: 96a; O'Brien: 96a).

Several SANE programs plan to add forensic examination of battered women, children who are physically abused, and other crime victims, as well as the possible addition of automobile accident victims to their existing services. Several programs complete nonliving victim forensic examinations, and others are considering doing so as well.

Even if the intent is to eventually see all ages of rape victims and populations other than sexual assault, it would be wise to start with a small well-defined population and expand services to additional populations as staffing, funding, and other resources allow. This is especially important when there is not a firm figure available of the expected caseload.

Deciding on Program Location

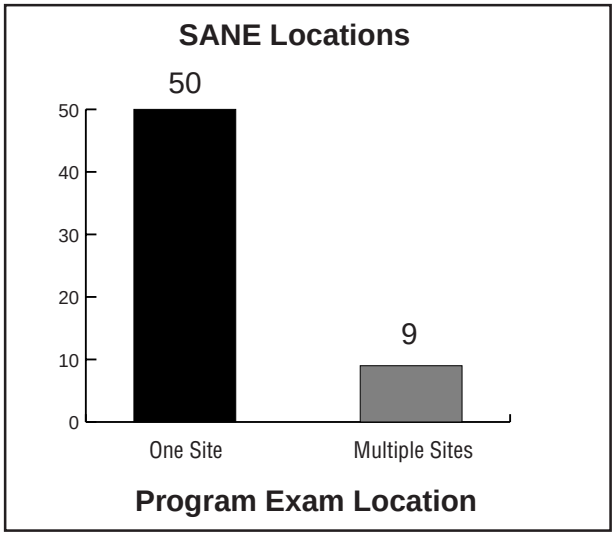
When establishing a new program, one of the most basic decisions is the location of the SANE examination site. Since SANE programs provide service 24 hours a day, 7 days a week, safety and security for staff and victims is an important consideration.

Other considerations include the following:

- Physical and psychological comfort of the client.
- Access to medical support services to provide for care of injuries.
- Pharmacy or medication access.
- Access to psychological support services.
- Access to laboratory services.
- Access to the necessary supplies and equipment to complete an exam.

One Location or Multiple Exam Sites

Fifty of the SANE programs responding to the survey routinely complete exams at only one location. Ten of these specified that they will go to other locations such as the jail (for suspect exams), morgue, health department, women's clinic, or other hospitals to perform evidentiary exams, if necessary. Examples where an evidentiary exam might be completed in a location other than the primary exam sites are when a SANE program that usually sees clients at a community clinic transfers a client with injuries to the ED for emergency care. Another example is when a victim first goes to a referring hospital with injuries that make it difficult to move her to the primary SANE exam site. In both cases, the SANE goes to the ED to complete the exam.



Nine programs surveyed routinely go to more than one site to complete exams. Five of these go to two hospital EDs, one goes to two different hospital clinic locations, and one goes to seven different hospital ED locations. The later program will soon be adding an additional location, a university medical clinic. One free-standing program routinely goes to nine different community locations, including EDs and clinics to complete exams. Another goes to four sites including a jail, two different EDs, and a clinic.

Advantages of a Single Exam Site

The primary advantage of a single location is that all necessary exam supplies and equipment can be centrally located in a setting familiar to the SANE and only one set of equipment is necessary. Duplicating the equipment at more than one site can be very costly, especially when a colposcope is used. Colposcopic examination is quickly becoming state-of-the-art.

Disadvantages of a Single Exam Site

Hospital administrators understandably do not like to be in a position of sending their clients to another facility for care, especially to another hospital ED. It is inconvenient for the victim; it makes the hospital staff appear less capable; and hospital administrators perceive it as bad for business. Because of these facts, many hospital administrators would prefer that the SANE come to their facility.

When initially deciding if nurses should go to other hospitals, or if all victims could be sent to one hospital site, the Sexual Assault Resource Service (SARS) in Minneapolis kept track of the number of rape victims sent from a nearby hospital to their one exam site at a different hospital, over a 3-month period. Only one out of three clients reporting a rape at the referring hospital made it to the second hospital where the SANE program was located, even when many were given a cab voucher for transfer (Ledray, Linda E. Unpublished data. Sexual Assault Resource Service, Minneapolis, MN, 1984.) Based on these results, the

Minneapolis SANE program decided that additional hospital sites would be added. Approximately one hospital ED site was added each year until SARS was providing services to all seven hospital EDs in Hennepin County, with a 1-hour maximum response time.

Adapting the SANE Program to Multiple Exam Sites

To deal most effectively with multiple exam sites, SARS has a space identified for SANE supplies at each hospital and has, in addition, provided each SANE with a portable exam kit (a large tackle box) where routine supplies and paperwork are kept for easy transport. Hospitals wanting the SANE to come to their facility are responsible for obtaining the necessary pieces of large equipment that cannot be transported. Every effort should be made to keep the policies and procedures as consistent as possible at all seven hospitals to avoid confusion, especially with new hospital or SANE program staff.

Another program with multiple hospital sites decided to compromise by locating their equipment, including a colposcope, at one hospital where the SANE does the majority of their exams. The SANEs remain available to go to other specified sites when necessary if injuries preclude transport to the primary site. In these cases, the SANE will carry routine supplies and paperwork in a portable exam kit.

Disadvantages of Multiple Exam Sites

A disadvantage of multiple sites for the SANE staff is that even when every effort is made to maintain consistency, equipment, policies, and procedures vary somewhat from site to site. Dealing with these variances can be confusing, especially for new staff.

Regional SANE Programs

Especially in rural areas where no one medical facility sees large numbers of sexual assault cases, multiple sites covering a regional area but using the same SANE staff may be the only cost-effective method of providing SANE program services. These sites will likely span a large area with several community hospitals or clinics involved, and the SANE may travel 2 hours or more to reach some examination sites.

Regional SANE programs are also an important alternative from a staff training and competency perspective. By serving a larger, regional area, the SANE staff will see more clients collectively and each will be able to complete a sufficient number of exams to develop and maintain their clinical competence.

Regional SANE programs may be sponsored by a single agency and provide services to other agencies in the region on a fee-for-service basis, or the program costs may be shared by a consortium of agencies.

Community-Based Program Exam Sites

Of the nine programs that are administratively community-based programs, five also do the exams in a community-based facility: two of these have exam sites in a free-standing clinic; two at rape crisis centers; and one in a YWCA. The other four are community-based administratively, but they actually do the exams in a hospital: one of these programs completes exams in two hospital EDs and three complete the exams in hospital-based clinics specifically set up for their use.

The community-based programs typically refer to an ED for treatment of injuries, and all but two have a medical director. The two programs without an identified medical director both have a physician who reviews their protocols on a consulting basis.

Programs with community-based exam sites, such as the Memphis program and the program operating at the YWCA, Grand Rapids, Michigan have a very specific protocol for the evaluation of injuries and for medication standing orders. They also have a medical director who is readily available by pager. In Grand Rapids, when a rape victim comes to a

referring hospital, hospital staff page the on call rape crisis volunteer advocate and the police. The advocate calls the SANE and then directs the victim to the YWCA. If necessary, the advocate may go to the hospital and escort the victim to the YWCA, where the SANE and the police meet them. Since the YWCA building is not open 24 hours a day, the police officer also provides security after normal operating hours. The SANE performs the urine pregnancy test (UPT) using a simple 4-minute urine test similar to the home pregnancy test and prepares and examines a wet mount for motile sperm. All the medications are located on site and are given to the victim prior to her departure (Dunnuck, Chris. Personal communication. 25 November 1996).

Although programs completing exams outside a hospital setting are few in number, they do offer some advantages to the hospital-based program. In States where hospitals are mandated to report felony crimes, the State statutes for mandated reporting do not apply to these community-based programs. In these cases, the SANE will encourage reporting but will ultimately respect the decision of the client. There is also more privacy in a community-based exam site. Especially in a small community, it is likely that the victim or her family will encounter other people they know. All necessary supplies and equipment are usually located at the community-based exam site for easy access. In addition, there is no additional billing for medical care or services.

Hospital ED-Based Exam Sites

Two of the initial three programs developed in the 1970's were based in a hospital ED, and one was located at a community clinic. This trend has continued today with the vast majority of identified programs indicating that they are hospital ED-based. Fifty of the 59 programs responding to the survey are hospital based. Thirty-nine of these programs primarily complete exams in one or more EDs, eight in a hospital clinic, and three in both a hospital clinic and the ED.

Advantages of the ED Exam Site

There are numerous advantages to completing the evidentiary exam in the ED. The ED operates 24 hours a day, 7 days a week and is a secure facility with a wide array of support services available on site. Physicians are available for easy consultation about medications and injuries. Any medications ordered can be dispensed to the victim prior to her discharge, ensuring she gets the necessary medications. Laboratory facilities are readily available to complete tests such as UPT's, and if necessary, to assist with a blood draw.

Often rape victims come to an ED seeking care for minor injuries or wanting treatment for STDs or because they are concerned about being pregnant. If the SANE program is located in the ED, the SANE comes to the ED to complete the evidentiary exam. Furthermore, the victims do not have to be sent elsewhere because all the necessary medical expertise is readily available to evaluate and care for any sustained injuries.

The medical expertise available in the ED does not come without a price, however. If the cost of the ED overhead and ED physician fee is charged to the victim, to her insurance, to the SANE program, or to the State reparations board, it can represent a sizable sum. It is important to decide if the cost is justified. We now know that only a small percentage of victims, 22 percent to 27 percent, have even minor injuries such as bruising or a cut, which require no treatment. Even fewer, 3 percent to 4 percent, have injuries requiring treatment, and less than 1 percent are so severely injured they require hospital admission (Solola & Severs: 83; Tucker, Ledray & Werner: 90).

To better determine how often the SANE was concerned about potential injury even after the victim had been cleared by the ED staff, one study reviewed 164 SANE cases completed between June and November of 1996. In 44 (27%) cases, the SANE requested additional medical evaluation of injuries (Ledray, Linda E., Unpublished data. Sexual Assault Resource Service, Minneapolis, MN, 1996). It is possible that the ED staff would

triage for injuries even more thoroughly if they knew the client was being moved to a nonmedical setting. It appears this extensive medical coverage is utilized with a very small number of victims, and it is not necessary in most cases.

Overcoming Disadvantages of the ED Exam Site

To keep the costs down and retain service in the ED, one solution may be to negotiate a more reasonable fee for the use of the ED and ED staff time. One program has negotiated a $50 fee for the use of the ED, which also includes the physician's time and all medications given the victim (Kathy Bell. Personal communication, 26 November 1996). Community-based programs may actually charge the hospital a fee for coming to the ED to complete the exam for their clients (Colleen O'Brien. Personal communications. 25 November 1996).

EDs can be busy, inhospitable locations, where the victim's privacy may be compromised. Care must be taken to shield the victim from distractions and loss of privacy. Often a specific exam room away from the center of the ED can be fitted with a pelvic table and designated for the use of the SANE. Simple additions such as wallpaper, a more comfortable chair, a shower for use after the exam, and a telephone can significantly increase the comfort level of the victim.

Hospital Clinic-Based Exam Sites

Eight of the hospital-based programs and three additional programs that are administratively based in the community conduct their exams in hospital clinics. These clinic settings include urgent care, a women's assessment center, and clinics specifically designated for sexual assault victims. The community-based programs that use hospital clinic space are usually in donated space, and the victim does not become a hospital patient unless she has sustained injuries and is transferred to the ED for treatment.

One clinic-based program initially completed exams only in the ED, but recently moved all of its exams to a clinic located close to the ED. Two other programs, currently ED-based, are considering a similar move in the near future. In many ways, this appears to represent the best of both worlds. The clinic locations are away from the hustle and bustle of the ED, and the high overhead costs. The patient doesn't need to go to a second location when she reports her rape to the ED; she is simply walked down the hall to the clinic when the SANE arrives. Family and friends can use hospital facilities, such as the coffee shop, while waiting, and they can still contact the triage nurse with questions while the exam is being completed.

If the SANE is concerned about injuries she feels require further evaluation, or if she wants to consult with a physician about medications, that is easily accomplished in a hospital clinic-based program. Laboratory facilities and support are also readily available, and prescriptions can be filled at the hospital pharmacy and sent home with the victim. In addition, hospital social workers, crisis psychiatric nurse consultants, or a chaplain is likely to be available on site to sit with a distraught victim or family member until the SANE arrives.

Summary of SANE Location Trends

The majority of SANE programs continue to be hospital based, with most located in the ED. However, there seems to be a new trend to locate SANE programs outside of an ED. Fourteen of the 59 programs responding now complete exams in a hospital clinic, 11 of these only complete exams in a clinic, and 2 also complete exams in the ED. It is expected that others will soon follow this trend by adding clinic exam sites.

Now that the credibility of the SANE model has been established, it is no longer necessary for the close medical supervision of the ED setting. Research demonstrates that few victims sustain injuries requiring ED care. While communities

certainly have different resources and different needs, a hospital-based clinic setting, especially one in close proximity to the ED for referrals and security at night, appears to have more advantages than disadvantages. The community-based program site, however, also offers some advantages over the hospital-based program. For example, some States mandate hospitals to report felony crimes, but these State statutes do not apply to the community-based programs. While the SANE will encourage reporting, she will respect the decision of the client. Also, the victim's privacy is more protected in a community-based exam site. Finally, the victim does not receive additional billing for medical care or services.

CHAPTER 8 SANE Program Staff

Who typically directs a SANE program and who is best qualified to do so? To whom does the director report and what role does she play? What qualifications do existing SANE programs look for when hiring staff? How large of a staff is needed? How are SANEs typically paid, and what are the options? Selecting the right staff is a critical step toward establishing a successful SANE program. This chapter provides information on how existing SANE programs have responded to these staffing questions and which options to consider when starting a SANE program.

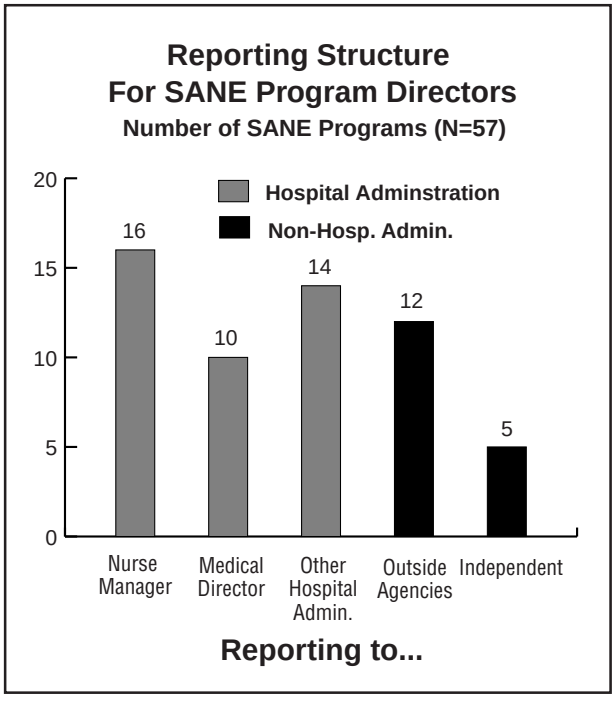
SANE Program Directors

Fifty-three (93%) of the SANE programs responding to the survey have nurses as the SANE program director. Of the six remaining programs, one is run by a physician's assistant (PA); one by a social worker (M.S.W.); one by a nonnurse health administrator; one by a nonnurse educator (M.S. Ed.); and two by physicians. Followup phone calls to the nonnurse directed programs revealed that four of these programs have a nurse identified as the program coordinator who functions in much the same way as a nurse program director. The two exceptions include the program run by an M.S. Ed. that is operated jointly with a rape crisis center and a unique program operated by a PA and primarily staffed by PAs.

Reporting Structure

Forty of these SANE program directors report directly to hospital administration. Of these 40, 16 report to a nurse manager (of these 16, 9 are the emergency department nurse manager); 10 report to a medical director (of these 10, 8 are the director of emergency medicine). An additional 14 of the 40 report to a hospital administrator including the VP of patient care (N=4); assistant administrator (N=3); hospital CEO (N=2); ambulatory services (N=2); ED administrator (N=1); human resources (N=1); and a specialized women's health clinic director (N=1).

Twelve SANE program directors report to agencies outside of a hospital administrative structure. These include a rape crisis center director (N=2), YWCA administrator (N=2), district attorney (N=2), police detective (N=1), family violence coordinator (N=1), and advisory boards or coordinating boards (N=4). Five programs are independent and indicate no reporting structure outside their organization. Two programs did not respond to this question.



Job Duties

In most SANE programs, the director is responsible for the overall program operation and vision, as well as managing the day-to-day operation of

the SANE program. The director may also be responsible for the budget, including the procurement of the necessary funding for ongoing program operation. The director is responsible for staff recruitment, hiring, training, and continuing professional development. Another important job function includes avoiding or reducing staff burnout by keeping the job environment as healthy as possible for the staff and for herself (an important topic, that is discussed in greater detail in Chapter 14, Maintaining a Healthy Ongoing Program). Providing staff with a safe, supportive work environment ensures that the staff feels comfortable bringing its questions, concerns, and issues to be discussed and resolved. In addition, the SANE program director must ensure that adequate staff is available and that backup emergency options are in place for providing continuous program coverage.

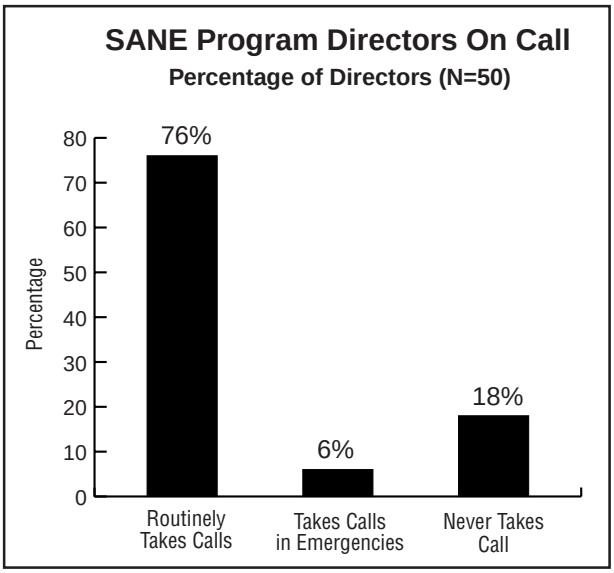
The SANE program director serves a valuable role as the liaison with other community agencies. She must be an active member of the SART team and may be a key player in ensuring that the team membership remains active and involved. Many SANE directors are actively involved in community education about sexual assault issues and the role of the SANE. This may include both informal community presentations and formal classroom instruction at the local university.

It is also the director's responsibility to oversee ongoing program evaluation and research activities and ensure that the results of these efforts are incorporated into modifying and improving the program.

On Call

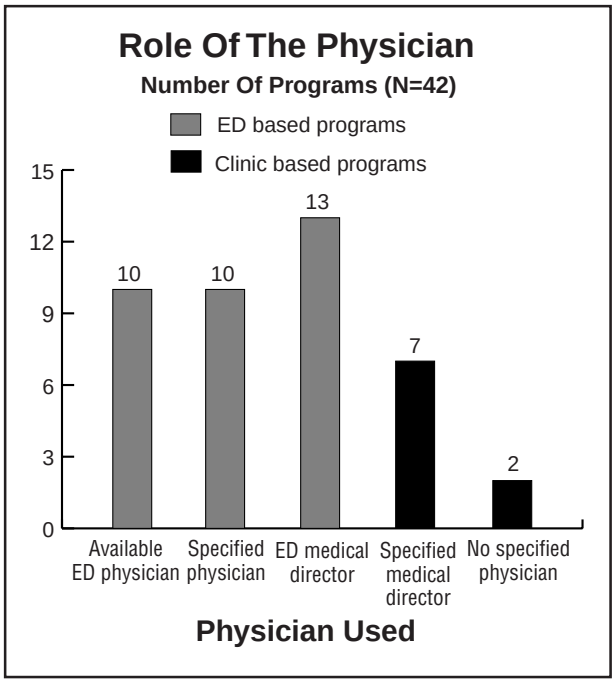
Most SANE directors are RNs who are actively involved in the clinical component of the SANE program and take call. Sometimes this is done to meet the needs of the program, but it is usually seen as an important way for them to maintain their professional expertise and credibility as well as enhancing job satisfaction.

The survey results indicate that the majority of the directors, 76 percent (N=38), take call routinely. Many of these are smaller programs where the director takes call during weekday office hours. If the director is on salary during this time, she is not paid additional on call pay. A director who takes call when she is not salaried is usually paid or receives compensatory time. One director, who owns a private, for profit, SANE program, is not specifically compensated for on call time. In three programs, 6 percent, the directors only take call during an emergency. They may fill in during off hours that cannot be covered by the other staff, or they work "backup" call taking the cases that come in when the primary nurse on call is already busy conducting an exam. Nine directors, 18 percent, never take call, even those who are qualified to do so.



The Role of the Physician

Of the 33 ED-based programs responding, approximately one-third (N=10), have no medical director but rely upon the physician available in the ED to staff SANE cases and sign off prescribed medications and charts in the ED. Ten others have a specified physician who approves their protocols and routinely reviews their cases. The remaining 13 consider themselves a part of the ED, and the ED



medical director is their medical director as well. Seven of the nine clinic-based programs have a specified medical director, two do not.

Staff Selection

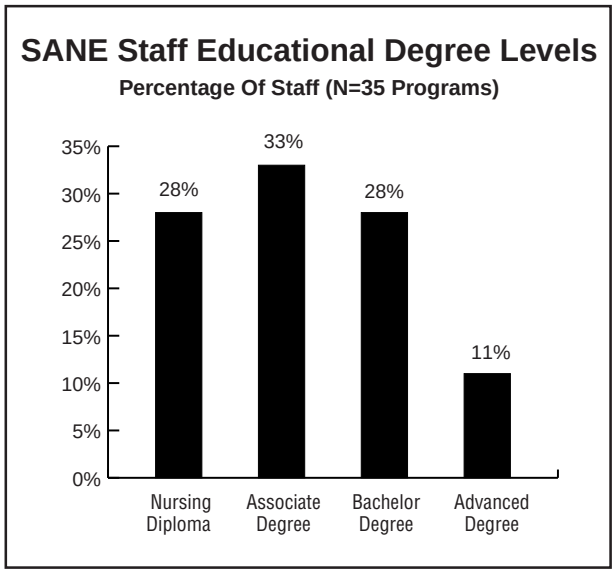
Most SANEs are female nurses. In the survey of SANE programs, only one program indicated that it has a male nurse who takes call. Studies show that approximately 50 percent of victims, even male victims, prefer to have the exam completed by a woman and sometimes insist on being seen by a woman (Wright, Duke, Fraser & Sviland: 89; Ledray: 96a; Lewington: 88).

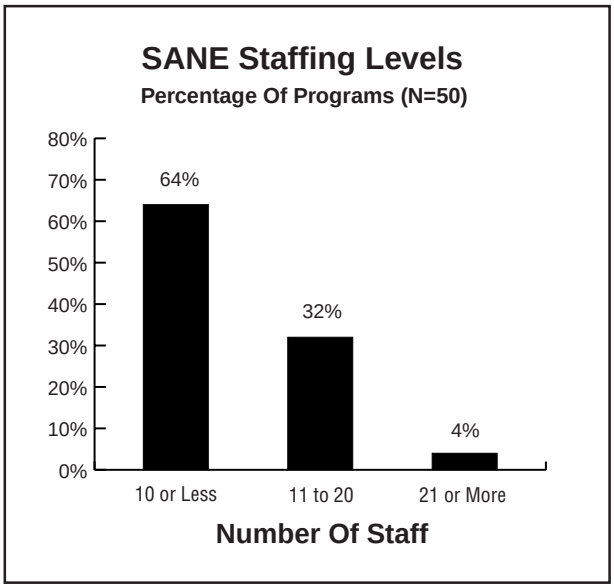
Good clinical skills along with good written and oral communication skills are identified as important qualifications for a SANE (Antognoli-Toland: 85). A background in obstetrics-gynecology and psychiatry, as well as experience in positions that require independence, such as public health nursing, school nursing, and ED nursing is preferred by one program (Ledray: 92a). Good assessment skills, including the ability to evaluate a situation and know when to ask for help, are essential staff requirements (Ledray: 93b).

One program director indicated that while she would never exclude a nurse solely on the basis of past victimization, she is aware that it is essential for nurses who are rape victims themselves to resolve their own issues through formal counseling prior to employment as a SANE. The director believes extensive counseling enhances the SANE's ability to maintain personal and professional boundaries. Even many years later after extensive counseling, difficult periods may occur, such as the anniversary of the SANE's rape or a particular case that is too close to her own experience, which may prevent her from being effective. Even though a past rape experience may give the nurse more empathy, a SANE cannot help someone else resolve issues if she has not yet effectively resolved them for herself (Ledray: 92a).

While many SANEs have advanced nursing degrees, the majority do not. It has been clearly demonstrated that an advanced nursing degree is not necessary to successfully function in this role (Ledray: 96a). Moreover, since large pools of nurses with advanced degrees are not readily available in many metropolitan areas, they certainly would not be available in rural communities. The minimum requirement is that the individual is a registered nurse (RN). While one forensic program is run and staffed by physician assistants (PA), and two programs have physicians taking call, by definition they cannot be SANEs. It is not recommended that they be hired in this capacity. While physicians and PAs certainly can complete an evidentiary exam, they may require a higher salary compensation, and this may become an issue in the clinical practice of the group. In addition, PAs cannot function independently as the RN can. PAs can legally only practice under the direction of a physician.

The 35 programs reporting the educational level of SANE staff, indicated that they had a nearly equal percentage of nursing diploma (28%), associate degree (33%), and bachelor degree (28%) prepared nurses working as SANEs. A relatively large number of SANEs were with advanced degrees (11%).





Staffing Patterns

Determining the SANE staffing level depends on the number of cases expected monthly, coupled with the consideration that regardless of the number of cases, SANEs must be available 24 hours a day, 7 days a week. Only one program surveyed indicated it was not able to provide continuous coverage due to a shortage of staff. Two programs with continuous coverage were, however, able to do so with just ONE SANE! One of these nurses saw 80 cases per year and worked another job as well. She did occasionally take a vacation, at which time the ED staff completed the sexual assault exams. The general consensus from SANEs is that, while possible, it is extremely difficult to complete more than two sexual assault exams without time off between cases.

Of the programs surveyed, 32 (64%) had 10 or fewer staff taking call, 16 (32%) had 11 to 20 staff, and only 2 programs (4%), had more than 20 staff. One of these had 30 staff and completed 1,600 exams a year; the other had 36 staff and completed 200 exams per year.

Only 31 programs reported both the SANE staff number and the number of exams completed each year. Of these, the reported staff to exam ratio varied from a low of one staff to three exams, to an extreme high of one staff to 225 exams per year.

The majority of programs, (84%), reported a manageable SANE to exam ratio of 40 exams or less per year, per SANE: 12 programs, (39%), reported a SANE to exam ratio of 10 or less per year, per SANE; 10 programs, (32%), reported a SANE to exam ratio of 11 to 20 cases per year, per SANE; 4 programs, (13%), reported a SANE to exam ratio of 21 to 40 exams per year, per SANE. Five programs, (16%), reported a very high ratio of 75 to 225 exams per SANE, per year.

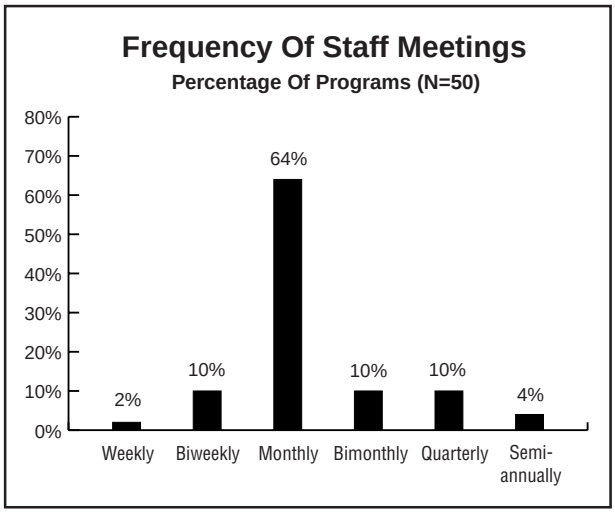
The program with the highest SANE to exam ratio of 1:225 employed only four SANEs in a program that averaged 900 exams per year. The next highest ratio was 1:120. In this program 10 SANEs see an average of 1,200 cases per year. Unlike any other program, SANEs in this program are paid a salary for 8 hours Monday through Friday when most of their cases, child sexual abuse cases, are seen by appointment. They also work on call during the evenings, nights, and weekends. They are paid $30 per hour, and their nursing coordinator reports these SANEs want more hours rather than fewer hours (Pat Speck. Personal communication. 16 January 1997).

Staff Meetings

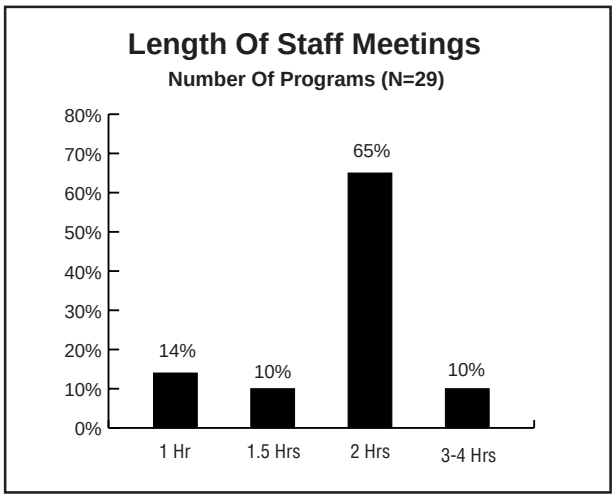
Because SANEs work in isolation, it is essential that they have the opportunity to meet regularly to

discuss cases, policies, and procedures; to receive additional training and support; and to "debrief."

Of the programs responding to the survey, the majority, 64 percent (N=32), meet on a monthly basis. Another 10 percent (N=5) of the programs meet biweekly, 10 percent meet bimonthly, and 10 percent meet quarterly. Only 4 percent (N=2) meet semiannually, and 2 percent (N=1) meet as frequently as weekly.



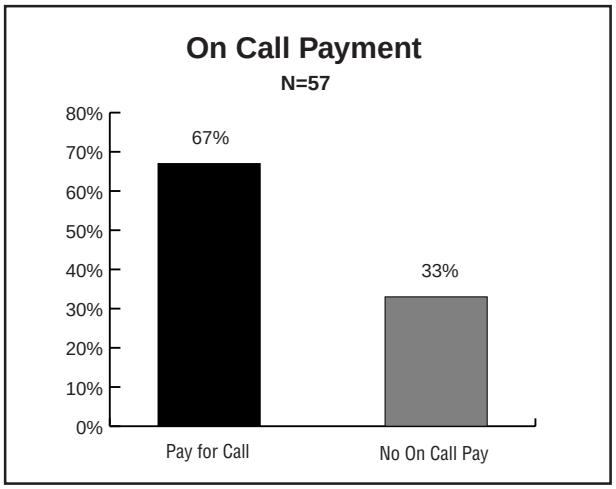
Sixty-five percent (N=19) of staff meetings last 2 hours, while 10 percent (N=3) last 1.5 hours, and 14 percent (N=4) last 1 hour. Three programs responding (10%) indicated their staff meetings can last 3 to 4 hours. One of these programs meets only quarterly and two programs meet monthly.



SANE Salaries

The literature indicates that most SANE programs pay the nurses per case for the exam. The range documented is from $100 per exam (Bell: 95; Massachusetts Nurse: 95; Thomas & Zachritz: 93) to $150 per exam (Frank: 96). One program indicates that they pay the SANE a 3-hour minimum at the local staff nurse salary level, more if the exam takes longer than 3 hours (Ledray: 92a). The programs paying more for each exam indicate that they do not pay for costly on call time (O'Brien: 96; Thomas & Zachritz: 93). One program reported that they pay the SANE $50 per hour for courtroom testimony (O'Brien: 96) and another pays $100 per appearance (Thomas & Zachritz: 93).

The survey results were somewhat different than the literature. Two-thirds of the responding programs indicated that they paid for on call time and one-third did not.



On call pay ranged from $1 per hour to $7.50 per hour, with an average pay of $2.89 per hour for on call time. The programs not paying for on call time did not necessarily pay more for exams. The lowest paying program pays no on call time and paid the SANE $18.00 per hour for the exam. The highest paying program was the program with the 1:225 staff to exam ratio that hired only nurses with an advanced degree. In addition to paying $30.00 per

hour for day shift work during the week, they pay $5 per hour for on call time, and $200 per case when called in for an exam.

SANE programs with a small number of cases, often in rural areas, simply cannot cover the high cost of on call pay. In some areas, the hospital nursing union contract may require the hospital to pay nurses on call pay. In these instances, the SANE program may need to negotiate with the union to make an exception for the SANE program. If this is not possible, the SANE program may need to be administratively based outside the hospital to avoid cost prohibitive on call pay requirements.

One-third of the responding programs pay the SANE a per case rate for the exams with a range of $50 to $200 per exam. The other two-thirds of the programs pay an hourly rate from $18 to $50 per hour for the actual time spent completing the evidentiary exam. The average rate paid is $25 per hour for the exam. Some programs indicate they pay a rate equal to the community staff nurse hourly salary, others pay 1.5 times the community staff nurse salary. Some have established a minimum number of hours the SANE is paid when she responds to a case. This minimum ranged from 2 to 4 hours. The time estimated to complete an exam ranged from 2.5 to 5 hours with an average of 3.2 hours. More than half, 30 programs, also pay the same hourly rate for attending staff meetings.

SANE Staffing Recommendations

The following SANE staffing recommendations are based on the results of the survey indicating current practices, the literature reviewed, and the experience of the advisory committee.

Program Director

The individual best qualified to act as a program director is a SANE qualified to complete the evidentiary exam and who maintains her competence. This recommendation is based on survey results indicating the frequent need for SANE program directors to take primary and emergency backup call. This provides an important depth of coverage not otherwise available. It also gives the director considerably more credibility with her staff and the community.

In some States, the SANE director can also be called to court as the “keeper of the records” to testify to the facts contained in the records collected by SANEs on her staff. As a SANE, the director can also testify as an expert witness if she maintains her clinical competence.

It is also important that the program director have management skills, including budget and program evaluation skills so that she is able to effectively represent the program in the community. A knowledge of community resources is useful. The ability to conduct staff training, to provide community and professional education, and to make conference presentations is an equally important qualification for an effective SANE program director to possess.

The program director does not need to occupy a full-time position; in fact, in most smaller SANE programs, the position is not full-time. To have some paid administrative time available for the director is always necessary, but the amount of time will vary greatly with the size and budget of the program. Having the director function on call regularly is also an effective means for her to augment her income while maintaining her clinical expertise.

Medical Director

While a relationship with a physician is essential for prescription and injury protocols, and general medical consultation, it is not necessary to have a medical director. SANE programs are nursing programs, and the primary activities are nursing activities not requiring medical authority. Because of this, a reporting authority through nursing is sufficient.

If the decision is made that medical authority is preferred, identify a consulting physician who is familiar with the program needs and who will be available for consultation and to help establish protocols. Programs based at a medical facility can utilize physicians on duty, to sign prescriptions at the time of the exam.

SANE Staff

Any interested and qualified registered nurse who completes the training is qualified to be a SANE. An advanced degree is not a requirement. The training must be conducted by an experienced SANE, preferably with at least 2 years of SANE experience. Continuing education and SANE exam experience requirements should be met yearly for continued active SANE status.

Summary

Although national standards have not yet been established, the survey of existing SANE programs has identified many similarities. By far, the majority of SANE programs are directed by nurses who report to a nurse manager or hospital administrator. All but one SANE identified is female, and only 11 percent have advanced degrees, reinforcing the recommendation in the literature that an advanced degree is not necessary and should not be a requirement when developing a SANE program. While most programs employ 10 or fewer SANEs, staffing patterns vary greatly and are not directly a function of the number of exams completed per year.

Salaries vary greatly and range from a low of $18 per hour with no on call pay and no additional per exam pay to a high of $30 per hour for scheduled hours with a $5 per hour on call pay, and $200 per exam when not on salary. Two-thirds of the programs pay for on call time at an average rate of $2.89, and two-thirds pay an hourly rate for the exam time averaging $25 per hour.

While the number of SANEs hired and the number of victims requiring services vary greatly from program to program, sufficient staff should be available so that a SANE does not routinely complete more than two exams during one on call shift. Establishing and maintaining an on call schedule is addressed in the next chapter.

CHAPTER 9 SANE TRAINING

The registered nurses (RNs) who are selected for SANE duties must receive the proper training to ensure that they perform effectively in the SANE role. No matter how motivated an RN may be or how well she functioned in her former positions, the SANE program will not be successful unless each employee has the proper training for her particular role. What training is needed? How are programs today training their staff? What are the current training options? Where can staff go for training? Who is qualified to do SANE training?

Choices must be made between the ideal situation and the realistic training needs of the program. The goal must always be to provide the best possible training for the SANE staff that is possible with the resources available and without putting unrealistic demands on either the staff or the budget.

Certification

National Certification

There is currently no national SANE certification. However, the IAFN recognizes the importance of establishing national-level certification for SANEs to ensure both consistency in practice and credibility in the courtroom. As a first step toward this end, a committee chaired by Patricia Crane, MSN, NP, RNC and cochaired by Diana Schunn, RN, BSN, has developed goals for SANE training programs and is working on recommendations for SANE training curricula. These were approved and adopted by vote of the SANE council at the October 1998 IAFN conference. They will be available through IAFN.

State-Level Certification

State-level certification is an option being considered by several States, since at this time, there is no standardized national certification or training requirements for SANEs. Massachusetts has recently developed a statewide sexual assault training program under the auspices of the Public Health Department for both nurse and physician certification. Massachusetts requires recertification every 2 years based on competency (Massachusetts Nurse: 95). Texas has established a multidisciplinary group working out of the Attorney General's Office and criteria for State level certification (J. Ferrell. Personal communication. 3 October 1998). Other States may follow with similar requirements.

The desire to develop State certification or licensure in the absence of national certification is largely driven by the desire to establish credibility when the SANE is required to testify in court. However, since IAFN is actively seeking to develop national standards and certification, State agencies may better meet their needs by concentrating on providing solid basic SANE training for their local SANE programs to ensure their credibility in the courtroom rather than focusing on the credentialing process.

A problem inherent with State credentialing is that there will likely be considerable variation in expectations of the practicing SANE and a lack of consistency in the training requirements from State to State. Implementation of State certification will probably create a new level of government regulation of SANE practice that may be impossible to dismantle when national certification is implemented. Each State will then need to decide if the national certification will be required instead of the

State requirements, or justify why the State requirements will be required in addition to the national requirements.

Local Certification

It is important to note that even when a specific trainer provides "certification" after completing a SANE training course, it is important to ask who or what institution is "certifying" the training, since there is no nationally recognized certification. In most cases it is a local hospital or SANE program. Continuing Education Units (CEU) should always be provided with training.

SANE Training Options

A common question from someone wanting to start a SANE program is "Can I send one person to a training program, then have her come back and train the remainder of the staff?" The overwhelming advice from experienced SANEs is "NO!" While the question is usually asked in an attempt to reduce initial startup costs, which is an understandable concern, the training will not be adequate, and the quality of the SANE program will be jeopardized. Cut costs somewhere else.

There are three primary options for SANE training. The first option is to send the entire staff to an established basic SANE training program. A second option is to hire a qualified SANE trainer to come to the community to conduct a complete training program for all SANE/SART staff. The third option is to organize part of the training locally, utilizing local expertise, and hire a qualified SANE trainer to come to the community to conduct the portion of the training specifically related to SANE evidence collection and documentation. This person may or may not also act as a consultant to the program.

SANE Training Today

In the survey of existing SANE programs, approximately one-third of the programs surveyed provide their own SANE training and two-thirds utilize an established SANE training program for the initial training. Existing basic SANE training programs typically consist of approximately 40 hours of classroom instruction.

SANE Training Topics

- Definition of the SANE role.
- Collection of evidence (including forensic procedures such as maintaining the chain-of-evidence).
- Testing and/or treatment of STDs.
- Evaluation and prevention of pregnancy.
- Typical victim responses and crisis intervention.
- Assessment of injuries.
- Documentation.
- Courtroom testimony (Mock Trial).
- Corroborating with related community agencies.
- Competently completing an exam.
- Forensic photography.

Some programs also specify a designated number of clinical hours after completing the classroom training. The range, when required, is from 40 hours (Kettleson: 95) to as many as 96 hours of additional clinical experience (Antognoli-Toland: 85). Additional clinical hours usually include experience in the following areas:

- Normal vaginal speculum and bi-manual examination experience.
- Normal well-child examinations (for programs seeing children).
- Courtroom observation.
- Specified number of adult or child evidentiary exam observations.

Most programs do not have a set number of required clinical hours but rather train until the new SANE indicates that she feels comfortable with the procedures and demonstrates competency. Some programs require the trainee to return a signed certificate of completion for the clinical component prior to receiving their course completion

certification. Other programs require the trainee to demonstrate competence utilizing a competency checklist for each clinical skill (Gaffney: 97). (See Appendix H: Clinical Skills Competency Checklist). Still other programs have the SANE complete an exam, either simulated or real, while being observed, to demonstrate competency.

Once trained, all but eight programs surveyed indicated they require specific criteria for maintaining certification. While no two programs are the same, the most common requirements include the following:

- Completion of a specific number of exams per year.
- Attendance at staff meetings.
- CEUs such as SANE relevant literature reviews.
- Conference attendance.
- Externships with physicians and nurse practitioners.
- Continuing to take call and remain actively involved in the SANE program.

Any interested and qualified registered nurse who completes the training can become a SANE. An advanced degree is not a requirement. The training must be conducted by an experienced SANE, preferably with at least 2 years of SANE experience. Continuing education and SANE exam experience requirements should be met yearly for continued active SANE status.

Utilizing an Existing Training Program

If financial resources permit, the entire staff may attend one of several SANE training programs available. (See Appendix D: SANE Training Programs). This option provides assurance that the training will be competent and the trainer experienced. Some programs have chosen to send some staff to one training program and other staff to a different program so that they can share their varied experiences. This also provides opportunities to develop professional networks and mentoring relationships with experienced SANEs.

There are a couple of disadvantages to utilizing the existing programs. First, if the SANE staff is large, it can be expensive. The cost for the basic SANE training ranges from $250 to $500 per person, plus travel expenses. The cost for an advanced clinical training course can run $1,200 per week, plus travel expenses. If the staff is small or if there is a training program nearby, attending a SANE training course may be a more realistic option. Another possibility might be to provide the initial SANE training locally but later send a representative to one of the existing basic or advanced training programs to develop additional expertise to bring back and share with the other program staff. If an individual SANE is being added to the staff, it can be more financially feasible to send one person to an established training program.

A second problem may be timing. These programs are usually run only once a year. Program startup timing might not coincide with the dates of the preferred training program. If existing training programs and training dates are identified in the early strategic planning phase, this problem might be avoided. If the SANE staff is sufficiently large, a special training program may be negotiated specifically for that community.

A common misconception is that the training responsibilities have ended once the initial SANE training through an established SANE course is completed. A big piece of the initial training job is completed, however, issues such as the role of the local police, rape center, prosecutor's office, and the appropriate interactions among these agencies and the SANE program must be addressed. Local policies, procedures, and protocols must also be addressed.

Importing a SANE Training Program

If a large SANE staff is involved, it may be more cost effective to hire a qualified trainer to come

to the local area and provide a complete SANE training program. The cost as of 1997 is approximately $1,000 to $1,200 per day for the trainer, plus travel expenses (See Appendix E: SANE Trainers). Hiring a trainer affords more control over the training dates, and if one trainer is not available during the preferred dates, another trainer may be able to better accommodate program needs. Importing a trainer also allows for more flexibility in the training format. Instead of a one-week program, for instance, the training can be divided into 2- or 3-day segments to better meet the SANE staff schedules. Training can occur 2 days, 1 week, and 3 days another, for instance. The training agenda can also be negotiated, to better meet the SANE staff needs. CEU's should always be provided for the training. Once again, it is still important to recognize the need to include training specific to the local SANE program and community needs.

Organizing Local SANE Training

Another option, which may be time-consuming, but more cost effective, is the organization of training that maximizes the use of local experts. A big advantage of this option is the involvement of other programs in the area. If other organizations are involved in the training, they are more likely to be committed to the success of the program. They also will be more familiar with the SANE staff and an important step will be taken towards building local support and fostering open communication among agencies. Taking the opportunity to recognize and utilize agencies' expertise will increase the SANE's opportunity to share experiences with the agencies and ensure that the SANE staff knows the information these local community agencies indicate is "the most important."

Identifying Local Experts

Local experts must be carefully screened. Just because a local facility is now completing rape exams does not mean that its staff is necessarily up to date and doing these exams according to the current SANE state-of-the-art evidentiary exam standards.

If there is a school of nursing in the area, explore the option of developing a SANE training program for credit, or for no credit, but associated with the school of nursing.

Look to experts from the local rape crisis center to teach about the crisis response of rape victims and crisis intervention needs.

Local police can best talk about State rape laws and the investigation process. They can also address the evidence they find most helpful to them in investigating a sexual assault case. They can discuss how they would like to interact with the SANE in the ED or clinic. A local police photographer will be a good source of information about photographing injuries.

Staff from the prosecuting attorney's office can provide valuable information about the type of evidence needed and the State laws regarding reporting and confidentiality. That office can also help prepare the SANE staff for courtroom testimony, and may even provide mock courtroom experience. Often used in legal training programs, mock trial experience can significantly reduce the anxiety often associated with the initial courtroom appearance.

A nurse practitioner or physician from a local obstetrics department or planned parenthood center will be able to provide comprehensive training about normal pelvic examination, pregnancy risk evaluation, treating for STDs, and the use of the colposcope. If there is a local STD clinic, it may be another good resource. Make arrangements with whoever provides this initial training to have the SANE staff go to this clinic to practice normal pelvic exams and colposcopic examination. The local hospital clinical laboratory will be a good resource to review blood drawing technique and also to provide additional practice. A physician from a local ED or clinic may welcome the opportunity to meet with the SANE staff and talk about

assessing physical trauma. If the ED does the training, the ED staff will likely feel more comfortable with the trauma assessment skills of the SANEs. Clinical skills competency checklists can be provided to these outside organizations and clinicians in order to standardize the skills training (See Appendix H: Clinical Skills Competency Checklist).

It can be helpful to have the SANE staff go to other community sites for training such as the police department or the county attorney's office. This will allow SANE staff to meet other members of these agencies. Include a tour of the local crime lab so the SANEs can learn more about how the evidence they will collect is processed and analyzed.

Selecting a SANE Trainer

It will still be necessary to select a qualified SANE trainer to come and teach other portions of the training. This should include at least the following information:

- Collection of evidence, what to look for and where, and what to collect and how.
- Maintaining chain-of-evidence.
- Presenting credentials as a SANE in court.
- Patterns of injuries in sexual assault cases.
- Data collection and recording.
- Consent specific to sexual assault forensic exam (How SANE consent differs from routine medical coniínt for treatment).
- Patient confidentiality.
- Reporting.
- Working with the noncompliant rape victim.
- Adolescent rape issues.
- Child-victim specific issues, if the program will be seeing child victims (See the section in Chapter 12 on Preparing the Child for the Exam).

When looking for a trainer, in addition to the cost, look for someone who has a minimum of 2 years experience, preferably 5, as a SANE doing evidentiary exams and who is still actively involved clinically with a SANE program. A trainer should have a minimum of a B.S.N. and preferably an advanced nursing degree. Education training and experience is essential. University faculty experience is extremely helpful, but at a minimum, look for someone with experience conducting SANE training. Ask to see her Curriculum Vitae and ask for names and phone numbers of others for whom she has provided training. Call her references to see how satisfied they were with the training they received and the assistance she provided.

When hiring a trainer to come to the community, she should be flexible and willing to meet the SANE staff training needs. Be sure to establish ahead of time if she will also be willing to consult with the SANE staff or director about the SANE program development before the training and to answer questions after the training. Ask if there will be an increased cost for this additional assistance.

SANE/SART Training Resources

Color Atlas

An excellent training resource for information on the evidentiary exam is the *Color Atlas of Sexual Assault* (Girardin, Faugno, Seneski, Slaughter, & Whelan: 97) Written specifically for the SANE by SANEs, it contains 221 color illustrations primarily of genital anatomy and trauma. It includes normal and abnormal findings with complete explanations for the SANE. It distinguishes assault from nonassault injuries and includes a section on emotional care of the assault victim as well. Published by Mosby, it is available through local bookstores.

Evidentiary Exam Videotape

Two videotapes are currently available, both produced by SANEs, for use as an adjunct to evidentiary exam training. One was produced by American Forensic Nurses and the other by Manfred Hochmeister, MD and Jamie Ferrell, RN, BSN.

American Forensic Nurses, a California-based SANE/SART program, has developed a 45-minute videotape "The Sexual Assualt Examination: Essential Forensic Techniques" with a supplemental training manual about the SANE exam (Phone: 760–324–1124; Fax: 760–321–2750). If you indicate that you heard about this training aid in this manual, Western Nurse Specialists (WNS) has offered to donate $25 from each videotape sale to this project to provide additional technical assistance toward developing SANE programs. A comprehensive and uptodate SANE/SART specific training tool, it includes the following information:

- SART members roles.
- Interview process.
- Medical-legal examination.
- Forensic photography.
- Genital trauma and examination.
- Chain-of-custody.
- Victim followup care.

The videotape by Manfred Hochmeister, MD and Jamie Ferrel, RN, VSN, "Sexual Assault: The Health Care Response" is a comprehensive guide to the forensic examination and evidence collection of the adult sexual assault client. A version is available for medical personnel and another version for nonmedical personnel. Newly released in 1999, this step-by-step videotape documents the latest techniques in forensic examination and evidence collection. This videotape can be ordered for $95 from the Institute of Legal Medicine, University of Bern, Buehlstrasse 20, CH-3012, Switzerland; or (from the US and Canada) by Fax (0041) 011 31 31 631 84 15.

SANE Training Components

Whether evaluating an existing SANE training program or developing a new local training program, ensure that, at a minimum, the following components are included:

Programmatic

- Role of the SANE and forensic nursing history.
- Program goals, objectives, vision, and mission.
- Review of program policies and procedures.
- Working with the media.
- Facilities familiarization.
- SANE program evaluation research.
- Training program evaluation.

Medical

- STD review of statistics, symptoms, and treatment options.
- Pregnancy risk evaluation, prevention, testing options, termination options.
- The normal genitalia (pelvic and anal) and normal growth and development in adults, adolescents, and children (when applicable).
- Techniques for blood drawing.
- Physical assessment, identifying injuries and criteria for medical referral to physicians.
- Using the colposcope and obtaining 35mm and/or video pictures (if available).
- Followup resources and needs of the rape victim.

Legal

- Local State rape laws and the police report and investigation process.
- Role of local law enforcement (street police and police investigator).
- Obtaining consent.
- Maintaining confidentiality.
- Role of the local prosecuting attorney.
- The local court process.

Forensic Practices and Procedures

- Noting the types of evidence collected in rape cases and the utilization of evidence.
- Determining the source of specimens.

- Maintaining chain-of-evidence.
- Utilizing evidentiary exam timing and protocol.
- Noting extragenital pattern injuries in sexual assault.
- Noting genital injuries in sexual assault.
- Photographing injuries.
- Collecting, labeling, storing, and processing laboratory specimens.
- Medical-legal interviewing.
- Documenting and recording with a jury in mind.
- Testifying in court as an expert witness and factual witness.

Psychological

- The emotional needs of the rape victim and how to meet them.
- Crisis intervention with the rape victim.
- Suicide risk evaluation.
- Role of the local rape crisis center.
- Victim's fears about reporting and what it means to report in the local community.
- Discharge and followup resources and needs of the rape victim (including safety assessment and planning).
- Diversity and cultural issues.

Continuing SANE Education

Once the SANE staff is trained, it is important to establish criteria for continuing education. Recommendations for continued education include, at a minimum, the following on a yearly basis:

- Maintaining RN licensure.
- Completion of at least one SANE exam.
- Ongoing SANE training such as attending or presenting one SANE inservice, providing CEU credit, peer chart review, or attending or presenting a SANE case presentation, attending or presenting at a Forensic Nursing or Forensic Science conference.

Additional recommendations include the following:

- Membership in IAFN.
- Membership in the American Nurses Association (ANA).
- Membership in the local State nurses association.

Future SANE Training Trends

Offering forensic nursing courses and SANE training at the university level, utilizing an experienced nursing faculty appears to be the current trend. There are already several forensic nursing courses offered at the university level which qualify for university credit and that offer advanced degrees. These include Fitchberg University in Worchester, Massachusetts and Beth-El College of Nursing, Colorado Springs, Colorado. Other institutions, such as Columbia University, School of Nursing in New York, New York, offer SANE training programs that do not qualify for university credit. Mount Royal College in Calgary, British Columbia offers forensic nursing courses via the Internet that can, of course, be accessed from any computer, anywhere in the world, for credit through their institution.

Summary

SANE training is currently not standardized nationally and both the quality and components vary greatly from one program to the next. Most existing SANE programs utilize an established SANE training program, and once trained, have specified criteria for continued local certification.

It is anticipated that within the next 2 years there will be standardized minimum training requirements recognized by IAFN. These minimum training requirements will be required for the national certification that will follow.

CHAPTER 10

ESTABLISHING AND MAINTAINING PROGRAM COVERAGE

It is essential to develop and maintain a reputation for reliability in the community, especially when the service is new. The referring community programs must know that if they call the SANE, or refer a rape victim to the SANE facility, a SANE will arrive in a reasonable period of time to see the victim and follow appropriate protocols.

Using Staff Positions

The only way to eliminate response time is to have SANEs available on site. It takes a very high volume of cases or the ability to schedule exams to make this model cost effective. There are no identified SANE programs with paid SANE staff available on site 24 hours a day. One SANE program with a very high volume, 1,200 to 1,500 cases per year, has found it cost effective to have SANEs available on site Monday through Friday during office hours. Although they see injured victims in the ED, the SANEs otherwise work at only one clinic where all noncritical victims are brought in by law enforcement or children's services. While they do see adults who walk in, more than three-fifths of their cases are children and adolescents. Programs that work with children and do exams on a nonurgent, scheduled basis are more likely to have salaried positions with regular hours.

Smaller programs may also have the SANE director see cases during her office hours. Assuming her office is near the exam site, this cuts costs, reduces the need for additional staff, shortens the response time, and helps her to maintain clinical competence.

Using On-Call Positions

When exams cannot be scheduled, which is the situation in most sexual assault cases, utilizing on-call positions is cost effective. When establishing the SANE on-call schedule, decisions must be made about the length of on-call shifts, how they will be assigned, what changes in the on-call schedule are allowable, and how these changes will be made. Decisions must also be made about how the SANE will be paid for on-call time, the allowable maximum response time, when the SANE should be paged and by whom, and what type of pager system will be used. In addition, a formal or informal backup call system should be considered.

Length of On-Call Shift

Smaller programs with fewer cases usually have longer on-call shifts. These may be 24- or 48-hour shifts. As the caseload increases, the on-call shifts typically decrease in length to 12 hours and even to 8-hour shifts. Eight-hour shifts that coincide with area hospital nursing schedules make it easier for the SANE to work her call around other scheduled work. The standard practice is to have the shifts short enough that the SANE will be unlikely to complete more than two exams during any one shift. Shorter shifts, however, mean more shifts to cover, which usually means hiring and training more staff.

Assigning On-Call Shifts

Most often each SANE is hired to take a predetermined number of on-call shifts each month. The number of shifts will usually vary from SANE to SANE and is a function of her availability and the needs of the program. Each SANE may initially be assigned an equal number of day, evening, and night shifts, or an individual SANE may routinely be responsible for a particular shift. The shifts assigned may also vary greatly week to week and month to month, depending on the availability of the SANE staff. Except under unusual circumstances, no SANE should be assigned to take more

than two nights in a row when she is working another job. When SANE shifts vary month to month, the call schedule should be made at least 2 weeks prior to the end of the month.

Staff may prefer to work the same shift all month, perhaps the same day of the week if there are 24-hour call shifts. This consistency allows staff to plan their other jobs around their call schedule. While this process makes scheduling very predictable, it can result in a more rigid call schedule and requested changes in the call schedule must be worked out with other staff in advance. Emergencies, vacation requests, and special needs of the SANE staff need to be accommodated whenever possible.

Work shifts often assigned on a nursing unit are another option for scheduling on-call shifts. With this option, the program director tries to accommodate the SANE's specific requests when making out the schedule. This method, however, is labor intensive for the nursing director, and the results rarely please staff.

There is another method that provides for considerable flexibility, gives the responsibility to the staff to select the shifts they want, while maintaining some external "fairness" about who takes which shifts, thus resulting in a happier staff. This method is referred to as the "poker chip method." In this method, each SANE has a predetermined number of day, evening, and night shifts she has agreed to take as well as an agreed-upon number of weekend shifts. The schedule is completed at a staff meeting, and it is important that everyone is present or has arranged for another SANE to represent her desires.

Each SANE is given a red poker chip for each evening shift for which she is responsible, a blue chip for each day shift, and a white chip for each night shift. She is also given a white square for every weekend shift which she is expected to cover. (Weekend shifts are considered Friday evening through Sunday night.) While everyone is initially assigned a specified number of weekend, day, evening, and night shifts, periodically they are given the option of trading shifts or giving away shifts. A record is kept by the program director. Shifts can also be traded informally each month before the call schedule is developed.

The director, or her representative, reads through the list of available shifts for the month one by one. As she does so, much like in a card game, the first SANE to speak up gets the shift. The SANE puts the appropriate chip in the center of the table for each shift she takes, until all shifts are gone and everyone has used all their chips. If there are holes in the schedule after the first time through, the director reads through the list of remaining shifts again until all are filled. Nurses who have participated in a self-scheduling process of this nature have ensured that all shifts are covered.

Changes in the On-Call Schedule

While it is understandable that changes in the on-call schedule will need to be made, it is important that nonemergency on-call schedule changes be kept to a minimum. Whenever a change is made, the likelihood of paging errors increases. This is especially true if each SANE has a different pager number assigned. In these cases, whenever possible, both the nurse initially assigned and the nurse taking call for her need to keep their pagers turned on. For nonemergency on-call changes, the SANE is usually responsible for finding her own replacement and to call all agencies that might page her with the changes, including law enforcement, rape crisis advocate, the SANE office, the answering service, and each participating hospital. In emergency situations, the SANE should call the office or director at her home, and she will arrange for coverage and notification of the change.

Paid and Unpaid On-Call Service

Our survey of existing SANE programs indicated that two-thirds of the responding programs pay for on-call time and one-third do not. The programs not paying for on-call time did not necessarily pay more for exams, even though the literature suggested they did, and they probably should do so.

Paying for on-call coverage is cost prohibitive for small SANE programs that see fewer than 100 cases each year. If the SANE program is not covered by a union contract, the director may have the option to pay more per exam, rather than paying for on-call time. An equitable solution is payment of per-case amount that is equal to a 3-hour minimum salary at the prevailing nursing wage in the community (or time and one-half, if financial resources allow), plus what the nurse would make if she were paid at the local nursing community on-call rate for the entire length of her shift.

Response Time

The agreement with cooperating facilities served should always include a maximum acceptable response time from the moment the SANE is paged until she arrives at the door. This is important so that everyone involved (the victim, the medical staff, the police, and the SANE) knows what to expect. A realistic response time needs to be established. While minimizing waiting time for a victim is important, this consideration must be balanced with a realistic view of the program's capabilities and resources.

Most existing SANE programs have set 1 hour as the maximum acceptable response time for the SANE; from the time she is paged until she arrives at the ED or clinic. The SANE response time, from the point when she is paged to that of arriving for the exam, is 30 minutes in some programs (Speck & Aiken: 95; Holloway & Swan: 93) and generally no more than 60 minutes in others (Ledray: 92a). The time limit set should be primarily determined by the geographical area served by the SANE program. Even 1.5 hours may not be realistic for a regional center that serves a large area. In this case, it may be necessary to set a 2-hour maximum response time.

Establishing too short of a maximum response time is not good for the program. It is better to have a longer response time that can consistently be met than to have a shorter response time that cannot be met. If the SANE arrives earlier than an expected 1-hour response limit, the staff and the victim will be happy to see her early, and she will feel good about her response. If she arrives later than a 30-minute expected response time, however, the opposite will be true. The maximum response time is not the usual or average amount of time for a response, but the maximum expected response time. The SANE should always respond as soon as possible.

Each SANE director needs to decide if she wants to routinely track response time, rather than wait for a problem to arise. Whenever the SANE's response takes longer than the established limit, the program director needs to be advised of the reasons why. It is easy to have the SANE note the time the victim arrived in the ED or clinic, the time she was first paged, and the time she arrived. She should also note the reason for any delays as well. Some law enforcement and medical facilities will record this information routinely. (See Appendix J: SANE Forms.)

When Should the SANE Be Paged and by Whom?

To shorten the victim's wait, the director must analyze all factors that may contribute to a delay. First, look at when and by whom the SANE is paged. In most existing SANE programs, the SANE is paged by the triage nurse or by the clinic receptionist when the victim arrives at the ED, unless the SANE program is operating in a jurisdiction that requires the police to be notified first to determine if a crime has been committed (See Chapter 4: SART: A Community Approach under the section "How a Sexual Assault RESPONSE Team Operates" and also Chapter 6: A Look at Funding under the section Where to Look for SANE Program Funding"). It is important to know how long response time takes after the victim has arrived. If the facility staff is waiting until the victim is seen by a physician and examined before they page the SANE, the system must be changed. This can significantly increase the SANE's response time.

It is important to set up a system that ensures the victim moves quickly through the initial triage process. While it is certainly important that urgent or life-threatening injuries to the victim take precedence over a rape exam, past experience has shown that a very small percentage of rape cases involve serious injuries. (See Chapter 11: SANE Program Operation, "Nongenital injury evidence" for a detailed discussion of the literature on this issue.)

Even in cases where immediate treatment is required, the SANE should be paged as soon as the rape victim arrives at the ED or clinic or as soon as the staff determine that a rape, or attempted rape was involved. The SANE and staff can then decide if the SANE should respond immediately, or if other urgent care will delay her rape exam. If they decide the SANE should not respond immediately, the SANE can at least get ready to come in and remain in contact with the ED or clinic so she can respond when needed.

Some protocols direct the police to page the SANE as they leave the crime scene with the victim on their way to the facility. This is an effective method to reduce the response time. It is essential that the police wait to page until they are on their way. If the police do page earlier, they must be sure to page back to the SANE if the victim changes her mind and refuses to go in for an exam.

Other programs have tried sending the SANE to the hospital when the local rape crisis center or teen pregnancy clinic, for instance, calls her to say they just saw a rape victim who they are sending over immediately. Many times these programs change their policy when victims do not show up at the hospital where the SANE is waiting. It can be less confusing, be less expensive to the SANE program, and saves a lot of time if the SANE is paged after the victim has arrived at an exam site. The exception to this might be having the police page the SANE when they are en route with a rape victim.

Delayed Response

Program policy should identify when the SANE may delay her arrival at the ED or clinic. These may include cases when the victim is so intoxicated she is unable to consent to an exam or cooperate with an exam and when it is uncertain if she was sexually assaulted. It may also include urgent cases in which the victim must be evaluated immediately to determine the extent of her physical injuries. Extensive injury alone is not necessarily a criterion for delaying the SANE's response. SANE exams can be completed in the stabilization room, the ICU, or the operating room and may result in capturing valuable forensic evidence that would otherwise be lost. This is a decision the SANE should make in conjunction with the physician and possibly with input from the police as well. In one case, police request for a SANE exam resulted in identifying superficial vaginal injuries while the patient was being prepped for lifesaving surgery. This evidence was the primary foundation for a conviction (Speck & Aiken: 95).

Selecting a Paging System

Each SANE should have her own pager. Paging systems are less expensive now than even a few years ago, and the cost savings of sharing a pager do not justify the inconvenience to the SANEs. Long-range pagers afford the SANE more flexibility and are highly recommended. It is also recommended that the pagers have a function that allows each pager two paging numbers that can be turned on and off independently. One number can then be assigned to every pager. This is the number that referring programs will page when they want the on-call SANE. The on-call SANE ensures that this number is functioning on her pager.

Each pager is then also assigned an individual number for each SANE. SANEs are not required to keep their pager on when they are not on call, but this allows each SANE the option of doing so, and it allows the program additional depth of coverage. If the on-call SANE has a question or needs assistance, she can page another SANE and

request her help. While the other SANE might not always be able to help, sometimes she can. This is especially useful for newer, less experienced SANEs. When everyone is willing to help in this way, being on call is a much less stressful experience. It is important for everyone to know help is available when needed.

While not as convenient for referring agencies, if a paging system allows for only one number per pager, use individual numbers for each SANE, and provide the referring programs with an on call schedule. Otherwise SANEs not officially on call would be forced to turn off their pagers or be constantly interrupted. It is very helpful to have SANEs not officially on call available to each other.

On-Call Backup

The best way to ensure that a SANE is always available is to implement a formal backup on-call system. A formal backup system is more likely to be necessary if the SANE program does exams at more than one location and if a large number of exams are completed.

The backup on-call SANE is usually utilized at the discretion of the primary on-call SANE. It is expected that backup will be called when there are requests for service from two different exam sites at the same time. Many programs recognize that it is very stressful to complete more than two exams in a single on-call period, and three exams are usually the upper limit that an individual SANE can be expected to perform. Because of this, in some programs, it is acceptable for the SANE to utilize a backup on-call system after she has completed two or three cases.

If the SANE is comfortable with her ability to complete the work in a timely manner, she is not required to call the backup. However, whenever she is unable to do a case, she can choose to call for backup. If the primary on-call SANE is unable to take call at the last minute due to a family emergency or illness, and no one else can take the shift, the backup SANE will be expected to move up to primary on-call status.

When primary on-call service is paid, backup on-call service is usually paid as well. Since the backup on-call SANE is much less likely to be called in, the pay is usually half the primary on-call rate, however. Usually, everyone is expected to perform the same amount of backup call as they take of primary call.

If the primary on-call SANE cannot get to the exam site within the specified maximum response time once a month or more because there is more than one case to be seen, it may be necessary to implement a backup on-call system.

Using an Answering Service

Since a SANE office staff is not available 24 hours a day, an answering service can be helpful to take office after hour and weekend calls. This will significantly reduce the pressure of routine calls going to the on-call nurse, yet it will ensure that emergency calls are properly directed. The cost is relatively low, especially when it is weighed against the quality of service and security of knowing that emergency calls from clients, EDs, clinics, or the community will be screened and properly routed.

If the decision is to use an answering machine instead of an answering service, emergency calls will need to be directed to another number where the victim in crisis can be evaluated and the proper staff paged. If the local rape crisis center has a 24-hour crisis phone line, with its permission, it may be possible to direct emergency calls to that number after SANE program office hours.

Summary

A balance must be reached between meeting the needs of the SANE staff and meeting the needs of the program. The better both needs are successfully integrated, the more effective the SANE program will be. Staff satisfaction increases, performance and productivity are maximized, while staff turnover is reduced, thereby decreasing program costs. Be creative in looking for ways to develop the on-call schedule and don't be afraid to change. If one system doesn't work, try something else.

CHAPTER 11

SANE PROGRAM OPERATION

When the on call SANE arrives at the ED or clinic she will complete all components of the evidentiary exam according to the established protocol. This protocol must be clear to the SANE, other SART members, and the staff at participating medical facilities. The SANE's awareness of the unique needs of special populations within her community is also important.

Medical Evaluation and Care of Injuries

When a sexual assault victim comes to the ED or clinic because she has been raped, a routine physical exam is not necessary, and it is not recommended. The victim must understand that the evidentiary exam is not routine medical care. The SANE will not be performing a routine PAP smear when she completes the pelvic exam. This should be communicated to the victim verbally and in the written consent (Ledray: 96a).

The ED or clinic staff is typically responsible for medically triaging the sexual assault victim for serious injury, including taking vital signs prior to the arrival of the SANE (Ledray: 92a). Unstable vital signs, altered consciousness, and peritoneal pain or bleeding will alert the physician or nurse to injury (Hampton: 95). If the injuries are life threatening or require immediate medical treatment prior to the arrival of the SANE, the ED or clinic staff should maintain forensic principles when documenting the injuries in the medical record. This may also involve taking pictures prior to treatment.

If possible, the SANE should collect the forensic evidence before treating injuries, as medical treatment can result in the loss of potentially valuable trace or biological evidence. Sometimes even with serious injuries if the victim is stable, the surgery can be delayed until after the forensic exam. (Speck & Aiken: 95). Forensic evidence can also be collected in the operating room while the victim is being prepped for surgery, if necessary.

The SANE Evidentiary Exam

In 1987, California became the first State to standardize statewide protocol (Arndt: 88). Since few States have standardized protocols, there is a significant variation in what evidence is collected and how it is collected in different SANE programs. However, the evidentiary exam always involves other components in addition to the collection of forensic evidence.

Essential Exam Components

- Forensic evidence collection.
- STD evaluation and preventive care.
- Pregnancy risk evaluation and prevention.
- Crisis intervention.
- Care of injuries (completed by the medical staff).

There are a number of articles explaining the specific components of the evidentiary exam, some step-by-step (Blair & Warner: 92; Bobak: 92; Girardin, Faugna, Seneski, Slaughter & Whelan: 97; Hampton: 95; Ledray: 92b; Ledray: 95; Ledray: 96a; Osborn & Neff: 89). All include the following specific evidentiary exam components.

Forensic Evidence Collection

Time frame. While a complete exam including all of the above components is usually only done during the first 36 hours after a sexual assault, an abbreviated exam is completed for up to 72 hours

after a sexual assault and, for some jurisdictions, up to 96 hours (Frank: 96). An uncomplicated exam, without injuries, can take 1 to 5 hours to complete (Frank: 96), however, it will more likely take only 2 to 4 hours (Lenehan: 91; Sandrick: 96; Holloway & Swan: 93).

Specific Evidentiary Exam Components

- Written consent.
- Assault history, including orifices where violence was used or penetration occurred and by what, and forms of violence used and where.
- Pertinent medical information including allergies, current pregnancy status, and menstrual cycle.
- General physical assessment for trauma.
- Assessment of involved orifices for trauma.
- Sperm and seminal fluid specimens from involved orifices.
- Foreign biological matter collection.
- Fingernail scrapings or clippings.
- Pubic hair combing for foreign hairs and other materials.
- Blood for typing and DNA screening.
- Saliva for victim secretor status (In many areas, this is no longer used and is now replaced by DNA).
- Urine specimen (when rape drug use is suspected).
- Collection of torn or stained clothing.

Primary Areas of Variation

- Amount of documentation.
- Prophylactic treatment for STDs vs. culturing.
- Collection of additional blood or urine specimens for drug and alcohol analysis.
- Clothing collected as evidence.
- Required number of head and pubic hairs if collected routinely.
- Utilization of colposcope or MedScope and light staining microscope.

Examples of sexual assault evidentiary exam protocols are included in Appendix I: SANE Protocols.

Use of evidence collected. There are four primary uses of the evidence collected by the SANE:

1. To confirm recent sexual contact.
2. To show that force or coercion was used.
3. To identify the assailant.
4. To corroborate the victim's story.

DNA Evidence. The use of deoxyribonucleic acid (DNA) evidence is a recent technology used primarily in the criminal justice process to identify an assailant. To do this, blood must also be drawn from the victim to distinguish her DNA from any foreign DNA found on or in her body.

In 1987, the first assailant was convicted of sexual assault with the help of DNA evidence. The case was upheld on appeal the following year (Lewis: 88). In 1991, the Minnesota Bureau of Criminal Apprehension (BCA) Laboratory became the first State crime lab to identify a suspect on the basis of DNA alone. As a result of this valuable investigative procedure, an otherwise unidentified rapist was found and convicted (Ledray & Netzel: 97).

The recognition of DNA as a valuable investigative tool, and the knowledge that many rapists are repeat offenders, led to the development of the FBI Combined DNA Index System (CODIS) (Miller: 96). The DNA Identification Act, included in the 1994 Crime Bill, allocated $40 million to expand DNA testing capabilities. As a result, today 57 laboratories in 27 States participate in the CODIS system (Miller: 96). These databases are used for "DNA fingerprinting" in much the same way as conventional fingerprint databases are used. Genetic profiles found in semen and blood evidence are now used to link serial rapists, identify offenders of multiple assaults and exonerate falsely accused suspects (Ledray & Netzel: 97).

DNA evidence can be obtained by collecting any available blood evidence that could have come from the assailant and remained on the skin or

clothing of the victim. If the victim reports that she scratched the assailant, fingernail scrapings should also be collected to find a match with the suspected assailant's blood or skin. Whenever possible, with the victim's permission, fingernail clippings are preferable to scrapings. An explanation should be given to the victim about how, with clippings, the crime laboratory can gently separate any material that is possibly from the assailant without contaminating his DNA which might be found with cells (and her DNA) from her nails. If the SANE scrapes the nails, she should scrape gently, not vigorously, to try to avoid sample contamination. DNA from semen can also be obtained by swabbing the involved orifices with a standard size cotton tip swab. Any dried or liquid foreign matter on the body or clothing should also be collected for DNA evidence (Ledray & Netzel: 97).

In addition, when the SANE completes the evidentiary exam, blood evidence or buccal cell scrapings from the side of the mouth is collected from the victim for DNA analysis to distinguish her DNA from that of the assailant (Frank: 96).

Hair evidence. The primary use of hair evidence is to identify the assailant. The collection of hair evidence from the victim is controversial. While accurate data is not available, obtaining foreign hair samples is rare. When foreign hair is collected, hair must also be available from the victim for comparison with any foreign hair that is found in or on her body. Some examiners always pluck 15 to 20 head hairs and pubic hairs as a part of the evidentiary exam (Osborn & Neff: 89). Others cut hairs rather than pluck, since many laboratories do not analyze the root (Osborn & Neff: 89). Other examiners do not collect hair evidence as a routine part of the evidentiary exam because collection is painful, and if hair evidence is needed from the victim, it is retrievable at a later date (Ledray: 92b).

Seminal fluid evidence. Seminal fluid evidence is used for two purposes: to show that recent sexual intercourse occurred and to identify the assailant. Since 34 percent or more of rapists are sexually dysfunctional (Groth & Burgess: 77) and others wear condoms (Norvell, Benrubi & Thompson: 84), it is important to remember that the absence of sperm or seminal fluid findings does not disprove recent sexual intercourse. Even when sexual intercourse has occurred, sperm may not be found if the assailant has had a vasectomy, is sexually dysfunctional, or the sperm deteriorated due to the time between the exam and the forced penetration (Tucker, Ledray & Werner: 90).

Vaginal secretions can be screened for the presence of sperm with a wet mount during evidence collection. While any microscope can be used, a light staining microscope developed specifically for use by the SANE aids significantly in simplifying this procedure. The light staining microscope enhances and makes the color of the sperm more distinct without staining the slide or altering it in any way. The image viewed through the light staining microscope is optically enhanced to make the sperm appear bright yellow against a blue background. It also eliminates the need for the user to find the optimal magnification. This enhanced image can also be photographed through an attachable camera for evidence (Peele & Matranga: 97; O'Brien: 96a). It can even be attached to the same monitor as the colposcope (Peele & Matranga: 97).

Seminal fluid evidence is analyzed for sperm, motile or nonmotile, and for acid phosphatase (ACP). ACP is actually an array of related isoenzymes which is found in much greater concentration in semen than in any other body fluid (Davies: 78). Vaginal secretions have been found to contain very low levels of endogenous ACP. The exact tissue source of the vaginal ACP is uncertain, but is believed to be endometrium. The two specific ACPs most often analyzed in the evaluation of sexual assault, are prostatic acid phosphatase (PAP) and prostatic specific antigen (PSA). Since vaginal ACP and prostatic ACP cannot be distinguished biochemically, the only reliable differentiation is the quantitative level. Since prostatic ACP found in semen is in much higher concentration than vaginal ACP, a high level would indicate that there has been recent sexual contact with seminal fluid being left in the vagina (Green:

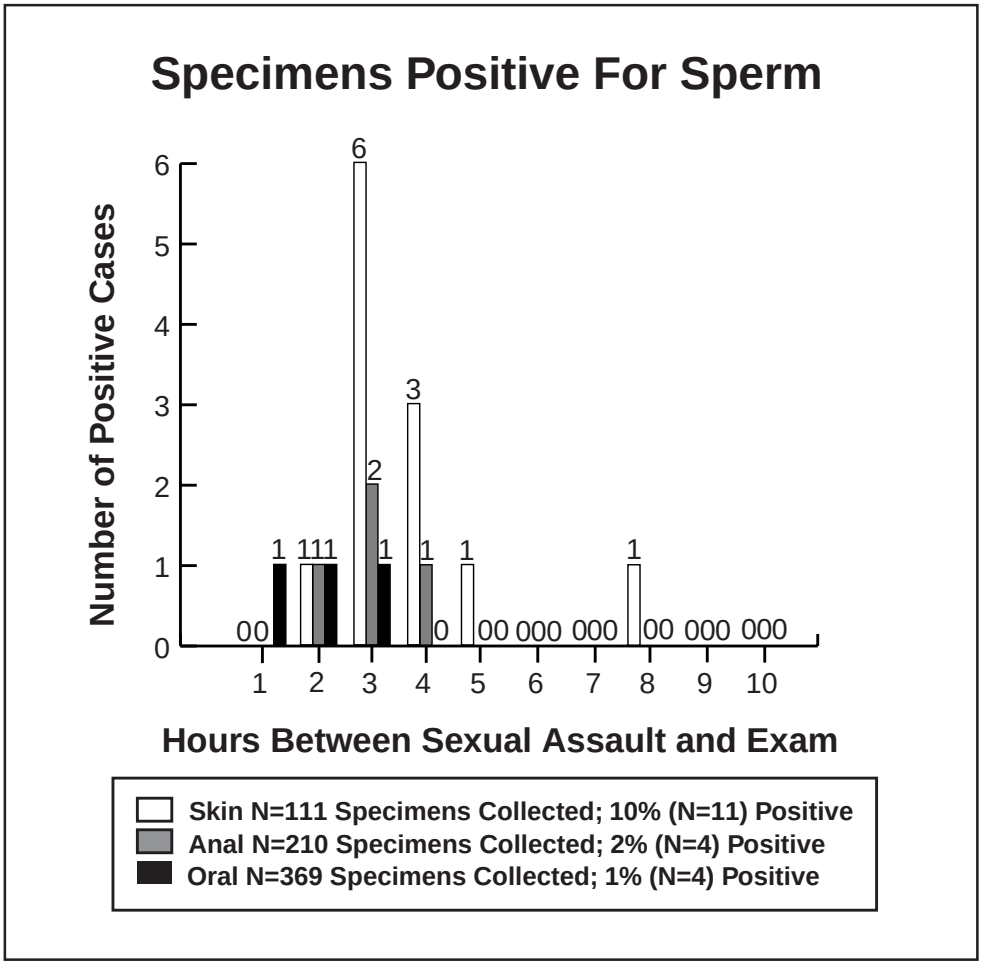
88). The interpretation of actual numeric results of analysis will be different depending on the specific substrate used by the laboratory as there is no standard. The laboratory must indicate how the analysis was done in order to determine how to interpret the findings as positive or negative for prostatic ACP.

Cases negative for sperm and positive for acid phosphatase typically involve an assailant who has had a vasectomy, but this result is also possible in cases involving an assailant who is a chronic alcoholic (Enos & Beyer: 80).

In a sexually functional, nonrape population, sperm has been found on exam within 24 hours after consenting sexual intercourse with known ejaculation, as often as 100 percent of the time (N=15) in one study (Soules, et al: 78), 65 percent (N=980) in another study (Silverman et al.: 78), and in as little as 25 percent (N=542) in yet another study (Randall: 86).

In a study of 1,007 rape victims examined, sperm was found in only 1 percent (N=3) of the 369 cases involving oral rape. All of the positive oral specimens were collected within 3 hours of the rape. Of the 210 cases with rectal involvement, only 2 percent (N=4) were positive for sperm. These exams were all completed within 4 hours of the rape. In the 111 skin specimens collected, 19 percent (N=12) were positive. All but two of the positive specimens were collected within 4 hours of the rape (Tucker, Ledray & Werner: 90).

Of the 919 vaginal specimens, 37 percent (N=317) were positive. Of these, the majority, 83

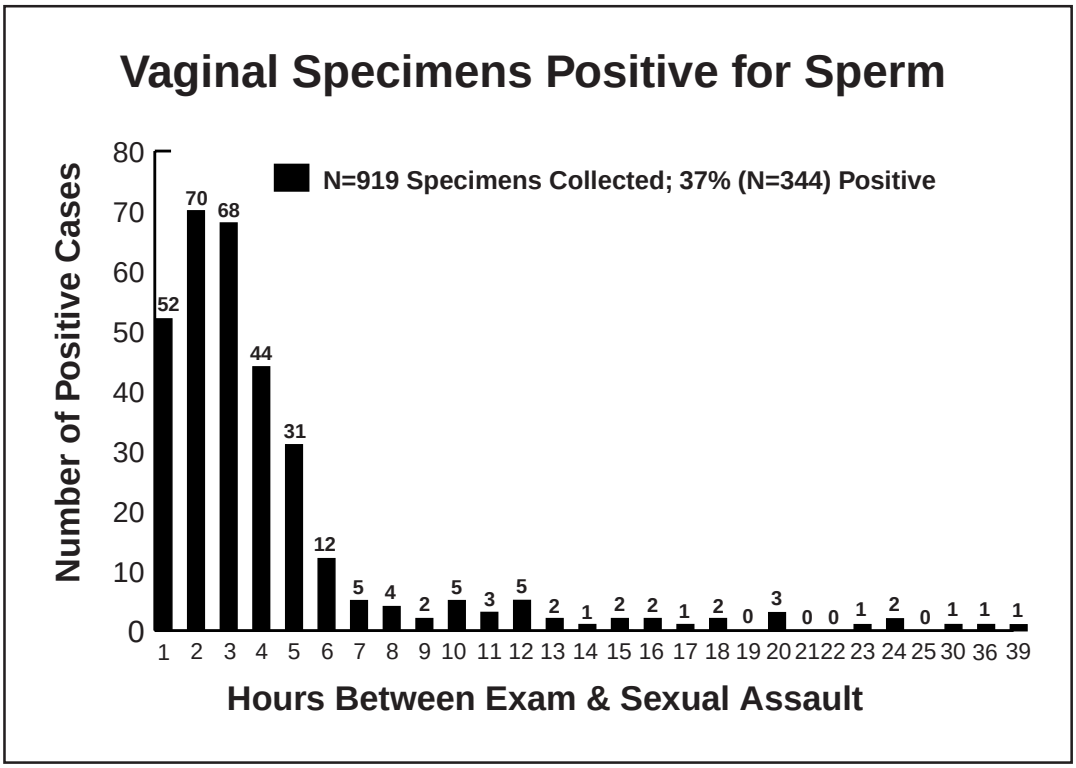


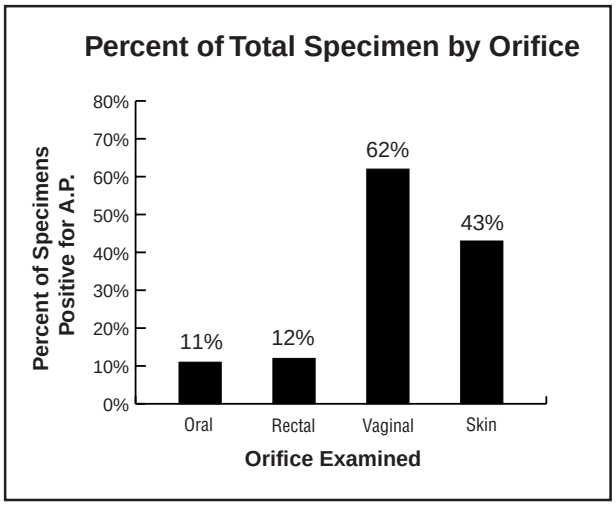
percent (N=263) were examined within 5 hours, and 307 were examined within 12 hours of the rape. Only 7 of the positive specimens were collected more than 20 hours after the rape (Tucker, Ledray & Werner: 90).

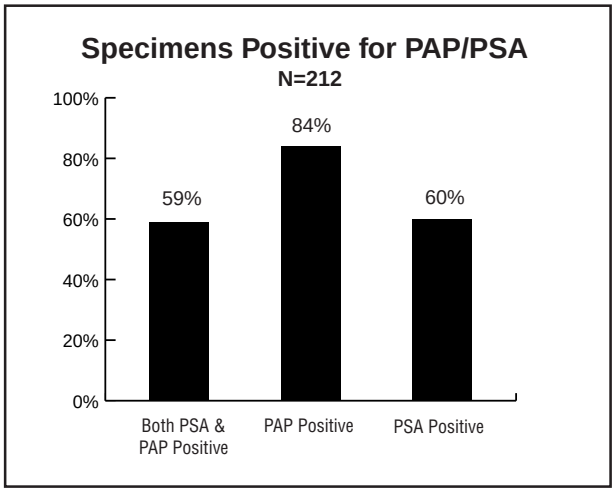
These data clearly indicate that the vaginal site is the most likely site to obtain specimens positive for sperm. It also indicates that by far the majority of positive results will be collected within the first 5 hours after the assault, and that even then, it is rare that specimens positive for sperm will be obtained in any site other than the vaginal site. It is imperative that the SANE is aware that this does not, however, mean sexual contact did not occur (Tucker, Ledray & Werner: 90).

Because of the small percentage of positive sperm specimens, the literature indicates that it can be very helpful to also analyze the specimens collected for prostatic acid phosphatase (PAP). While it is still more likely that specimens will be negative than positive, the results are more likely to be positive for PAP than for sperm. In the same study cited above, of the oral specimens, 11 percent (N=40) were positive for PAP; of the rectal specimens, 12 percent (N=32) were positive for PAP; of the skin specimens, 43 percent (N=72) were positive for PAP; and of the cases involving vaginal assault, 62 percent (N=566), were positive for PAP (Tucker, Ledray & Werner: 90).

In another study of 212 women who had consenting sex within 4 days, comparing PAP (prostatic acid phosphatase) to PSA (prostatic specific antigen), researchers got better results with PAP than PSA analyses. While both were positive in 59 percent of the cases, PAP was positive 84 percent of the time and PSA was positive 60 percent of the time. PAP was negative only 2 percent of the time when PSA was positive, and PSA was negative 25 percent of the time when PAP was positive (Roach & Vladutiu: 93). Most programs collect vaginal sperm and acid phosphatase specimens using cotton tip swabs. A few programs use a vaginal normal saline aspirate or vaginal washings for this purpose (Osborn & Neff: 89).







Vaginal washes. Vaginal washes to collect sperm evidence and DNA to identify the assailant are recommended by two clinicians (Sandrick: 96). One of these clinicians specifies that the vagina be washed with 10 ml of saline, which is then aspirated and saved for analysis (Roach & Vladutiu: 93). The crime laboratory in each State will have a preference as to which method to use.

Clothing evidence. Clothing is primarily useful as evidence to prove force was used. It can also be helpful to corroborate the victim's story. For instance, if the victim claims she struggled on the grass, grass stains on her clothing will corroborate this and the absence of grass stains can be used against her, as happened in the widely publicized *State of Florida* vs. *Smith* (Kennedy) trial. While some programs recommend collecting all of the victim's clothing (Frank: 96), most now specify that clothing should only be collected as evidence if it has tears or stains. While this may have been helpful when less well-trained ED personnel were collecting the clothing, a well-trained SANE can better decide what clothing will be useful evidence. For many victims, their winter coat or shoes may be valuable property that cannot be replaced. If some clothing does not hold important evidence, there is no reason for it to be turned over to law enforcement. When kept for evidence, clothing should be allowed to air dry prior to placing each article into a separate paper bag, labeled with the client's name, identifying number, date, time, SANE's name, and the type of article (Ledray: 92b).

Nongenital injury evidence. Physical injuries are the best proof of force and should always be photographed, described on drawings, and documented in writing on the SANE Exam Report as evidence of force (Ledray: 92b). Photographs are not meant to take the place of good charting (Pasqualone: 96). It is also important to note that the absence of injuries does not mean no force or coercion was used. Absence of injury does not prove consent (Tucker, Ledray & Werner: 90).

Specific consent to photograph is necessary but may be included as a standard part of the exam consent. In a facility which maintains medical records, two sets of pictures should always be taken. One set always remains with the medical record. The second set should be given to the police (although some programs give it to the victim) and will usually be the pictures used in court. Whenever pictures are taken, the first picture should always be of the victim's face, and others should follow in a systematic order, such as head to toe, or front to back. They should be taken first without a scale to show nothing is being hidden, then with a scale to document size. While a coin such as a quarter is sufficient, a gray photographic scale will also assist with color determination. Each picture should include a label with the victim's name in the picture. If a Polaroid camera is used, the SANE should print her name and title,

the date, the time, and the client's name and record number on the back of every Polaroid. Some programs may choose to use the medical record number instead of the victim's name.

Photographic documentation of injuries should be completed using a 35mm camera with a standard 50mm lens, or a 35-110 zoom lens, and 100-200 speed (ASA) color film. A disadvantage of 35mm pictures is that they must be sent out for developing and are often not available to the police when they investigate or to prosecutors when they are deciding if they will charge the case. Polaroid film has the advantage of allowing the victim to take one set of pictures with her when the exam is completed, and of being available to the police during their initial investigation. It has the disadvantage of poorer quality, especially for closeups. Polaroid film is also very expensive (Sheridan: 93). Injuries not properly documented with pictures may result in liability for failure to document (Pasqualone: 96). Therefore, staff must take pictures of all areas that have sustained injury, even of breasts and genitalia.

The nurse must be knowledgeable about patterns of injuries resulting from violence so she knows the appropriate questions to ask and where to look for injuries on the basis of the history (Sheridan: 93). Intentional injuries tend to be located more central on the body and accidental injuries more distal toward the extremities when domestic violence is involved. Injuries are most often inflicted where the victim can easily hide them. The most common injuries are broken ear drums from severe slapping, neck bruising from choking, punch bruising to the upper arm, and "defensive posturing" injuries to the outer mid-ulnar areas of the arms. Also common are whip or cord like injuries to the back; punch or bite injuries to the breasts and nipples; punch injuries to the abdomen, especially in pregnant women; punch and kick injuries to the lateral thighs; and facial bruising, abrasions, and lacerations (Sheridan: 93).

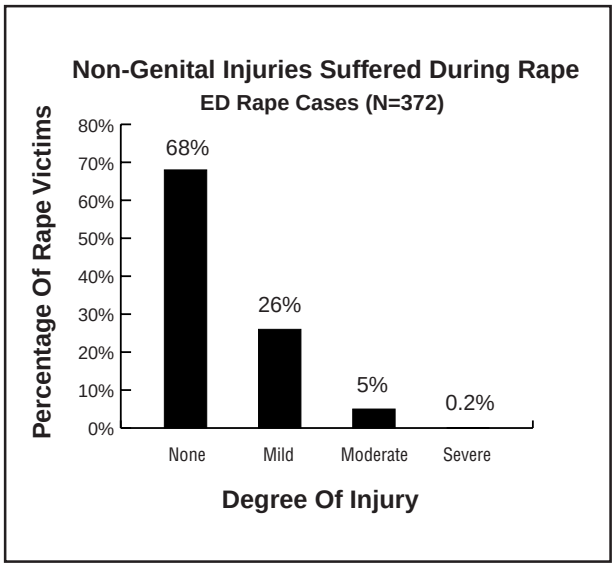
"Patterned injury" is different from the similar term, "pattern of injury" discussed above. Both are, however, important forensic terms. "Patterned injuries" are injuries where one can easily identify the object used to inflict the injury by the pattern left on the victim, such as a coat hanger, iron, extension cord, belt, or the imprint of a ring worn by the assailant. Bite marks are important patterned injuries that can be linked to a suspect's dental pattern. Since most assailants choke using their dominant hand, the finger-tip pattern can identify the assailant's handedness. A right-handed assailant will usually grab the victim's anterior neck so as to leave a single thumb bruise at the right lateral neck and several finger-tip bruises to the left lateral neck (Sheridan: 93).

The literature cautions the forensic nurse against trying to closely date the age of a bruise by its color. While we know that recent bruising is red or dark blue in color, and older bruising may be green-blue or yellow-blue, and older still bruising may be barely visible, people vary greatly in their rates of healing. Medications may affect bleeding and healing response as well. Sheridan suggests that deep blue-purple bruising is best documented as a "relatively recent bruise" or as "consistent with Mary Jane's report of being punched by Jim Smith 24 hours prior" (Sheridan: 93).

Physicians need to feel certain that any injuries or concerns about further evaluation of possible injury will be referred to them. Physicians need not be concerned that injuries will be missed by the SANE if they understand that she will err on the side of caution when evaluating and referring sexual assault victims to them (Ledray: 96a). Some programs have developed specific criteria for the nurse to use in determining when to consult with a physician. One program suggests that the nurse consult with a physician when there is extensive genital trauma, asymmetric joint swelling, head or chest trauma, neurological deficits, respiratory distress, need for medications, suspicion or need to confirm an existing pregnancy (Antognoli-Toland: 85).

The literature indicates injuries resulting from sexual assault are relatively rare. In a review of 372 ED rape cases, 68 percent of the victims seen had no injury, 26 percent had mild injuries, 5 percent moderate injuries and less than 1 percent, 0.2

percent, were severely injured. Victims 50 years old and over were twice as likely to be injured, 63 percent, compared with 32 percent of the victims under 50 years old (Tintinalli & Hoelzer: 85).



Another study found 5 percent of victims had major nongenital injuries, and women over 35 years of age were nearly twice as likely to be injured (Marchbanks, Lui & Mercy: 90). In another study of 440 rape victims, 46 percent had some nongenital trauma, however, only 1 percent required hospitalization (Cartwright, Moore, Anderson & Brown: 86). In a study of 98 rape victims, only 27 percent had even minor nongenital injuries not requiring treatment, 3 percent had injuries requiring treatment, and less than 1 percent required hospitalization (Tucker, Ledray & Werner: 90).

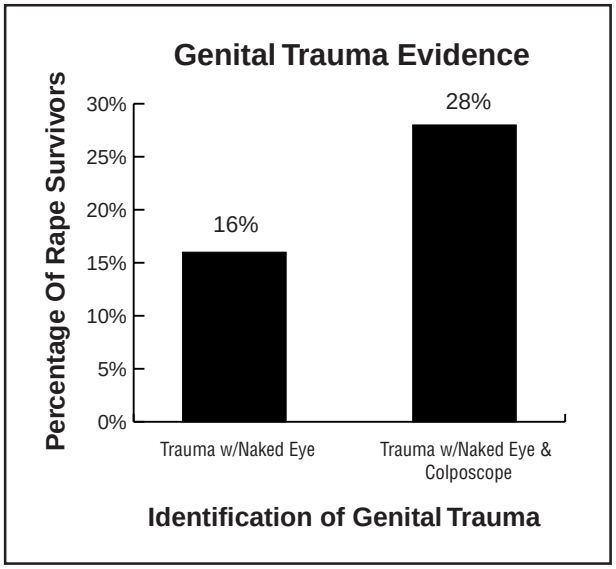
Genital trauma evidence. Genital trauma is useful to show both recent sexual contact and force. Just as with nongenital trauma, the absence of genital trauma does not indicate consent (Cartwright, Moore, Anderson & Brown: 86). While the examiner will usually not find genital injuries, this should not influence their testimony regarding the validity of the rape since most rape victims do not experience genital injury as a result of the rape (Bowyer & Dalton: 97). In one study, vaginal injuries represented only 19 percent of the total injuries and were always accompanied by complaints of vaginal pain, discomfort, or bleeding (Tintinalli & Hoelzer: 85). Another study found that 22 of 83 (27%) victims had genital injuries following a rape (Bowyer & Dalton: 97). Still another study found only 1 percent of rape victims had genital injuries so severe that they required surgical repair, 75 percent of which were upper vaginal lacerations (Geist: 88). They also found that upper vaginal lacerations usually presented with profuse bleeding and pain, and lower vaginal lacerations were more common in virgins.

The pattern of genital injury in female sexual assault victims has been a more recent area of study. Since the posterior fourchette is the point of greatest stress when forceful stretching occurs, and it is the point of first contact of the penis with the vagina, the resulting injury is characterized as an "acute mounting injury" (Slaughter & Brown: 92; Slaughter, Brown, Crowley & Peck: 97). Because no posterior fourchette injuries were found in a control group of sexually active adolescents, and injuries were found in 33 percent of the abused population, the researchers concluded that posterior fourchette injuries are indicative of sexual assault (McCauley, Gorman & Guzinski: 86).

In a study that compared the physical vaginal examination findings of 311 rape victims to a group of 75 women after consenting sexual intercourse, researchers found that 213 (68%) of the rape victims had genital trauma and only 8 (11%) of the consenting women had genital trauma. Furthermore, none of the women who were examined after consenting sex had injury in more than one site (Slaughter et al.: 97). Of the 213 victims with trauma, however, they found that 200 (94%) had trauma at one or more of four sites including posterior fourchette, Labia minora, hymen, or fossa navicularis; 162 (76%) had 3.1 sites of injury, making injury at more than one site indicative of rape. Trauma varied by site: tears appeared most often on the posterior fourchette and fossa navicularis; abrasions appeared on the labia; and ecchymosis was seen on the hymen. They also found that all women with tears reported vaginal bleeding. Five victims mistakenly

reported their menstrual period had begun. Researchers also concluded that timing of the exam was crucial because beyond 24 hours, the likelihood of identifying injury was significantly reduced. At followup examination, which occurred beyond 4 days (average of 25 days), all injury was resolved and there was no scarring and no evidence of the previous trauma. They also found that with the exception of hymenal tears, which were nearly four times more common in adolescent victims, injury was not related to age.

The literature also suggests that colposcopic examination to magnify genital tissue is an important asset to the identification of genital trauma (Frank: 96; Slaughter & Brown: 92; Slaughter et al.: 97; Peele & Matranga: 97). With the use of a colposcope, the number of cases increased by 8 percent because three or more genital injuries were identified as compared to identification with the naked eye (O'Brien: 97). Photographic equipment, both still and video, can be easily attached for forensic documentation. In one study, 28 percent of 440 rape victims had genital trauma, however, only 16 percent were identifiable without staining or colposcopic exam (Cartwright, Moore, Anderson & Brown: 86). In the legal arena, the use of the colposcope is well documented as an accepted practice in the examination of adults and children (IAFN: 96). The fact that it is noninvasive makes it particularly valuable for examination of young or elderly clients. The colposcopic exam is especially important as a part of the pediatric protocol (Soderstrom: 94).



With gross visualization alone, positive genital findings occur in only 10 percent to 30 percent of the cases (Cartwright et al.: 86; Tintinalli & Hoelzer: 85). With colposcopic examination, genital trauma has been identified in 87 percent (N= 114) of sexual assault cases (Slaughter & Brown: 92). When a colposcope is used, the magnification must always be documented, the pictures or video must be well focused and clear, standard positions for examination should be used and documented, and a method of measurement should be used (Soderstrom: 94).

In a study of genital trauma in a consenting population using the colposcope, 11 (61%) of 18 volunteers, who had consenting sex within 6 hours, had positive findings of micro trauma. This trauma was not visualized with gross visualization but required the use of the colposcope (Norvell, Benrubi & Thompson: 84).

Other studies indicate Toluidine blue and Gentian violet can significantly enhance the visualization of genital injuries compared with gross visualization alone. Toluidine blue is a nuclear stain commonly used to detect vulvar cancer (Norvell, Benrubi & Thompson: 84). It has also been found useful in sexual assault examinations to detect perineal lacerations and abrasions. Since it is spermicidal, the literature consistently suggests it should only be used after all specimens are collected. One study examined 22 women after being sexually assaulted within the previous 48 hours. Forty percent were found to have vaginal lacerations when examined using Toluidine blue. Of these, 70 percent (N=7) of the positives were nulliparas (Laufer & Souma: 82). Another study found that 14 of 24 (58%) cases were positive for genital trauma using Toluidine blue (McCauley et al.: 86).

Other clinicians indicate that while lacerations seen using Toluidine blue were also seen with colposcopic examination by an experienced examiner, the dye does make the injuries easier for the

lay audience, such as juries, to visualize. The colposcope is however, the preferred method for better genital trauma documentation (O'Brien: 97; Slaughter & Brown: 92; Norvell, Benrubi & Thompson: 84). In a review of 17 SANE programs, only 4 indicated they used Toluidine blue and 11 used a colposcope for the sexual assault evidentiary exam (Kathy Bell. Personal Communication. 26 November 1996).

Blood evidence. The SANE should always draw the victim's blood for type and DNA (Frank: 96). In addition, it is recommended that an additional tube of blood routinely be drawn for blood and alcohol analysis should this become an issue later if the case is charged (Ledray: 92a).

Urine evidence. Recently it has come to the attention of the medical community that a long-acting benzodiadepine, flunitrazepam (Rohypnol) and a powerful sedative, gamma hydroxy butyrate (GHB) are being used as date rape drugs. Victims may report a history of having only a couple of alcoholic beverages but quickly becoming extremely intoxicated. When the victim awakens, usually more than 12 hours later, she may find herself undressed, or partially dressed, with vaginal or rectal soreness making her believe she has been raped. The victim can often remember very little of the incident prior to awakening, other than flashes. Even though there is little memory and perhaps no certainty of a sexual assault, the SANE should adhere to the standard sexual assault protocol and collect the first voided urine for a drug screen. If the victim calls prior to coming to the hospital or clinic, she should be told to collect her first voided urine and bring it with her (Ledray: 96b; Anglin, Spears & Hutson: 97).

Flunitrazepam has been used for sleep disorders in Europe, Mexico, and Asia since its initial release in 1975. It is used legally in 80 countries and is widely and easily available, but it has not been approved for use in the United States. In October 1996, the United States passed a Federal law, The Drug-Induced Rape Prevention and Punishment Act of 1996, which provides for up to 20 years in prison for anyone who uses a controlled substance to commit a crime of violence, including sexual assault (U.S. House of Representatives: 96).

There has been such an intense community opposition to Rohypnol that in October 1997, the manufacturer Hoffmann La Roche Laboratories announced at the National Coalition Against Sexual Assault (NCASA) annual conference in Cleveland that it plans to add a color-releasing agent to Rohypnol making it easier to detect if covertly slipped into someone's beverage. Once approved by the regulatory agencies, the new Rohypnol tablets dissolve more slowly and they release a bright blue color as they dissolve. When dissolved in darker liquids, the drink appears cloudy. In all drinks, particles also float to the top of the beverage, signaling that something has been added (NCASA: 97).

Whenever the victim's story is consistent with a drug-facilitated rape, and if she is seen within 72 hours of the assault, a urine specimen should be collected for drug analysis. By calling 800–608–6540, the necessary paperwork with an authorization code will be Faxed to the SANE. She should complete the form and return it with a urine specimen by Fedex to the independent laboratory with whom Hoffmann LaRoche Laboratories have contracted to analyze the urine. The form will contain complete information on the process, and Hoffmann LaRoche Laboratories will cover all testing and shipping costs. It will take approximately 2 weeks for the complete drug analysis of the urine to be Faxed back (Ledray: 96c).

Followup Forensic Exams

In those cases where genital trauma was identified, a followup exam may strengthen the evidence of genital trauma. Photographs should be taken at the time of the followup exam to document the healing of the genital injuries for comparison purposes in court. Most SANE programs, however, do not routinely perform a followup forensic exam on every victim, and these exams may not be reimbursable in every State.

Helpful Tips for Evidence Collection

- When a speculum is used, it should be lubricated with water, not gel lubricant, so evidence is not contaminated (Hampton: 95).
- Swabs used to collect skin specimens should be barely moistened with normal saline (Hampton: 95). Others specify the use of water for this purpose (Ledray: 92b).
- Tetanus prophylaxis, if not already current, should be given when the evidentiary exam identifies any break in the skin or mucosa (Blair & Warner: 92).
- An alternate light source should be used on clothing before the victim disrobes (Hampton: 95), as well as on the body after disrobing to look for body fluids and foreign objects, such as sand, to corroborate the victim's story as well as to identify the assailant (Frank: 96).

Additional Components of the SANE Exam

STD Evaluation and Preventive Care

Since there is no evidence of cultures being useful in court, and there is data showing that they have been used against the victim to suggest sexual promiscuity, it is not recommended to culture for STDs as a part of the evidentiary exam (Ledray: 92a). Contracting an STD from the assailant is of significant concern to victims, however, and because it is of great concern, the issue must be addressed as a part of the initial exam. One study found that 36 percent of the rape victims coming to the ED stated their primary reason for coming was concern about having contracted an STD (Ledray: 91), however, the actual risk is rather low. The National Center for Disease Control estimates the risk of rape victims getting gonorrhea is 6 percent to 12 percent, Chlamydia is 4 percent to 17 percent, the syphilis risk is 0.5 percent to 3 percent, and the risk of HIV is less than 1 percent (CDC: 93).

Some programs still culture and treat prophylactically for STDs although they give no rationale for the cultures (Osborn & Neff: 89), other than to establish a baseline (Hampton: 95), which has no demonstrated forensic utility. There is also evidence that STD cultures for gonorrhea obtained at the initial exam immediately after the assault may not only indicate a pre-existing infection, but also that gonococcus may be deposited in the vagina with the seminal fluid of the assailant (Hayman & Lanza: 71; Ledray: 91).

STD cultures are very expensive and time-consuming for the victim who must return multiple times for testing and unfortunately most victims do not return (Blair & Warner: 92). In one study, only 25 percent of the victims seen in the ED returned for the initial STD followup visit (Ledray: 91), and in another study, only 15 percent returned. The researchers were able to contact 47 percent of those who had not returned for followup, and they found an additional 11 percent of these went elsewhere for medical followup, however, only 14 percent told the physician about the rape (Tintinalli & Hoelzer: 85). If cultures are taken, they do not have to be handled as evidence because they are not useful in court (Blair & Warner: 92). Most clinicians recommend prophylactic treatment following CDC guidelines (Frank: 96; Arndt: 88; Antognoli-Toland: 85; Tintinalli & Hoelzer: 85). For more information call the **National STD Hotline:** 800–227–8922.

HIV

Since the early 1980's, HIV has been a grave concern for rape victims even though the actual risk still appears to be very low. In an attempt to better evaluate this risk, 412 Midwest rape victims with vaginal or rectal penetration were tested for HIV in the ED, then again at 3 months post-rape, and again at 6 months post-rape. Not one seroconverted. This study also found, however, that even if the victim did not ask about HIV in the ED, within 2 weeks, she expressed a concern for herself or her sexual partner. While the researchers

did not recommend routine HIV testing, based on the recommendations of the study population, they recommend that even if victims do not raise the issue of HIV or AIDS in the ED, the SANE should, in a matter-of-fact manner, provide them information about their risk, testing, and safe sex options. This will allow them to make decisions based on facts, not fear, and reduce the psychological trauma of the fear of HIV (Ledray: 93b). It is important to note that this study was conducted in a community with a relatively low overall HIV rate. Communities with high HIV rates will have a greater risk that an assailant is HIV positive. While testing can begin as early as 6 weeks after exposure, 3 months or even 6 months is more often recommended to avoid multiple testing (Gostin, Lazzarini, Alexander, Brandt, Mayer & Silverman: 94).

The risk of HIV exposure after sexual contact, while it varies, overall is reported to be less than other routes of exposure such as needle sticks, needle sharing, mother to infant, or transfusions. While the actual risk varies from study to study, if the sexual partner is known to be HIV positive, the risk of HIV from sexual contact may be similar to the risk with a needle stick (Royce, Sena, Cates & Cohen: 97).

HIV Post-Exposure Prophylaxis

As a result of a recent case-control study which concluded that treatment with zidovudine after needle stick exposure decreased the odds of HIV infection by 79 percent, antiretroviral treatment is now considered the standard of care in parenteral (e.g., needle stick) occupational exposure to HIV. Unfortunately, data on the long-term toxicity of zidovudine and the safety of combined antiretroviral treatment are not available (Carpenter, Fischl, Hammer, et al.: 96). Since there have been several cases of possible HIV seroconversion after a rape, post-exposure prophylaxis is being selectively recommended for high-risk exposures in high-risk areas. Antiretroviral treatment is not advocated when the HIV status of the assailant is unknown due to the cost and potential toxicity of zidovudine (Foster & Bartlett: 89). When it is recommended in high-risk cases, the health status of the victim and her ability to withstand the potential side effects must be taken into consideration along with the severity of risk (Gostin et al.: 94).

As a result of various State laws and the Federal Sexual Assault Prevention Act of 1993 and The Violent Crime Control and Law Enforcement Act of 1994, involuntary testing of the offender is now required. While the testing point varies according to State law, in most States testing cannot be done until after the assailant is convicted of the rape and a court order is obtained for testing. This usually takes more than the 6 months necessary for the victim to seroconvert if she is going to do so, and in some cases it may take a full year or more to obtain the testing results from the assailant. Testing may not occur until the time of pretrial release when it is used to determine his risk of HIV transmission. While victims still want this information for their own peace of mind, the time delay does not preclude the need for the victim to be tested as well.

Initial post-exposure treatment must be started within 72 hours or it is not recommended. When given following a rape, post-exposure prophylaxis is the same as for occupational exposure to HIV. This involves giving zidovudine 200 mg three times a day and lamivudine 150 mg twice a day for 4 weeks. The costs for the medication and monitoring run approximately $800, and until the treatment is proven to be effective, insurers may refuse to cover the cost (Katz & Gerberding: 97). Since most SANE programs cannot assume this additional expense, and since the treatment must be started within 72 hours, if this option is discussed, it is important to have a treatment or referral policy in place so the victim can make an informed decision. For more information, call the **National AIDS Information Hotline:** 800–342–AIDS. (For Spanish speakers call 800–344–SIDA; For hearing impaired persons call TTY/TDD Hotline 800–AIDS–TTY).

Pregnancy Risk Evaluation and Prevention

Rape victims of reproductive age also fear becoming pregnant as a result of a rape. Pregnancy resulting from rape is indeed the cause of great concern and significant additional trauma to the victim. Most programs offer pregnancy prevention or interception for the woman at risk of becoming pregnant, if they are seen within 72 hours of the rape and have a negative pregnancy test in the ED. Sometimes referred to as "the morning-after pill," oral contraceptives such as Ovral are used for emergency contraception (ACOG: 96). Two tablets of a contraceptive containing ethinyl estradiol, 0.05 mg, and norgestrel, 0.5 mg, (Ovral) are taken at the time of the evidentiary exam and two more in 12 hours is the usual form of pregnancy prevention. Each dose should be given after an antiemetic agent to prevent nausea (Osborn & Neff: 89; Ledray: 92b; Hampton: 95; ACOG: 96). This will reduce the risk of pregnancy by 60 percent to 90 percent. If a low dosage ethinyl estradiol contraceptive, such as Lo-Ovral, Nordene, Levlen, Triphasil, or Trilevlen, is used, a dose equivalent to 100ug of estrogen, 4 tablets, should be provided for each dose (Yuzpe, Smith & Rademaker: 82). Two programs operating at a Catholic hospital went as far as to get special permission from the diocese to administer Ovral (Frank: 96; O'Brien: 97).

The risk of pregnancy from a rape is the same as the risk of pregnancy from a one time sexual encounter. This is estimated to be 2 percent to 5 percent (Yuzpe, Smith & Rademaker: 82; Holmes, Resnick, Kilpatrick & Best: 96). Holmes et al. found that the majority of these pregnancies occurred among adolescents and resulted from a known and often related perpetrator. Unfortunately, only 11 percent of these victims received immediate medical attention for the rape. Fifty percent decided to terminate the pregnancy later. An additional 11.8 percent had a spontaneous abortion, and 5.9 percent placed the infant up for adoption. With better preventive care after the rape, it is possible that more of these pregnancies and abortions could have been prevented.

One program suggests that the consent form for the use of pregnancy interception drugs include all three options available to the victim, and that one option is always checked and signed by the victim. This will provide clear documentation of why the medication (Ovral) is or is not given. The first would be the typical informed consent of possible complications with agreement to take the medication. The second would be "I understand that because (I am already taking a contraceptive/had a tubal ligation) pregnancy prevention is not recommended for me." The third option would be "even though pregnancy prevention was recommended by the SANE, I (the victim) chose not to take the medication" (Speck: 96).

Testing for pregnancy is always necessary prior to giving any medications, as 2 percent of rape victims have been found to be pregnant when the evidentiary exam was completed in the ED and not all were aware of the pregnancy (Tucker, Ledray & Werner: 90; Warner: 87). Fortunately, at least one study found pregnant women were less likely to be physically injured during a rape, and the rape had little immediate effect on the pregnancy. No spontaneous abortions or deliveries occurred within 4 weeks of the rape. A low birth rate (24%) and preterm deliveries (16%) were common, however (Satin, Hemsell, Stone, Theriot, & Wendel: 91).

If the victim chooses to take medication for pregnancy interception, it is also important to inform her about the effect on her next period. Up to 98 percent of patients will menstruate within 21 days after the treatment. In 90 percent of the cases, menses will be of normal duration for that patient. If the medication is given prior to ovulation, the onset of menstrual bleeding may be 3 to 7 days earlier than expected. If the treatment is given after ovulation, the onset of bleeding may be on time or delayed.

Unfortunately, this treatment is not 100 percent effective in preventing pregnancy. A review of 10 studies found an overall effectiveness rate of at least 75 percent. That does not mean that 25 percent

will become pregnant. It means that if 100 women have intercourse in the middle 2 weeks of their cycle, approximately 8 (8%) would become pregnant without postcoital interception. With interception only 2 (2%), representing a 75 percent reduction, of the 100 would become pregnant (ACOG: 96). If the victim has not had a period within 21 days she should be advised to have a pregnancy test.

Crisis Intervention and Counseling

Another basic component of the evidentiary exam is crisis intervention, mental health assessment, and referral for followup counseling. Many SANEs do their own crisis intervention and followup counseling (Speck & Aiken: 95; Ledray: 92b); others have rape advocates present in the ED or clinic or refer to a local rape center, social service, or to the hospital chaplain for followup counseling (Antognoli-Toland: 85).

While many victims may want to "go home and forget it," experience tells the SANE that victims are seldom able to effectively do so. Continued fear and anxiety resulting from the rape can significantly affect the victim's life, including her work, school, and relationships with others far into the future (Ledray: 96a). The psychological impact and treatment needs of the victim has been addressed extensively in the psychological literature. A review of these crisis needs is beyond the bounds of this summary. Dr. Burgess summarized and labeled the psychological impact Rape Trauma Syndrome (Burgess and Holmstrom: 74). Self-help books, such as *Recovering From Rape* (Ledray: 94), are available for the large majority of rape victims who do not return for counseling and are sometimes recommended to victims in the ED by SANEs (Ledray: 96a). The Assistance League, a national organization that for several years has provided clothing for rape victims after the evidentiary exam, began providing in October 1997 the book *Recovering From Rape* to sexual assault victims at the time of the evidentiary exam throughout the State of Minnesota and in parts of California (Maggie Trenkmann. Personal communication, October 24, 1997).

Maintaining Chain-of-Evidence

Maintaining proper chain-of-evidence is as important as collecting the proper evidence. Completed documentation, or chain-of-evidence, is essential and must include the signature of everyone who had possession of the evidence from the individual who collected the evidence to the individual bringing the evidence into the courtroom. If this proper chain-of-evidence is not maintained, the evidence will be inadmissible (Ledray: 93b). If the SANE must leave the room for any reason during the exam, the evidence must go with her (Frank: 96). She must be able to say in court that the evidence was in her possession from the time it was collected until the time it was secured in the locked refrigerator or given to law enforcement. Maintaining chain-of-evidence is critical to prevent any possibility of evidence tampering and to prevent the defense counsel from raising the issue of reasonable doubt of evidence integrity.

It is not necessary, nor is it appropriate, for the police officer to be in the exam room when the evidence is collected to maintain proper chain-of-evidence. The police can leave the area, and the nurse can call them when the exam is completed, in 2 to 3 hours, to return and pick up the evidence. Both signatures on the chain-of-evidence document are all that is necessary. When the police cannot immediately return, the SANE can place the evidence in a locked storage area, preferably a refrigerator with limited access, and when the police do return, any available nurse can sign that she removed the evidence from the refrigerator and gave it to the police officer (Ledray: 93b).

Maintaining Evidence Integrity

While it is suggested that the specimen be refrigerated for long-term storage to prevent deterioration of the specimens, it is essential that the evidence be kept in an area of less than 75 degrees Fahrenheit and the blood not be frozen. This means that

storage in an air-conditioned room is sufficient for short-term storage (Ledray: 93b).

Documentation

The amount of documentation varies from program to program. Some SANEs ask specific investigative details including what the walls looked like in the area where the victim was raped (Frank: 96). Detailed information is included in the Comprehensive Sexual Assault Assessment Tool (CSAAT). This tool was developed to provide a systematic guide for collecting information about the rape victim and offender. It includes detailed investigative information about the victim and offender as well as victim forensic data and data about the victim's post-rape functioning. If this tool is widely employed by SANEs across the country, then it can be used as a research tool to compile statistics across programs (Burgess & Fawcett: 96).

Other authors caution against collecting this detailed investigative information and suggest that the SANE should only ask for information necessary to deal with the immediate physical and psychological needs of the victim as well as to appropriately collect and interpret the physical and laboratory findings. Details reported by the nurse that differ from the police report may be used by the defense attorney to show discrepancies in the victim's story. The only documentation required is information necessary to guide the exam and treat the victim (Smith: 87).

It is important to remember that in addition to the SANE assault exam report, the entire chart is a part of the legal record and can be submitted as evidence if the case goes to court. All statements, procedures, and actions must be accurately, completely, and legibly recorded (Blair & Warner: 92). It is important to accurately and completely assess and document the emotional state of the victim and quote important statements made by the victim, such as threats made by the assailant (Antognoli-Toland: 85; Sheridan: 93).

Basic Documentation

- Location, date, and time of assault.
- Nature of physical contacts.
- Race, identity (if known), and number of assailants.
- Weapons and restraints used.
- Actual and attempted penetration of which orifice by penis, objects, or fingers.
- Sites of ejaculation, if known.
- If a condom was used.
- Activities of the victim that may have destroyed evidence, such as bathing, douching, bowel movement, use of tampon.
- If there was consenting sex within the last 72 hours and with whom.
- If the victim has changed clothes.
- Contraceptive use.
- Current pregnancy.
- Allergies.
- Victim's general appearance and response during exam.
- Physical injuries.

Sources: (Osborn & Neff: 89; Antognoli-Toland: 85; Ledray: 92b; Slaughter & Brown: 92).

It is important not to be afraid to include the name of the assailant, just be sure to use qualifying statements such as "patient states" or "patient reports" If the exam findings match the history given by the victim, the nurse should also document that "there is congruence between the victim's story and her injuries" or "the injuries are consistent with the victim's account of the assault" (Sheridan: 93).

There is disagreement over the use of the term "alleged" in medical documentation of a sexual assault. Non-SANE medical personnel were taught to use the term "alleged" because it was up to the

court to decide if the rape occurred (Bobak: 92). Several prosecuting attorneys state medical professionals should never use the term "alleged" in medical documentation as the term has negative connotations and may be interpreted by judges and juries as meaning the victim exaggerated or lied (Sheridan: 93).

After the Exam

Many SANE programs have a place for the victim to shower, brush her teeth, and change clothes after the exam. They often provide her with a change of clothes as well (Holloway & Swan: 93; Thomas & Zachritz: 93; Frank: 96; Sandrick: 96). The Assistance League, a national charitable organization, provides these services to rape victims in many States throughout the country. If a chapter exists in an area that does not currently provide this service, it may be willing to do so after being made aware of the need.

It is not unusual for the victim to be afraid to return home alone, so it is important to offer to call a friend or relative to be with the victim during the exam and to take her home (Ledray: 96a). More than 50 percent of rape victims move or change their phone number as a result of the rape (Tintinalli & Hoelzer: 85). Anticipating this potential move, while in the ED, the SANE may want to get the phone number of a close friend who will always know how to contact the victim.

Since the victim may be in a state of emotional shock at the time of the initial examination, it is important to provide her with written discharge information to take home with her (Osborn & Neff: 89; Speck & Aiken: 95). Followup phone calls within 24 to 48 hours to check on her emotional and physical status, medical concerns, and compliance with medications provided and to assist with additional referrals are also recommended (Osborn & Neff: 89; Ledray: 96a; Tintinalli & Hoelzer: 85).

Testifying in Court

Only a small percentage of cases will actually go to trial, and the SANE will be called to testify. In a review of 372 cases seen in a Detroit ED in 1980, only three went to trial and required medical testimony. Testimony about the injuries was a significant issue in only one of these cases. Ninety-seven percent of the guilty pleas resulted from plea bargains (Tintinalli & Hoelzer: 85). It is important, however, to treat every case as if it will go to court. Charting clearly and completely at the time of the initial exam is the best preparation.

The SANE should always meet with the prosecutor prior to testimony to be better informed about the significant issues involved and the defense that will likely be used to properly prepare her testimony in the particular case. For instance, if it is significant that no physical injuries were found, the SANE should review the data on the likelihood of injury during rape; if it was a delayed report, she should review the data on the typical time between rape and reporting. If the prosecutor does not initiate this meeting, the SANE should do so. Because of her training and experience, the SANE will likely be qualified to testify as an expert, rather than just a factual witness, in sexual assault cases (Ledray & Barry, 1998).

The SANE needs to conduct herself professionally and confidently in the courtroom. She should dress appropriately for the occasion. When sure of the facts, she should communicate that certainty. When she is uncertain or if she does not know the answer to a question, the SANE should also communicate this. If she does not understand a question, she should ask for the question to be repeated and should never attempt to guess the meaning of the question. She should never demonstrate anger, even if the defense attorney asks the same question repeatedly. It is important for the SANE to define her area of expertise and not testify about other matters such as the accuracy of DNA evidence. Watching a criminal trial or participating in a mock trial is excellent preparation and increases confidence.

Working with Special Populations

Male Victims

As with the rape of women, the rape of men is often not sexually motivated, but rather is a crime of aggression (Groth: 90). Sexual assault treatment centers report that males comprise approximately 6 percent to 10 percent of their clientele (Koss & Harvey: 91; Libscomb, Muram, Speck & Mercer: 1992). Male rape is generally thought to be more underreported than female rape. Male rape victims are even less likely to report than women because of the extreme embarrassment that they typically experience and because many men fear being misunderstood as homosexual. Most male rape victims have not considered the fact that men are also raped, and this contributes to the devastation and stigmatization that they experience. This trauma is similar to that experienced by a female victim who, while aware that rape does occur, never considered that she could become a victim of rape.

Lipscomb, Muram, Speck, and Mercer (1992) reviewed 99 male rape cases seen at their center. Of these, 80 were incarcerated and 19 were from the community. The men represented 5.7 percent of their clientele. They found that all of the men were raped by other men, except for one who was raped by two women during a robbery and extortion attempt. None of the victims was injured to the point of needing medical attention. As with women, threat of physical force alone was sufficient to subdue them. Only two men, both inmates, sustained even minor injuries. The community victims were older and more likely to have had weapons used against them.

Another study conducted by Kaufman et al. (1979) comparing 14 male victims with 100 female victims, found that the males were more often injured. Nine males (64%) were beaten, five severely, compared with 23 percent of the women. The men were also more likely the victims of multiple assaults by multiple assailants and were more likely to be held captive. The men were more likely to seek treatment for injuries without revealing the sexual assault. Five of the men did not initially report their sexual assault. It is important to teach emergency personnel to ask men who present for treatment of physical injuries if they have been sexually assaulted in a way that preserves dignity for the victim and demonstrates a nonjudgmental or neutral attitude on the part of the caregiver.

Male victims of sexual assault experience post traumatic stress reactions similar to those observed among female victims with fear being most commonly reported, followed by depression, suicidal behavior or ideation, anger, somatic problems, sexual dysfunctions, and disturbances in peer relationships (Koss & Harvey: 91). Men will need the same level of crisis intervention and followup care as women. However, males may be less likely than females to seek and receive support from family and friends. Their ability to seek support will vary according to the level of stigmatization they feel, the circumstances of the rape, and the sensitivity of care they receive in the ED or SANE community clinic. Donnelly and Kenyon (1996) point out that when a man is rectally raped, pressure on the prostate can produce erection and even orgasm, which may be confusing to male victims. Heterosexual men may struggle with issues surrounding sexual orientation. Some men may feel that their body has betrayed them. The SANE can allay fears and confusion by explaining that this is a physiological reaction to pressure on the prostate.

Victim gender is not an indicator of the offender's sexual orientation or preference. In a study of convicted male sex offenders who raped men, A. Nicholas Groth (1990) found that at the time of their offense, all of the men were actively engaged in consenting sexual encounters or relationships, with 9 percent reporting that those encounters were almost exclusively with other men and 32 percent reporting sexual activity with both men and women. In Groth's study, 27 percent of the convicted sex offenders reported that they confined their consenting sexual activity to women and half of them were married.

The SANE serves male victims well by taking the time to listen to what their experience was, what they were feeling as it happened, and what their immediate concerns are. It is helpful to describe common reactions men have after being sexually assaulted and to stress that men do get raped regardless of who they are, what they were doing, or how they look. Men may worry that they appear too effeminate, and this caused the assault. Gay men may wonder if the offender assaulted them because of their sexual orientation and struggle with resultant self-blame. All men, just as with all women, need to be reassured that their appearance, sexual orientation, and sexual preference had nothing to do with them being raped. Men are susceptible to the same techniques by which rapists gain control over female victims, the use of weapons, entrapment, intimidation, threats, and coercion.

Men who have been raped by women suffer the same feelings of helplessness, fear, and anxiety as do women who have been raped by men. They will, however, need more anticipatory guidance in considering how friends and family members may react. Many men will react to a man who tells them he was raped by one or more women by laughing and saying, "Why doesn't that ever happen to me?" The victim is left with his intense fear and anxiety invalidated which can lead to feelings of self-doubt, isolation, stigmatization, and depression.

Same Gender Sexual Assault

While little quantitative or qualitative research is available on same gender sexual assaults, it is important for the SANE to understand the dynamics involved in same gender assaults. The term "homosexual assault," which is often used in the literature, is not accurate in that many of the perpetrators of same gender sexual assaults are not "homosexual."

The majority of same gender acquaintance assaults occur as part of a pattern of domestic abuse in same gender relationships. The rate of same gender domestic abuse reflects that of the heterosexual population, about 30 percent (Abbott: 97). It is important for the SANE to sort through her feelings about same gender relationships so that she can treat all victims with dignity, respect, and compassion. All people who have been abused by their partners report the same range of feelings of fear, anger, guilt, depression, and anxiety over their living situation.

The majority of stranger assaults on people of the same gender involve men, usually heterosexual men. When the victim is gay or perceived to be gay, and the perpetrator attempts to humiliate or demean him, the assault can be considered in some States as part of a hate or bias crime involving power and control over the victim. Not all States consider same gender sexual assault as a bias crime. Alabama, for example, states that a bias crime is one based on the offender's bias towards a victim's race, color, ethnicity, religion, physical, or mental disability. Both gay and heterosexual victims who have been sexually assaulted are at high risk for depression and suicidal behavior. After being sexually assaulted by a man, gay men frequently feel more stigmatized and vulnerable, and heterosexual men usually go through a process of questioning their sexuality (Abbott: 97).

While female same gender assault is very rare, it does happen. Women who are forced to have sex with other women experience the same emotional reactions as women who are forced to have sex with men. They may also go through a process of questioning their sexuality if they are heterosexual or have an increased sense of vulnerability if they are lesbian or bisexual. The SANE needs to sort through what kind of contact took place and collect evidence wherever there may be hair, saliva, or vaginal secretions from the assailant.

Gay and Lesbian Victims

As with all people who have been sexually assaulted, the degree to which persons who are gay or lesbian will be able to recover from a sexual assault depends on the amount of support they have. Their recovery will also be affected by the amount of discrimination they experience from the

community around them including the health care and legal professionals charged with their care after the assault. Fear of disclosure is frequently a major issue, even for people who are very publicly open about their sexual orientation because of the further loss of control it represents. Even if the assault was not a crime of bias or hate, often it feels as though it is and results in increased anxiety, deep personal doubt, negative self image, and depression (Miller: 97).

People who are well integrated into the gay and lesbian community may, however, have additional strengths with which to deal with the sexual assault, gained from the coming out process and the constant consideration of hate and bias crimes and how to heal from them (Miller: 97).

At particular risk are adolescents who live in families or communities where homosexuality is not accepted and who are just beginning to explore issues of same gender sexual orientation but do not have supportive connections in the gay and lesbian community. Being raped by someone of the same gender and considering the ramifications of reporting can produce extreme anxiety. The SANE needs to understand that the adolescent's sexual identity is in the process of unfolding and using labels like "gay" or "lesbian" may be premature and threatening. It is less threatening to talk about attractions and interests. Confidentiality is of utmost importance for these youth as premature disclosure of sexual orientation can be extremely dangerous when the adolescent does not have the strength or support in place to deal with homophobic reactions of people in their family and community. **Psychological autopsies have shown that roughly one-third of all adolescents between the ages of 15 to 19 who have committed suicide were struggling with issues of sexual identity** (Dexheimer Pharris: 95). SANEs must pay special attention to helping adolescents, who have experienced same gender sexual assaults, sort through all of the ramifications of reporting. These youth will need referral for supportive services as they sort through their reactions to the assault and continue to explore issues surrounding sexual identity.

Lesbian victims of sexual assault by men experience a unique constellation of concerns. Lesbians constitute the lowest risk group for sexually transmitted diseases of all sexually active adults and may not be well aware of current STD risks from heterosexual exposure. They also have not had to worry about pregnancy risks and will need careful counseling about pregnancy risk and prophylaxis. For women who have not had sex with a man, vaginal penetration may be painful both physically and emotionally. Lesbian women often report sexual dysfunction after a rape which can be confusing as they ponder why the experience of violence with a man has carried over to their nurturing sexual relationship with another woman. Lesbians, like others, often wonder if the rape was their fault, but it may also bring up a deep-seated sexual confusion as the victim questions if she really wanted the assault to happen and whether it occurred because she looks straight. Many lesbians feel intense shame at having been violated by a man and forced to have sex with someone other than her gender or sexual preference—which represents an extra dimension beyond the experience of straight female or gay male rape victims. Common emotional reactions include a sense of isolation, vulnerability, punishment, and paranoia (i.e.,"Did he pick me because I look gay?"). Many lesbians report a deep sense of shame at having been violated by a man, which damages their sense of self in that they had previously prided themselves on their independence and self-sufficiency but now feel extremely vulnerable. It is important that SANEs have accurate information about lesbianism and anti-lesbian crime so that they can provide sensitive, appropriate care to lesbians who have been sexually assaulted (Tallmer: 96).

People with Developmental Disabilities

A review of assault rates indicates that from 68 percent to 83 percent of people with developmental disabilities will be sexually assaulted in their lifetime, which represents a 50 percent higher rate than the rest of the population (Pease & Frantz: 94). Of the sexual assaults of people with developmental disabilities, 30 percent are by family

members, 30 percent by friends or acquaintances, and 27 percent by service providers, with the likelihood of abuse by service providers increasing as the severity of disability increases. People with developmental disabilities are more likely to be re-victimized by the same person and more than half never seek assistance from legal or treatment services (Pease & Frantz: 94). Reporting may involve a loss of independence, for example, if a person is enjoying a new sense of independence in a group home. Reporting an ongoing assault by a staff member or other resident may pose the threat of reinstitutionalization.

When someone is sexually assaulted by a person from a professional helping agency licensed by the State, a criminal report may be filed by the victim, however, the SANE as a mandated reporter will need to assure that the State licensing agency receives a report of the abuse to investigate misconduct. Some States have vulnerable adult protection agencies that serve as contact points for such reports.

One of the factors that keeps people with developmental disabilities at a greater risk for sexual assault is the lack of good educational curricula to instruct people with developmental disabilities about the nature of sexual assault and how to assert themselves in establishing and maintaining self-protective sexual boundaries. Even though 99 percent of assaults on people with disabilities involve offenders who are known to the victim, the majority of self-protection curricula is geared towards stranger rape (Seattle Rape Relief: 97). Readers are referred to a manual written by Terri Pease, Ph.D. and Beverly Frantz, M.S. entitled *Your Safety...Your Rights & Personal Safety and Abuse Prevention Education Program to Empower Adults with Disabilities and Train Service Providers* published in 1994 by the Network of Victim Assistance, 16 N. Franklin Street, Suite 105, Doylestown, PA 18901, 215–348–5664. A video by the same name is available through Fanlight Productions, 47 Halifax Street, Boston, MA 02130, 617–524–8838.

In caring for people with developmental disabilities, it is important for the SANE to do a brief assessment of the victim's cognitive capacity so that appropriate care can be given. Specifically, the SANE needs to determine if the victim has the ability to provide informed consent, which entails the cognitive capacity to weigh the risks and benefits of different treatment options and the ramifications of reporting or not reporting an assault. The ability to provide informed consent is affected not only by cognitive capacity but also by the level of emotional stress a person is experiencing. People who are otherwise very high functioning may lack the ability to make even simple decisions after experiencing the trauma of an assault. The SANE must continually assess whether the victim understands what she is saying and doing.

In determining decisionmaking competence, the SANE is balancing two very important ethical values: protecting and promoting the individual's well-being and respecting the individual's self-determination (Buchanan & Brock: 89). A first consideration is whether or not the person is her or his own guardian and whether she or he functions independently in the community. In cases where the person has been deemed legally unable to provide informed consent, it may be necessary to contact a legal guardian to obtain consent to do an evidentiary exam. If a legal guardian is not available, the SANE proceeds with evidence collection, acting in what she perceives to be the victim's best interest and informs the legal guardian as soon as he or she is available. Exams are never done against a person's will. The reason for the exam should be explained in terms that victims can understand and their consent/assent should be obtained regardless of legal ability to provide informed consent. In situations where the victim is not able to verbally express his or her wishes, the SANE must be sensitive to grimaces and body movements so as to never retraumatize a person who has been sexually assaulted. As with any person who has been sexually assaulted, throughout the exam, the SANE explains what she is doing and why, in terms that the victim can understand.

The SANE must also determine the sexual assault victim's capacity for processing information. The use of concrete examples and language is recommended for all victims. Even though a person may be living on her own or driving a car, she may not be able to read or to process complex abstract concepts. People who have developmental or learning disabilities may be reluctant to admit that they cannot read well or at all. It is best to say, "There are some important things I would like to teach you. How do you learn best? By having someone tell you? Through pictures? Through reading?" The SANE will need to assess retention of new information. A social worker or public health nurse may need to be involved in planning post-assault care.

People with limited abstract reasoning skills will need help in trying to determine who to tell about the assault and who they do not want to know about the assault. Often when they return home or to school or work, people with developmental disabilities freely disclose details of the assault and become revictimized by the attention of those around them. The SANE can greatly assist the victim by talking through how different people will react, who needs to know, how much to share with whom, and what the possible ramifications are of sharing information. For people who are unable to imagine people's possible reactions and who are very verbal, it may be best to encourage a few days off of school or work so that they can process their strong feelings and reactions with staff or counselors rather than with people on the bus or at work or school.

In considering whether to share information about the assault with other professionals in the victim's life, the SANE is weighing the person's well-being with the right to confidential care and need to be in control of who is told. When staff from group homes or other social service agencies are present, it is important to honor the victim's right to confidentiality and discuss with her or him what information can be shared. Confidentiality should not be broken except when there is a clear need to involve another caring person to protect the victim from additional harm.

People with Physical Disabilities

People with physical disabilities may also be at greater risk for sexual assault, especially if they are dependent on others for personal care. Ninety-nine percent of offenders who sexually assault people with disabilities are known to their victims (Seattle Rape Relief: 97). When the offender is someone who is supposed to be in a helping relationship, concerns about loss of services and independence arise. The victim is left with fear and anxiety over the potential harm from people whom they should be able to trust and rely on for assistance and support. This can lead to overwhelming feelings of vulnerability, stigmatization, and depression. If the assailant works for a helping agency, a report to the State licensing board is mandated.

After having been sexually assaulted, people who are differently abled respond emotionally in all the same ways that people who are currently able-bodied respond. They may, however, need to talk through how they perceived the role their disability might have played in making them more vulnerable to the assault. The SANE can listen to their concerns and what the experience was like for them. They will benefit from reviewing the roles force, threats, and coercion play in rape and from being reminded that even strong able-bodied men and women are sometimes raped.

People who are differently abled are only "disabled" to the extent that their differences are not accommodated for by society. It is imperative that SANE programs provide services that are equally accessible to all people.

Because so much of the post-assault care involves an exchange of information (telling the story of the assault, discussing feelings, explaining the evidentiary exam, teaching about common symptoms of rape related post traumatic stress disorder and means of coping, etc.), people who are deaf or hard of hearing will need sensitive and appropriate care. *Deaf* is defined as a hearing loss of such severity that the individual must depend primarily upon visual communication such as writing, lip reading, manual communication and gestures. *Hard of*

hearing is defined as a hearing loss resulting in a functional loss, but not to the extent that the individual must depend primarily upon visual communications (Schumacher & Hung Lee: 97). While deafness is not a handicap in and of itself, deaf and hard of hearing people are handicapped by the lack of services that provide sign language interpreters. SANE programs must have a system in place to communicate with people whose primary means of communication is signing. The program should also provide access to a TTY/TDD (teletypewriter/telecommunications device) for deaf and hard of hearing people to call.

The following guidelines for caring for people who are deaf or hard of hearing were compiled by Kathy Schumacher, edited by May Hung Lee and published in the *Minnesota Coalition Against Sexual Assault Training Manual* (1997, pp. 2-49–2-51):

- When Deaf [or] Hard of Hearing victims seek services, they will have the same basic needs and fears that hearing victims have. They need to feel welcome. Motion the person to follow you to a quiet office. Tell the individual your name. Write it down on paper if the victim does not seem to understand. Ask the victim if he or she wants an interpreter—there are sign language interpreters as well as oral interpreters. Also, let the victim know (on paper, if necessary) that you will be calling for an interpreter.
- It is important to have the Deaf [or] Hard of Hearing person's attention before speaking. Since she cannot hear the usual call for attention, she may need a tap on the shoulder, a wave of the hand, or other visual signals to gain her attention. Do not speak before she is ready to listen.
- If the victim is wearing a hearing aid, do not assume she will or should have good hearing. She will still have some difficulty and will benefit from your consideration.
- Whether she indicates she can read lips or not, body language and gestures will help communication. Write down any words she seems to be having trouble understanding. Be sensitive to the fact that she will be observing closely your body language and will pick up on visual signs of frustration. Try to relax and to help her relax.
- Look directly at the person while speaking. Even a slight turn of the head can obscure the Deaf [or] Hard of Hearing person's vision. Do not talk to her if your back is turned or when you are in the dark or in another room. Do not turn away in the middle of a sentence. Other distracting factors affecting communication include mustaches which obscure lips, smoking, pencil chewing, and putting your hands in front of your face.
- Do not speak to a Deaf [or] Hard of Hearing person with your back to a light, window or mirror. Have the light in YOUR face, not hers.
- Every Deaf [or] Hard of Hearing person will communicate in a different way. Some will use speech only; some will use American Sign Language only; some will use a combination of sign language, finger spelling, and speech; some will use body language and facial expressions to supplement their interactions. Deaf [or] Hard of Hearing people use many ways to convey an idea to another person. Sign language is an inclusive term that refers to any method of communication: American Sign Language, signing exact English, finger spelling, and any combination of these.
- Just as each individual has her own style of speaking, grammar usage, vocabulary, and favorite idioms and clichés, Deaf [or] Hard of Hearing people also have their own individualized manner of speaking in sign language. People who use exact English are probably more able to converse through written means. Often, hiring a sign language interpreter will be your only effective communication method with someone whose native language is American Sign Language. Understand that American Sign Language

(ASL) is not the same as English. The interpreter is trained to recognize and utilize similar signs as the Deaf [or] Hard of Hearing person. Examples of American Sign Language, as written may be: *Movie last night. Wow good. Should see you. Laugh roll* ("The movie I saw last night was very good. You should see it. I laughed so hard I was almost falling on the floor."), or *Home many problems. Not good my house. Want out finish trouble.* ("There are a lot of problems at home. My house is not a pleasant place right now. If my husband/boy friend/partner leaves, the trouble may stop.") To someone familiar to sign language, this manner of expression is quite clear. Interpreting word for word is not always understandable.

- Try to maintain eye contact with the deaf person. Eye contact helps convey the feeling of direct communication. If the interpreter is present, continue to talk directly to the deaf person. Do not use phrases such as "Tell her that." Speak directly to her.
- Be flexible in the use of language. English may not be a Deaf [or] Hard of Hearing person's primary language, and therefore you may need to simplify your sentences.
- Pantomime, body language, and facial expressions are important factors in communication. Experiment with different techniques. Be sure you use all of them.
- Do not shout or use exaggerated lip or facial movements. Use an almost normal rate of speaking—not too fast, but not so slowly that the natural rhythm is lost. The thought should come as a whole. Take care to "round off words." Enunciate clearly and distinctly, keeping the voice as vibrant as possible.
- Do not assume the victim can read lips.
- Use words with the most lip movement, such as "25 cents" instead of "a quarter."
- If she does not understand, change the wording. Use other expressions that get the same point across. Do not repeat the same phrase over and over.
- People with some hearing loss find it is hard to hear in the presence of background noise, so be sure to move away from such noise.
- Ask her to let you know what to do to better enable her to understand you—her hearing ability will vary with rooms, background noise, fatigue, and many other factors.

People who have impaired vision usually do not need assistance in familiar surroundings but will need accommodations when they are in the hospital or clinic for a sexual assault exam. They will need to be oriented to their surroundings. It will be especially important to talk about everything you are doing. Before you touch them, explain that you will be touching them and how and why. When moving from one room to the next, they can be offered your arm to grasp above the elbow for guidance. Verbally point out obstructions, like chairs, exam tables, etc. Always tell the person when you are leaving the room. If the victim has a guide dog, do not be diverted by [it] or ask about the dog's reaction—this distracts blame from where it belongs—with the rapist (Erb: 96).

The Elderly

Many people do not recognize that the elderly are at risk for sexual assault. Older women with impaired mental functioning are especially vulnerable. Rape may go undetected when health care professionals overlook the signs. Community health care facilities with large populations of elderly women need to be educated by the SANE regarding symptoms of a potential sexual assault and how the health care facility staff should respond when an assault is suspected. Whenever an assault occurs in a health care facility, the appropriate governmental adult protection agency must be notified, and they in turn are responsible for reporting the incident to the State health care facility regulating agency.

Decreased hormonal levels following menopause result in a reduction in vaginal lubrication and cause the vaginal wall to become thinner and more

friable. Therefore, elderly women are at an increased risk for vaginal tears and injury when they have been vaginally raped. Because of these physiological changes, a pedersen speculum, which is longer and thinner than the graves speculum, should be used during the pelvic exam for evidence collection, and special care should be taken to assess for intravaginal injury. In some elderly women, the SANE will need to simply insert the swabs and avoid the trauma of inserting a speculum. Just as with premenarchal young women and children, if there are external tears in the introitus, internal injuries must also be considered.

Declining physical strength and agility heightens the elderly's fear of not being able to resist or escape an assault. For the elderly, loss of hearing increases the fear that an intruder will not be heard. Loss of visual acuity causes shadows to take on an ominous quality heightening fear. Frail elderly are at greater risk for injury. After an assault, well-meaning relatives may wish to place an elderly family member who has been raped in a nursing care facility, which serves to further limit their independence and poses the threat of never returning to independent living (Simmelink: 96). The SANE can assist elderly victims and their family members to make plans that maximize the person's independence yet assure her safety. The SANE is able to refer the family to individuals and agencies that can work with them in assuring an appropriate placement, if needed. Any placement should protect the elderly rape victims without further limiting her enjoyment in life and sense of autonomy.

Self-Injury Victims

Self-injury victims are a special subcategory of victims who may make false reports. It is particularly important that the SANE be aware of clues to false reports from this victim group. It is not uncommon for victims who have not resolved some past trauma to injure themselves and report having been raped. The victim may have actually had sex with someone who thought the sex was consensual, but during the sexual contact, the victim had a traumatic re-experiencing of a painful sexual assault in the past, or an incest experience and withdrew and dissociated from the partner. The victim may also have re-experienced the traumatic experience while alone. This usually occurs during times of stress for the woman, such as following the first disclosure of incest or the recent loss of a loved one who has been supportive, or following an intense therapy session in which the precipitating trauma was discussed.

Clues for the SANE to look for *in suspected false-reporting cases* include a vague description of the assailant, too vague for the described circumstances of the assault, often not even including his race; stalking, including leaving notes telling the victim how beautiful or terrible she or he is; superficial cuts or scratches of the inner thigh or inner arm, consistent with the victim's handedness; an unusual event reported as part of the rape, such as dirt and leaves in the vagina; unusual patterned injuries such as superficial straight patterned cuts intersecting the nipples described as occurring during a struggle; and multiple rape reports. The victim may also report a history of incest that resembles the current trauma she or he is reporting.

Fortunately, it is not the SANE's job to determine if the person was raped, so evidence collection with these cases should proceed as usual. The SANE should not, however, be afraid to indicate "injuries inconsistent with reported history" if that is the case. Since the role of the SANE is to provide the care required for every victim, in these cases especially, mental health assessment and referral are essential (Ledray: 94).

Refugees and Immigrants

Refugees are people who had to leave their native country and are seeking asylum in the United States because it was too politically or physically dangerous to stay in their homeland. Immigrants are people who have chosen to come to the United States. In the past few decades, many men and women came to the United States from Southeast Asia, South America, Central America, Northern Africa, and Bosnia as a result of war. Refugees and new immigrants are especially vulnerable to

victimization. They may be particularly vulnerable if they immigrated illegally and are afraid to report violent incidents or if they are uneducated and unaware of their rights, or how to access services. Assailants assume that people who are undocumented will not report an assault to the legal authorities for fear of being deported. Sexual predators capitalize on the vulnerability of recent immigrants and refugees.

While accurate numbers are not available, the literature indicates that in refugees seeking counseling, 52 percent of the men and 80 percent of the women were sexually tortured during the war or political conflict in their home country (Agger: 87). When people who have been sexually tortured are raped, they not only experience the trauma of the rape, but also are vulnerable to a traumatic re-experiencing of the sexual torture. For refugees who were subjected to torture in their native countries, a doctor or nurse was often present at the time of torture. For this reason, the mere presence of medical personnel after a rape may be anxiety producing. SANEs should be aware of this possible history and realize that due to the devastating nature of the experience and its emotional sequelae, most torture victims will not readily disclose a history of torture. Extra care must be taken to assure refugee or immigrant rape victims that they do not have to do anything they do not want to do and that if something hurts, they should let the SANE know, and the SANE will stop. The SANE should explain what she is doing and why. The victim should be encouraged to keep her eyes open during the pelvic exam—this will reduce the likelihood of flashbacks to the torture experience. Torture victims who have been raped need to hear that they have not sustained any permanent physical damage and be reassured that their body will heal, if this is the case. Just as with incest victims, they will need additional support in the rape recovery process.

If a female victim comes from a culture that blames the victim for rape or does not consider her marriageable once raped, she may deny that she was raped. If married, she may reasonably fear that her husband will blame her and/or reject her if she admits to being raped. Both male and female victims may admit to a physical assault, especially if there are injuries to explain, however, even when asked directly, they may deny any sexual contact. This will be problematic to the SANE, the police, and the prosecutor if the evidence of the rape is identified later. Valuable evidence will have been lost and credibility as a witness will be in jeopardy. To facilitate a truthful disclosure early, it is essential that the SANE interview the victim in privacy and work at building a trusting relationship. If the victim does not speak English, a professional interpreter must be provided.

Because the consequences of rape within their cultural context are so grave, women from some non-Western cultures may not seek treatment immediately following a rape. They may wait until an injury, pregnancy, or a sexually transmitted disease forces them to seek medical care. They may also be in extreme emotional crisis and suicidal. Understanding the meaning of rape in their culture and knowing appropriate, culturally sensitive referral sources is crucial. Strict confidentiality, even from other family members and staff from the victim's culture must be maintained (Mollica & Son: 89). While bicultural staff are most often an advantage and facilitate understanding and credibility, with some victims, they can be a threat to confidentiality for the victim and should not be present. The social stigma of people from the community knowing about the assault can be so powerful that it prevents the victim from telling what happened and getting needed care. The victim needs to have control over whether a specific professional interpreter will be utilized, especially if the interpreter is from his or her community. Although it is always essential to explain the person's legal right to confidential care, many people who come from war torn countries will not be able to trust promises of confidentiality, no matter how strong, because of the extensive use of informants in their home country. Under conditions of war, people are reluctant to confide in and trust even close friends. Therefore, a tension develops between the need to have a culturally specific interpreter skilled in the victim's dialect

present and the need to maintain complete confidentiality. Generally, both male and female victims of sexual assault will feel more comfortable with a female interpreter and staff.

Working with Interpreters

Providing interpreter services is not optional, it is legally mandated. The U.S. Department of Health and Human Services considers lack of interpretation to be a form of discrimination. Title VI of the Civil Rights Act of 1964 [601 78 Stat 252 942 USC 2000d)] states that "no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" (Center for Cross-Cultural Health: 97).

The legal aspect of the SANE exam demands that the environment be one in which the assault victim is comfortable enough to honestly describe what happened to her. Due to possible cultural sensitivities and the potential of breach of confidentiality, family members or friends should never be used as interpreters in providing care and collecting evidence. Many SANE programs utilize the interpreter services of local medical and legal agencies. Professional interpreters not only speak both languages but are also trained in how to make a person's message clear. The professional interpreter is also held accountable for confidentiality, accuracy, and unbiased interpretation of what has been said. Consequently, it is also not sufficient to use a bilingual staff person to interpret. Employing highly skilled, professional interpreters is an essential component of providing comprehensive services to non-English speaking victims of sexual assault. Interpreter services need to be planned in advance for the immigrant groups residing in the SANE's area of service. (The reader is referred to this chapter's section on "People With Physical Disabilities," which covers issues surrounding the need for interpreters for people who are deaf or hard of hearing.)

The following guidelines adapted from the Center for Cross-Cultural Health's handbook, *Caring Across Cultures: The Provider's Guide to Cross-Cultural Health Care* (1997) outline important principles in working with interpreters:

- Meet with the interpreter briefly before the interview to explain the situation and what kind of questioning and teaching you will need to be doing. Attend to any personal issues the interpreter may have regarding sexual assault. Discuss how the interaction will proceed and where the interpreter should sit. If the interpreter needs to be in the room during the exam, she can be on the other side of a curtain to assure maximal privacy for the victim. [Note: Ask the interpreter about any areas requiring cultural sensitivity prior to the interview.]
- When speaking, address yourself to the victim, not the interpreter. Maintain eye contact, as appropriate, with the victim, not the interpreter. Speak directly to the victim, addressing him or her as "you," not the interpreter.
- Don't say anything you don't want the victim to hear. Expect everything to be translated. Realize that what may be said in a few words in one language, may require a lengthy paraphrase in another.
- Speak clearly, in a normal voice and not too fast. Stop at comfortable intervals for the interpreter so that she can translate what you are saying accurately and completely [—generally] one long sentence or three or four short ones. Stop at a natural place for the interpreter to pass your message along. Always stop at the end of a sentence. Short simple sentences are easier to translate.
- Expect the interpreter to interrupt when necessary for clarification or to take notes if things become complicated.
- Avoid jargon and technical terms. You may need to repeat what you have said in different words if your message is not understood.

- Meet with the interpreter afterward to assess how things went and to see if she is satisfied with the accuracy of the information passed along. Also attend to any vicarious traumatization she may be experiencing from having passed along the story of the assault.
- Have the interpreter sign a statement that she interpreted for you and the victim including the date, time, and agency for which she works.

In situations where an interpreter is not available for the language of the victim, or when the available interpreter is a member of the victim's community and she or he prefers a stranger, there are phone medical interpreter services that can be accessed. The drawbacks of phone interpreter services are the expense and the inability to pick up on nonverbal cues. The following services can be accessed for interpreter services (Center for Cross-Cultural Health: 1997):

AT&T Language Line Service, 1 Lower Ragsdale Drive, Monterey, CA 93940, 800–874–9426 or 800–752–0093 (call to set up an account or hear a recorded demonstration of the Language Line service). The service have up to 140 languages and is available 24 hours a day, 7 days a week. They can usually connect you with an interpreter within 60 seconds. For frequent users who subscribe to the service on a monthly basis, the rates are $2.20 to $4.50 per minute depending on the language and the volume discounts available. For users who cannot predict their need on a monthly basis or justify a monthly minimum, the rates are $3.50 to $4.50 per minute depending on the language. For occasional users, the rates are $4.15 to $7.25 per minute, depending on the language.

Pacific Interpreters, Inc., 1020 SW Taylor, Suite 280, Portland, OR 97205. 800–870–1069 or *information@pacinterp* (e-mail). They have more than 65 languages and specialize in interpreting in the health care and social service areas and charge $1.95 per minute with volume discounts available.

Providing Culturally Congruent Care

The way people react to and recover from sexual assault is largely determined by the culture(s) within which they live. An essential part of SANE training involves assuring competency in providing culturally congruent care. Culture does not simply refer to ethnic origin or race, but rather implies all of the groups and subgroups that surround and support individuals. Transcultural nurse theorist Madeleine Leininger (1995) defines culture as the learned, shared, and transmitted knowledge of values, beliefs, norms, and lifeways of a particular group that guides an individual or group in their thinking, decisions, and actions in patterned ways. *Subculture* is closely related to culture and refers to a group that deviates in certain areas from the dominant culture in values, beliefs, norms, moral codes, and ways of living with some distinctive features of its own. Leininger (1995) defines culturally congruent care as those cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are mostly tailormade to fit with an individual's, group's, or institution's cultural values, beliefs, and lifeways in order to provide meaningful, beneficial, satisfying care that leads to health and well-being.

An individual's culture(s) will shape the way she experiences a sexual assault and how she will recover from it. To provide culturally congruent care and to be of maximal assistance to her clients, each SANE needs two essential skills: 1) the ability to acquire essential knowledge about the cultures and subcultures in her service area and 2) the ability to do a culturalogical assessment to determine the degree to which each individual ascribes to cultural values and mores governing sexual assault and recovery from trauma.

There is a temptation to use a cookbook approach to caring for people from various cultural backgrounds, listing how each individual culture sees

sexual assault. While broadly informative, this approach carries the danger of stereotyping individuals and of not responding in a way that is comfortable or helpful to them. The SANE does, however, need to know the potential differences and similarities between her culture and the culture(s) of the people she serves. The following process is recommended:

1. Analyze your own cultural beliefs and values. Formal cultural assessment guides are available to assist nurses in this process such as that provided by the Center for Cross-Cultural Health (1997).

2. Get to know the cultures in your service area. General cultural guidebooks such as those written by Lipson, Dibble, and Minarik (1996) and Geissler (1993) provide an overview of different cultures, but it is best to meet with people from the cultures represented in your community who are knowledgeable about health care practices. Listen to them about their experiences and beliefs surrounding sexual assault, reporting, and recovery. **Optimally a partnership will be formed to best serve people from that community.** Each SANE program needs to be proactive in establishing these partnerships with all communities in the service area.

3. Become proficient in conducting culturalogical assessments. This involves assessing where each individual is at in terms of their own unique set of values, beliefs, and lifestyle. It also involves being aware that clients may belong to subcultures or groups such as gay, lesbian, transgender, and bisexual communities; a subculture of homeless people; the deaf community, etc. The SANE can get a good sense of the person's cultural influences by asking, "How will the people who are important to you react to this assault?", and exploring the meaning of the rape and people's reactions to the victim. The SANE needs to listen to how the victim perceives the ramifications of reporting, not reporting, telling others, etc. For example, in some communities an adolescent girl who is vaginally raped may be ostracized from the community or no longer considered marriageable. The SANE needs to thoroughly explain the limits of confidentiality within the legal system and listen to how the young woman feels, what she thinks might happen, and what she wants to do. Victims may be reluctant to further stigmatize people of their race. Many women who have been raped by men from their own minority racial group are faced with intense conflicting feelings of wanting to hold the assailant accountable, yet not wanting to send another man of her race to jail. If victims perceive the legal system as being racist and not trustworthy, they may fear sending an innocent man to jail for their assailant's crime (White: 94; Wilson: 94). The SANE needs to be aware of and sensitive to these dynamics in her community.

4. Be aware of culturally appropriate referral sources for followup care and develop partnerships with them. Culture shapes the way we frame traumatic experiences and how we best heal from them. They may thus reach for a larger lesson to be learned from the experience and not be so extremely overwhelmed by feelings of guilt and shame, but rather deal with the painful situation by using tolerance, denial, or stoicism (Kanuha: 97). Other cultures may have a specific ritual for healing post traumatic stress, such as the Navajo Enemy Way ceremony. This is a ritual in which the family and tribe accept responsibility for the impact of trauma on young returning warriors through the use of a healing ceremony which facilitates processing war trauma and reintegration into the peacetime community (Marsella, Friedman, Gerrity & Scurfield: 1996). Juris Draguns (1996) points out that cultures vary in their components of intervention to post traumatic stress disorder in the following ways:

- Use of interpretations and their rationale and basis.
- Extent and nature of verbal interaction between client and therapist.
- Role of verbal communication.
- Role differentiation between client and therapist.
- Respective weights of physical and somatic and psychological distress.

- Role of ritual in psychotherapy.
- Use of metaphor, imagery, myth, and storytelling in psychotherapy.
- Nature of relationship between therapist and client.

SANE programs need to be aware of the cultural differences in the above areas for the cultures represented in the area they serve in order to provide culturally congruent crisis intervention services. Updated information on how specific cultures provide crisis intervention can be one function of the partnerships alluded to earlier between SANE and cultural communities within the service area. Cultures are not stagnant and do change so updates on how cultures view and respond to rape are essential.

Additional Program Components

Additional components of SANE programs referred to in the literature include education and training for the medical and nursing community (Speck & Aiken: 95); 24 hour hotline (Speck & Aiken: 95); court advocacy services (Speck & Aiken: 95); scientific research and program evaluation (Speck & Aiken: 95; Burgess & Fawcett: 96; Holloway & Swan: 93; Ledray: 93); followup counseling (Speck & Aiken: 95; Ledray: 92b); and consultation services with other SANE programs (Speck & Aiken: 95; Ledray: 92a).

As SANE programs mature, these program components grow as well. New SANE programs will likely concentrate their efforts on providing clinical services and obtaining training for their own staff. As SANEs become more experienced, they may begin to provide training for other professionals and nonprofessionals in the community. With even more experience and depth of knowledge, they may be able to provide consultation services to newer SANE programs.

Summary

Collecting evidence for the evidentiary examination of the rape victim is the central focus of the SANE program operation. While guidelines can certainly be provided concerning what evidence should generally be collected, it is important to recognize that every case will likely be just a little different from another. Additionally, each SANE needs to have a thorough understanding of the forensic principles involved and an understanding of special populations that may be encountered so that each rape victim can receive the best possible care available.

CHAPTER 12

PEDIATRIC SANE EXAM

Nursing care of children who have been sexually abused or sexually assaulted involves all of the skills utilized by SANEs in caring for adults, with the added knowledge of pediatric growth and development. SANEs who work with children need to be able to give care that is appropriate to each child's age and developmental stage. This chapter will address special considerations of a pediatric SANE exam and is to be read in conjunction with the entire manual. Only the differences between a pediatric and adult SANE exam and sexual assault examination will be discussed.

Child sexual abuse is defined as the involvement of developmentally immature children or adolescents in sexual activities that they do not fully comprehend, to which they are unable to give informed consent, or that violate taboos or family relationships (Emans, Laufer & Goldstein: 98). It can range from exhibitionism, to fondling, to intercourse. Approximately two-thirds of child victims are abused by a family member (Reghr: 90). When a child has been sexually abused by a relative or someone who is responsible for his or her care, or when the abuse is the result of parental neglect, the SANE must deal with issues pertaining to the child's protection and involve the appropriate governmental protection agencies.

The term *sexual assault* refers to any sexual act performed by one person on another without that person's consent. The assault may involve the threat of force or the person may not be able to give consent because of age, mental or physical capacity, or cognitive impairment due to drugs or alcohol (Emans, Laufer & Goldstein: 98). Sexual assault of a child is usually an acute traumatic event. Child protection and police notification laws for sexual assault vary from State to State with some States mandating a report to police and child protection only if the assault occurred as a result of parental neglect. In other States, a police report is mandated for all sexual assaults of children. It is important that each SANE knows the mandatory reporting guidelines for the jurisdiction in which she works.

The sexual assault exam will be affected by the relationship of the child to the offender; the child's physical, emotional, and mental development; the child's ability to communicate and understand; and the child's ability to trust another person (i.e., the SANE). Attention must be given to recognizing and responding to these factors.

The goal of a pediatric SANE exam is to provide comprehensive sexual abuse evaluation and nursing care to a child and her family in an environment that is comfortable for the child. Consideration is given to the physical and emotional needs of the child, collection of evidence, screening for and prevention of STDs and pregnancy, providing for the safety of the child, and referral for followup medical care and counseling.

Setting

A busy hospital emergency room can be frightening to a young child, therefore it is recommended that pediatric exams be completed in an alternative setting when possible (Stovall, Muram & Wilder: 88). A quiet setting away from traffic and decorated to appeal to children will help the child feel relaxed and welcomed

Special Training

Pediatric SANEs need to be knowledgeable about the physical, intellectual, and emotional development of children and adolescents. Ideally, the SANE will have pediatric training and possess highly developed skills in communication with

children. The SANE must be comfortable with children and enjoy working with them. Thorough knowledge of the developmental stages of childhood is essential, as is an understanding of pediatric anatomy and the ability to interpret normal and abnormal findings. Skills and experience in conducting interviews with children, collecting and documenting forensic evidence, and testifying in court are also important. Pediatric or family practice nurse practitioners or nurses with experience working with children are good candidates for SANE training where children are part of the client population.

Sexual Assault Response/ Resource Team (SART)

Chronic sexual abuse of children is generally inflicted by someone who is known to, or part of, the child's family. Often the abuse has occurred for some time before it is discovered, and it may have a profound and long-lasting impact on the child and family. To respond to the complex needs of children and their families, most pediatric SANE programs utilize a team approach to effectively gather needed information and evidence. In addition to the SANE, the team may include other health care staff, workers from child protection, and representatives from law enforcement (i.e., police, district or county attorney).

Interview

A skilled interview and documentation as to what the child says during the exam are essential components of the evidence collection process. Past studies support the fact that the majority of children with legally confirmed sexual abuse have normal or nonspecific genital findings (Adams, Harper, Knudson & Revilla: 94; DeJong & Rose: 91; Muram: 89). In a study of 236 children where the perpetrators were convicted for sexual abuse, normal genital examination findings were reported in 28 percent of cases. Nonspecific findings were reported in 49 percent, suspicious in 9 percent, and abnormal in 14 percent (Adams et al.: 94). In cases with normal or nonspecific findings, the child's statements are the primary evidence used in successful conviction. Successful prosecution may depend on the child's ability to tell what happened, and the skill of the person eliciting, documenting, and testifying to the child's story. The purpose of the initial interview is to create an opportunity for the child to tell what happened in a way that will both benefit the child and obtain objective verbal evidence for prosecution. In a good interview, the child will feel listened to, understood, valued, and affirmed, and thus begin the road to recovery. At the same time, subjective verbal evidence from the child will be documented by the licensed professional or SANE for use by the courts.

Who Conducts the Interview

Careful consideration must be given to who will conduct the interview. Interviewers need to be trained by experts in forensic interviewing techniques. They must have a thorough understanding of child development and abuse dynamics. It takes experience and training to know how to frame questions that elicit information from the child that will be admissible in court. Some SANE programs may choose to provide the advanced training necessary to prepare the SANE to conduct pediatric forensic interviews. Other SANE models may use a team approach, having the SANE collect the physical evidence, with a social worker, psychologist, child protection worker, or law enforcement officer completing the bulk of the forensic interview.

Victim Interview

An initial interview with the child should take place as soon as possible after the suspicion of abuse has been disclosed so that the child's statements are not affected by memory loss or influenced by talking to others. Consideration is given to the child's readiness and ability to talk, the child's physical and emotional needs, time of last suspected incident, and the availability of a trained person to conduct the interview. If the last incident of abuse occurred within 72 hours, a physical exam and evidence collection should be done as soon as possible to preserve evidence. If a child becomes

reluctant to discuss the abuse later, initial statements will be important evidence. It is important to be aware of and sensitive to the child's eating and sleep schedules. In cases where the abuse occurred more than 72 hours ago and the child is tired, hungry, or unwilling to talk, or if an experienced interviewer is not available, delaying the interview would be a wise decision.

The interview should take place in a quiet room with a minimum of distractions. A two-way mirror, if available, allows medical and legal professionals who also need the information to observe the interview without making the child feel uncomfortable. A few simple toys to establish rapport as well as paper and crayons to illustrate what happened may be helpful. Too many toys and equipment in the area may prove distracting for the child.

Although all team members may need the information obtained from the interview, it is recommended that one person alone conduct the interview and that repeat or multiple interviews be avoided whenever possible. Repeated questions run the risk of implying to a child that he or she is not believed or that the answers provided earlier may not have been correct answers. Children's answers to repeated questions may acquire a rote quality that detracts from their credibility. Children questioned repeatedly may also become bored or uncomfortable and deny the abuse occurred in an effort to end the interview (Paradise: 90). To allow other team members access to the information obtained in the interview, the use of two-way mirrors, videotaping, and concise, detailed written documentation are recommended (Jezierski: 92; Levitt: 93; Pope & Brucker: 91; Sacks: 89; Stovall, Muram & Wilder: 88; Wright, Duke, Fraser & Sviland: 89).

A parent, guardian, or advocate may request to be present during the interview. While in some States this may be the victim's right, their presence is generally not recommended when interviewing children who have been sexually abused (Kivlahan, Kruse & Furnell: 92). A parent or guardian's presence is often distracting. The parent's nonverbal reaction to disclosed information or possible coaching may influence what the child discloses. Also, anyone who observes the interview may become a witness and thus may be excluded from the courtroom at a later date when their supportive presence is needed by the child (Sorenson, Bottoms & Perona: 97).

The interviewer's first task is to create a safe and trusting environment in which rapport can be established with the child. The interviewer should introduce him or herself to the child, explain the purpose of the interview, sit at eye level, and maintain eye contact. The child needs to be told that she is not in any trouble. Beginning the interview with several neutral questions will give the child time to relax and become familiar with the interviewer. The child can be asked about favorite toys, pets, school, friends, who they live with, the names of the people in their families, what they like best about the people they live with, what they like to do when they are alone, what makes them happy, sad, mad, scared, etc. (Kolilis, 1996). This will also allow the interviewer time to assess the child's linguistic, cognitive, behavioral, and social development (Levitt: 93; Sorenson, Bottoms & Perona: 97).

Next, general open-ended questions, such as "Why are you here today?" or "What were you told about coming here?", can be asked to elicit a narrative response as the interview moves into a discussion of the abuse. The child is asked to tell what happened and then allowed to tell the story in his or her own words with as few interruptions as possible. Neutral statements such as "Can you tell me more about that?" or "What happened next?" or "What else?" will support children and encourage them to continue. Open-ended, nonleading, neutral questions are recommended. Direct or "yes" and "no" questions should be used only to verify or clarify what has been shared (Levitt: 93; Sorenson, Bottoms & Perona: 97). "Why" questions are avoided as they imply blame. The child should be told that it is okay to respond "I don't know" or "I don't remember."

Young children are concrete thinkers and may not know that a pronoun refers to the subject of a previous sentence, therefore the interviewer needs to be careful with words like "he," "she," "there," and "that" as they may hold a different meaning or be confusing to the child. Children under 9 or 10 years are not always able to give accurate estimates of time, distance, weight, color, or relational ties. "Why" and "when" questions should be avoided in this age group. "When" can be answered by "Where were you, and where was mommy or other family when it happened?" As concrete, literal thinkers, young children may, for example, answer "no" to the question, "Did you have your clothes on?" when they were wearing their pajamas (Graham Walker: 97). Clarifying questions will need to be asked. For example, "So, you were naked?" "No, I had my pajamas on." SANEs need to be knowledgeable on the developmental stages of childhood, which are included in most pediatric nursing texts (Rollins: 95; Sieving: 95).

Some programs use anatomical dolls or anatomical diagrams as interview aids, while others rely on the use of children's drawings. The use of anatomical dolls has raised controversy, and guidelines for their use has been established (APSAC: 95). Some courts have disallowed the evidence related to their use. Decisions to use anatomical dolls or not should be made in conjunction with the local prosecuting attorney's office. Ceci and Bruck (1993) reviewed the literature in the area of children's memory and suggestibility and found children age 4 years and younger to be more suggestible than older children. Other studies done on the use of anatomical dolls as interview aids with children ages 3–7 have found that the dolls increase recall accuracy with little or no increase in false reports of genital touching (Katz et al.: 95). Anatomical dolls allow the child to "show" rather than "tell" what happened when verbalization is difficult. The child is told that the dolls are used to help talk about and show things that really happened. Dolls have been found by some to be useful in confirming the interviewer's understanding of the child's description of the abuse and reduce the likelihood of misunderstanding (APSAC: 95).

If anatomical dolls are used, it is essential that the interviewer be trained in their use.

Anatomical dolls or diagrams are used by some programs to determine what words the child uses to label body parts. It is important to know what children call their own body parts. The interviewer goes through the identification from head to toe and shows no surprise as the child names the body parts. Questions like "What do you call this part?" "What is it for?" and "Is it for anything else?" can be asked as the interviewer points to sexual and nonsexual body parts.

If anatomical diagrams are used, they should be age, gender, and race appropriate. After identifying and labeling all body parts, the child is instructed to use a crayon to draw a circle around the parts of his or her body that the person touched. The child is then asked to draw a circle on the perpetrator diagram around the parts of his or her body that were used to touch the child. The drawings are placed side by side, and the child is asked to draw a line between the parts of the adult body that were marked and the parts of the child's body that were marked and is asked to tell what parts are being connected. The diagrams must be labeled and made a part of the permanent record.The child signs the sheets, they are dated and signed by the interviewer, and a notation is made that states, "words describing body parts are the words used by the child" (Poyer: 97).

Objectivity and a neutral response to the content of disclosure should be maintained throughout the interview. The SANE should be comfortable discussing sexual abuse with the child and never respond with shock or disbelief. The child's expression of feelings, both physical and emotional, can be elicited and supported throughout the interview by asking, "How did that make you feel?"

In concluding the interview, the child is asked if he or she has any questions. Questions should be answered honestly. Promises which cannot be kept should not be made. The child should be thanked for participating in the interview.

Written documentation of the interview process should include the specific questions that were asked as well as verbatim answers from the child. The child's nonverbal behavior, such as changes in facial expression, and emotional responses are also documented. The child's drawings are labeled. The name and title of all people present during the interview must be recorded (Muram: 87; Paradise: 90; Tipton: 89). When the interview is taped, the date, time, location, name of child, and name and title of the interviewer and anyone else present must be included in the recording.

Caretaker Interview

The child's caretaker is interviewed individually and separately from the child by the SANE. The caretaker is requested to provide information about events leading up to the assault and what is known about the incident (what, where, when, who). Complete name and address of suspected offender, if known, relationship of the suspected offender to the child, the child's medical history, and observed changes in the child's behavior or physical condition should be taken as an initial assessment. When known, the suspected offender is never present during the interview or evaluation process. The interviewer gathers information about the circumstances under which the caretaker first learned of the allegations and assesses the family's reactions and support systems (Davies et al.: 96). The SANE must also determine whether protective issues exist so that a safe disposition can be planned for the child.

Consent, Confidentiality, and Reporting

Minor Consent

In some States, a parent or legal guardian must sign a consent giving authorization to complete the exam, photograph injuries, collect evidence, provide medical treatment, and release information to the proper authorities. In other places, individual State law dictates who can consent for a child to be examined and who can access evidence and information in a child abuse investigation. Exceptions to parental consent exist when the parent or legal guardian is also the suspected offender or when a parent cannot be found and time-sensitive evidence must be collected. In these situations, a police officer, a representative from the State children's services or the court may authorize an exam.

On occasion, minors present on their own, without a parent or guardian, requesting confidential care for sexual abuse or assault. Adolescent minors may be able to consent for themselves. It is imperative that the SANE be aware of the specific laws in her legal jurisdiction governing minor consent for medical and forensic care, specifically STD and pregnancy assessment and treatment.

Even in situations where the law mandates that the consent of a parent, guardian, or legal authority is necessary to conduct a sexual abuse/assault evidentiary exam, the minor's consent is also always necessary to proceed with the exam. An exam is **never** done against the patient's will, no matter what age.

Confidentiality

Medical records including photographs are protected by confidentiality laws. In most States, parents have the right to access their child's medical records, but not records related to police investigation. Challenges to confidentiality often arise when the parent is the suspected offender or the noncustodial parent demands to see the medical record and the custodial parent refuses. Some States and SANE programs have solved this problem by separating medical records (which includes medical history, diagnosis or impressions, medical treatments, and medical referrals) from the forensic investigative record (which includes anatomical descriptions of genitals and pattern injuries, investigative interviews, and verbal history of the assault/abuse). Other States have created laws which protect the confidentiality of the medical record by forcing the medical provider to lock up the forensic record and to release it only to a team member or

by protective court order. By separating the medical and forensic records, the critical evidence of the investigation remains confidential and belongs to the investigating law enforcement jurisdiction (Aiken & Speck: 91). When the SANE's forensic record is considered part of an investigative record, it is usually protected under laws that govern police investigations and is protected until it becomes public in a legal proceeding such as discovery. If maintained as part of the patient chart, forensic investigative records and child maltreatment forms can be clearly marked, "denial to access" to alert medical records personnel not to release them without a court order or request from the investigative team. However, keep in mind when you are designing your record system around confidentiality issues, any record that has relevance to the court can be subpoenaed unless protected by the court (Nass: 91).

A team consisting of representatives from law enforcement, child protection, the county or district attorney's office, medical institution, and the SANE program should develop a written protocol addressing confidentiality and consent issues that adheres to individual State laws.

Adolescents

Since the 1970's, an increasing body of Federal and State legislation allows minors to consent to their own medical care in the areas of sexual and reproductive health and chemical dependency, or in cases where they have some degree of emancipation from their parents (i.e., if they are married, have given birth, are in the military, are living apart from their parents, or are legally emancipated). When this legislation is called upon to enable an adolescent to consent for his or her own care, the adolescent alone has the right to access or release the medical records related to that care. As of 1995, most States did not have statutes specifically enabling or prohibiting minors' consent for sexual assault evidentiary exams (English, Matthews, Extavour, Palamountain and Yang: 95; Dexheimer Pharris & Ledray: 96). Given that citizens of any age may report crime without parental consent, some SANE programs have chosen to provide primary and secondary care to the raped adolescent who seeks screening and prophylaxis for STDs, care of injuries, and contraceptive and pregnancy related care under the laws that govern these categories of medical care of adolescents. Laws governing minor consent and confidentiality vary from State to State, and SANEs need to know the laws governing minor consent in the jurisdictions they serve.

Adolescents consenting to their own care need to be informed by the SANE of the limits of confidentiality. When a police report is being filed, the adolescent should be told which information becomes part of the public record, who will have access to it, and under what circumstances. The SANE must also be aware of billing policies, so that adolescents can be informed if their parents might receive an itemized bill or statement of services provided. Whether or not the SANE involves a parent or legal guardian will depend on the adolescent's ability to provide informed consent, the State's laws allowing adolescents to give consent for their own care, the adolescent's expressed desire regarding parental involvement, and the existence of adequate post-assault support for the adolescent (Dexheimer Pharris & Ledray: 97).

Mandated Reporting

All States have designated mandated reporting of suspected child abuse. In most States, health care professionals are mandated to report when their professional service brings them into contact with a minor child whom they suspect may be a victim of abuse by a person who is responsible for their care, in a position of authority, or has a significant relationship (i.e., family member or someone living in the same home). A report may also be mandated in situations where a sexual assault occurred as a result of parental neglect. In some States, any criminal sexual conduct mandates a report to the police. It is essential that all team members have a thorough understanding of the laws governing mandatory reporting of child abuse and sexual assault in the legal jurisdictions they serve.

Specifically, they must know what, when, how, and where to report.

Collection of Physical Evidence

This section highlights the ways in which a pediatric exam differs from an adult exam. Please remember that the information here should be used in conjunction with the information regarding adult exams contained throughout the manual. The pediatric protocols and sexual assault exam forms for two successful SANE programs that care for children are included in Appendix I.

Goal

The goal of the pediatric sexual assault exam is to 1) identify the child's emotional and physical needs related to the assault, 2) collect and document evidence following a suspected sexual contact, and 3) provide appropriate followup health care and counseling referrals.

Components

The components of the exam include a general physical examination, thorough examination of the oral and anogenital area, collection of forensic evidence, screening for evidence of sexual contact such as STD and pregnancy, prophylactic treatment to prevent STDs and pregnancy when needed, crisis intervention and emotional support for the child and family, and referral for followup care (Kaufhold: 93; Kivlahan, Kruse & Furnel: 92; O'Brien: 92; Sacks: 89).

When to Do an Evidentiary Exam

A child who presents within 72 hours of a suspected incident of sexual abuse will immediately receive a complete evidentiary exam. The exam will include visual inspection and collection of specimens to detect semen and cultures for STDs as deemed appropriate per the child's reported history. Specimens are only collected in the orifices and body surfaces reported to have had contact with the assailant's body fluids. When greater than 72 hours have elapsed since the last suspected incident of abuse, an exam will be arranged as soon as convenient for the child, family, and examiner. The nature of the exam will depend on the history of suspected abuse and includes assessment for genital abnormalities and cultures for STDs when indicated (American Academy of Pediatrics, Committee on Adolescence, 94; American Academy of Pediatrics, Committee on Child Abuse and Neglect: 91; Kaufhold: 93; Kivlahan, Kruse & Furnell: 92; Levitt: 93; Stovall, Muram, Wilder: 88).

In addition to a positive history of sexual contact, other factors considered in the decision to collect evidence may include 1) nonspecific or specific genital findings upon examination, 2) access to the victim by suspected offender, 3) inconsistent history from child and or parents, or 4) evidence of acute injury. In one program, when these factors were considered, this group was four times more likely to have definitive laboratory evidence of assault than the group with a negative history and normal findings (Speck: 1999).

The age of the suspected offender also needs to be considered. If the reported offender is younger than the age of spermarche, sperm evidence will not be found. For most boys, sperm is first produced at age 13, but may occur as young as age 11 (Neinstein: 96).

Preparing the Child for the Exam

The child should be prepared for the evidentiary exam by explaining what will happen in terms that the child can understand. In preparation, the child should be shown equipment such as the colposcope, gloves, and swabs and allowed to try them out on a stuffed animal or doll. An animal or doll can be used to demonstrate procedures and positions that the child will experience. This brief playtime has been shown to reduce the child's anxiety while allowing the examiner an opportunity to assess the child's developmental, behavioral, and emotional status. Many examiners believe that, if possible, the exam should be completed apart from the child's parents or guardians. Others think a parent, guardian, or support person who has been

chosen by the child to be present during the exam may reduce the child's anxiety. Most children are content to be examined apart from their parents, and additional historical information can then be elicited during the exam to further clarify the details of the sexual assault.

With adequate preparation, most children will be able to relax and participate in the evidentiary exam. Under no circumstance should a frightened, resistant child be restrained to complete the exam. Restraint and force, often a part of the sexual abuse experience, will only heighten the child's fear and anxiety and intensify the psychological impact of the abuse. The SANE may experience a rare occasion where a child's fears cannot be calmed and he or she cannot be distracted, and yet it is felt that an immediate exam is necessary. In these rare situations, the use of sedation such as Versed (HCMC Pediatric Sexual Abuse Exam Protocol: 97), Diazepam, Chloral hydrate or Fentanyl (O'Brien: 92) has been recommended.

After preparation of the child for the exam, it is recommended that the examiner begin with a routine, complete pediatric physical examination. This will allow the SANE to gain the child's trust and understanding that the anogenital exam is part of that routine exam. Sexual development should be indicated according to the Tanner scale (Sieving: 95).

Exam Positions

The two most popular examination positions for children during inspection of the genitalia are the supine frog leg position and the prone knee-chest position. In the frog leg position, the child is supine on the exam table with head elevated, hips flexed, soles of feet together and drawn up towards the buttocks. Frightened or younger patients may be examined in the frog leg position while sitting on a trusted person's lap (Soderstrom: 94). The knee chest position places the child's head, chest, and knees on the examining table while the buttocks are elevated for visualization of the genitalia. Other positions for evaluation of the genitalia include the lateral recumbent with knees flexed. This position might be used when the history dictates that the assault occurred in the prone knee chest position. Abnormalities seen in the supine frog leg or lateral recumbent positions may disappear when the patient is inspected in the prone knee chest position.

When the child is ready, the SANE will carefully examine all orifices where sexual contact is suspected. In an anogenital exam in girls, the exam includes careful inspection of the perineum, the clitoris, the hymen, and the anus. Careful inspection of the perineum includes inspection of the mons, the clitoris, the labia majora, the labia minora, the vestibule, the urethra, the hymen, the visible vaginal structures, the fossa navicularis, the posterior fourchette, the perineal body, and the anal structures including the verge (anocutaneous line), the pecten, the pectinate line and anal crypts, anal papilla and rectal columns, and rectal ampullae when visible. Visualization of the hymen can be done by applying gentle traction on the labia majora by grasping them between the thumb and forefinger on each side and gently pulling in an outward and downward direction. This method should open the vulvar structures for full visualization by the examiner. The hymen is examined for recent or past trauma, and the diameter of both the hymenal opening and hymenal rim is noted (Levitt: 93). The physical examination of male children includes careful inspection of the inner thighs, penis, glans, scrotum, and anus. The anus in male and female children can be evaluated by gently separating the buttocks and waiting for the child to relax.

Documentation should include tanner staging and anogenital findings. All anogenital findings must be documented completely and accurately on genital or anal diagrams or by magnified photography. Any fresh or healed injuries or signs of STDs are clearly described, noting color, size, and location of any discoloration, tears, abrasions, ecchymosis, or swelling.

Recommended Equipment

Use of a colposcope or medscope for examination of the genitalia in pediatric cases is strongly encouraged. This equipment provides the examiner with excellent illumination and magnification, making clarification of detected injuries easier. Camera and video attachment allows for the documentation of findings (Kaufhold: 93; Levitt: 93; Soderstrom: 94). Conventional (non-colposcopic) protocols have historically yielded positive genital findings in only 10 percent to 30 percent of cases. In reporting 4 years' experience with the colposcope in the exam of children for possible sexual abuse, Woodling and Heger (1986) identified lesions which would have been missed without the aid of the colposcope in 10 percent of the cases. Myers et al. (1989) studied the use of colposcopy in 500 females, 91 percent of whom were under age 19. They found that colposcopy provided additional information about physical findings not seen during visual examination of genitalia in 11.8 percent of cases (Myers, Bays, Becker, Berliner & Saywitz: 89). Teixeira (1981) had similar findings in the colposcopic evaluation of 102 children under 14 years of age, with the colposcope proving useful in clarifying the diagnosis. Teixeira found colposcopic examination helpful in assessing fimbriated hymens in children under the age of 10. In a retrospective chart review comparing genital findings prior to program acquisition of colposcope with findings after colposcopic examination was initiated, one SANE program found the colposcope to not only increase detection of microtrauma by 11 percent in children and adolescents, but it also changed the location where most frequent injuries were detected. In girls from birth to 12 years of age, prior to colposcopic exam initiation, the order of most frequent areas of injury detected was 1) hymen, 2) labia minora, 3) posterior fourchette, and 4) rectum. With the colposcope, the order of most frequent site of injury in this age group was 1) hymen, 2) rectum, 3) labia minora, and 4) posterior fourchette. In girls ages 13 to 17, the order of most frequent site of injury precolposcopy was 1) hymen, 2) posterior fourchette, 3) labia minora, and 4) cervix. With the colposcope, that order changed to 1) hymen, 2) cervix, 3) posterior fourchette, and 4) labia minora (O'Brien: 97).

The medscope, which is an adapted dental camera, provides photographic documentation that has a greater depth of field than the colposcope, is less expensive, and can be used to document injuries elsewhere on the body (McDonald: 97).

In the absence of the colposcope, videocolposcope, or medscope, the standard fluorescent ring lamp with magnifying capacity of 5X is helpful in assessing vaginal trauma (Tipton: 89). Another alternative is the use of a 35 mm camera with a 105 mm macro 1:1 telephoto lens with an attached flash ring (Kaufhold: 93). Hand held magnifying lenses (5X) have also been used.

McCauley, Gorman, and Guzinski (1986) found the use of 1 percent toluidine blue dye to increase the detection rate of posterior fourchette lacerations from 16.5 percent to 33 percent in a pediatric sexually abused population and from 4 percent to 28 percent in an adolescent population. Although these findings support the use of toluidine blue dye in detecting injuries, it is important to consider that toluidine blue dye has been found to be spermicidal (Laufer & Souma: 82). If applied prior to the collection of vaginal specimens, the dye may alter the evidence of motile sperm found on a wet mount. The effect of the dye on venereal disease detection is unknown. However, Hochmeister et al. (1997) found that neither the dye nor the various dilutants (1 percent acetic acid or lubricants) had a negative effect on the ability to obtain DNA profiles using either RFLP or PCR methods of detection. Any program considering the use of 1 percent solution of toluidine blue dye should ensure that use of the dye does not interfere with laboratory procedures used in the detection of biological samples (semen, sperm, saliva, blood). If collecting specimens prior to applying the dye, the SANE must keep in mind that this may leave room for the argument in court that the findings were made with the insertion of speculum or swabs.

Additional recommended equipment may include Foley catheters for better visualization of the hymen of menstruating adolescents. In rare instances, pediatric anoscopes or speculums may be needed, however, because of the pain involved with their insertion, they are generally used only under general anesthesia and not in the outpatient setting. The reader is referred to the SANE literature for guidance on the use of these tools.

Evidence Collection Sites

Current common practice dictates that specimens for semen be collected only from orifice and skin locations that the child indicates were involved in any assault that occurred within the past 72 hours or according to jurisdictional protocol. The only difference in the collection of skin, oral, rectal, or vaginal specimens between adult and pediatric exams will be in the case of vaginal specimens in the prepubertal girl. A speculum examination in the prepubertal girl may be extremely painful and is not necessary or recommended for the collection of vaginal specimens or cultures. Speculum insertion is recommended when there is suspected penetrating vaginal injury and bleeding from an internal source. In this case, speculum examinations in the prepubertal child can be done under general anesthesia (Paradise, 90). In the prepubertal girl, vaginal specimens can be collected with a dry cotton sterile swab. Some authors suggest a small urethral size swab be used to collect vaginal specimens when the vaginal site is involved (Kaufhold: 93; Levitt: 93; Muchlinski, Boonstra & Johnson: 89; Sacks: 89), however, Ledray and Netzel (1997) have found that evidence will not be obtained as often using a small diameter swab, especially if the fiber is not cotton. In prepubertal girls, gonorrhea and chlamydia cultures can be obtained from the introitus because in prepubertal girls these bacteria grow in the vaginal epithelium.

STD Testing

Baseline testing for asymptomatic prepubertal children is not recommended except in the following circumstances: 1) the suspected offender is known to have an STD or to be at high risk for STDs, multiple partners, or past history of STD; 2) the child has symptoms or signs of an STD; or 3) there is a high STD prevalence in the community (CDC: 93). Other decisions to test for STDs should be made on an individual basis by the SANE and may include meeting the needs of a parent who wants to be sure no STD was transmitted. For adolescents who have been sexually abused over time, baseline testing should follow the above guidelines, keeping in mind that adolescents can have gonorrhea and chlamydia and be asymptomatic. Adolescents who present for an evidentiary exam for a one-time assault that occurred within the past 3 days are not tested for STDs but rather treated prophylactically for gonorrhea, chlamydia, and syphilis and referred for followup testing in 2 weeks. When testing is to be done, it may include culturing for gonorrhea and chlamydia from the introitus in prepubertal girls or endocervix in adolescent girls, and rectum and throat in both boys and girls. A syphilis serology should also be obtained, and HIV serology offered (Kaufhold: 93). A wet prep can be done for trichomonas. Testing for gonorrhea and chlamydia should be repeated in 2 weeks, syphilis serology in 6 to 8 weeks, and the HIV serology in 3 months and again in 6 months.

The practice of routine testing for STDs in asymptomatic prepubertal girls following disclosure of sexual abuse has recently been challenged with new information. In a study conducted at the Memphis Sexual Assault Resource Center, only 1.4 percent of 865 prepubertal girls seen within 72 hours of assault were found to test positive for N. gonorrhea. All subjects who tested positive were symptomatic. There were no asymptomatic positive results. Based on this information, it has been suggested that routine screening for gonorrhea in asymptomatic prepubertal girls is not indicated. Re-evaluation in 2 weeks following the assault is recommended (Muram, Speck & Dockter: 96).

Hair Specimens

The pulling of head and pubic hair is generally no longer done in pediatric exams. However, it is important that deleting this practice be confirmed

with the local county or district attorney and the State forensic laboratory.

Interpretation of Findings

Sexual assault examiners can expect to be called upon to testify in court whether or not their findings are consistent with sexual assault. Much debate has arisen over what is normal and what is abnormal in pediatric genital findings. It is essential that a beginning Sexual Assault Nurse Examiner train and consult with an experienced examiner. Interpretation of findings takes both experience and knowledge. Serious consequences can result if an inexperienced examiner assigns more or less meaning than is appropriate to genital findings. Numerous references and guides exist to assist SANEs in determining how to interpret and classify findings (Adams: 97; Adams & Knudson: 96; Aiken: 90; Chadwick et al.: 89; Girardin, Faugno, Seneski, Slaughter & Whelan: 97; Heger & Emans: 92; Muram: 89). A classification system is only a guideline to facilitate communication with nonmedical personnel. The following exemplar is a classification system developed by David Muram (1989) and used by many SANE programs for prepubertal girls:

Class 1: Normal Appearing Genitalia

Class 2: Nonspecific Findings

Abnormalities of the genitalia that could have been caused by sexual abuse but are also often seen in girls who are not victims of sexual abuse, e.g., inflammation and scratching. These findings may be the sequelae of poor perineal hygiene or nonspecific infection. Included in this category are redness of the external genitalia, increased vascular pattern of the vestibular and labial mucosa, presence of purulent discharge from the vagina, small skin fissures or lacerations in the area of the posterior fourchette, and agglutination of the labia minora.

Class 3: Specific Findings

The presence of one or more abnormalities that strongly suggest sexual abuse can include the following findings: recent or healed lacerations of the hymen and vaginal mucosa, hymenal opening of one or more centimeters, procto-episiotomy (a laceration of the vaginal mucosa extending to involve the rectal mucosa), and indentations on the vulvar skin indicating teeth marks (bite marks). The category also includes patients with laboratory confirmation of a venereal disease (e.g., gonorrhea).

Class 4: Definitive Findings

Any presence of sperm (Muram: 89, p. 212).

In order to communicate the meaning of their findings, SANEs should familiarize themselves with the literature on the frequency of findings in confirmed cases of sexual abuse for each category of the classification system they use. For example, when testing the above classification system, Muram (1989) found that of 31 girls who were confirmed victims of sexual abuse, no abnormalities were detected in 29 percent and nonspecific abnormalities were detected in 26 percent. Abnormal findings suggesting sexual abuse (class 3) were seen in only 45 percent of the girls. Another study reports that of 205 prepubertal girls who were victims of sexual abuse, 32 percent had no abnormalities (class 1), 22 percent had nonspecific findings (class 2), and 46 percent had abnormal findings (class 3) that strongly suggested sexual abuse (Aiken: 90). These studies suggest that physical findings alone are insufficient documentation and must be accompanied by information gleaned from a thorough history, a skilled interview, and observation of the child's behavior (Aiken: 90).

Antibiotics for Prevention and Treatment of STDs

In general, routine prophylactic antibiotic treatment to prevent STD in children following the disclosure of sexual abuse is not recommended (Giardino, Finkel, Giardino, Seidl & Ludwig: 92; Muram: 87; Paradise: 90). Prophylactic antibiotics are not recommended in the prepubertal population because 1) the risk of acquiring STDs

is low, 2) no single antimicrobial agent is effective against all infections, and 3) often abuse has been ongoing over a long period of time necessitating higher antibiotic doses than those prescribed for prophylaxis. Treatment with antibiotics may be considered when the offender is known to have an STD, the child is unlikely to return for followup, it is a one-time assault by a stranger, or multiple assailants have been involved.

The American Academy of Pediatrics, Committee on Adolescence (1994) recommends that prophylactic antibiotics be offered to adolescents to prevent syphilis, gonorrhea, and chlamydia. The SANE must remember that all three of these bacterial infections can be present in an asymptomatic adolescent and that prophylactic doses do not equal treatment doses. If adolescent females have been infected and are not treated, these infections pose the risk of PID with long-term consequences, including sterility. Guidelines for prophylactic treatment for STDs including hepatitis B, and treatment of known infection are contained in the *Sexual Transmitted Diseases Treatment Guidelines,* Center for Disease Control (1997).

Pregnancy Risk Evaluation and Treatment

Females who have begun menstruation will need to be evaluated for pregnancy risk and offered postcoital contraception as described elsewhere in this manual. For the prepubertal physically mature female who is not yet menstruating, postcoital interception should be evaluated as an option in consultation with the parent and supervising physician.

Psychological Considerations

The disclosure of sexual abuse will create intense conflicting emotions and psychological needs for the child and the family. At disclosure, the child may experience both tremendous relief and fear. The child may feel responsible for the disruption in the family that disclosure may bring. Emotions that children feel at this time include shame, guilt, anger, confusion, fear, betrayal, isolation, sadness, and fear of abandonment. At disclosure, during the interview process and during the evidentiary exam, the SANE and other team members can begin to address the child's emotional needs and initiate the healing process.

After the SANE exam, the child should be thanked for reporting the crime and participating in the interview and exam. Children should be told that what happened was not their fault and that their body is normal. One way to do this is to explain the process of healing. If the child is acutely injured, the injury should be explained, and the SANE should explain that the child's injuries can be expected to heal because the body is normal. Signs and symptoms of infection can be taught also. If the injury has healed, the child may be told that the injury has already healed. If the child has no evidence of injury, the child should be told there is no evidence of injury. Either way the child should be told their body is normal. Implementing the nursing process by encouraging the child to make choices during the examination, facilitating the development of a safety plan, and teaching personal safety techniques will give the child a sense of power and control.

Addressing the emotional issues will necessitate an understanding of the child or adolescent's developmental tasks affected by the abuse or assault, previous traumatic experiences and recovery, sources of support, and other concurrent stressors. Older adolescents may need more individual care in addition to support given to the entire family.

Family members will also be significantly affected by the disclosure of sexual abuse. The impact of the abuse on the child and the family will depend on the nature and duration of the abuse, the relationship of the assailant to the family, the amount of support the family has, the coping skills and stability of the family, and any recent crises the family may have experienced. Emotions that parents and guardians may feel include guilt for

not protecting the child, anger, sadness, confusion, and helplessness. While parents will need to have their feelings validated at the time of disclosure, they also need a great deal of information. They need to know what behaviors may be exhibited by their child and how to meet her emotional needs.

Turman and Dinsmore (1997) report the following common reactions for children following traumatic events. Children from birth to age 2 may react to trauma by increased clinging, crying, biting, throwing things, and becoming agitated. Children ages 2 to 6 may re-enact the trauma over and over, develop separation anxiety, become more withdrawn, regress in previously mastered skills, eat less, have nightmares, or act out. Children ages 6 to 10 typically react to trauma with difficulty concentrating, and often report headaches, stomachaches, dizziness, loss of appetite, and sleep disturbances. They may have trouble controlling their behavior and their imaginative skills may lead to embellishment of the event. They also will often show signs of regressed behavior. From ages 10 to 14, trauma may be manifested by regression, shows of anger, mood swings, theatrical portrayal of the traumatic event, self-judging and stigmatizing, withdrawal from family and school, psychosomatic illnesses, and minimization of the traumatic event in an attempt to deny it. Adolescents often respond to trauma by becoming very critical of parental or authority figures, turning to their parents only when severely troubled. Teens often try to deny the assault happened and spend time behind locked doors or withdraw into music. They also often become self-judging and suffer self-esteem issues. Common reactions to unresolved trauma in the adolescent population include risky sexual behavior, chemical (ab)use, running away, depression, eating disorders, sleep disturbances, suicidality, regressed behavior, and psychosomatic illnesses. School can be very difficult because of the impaired ability to concentrate and alterations in peer relationships, and students who have been sexually abused or assaulted may need special accommodations for a period of time. Slipping behind in school work is an additional assault on a traumatized student's fragile self esteem. While sexual abuse or assault can be very traumatizing for youth, it doesn't have to be. Children whose families take action to keep them safe and show them love and understanding usually do not experience long-term effects from the abuse.

Families need to know what steps to take next for legal, medical, and psychological followup, and they need to know which community resources to turn to for help in the days ahead. Assessment of the family's needs is complex, therefore it is recommended that all families be referred for counseling following disclosure of sexual abuse. A list of resources available in the community should be provided for the family at the time of the evidentiary exam. If possible, an initial appointment for followup counseling should be made before the family leaves the clinic or emergency room. It is also recommended that a member of the sexual abuse team call the parent or guardian a few days following the exam to offer additional resources or information.

Discharge Planning

Child Protective Services

In all States, Child Protective Services (CPS) are State legislated and mandated investigators who are responsible for devising a safety plan for children at imminent risk for harm. The SANE must consider the potential for harm to the child prior to their release/discharge from the SANE program. Open communication between the SANE and the CPS caseworker facilitates consultation and encourages involvement of the CPS caseworker prior to releasing the child to the parents or guardian. When there is doubt about the child's safety, she should not be released to the parents, and the CPS caseworker or law enforcement should be consulted in developing a safe discharge plan. The SANE must follow the mandatory reporting protocol of the jurisdiction in which she practices and assure safe disposition of the child.

Medical Care

The child's care giver will need to be instructed on the care of any injuries and given medication instructions, if applicable. Followup appointments with the primary health care provider should be made for repeat STD testing, if necessary, and for re-assessment of injuries. These appointments should be scheduled for the patient's followup medical needs and will generally follow a schedule of evaluation in 2 to 3 weeks, 3 months, and 6 months (CDC: 1993).

Other

In hospital centers, the care giver should be given telephone numbers for the rape crisis center, victim/witness (advocacy) programs, law enforcement, county or district attorney's office, CPS, as well as information on crime victim compensation programs. In integrated interdisciplinary community programs where SANEs, law enforcement, advocacy, and counseling work together sharing information, these professionals pick up the case immediately and contact the family with information.

Summary

This chapter addresses special considerations for SANE programs serving pediatric populations. SANEs who care for children must be comfortable interacting with children and knowledgeable of pediatric growth and development. Pediatric SANE programs operate out of a quiet, child-friendly environment and are designed to meet the unique needs of children and their families. The goal of the pediatric SANE program is to 1) identify the child's emotional and physical needs related to the assault, 2) collect evidence following a suspected sexual contact, and 3) provide appropriate followup health care and counseling referrals. SANEs must know local laws governing the care of minors so that they can determine in which situations law enforcement and child protection agency involvement is mandatory and when minors can consent for their own care. No matter what age, the patient's consent is always necessary to proceed with an exam; patients are never forced to undergo an exam. In child abuse exams, the interview is an essential part of the forensic evidence collection. Studies have shown that the majority of children with legally confirmed sexual abuse have normal or nonspecific genital findings. It is therefore recommended that interviews be conducted by an expertly trained professional.

Components of the evidentiary exam include a general physical examination, thorough examination of the oral and anogenital area, collection of forensic evidence, and screening for evidence of sexual contact such as STD and pregnancy when indicated. Specimens are only collected from the orifices and body surfaces reported to have had contact with the assailant's body fluids. A speculum is not used in examining prepubertal girls, unless penetrating injury is suspected and then it is usually done under general anesthesia. For adolescents, prophylactic treatment to prevent STDs and pregnancy is recommended. Additional supplies needed to care for a pediatric population include child-friendly pictures and furniture, a few simple toys, crayons, drawing paper, and equipment for magnified photography (colposcope). An ample supply of teddy bears who may be looking for adoption is also helpful.

CHAPTER 13

POLICIES AND PROCEDURES

The purpose of this chapter is to provide examples of SANE program policies and procedures for consideration or adaptation by a new SANE program. It is anticipated that every community and program will have unique needs, and so program policies and procedures will need to adapt. The following policies and procedures reflect the Minnesota hospital-based model and have common components of an integrated community-based model. When appropriate, the policy or procedure provided is followed by a "rationale" describing which factors were taken into consideration when developing the policy. These examples of hospital-based SANE policies and procedures are meant as a starting point and as a guide.

Consent

Policy

The SANE must obtain written consent to perform the following activities:

- Complete an evidentiary exam.
- Release the exam report and evidence.
- Communicate with law enforcement (except in mandated reporting cases).
- Photograph (35mm, Polaroid, or video).
- Provide medication for pregnancy interception.
- Release oral or written information to other agencies.

One program suggests that it is important that the consent form for the use of pregnancy interception, such as Ovral, include all three options available to the victim.

Procedure

Prior to any of the above activities, the SANE explains the SANE role to the victim, what is to be done, and why. She asks the victim to read and sign the appropriate consent form(s). On the pregnancy interception form, the three options available to the victim reflect the risks associated with both informed consent and informed refusal to take medication to prevent a pregnancy. One option on the pregnancy interception form should always be checked and signed by the victim.The original copy of all consent form(s) remains with the agency record (hospital or clinic).

Rationale

The victim should always check one option on the pregnancy interception form. This provides clear documentation of why the pregnancy interception is or is not given. The first option would be the typical informed consent of possible complications with agreement to take medication for pregnancy interception, such as Ovral. The second option would be "I understand [that because I am already taking a contraceptive/had a tubal ligation] pregnancy prevention is not recommended for me." The third option would be "even though pregnancy prevention was recommended by the SANE, I (the victim) chose not to take the medication" (Speck: 96). (See Appendix J: SANE Forms).

Court Testimony

Policy

It is understood that the SANE will respond to any subpoena regarding an exam she has completed. She will cooperate to whatever extent possible to

make herself available to testify in court when needed. The SANE program will pay the agreed rate of pay for a variety of activities associated with court testimony, which may include pretrial conferences, preparing for testimony, traveling, waiting to testify, and testifying.

Even when the nurse is no longer employed by the SANE program, she will remain obligated to the court of jurisdiction to testify and will be paid to do so.

Procedure

Subpoenas will be sent to the SANE office. As soon as a subpoena arrives the SANE office secretary will contact the appropriate SANE, who will then contact the subpoenaing attorney, usually the prosecutor's office.

Drug and Alcohol Screening (Other than for Rape Drugs)

Policy

Drug and alcohol screening may be obtained for two purposes. These are for medical-legal liability and as crime evidence.

Crime evidence. The SANE will ALWAYS draw two extra tubes of blood for potential use as crime evidence. These are placed in the rape kit and labeled "hold for alcohol/drug screen."

Medical-legal concern. An alcohol or drug screen will ONLY be run Stat in the ED when there is a medical-legal concern that the victim is intoxicated and cannot be discharged without liability.

The SANE will always document on the SANE Exam Report the presence of other indicators of intoxication such as steady or unsteady gait; coherent or incoherent speech; orientation or disorientation to person, place, or time; any odor of alcohol on the breath; intact memory or lack of memory for recent or past events; and any statements concerning drug or alcohol use before, during, or after the sexual assault.

Procedure

If the SANE is concerned that the victim is under the influence of mood-altering substances that may impair her judgment to the point of making it unsafe to discharge her from the ED, she will consult with a physician and draw blood for drug or alcohol testing. This specimen will be run by the ED or hospital laboratory prior to discharging the client.

In all other cases, the blood will be placed in the rape kit for later analysis by the crime laboratory, if necessary. In these cases where the client does not appear intoxicated, the SANE will explain to the client that she is drawing blood so that if the assailant attempts to say she consented to exchange sex for drugs, or she was so intoxicated that she does not remember consenting, there will be evidence to dispel his defense.

Rationale

Drug and alcohol screening of sexual assault victims has historically been controversial because this information has the potential to be used against the victim to blame or shame her or to attempt to impugn her testimony in court. Unfortunately, drugs and alcohol are today being intentionally used more frequently by assailants as a weapon to overcome the resistance of a potential victim. As we better understand this behavior, we also better understand the necessity of obtaining blood for drug and alcohol evidence.

When intoxication is suspected by medical personnel, the victim must be tested prior to discharge from the ED to avoid medical-legal liability for releasing an individual who is legally intoxicated and may be a harm to themselves or others.

Blood is used instead of urine because of the preference of the crime lab for analysis and storage. Be sure to check with the local crime laboratory personnel. Drug and alcohol screens are not run routinely as they are very expensive tests and can be run at a later time by the crime lab if the level of victim intoxication becomes a question when the case goes to court.

Unfortunately, in many cases, the offender will claim the victim consented to exchange sex for drugs. A negative drug screen can be helpful to disprove this defense. The offender may also claim the victim was so intoxicated that she does not remember consenting. Even if she did use drugs or alcohol, an accurate blood level can be used to corroborate her statement.

Evaluation of Nongenital Injuries

Policy

When the rape victim first arrives at the ED or clinic, the ED or clinic staff will triage for injuries. Any injuries requiring immediate treatment will be stabilized and treated at that time. If immediate treatment is not required, the SANE will collect evidence and document injuries prior to referring the victim back to the ED or clinic MD for any necessary treatment.

The SANE will consult with or refer to a physician whenever she is concerned about the victim's medical well-being and when any of the following are identified:

- Extensive genital trauma.
- Pregnancy.
- Asymmetric joint swelling.
- Head or chest trauma.
- Neurological deficits.
- Respiratory distress.

Procedure

After the SANE completes the evidentiary exam in the ED or clinic, she will discuss the treatment and care with the staff physician. She will, at that time, express her concerns about any physical issues and ask the physician to further evaluate the victim prior to discharge, if necessary. If the physician is unable to see the victim immediately, the SANE will transfer the victim back to the ED or clinic nursing staff for supervision until she is cleared medically.

Rationale

Nongenital injuries inflicted during rape are generally superficial and do not need medical intervention. In the 1 percent to 3 percent of victims who do have emergency injuries, delay could mean the difference between health and disability, even death.

It is important for the SANE to develop good nursing assessment and evaluation skills to allow her to accurately triage the victim for physical injury. If physicians feel confident the SANE will do a thorough physical assessment for medical sequelae and refer back to them, they will have confidence in the SANE's role as a collaborator in providing comprehensive care for the victim.

Evidentiary Examination Timing

Policy

A complete evidentiary exam will be completed on all sexual assault survivors seen at a participating facility up to 36 hours (often up to 72 hours for pediatric cases) after a sexual assault. This policy may vary from State to State and may extend to 96 hours after a sexual assault in some States. A complete exam includes the following five components:

1. Collection of medical-legal evidence utilizing a rape kit and following the SANE program protocol.

2. STD risk evaluation and prophylactic treatment.

3. Pregnancy risk evaluation and emergency interception.

4. Care and documentation of injuries.

5. Crisis intervention and followup referrals.

Post-36 hour exam. A post-36 hour exam will be completed between 36 and 72 hours (96 hours in some jurisdictions) after a sexual assault. It does NOT include the collection of evidence in the rape

kit, but may include the collection of other physical or verbal evidence of the crime. It also includes the following:

- STD risk evaluation and prophylactic treatment.
- Pregnancy risk evaluation and emergency interception.
- Care and documentation of injuries.
- Crisis intervention and followup referrals.

Post-72 hour exam. A post 72-hour exam is completed in some cases including those with injuries that can be documented. The police should be encouraged to bring these cases to the SANE for documentation. If the ED or clinic staff is uncertain what the client wants or needs, they will page the SANE who will go into the facility and make her own determination about the needs of the victim. If there are no injuries and the ED or clinic staff feel comfortable assessing the needs of the victim, the SANE may not be paged. Hospital and clinic staff should always call the SANE if there is any torn or soiled clothing for the SANE to collect as evidence or if there is physical evidence, such as injuries, for the SANE to document on the Sexual Assault Exam Report Form (For form see Ledray: 93b).

Any clothing, especially underpants worn directly after the assault, towels, or bedding that may have dried semen, will be bagged for evidence even beyond the 72-hour limit. In addition, injuries can be documented beyond the 72-hour limit.

Procedure

When the ED or clinic staff page the SANE to report that a client has arrived, the SANE will ask them when the assault occurred and if there are any injuries. Based on this information, the SANE will decide if she needs to go in, and she will let the ED or clinic staff know what she will be doing and why.

Rationale

These exam timing recommendations are based on the likelihood of collecting sperm and seminal fluid evidence. As DNA collection and analysis becomes more sophisticated, this policy may change significantly and exams may be completed for a much longer time period. Historically rape kits were collected up to 48 hours after the assault (Green: 88). This was based on fertility studies which defined sperm viability and presence in the vaginal and cervical areas for up to 48 hours after intercourse. More recent studies focusing on sexual assault evidence collection have challenged this 48-hour rule (Speck: in press). In a sample of 1,007 rape exams, most of the positive specimens were collected within 12 hours of the rape. The only positive sperm specimens collected beyond 36 hours of the rape were N=6 vaginal specimens collected in young adolescents, 16 years of age or younger (Tucker, Ledray & Werner: 90).

Once semen has dried on clothing, it will no longer deteriorate, but may provide positive results for weeks and even months or years after the assault. Antibiotics can be given to prevent the transmission of syphilis, gonorrhea, and chlamydia, and pregnancy interception can prevent a pregnancy if given within 72 hours after sexual intercourse. However, the sooner it is given the more reliable the results. Since prophylactic care to prevent an STD is not recommended after 72 hours, the victim should be referred for testing and treatment based on the results of these tests.

Examination Sites for Evidence Collection

Policy

The history from the client is critical in directing the SANE's investigation and evidence collection. Specimens are only collected from the orifices or sites the adult or adolescent victim indicates were involved in the sexual assault.

Procedure

After obtaining informed consent to conduct an examination, the SANE will ask the victim to tell her what happened and will specifically ask what

orifices (oral, anal, or vaginal) were involved and where there might have been ejaculation. An alternate light source will also be used to identify where skin specimens might be collected. The SANE will then collect specimens only from the reported orifices.

Rationale

Collection of evidence in the adult or adolescent victim is based on and driven by the victim's consent and willingness to participate in the investigative process (IAFN SANE Standards of Practice: 96). It is disrespectful to assume the victim is lying and collect specimens from orifices where she denies any contact occurred. There are also no data to show that useful evidence has been collected from an orifice not reported to be involved. It is very expensive and time-consuming to collect and analyze unnecessary specimens. Collection of a positive specimen from an additional site might even undermine the victim's credibility.

An exception to this policy would be cases in which the victim is unconscious or has little memory of the assault possibly as a result of drug use, voluntary or involuntary, or because the victim is incoherent or developmentally disabled. When the victim cannot provide information on the sites involved, the SANE should collect evidence from all orifices. By going ahead and collecting the biological evidence so it is not lost, the SANE is acting on what she believes is in the victim's best interest. The other exception would be in States where collection from all orifices is required.

HIV

Policy

The SANE will not routinely do baseline testing for HIV at the time of the evidentiary exam. She will talk with the victim about her risk, fears, and concerns regarding the possibility of contracting HIV. If the rape is considered a high risk for HIV exposure, she will recommend that the victim be tested for HIV after 3 months and again 6 months after the rape.

Prophylactic treatment for HIV is not routinely recommended or offered due to the potential toxicidity of the medications used (e.g., zidovudine), its high cost, and current low community HIV risk. If the case is a high-risk case, the victim should be given information about postexposure prophylaxis and referral information. Postexposure prophylaxis must be decided on a case-by-case basis. If it is known, or there is good reason to expect that the assailant was HIV positive, the victim should be referred to the ED physician for evaluation for postexposure prophylaxis. When utilized, it must be started as soon as possible and within 72 hours.

High-risk factors include the following:

- Anal rape.
- Vaginal rape when other STDs are present that would threaten the integrity of the vaginal mucosa.
- Vaginal rape with traumatic tearing injury.
- Known or suspected HIV positive offender.
- Known or suspected IV-drug use by the offender.
- Known or suspected bisexual activity of the offender.

Procedure

The SANE will determine if the rape is high risk for HIV exposure. She will inform the victim of current community HIV transmission rates and discuss her level of risk. She will also provide the victim with the appropriate written literature and followup information on HIV testing sites and safe sex practices for the victim and her sexual partner to consider until she can be tested for HIV. When appropriate, information on HIV postexposure prophylaxis will also be provided.

Rationale

As discussed in Chapter 11, how to best deal with the issue of HIV is complicated and controversial (Blair & Warner: 92). Because the rates of infection vary from State to State, so does the actual risk of

infection. It is important to evaluate the actual community prevalence of HIV before determining the local HIV policy. Zidovudine is the current drug of choice for health care workers exposed to the HIV virus in a needle stick incident. However, due to its potential toxicidity, its use is not recommended when the HIV status of the assailant is unknown in a sexual assault (Foster & Bartlett: 89).

Holiday and Weekend Work

Policy

Each SANE will be expected to be available to take call every third weekend and every third holiday and its associated weekend. This includes the following holidays.

Procedure

Staff are given one white square of paper for each shift of weekend call that they are responsible for a month. Before the scheduling begins, they have the opportunity of accepting additional weekend shift squares from others, or giving away their squares. Each time they take a weekend shift, they place one square in the center of the table until all of their squares are gone and all shifts are covered.

Holidays*

New Year's Day	Veterans Day
Martin Luther King, Jr. Day	Thanksgiving Day
President's Day	Friday after Thanksgiving
Easter	Christmas Eve Day
Memorial Day	Christmas Day
Independence Day	New Year's Eve
Labor Day	

* Weekends begin Friday evening and run through Sunday night.

Interpreters

Policy

Whenever a client does not speak English or is deaf, with her permission, an interpreter should be called, even if a family member or friend is available to interpret. If an interpreter is not available on site, a telephone interpreter service should be employed. The hospital where the exam is being completed is responsible for payment of the professional interpreter's fees.

Procedure

As soon as the SANE determines that the client cannot speak fluent English, she attempts to explain to the client that she wants to call for an interpreter. If the client agrees, an interpreter is then called. She should not begin the exam until the interpreter has arrived. The SANE will first have the interpreter explain to the victim that all information is confidential and that she cannot disclose anything said to anyone outside of the room at any time without the victim's written permission or she will lose her job.

The interpreter should be used for all aspects of care including the following:

- Explanation of patient's rights.
- Explanation of confidentiality.
- Obtaining informed consent.
- Explanation of exam procedures and purpose.
- Followup instructions and discharge.

The interpreter should be "debriefed" by the SANE after the victim has left. This should include a reminder about maintaining complete confidentiality. Resources for telephonic interpreter services are listed in Chapter 11: SANE Program Operation, in the section entitled "Working with Interpreters."

Rationale

It is important to get the client's permission before calling an interpreter, especially when the community of her nationality is small, and it might be possible that her confidentiality could be broken by calling a local interpreter whom she may know. It is also important, however, not to assume that the victim will be completely honest about what happened when a family member is present. This is especially true in cultures where victim blaming is predominant. It is imperative to be aware of the cultural beliefs and biases.

If the services of a particular language are used frequently, it may be helpful to do special training with interpreters to ensure that they are aware of the special needs of this population and to encourage them to find ways of dealing with the impact the information may have on themselves. When the victim is seen more than once for followup, utilizing the services of the same interpreter for each visit is advised to facilitate establishing rapport. Debriefing to deal with the impact of the information on the interpreter is essential.

Malpractice Insurance

Policy

As long as the SANE is practicing within the scope of her employment, including work in other community hospitals to which the county has agreed to provide services, she is covered for professional malpractice under the provisions of the county hospital by which she is employed. She is not required to carry her own malpractice insurance, and it is not recommended that she do so.

The indemnification plan protects the SANE against liability claims resulting from her work for the county. If she should be sued, the county will defend her in court, settle the claim, and pay the amount of any judgment rendered. Regardless if the allegations against her are true or false, the plan will protect her. The indemnification plan applies to any of her actions or omissions that occur while she is an employee performing her SANE duties, even if she has left the employment when the suit is brought. The plan does not cover actions that are outside the scope of her employment or which constitute criminal or unauthorized conduct.

Rationale

If the SANE is employed by a hospital or another institution, that facility will usually provide malpractice insurance for all employees and should also provide liability defense and indemnification coverage for the SANEs. In this case, it is not necessary for the SANE to carry her own malpractice insurance, and some institutional attorneys may recommend that the SANE not carry additional insurance as that will just encourage claims naming her personally in a law suit, and her personal insurance will be used first to pay any claim for damages that may occur. If she is named, the hospital that employs her will represent her. Other attorneys may recommend the SANE always carry her own professional liability insurance. The SANE should check with her institutional attorney and her personal attorney before deciding if she wants or needs to carry additional malpractice insurance. Ask to see a copy of the institution indemnification plan. If the SANE is not covered by an institution, the hospital where she provides service will most certainly require proof of professional liability insurance with specified required limits before she is allowed to practice at their facility.

Mandatory Institutional Inservices

Policy

The SANE will be expected to attend all mandatory training for the institutions with which the SANE program is associated. She will be paid for her time at the training by the SANE program. These include the following issues: CPR Training, Patient Confidentiality, Fire and Safety, and Patient's Rights.

Procedure

The SANE director will provide the SANE with a list of times and dates for the inservices. The SANE will make the necessary arrangements to attend and will inform her Director when each program is completed.

Mandatory Reporting of Sexual Assaults of Vulnerable Adults and Minors

Policy

The SANE is mandated to report the sexual assault of a vulnerable adult to adult protection services or the police. The SANE is also mandated to report to the police or child protection services the sexual assault of a minor by a family member, caretaker, or a person in a position of authority over the minor, or a sexual assault that was a result of parental neglect. In some cases, this report may already have been made prior to the SANE's arrival. In the State of Minnesota, the SANE is NOT mandated to report statutory rape.

Procedure

When the SANE determines that a minor or vulnerable adult meet the reporting guidelines, she will ask for evidence that a report has already been made. If a report has not been made, she will immediately report the assault to the proper authority.

Rationale

It is important to confer with the institution attorney and be aware of the State laws as well as the Federal laws. States have different laws regulating mandatory reporting for child sexual abuse, vulnerable adults, felony sexual assault of adults, and statutory rape. (See statutory rape policy and procedure this chapter.)

Medication Administration

Policy

Medications to prevent a pregnancy, prevent a sexually transmitted disease, treat minor injuries, or prevent nausea may be administered to the victim in the ED or clinic following the established medical protocol. In hospital-based programs, the SANE will confer with the physician on duty. When prescribed, medications should be provided to the victim prior to her departure from the facility as a part of the evidentiary examination and at no additional charge.

Procedure

The SANE will meet with the client to decide what her needs and desires are concerning pregnancy and STD prevention. The SANE will also assess the victim's allergies and obtain a UPT. Based on the results and following the medical protocol, the SANE will recommend a course of action to the staff MD on duty and get the physician's signature on the chart and on the prescription blank. The SANE will get the necessary consent forms signed (e.g., Ovral Consent/Pregnancy Interception). She will then obtain the medications for the client and provide her both oral and written instructions prior to her discharge. Programs that utilize nurse practitioners with prescriptive authority may choose to write their own prescriptions.

Rationale

While the SANE program has an established medical protocol, pre-approved by each participating facility or supervising physician, SANEs do not have prescriptive authority and the MD on duty is ultimately responsible for medical care provided, including the administration of medications. A close working relationship and case review is essential.

In most programs, the medication expense is included in the total evidentiary exam charge. It is not billed separately, as some agencies do not reimburse for medications. Programs that function as an extension of a public health clinic may administer the medication directly and at no additional charge through the clinic.

Noncompliant Victims

Policy

If for any reason, the victim refuses to sign the consent for treatment, or after signing the consent form states she does not want an exam, or any portion of the exam, the SANE will respect the client's wishes.

Procedure

The SANE will explain the purpose of the exam and process to the client, discuss her concerns, and inform her of the use and release of the evidence. She will then ask her to read and sign the consent form. If she refuses to do so, the SANE will ask what her specific objection is and talk with her about this. If she still refuses to sign, the SANE will inform her of the consequences of her refusal (the loss of evidence and the possibility that she will be responsible for the ED or clinic exam charges). If she consents to parts of the exam, but not the complete exam, the SANE will comply with her desires.

Rationale

Informed consent is always necessary for examination and treatment. The adult or even an adolescent has the right to refuse treatment, depending on the State law, regardless of the desires of any parent or guardian. However, the age limit for the adolescent varies from State to State. For some States, the age limit is 12 years of age and up, for others 16 and up, or 18. It is essential to consult with the institution attorney and know the State laws. (See Appendix J: SANE Forms.)

Nonreporting Victims (Adolescent and Adult)

Policy

If the client is uncertain that she wants to report while in the ED or clinic, the SANE will discuss her fears and concerns to help her make an informed decision about reporting. If she is still uncertain and the rape occurred within 36 hours, she will be encouraged to let the SANE collect evidence so that it is not lost if she decides to report later. If she is certain she does not want to report, she will be offered STD prevention and pregnancy risk evaluation and preventive care. While the SANE will strongly encourage the victim to exercise her right and responsibility to report a sexual assault, the victim always has the right to make her own decision, and that decision will be respected and honored by the SANE. No third party report will be made except where required by State law.

Procedure

When the SANE first arrives, she will ask the victim if she has reported. If she has not, she will ask her if she would like to do so. If she is uncertain, reporting will be discussed and a decision made before any further action is taken.

Rationale

While it is believed that reporting a sexual assault or attempted assault is the right and responsibility of every victim and the only way to stop rape, only the victim can ultimately make that decision. It is important that the SANE understand why the victim might be reluctant to report so that she can provide her with accurate information about reporting and better enable the victim to make an informed decision. It is always important that the SANE be thoroughly familiar with the laws of her State, including any mandatory reporting statute for felony sexual assault. The resulting responsibilities must be appropriately included in the policies and procedures.

On-Call Schedule (Primary)

Policy

A SANE is on call, off premises, for an 8-hour period starting at 8:00 a.m. each day. Each nurse will be assigned her own pager. Each SANE is hired to take a predetermined number of shifts of call each month. The number of shifts each nurse is assigned varies from SANE to SANE and is a function of her availability and the needs of the program. Each SANE is initially assigned an equal number of day, evening, and night shifts. Except under unusual circumstances, no SANE will be assigned to take more than 2 nights in a row and no more than 20 eight-hour shifts of primary call per month. The call schedule is completed 2 weeks prior to the end of the month at a staff meeting for the following month.

The SANE is responsible for making sure her pager is functional and that she remains within the pager range. Under normal circumstances, the SANE is expected to respond to the ED or clinic as soon as possible or within a maximum of 1 hour from the time she is paged. Exceptions when a delayed response may be necessary or acceptable are outlined under "delayed responses."

The next working day after taking call, the SANE is responsible to report any new cases to the office secretary including information for followup and any additional pertinent information. The secretary will give her the case number at that time.

While it is acknowledged that changes in the on-call schedule will need to be made, it is important that nonemergency on-call schedule changes be kept to a minimum due to the increased likelihood of errors occurring when changes are made. Whenever possible, both the nurse initially assigned and the nurse taking call for her will keep their pagers turned on. For nonemergency on-call changes, the SANE is responsible to find her own coverage and to call the office, answering service, and each participating hospital with the changes. In emergency situations, the SANE should call the office or the SANE director at home, and they will arrange for coverage.

SANEs will be paid the local nursing contract hourly call rate for primary on-call time.

Procedure

The "poker chip" call schedule development method. Each SANE is given a red poker chip for each evening shift for which she is responsible, a blue chip for each day shift, and a white chip for each night shift. While everyone is initially assigned equal numbers of day, evening, and night shifts, periodically they are given the option of trading shifts or giving away shifts. A record is kept by the program director. Shifts can also be traded informally each month when the call schedule is developed.

As the call schedule is developed, the SANE puts the appropriate chip in the center of the table for each shift she takes until all shifts are gone and everyone has used all their chips.

Whenever the SANE goes into the ED or clinic, she will record on the Exam Data Form the time the client arrived at the ED or clinic, the time she was paged, and the time she arrived at the ED or clinic. The reasons for any planned or unplanned delay exceeding the expected maximum response time of 1 hour will also be recorded. If the delay was significant, disruptive, or if the ED or clinic staff appeared upset by the delay, the SANE will also call the SANE director the next morning to explain the situation to her. Every 2 weeks, the SANE will turn in her patient records including the Sexual Assault Data Sheet to the SANE office.

Delayed responses. Under the following circumstances, a delayed response may be necessary or acceptable:

- When the victim is too intoxicated to consent to an exam, cooperate with an exam, or give an accurate account of the circumstances under which it is suspected she was raped. The SANE, in consultation with the medical staff, will determine if the victim should be allowed to sleep in the ED until she is more responsive, and the evidentiary exam can be completed.

- When the medical staff decide it is in the best interest of the victim to have x-rays or other lifesaving medical treatment completed prior to the exam. If possible, and in concurrence with the physician, the SANE will come in and collect the necessary evidence in the stabilization room, the operating room, or the ICU.
- When the primary on-call SANE is busy completing a case and must call the backup on-call SANE. The SANE should also explain this to the staff, in case it necessitates a delay in response time.
- If the primary and backup on-call SANEs are both busy conducting examinations when there is another case. The primary SANE should inform the referring staff of the situation and give them an estimate of the time a SANE can arrive. Supportive staff such as a hospital chaplain, mental health worker, social worker, or an advocate should be contacted to wait with the victim. She should also update the referring staff of her situation if there is a change in her expected response time.

Whenever there is a delay in responding, the SANE should remain in contact with the ED or clinic periodically. She should also contact the referring agency prior to going off call to check on the victim's situation and report the status of the case to the oncoming SANE.

On-Call Schedule (Backup)

Policy

To ensure a SANE is available should the primary SANE on call need assistance, a second person is always on backup call. SANEs are paid half the primary on-call rate for backup call. Everyone is expected to take the same amount of backup call as they take of primary call.

The backup on-call SANE is utilized at the discretion of the primary on-call SANE. It is expected that backup will be called when two cases come in to two different hospitals at close to the same time, and after the SANE has completed two or more exams on one shift. If the SANE feels comfortable with her ability to complete the work in a timely manner, she does not have to call the backup. Whenever she feels unable to do a case, she can choose to utilize backup.

If the primary on call SANE is unable to take call at the last minute due to a family emergency or illness, and no one else can take the shift, the SANE on backup call will be expected to move up to primary.

Photographs

Policy

Whenever there are injuries, the SANE will take two sets of Polaroid pictures and one set of 35mm pictures of all injuries. Pictures of vaginal injuries will be taken with the colposcope. All pictures will include a label in the picture with the victim's name, date, time, and SANE's signature, and a standardized measurement instrument to indicate the size of the injury. Some hospitals use the patient's medical record number in place of the patient's name.

Procedure

One set of Polaroid pictures is placed in a sealed envelope and kept with the client record. The second set of Polaroid pictures is placed in a sealed envelope, which is also labeled with the client's name, date, time, and SANE's signature, and attached to the outside of the rape kit with a rubber band. The undeveloped roll of 35mm film is secured and labeled in the same way and attached to the rape kit.

Rationale

Polaroid pictures are taken so the police and prosecuting attorney have a visual presentation of the injuries when they are deciding if they can or should charge the case. A roll of 35mm film is also taken because there may be deterioration on the

Polaroid pictures if there is a significant delay before the case goes to court.

Pregnancy Risk Evaluation and Emergency Interception

Policy

The SANE will evaluate the risk of pregnancy for every victim seen in the ED or clinic. If she determines that the victim is at risk of becoming pregnant as a result of the rape, the SANE informs the victim and explains to her options to prevent a pregnancy.

Procedure

To determine if the victim is at risk of becoming pregnant, the SANE should determine the following:

- Was there vaginal-penile contact?
- Is the victim mid-cycle or are her menstrual cycles irregular?
- Is she using contraceptives or has she had a tubal ligation or hysterectomy?
- Is she currently menopausal?
- Is she pregnant based on the results of a UPT (urine pregnancy test) completed in the ED or clinic?
- Does she understand how the medication being offered will prevent a pregnancy?

If it is determined that the victim is at risk, her UPT results are negative, it is within 72 hours of the rape, and she wants to take medication to prevent a pregnancy from occurring, the SANE will consult with the staff MD. With the MD's concurrence, the SANE explains the risks and has the victim read and sign the Ovral consent form. The SANE then gives the victim two 50 mg Ovral tablets to take immediately with Tigan 250 mg to prevent nausea (it is best to give the Tigan about 30 minutes prior to the Ovral and to have her eat a couple of crackers or a piece of bread). She also gives her two additional Ovral tablets and another Tigan 250 mg to take in 12 hours. The SANE instructs the victim to call if she becomes nauseated and vomits within 1 hour of taking the Ovral.

Rationale

Deciding to prevent a pregnancy is a moral decision which can be made only by the victim. In order to make an informed decision, she must know her risk of becoming pregnant and the options to prevent a pregnancy. The SANE has an ethical responsibility to provide the rape victim with this information. Two programs operating at Catholic hospitals went as far as to get special permission from the diocese to administer Ovral (Frank: 96; O'Brien: 97).

The risk of pregnancy from a rape is the same as the risk of pregnancy from a one-time sexual encounter. This is estimated to be 2 percent to 4 percent (Yuzpe, Smith & Rademaker: 82). It is important to always test for pregnancy first, as 2 percent of rape victims are pregnant in the ED and not all are aware of the pregnancy (Tucker, Ledray & Werner: 90; Warner: 87).

The above recommendation is the standard form of prevention (Osborn & Neff: 89; Ledray: 92b; Hampton: 95), and it is currently offered at most existing SANE programs. This reduces the risk of pregnancy by 60 percent to 90 percent. Programs using a low dosage ethinyl estradiol contraceptive, give a dose equivalent to 100 mg of estrogen, 4 tablets, for each dose (Yuzpe, Smith & Rademaker: 82). (For additional information see Chapter 11: SANE Program Operation.)

Program Evaluation and Research

Policy

Every SANE should spend a portion of her time collecting data that will be used in program evaluation or research activities. This is an integral part of the SANE role, and it is an ongoing job expectation. In addition, the SANE will bring

potential program evaluation or research questions to the attention of the SANE program director for consideration of future systematic evaluation research. The SANE will be paid at her normal rate of pay for her time spent on any aspect of program evaluation or research with funds from the SANE program or another source, such as a special grant.

The SANE program director is responsible for the development, funding, and operation of all program evaluation and research projects. She should delegate data collection and other evaluation research activities to interested SANEs. While all SANEs are expected to participate in data collection as a part of their routine client interaction, additional evaluation research activities are optional.

The SANE program director is responsible for deciding how the results of program evaluation research should be utilized by the SANE program. However, all SANEs are expected to provide suggestions and input into this process. SANEs who are interested are also encouraged to submit the results of these special projects for publication with the director's concurrence.

Procedure

The SANE program director should explain all evaluation research activities to the SANEs and provide them with the necessary forms and instructions for completion. She should also work with them to develop, obtain funding, and implement new projects.

Rationale

The role of the SANE and the treatment of sexual assault victims is a relatively new field. To ensure that the best possible services and treatment options are provided, SANEs have a responsibility to do continual program process and outcome research. SANEs cannot afford to assume that the current practice and methodology is necessarily the "best" way to provide services or the best services to provide victims. Only by continually evaluating service delivery process and outcome can programs continue to develop and grow professionally and provide even better services to victims.

Psychiatric Inpatient/ Extended Care Unit Sexual Assault Evaluation

Policy

Whenever the staff of an inpatient psychiatric unit at a hospital served by the SANE program determines or suspects that a psychiatric patient was involved in sexual contact with another patient or with any other person while on the unit, they will immediately page the on-call SANE. The SANE will determine, in conjunction with the inpatient staff, if the SANE examination will be conducted in the psychiatric unit or if the patient will be transported to the usual SANE examination area. If the same situation occurs on an extended care unit, the patient will be transported to a contracting facility for the SANE examination.

The SANE will assess the situation when she arrives to determine the following:

- Was the sexual contact consensual?
- Does the patient have the ability of giving informed consent?
- Was there a possible violation of the facility's duty to protect the patient?

If the patient is a vulnerable adult, a report must be made to the police or adult protection services. If the incident is the result of a clear case of neglect or failure to protect on the part of the health care facility, or if the perpetrator was an employee of the facility, the State's health care facility regulating agency also must be informed so a proper investigation can be conducted.

Procedure

The SANE will verify legal authorization to consent by checking the signature on the patient's admission consent form and by checking the chart for documentation of a designated legal guardian. If the patient is not able to give consent, the SANE will attempt to get the proper consent. The SANE will then assess the patient's cognitive capacity.

If the SANE determines that the patient is coherent, she will explain her reason for being there and inform the patient of her rights. The SANE will then assess if the patient is aware of what happened and, if so, if the patient considers the sexual contact consensual. With the consent of the patient, she will complete a sexual assault evidentiary exam. A police or adult protection report will also be made with the patient's permission or as mandated by law.

Rationale

A client who is not capable of giving consent for medical care is likely not capable of giving consent for sexual contact and is thus a vulnerable adult. Also, by virtue of her status as an inpatient, the patient is likely vulnerable (Dexheimer Pharris & Ledray: 97).

Rape Drug Screening Rohypnol, GHB, and Others

Policy

Whenever the SANE suspects that the rape victim was drugged by flunitrazepam (trade name Rohypnol), GHB (gamma hydroxybutyrate), or any other "Date Rape Drug" used to incapacitate the woman, within the previous 72 hours or less, with the victim's informed consent, the SANE will save the first voided urine and send it to the independent laboratory hired by Hoffman-La Roche for free confidential drug testing. In some jurisdictions, urine collection may occur up to 96 hours post-ingestion since some drugs, such as valium, may be detected for a longer period of time.

The SANE will inform the victim that the testing will be done confidentially, identifying her only by a number, and will test for flunitrazepam, other benzodiazepines (the family of compounds to which flunitrazepam belongs), marijuana (cannabinoids), GHB, cocaine, amphetamines, some opiates, barbiturates, and alcohol.

Indicators the SANE would use in making the determination of possible rape drug use 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 recognizes feeling strange, then feeling suddenly "very drunk." Unfortunately, she may still look normal and while a little unsteady on her feet, she may be able to walk out of the bar 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 8 or more hours later, uncertain if she has been raped, but believing she may have been raped 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,"or "R-2."
- History of feeling or being told she suddenly appeared drunk, drowsy, dizzy, confused, with impaired motor skills, impaired judgment, and amnesia.
- History of "cameo appearances" in which the victim remembers waking up, possibly seeing the assailant with her, but being unable to move, and passing out once again.
- High school or college age, as GHB and Rohypnol abuse is more common, but not limited to these populations, especially in Florida, Texas, and Mexico. Unfortunately, its presence is quickly spreading across the country and may be seen in any State.

Procedure

When the victim reports within 72 hours (96 hours in some jurisdictions) of likely drug ingestion, the SANE will obtain the first voided, clean

catch specimen, maintaining chain-of-custody using the Sexual Assault Laboratory Results form (See Appendix J: SANE Forms). She will document the time of likely drug ingestion, the number of times the victim has voided since ingestion, and any prescription medication she is currently taking.

> Obtain an authorization from Hoffman-La Roche laboratories for free testing by calling 800–608–6540. When this number is answered the SANE will be asked to provide an identifying case number. (This may be the SANE case number or medical record number, or a number determined using a system of choice).
>
> Hoffman-La Roche will fax a form with an authorization number. Complete the form and sign it, call FedEx to pick up the specimen. If FedEx does not arrive prior to the SANE's leaving the ED, the specimen should be locked in the ED specimen refrigerator with the other evidence and a chain-of-evidence form should be attached. The ED nurse will sign that she gave the specimen to FedEx. It will be taken to the independent laboratory, ElSohly Laboratories, with whom Hoffman-La Roche has contracted to perform the drug screen.

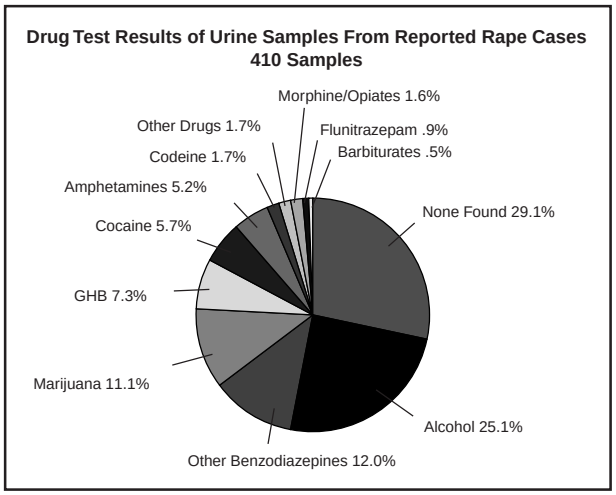
Rationale

According to the Drug Enforcement Agency and rape crisis centers, the use of drugs to make a woman more vulnerable to rape has been increasing dramatically across the United States since 1995. In addition to alcohol, two drugs known to be used for this purpose are Rohypnol and GHB. Rohypnol trafficking and possession cases have been identified in 36 States. Rohypnol is widely used across Europe and Latin America where it is prescribed as a preoperative sedative and for treating insomnia. GHB is a behavioral central nervous system depressant that actually excites the brain into an epileptic seizure and shuts down other CNS functions. It is used illegally by body builders and RAVE party goers. Both drugs are powerful, fast-acting sedatives that share similar side effects including resulting memory loss for large periods of time.

In 1996, Congress passed the Drug-Induced Rape Prevention and Punishment Act, imposing up to a 20-year prison term for anyone giving an illicit drug to another person without their consent with the intent of committing rape. Congress increased the penalties for both trafficking in Rohypnol and the use of Rohypnol and other controlled substances by sexual predators. Despite the Federal law, prosecution for rape and for the use of Rohypnol and other rape drugs continues to be handled primarily at the State level. This law also required the Drug Enforcement Agency (DEA) to study reclassifying Rohypnol from a Schedule IV sedative/hypnotic to a Schedule I of the Federal Controlled Substances Act. This reclassification is a method for providing closer control of more dangerous drugs. The producers of Rohypnol, Hoffman-La Roche, oppose this reclassification.

The drug screen, completed by ElSohly Laboratories, is currently the most economical testing available to identify flunitrazepam and other drugs. While some individuals recommend testing by a laboratory with no association to Hoffman-La Roche Laboratories, most hospital laboratories cannot test for flunitrazepam, and the screen can cost in excess of $850. Most programs do not have the funding to allow for this additional cost. Hoffman-La Roche is paying the fees, but an independent contracted lab, ElSohly Laboratory, is performing the tests, and ElSohly Laboratory's work is respected in the field. Therefore, ElSohly's test results should not be considered unreliable. However, there are a number of laboratories across the country, including some crime labs, capable of identifying flunitrazepam, and many large agencies have chosen not to use ElSohly laboratories for their testing site.

Urine is used instead of blood because both Rohypnol and GHB are out of the blood stream within 4 hours. While it is not known for certain how long these substances can be detected in the urine, it is believed GHB can be identified for only up to 12 hours after ingestion. Rohypnol can be detected for 36 to 60 hours, however, identification is more likely when the sample is collected



within 36 hours after ingestion. Specimens can be collected up to 72 hours (96 hours in some jurisdictions) because other drugs that may have been used can be detected for a longer time period.

The above chart reflects the 1997 statistics. As of February 1998, 578 samples have been tested by ElSohly Laboratories as a part of this program, and only five specimens have been found positive for Flunitrazepam (Rohypnol) and 30 for GHB.

Records

Policy

The SANE is responsible for completing all SANE records before leaving the ED or clinic. The original copies of all hospital records are left as a part of the hospital chart (See Appendix J: SANE Forms). These include the following:

- Sexual Assault Exam Report.
- Waiver of Medical Privilege and Authorization for Release of Medical and Legal Information.
- Ovral Consent Form (when appropriate).
- Laboratory Request Forms (when appropriate).
- Critical Item Suicide Potential Assessment (when appropriate).

Forms used for internal data collection and program evaluation purposes are returned to the SARS office (See Appendix K: SANE Evaluation Tools). These include the following:

- SANE Data Form.
- SANE Clinical Data Sheet.

A copy of the consent for release of information and a copy of the Sexual Assault Exam Report should be attached to the evidence provided the police.

Procedure

The SANE completes all paperwork while in the ED or clinic, makes the necessary copies, and attaches them to the rape kit for the police.

Rationale

It is essential that all original paperwork is completed immediately. Some programs maintain the records in their clinic, separate from hospital medical records, to ensure additional confidentiality.

STD Evaluation and Prevention (Other than HIV)

Policy

The SANE should not culture for any STD in the ED or clinic. If the victim is being seen within 72 hours (96 hours in some jurisdictions) of the rape and is at risk, the SANE will offer prophylactic treatment for gonorrhea, syphilis, and chlamydia according to the medication protocol. Adolescents 12 years of age and older do not need parental consent to be treated for STDs.

Procedure

If the victim is at risk and wants treatment to prevent STDs, the SANE determines her pregnancy status by getting a UPT, and she asks her about allergies to medications. She then discusses the case with the ED or clinic physician. She reminds them of the medication protocol and obtains a prescription signed for the medication that is given to the victim. The medication is

obtained according to ED or clinic procedure and given to the victim with instructions prior to discharge. (See Chapter 12: The Pediatric SANE Exam, for exceptions.)

Rationale

There is no evidence that initial baseline cultures or cultures taken on followup are useful in court, and there is data showing they are sometimes used against the victim to suggest sexual promiscuity. As a result, these initial ED cultures are not recommended (Ledray: 92b). Culturing is also very expensive and time-consuming for the victim who must return for testing, and unfortunately most victims do not return (Blair & Warner: 92). In one study, 25 percent of the victims seen in the ED returned for the initial STD followup visit (Ledray: 91), and in another study, only 15 percent returned. In this second study, they were able to contact 47 percent of those who had not returned for followup, and they found an additional 11 percent of these went elsewhere for medical followup, however, only 14 percent told the physician they saw for followup about the rape (Tintinalli & Hoelzer: 85). Most clinicians recommend prophylactic treatment following CDC guidelines (Frank: 96; Arndt: 88; Antognoli-Toland: 85; Tintinalli & Hoelzer: 85). If cultures are taken, they need not be handled as evidence because they are not used in court (Blair & Warner: 92).

As of 1995, all States have statutes allowing adolescents to consent for diagnosis and treatment for STDs although there is variation in the age limit from State to State (Dexheimer Pharris & Ledray: 97).

Statutory Rape/Teen Consenting Sex

Policy

If parents bring their teenaged daughter to the ED or clinic insisting on having a rape exam completed to ascertain if she is sexually active, the hospital or clinic pages the SANE on call, and she goes into the facility to assess the situation.

After talking to the parents, the SANE talks with the teenager alone. She informs the teenager of the statutory rape laws, the purpose for these laws, and of her right to refuse to have an exam. The SANE then assesses if sex occurred and, if so, when; if the sex was consenting; the age of the partner; and if she wants to have a rape exam. If the teenager claims there was no sex, or if she claims the sex was consenting and she does not want an exam, the SANE does not perform an exam. If the age difference meets the terms of the statutory rape laws, but after talking to the SANE, the daughter still refuses the exam, no exam will be completed.

The SANE does, however, offer treatment for STDs and pregnancy prevention. The SANE is NOT mandated to report statutory rape in the State of Minnesota unless the adult perpetrator is a caretaker or an adult in a position of authority over the minor. If the sexual contact was with a teacher, relative, counselor, teen group leader, or other person in a caretaker position, it may fall under mandatory reporting statutes. If so, the SANE must explain this to the adolescent and her parents and, when appropriate, make the necessary report. The adolescent still will not be forced to undergo examination against her will.

Procedure

The SANE first talks with the parent(s) and daughter together, then she talks with the daughter alone. If uncertain how to proceed, the SANE should call the SANE on backup call or the SANE program director to discuss the case. After talking to the daughter and deciding on her preferred course of action, the SANE staffs the case with the ED or clinic staff, explaining her decision and rationale to them, in case the parents decide to talk to someone else. She then explains her decision and rationale to the parent(s). She should acknowledge their concerns about their daughter's sexuality and talk about their other options for

dealing with their daughter's sexual activity other than a rape exam or rape charges. The SANE always offers referrals for family counseling.

Rationale

It is important to acknowledge and plan a strategy ahead of time to deal with the two issues involved:

1. State and Federal statutory rape laws and the local enforcement policy.

2. Parental concern over the sexuality of an adolescent.

Statutory rape laws have been on the books of most States for decades but have generally not been enforced. In an attempt to reduce the number of teenage pregnancies and lower the costs of welfare, a growing number of policymakers are encouraging aggressive enforcement of statutory rape laws. This move is based on the widespread belief that many of the young mothers became pregnant as a result of coercive sex by older men, and increased enforcement of statutory rape laws is necessary to protect them from abuse and exploitation (Donovan: 97). Enforcement is also based on the yet unsubstantiated belief that if these men fear they will be prosecuted for statutory rape, they will not become sexually involved with these minors, and the number of teenage pregnancies will thus be reduced. As Donovan (1997) points out, however, health care providers fear that if they are forced to report these cases as statutory rape, the teenagers will either not seek care or not be truthful with the providers.

This has prompted considerable public debate, and changes in the laws of several States have already occurred. In 1996, Florida voted to make the impregnation of a girl 16 years of age or younger by a male 21 years of age or older a reportable form of child abuse. Recognizing the potentially negative impact on health care, they excluded health care workers and counselors who provide services to pregnant teenagers from the mandated reporting requirements. California implemented a statutory rape vertical prosecution program in 1995, which included the hiring of additional dedicated staff. This resulted in a significant increase in the number of statutory rape cases they charged and convicted (Donovan: 97).

The SANE must be thoroughly familiar with the pertinent Federal and State statutes and the institutional policies and expectations (Dexheimer Pharris & Ledray: 97). It is important to talk with the institutional attorney, prosecuting attorney, and police about enforcement of the statutory rape laws and the rights of an adolescent to refuse an exam. For instance, the SANE may make a greater effort to get consent for an exam from a 15 year old who is "dating" and is sexually active with a 25 year old, than she would from a 15 year old who is sexually active with her 18 year old boyfriend, even though both technically meet the statutory rape guidelines. A police report will be made by the SANE only when mandated by law.

It is important to acknowledge the parents' concern for their daughter and their desire to keep her safe. It is equally important not to make a moral judgment but rather to provide them with additional information about other options. It may be necessary to also inform them of birth control options to prevent pregnancy and of STD prevention. Parents struggling with their adolescent daughter's sexual activity may benefit from a referral for family counseling with a professional skilled in adolescent health and sexuality issues.

Suicide Potential Evaluation

Policy

The SANE will complete a Critical Item Suicide Potential Assessment (CISPA) form whenever the following is true:

- The victim expresses suicidal thoughts.
- The SANE is concerned that the victim may attempt to hurt herself.
- When asked, the victim confirms that she has thought of harming herself.

- The victim has a history of suicidal thoughts or attempts.

If the CISPA score indicates that the victim is at risk, the SANE will request an evaluation by the Crisis Intervention staff prior to discharge. If the client refuses this referral, the identified consulting physician should be notified and the refusal noted in the chart. The SANE will then consult with the medical staff to determine if the victim meets the criteria for a medical protective hold as dangerous to herself or others. If so, the SANE will complete her exam and turn the care of the victim over to the ED or clinic staff. The consulting physician will place a medical protective hold on the victim. If the victim attempts to leave the facility, security must be called to detain her.

Procedure

The SANE will ask the victim if she has thought of harming herself. When there is any concern of immediate or potential suicide risk, the SANE will complete the CISPA and communicate her concerns and the results of the CISPA to the physician when she discusses the victim's case with the physician. The original CISPA will be kept with the patient's medical record.

Rationale

Suicide attempts are a real concern following a sexual assault and in most cases can be prevented through appropriate recognition of risk and prevention. Any expressed suicide thoughts must be taken seriously and carefully evaluated. (See Appendix J: SANE Forms.) Be sure to check with an institutional attorney and know the local State laws concerning when a medical protective hold can be applied and by whom.

Time Cards/Time Sheets

Policy

Each SANE is responsible for completing a time sheet and a time card and for submitting them to the SANE office secretary. Each entry will include the date, hours worked, location, type of work (e.g., ED visit, staff meeting, court testimony, meeting with director, community presentation, office work, etc.) and the client number when appropriate.

Procedure

The completed time card and time sheet will be signed by the SANE and delivered to the office by the end of the work day (5:00 p.m.) to guarantee payment on time.

Unavailability/Vacation

Policy

Under normal circumstances, no more than two SANEs should be on vacation or unavailable for call at the same time. A planned absence or unavailablitiy for 1 week or more must be approved in advance by the SANE director.

Procedure

After speaking with the SANE director, the SANE must enter the dates of her unavailability in the vacation book.

Unconscious Victim

Policy

If the client is unconscious and unable to sign a consent, the SANE will attempt to contact a parent, guardian, or relative for consent to conduct an evidentiary exam. When no appropriate parent or guardian is available, the exam will be completed after documenting the situation and attempts made to obtain consent.

Procedure

The SANE will document on the patient's record the reasons for not being able to obtain consent and the reasons for conducting an evidentiary exam after conferring with the ED or ICU staff and/or police involved. She will then proceed to

complete an evidentiary exam and secure the evidence collected maintaining proper chain-of-custody. When in doubt, she will collect evidence from all orifices. When the victim regains consciousness or an appropriate parent or guardian is located, consent will be obtained to release the evidence to the police.

Rationale

If biological evidence is not collected as soon as possible, it will be lost. By going ahead and collecting the evidence, the SANE is acting on what she believes is in the victim's best interest. The evidentiary exam is not invasive, and it does not expose the victim to any undue risk or harm. (While State law usually recognizes the doctrine of implied consent, it is important to confer with the hospital or State's attorney when developing a protocol to ensure that the SANE protocol is based on local State law.)

CHAPTER 14

MAINTAINING A HEALTHY ONGOING PROGRAM

Maintaining a healthy work environment involves developing and fostering a healthy effective program model and a healthy productive staff. While SANEs report that working with sexual assault clients is a privilege and that they are fortunate to work with this population (Ledray: 93b), they also recognize that this service is very emotionally draining (Arndt: 88; Ledray: 92a). As a result of this work, SANEs may fear for their own safety, fear the assailant may go after them, experience vicarious traumatization with sexual, cognitive, and emotional impairment, or just be physically exhausted after seeing numerous clients and serving long hours on call (Frank: 96).

SANE Vicarious Traumatization and Burnout

Working with victims of trauma is stressful to the caregiver and has been recognized as a source of burnout and vicarious traumatization. Vicarious trauma is the enduring psychological consequence of a caregiver's exposure to the traumatic experiences of the victims for whom they care (Schauben and Frazier: 95). Responses include a change in the caregiver's belief that the world is safe and that people can generally be trusted. As a result of their work, SANEs can experience symptoms of post-traumatic stress disorder (PTSD), such as sleep disturbance, nightmares, intrusive thoughts, easily irritated feelings, exaggerated startle response, withdrawal from others, feelings of increased vulnerability, and emotional reactions such as fear and anxiety (McCann & Pearlman: 90).

The impact of continuous work with sexual assault victims goes beyond what is typically referred to as "staff burnout." In particular, sexual assault work affects the caregiver's sexuality and increases her awareness of the potential for violence in her own life (Pearlman & Saakvitne: 95).

Little empirical research has specifically evaluated the impact of work with sexual assault victims on the caregiver. Recognizing that the SANE role, with long hours on call and working with multiple victims of severe trauma, can be stressful to the SANE is important. No matter what measures are taken to reduce the impact, some staff will leave as a result of this burnout (O'Brien: 96a). Some SANEs may need to leave the position either temporarily or permanently to reduce the stress in their lives and maintain a healthy balance. However, better understanding of the potential negative impact and the corresponding development of strategies to address the consequences can reduce this costly distress and turnover.

In a study of both sexual assault counselors and counselors who work with a wide variety of populations, Schauben and Frazier (1995) found that the percentage of sexual assault victims in an individual's caseload was associated with a disruption in his or her belief about the safety of the world and the goodness of other people, symptoms of PTSD, and self-reported vicarious trauma. However, the study also indicated that work with a higher percentage of rape victims was not correlated with job burnout or the negative effect associated with depression. In fact, the researchers indicated that many of the caregivers in their study reported many positive aspects of the work that they found rewarding in spite of the heavy caseload. Counselors reported that their ability to help people in crisis move toward recovery was a positive aspect of their work.

Identifying Symptoms

The SANE must be aware of the typical symptoms of vicarious traumatization in order to reduce the negative impact of work with sexual assault victims. The SANE director should assist SANEs in

recognizing symptoms to ensure that they remain effective in their work with victims. A SANE suffering from burnout or vicarious traumatization will be less effective in helping the victims she sees, and without timely intervention, she ultimately may have to take a leave of absence or leave the position.

The SANE director may choose to provide all SANEs with copies of the PTSD Checklist and Burnout Self-Evaluation Tool included in the appendix. She may want to encourage each SANE to complete these evaluations annually to assist the SANE in recognizing and measuring her current level of distress (See Appendix K: SANE Evaluation Tools).

SANEs should recognize that stress is also associated with other areas of the SANE's life, such as raising children, other relationships, and money problems, not just from her work with victims. Regardless of the origin, stress always has the potential to affect the SANE's ability to work effectively with victims. Recognizing the stress, identifying the cause, and taking steps to resolve or reduce the stress are critical measures in maintaining balance and ensuring effectiveness in both the personal and work lives of the SANE.

Symptoms of Vicarious Traumatization or Burnout

The following boxed information lists symptoms of vicarious traumatization or staff burnout that should be considered and evaluated. This is not an exhaustive list. One incident of a symptom is less significant than a newly developed pattern of symptoms. For example, a particular SANE may always be late to meetings or be somewhat sloppy in completing her paperwork. While that may be a problem, the SANE director would be more concerned that these behaviors were indicative of vicarious traumatization if an otherwise very neat SANE, who is typically on time, changes her behavior. It would be of special concern if the change followed a particularly difficult case or a particularly busy period.

Reducing Impact on Staff

Reducing the potential impact of working with this victim population begins with careful screening of potential SANEs to identify and hire those individuals with healthy boundaries and good personal support systems. Maintaining a healthy sense of humor about the work is also important. While individuals who do not work with victim

Cognitive Impact:

- Forgetfulness.
- Trouble concentrating.
- Cynicism.
- Perfectionism.
- Apathy.
- Reduced productivity.
- Rigidity.
- Negative attitude.
- Preoccupation with trauma.
- Minimization.
- Inability to accept limitations.
- Thoughts of harm to self or others.

Emotional Impact:

- Anger.
- Depression.
- Hyper vigilance.
- Anxiety.
- Irritability.
- Emotional liability.
- Crying excessively.
- Fears.
- Isolation.
- Suspiciousness.
- Numbness.
- Suicidal thoughts.

Behavioral Impact:

- Alcohol or drug abuse.
- Not being available for call when scheduled.
- Excessive physical illness.
- Easily irritated.
- Sleep disturbance.
- Eating disturbance.
- Weight loss or gain when not trying to lose or gain weight.
- Inability to complete tasks on time.
- "Sloppy" completion of paperwork.
- Tardiness for meetings and taking an excessive time to get into the ED.

Sexual Impact:

- Intrusive deviant sexual images.
- Deviant sexual urges.
- Trouble becoming aroused.
- Vaginismus.
- Disturbed body image.
- Inability to reach orgasm.
- Seeing deviant sexual activity as "normal."
- Identifying all sexual activity as rape.

populations may not understand the humor, the SANE director needs to allow and even encourage humor that is not disrespectful of the victim.

To expect the work environment to meet all the SANE's support needs is unrealistic. Encouraging staff to have outside interests, to take adequate time off, and to go on vacations to renew themselves is essential. It may even be necessary for a SANE to take an extended leave of absence.

The SANE director should exemplify the need to take care of oneself and to prevent vicarious traumatization. She should encourage SANEs to nurture outside interests, especially activities that provide a physical release and a healthy balance in life. Hobbies are important stress reducing activities, especially hobbies that allow for a sense of completion of a task or goal and that allow for complete disengagement from work. SANEs need to set personal limits and maintain strong boundaries, such as not giving their home phone numbers to victims and seeing clients only during official duty hours. The on-call SANE should handle all emergencies. While she may consult with the SANE who initially saw the victim in the ED, it is not recommended to expect the same SANE to be available to answer questions 24 hours a day, 7 days a week.

Schauben and Frazier (1995) also asked counselors working with sexual assault victims about the strategies they used to deal with work-related stress. The strategies used most often included seeking emotional support from friends and family, getting advice about what to do from a colleague, and humor. The researchers found that respondents who used these coping strategies were less likely to use alcohol or drugs, denial, or disengagement. Thirty-five percent of the respondents also reported that they engaged in activities that promoted physical health, such as exercise and eating healthy food. Meditation, being outdoors in a natural environment, and keeping a journal were the next most frequently reported strategies for stress reduction. Leisure activities such as going to the movies, reading, gardening, and listening to music also were frequently reported as helpful ways to reduce work-related stress. Getting adequate sleep and proper nutrition are also good preventive measures.

Other measures found helpful to prevent or combat vicarious traumatization and burnout include monthly staff meetings which incorporate case reviews and provide debriefing and mutual support, especially for the more distressing cases (Tobias: 90; Arndt: 88; Holloway & Swan: 93). Sometimes it may be necessary to refer staff to a counselor or psychologist for additional emotional support (Holloway & Swan: 93).

Providing adequate professional development and ongoing advanced training is another important method of avoiding burnout. SANEs that are continuing to grow and develop professionally express more job satisfaction and are more likely to remain with the program.

Maintaining adequate SANE staffing is critical to ensuring that the stress associated with call duty does not become excessive. Determining the number of SANEs to hire is not an easy decision, however. If the staff is too large, then SANEs do not see enough cases to maintain their proficiency or income. Costs associated with payment for time spent in staff meetings and training also rise tremendously.

As discussed in chapter eight, when SANEs are consistently completing two cases in a single on-call period, it may be time to reduce the on-call hours in a shift (e.g., from 12 hours to 8 hours) and hire more SANEs. This is more likely to occur during the first few years of program operation when the caseload grows the most rapidly. When signs of stress such as increased illness or dissatisfaction begin to appear, or when a larger than usual number of unfilled shifts remain in a new on-call schedule, it may be time to re-evaluate the number of shifts assigned to each SANE. This should be done at a minimum every year, and every 6 months may be necessary during the first few years when the number of victims seen is more likely to be increasing rapidly.

Program Evaluation

Program evaluation allows for a systematic assessment of program strengths and limitations in order to improve the program service delivery process and outcomes. The linking of program process or performance with participant outcomes helps program staff evaluate their progress and modify the program as appropriate. Information obtained through program evaluation can be used by administrators or funders to make decisions about future program goals, strategies, and options. This may include information such as the average number of exams completed each month or year by SANEs that can then be used to decide if it is time to consider hiring new staff.

Ongoing program evaluation must be an integral part of every SANE program. Evaluation is not effective as a one-time activity completed for "outside" purposes, such as those that might be imposed by a funder. Evaluation is much more effective as an ongoing process to answer "internal" questions posed by program staff. Evaluation is usually problem-focused. Its goal is often to provide information to help solve a specific problem. When the issues and problems evaluated come from the SANE staff, it is more likely that the results will be utilized to improve the services delivered. Program evaluation is a tool to help staff learn what they do well, what goals they are accomplishing, and where they could improve in order to achieve unrealized goals.

Formal and Informal Evaluation Strategies

Program evaluation may take the form of formal evaluation using experimental research designs, or it may involve informal data collection strategies. While using formal and informal evaluation strategies may accomplish many of the same functions, formal evaluation projects tend to utilize more rigorous methods, with larger groups and over longer periods of time. Formal evaluations also tend to utilize standardized tools with established reliability and validity, or they establish the reliability and validity of measures developed prior to the implementation of the formal evaluation.

There are three general types of program evaluation: process evaluation, output evaluation, and outcome evaluation. Each may be accomplished formally or informally. Appendix K includes sample program evaluation tools that can be implemented and utilized for effective SANE program evaluation at all levels.

Process Evaluation

This type of evaluation focuses on how program services are delivered. Examples of process evaluation include the following:

- Sexual assault victims are surveyed and asked if it is helpful to have the rape advocate come into the ED automatically or paged first.
- Sexual assault victims are asked if the issue of HIV should be brought up in the ED or at a later point in time.
- Followup telephone surveys are conducted 2 months after the assault to see if sexual assault victims took advantage of referral information provided to them in the ED.
- Rape victims who did not come in for counseling are called 2 months after the assault. They are assessed for symptoms of PTSD and asked if they are interested in coming in for counseling at this point in time. The follow through rate with counseling visits scheduled is compiled at this time.
- Victims are surveyed 2 weeks after the ED visit and asked about their satisfaction with care provided by the police, hospital medical staff, SANE, and the rape advocate.
- SANEs complete data sheets in the ED on every client seen which provides the following information:
  - The time between the victim's arrival at the ED and the SANE's arrival.
  - If no police report was made prior to the SANE's arrival, whether the SANE tried to resolve the client's fears and counsel the victim about the importance of filing a police report.

Output Evaluation

Output or performance evaluation assesses the amount and type of work accomplished by the SANE program. This may include information such as the following:

- The number of evidentiary exams completed each month.
- The number of community training programs completed.
- The number and content of phone calls from rape victims.
- The number of followup visits by rape victims or the percentage of victims seen in the ED that return for counseling.
- The number of program brochures distributed.
- The number of public service announcements (PSAs) in the media.
- Peer chart reviews for completeness and accuracy of documentation.

Outcome Evaluation

Outcome evaluation focuses on the results of the service delivered to the targeted individuals or groups. When designing an outcome evaluation, it is important to identify the target individuals or groups. Then it is important to explicitly state what will change in the target group. Knowledge, attitude, behavior, belief, or symptoms may be expected to change as a result of the intervention. With sexual assault, it may be the reduction of symptoms of PTSD.

The results evaluated may be immediate, short-term, or long-term.

Immediate Outcome. The immediate outcomes of service may include the following:

- Victims who did not initially want to report the rape decide to do so after talking with the SANE.
- Victims decide to take STD and pregnancy prevention medication.
- Independent assessment of the rape kits completed by SANEs and nonSANEs are done to see if the correct evidence was collected, properly documented, and the chain-of-evidence maintained.
- Peer review of the impact of SANE testimony on courtroom testimony is gathered.

Short-Term Outcome. Short-term outcome may include the first few weeks or months after the assault and include evaluations of the following:

- The percentage of victims who become pregnant even though they are provided preventive care in the ED.
- Case presentations and peer reviews.

Long-Term Outcome. Evaluations of client outcomes 1 year after the rape and beyond are generally considered long-term evaluations. The longer the time period between the initial contact and the evaluation followup, the more difficult it will be to locate former victims. A smaller sample can be expected. This smaller sample may or may not be representative of rape victims, since those who cannot be located may be better or worse off. Examples would include the following evaluations:

- One year anniversary telephone calls or mailed questionnaires assessing symptoms of PTSD in clients seen for counseling and in those not seen.
- Courtroom outcomes of SANE and nonSANE cases in the area, that would assess, for example, the proportion of guilty verdicts in the SANE cases as compared to the nonSANE cases.
- Client satisfaction questionnaires completed 1 year after the rape that provide feedback from clients having gone through the judicial or legal system.
- Yearly meetings with other community agencies to evaluate their satisfaction with the SANE program.
- Community sexual assault felony charge rates and prosecution rates of SANE and non-SANE cases.

Data Collection and Analysis

Evaluation data may be collected using standardized tests with established reliability and validity. It also may be collected using informal questionnaires developed specifically for a SANE program evaluation. The data provided may be a simple count, an average or percentage of cases, or it may involve sophisticated statistical analysis. Often, graphical representations of group or individual values is extremely helpful in understanding results.

Appendix K includes a sample of process, output, and outcome tools that may be useful in evaluating the SANE program impact on the individual victim and the community. Also included are evaluators' comments on the use of the tools (See Appendix K: SANE Evaluation Tools).

Evaluation Utilization

In addition to answering questions raised by SANE staff and ultimately improving SANE services, evaluation findings may be useful to the SANE program in other ways. Findings may be used to convince funders to fund new program components or continue funding for effective programs. Community leaders who support the SANE program may want access to the results to justify their ongoing support and to obtain the additional support of their colleagues. The media may be interested in the results. Other SANE programs will likely be interested in the evaluation findings as they implement programs in their community.

Providing the results of the SANE program evaluation data to community organizations is useful for building the credibility and trust of the community and of potential clients even if the results are negative or show how the program can be improved. Ongoing program evaluation is a characteristic of effective organizations. When community organizations decide what programs they are going to support, they will want to see documentation of program effectiveness.

Steps of Program Evaluation Planning

1. List the SANE program's primary goals and activities.
2. Identify problem areas, questions, or concerns.
3. Identify the outcome(s) of those individuals or groups who make use of SANE services.
4. Formulate evaluation question(s).

5. Identify the type of information needed to answer the question(s).
6. Identify how to obtain the information.
7. Decide who will obtain the information and over what time frame.
8. Decide how the information obtained will be used.

Evolution of SANE Program Evaluation

The type and intensity of the evaluation that will be the most helpful will evolve as the SANE program evolves. Programs and staff that are new can benefit most from effective process evaluation. Informal, simple, process evaluation of immediate or short-term impact will be useful to staff in evaluating their program policies and procedures and in making early decisions about possible changes in service delivery. Programs that are more established may decide to implement a more elaborate victim and system outcome evaluation component which includes both short-term and long-term components. The SANE program can often make use of evaluation or resource expertise at nearby universities. Sometimes a graduate student in evaluation studies or a related field may be able to integrate their thesis with the evaluation of the SANE program. Local evaluation consultants may also be solicited to help the program; sometimes they will be willing to do so pro bono. Even if external consultants are used, the SANE director and staff should play the primary role in creating the evaluation questions and deciding upon the outcomes that are appropriate for their own program.

Maintaining a Healthy Ongoing Relationship with Other Agencies and Organizations

Open communication is the most important component of maintaining a healthy relationship with the other community agencies with which the SANE program works. Regular formal meetings with the SANE/SART is an effective method of maintaining open communication.

More effort may be required to establish this communication with agencies that are not a part of the SART, but it is no less important. Inviting a representative to a SANE meeting where a topic of mutual interest is discussed is one way of accomplishing this objective. Informal meetings or lunches are another way to do the same. Making a point to talk informally at statewide training programs and conferences is also useful.

It is essential that the SANE program maintains membership in community, county, State, and national organizations that promote ongoing collaboration. Not only is communication facilitated, but these memberships greatly enhance the ability of the SANE program to effect change and advance the services to victims both locally and nationally. In addition to the local SART, target organizations might include the following:

- State and national sexual assault coalitions.
- International Association of Forensic Nurses (IAFN) and State chapters of IAFN when available.
- National Organization for Victim Assistance (NOVA).
- State Nurses Association and American Nurses Association.
- American Professional Society on the Abuse of Children (APSAC).

Summary

Maintaining a healthy staff, working cooperatively with other agencies, and conducting ongoing program evaluation are important and necessary components of SANE program operation. Unfortunately, all too often, program directors who have good intentions become overwhelmed with the expectation that they “must” do elaborate program evaluation and as a result do none. Limitations in staff time, equipment, and resources are real. Sometimes the decision is made to eliminate program evaluation and measures to better train and support staff in an attempt to save these resources. However, when staff are not adequately

supported and evaluation is not incorporated as an integral part of the SANE process, the real result may be the waste of valuable resources.

Many of the SANE programs in existence today are operating because nurses or physicians who visited or previously worked in hospitals with a SANE program saw the advantages a SANE program provides to the community-at-large (Arndt: 88). Probably the best testimony of the efficacy of the SANE model is that communities that now have SANE programs wonder what they did without them (Lenehan: 91). Good evaluation will ensure that these programs continue to strengthen, grow, and better meet the needs of the people they serve.

APPENDIXES

APPENDIX A

PROJECT STAFF AND ADVISORY COMMITTEE

Project Staff

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Memphis Sexual Assault Resource Center
Memphis, TN

APPENDIX B PARTICIPATING SANE PROGRAMS

List of Operating SANE Programs

ALABAMA
SANE program
c/o Rape Crisis Center
501 N. Bishop Lane
Mobile, AL 36608
Contact: Teresa Lynn, RN, BSN
(334) 450-2244

ALASKA
Alaska CARES
Contact: Diana Weber
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Anchorage, AK 99508
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SART/SANE Program of Matanuska Valley
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Coordinator: Rita Bennett
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Palmer, AK 99645
Phone: (907) 746-8503

South Peninsula Hospital SANE Program
4300 Bartlett Street
Homer, AK 99603
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ARIZONA
SARS
Tucson Rape Crisis Center
1632 North Country Club
Tuscon, AZ 85716
Contact: Nora Gilray, RN, SANE
(520) 529-0634

CALIFORNIA
American Forensic Nurses
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Palm Springs, CA 92262
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Phone: (909) 796-6300
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Center for Forensic Excellence
Contact: Darlene Bradley
11234 Anderson Street
Loma-Linda, CA 92354
Phone: (909) 478-8077
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Dominican Hospital SART/SANE Program
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County Sexual Assault Response Team
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Oakland, CA 94602
Contact: Hillary Larkin, RA
Phone: (510) 437-8396

Napa-Soland SART Program
1100 Trancas Street, Suite 202
Napa, CA 34558
Contact: Elizabeth Cassinos
Phone: (707) 226-9145

San Francisco Rape Treatment Center
2801 A 25th St.
San Francisco, CA 94110
Contact: Carmen Henesy, RN
Phone: (415) 821-3222

SANE Ukiah Valley Medical Center
275 Hospital Drive
Ukiah, CA 95482
Contact: Karen Paoli, RN
Phone: (707) 463-7400, ext. 1342

SART/SANE
California Hospital Medical Center
1401 South Grand
Los Angeles, CA 90015
Contact: Jeannie Stephenson, RN
Phone: (213) 742-5519

SART
Hanford Community Medical Center
450 Greenfield Avenue
Hanford, CA 93230
Contact: Georgeanne Greene, Coordinator
Phone: (209) 585-5258
Fax: (209) 585-5325

SART Palomar Pomerdo Health System
Contact: (Ages 0-13): Diana Fuagno, RN, BSN CPN
555 East Valley Parkway
Escondido, CA 92025
Phone: (619) 739-3444
Ages 14-Adult: Margaret Whelan, RN
15615 Pomerado Road
Poway, CA 92064
Phone: (619) 739-3444

Sexual Assault Response Service
Antelope Valley Hospital
1600 West Avenue J
Annex Suite B
Lancaster, CA 93534
Contact: Sandy Darrington
Phone: (805) 723-7273 ext. 5566
Fax: (805) 949-5566

Sexual Assault Response Team (SART)
Kern Medical Center
1830 Flower Street
Bakersfield, CA 93305
Contact: Kris Petty, RN, SANE, or Thum, RN, SANE
Phone: (805) 326-2679

Sexual Assault Response Team (SART)
Marshall Hospital
Marshall Way
Placerville, CA 95667
Contact: Nancy Housel, RN, SANE
Phone: (916) 622-1441, ext. 772

Sexual Assault Response Team (SART)
Santa Barbara County Health Care Services
300 San Antonio Road
Santa Barbara, CA 93110
Contact: Therese McKenna, RN, SANE
Phone: (805) 681-5468

Sexual Assault Response Team
Santa Clara Valley Health and Hospital System
751 S. Bascom Avenue, Bldg H-12
San Jose, CA 95128
Contact: Sandra McKinnon, Rn, NP
Phone: (408) 885-6460

Suspected Abuse Response Team
2180 Johnson Avenue
San Luis Obispo, CA 93401
Contact: Maggie Nally, RN, SANE
Phone: (805) 781-4878

Tulare District Hospital SART
821 Cherry Street
Tulare, CA 93274
Contact: Angie Zakula, RN
Phone: (209) 688-0821

University of California Davis Medical Center
Forensic Evaluation Team
2315 Stockton Blvd.
Sacramento, CA 96817
Contact: Bill Green, MD
Phone: (916) 734-2011

Violence Intervention Program
LAC-USC Medical Center
1240 North Mission Road
Los Angeles, CA 90033
Contact: Deborah Kilgore, Director
Phone: (213) 226-3961
Fax: (213) 226-2573

Western Nurse Specialists Inc.
25809 Business Center Dr., Suite A
Redlands, CA 92373
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Mary Rudolph, RN, SANE
Phone: (909) 796-6300

CANADA

Health Sciences Center Adult Emergency
820 Sherbrook Avenue
Winnipeg, Manitoba, Canada R3A1R9
Contact: Beth Ariss, RN
Phone: (204) 633-0886

Ontario Network of Sexual Assault Care and
Treatment Centres
c/o Women's College Hospital
76 Grenville Street
Toronto, Ontario, Canada M5S1B2
Contact: Sheilia McDonald
Phone: (416) 323-6400, ext. 4472

SANE Program
Grant-MacEvan Community College
City Center Campus
Health & Community Studies Division
10700 - 104 Avenue
Alberta, Canada P5J2P2
Coordinator: Elaine DeGrandpre
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Fax: (403) 497-5720

Sexual Assault Services
British Columbia Womens Center
4500 Oak Street
Vancouver, BC Canada V6H3N1
Contact: Carolyn Dudley
Phone: (604) 875-3284
Fax: (604) 875-3136

Sexual Treatment Center
339 Crawford Avenue
Windsor, Canada N9A5C6
Coordinator: Kathy McIntosh
Phone: (519) 255-2234
Fax: (519) 255-2255

Sexual Assault Treatment Program
c/o Sudbury General Hospital
700 Paris Street
Sudbury, Ontario, Canada P3E3B5
Contact: Mary Carter, Coordinator
Phone: (705) 675-4743
Fax: (705) 675-4781

Surrey Memorial Hospital SANE Program
13750 96th Avenue
Surrey, B.C. Canada V3V1Z2
Contact: Sheila Early
Phone: (604) 581-2211 ext. 2513

Victoria Sexual Assault Service
Royal Jubilee Hospital Victoria
2101 Richmond Avenue
Victoria, BC Canada V8R4R7
Contact: Sue Dean
Phone: (604) 727-4354

COLORADO

Boulder County Rape Crisis Team
2885 East Aurora #13
Boulder, CO 80303
Contact: Judy Houchins

Memorial Hospital SANE Program
1400 E. Boulder
Colorado Springs, CO 80909
Contact: Sharon Stinson, RN, SANE
Phone: (719) 575-2422 or (719) 475-6820

Poudre Valley Hospital
1024 Soth Lemay Avenue
Fort Collins, CO 80524-3998
Contact: Susan Webster, RN
Phone: (970) 495-7000

Pueblo Suicide Prevention & Rape Crisis Center
1925 East Orman Avenue, Suite G-25
Pueblo, CO 81004
Contact: Shannon Richter

SANE of Larimer County
McKee Medical Center
2000 Eoise Avenue
Loveland, CO 80538
Contact: Linda Beede, FNP
Phone: (970) 203-2513

Sexual Assault Survivor, Inc.
P.O. Box 5135
Greeley, CO 80631-0135
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DELAWARE
Medical Center of Delaware SANE Program
4755 Ogletown-Stanton Road
Newark, DE 19718
Contact: Kathy Rainey, RN, or Peggy Humphrey, RN
Phone: (302) 733-1700

FLORIDA
NEP/Forensics
2214 East Henry Avenue
Tampa, FL 33610
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SANE Inc.
C/O Florida Hospital Kissimmee
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Kissimmee, FL 34742
Contact: Pam Steioff, RN, SANE
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GEORGIA
Gwinnett Sexual Assault Resource Center
PO Box 186
Duluth, GA 30136
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Northeast Georgia Medical Center
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Gainesville, GA 30501
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SANE of N.E. Georgia
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Southeast Georgia Forensic Nursing Service
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Southeast Georgia Regional Medical Center
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Hawaii Island SANE Project
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Center of Hope
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Fort Wayne Sexual Assault Treatment Center
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KANSAS
SANE/SART
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Wichita, KS 67218
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MARYLAND
SANE
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701 East Charles Street
La Plata, MD 20646
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SANE Program
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100 Hospital Road
Prince Fredrick, MD 20678
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Sexual Assault Forensic Examiner Program
Mercy Medical Center
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301 St. Paul Place
Baltimore, MD 21202
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MICHIGAN
SANE Program
C/O Emergency
Munson Medical Center
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Traverse City, MI 49684
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Phone: (616) 935-6333

Sexual Assault Nurse Examiners
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PO Box 30480
Lansing, MI 48909-7980
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Sexual Assault Program
YMCA
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Grand Rapids, MI 49503
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MINNESOTA
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Midwest Children's Resource Center
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Phone: (800) 422-0879

S.A.F.E. Program
Regina Medical Center
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Hastings, MN 55033
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Sexual Assault Resource Service
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MISSOURI
Kansas City SANE
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Kansas City, MO 64108
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Fax: (816) 454-0431

SART Sexual Assault Response Team
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Columbia Health Department
Columbia, MO 65205
Contact: Mary Martin, RN, NP
Phone: (601) 736-2676

The Children's Mercy Hospital
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Kansas City, MO 64108
Contact: Bev Arnold-Biagioli, CNS, Child Protection
(816) 234-3000

St. Louis Children's Hospital
400 S. Kingshighway Blvd.
St. Louis, MO 63110
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NEBRASKA
SANE/SART Program
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Lincoln, NE 68506-1299
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NEVADA
Sexual Assault Response Program
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Dayton, NV 89403
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(702) 885-4161

NEW HAMPSHIRE
New Hampshire/Vermont SANE Program
RR 1 Box 384
Cornish, New Hampshire 03475
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Fax: Same as above.

NEW MEXICO
Albuquerque SANE Collaborative
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Albuquerque, NM 87176-7137
Contact: Pat Schindler, RN, SANE
Phone: (505) 266-7711

NEW YORK
Forensic Sexual Assault Examiners Inc.
PO Box 556
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Contact: Patricia Kelly, RN, SANE
Phone: (516) 957-1409

Rensselaer County SANE Program
Samaritan Hospital
2215 Burdett Avenue
Troy, NY 12180
Contact: Ann Coonrad, Coordinator
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Ulster County SANE Program
c/o Office of District Attorney
275 Wall Street
Kingston, NY 14201
Contact: Laurel Herdman, Executive Director
Phone: (914) 339-7080
Fax: (914) 340-3185

Westchester SANE
Victims Assistance Service
2269 Sawmill River Road
Elmsford, NY 10523
Contact: Karen Coleman, SANE Coordinator
Phone: (614) 345-3113

NORTH CAROLINA
North Carolina Coalition Against Sexual Assault
Contact: SAFE/SART Project Coordinator
174 Mine Lake Court - Suite 100
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Fax: (919) 676-1355

OHIO
SANE Program
Blanchard Valley Regional Health Center
145 West Wallace Street
Findlay, OH 45840
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SANE/SART Project
Union County
500 Landon Avenue
Marysville, OH
Contact: Rebecca Dillon, RN, CEN
Phone: (937) 644-3833

Summit County SANE Program
Summa Health System
525 East Market Street
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Akron, OH 44309-2090
Contact: Renee Collette, RN, BSN, BA, CEN, SANE

OKLAHOMA

Broken Arrow Oklahoma SANE Program
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Contact: Judy Dyke, RN NREMT-P
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Central Oklahoma Clinical Forensic Consultants Inc.
PO Box 60216
Oklahoma City, OK 73146
Contact: Robert Williamson, RN
Phone: (405) 272-0316

Forensic SANE Program
Claremore Regional Hospital
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Claremore, OK 74017
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Oklahoma City Sexual Assault Examiner Program
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Room EB 319
Oklahoma City, OK 73126
Coordinator: Linda Cummins
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Shawnee Regional Sexual Assault Nurse Examiners
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Shawnee, OK 74801
Contact: Charlotte Howard, RN
Phone: (405) 878-8140

Tulsa Sexual Assault Nurse Examiners Program
c/o Tulsa Police Department
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Tulsa, OK 74113
Contact: Kathy Bell, RN
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PENNSYLVANIA

Evangelical Community Hospital SANE Program
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Lewisburg, PA 17837
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Child Forensic Nurse Examiners
Lenok Health Center
21 Slocum Avenue
Tunkhannock, PA 18657
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SAFE Program
Harrisburg Hospital
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Harrisburg, PA 17105
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SANE Doylestown Hospital
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Doylestown, PA 18901
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TENNESSEE

Chattanooga Sexual Assault Crisis and Resource Center
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Chattanooga, TN 37403
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Memphis Sexual Assault Resource Center
1331 Union Avenue, Suite 1150
Memphis, TN 38112
Contact: Pat Speck, RNC, MSN, FNP
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"Our Kids" - Nashville
1900 Hayes Street
Nashville, TN 37203
Contact: Sue Ross, PNP, or Julie Rosof, ENP
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TEXAS
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SANE Program
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SANE Program
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John Peter Smith Hospital
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Fort Worth, TX 76104
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SANE Program
Emergency Services
Harris Methodist Hospital
1600 Hospital Parkway
Bedford, TX 76002-6913
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Sexual Assault Nurse Examiners Program
Northwest Texas Hospital Health Care System
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Amarillo, TX 79175
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Day Harris, Resource Coordinator for ER Services
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SANE Program of Ben Taub
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UTAH
Cache Valley SART
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Logan, UT 84321
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VIRGINIA
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Richmond VA SART
Contact: Stacey Lasseter
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Carilion Roanoke Community Hospital SANE Program
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Inova Fairfax Hospital
3300 Gallows Road
Falls Church, VA 22042
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Rockingham Memorial Hospital
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SANE Program
Chesapeake General Hospital
PO Box 2038
Chesapeake, VA 23320
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SANE Southside Regional Medical Center
801 South Adams
Petersburg, VA 23803
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Phone: (804) 862-5680

WASHINGTON

Ione Annette Arden
Blue Mountain Medical Group
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Phone: (509) 522-0100

St. Peter Hospital SA Clinic
413 Lilly Road NE
Olympia, WA 98506
Contact: Nancy Diaz
Phone: (360) 493-4071
Fax: (509) 527-1080

WISCONSIN

Berlin Hospital SANE Program
225 Memorial Drive
Berlin, WI 54923
Contact: Bonnie Manthei, RN
Phone: (414) 498-4563

Meriter Emergency Services
c/o SANE Program
207 South Park Street
Madison, WI 57315
Contact: Colleen O'Brien
Phone: (608) 267-6206

SANE Program
St. Elizabeth ER Department
1506 South Oneida Street
Appleton, WI 54915
Contact: Rosemary Dvorachek, Coordinator
Phone: (920) 738-2100
Fax: (920) 730-5912

SANE Program
St. Lukes Hospital
St. Mary's Medical Center
3801 Spring Street
Racine, WI 53406
Contact: Barbara Campbell, RN
Phone: (414) 636-4201

SANE St. Mary's Medical Center
1726 Shawans Avenue
Green Bay, WI 54303
Contact: Marlene Scheffen
Phone: (414) 498-4563

SANE
St. Mary's Hospital
1044 Kabel Avenue
Rhinelander, WI 54501
Contact: Mary Hageny, RN
Phone: (715) 369-6600

St. Vincent Hospital SANE Program
PO Box 13508
Green Bay, WI 54307-3508
Contact: Paula Hafeman, RN, MSN, CEN
Phone: (414) 433-8391

Sexual Assault Treatment Center
PO Box 0342
Milwaukee, WI 53201-0342
Contact: Marlene Putz, RN
Phone: (414) 937-5209

APPENDIX C

RAPE KIT SUPPLY RESOURCES

Sexual Assault Evidence Kit Suppliers

When seeking bids for sexual assault evidence kits, it's important to ask if the supplier is an FDA approved packing facility. The following FDA approved companies supply the vast majority of programs in the United States:

Tri Tech
4019 Executive Park Blvd. S.E.
South Port, North Carolina 28461
1-800-438-7884

Sirchie Finger Print Laboratories
100 Hunter Place
Youngsville, North Carolina 27596
1-919-554-2244

Lynn Peavey
14865 W. 105th St.
Lenexa, Kansas 66219
1-913-888-0600

APPENDIX D

SANE TRAINING PROGRAMS

The following is the list of SANE training programs which accept applications from nurses interested in attending training at their location:

South Peninsula Hospital
4300 Bartlett Street
Homer, Alaska 99603
Colleen James, RN
907-235-0287
Once a Year: October

American Forensic Nurses
255 North El Cielo Road
Suite 195
Palm Springs, CA 92262
Faye Battiste-Otto, RN
760-779-2280 (pager)
909-796-6300
Twice a Year: Spring and Fall

Palomar Pomerado Health System
15615 Pomerado Road
Poway, CA 92064
Diana Faugno, RN, BCFE
760-739-3444
Once a Year: Winter
Mock Trial Training: May

Forensic Nursing Specialists
P.O. Box 2512
Santa Cruz, CA 95063
Sandra Goldstein, MS, RN
408-465-9826

SANE/SART Program
Via Christi Medical Center
3600 East Harry
Wichita, KS 67218
Diana Schunn, RN
316-689-5252
Once a Year

Mercy Safe Program
Mercy Medical Center
St. Paul Place
Baltimore, MD 21202
Carole Kimmell, RN
410-332-9499
Once a Year: September

University of North Carolina Hospitals
Department of Emergency Medicine
CB 7594
Chapel Hill, North Carolina 27599
Susan Hohenhaus, RN, CEN
919-966-1088
Twice a Year: January and July

Tulsa Sexual Assault Nurse Examiner Program
Tulsa Police Department
600 Civic Center
Tulsa, OK 74103
Kathy Bell, RN
918-596-7608
Two or Three Times per Year

Memphis Sexual Assault Resource Center
2675 Union Avenue Extended
Memphis, TN 38112
Pat Speck, MS, RN
901-272-2020
Advanced Training Only

Texas Office of the A.G.
Sexual Assault Prevention & Crisis Services Division
P.O. Box 12548
Austin, TX 78711
Jamie Ferrell, SANE Program Director
512-936-1661
Scheduled based on community readiness/needs

INOVA SANE Program
INOVA Fairfax Hospital
3300 Gallows Road
Falls Church, VA 22042-3300
Sue Brown, RN, BSN
703-698-3505
Once a Year: End of March

YWCA/SANE Program
c/o Meriter Emergency Services
202 Park Street
Madison, WI 53715
Colleen O'Brien, RN, MS
608-267-6000 Ext. 7063
Once a Year: First Week in May

APPENDIX E SANE TRAINERS

Following is the list of SANE Trainers who are available to provide training at the time and location of your choice:

Sherry Arndt, RN, MPA
Forensic Nursing Services
Prairie Division
RR 1 - Box 171
Comfrey, MN 56019-9713
507-877-3663

Faye Battiste-Otto, RN
American Forensic Nurses
255 North El Cielo Road
Suite 195
Palm Springs, CA 92262
760-779-2280 (pager)
909-796-6300

Kathy Bell, RN
Tulsa Sexual Assault Nurse Examiner Program
Tulsa Police Department
600 Civic Center
Tulsa, OK 74103
918-596-7608

Sue Brown, RN, BSN
INOVA SANE Program
INOVA Fairfax Hospital
3300 Gallows Road
Falls Church, VA 22042-3300
703-698-3505

Diana Faugno, RN, BCFE
Palomar Pomerado Health System
15615 Pomerado Road
Poway, CA 92064
760-739-3444

Jamie Ferrell, RN, BSN, CEN, SANE
1306 Buena Vista
Amarillo, TX 79106
512-936-1661

Sandra Goldstein, MS, RN
Forensic Nursing Services
P.O. Box 2512
Santa Cruz, CA 95063
408-465-9826

Susan Hohenhaus, RN, CEN
University of North Carolina Hospitals
Department of Emergency Medicine
CB 7594
Chapel Hill, NC 27599
919-966-1088

Colleen James, RN
South Peninsula Hospital
4300 Bartlett Street
Homer, Alaska 99603
907-235-0287

Linda E. Ledray, PhD, RN, FAAN
Professional Resource Service
Foshay Tower
Suite 1108
821 Marquette Avenue South
Minneapolis, MN 55402
612-889-0889

Diana Schunn, RN
SANE/SART Program
Via Christi Medical Center
3600 East Harry
Wichita, KS 67218
316-689-5252

APPENDIX F FUNDING RESOURCES

STATE AGENCIES ADMINISTERING THE DEPARTMENT OF JUSTICE/OFFICE OF JUSTICE PROGRAMS FORMULA GRANT PROGRAMS

9/11/97

STATE	VOCA VICTIM COMPENSATION FORMULA GRANT PROGRAM	VOCA VICTIM ASSISTANCE FORMULA GRANT PROGRAM	STOP VIOLENCE AGAINST WOMEN FORMULA GRANT PROGRAM	EDWARD BYRNE FORMULA GRANT PROGRAM
Alabama	Alabama Crime Victims Compensation (334)-242-4007 OVC Contact: (202) 616-3579	Alabama Department of Economic & Community Affairs (334) 242-5843 OVC Contact: (202) 616-3579	Alabama Department of Economic & Community Affairs (334) 242-5803 VAWGO Contact: (202) 305-2404	Alabama Department of Economic & Community Affairs (334) 242-5891 BJA Contact: (202) 305-2358
Alaska	Violent Crimes Compensation Board (907) 465-3040 OVC Contact: (202) 616-3565	Council on Domestic Violence & Sexual Assault (907) 465-4356 OVC Contact: (202) 616-3565	Council on Domestic Violence & Sexual Assault (907) 465-4356 VAWGO Contact: (202) 305-2379	Alaska State Troopers (907) 269-5082 BJA Contact: (202) 616-3456
American Samoa	No Compensation Program	Criminal Justice Planning Agency [011] (684) 633-5221 OVC Contact: (202) 616-3565	Criminal Justice Planning Agency [011] (684) 633-5221: VAWGO Contact: (202) 305-1792	Office of the Attorney General [011] (684) 633-4163 BJA Contact: (202) 305-1764
Arizona	Arizona Criminal Justice Commission (602) 542-1928 OVC Contact: (202) 616-3579	Arizona Department of Public Safety (602) 233-2480 OVC Contact: (202) 616-3579	Governor's Office for Women (602) 542-1755 VAWGO Contact: (202) 305-2379	Arizona Criminal Justice Commission (602) 542-1928 BJA Contact: (202) 305-2148
Arkansas	Crime Victims Reparations Board (501) 682-3660 OVC Contact: (202) 616-3210	Office of Intergovernmental Services Department of Finance & Administration (501) 682-5206 OVC Contact: (202) 616-3210	Office of Intergovernmental Services Department of Finance & Administration (501) 682-5206 VAWGO Contact: (202) 305-2404	Office of Intergovernmental Services Department of Finance & Administration (501) 682-1074 BJA Contact: (202) 514-8874
California	State Board of Control (916) 324-6629 OVC Contact: (202) 616-3565	Governor's Office of Criminal Justice Planning (916) 327-3687 OVC Contact: (202) 616-3565	Governor's Office of Criminal Justice Planning (916) 324-9216 VAWGO Contact: (202) 305-2381	Governor's Office of Criminal Justice Planning (916) 324-9166 BJA Contact: (202) 616-3294

STATE	VOCA VICTIM COMPENSATION FORMULA GRANT PROGRAM	VOCA VICTIM ASSISTANCE FORMULA GRANT PROGRAM	STOP VIOLENCE AGAINST WOMEN FORMULA GRANT PROGRAM	EDWARD BYRNE FORMULA GRANT PROGRAM
Colorado	Division of Criminal Justice (303) 239-4402 OVC Contact: (202) 616-3579	Division of Criminal Justice (303) 239-5703 OVC Contact: (202) 616-3579	Division of Criminal Justice (303) 239-5728 VAWGO Contact: (202) 305-1792	Division of Criminal Justice (303) 239-4442 BJA Contact: (202) 616-3456
Connecticut	Office of Victim Services (860) 529-3089 OVC Contact: (202) 616-2032	Office of Victim Services (860) 529-3089 OVC Contact: (202) 616-2032	Office of Policy & Management (860) 418-6403 VAWGO Contact: (202) 307-3180	Office of Policy & Management (860) 566-3500 BJA Contact: (202) 305-1762
Delaware	Delaware Violent Crimes Compensation Board (302) 995-8383 OVC Contact: (202) 616-3581	Delaware Criminal Justice Council (302) 577-3697 OVC Contact: (202) 616-3581	Delaware Criminal Justice Council (302) 577-3430 VAWGO Contact: (202) 307-3180	Delaware Criminal Justice Council (302) 577-3466 BJA Contact: (202) 305-2925
District of Columbia	Crime Victims Compensation Program (202) 879-4216 OVC Contact: (202) 616-3581	Office of Grants Management & Development (202) 727-6537 OVC Contact: (202) 616-3581	Office of Grants Management & Development (202) 727-6554 VAWGO Contact: (202) 305-2404	Office of Grants Management & Development (202) 727-6537 BJA Contact: (202) 307-6068
Florida	Office of the Attorney General Compensation Bureau (904) 414-3301 OVC Contact: (202) 616-3581	Office of the Attorney General Bureau of Advocacy & Grants Management (904) 414-3300 OVC Contact: (202) 616-3581	Governor's Task Force on Domestic & Sexual Violence (904) 921-2168 VAWGO Contact: (202) 307-3180	Bureau of Community Assistance (904) 488-8016 BJA Contact: (202) 616-3295
Georgia	Criminal Justice Coordinating Council (404) 559-4949 OVC Contact: (202) 616-3581	Criminal Justice Coordinating Council (404) 559-4949 OVC Contact: (202) 616-3581	Criminal Justice Coordinating Council (404) 559-4949 VAWGO Contact: (202) 305-2404	Criminal Justice Coordinating Council (404) 559-4949 BJA Contact: (202) 616-3295
Guam	No Compensation Program	Department of Law Government of Guam [011] (671) 475-3324 ext. 285 OVC Contact: (202) 616-3565	Bureau of Women's Affairs Office of the Governor [011] (671) 475-9162 VAWGO Contact: (202) 305-2381	Bureau of Planning Office of the Governor [011] (671) 472-8931 BJA Contact: (202) 305-2356

STATE	VOCA VICTIM COMPENSATION FORMULA GRANT PROGRAM	VOCA VICTIM ASSISTANCE FORMULA GRANT PROGRAM	STOP VIOLENCE AGAINST WOMEN FORMULA GRANT PROGRAM	EDWARD BYRNE FORMULA GRANT PROGRAM
Hawaii	Department of the Department of the (808) 586-1282 OVC Contact: (202) 616-3565	Department of the Department of the (808) 586-1282 OVC Contact: (202) 616-3565	Department of the Attorney General (808) 586-1096 VAWGO Contact:	Department of the Attorney General (808) 586-1151 BJA Contact: BJA Contact: (202) 616-3294
Idaho	Idaho Crime Victims Compensation Program (208) 334-6070 OVC Contact: (202) 616-3565	Idaho Department of Health & Welfare (208) 334-5580 OVC Contact: (202) 616-3565	Idaho Department of Law Enforcement (208) 884-7042 VAWGO Contact: (202) 305-1792	Idaho Department of Law Enforcement (208) 884-7040 BJA Contact: (202) 305-1764
Illinois	Illinois Court of Claims (217) 782-7101 OVC Contact: (202) 616-3210	Illinois Criminal Justice Information Authority (312) 793-8550 OVC Contact: (202) 616-3210	Illinois Criminal Justice Information Authority (312) 793-8550 VAWGO Contact: (202) 305-2649	Illinois Criminal Justice Information Authority (312) 793-8550 BJA Contact: (202) 616-8958
Indiana	Indiana Criminal Justice Institute (317) 233-3383 OVC Contact: (202) 616-3210	Indiana Criminal Justice Institute (317) 233-3341 OVC Contact: (202) 616-3210	Indiana Criminal Justice Institute (317) 232-7610 VAWGO Contact: (202) 305-2977	Indiana Criminal Justice Institute (317) 232-2561 BJA Contact: (202) 305-2354
Iowa	Office of the Attorney General Crime Victim Assistance Division (515) 281-5044 OVC Contact: (202) 616-3210	Office of the Attorney General Crime Victim Assistance Division (515) 281-5044 OVC Contact: (202) 616-3210	Governor's Alliance on Substance Abuse (515) 242-6379 VAWGO Contact: (202) 305-2977	Governor's Alliance on Substance Abuse (515) 242-6379 BJA Contact: (202) 305-2903
Kansas	Office of the Attorney General (913) 296-2359 OVC Contact: (202) 616-3579	Office of the Attorney General (913) 296-2215 OVC Contact: (202) 616-3579	Office of the Attorney General (913) 296-2215 VAWGO Contact: (202) 305-2977	Kansas Criminal Justice Coordinating Council (913) 296-0926 BJA Contact: (202) 305-2903
Kentucky	Crime Victims Compensation Board (502) 564-7986 OVC Contact: (202) 616-3210	Kentucky Justice Cabinet (502) 564-7554 OVC Contact: (202) 616-3210	Kentucky Justice Cabinet (502) 564-7554 VAWGO Contact: (202) 305-2404	Kentucky Justice Cabinet (502) 564-7554 BJA Contact: (202) 305-2358

STATE	VOCA VICTIM COMPENSATION FORMULA GRANT PROGRAM	VOCA VICTIM ASSISTANCE FORMULA GRANT PROGRAM	STOP VIOLENCE AGAINST WOMEN FORMULA GRANT PROGRAM	EDWARD BYRNE FORMULA GRANT PROGRAM
Louisiana	Louisiana Commission on Law Enforcement (504) 925-4437 OVC Contact: (202) 616-3579	Louisiana Commission on Law Enforcement (504) 925-1757 OVC Contact: (202) 616-3579	Louisiana Commission on Law Enforcement (504) 925-4443 VAWGO Contact: (202) 307-3180	Louisiana Commission on Law Enforcement (504) 925-3513 BJA Contact: (202) 514-8874
Maine	Maine Department of Victims Compensation Program (207) 626-8800 OVC Contact: (202) 616-2032	Maine Department of Human Services (207) 287-5060 OVC Contact: (202) 616-2032	Maine Department of Public Safety (207) 624-8758 VAWGO Contact: (202) 307-3180	Maine Department of Public Safety (207) 877-8016 BJA Contact: (202) 307-6068
Maryland	Department of Public Safety & Correctional Services (410) 764-4094 OVC Contact: (202) 616-2032	Maryland Department of Human Resources (410) 767-7477 OVC Contact: (202) 616-2032	Governor's Office of Crime Control & Prevention (410) 321-3521 ext. 330 VAWGO Contact: (202) 307-3180	Governor's Drug & Alcohol Abuse Commission (410) 321-3521 BJA Contact: (202) 305-1762
Massachusetts	Office of the Attorney General (617) 727-2200 ext. 2251 OVC Contact: (202) 616-2032	Massachusetts Office for Victims Assistance (617) 727-5200 OVC Contact: (202) 616-2032	Executive Office of Public Safety (617) 727-6300 extension 305 VAWGO Contact: (202) 305-2404	Executive Office of Public Safety (617) 727-6300 BJA Contact: (202) 307-6068
Michigan	Crime Victim Services Commission (517) 373-0979 OVC Contact: (202) 616-3210	Crime Victim Services Commission (517) 373-1826 OVC Contact: (202) 616-3210	Michigan Department of Social Services (517) 335-3931 VAWGO Contact: (202) 305-2977	Office of Drug Control Policy (517) 373-2952 BJA Contact: (202) 307-6061
Minnesota	Crime Victims Reparations Board (612) 282-6267 OVC Contact: (202) 616-3210	Department of Corrections (612) 642-0221 OVC Contact: (202) 616-3210	Department of Corrections (612) 643-3593 VAWGO Contact: (202) 305-2649	Department of Public Safety (612) 296-0922 BJA Contact: (202) 307-0710
Mississippi	Mississippi Crime Victim Compensation Program (601) 359-6766 OVC Contact: (202) 616-3579	Department of Public Safety Division of Public Safety Planning (601) 359-7880 OVC Contact: (202) 616-3579	Department of Public Safety Division of Public Safety Planning (601) 359-7880 VAWGO Contact: (202) 305-2404	Department of Public Safety Division of Public Safety Planning (601) 359-7880 BJA Contact: (202) 305-1767

STATE	VOCA VICTIM COMPENSATION FORMULA GRANT PROGRAM	VOCA VICTIM ASSISTANCE FORMULA GRANT PROGRAM	STOP VIOLENCE AGAINST WOMEN FORMULA GRANT PROGRAM	EDWARD BYRNE FORMULA GRANT PROGRAM
Missouri	Division of Workers' Compensation (573) 526-3511 OVC Contact: (202) 616-3210	Missouri Department of Public Safety (573) 751-4905 OVC Contact: (202) 616-3210	Missouri Department of Public Safety (314) 751-4905 VAWGO Contact: (202) 305-2649	Missouri Department of Public Safety (314) 751-4905 BJA Contact: (202) 307-6061
Montana	Montana Board of Crime Control (406) 444-3653 OVC Contact: (202) 616-2032	Montana Board of Crime Control (406) 444-3604 OVC Contact: (202) 616-2032	Montana Board of Crime Control (406) 444-3604 VAWGO Contact (202) 305-1792	Montana Board of Crime Control (406) 444-3604 BJA Contact: (202) 305-2356
Nebraska	Nebraska Commission on Law Enforcement & Criminal Justice (402) 471-2194 OVC Contact: (202) 616-2032	Nebraska Commission on Law Enforcement & Criminal Justice (402) 471-2194 OVC Contact: (202) 616-2032	Nebraska Commission on Law Enforcement & Criminal Justice (402) 471-2194 VAWGO Contact: (202) 305-2977	Nebraska Commission on Law Enforcement & Criminal Justice (402) 471-2194 BJA Contact: (202) 616-8958
Nevada	Nevada Department of Administration (702) 486-2740 OVC Contact: (202) 616-3565	Department of Human Resources & Development (702) 688-1628 OVC Contact: (202) 616-3565	Office of the Attorney General (702) 486-3095 VAWGO Contact: (202) 305-2592	Department of Motor Vehicles & Public Safety (702) 687-5282 BJA Contact: (202) 616-3294
New Hampshire	New Hampshire Department of Justice (603) 271-1284 OVC Contact: (202) 616-2032	New Hampshire Department of Justice (603) 271-1297 OVC Contact: (202) 616-2032	New Hampshire Department of Justice (603) 271-1234 VAWGO Contact: (202) 307-3180	New Hampshire Department of Justice (603) 271-1297 BJA Contact: (202) 307-1232
New Jersey	Victims of Crime Compensation Board (201) 648-2107 ext. 7716 OVC Contact: (202) 616-3581	New Jersey Department of Law & Public Safety (609) 984-7347 OVC Contact: (202) 616-3581	New Jersey Department of Law & Public Safety (609) 984-3880 VAWGO Contact: (202) 307-3180	New Jersey Department of Law & Public Safety (609) 292-5939 BJA Contact: (202) 307-0283
New Mexico	New Mexico Crime Victims Reparation Commission (505) 841-9432 OVC Contact: (202) 616-3579	New Mexico Crime Victims Reparation Commission (505) 841-9432 OVC Contact: (202) 616-3579	New Mexico Crime Victims Reparation Commission (505) 841-9432 VAWGO Contact: (202) 305-2592	Department of Public Safety (505) 827-9099 BJA Contact: (202) 616-3456

STATE	VOCA VICTIM COMPENSATION FORMULA GRANT PROGRAM	VOCA VICTIM ASSISTANCE FORMULA GRANT PROGRAM	STOP VIOLENCE AGAINST WOMEN FORMULA GRANT PROGRAM	EDWARD BYRNE FORMULA GRANT PROGRAM
New York	New York Crime Victims Board (518) 457-8063 OVC Contact: (202) 616-3581	New York Crime Victims Board (518) 457-1779 OVC Contact: (202) 616-3581	New York State Division of Criminal Justice Services (518) 485-7913 VAWGO Contact: (202) 305-2404	New York State Division of Criminal Justice Services (518) 457-8462 BJA Contact: (202) 307-1232
North Carolina	North Carolina Victims Compensation Commission (919) 733-7974 OVC Contact: (202) 616-3581	Governor's Crime Commission (919) 571-4736 OVC Contact: (202) 616-3581	Governor's Crime Commission (919) 571-4736 VAWGO Contact: (202) 307-3180	Governor's Crime Commission (919) 571-4736 BJA Contact: (202) 616-3295
North Dakota	North Dakota Department of Corrections Division of Parole & Probation (701) 328-6195 OVC Contact: (202) 616-3210	North Dakota Department of Corrections Division of Parole & Probation (701) 328-6195 OVC Contact: (202) 616-3210	North Dakota Department of Health Division of Maternal & Child Health (701) 328-3340 VAWGO Contact: (202) 305-2649	North Dakota Bureau of Criminal Investigation Attorney General's Office (701) 328-5500 BJA Contact: (202) 305-2354
Northern Mariana Islands	No Compensation Program	Criminal Justice Planning Agency [011] (670) 664-4550 OVC Contact: (202) 616-3565	Criminal Justice Planning Agency [011] (670) 664-4550 VAWGO Contact: (202) 305-2379	Criminal Justice Planning Agency [011] (670) 664-4550 BJA Contact: (202) 305-2356
Ohio	Victims of Crime Compensation Program Court of Claims of Ohio (614) 466-7764 OVC Contact: (202) 616-2032	Ohio Attorney General's Office (614) 466-5610 OVC Contact: (202) 616-2032	Office of Criminal Justice Services (614) 728-8738 VAWGO Contact: (202) 307-3180	Office of Criminal Justice Services (614) 466-7782 BJA Contact: (202) 307-1232
Oklahoma	District Attorney Council Crime Victims Compensation Board (405) 557-6704 OVC Contact: (202) 616-3579	District Attorney Council (405) 557-6704 OVC Contact: (202) 616-3579	District Attorney Council (405) 557-6707 VAWGO Contact: (202) 305-2649	District Attorney Council (405) 557-6707 BJA Contact: (202) 307-0710
Oregon	Department of Justice Crime Victims' Compensation Program (503) 378-5348 OVC Contact: (202) 616-3565	Department of Justice Crime Victims' Assistance Section (503) 378-5348 OVC Contact: (202) 616-3565	Criminal Justice Services Division (503) 378-3725 VAWGO Contact: (202) 305-1792	Criminal Justice Services Division (503) 378-3725 BJA Contact: (202) 616-3294

STATE	VOCA VICTIM COMPENSATION FORMULA GRANT PROGRAM	VOCA VICTIM ASSISTANCE FORMULA GRANT PROGRAM	STOP VIOLENCE AGAINST WOMEN FORMULA GRANT PROGRAM	EDWARD BYRNE FORMULA GRANT PROGRAM
Pennsylvania	Pennsylvania Commission on Crime & Delinquency (717) 783-0551 ext. 3093 OVC Contact: (202) 616-3581	Pennsylvania Commission on Crime & Delinquency (717) 787-8559 ext. 3031 OVC Contact: (202) 616-3581	Pennsylvania Commission on Crime & Delinquency (717) 787-8559 ext. 3031 VAWGO Contact: (202) 307-3180	Pennsylvania Commission on Crime & Delinquency (717) 787-2040 ext. 8559 BJA Contact: (202) 307-6068
Puerto Rico	No Compensation Program	Attorney General's Office (809) 723-4949 OVC Contact: (202) 616-3581	The Commission for Women's Affairs (809) 721-7676 VAWGO Contact (202) 307-3180	Department of Justice (809) 725-0335 BJA Contact: (202) 616-3295
Republic of Palau	No Compensation Program	Ministry of Health [011] (680) 488-1002 OVC Contact: (202) 616-3565	No STOP Violence Against Women Program	No Edward Byrne Program
Rhode Island	General Treasurer's Office (401) 277-2287 OVC Contact: (202) 616-2032	Governor's Justice Commission (401) 277-2620 OVC Contact: (202) 616-2032	Governor's Justice Commission (401) 277-4497 VAWGO Contact: (202) 307-3180	Governor's Justice Commission (401) 277-2620 BJA Contact: (202) 307-0283
South Carolina	Office of the Governor Division of Victim Assistance (803) 734-1930 OVC Contact: (202) 616-3581	Office of Safety & Grants (803) 896-8712 OVC Contact: (202) 616-3581	Office of Safety & Grants (803) 896-8712 VAWGO Contact: (202) 305-2404	Office of Safety & Grants (803) 896-8708 BJA Contact: (202) 305-1767
South Dakota	South Dakota Department of Social Services (605) 773-6317 OVC Contact: (202) 616-3210	South Dakota Department of Social Services (605) 773-4330 OVC Contact: (202) 616-3210	South Dakota Department of Social Services (605) 773-4330 VAWGO Contact: (202) 305-2977	Governor's Office of Operations (605) 773-6313 BJA Contact: (202) 307-6061
Tennessee	Division of Claims Administration (615) 741-2734 OVC Contact: (202) 616-3579	Department of Human Services (615) 313-4767 OVC Contact: (202) 616-3579	Office of Criminal Justice Programs (615) 741-8277 VAWGO Contact: (202) 305-2404	Office of Criminal Justice Programs (615) 741-8277 BJA Contact: (202) 305-1767

STATE	VOCA VICTIM COMPENSATION FORMULA GRANT PROGRAM	VOCA VICTIM ASSISTANCE FORMULA GRANT PROGRAM	STOP VIOLENCE AGAINST WOMEN FORMULA GRANT PROGRAM	EDWARD BYRNE FORMULA GRANT PROGRAM
Texas	Crime Victims Compensation Division Office of the Attorney General (512) 936-1200 OVC Contact: (202) 616-3579	Criminal Justice Division Office of the Governor (512) 463-1919 OVC Contact: (202) 616-3579	Criminal Justice Division Office of the Governor (512) 463-1919 VAWGO Contact: (202) 305-2649	Criminal Justice Division Office of the Governor (512) 463-1952 BJA Contact: (202) 616-8958
Utah	Office of Crime Victim Reparations (801) 533-4000 OVC Contact: (202) 616-3579	Office of Crime Victim Reparations (801) 533-4000 OVC Contact: (202) 616-3579	Office of Crime Victim Reparations (801) 533-4000 VAWGO Contact (202) 305-2381	Commission on Criminal & Juvenile Justice (801) 538-1060 BJA Contact: (202) 305-1764
Vermont	Center for Crime Victims Services (802) 241-1250 OVC Contact: (202) 616-2032	Center for Crime Victims Services (802) 241-1250 OVC Contact: (202) 616-2032	Center for Crime Victims Services (802) 828-5456 VAWGO Contact: (202) 305-2404	Vermont Department of Public Safety (802) 244-8781 BJA Contact: (202) 307-1232
Virginia	Division of Crime Victims' Compensation (804) 367-8686 OVC Contact: (202) 616-2032	Department of Criminal Justice Services (804) 786-3923 OVC Contact: (202) 616-2032	Department of Criminal Justice Services (804) 225-3900 VAWGO Contact: (202) 307-3180	Department of Criminal Justice Services (804) 786-1577 BJA Contact: (202) 305-2358
Virgin Islands	Criminal Victims Compensation Commission (809) 774-1166 OVC Contact: (202) 616-3581	Law Enforcement Planning Commission (809) 774-6400 OVC Contact: (202) 616-3581	Law Enforcement Planning Commission (809) 774-6400 VAWGO Contact: (202) 305-2404	Law Enforcement Planning Commission (809) 774-6400 BJA Contact: (202) 616-3295
Washington	Crime Victim Compensation Program (360) 902-5340 OVC Contact: (202) 616-3565	Department of Social & Health Services (360) 902-7994 OVC Contact: (202) 616-3565	Department of Community, Trade & Economic Development (360) 753-9684 VAWGO Contact: (202) 305-2381	Department of Community, Trade & Economic Development (360) 586-0665 BJA Contact: (202) 616-3456
West Virginia	Crime Victims Compensation Fund (304) 347-4850 OVC Contact: (202) 616-2032	Criminal Justice & Highway Safety Division (304) 558-8814 OVC Contact: (202) 616-2032	Criminal Justice & Highway Safety Division (304) 558-8814 VAWGO Contact: (202) 305-2404	Criminal Justice & Highway Safety Division (304) 558-8814 BJA Contact: (202) 514-8874

STATE	VOCA VICTIM COMPENSATION FORMULA GRANT PROGRAM	VOCA VICTIM ASSISTANCE FORMULA GRANT PROGRAM	STOP VIOLENCE AGAINST WOMEN FORMULA GRANT PROGRAM	EDWARD BYRNE FORMULA GRANT PROGRAM
Wisconsin	Office of Crime Victims Services (608) 266-6470 OVC Contact: (202) 616-3210	Office of Crime Victims Services (608) 267-2251 OVC Contact: (202) 616-3210	Office of Justice Assistance (608) 266-7185 VAWGO Contact: (202) 305-2649	Office of Justice Assistance (608) 266-7282 BJA Contact: (202) 307-0710
Wyoming	Office of the Attorney General Crime Victims Compensation Commission (307) 635-4050 OVC Contact: (202) 616-2032	Office of the Attorney General Crime Victims Compensation Commission (307) 635-4050 OVC Contact: (202) 616-2032	Office of the Attorney General (307) 777-7841 VAWGO Contact: (202) 305-1792	Division of Criminal Investigation (307) 777-7181 BJA Contact: (202) 305-2148

OVC Office for Victims of Crime
VOCA Victims of Crime Act
BJA Bureau of Justice Assistance
VAWGO Violence Against Women Grants Office

APPENDIX G STARTUP CHECKLIST

Fort Wayne Sexual Assault Treatment Center
Starting From Scratch

This list was compiled as a result of numerous frantic phone calls asking, "How do you know what you need for the everyday stuff." Well, our necks became sore from looking around the room and dictating over the phone so thus the "starting from scratch" list was conceived. Please realize that we are very fortunate and have had the opportunities to acquire a lot of supplies early on. Programs certainly do not need everything we have to start performing forensic exams. Please use this list as a resource to double check what you have, what you may have and... oops what you forgot. Many of you have heard the following but grit your teeth and read on: ***Look at our program and others and take what you need. There is no "one" or "right" way to set up a SART.*** Let there be no doubt, it is one of our goals to have this ingrained in your cerebral gray matter. Our program was originally modeled after Pomerado Hospital SART in Poway, California and Tulsa Police Department SART in Oklahoma. We have borrowed from others such as the Madison, Wisconsin and Memphis, Tennessee programs as well and as we continue to learn new things there is no reason to "re-invent" the wheel. Be creative, use your community resources and stick with it. Enough rambling... lets get to the goods!

Our "Stuff"

Waiting Room

Chairs
Couch
End Tables
Lamp
Magazine Rack
Brochure Rack
Pictures/Decoration
Coat Rack

Interview Room

4-5 Person Table w/chairs
Brochure Rack (big enough for forms)
Coffee Pot
Refreshment Refrigerator
Decor
Hooks With Coffee Mugs
Coffee, Tea, Chocolate Milk (mix), Pop
Sugar packets, Spoons, Creamer
Coffee Stirrers, Styrofoam Cups, etc.

Office

Desks (2)
Rolling Desk Chairs (3)
Phones
(2-in office)
Open and Closed Ended Folders

Brother MFC 4550 Printer/Scan/Copy
Dell Computer, Keyboard, Monitor
Microsoft Office, Microsoft Publisher
Copy paper
Clock

FWSATC 1

Offices Continued……

Steel Filing cabinets
(non locking, 51" x 15")
(locking, 30" x 36")
Form/mailbox case
Shelves
Reference Books
(see reference and resource list)
Letter Head Paper
Letter Head Envelopes
Manila Envelopes (all sizes)
Postage
CD/Radio player
Policy and Procedure Book
Journals
FTWSATC Journal Article Volumes I, II, III
Course Books from other professional courses attended by staff.

Pencils, Pens, Note Pads, Paper clips
Rubber Bands, Thumb Tacks, Staplers
Staples, Screw Driver, Markers, Tape
Color Paper
Envelopes (w/out Center name)
Our Brochures
Business Card holder
w/ Center/Individual Cards
Phone Book
Zip Code Book
All Forms (see form list)
Paper Shredder
Decor

Closet

Wall Hooks
(extra FWSATC Shirts)
Plastic Storage Shelving Unit
Store paper products/brochures etc.

Extra toiletries
Binders
Misc.

Bathroom

Shower
Urine cups
Free Condoms
(Prevent transmission of
STD contracted from assailant.)
Cleaning Supplies
Toilet
Sink

Small Brochure Rack Containing:
Pamphlets - such topics:
Contraceptives, Melanoma
Alcoholics Anonymous
Herpes, Testicular Exam
Breast Self Exam
AIDS, Hepatitis, STD's
Dom. Violence Safety Plan
Narcotics Anonymous
Mental Health Services
Pregnancy Issues
+ other community pamphlets available.

FWSATC 2

Services

Black/White and Color Film- (Fort Wayne Police Department)
Film Developing - the PD investigating the crime
Insurance - Fort Wayne Police Department for Business Liability
Office Insurance for Property and General Liability
Parking (SJMC)
Garbage Pickup From Saint Joseph Medical Center (SJMC)
Linen and exam room supplies (SJMC)
Electricity, Heat Air Conditioning (SJMC)
Staff Pagers(FWSATC)
All Phone Service, Answering Service, Printing (all paid for by FWSATC)
Cellular Phones for managers (FWSATC)
Pagers (Managers from Allen County Prosecutors Office)
Cab Service for victims/survivors (Fort Wayne Womens Bureau)
Counseling (Fort Wayne Womens Bureau)
Assistance through the Criminal Justice System and
Bills related to Sexual Assault
(Fort Wayne Police Department Victim Assistance)
Sexual Assault Examination Kits-
(provided by Indiana State Police Department)
Medicine
some provided (+ condoms) by the Fort Wayne Board of Health (BOH)
some provided by representatives of drug companies
some provided by physicians
HIV, STD, Hepatitis Testing
(BOH , Health Care Provider or other community services recommended)
No Cleaning Service- office must be secured
Mail Pick Up- Post Office
Security (SJMC)

- Keys to entrance from office building and into office are available only to staff.

- SJMC has a key and will open waiting room to victims/survivor if he/she arrives before the SANE. However, the victim/survivor **must** be accompanied by a member of the SART. SJMC security may only open this area. They may enter the other areas without a staff member only in the event of an emergency.

Exam II

Currently being used as a quick storage area for supplies for Exam I and has sink and AC outlets.

FWSATC 3

Evidence/ Medicine Room

Urine Pregnancy Tests
Bactistatin Soap
Drug Books and Teaching Aids
Medicine Cups
Labels
Steel Filing Cabinets
(locking 46" x 65")
(locking 30" x 46")
Toiletries
Underwear (all sizes), Socks, T- Shirts, Sweat Pants and tops (all sizes)
Evidence Refrigerator
Clear Packing Tape (seal evidence)
Brown Paper Bags and Plastic Bags
Toiletries
Medicine Refrigerator
Medicine Envelopes and Containers

Each Nurse has her own lock with a key. There is a master set of keys available in the event there is need for more than one kit to be stored. This master set is available to the manager on call only.

Medicines: (* denotes provided by BOH)

*Doxycycline
Azithromycin
Phenergan
Motrin
Surfak
Epinephrine
Ovcon (or equivalent)
*Cipro
*Rocephrin
Tylenol
Tetanus
Benedryl
1000 cc NaCl with tubing

Exam I

Cryomedic Colposcope - (provided by Parkview Hospital) Now Circon (708) 957-6490
35mm capability
Video photography capability
Monitor
Foot Peddle
Cannon Elan 35 mm hand held camera with a 50 mm macro lens
Gateway 2000 Computer
Keyboard
Photographic Software (Second Opinion) Photographs stored on disc and prints can be made upon PD or PA request. (310) 534-2444
HP Desk Jet Printer
Midmark Pelvic Chair (this is much better than a pelvic table!!!!) 1-800 MIDMARK
Dry- Fast Swab Dryer (Kinderprint, Inc. 1-800-227-6020) We also have blueprints from the Pomerado Hospital SART/SANE course on how to make one. Since we got ours from Kinderprint the price has probably doubled.
ABFO Rulers (1-800-852-0300) approx. $4 each

Exam I continued....

Clock
Mayo Stand
CD/Radio
Linen
Sharps Containers
Red Rubber Catheters
Toluidine Blue Dye
Ammonia Inhalants
Plastic Speculums- 3 Sizes
Syringes (10cc, 3cc, TB)
Paper Bags
Bandaids
Powder free gloves
Garbage Bags
Sterile scissors, hemostats, tweezers
Sterile gauze pads- all sizes
Special blood, urine containers
(for drug screens)
ISP Kits
(Indiana State Police)
Protective Wrap for colposcope
(as in dentist office)
Follow-Up Calander
Post-it Notes

Phone
Goose Neck Lamp
Woods Lamp
Cleaning solution
Protective Eyeware
NaCl, Sterile H20 (10cc vials)
Vinegar/H20 (to spray off Toluidine)
Disposable Underpads or Chux
Cotton Tip Applicators
Phlebotomy Equipment
Vacutainers and Safety Lock
Blood Collection Sets
Alcohol and Betadine Preps
Vacutainer needles, 21ga, 22 ga
Extra blood tubes (if not in Kit)
Mini Tape Recorder
Ace Bandages, Sterile gloves
Cotton Balls
Exam Supply Cart
Electronic Thermometer
B/P Cuff, Stethoscope,
Portable Door Bell Receiver
Masks, Bactistatin Soap
Bacitracin Ointment

Forms

* Forms Turned Over to Police Department -> Help Forms For Staff
~ Forms For FWSATC Benefit

* Sexual Assault Examination Form (all consents included)
* Follow-up Examination Form (FWSATC only does follow up exams if injury)
* Chain of Custody Forms For Different Police Departments
* Serology Forms
* Addendum
* Blood Sample For Drug Consent
* Urine Sample for Drug Consent
* Urine/Blood for Drug Screen Chain of Custody
~ Medication Information Sheets
~ Consent and Information for Ovcon (or equivalent) Form *FWSATC 5*

Forms Continued.....

~ Discharge Form
~ Photograph Referral Form
(Used if SANE finds something on colopscope or visual examination that is unusual and can be photographed and sent to Victim/Survivors primary health care provider. This is not used for expected findings related to sexual assault but only for potential health care issues.)
~ Release of Medical Information Form
(Used if SANE finds something that may be necessary for referral to a heal care provider. Again, this is not used for expected findings related to sexual assault.)
~ Refusal of Treatment
~ Referral for Medical Consultation and/or Treatment
-> Exam / Evidence Flow Sheet
-> Follow -up calendar

APPENDIX H

CLINICAL SKILLS COMPETENCY CHECKLIST

Sexual Assault Nurse Examiner Checklist
Certification to Perform Sexual Assault Evidentiary Exam

Name: _____

Complete SA Exam Following Protocol	Dates	Preceptor Signature
Introduce self and explain the 5 services provided by SANE		
Explain parameters of confidentiality and obtain consent		
Assist in police report decision		
Complete interview		
Collect, mark, and secure appropriate clothing		
Conduct full body exam for injuries		
Woods lamp exam		
Examine oral cavity for injuries and collect DNA specimens		
Examine external genitalia for injuries		
Pubic hair combing		
Collect perineal/skin DNA specimens		
Perform pelvic and bimanual exam		
Collect vaginal DNA specimen		
Perform exam for anal injuries/rectal exam and collect DNA specimens		
Use light staining microscope		
Photograph genital injuries using colposcope		
Photograph injuries using camera		
Collect saliva sample		
Draw victim's blood and prepare DNA swatch		
Label and secure/transport BCA and hospital lab specimens		
Counsel patient about STD/pregnancy risk		
Staff case with physician		
Incorporate the 7 essential components of crisis intervention into discharge teaching		
Arrange follow-up counseling/safe disposition		

Sexual Assault Resource Service Minneapolis, MN June 1998

COLUMBIA UNIVERSITY SCHOOL OF NURSING
FORENSIC NURSING SPECIALTY

Donna A. Gaffney, DNSC, RN, FAAN

SEXUAL ASSAULT EXAMINER

New York City, New York

FORENSIC NURSE SPECIALISTS
CERTIFICATION TO PERFORM SEXUAL ASSAULT EXAMINATION

PRECEPTORSHIP CHECKLIST

EXPERENCE	DATE	SIGNWHEN COMPLETED
Agencies		
Law Enforcement		
Case Review		
Police Ride-along		
District Attorneys		
Criminal Court Case		
Advocate Service		
Staff Meetings		
Crime Lab		
Tour		
Hospital Exam Room Order		
Orientation to examination		
Assessment Skills		
Minimum 10-12 pelvic exams: Speculum Bimanual		
Colposcope Time - 1 hour		
Sexual Assault Exams		
Observe Sexual Assault Exams		
Perform Sexual Assault Exam With Assistance		

COLUMBIA UNIVERSITY SCHOOL OF NURSING
FORENSIC NURSE SPECIALIST

Preceptorship

Thank you for being a preceptor for Sexual Assault Nurse Examiner. We hope the following information helps enhance the experience for the Nurse Examiners, and makes the preceptorship enjoyable for you as well.

What Is A Sexual Assault Nurse Examiner?

The Nurse Examiners are Registered Nurses or Nurse Practitioners who have an interest in working with sexual assault survivors. They have receive 32 hours of education help them perform four functions.

1. Perform comprehensive health assessments of sexual assault survivors.
2. Collect and document physical and laboratory evidence.
3. Provide information referral to enhance the continuity of care for a sexual assault survivor.
4. Present testimony in court, when required.

Please consult the enclosed information packet for additional background of the SANE Program.

What Can I Expect The Nurse Examiner to Know?

You will find a copy of the curriculum used to educate the Nurse Examiners in the enclosed packet. The Nurse Examiners have completed the classroom portion of their training, and are now ready to gain the clinical experience. You, as health care professionals, are in a unique position to provide nurses with the necessary learning experiences.

What Are The Goals Of the Preceptor?

The Nurse Examiner will be spening time with a variety of agencies. They will complete a preceptorship in the following settings:

1. Law Enforcement Agencies
2. Child Protective Services
3. The District Attorney's Office
4. The Victim/Witness Program
5. Family Planning Clinics
6. Pediatrician's Offices
7. Hospital Emergency Departments
8. Sexual Assault Exam Rooms

Each Nurse Examiner will be contacting the preceptor settings to arrange their time. You will find a list of preceptors in the enclosed packet.

SEXUAL ASSAULT RESPONSE TEAM

PRECEPTORSHIP

HOW CAN I HELP THE NURSE EXAMINER FEEL A PART OF THE UNIT WHERE I WORK? WHAT'S THE BEST WAY OF LETTING MY CO-WORKERS KNOW WHAT THE NURSES EXAMINER IS DOING?

By clearly informing the staff about the role of the Nurse Examiner, you have taken the first step in helping them feel like a part of your unit. Some actions which can help the Nurse Examiner feel welcome are:

1. Introduce the Nurse Examiner to your co-workers.
2. Give them a tour of your unit or work place.
3. Include the Nurse Examiner in as many aspects of your job and decision-making process as possible.
4. Take the Nurse Examiner with you for coffee breaks or meals.
5. Remember, the Nurse Examiner will function as a team member with other people from your discipline. Be receptive to their questions, and provide answers that are understandable.

Please feel free to call us at 212-305-3414 if you have any questions or comments. We value your participation in this program.

COLUMBIA UNIVERSITY SCHOOL OF NURSING

THE COMPREHENSIVE FORENSIC EXAMINATION OF THE SEXUAL ASSAULT VICTIM

NOTE: **ALWAYS TELL THE VICTIM WHAT YOU WILL BE DOING BEFORE PROCEEDING**

VISUALLY INSPECT PRIOR TO TOUCHING VICTIM

I. Inspection of the person

1. Place paper on floor.
2. Examine clothing for tears, dirt, grass, hair or other foreign bodies. Collect appropriate articles, photo documentation.
3. Examine unclothed body (above waist first, then have client put gown on and examine buttocks and legs. Photodocumentation.
4. Bites should be swabbed with cotton gauze, site marked, moisten area with tap water as needed.
5. Woods lamp for semen stains.

II. Inspection of the thighs, perineum and genitalia.

1. Do not use lubricants except tap water or insert finger into vagina.
2. Note any body tenseness: arching backs, tilted pelvis, gluteal muscles tensed, knees together, or feet or toes twitching.
3. When victim is on examination table, feet in stirrups, inspect inner thighs, lower abdomen, entire perineum and external genitalia.
4. Note the presence or absence of skin lesions, inflammation, irritation, abnormal swelling, tumors, lacerations, discoloration, varicosities, leukorrheal discharge, or anatomical abnormalities.

III. Speculum Examination

1. Insertion of the speculum:

Spreading the labia with two fingers of the left hand, insert the closed speculum in an oblique plane until it is beyond the hymenal ring.
Always be careful to exert downward pressure while inserting and during the speculum examination to avoid the sensitive anterior structures, especially the urethra.

- Turn the speculum to the horizontal plane pointing speculum straight back untill it is one third of the way
- Point speculum toward floor another one third of the way.
- When the shorter, upper blade is just in front of the cervix, lift the anterior blade with the thumb lever.
- Maneuver the anterior blade so that when widely opened the cervix will come into position between the blades.
- Secure the blades in position by tightening the screws of the speculum (or click into position if using plastic speculum).

2. Under good light inspect the cervix for trauma, lacerations, bleeding or discharge, polyps, erosions, lesions, cysts, color, acute or chronic cervicitis; Also note the character, amount, and source of discharge. Evidence collected as indicated in rape kit. (Colposcope used at this time).

3. On removing the speculum be careful not to catch the cervix, vaginal mucosa, or pubic hair between the blades. While you continue to maintain downward pressure, unscrew the thumb lever and withdraw slowly. Hold blades open and while you continue to withdraw the speculum inspect the vaginal mucosa for lacerations, bleeding, color, inflammation, neoplasms, and cysts. Close slowly as speculum is rotated so that it is closed when actually removed. (Colposcope can be used at this time).

4. When the speculum has been withdrawn to within an inch of the introitus, collapse the blades and turn the speculum in the oblique position. Spread the labia again as the speculum is removed from the introitus. Note the character of vaginal discharge collected on the speculum.

5. Spreading the labia with the two fingers of the left hand, insert the index finger of the right hand an inch into the introitus and press upwards and outwards on the urethra "milking it" and the Skene's glands. Note any exudate.

6. Sweep the fingers laterally and palpate the area of the Bartholin glands between the finger and thumb bilaterally. Note masses, tenderness, or exudate.

IV. Bimanual examination of pelvic organs (May be optional for some states or regions)

1. Relaxation of the abdominal muscles is essential:

- Slow, relaxed but firm movements will avoid pain.
- If tension should develop, stop, relax your hand, and relax and reassure the patient before continuing the examination.
- Remember to palpate with the flat part of your fingers rather than the less sensitive finger tips.
- It may help you to keep your vaginal hand relaxed by placing your right foot on a stool with your right arm resting on your right thigh. Then all forward and downward pressure would be exerted by leaning against your elbow.

2. Insertion of fingers:

- Lubricate the first two fingers of the right hand and insert into the vagina - palm down - maintaining downward pressure.
- If the patient is tense, just apply downward pressure at the introitus a few seconds before entering the vagina.
- When your fingers are well into the vagina, rotate your hand palm up so that the plane of the hand is in the 1 or 2 o'clock position.
- Keep the thumb vertical in the midline; the other two fingers curve out of the way.

3. Palpation of cervix:

- Push forward until each of the fingers is in a lateral fornix with the cervix between.
- Palpate the cervix and note position, consistency, irregular or roughened areas, size of the external os, direction in which the cervical os points, and whether the digital contact caused bleeding.

4. Palpation of uterus:

Because of the situation of the ligaments, cardinal laterally and utero-sacral posteriorly, the uterus will rotate in many directions.

NOTE:

* Lifting up on the cervix with the fingers in the lateral fornices will bring the uterus upward toward the abdominal hand.

* Lifting the vaginal index finger in the left fornix will rotate the uterus to the patient's right and vice versa.

- The natural position of the uterus is determined by passing the fingers along the front or back of the cervix to establish the position of the uterine body.
- First lifting the uterus between the vaginal and abdominal hand, note the size, consistency, and mobility of the uterus.
- Then by moving the uterus in different directions the surfaces of the uterus can be palpated.

5. To palpate the adnexa:

- Place the vaginal fingers in the right lateral fornix and the abdominal hand in the area of the right iliac crest.
- Bring the hands together and move them toward the midline.
- The vaginal fingers will best define the ovaries as they slip betweeen the fingers while the abdominal hand will act to press the adnexal masses firmly to the vaginal fingers.
- During this motion the size, shape, mobility, and consistency of the adnexal organs and masses can be noted.
- Repeat the same procedure on the left side.
- Remember that normal adnexa are often not palpable.

V. Rectal Examination (May be optional for some states or regions)

1. Change gloves and use tap water as needed. Inspect the rectal area for trauma, lacerations, bleeding or discharge. As in the vagina, the abdominal hand can be used to push the pelvic organs closer to the rectal finger. Note sphincter tone, rectovaginal septum, rectal pathology Often more definite information can be obtained by the combined rectovaginal examination especially when evaluating fistulas or vaginal-rectal tears.

SUMMARY OF COMPREHENSIVE FORENSIC EXAMINATION (PELVIC PROCEDURES)

PREPARATION OF PELVIC EXAMINATION:

1. Assemble equipment, rape kit, extra brown bags, cotton gauze and make sure it is in good working order. Organize room to facilitate evidence collection with rape kit.
2. Wash hands before starting procedure.
3. Use clean/sterile technique as indicated
4. Do not leave the room once evidence collection has begun and evidence kit has been opened.

POSITIONING FOR PELVIC EXAMINATION:

1. Time examination for minimal discomfort to patient
2. Proper body alignment will facilitate exam and be most comfortable to patient.
3. Minimal exposure of the person is important

TECHNIQUE FOR PELVIC EXAMINATION

A. Inspection
   1. Inspect perineum and anus
   2. Inspect labia majora and labia minora
   3. Inspect hymen, vaginal orifice, urethral orifice, frenulum, clitoris, prepuce
   4. Colposcopy if available
   5. Documentation of injuries
   6. Photographic documentation

B. Speculum Exam (with Colposcope if Available)
   1. Choose appropriate speculum
   2. Wet the speculum with tap water (warm water also warm speculum)
   3. Insert the speculum
   4. Open the speculum to expose the cervix
   5. Inspect the cervix with good light source
   6. Take needed specimens or cultures (according to steps in rape kit)
   7. Withdraw the speculum off cervix and inspect the vaginal walls
   8. Close speculum blades before withdrawing from vagina
   9. Check the speculum for character and odor of discharge
   10. Documentation of trauma
   11. Photographic documentation

C. Palpation
   1. Palpate paraurethral glands
   2. Palpate greater vestibular glands

D. Bimanual Examination - may be optional

   Cervix evaluated for:
   1. Location
   2. Position
   3. Size and shape
   4. Consistency and tenderness on movement

Uterus
1. Palpate for location
2. Palpate for position
3. Palpate for size and shape
4. Palpate for consistency
5. Palpate and determine accurately presence or absence of tenderness

Adnexal Areas
1. Palpate right adnexa for size and shape
2. Palpate right adnexa for position
3. Palpate right adnexa for consistency
4. Palpate and determine presence or absence of tenderness in right adnexa area
5. Palpate left adnexa for size and shape
6. Palpate left adnexa for position
7. Palpate left adnexia for consistency
8. Palpate and determine accurately presence or absence of tenderness in left adnexal area

Pap Smear - may be optional
1. Take a smear from the ectocervix as indicated
2. Take a smear from the endocervix

Gonorrhea Culture - may be optional
1. Take a smear from the endovervical canal leaving cotton tipped swab in place 15-30 seconds
2. Place on proper culture media

Chlamydia Culture - may be optional
1. Take a smear from endocervical canal, cervical os and fornices.
2. Place cotton tipped swab in culture medium

Microscope - may be optional
1. Prepare slides with proper solution
2. Focus properly
3. Describe presence/absence of spermatozoa

Sample Charting of Normal Pelvic Exam Findings

External Genitalia:	Escutcheon normal, without lesions B. U.S.'s lesions or enlargement (Bartholins, urethra, skenes)
Vaginal walls:	Rugated, pink, without discharge, cystocele
Recto/Vaginal:	Septum intact, no masses, without rectocele, good sphinctal tone
Cervix:	Multiparous, closed, moveable, nontender pink without erosion, Clear mucus from os
Uterus:	Smooth, firm, nontender, anteverted, anteflexed (A/V, A/F), mobile, no size
Adnexa:	Palpable, nontender, no masses

PELVIC EXAM

External Genitalia _____

Vagina _____

Cervix _____

Uterus _____

Adnexa _____

Recto/Vaginal _____

COLUMBIA UNIVERSITY SCHOOL OF NURSING

COMPETENCIES FOR PELVIC EXAMINATION OF NORMAL FEMALE

Name: _____ Agency: _____

Perform a complete and systematic pelvic examination of the apparently healthy adult female, screen for specified-conditions and record findings appropriately.

	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
1. Prepare patient for the examination									
1.1 Create a comfortable environment									
1.2 Explain procedure and reassume patient.									
1.3 Assist with positioning and draping of patient.									
1.3.1 Time position to reduce discomfort/anxiety.									
1.3.2. Assist the patient to maintain comfortable body position.									
1.3.3. Provide draping as desired/indicated to reduce discomfort/anxiety/embarrassment.									
2. Prepare for pelvic examination:									
2.1 Assemble all equipment, and make sure it is in working order.									
2.2 Wash hands before starting procedure and between patients.									
2.3 Use clean or sterile technique as indicated.									
3. Inspect external genitalia									
3.1 Inspect escutcheon, perineum.									
3.2 Inspect labia majora and minora.									
3.3 Inspect hymen, vaginal orifice, urethral orifice, frenulum, clitoris, prepuce.									
4. Palpate external genitalia, (optional)									
4.1 Palpate paraurethral glands.									
4.2 Palpate greater vestibular glands.									

Perform a speculum examination safely and with minimal discomfort to the patient.									
5.1 Choose appropriate speculum.									
5.2 Warm the speculum.									
5.3 Lubricate the speculum properly.									
5.4 Insert speculum.									
5.5 Open the speculum to expose the cervix.									
5.6 Inspect the cervix with good visualization .									
5.7 Withdraw the speculum and inspect vaginal walls.									
5.8 Close speculum blades before withdrawing from vagina.									
5.9 Check speculum for character and odor of any discharge.									
Take a gonorrheal culture (optional). Take a chlamydia culture on indication (optional).									
Take a pap smear on indication, accurately, safely, and with minimal discomfort to the person per institution (optional).									
Perform a bimanual examination with minimal discomfort to patient. (optional)									
8.1 Accurately identify the location, position, size, shape, tenderness, and consistency of the cervix.									
8.2 Perform a systematic exam of adnexal areas and the uterus determining the presence or absence of tenderness, and looking for location, position, size, shape and consistency.									
Perform a rectal examination accurately and with minimal discomfort to the patient. (optional)									
9.1 Inspect the sacrococcygeal and perianal area for masses, inflammation, rashes, excoriations.									
9.2 Inserting lubricated glove index finger over and sphincter, note: sphincter tone, tenderness, irregularities, or nodules.									

10.	Perform a recto-vaginal examination on indication, accurately and with minimal discomfort to the patient (optional).									
10.1	Inserting lubricated gloved index finger into vagina and second finger past the anal sphincter, palpate the recto-vaginal septum for nodularity, irregularity.									
10.2	Palpate the cervix and any portion of the uterus on indication.									
11.	Describe and record all findings clearly and accurately.									

DATE: PRECEPTOR: COMMENTS:

COLUMBIA UNIVERSITY SCHOOL OF NURSING

COMPETENCIES FOR FORENSIC PELVIC EXAMINATION OF SEXUALLY ASSAULTED FEMALE (12 YEARS AND OLDER)

Name: _____ **Agency:** _____

Perform a complete and systematic Forensic (pelvic) examination of the sexually assaulted adult female, screen for specified-conditions is indicated and record findings appropriately.

	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	
Create a Healing Environment									
1.1 Identify anxiety, muscular tension									
1.2 Instruct and guide victim to relax, center, meditate									
Prepare patient for the examination.									
2.1 Explain procedure and reassure patient (throughout exam).									
2.2 Assist with positioning and draping of patient.									
2.2.1 Time position to reduce discomfort/anxiety									
2.2.2 Assist the patient to maintain comfortable body position.									
2.2.3 Provide draping as desired/indicated to reduce discomfort/ anxiety/embarrassment.									
2.3 Demonstrate the proper preparation of evidence collection (steps as indicated according to state evidence kit).									
Prepare for pelvic examination:									
3.1 Assemble and organize all equipment, sexual offensive evidence collectior kit, extra brown bag, and make sure it is in working order.									
3.2 Wash hands before starting procedure and between patients.									
3.3 Use clean or sterile technique as indicated.									
Inspect external genitalia for injuries.									
4.1 Inspect escutcheon, perineum.									

		Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
4.2	Inspect labia majora and minora.									
4.3	Inspect hymen, vaginal orifice, urethral orifice, frenulum, clitoris, prepuce.									
4.4	Photo documentation.									
5.	Perform a speculum examination safely and with minimal discomfort to the patient.									
5.1	Choose appropriate speculum.									
5.2	Warm and speculum and lubricate with water only the speculum properly.									
5.3	Insert speculum.									
5.4	Open the speculum to expose the cervix.									
5.5	Inspect the cervix with good visualization for injuries.									
5.6	Swab vagina for evidence collection.									
5.7	Colposcopy and photo documentation.									
5.8	Withdraw the speculum and inspect vaginal walls for injuries.									
5.9	Colposcopy and photo documentation.									
5.10	Close speculum blades before withdrawing from vagina.									
5.11	Check speculum for character and odor of any discharge.									
6.	Take a gonorrheal culture (as indicated) and a chlamydia culture (as indicated).									
7.	Take a pap smear on indication, accurately, safely, and with minimal discomfort to the person per institution (optional).									
8.	Perform a bimanual examination with minimal discomfort to patient.									
8.1	Accurately identify the location, position, size, shape, tenderness, and consistency of the cervix.									
8,2	Perform a systematic exam of adnexal areas and the uterus determining the presence or absence of tenderness, and looking for location, position, size, shape and consistency,									

	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Perform a rectal examination accurately and with minimal discomfort to the patient.									
9.1 Inspect the sacrococcygeal and peranal area for injuries, inflammation rashes, excoriations, or discharge.									
9.2 Collect anal swab and smear.									
Describe and record all findings clearly and accurately using descriptive, objective, non-judgmental terms.									
Date Preceptor Comments:									

APPENDIX I SANE PROTOCOLS

S.A.N.E. PEDIATRIC SEXUAL ASSAULT PROTOCOL

Police Department _____ **Case #:** _____

Name of Patient: _____
Name of Person Providing History: _____ Relationship to Patient: _____
Date/time of assault: _____ Location of assault: _____
Date of Disclosure: _____ To Whom: _____
Social Services: Reported to: _____ Time: _____
Name(s), number and race of assailants(s): _____
What happened?

_____
_____
_____
_____

						Reported by
Oral copulation of genitals						
of victim by assailant	Yes	No	Attempted	Unsure	No Disclosure	_____
of assailant by victim	Yes	No	Attempted	Unsure	No Disclosure	_____
Oral copulation of anus						
of victim by assailant	Yes	No	Attempted	Unsure	No Disclosure	_____
of assailant by victim	Yes	No	Attempted	Unsure	No Disclosure	_____
Masturbation						
of victim by assailant	Yes	No	Attempted	Unsure	No Disclosure	_____
of assailant by victim	Yes	No	Attempted	Unsure	No Disclosure	_____
other	Yes	No	Attempted	Unsure	No Disclosure	_____
Penetration of vagina by (circle):						
Penis	Yes	No	Attempted	Unsure	No Disclosure	_____
Finger	Yes	No	Attempted	Unsure	No Disclosure	_____
Foreign Object	Yes	No	Attempted	Unsure	No Disclosure	_____
Describe the Object	Yes	No	Attempted	Unsure	No Disclosure	_____
Penetration of rectum by						
Penis	Yes	No	Attempted	Unsure	No Disclosure	_____
Finger	Yes	No	Attempted	Unsure	No Disclosure	_____
Foreign Object	Yes	No	Attempted	Unsure	No Disclosure	_____
Describe the Object	Yes	No	Attempted	Unsure	No Disclosure	_____

Did ejaculation occur? Yes No Unsure No Disclosure
If yes, describe the location on the body _____
Foam, jelly or condom used (Circle) Yes No Unsure
Lubricant used (Describe) _____ Yes No Unsure

Fondling, kissing or licking (Circle) Yes No
If yes, describe the location on the body _____
Other acts: _____
Physical injuries and/or pain described by patient:

_____
_____

Signature _____

Methods employed by perpetrator:

Weapon inflicted injuries	Yes	No	Area of Body: _____
Type of weapon(s): _____			
Physical blows by hands or feet	Yes	No	Area of Body: _____
Grabbing/grasping/holding (Circle)	Yes	No	Area of Body: _____
Physical restraints	Yes	No	Area of Body: _____
Type(s) used: _____			
Bites	Yes	No	Area of Body: _____
Choking	Yes	No	
Burns (including chemical/toxic)	Yes	No	Area of Body: _____
Threat(s) of harm	Yes	No	
To whom: _____			
Type: _____			

Other method(s) used: (Describe)

_____

_____

Post assault hygiene activity: (Not applicable if over 72 hours)

Urinated	Yes	No
Defecated	Yes	No
Genital wipe/wash	Yes	No
Bath/shower	Yes	No
Douche	Yes	No
Removed/inserted tampon, sponge, diaphragm: (Circle)	Yes	No
Brushed teeth	Yes	No
Oral gargle/swish	Yes	No
Changed clothing	Yes	No

Past History:

Sexual Abuse	Yes	No	Reported ____ Date _____
Physical Abuse	Yes	No	Reported ____ Date _____
Emotional Abuse	Yes	No	Reported ____ Date _____

Recent Behavioral/Emotional Changes: Yes No Describe _____

_____

_____

_____

HEALTH HISTORY

Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures or medical treatment which may affect physical injuries? Yes No

_____

STD History: _____

First Pelvic Exam Yes ___ No ___ Last Pelvic Exam Date _____

Onset of Menses _____ Tampon Use: Yes ___ No ___ Size _____

LMP _____

Contraception at time of Assault:

None ___ BCP ___ IUD ___ Hyst/TL ___ Diaphragm ___ Other _____

Known to be Pregnant: Yes ___ No ___ At Risk: Yes ___ No ___

If >6 weeks preg. test: Positive ___ Negative ___ Not Done ___ Serum ___ Urine ___

Signature _____

	WNL	VARIANT (Describe)	NOT DONE
General Appearance:			
Skin -			
Head -			
Hair -			
Eyes -			
Ears -			
Nose -			
Mouth/Dental -			
Breast -			
Heart - AP			
Lungs -			
Back -			
Abdomen/Trunk -			
Extremities:			
Lower -			
Upper -			

Genital Tanner Stage: 1 2 3 4 5

FEMALE GENITAL ASSESSMENT:

Woods Lamp Exam: Yes ___ No ___ Finding: _____
Colposcopy: Yes ___ No ___ 35mm Camera: Yes ___ No ___ Photographer _____
Position: Frogleg ___ Knee-Chest ___ Other _____

	WNL	ABN	DESCRIBE
Medial aspect of thighs	___	___	_____
Mons	___	___	_____
Labia Majora	___	___	_____
Clitoral Hood	___	___	_____
Clitoris	___	___	_____
Periurethral Tissue	___	___	_____
Urethral Meatus	___	___	_____
Labia Minora	___	___	_____

Hymenal: _____ Transverse Diameter _____ Posterior Rim _____
Hymen: Annular _____ Cresentric _____ Cuffed _____ Other _____

Posterior Fourchette	___	___	_____
Vaginal Vault	Visualized		Not Visualized
Cervix	Visualized		Not Visualized
Uterus/Adnexa	Palpated		Not Palpated

Perianal: _____
Rectal: Done ___ Not Done ___ Tone ___
Wet Mount Exam: Yes ___ No ___ Source: Cervical ___ Vaginal ___ Other ___
Seen: Yes ___ No ___ Motile: Yes ___ No ___
Guaiac: Positive ___ Negative ___ Not Done _____
Pictures Taken: Yes ___ No ___ Photographer: _____
Documentation on Anatomical Sheet: Yes ___ No ___
Behaviors Observed During Exam:

Controlled	___	Expressive	___	Mixed	___	Agitated	___	Cooperative	___
Fidgeting	___	Fearful	___	Listless	___	Loud	___	Quiet	___
Staring	___	Sobbing	___	Tearful	___	Tense	___	Trembling	___
Yelling	___	Other:	_____						

Response to questions: Pre-Verbal ___ Briefly ___ Readily ___ Reluctantly ___

Signature _____

DISCHARGE PLANNING SUMMARY FOR _____

During your visit we have discussed the following concerns:

PREGNANCY

You were tested for pregnancy: Yes _____ No _____
Your Pregnancy test result was: Positive _____ Negative _____ Testing not indicated _____
You were given _____ as emergency contraception to prevent pregnancy.
Take _____ tablets now and _____ tablets in 12 hours by mouth. See instruction sheet included.

SEXUALLY TRANSMITTED DISEASES

You were tested for: Gonorrhea _____ Chlamydia _____ Trichomoniasis _____
Hepatitis B _____ HIV _____ Herpes _____ Syphilis _____
You received _____ as treatment to prevent Gonorrhea.
You received _____ as treatment to prevent Chlamydia.
You received _____ as treatment for _____
_____
It is recommended that you have a follow-up test in 6 weeks for ____ Syphilis
It is recommended that you have a follow-up test in 3 months for ____ HIV
You have been immunized for Hepatitis B____ Yes ____ No ____ Don't Remember
You completed #1 ____, #2 ____, #3 ____ in the Hepatitis B series.
I recommend you _____
_____

SAFETY

Discharge to:
_____
_____

FOLLOW-UP PHONE CALL

Plan: I will call you in ___ days to give you your test results and see how you are doing. If you need to speak with me before that time, please call and leave a message at 267-6206 and I will call you back.
_____

COUNSELING

Plan: You have been given a packet containing information about your care today, community resources that are available to assist you, and important issues related to recovery. In addition, if you would like to talk with a Crisis Advocate, call 251-7273. Someone is available to talk with you 24 hours a day.
_____

MEDICAL FOLLOW-UP

You have identified _____as your primary health care provider.
You have decided to seek follow-up care with _____
Please call and make an appointment to be seen in _____ days.
_____
_____

_____ _____
Nurse Examiner Client

This protocol was developed by the Sexual Assault Nurse Examiner staff, Madison, Wisconsin.

APPENDIX J SANE FORMS

525 Portland Ave., 7th Level, Mpls., MN 55415 • 347-5832

WAIVER OF MEDICAL PRIVILEGE AND AUTHORIZATION FOR RELEASE OF MEDICAL AND LEGAL INFORMATION FOR VICTIMS OF ASSAULT

Patient's Name:_____Medical Record No._____

I hereby authorize this hospital to examine and treat me (my_____, relationship) for any injury or disease sustained as a result of this assault. I also authorize this hospital to take any and all medical tests that may be necessary or helpful for treatment or for legal evidence, and to photograph any injury or abnormality found.

I also authorize this hospital to release all of the evidence found and all of the information contained in the medical records concerning this assault examination and treatment to the law enforcement agencies that may be involved in investigating this assault or in prosecuting the assailant. I also request the law enforcement agencies to release evidence regarding my case to the hospital/Sexual Assault Resource Service.

I hereby waive all medical privilege in connection with such examination, treatment, and evidence found, and I expressly authorize the use of such medical information in any subsequent criminal prosecution in the State or Federal Courts against the assailant.

Care was rendered at _____in the Emergency/Outpatient

Department on or about_____to the patient under the name of

_____.

I UNDERSTAND THAT THIS IS NOT A ROUTINE MEDICAL CHECKUP BUT A SEXUAL ASSAULT EVIDENTIARY EXAM. THE NURSE DOING THE EXAM WILL NOT BE HELD RESPONSIBLE FOR IDENTIFYING, DIAGNOSING, OR TREATING ANY EXISTING MEDICAL PROBLEMS I MAY HAVE.

I UNDERSTAND THAT THIS WAIVER AND RELEASE AUTHORIZES A COMPLETE MEDICAL-LEGAL EXAMINATION TO BE DONE AND ALSO AUTHORIZES RELEASING THE RECORDS OF THAT EXAMINATION TO THE APPROPRIATE LAW ENFORCEMENT AGENCIES, BUT THAT NOTHING CONTAINED IN THIS WAIVER AND RELEASE OBLIGATES ME TO PROSECUTE THE ASSAILANT. I ALSO UNDERSTAND THAT THIS WAIVER SERVES AS A REQUEST FOR THE APPROPRIATE LAW ENFORCEMENT AGENCIES OR PROSECUTING AUTHORITY TO RELEASE INVESTIGATIVE DATA REGARDING MY CASE TO THE HOSPITAL/SEXUAL ASSAULT RESOURCE SERVICE.

Signed_____(patient)

Signed for_____by_____

who is the_____(relationship) of the patient

Date_____Time_____

Witness_____Date_____

City of Memphis
TENNESSEE

Memphis Sexual Assault Resource Center
CONSENT FOR EXAMINATION

CASE NUMBER _____

I, _____, do hereby authorize the Forensic Nurse Evaluator/Clinician at the Memphis Sexual Assault Resource Center to perform the following:

_____ a. Collect evidence, including hair combings, blood sample, photographs, body fluid samples, scraping of finger nails, and collection of clothing.

_____ b. Pelvic examination.

_____ c. Visual inspection of injuries and possible areas of assault including the oral cavity, the genitalia, and the rectum.

_____ d. Screen for venereal diseases, including cultures, body fluid samples, and/or blood collection.

_____ e. Collect urine and/or blood for drug screen.

_____ f. Collect urine for pregnancy test.

_____ g. Give medication for the intention of preventing pregnancy and/or infection.

_____ h. Other _____

FOR YOUR INFORMATION (PLEASE READ):

The information provided by you about your (your child's) case will be entered into a computer data base. Then the information will be combined with other data to be analyzed. Information about an individual's rape experience is private and shared only on a "need to know" basis. For example, if you are an adult and have given permission to report to law enforcement, the police will have access to the forensic report, evidence, and laboratory test results on the evidence. If the client is a child, the Child Protection Team will have access to the forensic report, evidence, and laboratory test results on the evidence.

The medical information contained in this record is private and protected under state law. It is also confidential, and in most circumstances, the medical record will be released only with your permission and a signed Release of Medical Information. However, there are exceptions: 1. Infrequently, medical information is subpoenaed by a court and must be released. 2. Occasionally the medical information is shared within the MSARC organization or the Child Protection Team on a "need to know" basis.

****

The procedures and services have been explained by the Forensic Nurse. By signing this form, I authorize the Forensic Nurse Evaluator/Clinician to perform the procedures and provide the services that are marked above. I understand that I can withdraw my consent at any time.

_____ _____
Patient Signature Parent/Guardian

_____ _____
Date Relationship to Patient

TELEPHONE CONSENT FOR MINORS:

_____ _____
Parent/Guardian Identifying Information (SS#, DL#, TP#)

_____ _____
Relationship to Patient Witness - Forensic Nurse Evaluator/Clinician

Original: Clinic
Copy: Client

HENNEPIN COUNTY MEDICAL CENTER
Minneapolis, MN 55415

NARRATIVE NOTES

Pt. Med. Rec. #:

Pt. Name:

180-00455 (9/95)

CONSENT FOR POST-COITAL ESTROGEN TREATMENT
(The Morning After Pill)

You must understand certain facts in order to make an informed decision about post-coital estrogen treatment.

I. Your doctor and nurse have determined from your history that you are at risk for getting pregnant from this exposure.

II. Estrogen therapy, if given soon after intercourse, has been shown to be effective in preventing pregnancy, but it is not 100% effective.

III. It is remotely possible that you have an undetected pregnancy from prior consented intercourse, despite your negative pregnancy test today.

IV. If you are already pregnant, or if you get pregnant despite taking post-coital estrogens this cycle, there is significant risk that your fetus will have extremity, heart, neurologic or other birth defects. If you become pregnant this cycle, you would be advised to have an abortion. You should avoid further exposure to pregnancy this cycle by using contraception or avoiding sex until your next period.

V. If you do not have your period within thirty days of taking the morning after pill, you must see your doctor promptly for a pregnancy test and counseling.

VI. Estrogens given in doses to prevent pregnancy cause many women to have nausea, vomiting and breast tenderness. This usually resolves in 24 hours. A rare, but serious and sometimes fatal, side effect is abnormal blood clotting.

VII. The morning-after pill is for emergency use only. It is not recommended for repeated use or as a routine method of contraception. If you do not desire to get pregnant in the future, you should see your doctor to discuss a contraceptive method appropriate for you.

The above information has been reviewed with me by Dr. _____ and I have had the opportunity to ask questions. I understand the nature, risks and side effects of this treatment.

_____ _____
Patient's Name Date

_____ _____
Witness Date

City of Memphis
TENNESSEE

SEXUAL ASSAULT RESOURCE CENTER
272-2020 (voice or TDD)

CONSENT TO ADMINISTER
EMERGENCY CONTRACEPTION TO PREVENT PREGNANCY **CASE #:** _____

INFORMATION FOR YOU: The hormone medication that is administered by the Memphis Sexual Assault Resource Center (MSARC) is considered an emergency treatment to prevent pregnancy. The medication is not labeled by the Federal Drug Administration for this purpose. However, its usefulness and safety for pregnancy prevention have been confirmed in published studies. If you take this medication, there are side effect and risks that may include:

1. The most common side effects are headaches, nausea and breast tenderness.
2. Another side effect is altered menstruation, such as heavy or irregular periods.
3. Pregnancy can occur in some instances even if you take the drug correctly. If you are already pregnant, our test may not be able to detect the pregnancy. In either case, the hormone may cause birth defects to the baby.
4. Rarely, the hormone medication can cause blood clots, a stroke, or a heart attack.

If you take all the medicine, your period should begin within two weeks after you complete the treatment. If your period does not begin within two weeks after you finish the medicine, we recommend a pregnancy test. Call MSARC to schedule an appointment with the nurse for a free test.

YOUR INFORMED CONSENT OR REFUSAL TO RECEIVE THIS MEDICINE:

- I have been screed for my personal risk by the nurse and been informed of the benefits and risks, side effects and limits of the medication. I understand that it has been shown to be effective in pregnancy prevention. I have had the opportunity to read this paper and have my questions answered concerning the administration of this drug.
- I do not hold the City of Memphis, the Sexual Assault Resource Center or the attending Sexual Assault Nurse Examiner responsible for any side effects that might result from my choice to use this medication, for any pregnancy which is pre-existing but undetectable, or for any pregnancy that might result from incorrect use of the medication.
- I hereby consent to treatment and I want to take the medication for the intention of preventing pregnancy that may result from the sexual assault. I authorize the Memphis Sexual Assault Resource Center and the attending Sexual Assault Nurse Examiner to give me the hormone for the emergency prevention of pregnancy. I understand that I can withdraw my consent at any time by my choice to not take this medication.

_____

Signature of the Client/Parent/Guardian Date SANE

- I understand that the Sexual Assault Nurse Examiner has chosen not to recommend the pregnancy prevention medication because (please check):

_____Menses Present _____Positive Urine HCG
_____ Sterilization Surgery (Type & Year: _____) _____On Oral Contraceptives
_____Outside Medication Protocol _____On Depo Shots (Date Last Shot:_____)
_____ Other (Describe:_____)

_____

Signature of the Client/Parent/Guardian Date SANE

- I choose NOT to receive the medication for the emergency prevention of pregnancy although it has been recommended by the Sexual Assault Nurse Examiner.

_____

Signature of the Client/Parent/Guardian Date SANE

MSARC: L2100.445, Rev. 10/88, 11/91, 01/96, 12/97.

SEXUAL ASSAULT EXAM REPORT

Pt. Med. Rec. #
Pt. Name:

MEDICAL HISTORY/ALLERGIES

Chronic Diseases _____

Current Meds _____

ALLERGIES _____

Date/Time of Exam _____ am/pm
☐ ADULT (≥ 17 yrs.) ☐ PEDS (≤ 16 yrs.)

FEMALE GYN HISTORY

Date Last Menstrual Period _____ Contrceptives Used: ☐ NO ☐ YES Type _____
Menstrual Cycle _____

EXAMINATION FINDINGS: or "DATA"

Incident reported to _____ Police Dept. CC#: _____ Squad #: _____
Assault Date _____ Time _____ am/pm Last Sexual Contact Prior to Assault _____

1. Body Orifices involved in Assault _____
2. Did Ejaculation Occur? ☐ No ☐ Unsure ☐ Yes If Yes, Where on/in Body? _____
3. Since Assault Pt. has: ☐ Bathed ☐ Showered ☐ Changed Clothing ☐ Douched ☐ Had Bowel Movement
4. Emotional State
   A. Patient's Behavior _____
   B. Patient's Comments _____

5. HCMC Specimens

	ORAL	VAG/ PENILE	RECTAL	SKIN
A. Seminal Fluid				
1. Sperm motility/acid p-tase				
2. Slide				
B. GC – 1. Antigen				
B. 2. Culture				
C. Chlamydia – 1. Antigen				
2. Culture				

D. Syphilis ☐ NO ☐ YES
E. Blood Alcohol ☐ NO ☐ YES Lab name _____
F. UPT ☐ NO ☐ YES Result _____
G. Other ☐ NO ☐ YES
Specify _____

6. BCA Specimens
   A. Hair Combing ☐ NO ☐ YES
   B. Saliva Sample ☐ NO ☐ YES
   C. Blood type/DNA ☐ NO ☐ YES
   D. Blood/Drugs ☐ NO ☐ YES
   E. Urine/Drugs ☐ NO ☐ YES
   F. Swab/Seminal Fluid ☐ NO ☐ YES
   ☐ Oral ☐ Vag ☐ Rectal
   ☐ Skin Where? _____
   G. Other
   Specify: _____

7. Photographs Taken: ☐ NO ☐ YES If Yes, list views _____
8. Stains on Clothing: ☐ NO ☐ YES If Yes, note location _____
9. Cothing obtained as evidence: ☐ NO ☐ YES If Yes, what? _____

Completed By: _____ _____
(Signature) (Print Name)

BCA Lab Specimens and Copy of Hospital Records
Released to _____
Agency _____
Released by _____

CLOTHING
Released to _____
Agency _____
Released by _____

SEXUAL ASSAULT EXAM REPORT

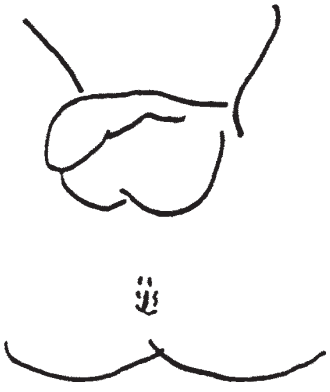
Pt. Med. Rec. #:

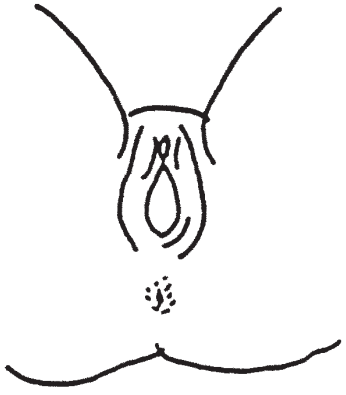
Pt. Name:

HISTORY/PHYSICAL:

ASSESSMENT:

INDICATE ABNORMALITIES AND SHADE IN TENDER AREAS (TURN OVER FOR FULL BODY DIAGRAM)





Completed By: _____ _____ _____

(Signature) (Print Name) (Date)

SEXUAL ASSAULT EXAM REPORT

Pt. Med. Rec. #:

Pt. Name:

PEDIATRIC DATA

Should case be assessed by CPS? ☐ NO ☐ YES If no, proceed to PLAN.

CPS notified? ☐ NO ☐ YES NAME: _____ PHONE # _____ DATE: _____

PERTINENT HISTORY (Include assailant's name, age and relationship to patient)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Father's Name: _____ DOB: _____ Address: _____ Phone #: _____

Mother's Name: _____ DOB: _____ Address: _____ Phone #: _____

Other children int home (List names, ages)

1. _____ 3. _____

2. _____ 4. _____

Other involved persons (List name, relationship to patient)

1. _____ 3. _____

2. _____ 4. _____

Child brought in by:

_____ Relationship: _____ Phone #: _____

Primary physician:

_____ Address: _____ Phone #: _____

PLAN

_____

_____

Medication: _____

_____

Instructions to patient: _____

_____

Follow-up:

Medical: ☐ PEDS ☐ GYN ☐ ADOL ☐ OTHER ☐ APPT. DATE: _____

SARS: ☐ APPT. DATE _____

Agency Referrals: ☐ CPS ☐ APS ☐ CIC ☐ OTHER LIST: _____

_____

Disposition _____ Address: _____ Phone #: _____

Other ways to reach patient: _____

Completed By: _____ _____

(Signature) (Print Name) (Date)

_____ _____

(Signature) (Print Name) (Date)

SEXUAL ASSAULT EXAM REPORT

CRISIS INTERVENTION CENTER

CISPA: Critical Item Suicide Potential Assessment

Criteria for requesting consultation by either psychiatrist or doctoral level clinical psychologist (LCP).

PT. NAME: _____

DATE: _____

TIME: _____ ☐ a.m. ☐ p.m.

A. CURRENT - PRIMARY RISK FACTORS (Obtain consultation if any one of the following is present):

I. Attempt

+ = Present
- = Absent

___ 1. Suicide attempt with lethal method (such as by firearms, hanging/strangulation, jumping from high places).
___ 2. Suicide attempt resulting in moderate to severe lesions/toxicity.
___ 3. Suicide attempt with low rescuability (such as no known communication regarding the attempt, discovery unlikely because of chosen location and timing, no one nearby or in contact, active precautions to prevent discovery).
___ 4. Suicide attempt with subsequent expressed regret that it was not completed and continued expressed desire to commit suicide or unwillingness to accept treatment.

II. Intent. Includes suicidal thoughts, preoccupation, plans, threats and impulses, whether communicated by the patient directly or by another person based on observations of the patient.

+ = Present
- = Absent.

___ 1. Suicidal intent to commit suicide imminently.
___ 2. Suicidal intent with a lethal method selected and readily available.
___ 3. Suicidal intent and preparations made for death (such as writing a testament or a suicide note, giving away possessions, making certain business or insurance arrangements).
___ 4. Suicidal intent with time and place planned and foreseeable opportunity to commit suicide.
___ 5. Suicidal intent without ambivalence or inability to see alternatives to suicide.
___ 6. Presence of acute command hallucinations to kill self whether or not there is expressed suicidal intent.
___ 7. Suicidal intent with currently active psychosis, especially major affective disorder or schizophrenia.
___ 8. Suicidal intent or other objective indicators of elevated suicide risk but mental condition or lack of cooperation preclude adequate assessment.

B. MEDIATING - SECONDARY RISK FACTORS:

The following items all significantly contribute to suicide risk but are of a less critical nature. For the purpose of this instrument, all items are considered of equal importance. Obtain consultation if, in addition to suicidal intent, seven of the following items are present:

+ = Present
- = Absent
o = Unknown

___ 1. Recent separation or divorce.
___ 2. Recent death of significant other.
___ 3. Recent loss of job or severe financial setback.
___ 4. Other significant loss/stress/life changes interpreted by patient as aggravating (such as victimization, threat of criminal prosecution, unwanted pregnancy, discovery of severe illness, etc.).
___ 5. Social isolation.
___ 6. Current or past major mental illness.
___ 7. Current or past chemical dependency/abuse.
___ 8. History of suicide attempt(s).
___ 9. History of family suicide (include recent suicide by close friend).
___ 10. Current or past difficulties with impulse control or antisocial behavior.
___ 11. Significant depression (whether clinically diagnosable or not), especially if accompanied by feelings of guilt, worthlessness, or helplessness.
___ 12. Expressed hopelessness.
___ 13. Rigidity (difficulty with adaptation to life changes).

C. MAJOR CONTRIBUTING DEMOGRAPHIC CHARACTERISTICS:

Not to be included in the ratings, but considered in the overall assessment of suicide risk.

1. Male (especially older white male).
2. Living alone.
3. Single, divorced, separated, or widowed.
4. Unemployed.
5. Chronic financial difficulties.

_____ _____
SIGNATURE TITLE

Zigfrids. T. Stelmachers, Ph.D.

GUIDELINES FOR USE OF THE CISPA

1. The CISPA is an instrument used to help determine overall suicide rating. The purpose of the form is twofold: a. To insure needed consultation is obtained; and b. to assist in assessment of suicide potential. It should be filled out in its entirety even if the patient is already classified as needing consultation. Psychiatrists or psychologists may serve as consultants.

2. CISPA is to be completed if suicide is listed as one of the three major problem areas. If suicide is an issue for the client or staff, it should be listed as a problem.

3. Presence or absence of a given factor should be indicated by a "plus" or "minus" sign, respectively. A zero means that the necessary information to check a given item was not or could not be obtained.

4. CISPAs should also be completed for patients who have been placed on a hold (whether issued by CIC or others) on the basis of danger to self even though a hold by itself already dictates consultation by CIC policy. This will assure a uniform and thorough evaluation of seriously suicidal patients and will assist consultants in their evaluation.

5. If the patient meets the criteria for requesting consultation but refuses it, the refusal should be honored and documented. However, if the patient meets the legal criteria for a hold, such hold should be issued and consultation obtained even on an involuntary basis.

6. The first staff member to evaluate the patient should be responsible for filling out the CISPA during the interview. If a patient is not interviewable in the opinion of the responsible staff member, a meaningful evaluation cannot be done at that time, including filling out a CISPA. The evaluation, including the CISPA, should be done when the patient becomes interviewable. If, in the meantime, the patient has been carted and has been transferred to the next shift, it becomes the responsibility of the staff on the next shift to do the evaluation and CISPA. However, the <u>immediate</u> suicide risk <u>at the time of patient's admission</u> to CIC should be recorded on the narrative note based on whatever information is available at that time.

GUIDELINES FOR USE OF THE CISPA

7. If, according to our adopted criteria, the patient requires a consultation but could not be first evaluated by the CIC staff because he or she was not interviewable at the time of admission, it is not acceptable to simply refer this patient to the consultant the next morning without any prior staff evaluation. Excessive workload may occasionally lead to such a practice, but it should be considered an exception to the rule. In those instances, the consultant should fill out the CISPA.

8. Should the patient's mental condition change over time, a new CISPA need not be completed. The next staff member who reevaluates the patient's condition should note the changes on the narrative note. Whether the patient needs a consultation at that time or not will depend on his or her mental condition at that time, not on the original assessment.

9. Determining "moderate to severe" lesion or toxicity is based on staff judgment. If in doubt, consult emergency room personnel or other CIC staff. It may be wise to err in the direction of being more conservative, i.e., to request a consultation if there is any doubt about the severity of injuries.

10. A consultation need not involve the consultant's personal evaluation of the patient. It can be simply a verbal consultation between the CIC staff member and the consultant. The results of this consultation and the name of the consultant should be recorded in the chart.

City of Memphis
TENNESSEE

SEXUAL ASSAULT RESOURCE CENTER
901/272-2020 (Voice or TDD)

NURSING-MEDICAL EVALUATION-TREATMENT FORM

CASE #: _____ TODAY'S DATE / TIME: _____

IDENTIFYING INFORMATION (please print):

PATIENT'S NAME: _____ PATIENT'S SS#: _____
PATIENT'S DATE OF BIRTH: _____ ATTENDING PARENT/GUARDIAN:
PATIENT'S AGE/RACE/SEX: _____ _____
PATIENT'S ADDRESS: _____ RELATIONSHIP: _____
CITY-STATE: _____ ZIP CODE: _____
HOME PHONE: _____ WORK PHONE: _____ MOBILE PHONE: _____
DIGITAL PAGER: _____ OTHER PHONE(S)/RELATIONSHIP: _____
CAN WE CALL YOU AT THE PHONES LISTED ABOVE? YES _____ NO: _____
ANY SPECIAL INSTRUCTIONS? _____
_____

PATIENT/VICTIM MEDICAL HISTORY:

OB/GYN HX: G ____ P____ tAB ____ sAB ____ ALLERGIES TO MEDICINES: _____
LMP: _____ _____
AGE OF 1st MENSES: _____ _____
CURRENT MEDICINES: _____ MEDICAL ILLNESS HX: _____
_____ _____
_____ _____
_____ _____
PAST HOSPITALIZATIONS: _____ SURGICAL HX: _____
_____ _____
_____ _____
_____ _____
SEXUAL ASSAULT/ABUSE HX: ____Y ____N MENTAL HEALTH HX: _____
IF YES, AGE @ ASSAULT(S): _____ _____
IF YES, SEEN AT MSARC? ____Y ____N _____
DOMESTIC VIOLENCE HX: ____Y ____N _____

MEDICAL/TOPICAL TREATMENT/ PROPHYLAXIS (CHECK ALL THAT APPLY):

_____ CEFTRIAXONE 125 MG IM
_____ DOXYCYCLINE 100 MG PO BID X 7 DAYS
_____ METRONIDAZOLE 2 GM PO STAT
_____ CIPROFLOXACIN 500 MG PO STAT
_____ AMOXICILLIN PO (DOSE: _____)
_____ EES PO (DOSE: _____)
_____ OTHER (DESCRIBE): _____
_____ VERBAL ORDER PER MEDICAL DIRECTOR
MEDS: _____
_____
_____

_____ EMERGENCY CONTRACEPTION
_____ VINEGAR DOUCHE
_____ ORAL HYGIENE
_____ TERAZOLE 7
_____ NONOXYNOL 9
_____ METRONIDAZOLE GEL .75%

ORDERING PHYSICIAN'S SIGNATURE:
_____

VITAL SIGNS: temp _____ (F) BP _____ BP re✓ _____ (if indicated)
N/A wt _____ (lbs) ht _____ (inches) cuff size (circle one) Ch Sm Med LG XLG
Arm (circle one) lt rt

SANE Signature

MSARC FORENSIC NURSE FORM
NURSING/MEDICAL EVALUATION/TREATMENT: Rev. 5/97

ADULT

FORENSIC EVALUATION OF ALLEGED SEXUAL ASSAULT

Case # _____

2 copies to Police Officer
1 copy to Clinic

1. Identifying Information:
   Name _____
   DOB _____ Age _____ Sex _____ Race _____

Alleged Assault:
Date: _____
Time: _____

Forensic Exam:
Date: _____
Time: _____

2. General Forensic Exam: (Describe trauma) _____

3. Forensic Genital and Anal Exam: (Describe trauma) _____

4. Post Assault:

Yes	No	
☐	☐	Urination
☐	☐	Douche
☐	☐	Sponge bath
☐	☐	Bath/Shower
☐	☐	Defecation

5. Behavior type demonstrated during exam:

☐ Controlled ☐ Expressed ☐ Mixed

☐ quiet ☐ tearful
☐ tense ☐ sobbing
☐ fidgeting ☐ yelling
☐ trembling ☐ loud
☐ listless ☐ agitated
☐ staring ☐ other _____

Responds to questions:

☐ briefly ☐ reluctantly ☐ readily

7. Summary of Evidence:

Yes	No	
☐	☐	Kit Collected
☐	☐	Pubic hair
☐	☐	Panties/Clothing

Released to: _____

Condition _____

☐ ☐ Other _____

Physical/Genital exam done with:

Yes	No		Yes	No	
☐	☐	Direct visualization	☐	☐	Colposcope exam
☐	☐	Bimanual exam	☐	☐	Pics taken # ____
☐	☐	Speculum exam			

6. Additional Observation or Remarks: _____

8. Testing: Sperm

	SEEN	MOTILE	NON-MOTILE	NOT SEEN	NOT DONE
Vaginal					
Oral					
Anal					

9. Instructions for Follow-up

	Yes	No
A. ORAL	☐	☐
B. WRITTEN		
Agency brochures	☐	☐
Medical follow-up inst.	☐	☐

I hereby authorize use of this report, collected evidence and any other report incidental thereto by the Memphis Police Services and/or other Shelby County cooperating law enforcement agencies.

Person Examined _____
Parent or Guardian _____
Date _____

Examining Clinician _____
Police Officer _____
R&I # _____

CHILDREN

Case #_____
Sibling Case #_____

FORENSIC EXAMINATION OF ALLEGED SEXUAL ASSAULT

2 copies to Police Officer
1 copy to Clinic

1. Identifying Information:
Name_____
Guardian ☐ Parent ☐ _____
DOB_____ Age_____ Sex_____ Race_____
Address_____
City/State_____ Zip Code_____
Phone (home)_____ (other)_____

Alleged Assault:
Unknown: ☐
Date:_____
Time:_____

Forensic Exam:
Date:_____
Time:_____

2. Anal-gential chart

Female/Male General	WNL	ABN	Describe
Tanner stage			
Breast 1 2 3 4 5	☐	☐	
Genitals 1 2 3 4 5	☐	☐	
Medial aspect of thighs	☐	☐	
Perineum	☐	☐	

	Yes	No	
Vulvovaginal/urethral discharge (describe)	☐	☐	
Flat plaques/growths (describe)	☐	☐	

Female	WNL	ABN	Describe
Labia Majora	☐	☐	
Clitoris	☐	☐	
Labia minora	☐	☐	
Periurethral tissue/ urethral meatus	☐	☐	
Perihymenal tissue (vestibule)	☐	☐	
Hymen	☐	☐	
☐ Cresent			
☐ Annular			
☐ Other (describe)			
☐ Unable to determine (describe)			
Diameter of hymenal lumen			
☐ Horizontal _____mm.			
☐ Vertical _____mm.			
Posterior fourchette	☐	☐	
Vagina	☐	☐	

Other _____

Exam position used for genital evaluation:
☐ Supine ☐ Mother's lap

Male	WNL	ABN	Describe
Penis	☐	☐	
☐ circumcised ☐ uncircumcised			
Urethral meatus	☐	☐	
Scrotum	☐	☐	
Testes	☐	☐	

Female/Male Anus	WNL	ABN	Describe
Buttocks	☐	☐	
Perianal skin	☐	☐	
☐ feces present			
Anal verge/folds	☐	☐	
Anal shape (describe)	☐	☐	
☐ linear			
☐ circular			
☐ irregular (describe)			
Anal tone	☐	☐	
Method of exam: ☐ Observation ☐ Digital exam			
Anal dilation	☐	☐	
☐ No dilation noted ☐ Funneling present			
☐ External ☐ Internal Spincter relaxation			
☐ Horizontal _____ mm. in _____ seconds			
☐ Vertical _____ mm. in _____ seconds			
☐ Feces in rectal ampulla			
Anal tags ☐ Yes ☐ No	Location:		
Anal fissures ☐ Yes ☐ No	Location:		

Exam position used for anal evaluation:
☐ Supine ☐ Lateral recumbent ☐ Mother's lap
☐ Prone ☐ Knee chest

Summary of Evidence
☐ Kit collected
☐ No kit
☐ Clothing
☐ Other

Released to:

Genital exam done with:
Direct visualization ☐
Colposcope ☐
Pictures taken ☐ #

Case # _____ **CHILDREN**

3. PERTINENT PAST MEDICAL HISTORY

Menarche age ..... ☐ N/A _____

Date of last menstrual period ..... ☐ N/A _____

Note history of physical injuries ☐ Yes ☐ No ☐ N/A _____

Pertinent medical history of ☐ anal-genital injuries, ☐ surgeries ☐ diagnostic procedures, or ☐ medical treatment? If yes, describe:

Previous child abuse investigation? ☐ Yes ☐ No ☐ Physical ☐ Sexual ☐ Neglect
(describe when and where)

5. Check behaviors observed during exam:

☐ tearful	☐ fidgeting
☐ sobbing	☐ trembling
☐ yelling	☐ controlled
☐ loud	☐ agitated
☐ quiet	☐ listless
☐ tense	☐ fearful
☐ cooperative	☐ other _____

responds to questions:
☐ readily ☐ briefly ☐ reluctantly

4. Symptoms described by patient: ☐ _____
by historian: ☐ _____
not evaluated: ☐

Physical symptom/hx:
- ☐ Abdominal/pelvic pain
- ☐ Vulvar discomfort or pain
- ☐ Dysuria
- ☐ Urinary tract infection
- ☐ Enuresis (daytime or nighttime)
- ☐ Vaginal itching
- ☐ Vaginal discharge
  Describe color, odor, amount _____
- ☐ Vaginal bleeding
- ☐ Rectal pain
- ☐ Rectal bleeding
- ☐ Rectal discharge
- ☐ Constipation
- ☐ Incontinent of stool (day/night)

Other: _____

6. Additional Observation or Remarks: _____

7. Treatment:
Hospitalization:
location _____
Prophylaxis:
pregnancy _____
gonorrhea _____

Testing:
pregnancy _____ VDRL _____
GC culture _____
Referral _____

8. Testing: Sperm

	SEEN	MOTILE	NON-MOTILE	NOT SEEN	NOT DONE
Vaginal					
Oral					
Anal					

9. Instructions for Follow-up

	Yes	No
A. ORAL	☐	☐
B. WRITTEN		
Agency brochures	☐	☐
Medical follow-up inst.	☐	☐

This report of the examination is an investigative report used as evidence by Memphis Police Services, Shelby County law enforcement agencies, Tennessee Department of Human Services, and other cooperating agencies.

Investigating Agency _____
DHS Social Counselor _____
Date _____

MRCC Forensic Evaluator _____
Police Officer _____
R&I # _____

PHYSICAL EXAMINER'S CHECKLIST (FEMALE)

CASE # _____

VICTIM'S NAME (print) _____ AGE _____ RACE _____

DATE/TIME OF ASSAULT _____

DATE/TIME OF EXAM _____

1. Bloody external physical trauma excluding genitalia: Absent _____ Present _____
   Location(s) _____
2. Menstrual flow: Absent _____ Present _____ First day of last period _____
3. Bloody genital trauma: Absent _____ Internal _____ External _____ Vaginal _____ Anal _____
4. Sperm: Not Seen _____ Motile sperm seen _____ Non-motile sperm seen _____ Not Done _____
5. a. Douche after assault: Yes _____ No _____ Don't know _____
   b. Bath, shower after assault: Yes _____ No _____ Don't know _____
   c. Sponge bath after assault: Yes _____ No _____ Don't know _____
   d. Urinated after assault: Yes _____ No _____ Don't know _____
   e. Defecated after assault: Yes _____ No _____ Don't know _____
   f. Condom used during assault: Yes _____ No _____ Don't know _____
   g. Lubricant used during assault: Yes _____ No _____ Don't know _____
      Name of lubricant _____
   h. Foreign object used during assault: Yes _____ No _____ Don't know _____
      Name of object(s) _____
6. a. Vaginal assault: Yes _____ No _____ Don't know _____
   b. Last voluntary vaginal intercourse (within 4 days): Yes _____ No _____ Don't know _____
      If less than 12 hours, time: _____ # of consensual partners in last 12 hours _____
7. a. Oral Assault: Yes _____ No _____ Don't know _____ Rinsed mouth before exam _____
   b. Last voluntary oral intercourse (within 4 days): Yes _____ No _____ Don't know _____
      If less than 12 hours, time: _____ # of consensual partners in last 12 hours _____
8. a. Anal Assault: Yes _____ No _____ Don't know _____
   b. Last voluntary anal intercourse (within 4 days): Yes _____ No _____ Don't know _____
      If less than 12 hours, time: _____ # of consensual partners in last 12 hours _____
9. Emission of semen (victim's impression):
   a. Vaginal: Yes _____ No _____ Don't know _____ Intravaginal _____ Extravaginal _____
   b. Oral: Yes _____ No _____ Don't know _____
   c. Anal: Yes _____ No _____ Don't know _____
   d. Other area: Yes _____ No _____ Don't know _____ Location(s) _____
10. Fingernails: Samples taken Yes _____ No _____
11. Miscellaneous sample from (name site) _____ to be tested for (name body fluid) _____
12. Miscellaneous sample from (name site) _____ to be tested for (name body fluid) _____

Copy 1 - Lab
Copy 2 - Police
Copy 3 - Clinic

_____
Forensic Nurse Examiner's Signature

City of Memphis
TENNESSEE

SEXUAL ASSAULT RESOURCE CENTER
901/272-2020 (Voice or TDD)

NURSING CARE PLAN (CHECK ALL COMPLETED ITEMS)
CASE #_____ **DATE:** _____

INTRODUCTION:
- ____ INTRODUCE FORENSIC NURSE BY NAME
- ____ ROLE EXPLANATION OF FORENSIC NURSE/SEXUAL ASSAULT NURSE EXAMINER
- ____ INFORMED CONSENT/REFUSAL OBTAINED
- ____ GRIEVANCE PROCEDURE SIGNED

MEDICAL CRISIS INTERVENTION:
- ____ REFERRAL TO ED/HOSPITAL
  WHERE: _____

PSYCHOSOCIAL INTERVENTION:
- ____ DCS/APS REFERRAL/NOTIFICATION (NAME OF AGENCY AND INDIVIDUAL):
  _____
- ____ PSYCHOLOGICAL EVALUATION REFERRAL (NAME OF AGENCY AND INDIVIDUAL):
  _____
- ____ EMERGENCY HOUSING (NAME OF AGENCY/INDIVIDUAL):
  _____

ANTICIPATORY GUIDANCE:
HEALTH TEACHING
- ____ PRE-EXAM PREPARATION
- ____ STD RISKS FOLLOWING SEXUAL ASSAULT
- ____ PRE STDs SCREENING COUNSELING
- ____ PREGNANCY INTERCEPTION
- ____ PERINEAL INJURIES
- ____ INJURIES ELSEWHERE
- ____ HYGIENE
- ____ GROWTH & DEVELOPMENT

OTHER HEALTH TEACHING:
_____
_____
_____

HANDOUTS
- ____ NURSING HANDOUTS DISTRIBUTED
- ____ COUNSELING HANDOUTS DISTRIBUTED
- ____ ADVOCACY HANDOUTS DISTRIBUTED
- ____ OTHER HANDOUTS (names) _____

_____

DESCRIPTION OF SERVICES TO CLIENT
- ____ DCS
- ____ LAW ENFORCEMENT
- ____ MSARC ADVOCACY
- ____ MSARC COUNSELING
- ____ MSARC NURSING
- ____ OTHER SERVICES (names) _____

_____

FOLLOW UP RECOMMENDATIONS:
- ____ FOR STD SCREENING
- ____ FOR POST TEST COUNSELING FOR STDs
- ____ FOR HEALTH PROBLEM TO PMD/CLINIC
- ____ FOR MENTAL HEALTH COUNSELING
- ____ OTHER (list) _____

_____

OTHER INSTRUCTIONS:_____
_____
_____
_____
_____

POST TEST COUNSELING
LETTER SENT (circle one) YES NO
APPOINTMENT SET FOR
(date/time):_____
ATTEMPT TO CONTACT BY PHONE (if applicable)
(date/initials):_____ na b lm

TELEPHONE OR OFFICE ENCOUNTER NOTE

S:_____
_____
_____
O:_____
_____
A:_____
_____
_____
P:_____
_____
_____
_____

SANE:_____ DATE:_____

TELEPHONE OR OFFICE ENCOUNTER NOTE

S:_____
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O:_____
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A:_____
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P:_____
_____
_____
_____

SANE:_____ DATE:_____

TELEPHONE OR OFFICE ENCOUNTER NOTE

S:_____
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A:_____
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P:_____
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_____

SANE:_____ DATE:_____

City of Memphis
TENNESSEE

NURSING CARE PLAN KEY
PAGE 1

THE NURSING CARE PLAN KEY IS PROVIDED AS A GUIDE FOR THE COMPLETION OF THE NURSING CARE PLAN (MSARC FORENSIC NURSE FORM: CARE PLAN/SOAP: 5/97). THE CARE PLAN MEETS THE STRUCTURE AND OUTCOME OBJECTIVES TO THE FOLLOWING SANE STANDARDS OF PRACTICE: THEORY, DATA COLLECTION, DIAGNOSIS, PLANNING, INTERVENTION, EVALUATION, QUALITY ASSURANCE, INTERDISCIPLINARY COLLABORATION, AND RESEARCH. THE INSTRUCTIONS FOLLOW:

Write in the: CASE #_____ & DATE: _____

INTRODUCTION: The SANE is instructed to check the line on the left of the completed items. When there is no check, the item is considered not completed.

✓INTRODUCE FORENSIC NURSE BY NAME : The SANE is expected to introduce herself to the client by providing her name and stating that she is the forensic nurse.

✓ROLE EXPLANATION OF FORENSIC NURSE/SEXUAL ASSAULT NURSE EXAMINER: In an appropriate location, the SANE is expected to provide an explanation of the SANE role, including but not limited to crisis intervention, physical evaluation, evidence collection, medical treatment, health teaching, follow up recommendations including medical referral, and testimony.

✓INFORMED CONSENT/REFUSAL OBTAINED: The SANE is expected to provide an opportunity for the client to consent or decline services offered by the SANE at any time during the initial evaluation of the victim following a sexual assault. This may include an initial consent from the client and later declination of any and/or all services, e.g., injection with Rocephin or forensic examination.

✓GRIEVANCE PROCEDURE SIGNED: The SANE will provide an explanation of the Grievance Procedure Form and request a signature from the client. This form was developed in response to grant requirements and our desire to create an outlet for victims who want to complain about our services.

MEDICAL CRISIS INTERVENTION:

✓REFERRAL TO ED/HOSPITAL: When the SANE refers to a local hospital for emergent medical treatment, the SANE will check this portion and write in the name of the hospital and the department if available, i.e., The MED ED.

PSYCHOSOCIAL INTERVENTION:

✓DCS/APS REFERRAL/NOTIFICATION (NAME OF AGENCY AND INDIVIDUAL): When the SANE determines that appropriate social agencies for child or adult protection have not been notified, the SANE will check this portion and write in the name of the agency notified, i.e., DCS or APS and the name of the individual taking the report, i.e. Jane Doe. If the report is made outside the acute evaluation time frame documented on the forensic report, the SANE will need to write in the date and time of notification and initial.

✓PSYCHOLOGICAL EVALUATION REFERRAL (NAME OF AGENCY AND INDIVIDUAL): When the SANE refers to a local hospital for emergent psychological treatment, the SANE will check this portion and write in the name of the hospital and the department if available, i.e., MMHI.

City of Memphis
TENNESSEE

NURSING CARE PLAN KEY
PAGE 2

✓ EMERGENCY HOUSING (NAME OF AGENCY/INDIVIDUAL): When the SANE determines that appropriate housing is an acute need of the client, social agencies providing emergency housing may be notified. The SANE will check this portion and write in the name of the agency notified, i.e., Salvation Army and the name of the individual taking the report, i.e. Jane Doe.

ANTICIPATORY GUIDANCE:

HEALTH TEACHING

✓ PRE-EXAM PREPARATION: In an effort to provide for the client's control and comfort over the forensic examination process, the SANE will provide an explanation of activities which will be expected to occur during the examination. The SANE will provide an opportunity for questions and work with the client to prioritize their concerns.

✓ STD RISKS FOLLOWING SEXUAL ASSAULT: The SANE may discuss the risks of STD transmission following a rape. Condom use will be recommended to the client with any/all partners until screening tests remain negative for 1 year. The SANE will provide an opportunity for questions and work with the client to prioritize their concerns.

✓ PRE STDs SCREENING COUNSELING: The SANE will explain that MSARC services include free health screening for STDs, that the tests are confidential and will be developed by the Memphis & Shelby County Health Department. These tests can be considered baseline tests recommended by the CDC. If any of the tests are positive, the client may be notified by the Health Department and since these tests (if positive) are reportable, the client may be asked to provide a summary of their risk factors and the name(s) of their partners. If the Health Department does not notify the client about positive tests, it does not mean that their tests were negative. The SANE will provide an opportunity for questions and work with the client to prioritize their concerns.

✓ PREGNANCY INTERCEPTION: The SANE will explain that MSARC services include the dispensing of birth control pills in doses that have been shown to prevent pregnancy. The SANE will determine from the health history if the patient is a candidate for the medication. The consent form will be reviewed with emphasis on the mechanism of action and the side effects of the medication. The SANE will provide an opportunity for questions and work with the client to prioritize their concerns.

✓ PERINEAL INJURIES: For the patient who has perineal injuries following the sexual assault, the SANE will teach the client proper care of the injured tissue, making appropriate treatment recommendations including but not limited to signs and symptoms of infection, infection prevention, partner treatment, sitz baths, topical treatments, antibiotics, etc. The SANE will provide an opportunity for questions and work with the client to prioritize their concerns.

✓ INJURIES ELSEWHERE: For the patient who has a non-urgent injury following the sexual assault, the SANE will teach the client proper care of the injured tissue, making appropriate treatment recommendations including but not limited to signs and symptoms of infection, infection prevention, topical treatments, etc. The SANE will provide an opportunity for questions and work with the client to prioritize their concerns.

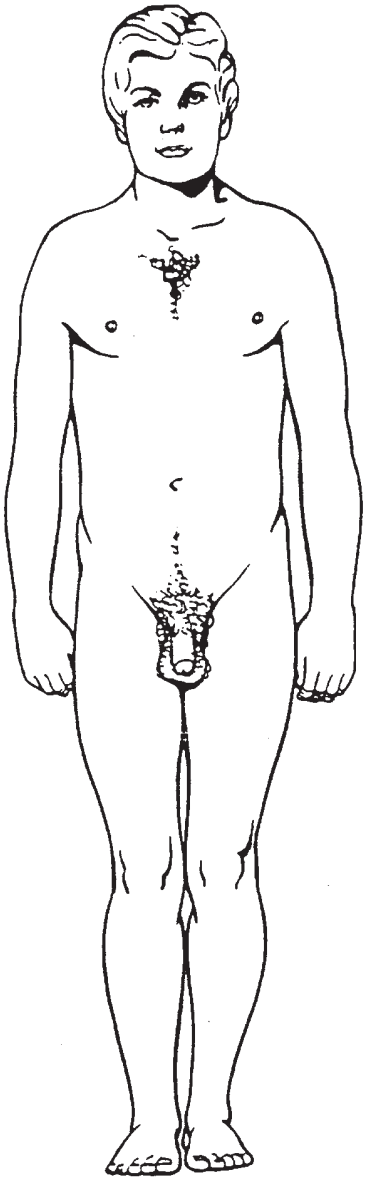
✓ HYGIENE: For the patient who has non-urgent injury due to hygiene, the SANE will teach the

CASE NO _____

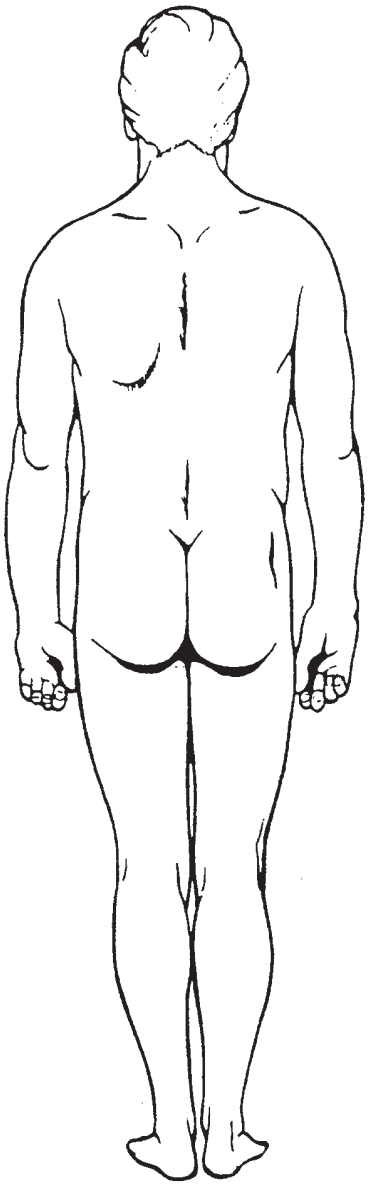
NAME OF VICTIM _____

DATE OF COLLECTION _____ **TIME** _____ **AM-PM**

NURSE/CLINICIAN _____



adult, male (front view)



adult, male (back view)

PHYSICAL CONDITION OF VICTIM:

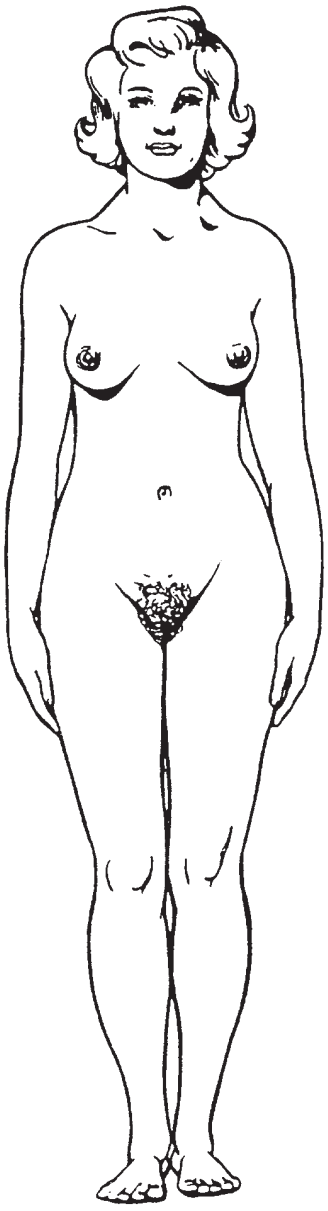
INDICATE ALL SIGNS OF PHYSICAL TRAUMA - E.G., BRUISES, SCRATCHES, MARKS, DISCOLORATIONS (SIZE AND COLOR), OR BITE MARKS ON ANY PART OF THE BODY. (NOTE ALL SIGNS OF TRAUMA ON THE APPROPRIATE ANATOMICAL DRAWING).

CASE NO _____

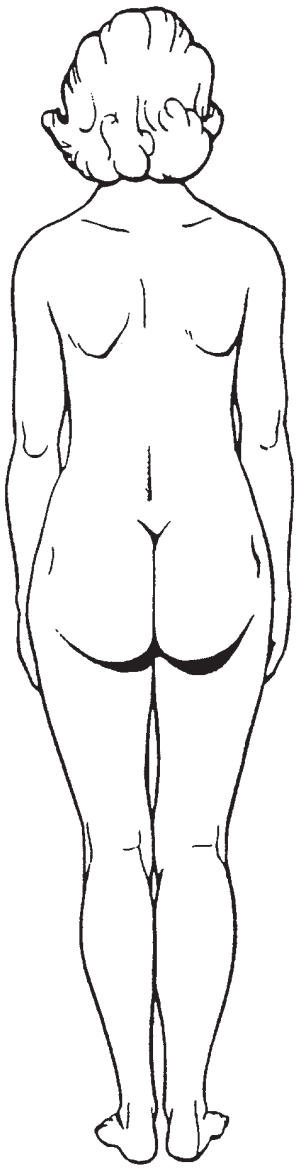
NAME OF VICTIM _____

DATE OF COLLECTION _____ **TIME** _____ **AM - PM**

NURSE/CLINICIAN _____



adult, female (front view)



adult, female (back view)

PHYSICAL CONDITION OF VICTIM:

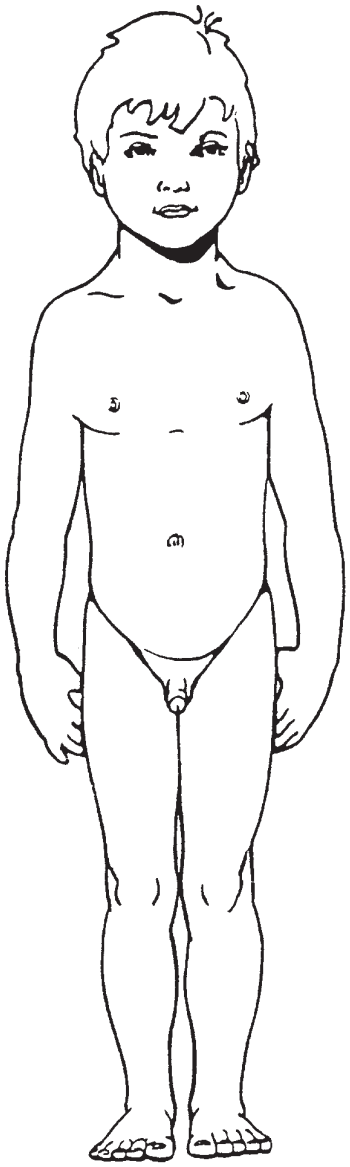
INDICATE ALL SIGNS OF PHYSICAL TRAUMA - E.G., BRUISES, SCRATCHES, MARKS, DISCOLORATIONS (SIZE AND COLOR), OR BITE MARKS ON ANY PART OF THE BODY. (NOTE ALL SIGNS OF TRAUMA ON THE APPROPRIATE ANATOMICAL DRAWING).

CASE NO _____

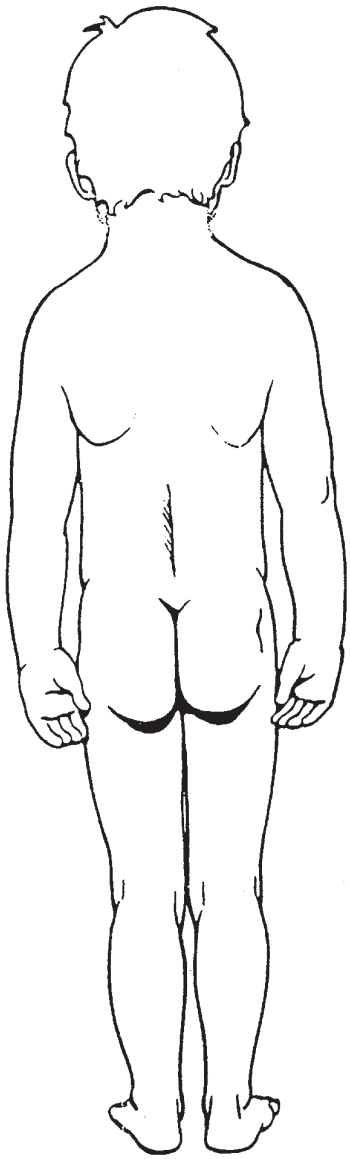
NAME OF VICTIM _____

DATE OF COLLECTION _____ **TIME** _____ **AM - PM**

NURSE/CLINICIAN _____



pre-school, male child (front view)



pre-school, male child (back view)

PHYSICAL CONDITION OF VICTIM:

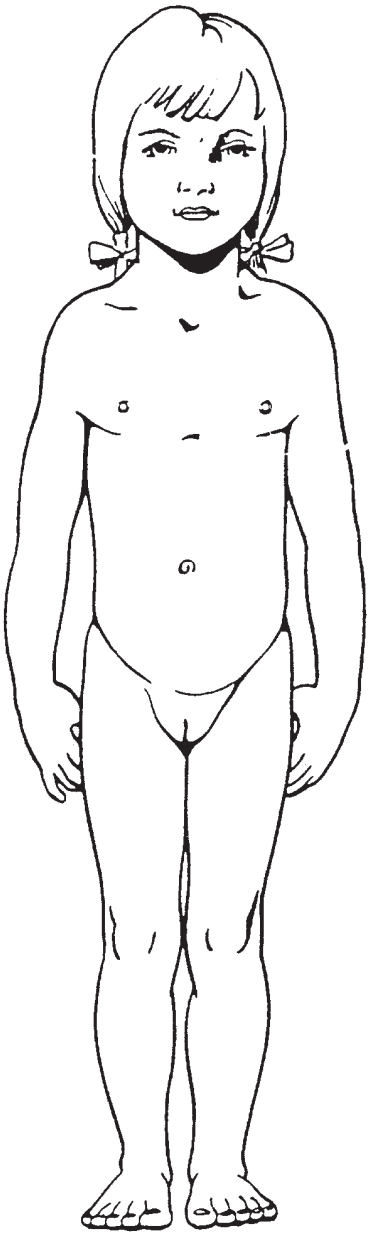
INDICATE ALL SIGNS OF PHYSICAL TRAUMA - E.G., BRUISES, SCRATCHES, MARKS, DISCOLORATIONS (SIZE AND COLOR), OR BITE MARKS ON ANY PART OF THE BODY. (NOTE ALL SIGNS OF TRAUMA ON THE APPROPRIATE ANATOMICAL DRAWING).

CASE NO _____

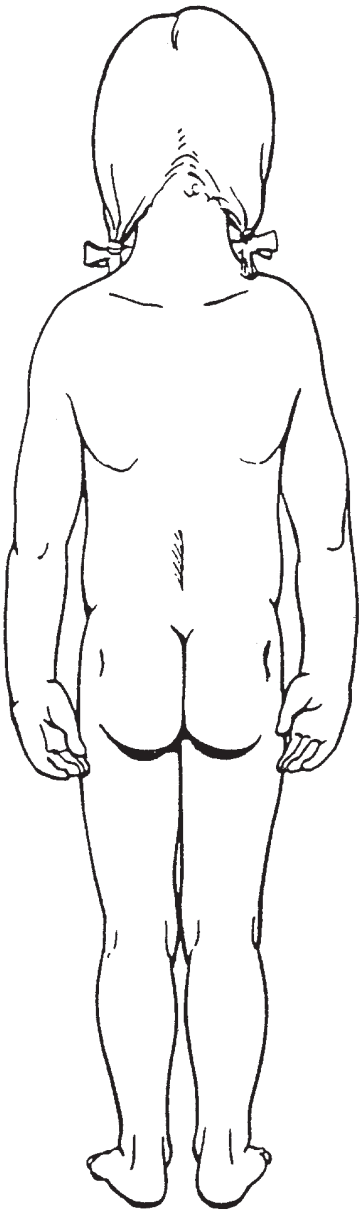
NAME OF VICTIM _____

DATE OF COLLECTION _____ **TIME** _____ **AM-PM**

NURSE/CLINICIAN _____



pre-school, female child (front view)



pre-school, female child (back view)

PHYSICAL CONDITION OF VICTIM:

INDICATE ALL SIGNS OF PHYSICAL TRAUMA - E.G., BRUISES, SCRATCHES, MARKS, DISCOLORATIONS (SIZE AND COLOR), OR BITE MARKS ON ANY PART OF THE BODY. (NOTE ALL SIGNS OF TRAUMA ON THE APPROPRIATE ANATOMICAL DRAWING).

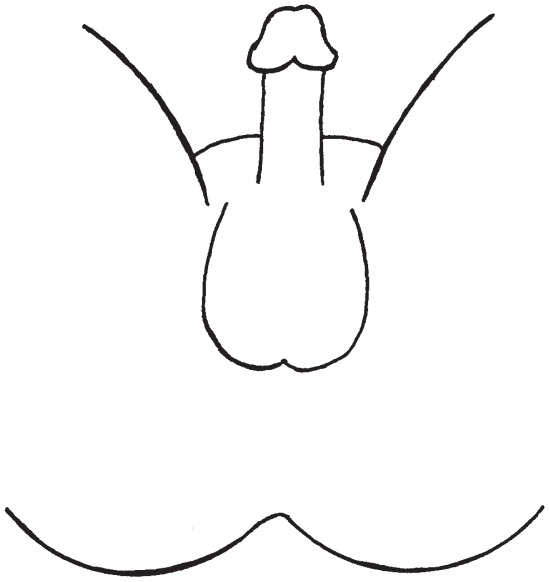
MALE GENITAL and ANAL FORENSIC EXAMINATION

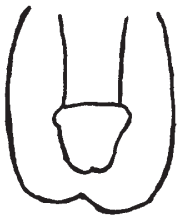
CASE NO. _____

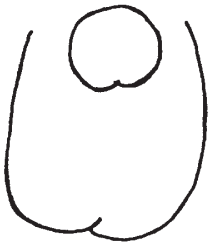
NAME OF VICTIM _____

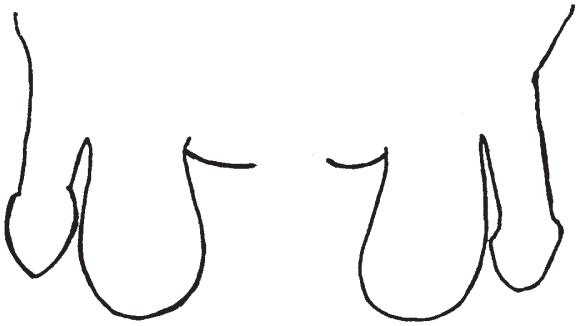
DATE OF COLLECTION _____ TIME _____ AM - PM

NURSE/CLINICIAN _____









Left Right

Comments: _____

☐ Refused ☐ Full Cooperation ☐ Partial Cooperation

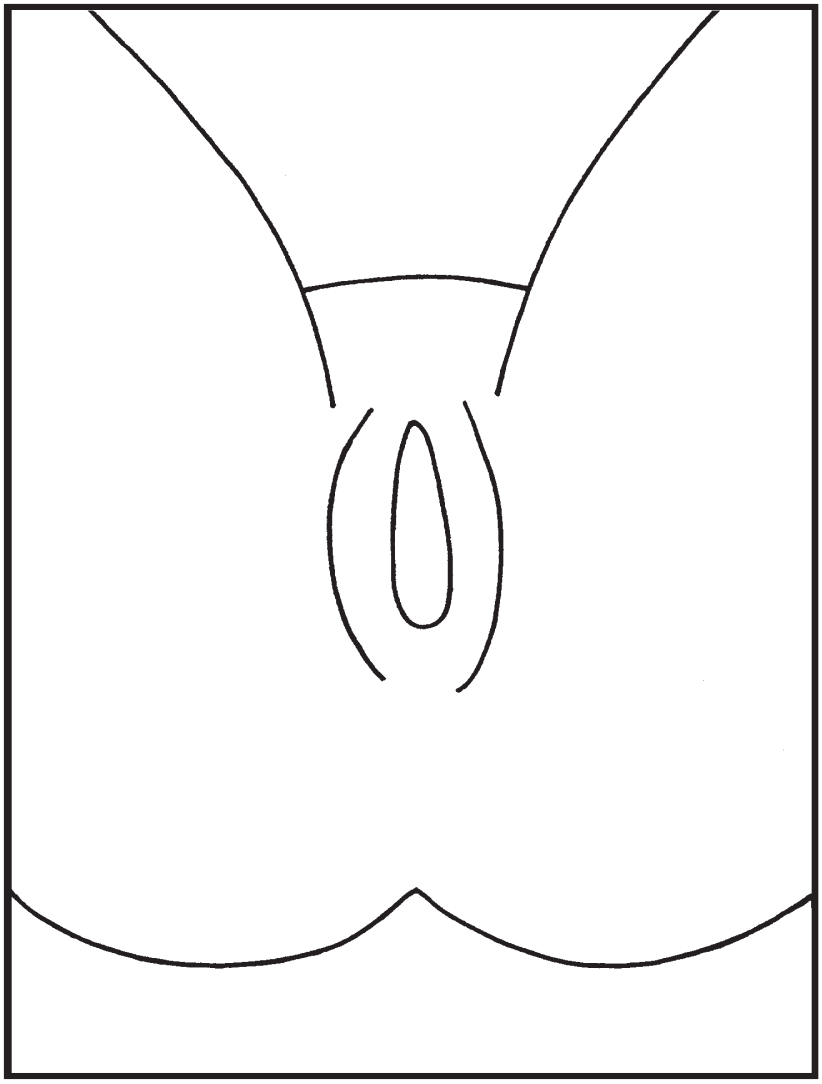
PREPUBERTAL FEMALE GENITAL and ANAL FORENSIC EXAMINATION

CASE NO. _____

NAME OF VICTIM _____

DATE OF COLLECTION _____ **TIME** _____ **AM - PM**

NURSE/CLINICIAN _____



Comments: _____

_____

_____

_____

_____

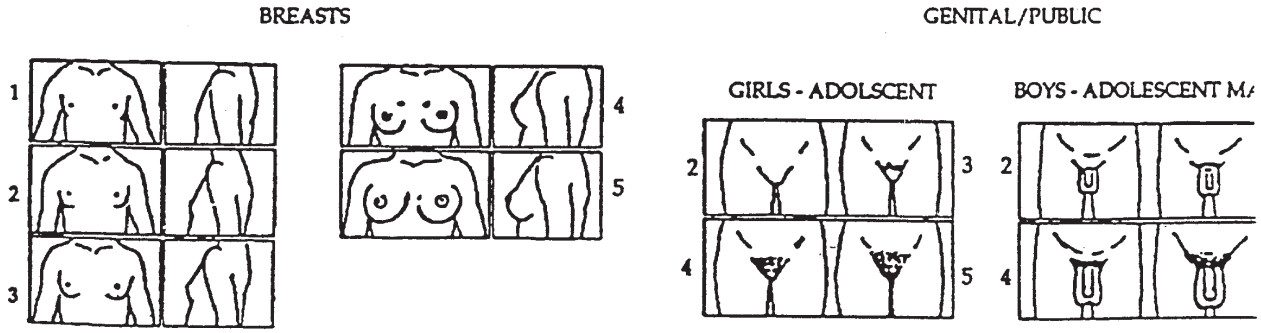
_____

☐ Refused ☐ Full Cooperation ☐ Partial Cooperation

TANNER CLASSIFICATION OF SEXUAL MATURITY

	GIRLS	BOYS/GIRLS	BOYS	BOYS
STAGE	BREAST GROWTH	PUBIC HAIR GROWTH	TESTES GROWTH	PENIS GROWTH
1	Preadolescent	None	Preadolescent	Preadolescent
2	Breast budding; Areolar hyperlasia with small amount of breast tissue	Long, downy pubic hair near the labia, straight or slightly curled	Enlargement of testes increased stippling and pigmentation of scrotal sac	Minimal or no enlargement
3	Further enlargement of breast tissue and areola, with no separation of their contours	Increase in amount and pigementation of hair, coarser and more curled	Further enlargement	Significant enlargement especially in length
4	Separation of contour; areola and nipple form secondary mound above level of breast	Adult in type but covers smaller area than in adult	Further enlargement scrotal skin darkens	Further enlargement especially in diameter
5	Larger breast with single contour (areola not elevated)	Adult in distribution	Adult in size	Adult in size

Thus, Tanner stages of a patient may be expressed as follows:
females-breast stage/pubic hair growth stage
males-pubic hair growth stage/testes and penis growth stage



SOURCE: Tanner, J. M. Growth and Adolesence, Blackwell Scientific Publication, 1962.

Copy 1 - Lab
Copy 2 - Police
Copy 3 - Clinic

PHYSICAL EXAMINER'S CHECKLIST (MALE)

CASE # _____

VICTIM'S NAME _____ AGE _____ RACE _____

DATE/TIME OF ASSAULT _____ MARITAL STATUS _____

DATE/TIME OF EXAM _____

1. Bloody external physical trauma excluding genitalia: Absent _____ Present _____
2. Bloody genital trauma: Absent _____ Internal _____ External _____ Penile _____ Anal _____
3. Sperm: Seen _____ Motile _____ Non-Motile _____ Not Seen _____ Not Done _____
4. Bath, Shower: Yes _____ No _____ Don't Know _____

   Sponge bath: Yes _____ No _____ Don't Know _____

   Condom Used: Yes _____ No _____ Don't Know _____
5. Last voluntary intercourse (within 4 days): Yes _____ No _____ Don't Know _____
   If less than 12 hours, time: _____
6. Oral Act: Yes _____ No _____ Don't Know _____ Rinsed mouth before exam _____
7. Anal Act: Yes _____ No _____ Don't Know _____
8. Emission of semen (victim's impression):

   Oral: Yes _____ No _____ Don't Know _____

   Anal: Yes _____ No _____ Don't Know _____
9. Fingernails: Clean _____ Blood _____ Scrapings taken _____

_____
Examiner's Signature

MEMPHIS SEXUAL ASSAULT RESOURCE CENTER

Counseling
Advocacy
Medical Services
Laboratory Analysis

1331 Union Avenue, Suite 1150
Memphis, Tennessee 38104-7508
(901) 272-3300 Administration (Voice and TDD)
(901) 272-2020 Crisis Hotline
FAX (901) 274-2769

CLIENT GRIEVANCE PROCEDURE

Dear Client:

We at the Memphis Sexual Assault Resource Center (MSARC) hope to provide you with fair and courteous service. If you have a problem with our agency which you are unable to resolve, you may file a grievance.

The State of Tennessee Victims of Crime Act guidelines specify that you notify our agency of your complaint within 24 hours of service. You may address your concerns to the Manager of the Center, in writing if possible, at 1331 Union Avenue, Suite 1150, Memphis, TN 38104. Within 24 hours of the receipt of your complaint, we will notify you in writing that we have received the letter and will offer a solution. If you still are not satisfied, we will provide for further response in writing by the Division Director or Chief Administrative Officer within 24 hours.

If you cannot notify us of your grievance within 24 hours, it is still our agency's commitment to address your concerns. We will be happy to discuss these over the phone, by calling 272-3300, or in writing. Our office hours are Monday- Friday, 8:30 AM-5:00 PM; all other times we are available for emergencies by calling 272-2020. Within ten days of notification, we will contact you to discuss resolution of your grievance.

Please sign below to indicate that you understand this procedure and have received a copy.

_____ _____

Client Witness

_____ _____

Case # Date

This agency does not discriminate on the basis of race, sex, age, national origin, color, religion, or handicap in the delivery of its services or in the resolution of its complaints.

Org. -Advocacy
Copy 1 -Counseling
Copy 2 -Forensic
Copy 3 -Patient

HENNEPIN COUNTY MEDICAL CENTER
Minneapolis, MN 55415

SEXUAL ASSAULT LABORATORY RESULTS

INSTITUTE WHERE EXAM PERFORMED _____
"I" ACCOUNT# _____

N 17149 (6/96)

PT. MED. REC. #: D.O.B.

PT. NAME:

DATE OF EXAM	TIME ☐ AM ☐ PM	DATE OF ASSAULT	TIME ☐ AM ☐ PM
EXAMINING NURSE		HOURS SINCE LAST PRIOR INTERCOURSE _____	☐ > 72 HOURS

CHECK (X) APPROPRIATE BOX FOR EACH SPECIMEN SUBMITTED

TEST		"X"	RESULTS AND DATE READ	TEST PERFORMED SIGNATURE/PRINTED NAME/TITLE	
SPERM MOTILITY	VAG				
	ANAL				
	ORAL				
	OTHER				
STAINED SMEAR	VAG				
	ANAL				
	ORAL				
	OTHER				
ACID PHOSPHATASE	VAG				
	ANAL				
	ORAL				
	OTHER				
NEISSERIA GONORRHEA ☐ CULTURE ☐ PROBE	VAG				
	ANAL				
	PHAR-YNGEAL				
	OTHER				
CHLAMYDIA ☐ CULTURE ☐ PROBE	VAG				
	RECTAL				
OTHER					

INSTRUCTIONS: *Verify patient and specimen(s) identification. Pleat-fold this form so that* ***ONLY*** *the Specimen Transaction Record is visible. Bag specimens and send with courier to HCMC lab.*

SPECIMEN TRANSACTION RECORD

EXAMINING NURSE/DEPARTMENT	GIVEN TO: NAME/DEPARTMENT	GIVEN TO: NAME/DEPARTMENT	GIVEN TO: NAME/DEPARTMENT

SPECIMEN ACCEPTED: NAME AND TITLE BY LABORATORY DEPARTMENT

1		4	
2		5	
3		6	

IMPRESSION

PATHOLOGIST: PRINTED NAME DATE

City of Memphis
TENNESSEE

DIVISION OF PUBLIC SERVICES
Memphis Sexual Assault Resource Center
901/272-2020(Voice or TDD)

FOLLOW UP INFORMATION AND INSTRUCTIONS
for Victims and their Primary Providers

CASE#:_____ TODAY'S DATE: _____

You may have been exposed to sexually transmitted diseases during your assault. TOMORROW, call your Managed Care Organization or Private Doctor. Make an appointment as soon as possible for tetanus and Hepatitis B immunizations. In addition, make an appointment for one month after your assault date for a follow up blood test for Syphilis, and pelvic tests for N. gonorrhea, Chlamydia trachoma, and other bacteria from the following areas:

☐ Throat ☐ Vaginal Introitus ☐ Cervix ☐ Anus ☐Urethra

We recommend baseline testing for HIV within the 1st week following your assault . In addition, we recommend that you have blood tests for HIV at 1 month, 3 months, 6 months, and 1 year following your assault. *We recommend condom use with your consensual partner until all tests return negative.*

You were prophylactically treated with the following medicines:

☐ Rocephin 125 mg IM (location)
☐ Doxycycline 100 mg po BID x 7 days
☐ Metronidazole 2 gm PO x I STAT dose
☐ Cipro 500 mg Po x I STAT dose
☐ Erythromycin _____ mg po (circle one) BID QID x7 days
☐ Amoxicillin _____ mg po TID x 10 days
☐ You were not treated prophylactically for STDs

In addition to your private doctor or your clinic, these tests are available from the:

Memphis/Shelby County Health Department - STD Clinic
814 Jefferson, Rm 221 Memphis, TN 38103
Call for an appointment: Telephone 576-7552

Medicaid, Medicare, TennCare and Private Insurance is accepted at this clinic. A $10.00 deposit is requested and charges will be carried if you have no insurance. Please speak to your Advocate about reimbursement through Victim's Compensation funds.

Please call for an appointment as soon as possible if you notice any of the following symptoms, such as:

an increase in discharge
burning or pressure duing urination
sores or blisters
"flu-like" symptoms
an "odor" from the vagina
painful intercourse
swollen lymph nodes
stomach pain

If you have any health questions, please call the nurse between the hours of 9:00 AM and 4:00 PM at the Memphis Sexual Assault Resource Center at *272-2020.*

REMEMBER TO TAKE THIS FORM WITH YOU TO YOUR HEALTH CARE PROVIDER ON YOUR *FIRST* FOLLOW UP VISIT.

Your signature means you received a copy of this form.

_____ _____ _____
Signature of Client/Parent/Guardian Date Nurse Examiner

Formerly The Memphis Rape Crisis Center

I-2100.445 (white/canary) 9/97

City of Memphis
TENNESSEE

SEXUAL ASSAULT RESOURCE CENTER
901/272-2020 (Voice or TDD)

LABORATORY FORM

CASE #: _____ DATE COLLECTED: _____

LAB (CHECK ALL THAT APPLY):

	DONE	TEST RESULT / SANE INITIALS	POST TEST COUNSELING COUNSELING DATE / SANE INITIALS
CT (CERVIX)	_____	_____	_____
CT (VULVA)	_____	_____	_____
CT (ANUS)	_____	_____	_____
CT (ORAL)	_____	_____	_____
GENPROBE (CERVIX)	_____	_____	_____
GENPROBE (ANUS)	_____	_____	_____
GENPROBE (URETHRA)	_____	_____	_____
HIV	_____	_____	_____
N.GC (CERVIX)	_____	_____	_____
N.GC (VULVA)	_____	_____	_____
N.GC (ANUS)	_____	_____	_____
N.GC (ORAL)	_____	_____	_____
RPR	_____	_____	_____
U-HCG	_____	_____	_____
WET MOUNT	_____	_____	_____

COLLECTION COMMENTS/OTHER:

_____

_____

_____

INSTRUCTIONS FOR SANEs WHEN LAB RESULTS RETURN: REVIEW AND DOCUMENT RESULTS; THEN ATTACH ALL LABORATORY SLIPS TO THIS PAGE.

MSARC FORENSIC NURSE FORM
LABORATORY: Rev. 5/97

APPENDIX K

SANE EVALUATION TOOLS

SEXUAL ASSAULT RESOURCE SERVICE CHART AUDIT

Client Number_____ SARS Nurse_____ Hospital_____

Required Information	Yes	No	Comments
Page 1 Date & Time of Exam & Assault/CC# documented			
Allergies & Medications documented			
LMP & UPT documented			
Behavior described & comments quoted			
Photos-views, type of camera & dispo noted			
Documentation of involved orifices			
Correct specimens collected/If not collected, reason indicated			
Page 2 If narrative, it is signed, dated & includes pt. quotes			
Page 3 Assessment consistent with documented findings			
Genital injuries drawn & described (measurement/ nature/location/color). Notation of full body inspection for injuries.			
Page 4 If injuries noted, are they included in H & P?, Size, color, nature, location of injuries noted.			
Page 5 CPS assessment marked yes or no (if yes, data filled in)			
Meds documented/if not given, reason indicated			
Staff MD signature present			
Records signed on each page by SANE			
Consent forms signed. Release signed for Ovral (if not, reason indicated			
Does documentation create a detailed picture of patient's emotional & physical presentation and reasoning behind forensic evidence collection/care provided?			

General Suggestions:

Client Satisfaction Survey

We are interested in knowing how you feel about the services you've received relating to the assault. This is confidential, so please tell it the way it was for you.

The Client Satisfaction Survey
was created by
Linda Ledray
at the
Sexual Assault Resource Service

Please circle the number corresponding to your opinion of each question provided below.

0 = Not At All 1 = A Little Bit 2 = Moderately 3 = Quite A Bit 4 = Extremely

OB-GYN CLINIC

Nurse was helpful ..... 0 .... 1 .... 2 ....3 4

Nurse cared about me ..... 0 .... 1 .... 2 ....3 4

Nurse believed me ..... 0 .... 1 .... 2 ....3 4

Nurse understood my feelings ..... 0 .... 1 .... 2 ....3 4

Nurse had time for me ..... 0 .... I .... 2 ....3 4

Nurse followed through with information ..... 0 .... 1 .... 2 ....3 4

Nurse explained things to me ..... 0 .... 1 .... 2 ....3 4

Other_____ ..... 0 .... 1 .... 2 ....3 4

Any specific good or bad experience(s) you would like to comment on about the OB-GYN Clinic?

Please circle the number corresponding to your opinion of each question provided below.

0 = Not At All 1 = A Little Bit 2 = Moderately 3 = Quite A Bit 4 = Extremely

HOSPITAL STAFF - EMERGENCY ROOM

Emergency Room nurse was helpful ..... 0 .... 1 .... 2 ....3 4

Nurse cared about me ..... 0 .... 1 .... 2 ....3 4

Nurse believed me ..... 0 .... 1 .... 2 ....3 4

Nurse understood my feelings ..... 0 .... 1 .... 2 ....3 4

Nurse had time for me ..... 0 .... 1 .... 2 ....3 4

Nurse was gentle ..... 0 .... 1 .... 2 ....3 4

Officer(s) explained things to me ..... 0 .... 1 .... 2 ....3 4

Other_____ ..... 0 .... 1 .... 2 ....3 4

Doctor was helpful ..... 0 .... 1 .... 2 ....3 4

Doctor cared about me ..... 0 .... 1 .... 2 ....3 4

Doctor believed me ..... 0 .... 1 .... 2 ....3 4

Doctor understood my feelings ..... 0 .... 1 .... 2 ....3 4

Doctor had time for me ..... 0 .... 1 .... 2 ....3 4

Doctor was gentle ..... 0 .... 1 .... 2 ....3 4

Doctor explained things to me ..... 0 .... 1 .... 2 ....3 4

Other_____ ..... 0 .... 1 .... 2 ....3 4

Any specific good or bad experience(s) you would like to comment on about the Emergency Room?

Please circle the number corresponding to your opinion of each question provided below.

0 = Not At All 1 = A Little Bit 2 = Moderately 3 = Quite A Bit 4 = Extremely

POLICE

Officer(s) was/were helpful ..... 0 .... I .... 2 ....3 4

Officer(s) cared about me ..... 0 .... 1 .... 2 ....3 4

Officer(s) believed me ..... 0 .... I .... 2 ....3 4

Officer(s) understood my feelings ..... 0 .... 1 .... 2 ....3 4

Officer(s) had time for me ..... 0 .... I .... 2 ....3 4

Officer(s) followed through with information ..... 0 .... 1 .... 2 ....3 4

Officer(s) explained things to me ..... 0 .... 1 .... 2 ....3 4

Other_____ ..... 0 .... 1 .... 2 ....3 4

Any specific good or bad experience(s) you would like to comment on about the police?

Please circle the number corresponding to your opinion of each question provided below.

0 = Not At All 1 = A Little Bit 2 = Moderately 3 = Quite A Bit 4 = Extremely

SEXUAL VIOLENCE CENTER

Program staff were helpful ..... 0 .... 1 .... 2 .... 3 4

Program staff cared about me ..... 0 .... 1 .... 2 .... 3 4

Program staff believed me ..... 0 .... 1 .... 2 .... 3 4

Program staff understood my feelings ..... 0 .... 1 .... 2 .... 3 4

Program staff had time for me ..... 0 .... 1 .... 2 .... 3 4

Program staff followed through with information ..... 0 .... 1 .... 2 .... 3 4

Program staff explained things to me ..... 0 .... 1 .... 2 .... 3 4

Other_____ ..... 0 .... 1 .... 2 .... 3 4

Any specific good or bad experience(s) you would like to comment on about the Center or Staff?

Please circle the number corresponding to your opinion of each question provided below.

0 = Not At All 1 = A Little Bit 2 = Moderately 3 = Quite A Bit 4 = Extremely

LEGAL SYSTEM
(Includes attorneys and
detective involved in the case)

They were helpful ..... 0 .... I .... 2 ....3 4

They cared about me ..... 0 .... 1 .... 2 ....3 4

They believed me ..... 0 .... 1 .... 2 ....3 4

They understood my feelings ..... 0 .... 1 .... 2 ....3 4

They had time for me ..... 0 .... I .... 2 ....3 4

They followed through with information ..... 0 .... 1 .... 2 ....3 4

They explained things to me ..... 0 .... I .... 2 ....3 4

Other_____ ..... 0 .... 1 .... 2 ....3 4

Any specific good or bad experience(s) you would like to comment on about the legal system?

City of Memphis
TENNESSEE

Sexual Assault Resource Center

Patient Satisfaction Survey

Forensic Nursing

Advocacy

Counseling

Education

2675 Union Avenue Extended
Memphis, TN 38112
901/272-2020

At the Memphis Sexual Assault Resource Center, we care about you. Your opinion and comments are important. Please respond to the statements below by drawing a circle around your response. All the information is confidential. When you finish, please mail the questionnaire back to us or drop it in the box in the waiting room.

Please circle your response to each of the statements.

1. When I called, my telephone calls were answered promptly.

Strongly agree Agree No opinion Disagree Strongly Disagree

2. The location of this office is convenient.

Strongly agree Agree No opinion Disagree Strongly Disagree

3. When needed, it was easy to schedule an appointment with the nurse.

Strongly agree Agree No opinion Disagree Strongly Disagree

4. If I came during regular office hours, the person at the reception desk was helpful.

Strongly agree Agree No opinion Disagree Strongly Disagree

5. The nurse explained what she did.

Strongly agree Agree No opinion Disagree Strongly Disagree

6. I understood the nurse's explanation.

Strongly agree Agree No opinion Disagree Strongly Disagree

7. I could ask the nurse questions and talk about my concerns.

Strongly agree Agree No opinion Disagree Strongly Disagree

8. The waiting time before being seen was reasonable.

Strongly agree Agree No opinion Disagree Strongly Disagree

9. In general, I felt better after using the services here at MSARC.

Strongly agree Agree No opinion Disagree Strongly Disagree

Age of client _____ years

Sex (please circle) Male Female

Race (please circle) Black White Asian Other _____ (please specify)

In your words, please tell us what helped you the most at MSARC:

Please tell us what helped you the least at MSARC:

If you have other comments or suggestions, please write them here:

You may write on the back if additional space is needed.

Thank you for taking the time to complete this questionnaire.

Your MSARC Case #_____

MSARC Survey:ma/ps/dm 10/91

Crisis Phone Line Log

Purpose: To document basic information about clients requesting service.

Copyright: This tool may be copied or adapted.

Crisis Phone Line Follow-Up

After completing regular intake information and providing crisis intervention or referral services:

1. Could you please tell me how you heard about this phone line service?_____
_____

2. Type of service provided:_____

3. Was a referral made?
   - ☐ no
   - ☐ yes. . . .agency:_____

4. Caller is:
   - ☐ primary survivor
   - ☐ secondary survivor. . . . . relationship to primary survivor:_____

5. Date of call: _________

6. Time of call: ___:____am/pm

7. Gender:
   - ☐ male
   - ☐ female

8. City or town of residence: _____

Optional:

9. Would you like to receive a follow-up phone call?
   - ☐ no
   - ☐ yes. . . . name: _____
     phone: _____

DEMOGRAPHIC INFORMATION FORM

All Information Provided is Voluntary

Individual

Program Name:_____ Code # _____

Date:____/____/____

1. Age:____

2. Gender: (Check One)

- ☐ 1. Male
- ☐ 2. Female

3. Where do you live: (Check one)

- ☐ 1. Urban area
- ☐ 2. Suburban area
- ☐ 3. Rural area

4. Which group(s) do you identify with: (Check all that apply)

- ☐ 1. American Indian/Alaskan Native
- ☐ 2. Asian/Pacific Islander
- ☐ 3. African American
- ☐ 4. Hispanic
- ☐ 5. White
- ☐ 6. Other:_____
- ☐ 7. Unknown

5. What is your total household income: (Check one)

- ☐ 1. $5000 and under
- ☐ 2. $5001 - $10,000
- ☐ 3. $10,001 - $15,000
- ☐ 4. $15,001 - $20,000
- ☐ 5. Above $20,000

6. What is the highest level of education you have obtained: (Check one)

- ☐ 1. Grade School: grade completed_____
- ☐ 2. Some high school: grade completed_____
- ☐ 3. GED
- ☐ 4. High school diploma
- ☐ 5. Technical School
- ☐ 6. Some college
- ☐ 7. Bachelors Degree
- ☐ 8. Post Bachelors

7. When was the last time you moved: (Check One)

- ☐ 1. In the last 6 months
- ☐ 2. In the past year
- ☐ 3. In the past 2 years
- ☐ 4. More than two years ago
- ☐ 5. Never moved

8. What is your primary occupation: (Check One)

- ☐ 1. Administration or Management
- ☐ 2. Homemaker
- ☐ 3. Professional
- ☐ 4. Sales worker
- ☐ 5. Secretarial or Support Staff
- ☐ 6. Skilled manual employee
- ☐ 7. Other:_____

9. What is your employment status: (Check all that apply)

- ☐ 1. Full-time hourly wage employee
- ☐ 2. Part-time hourly wage employee
- ☐ 3. Retired
- ☐ 4. Salaried Employee
- ☐ 5. Unemployed
- ☐ 6. Other:_____
  _____

10. Are you currently a student: (Check One)

- ☐ 1. No
- ☐ 2. Yes

11. How many hours per week do you do volunteer work: (Check One)

- ☐ 1. I do not do volunteer work
- ☐ 2. 1 - 5 hours per week
- ☐ 3. 6 - 10 hours per week
- ☐ 4. 11 - 15 hours per week
- ☐ 5. 16 - 20 hours per week
- ☐ 6. More than 20 hours per week

12. What are the ages of the children in your household:

1. No children _____
2. Pregnant--due date:____/____/____
3. Age of 1st child: _____
4. Age of 2nd child: _____
5. Age of 3rd child: _____
6. Age of 4th child: _____
7. Age of 5th child: _____
8. Age of 6th child: _____
9. Age of 7th child: _____
10. Age of 8th child: _____

13. What is your relationship to the children: (Check One)

- ☐ 1. Parent
- ☐ 2. Stepparent
- ☐ 3. Grandparent
- ☐ 4. Other relative
- ☐ 5. Non-relative
- ☐ 6. My relationship is not the same to all children

14. What is your relationship status: (Check One)

- ☐ 1. Never Married
- ☐ 2. Married
- ☐ 3. Remarried
- ☐ 4. Same-sex partner
- ☐ 5. Living together
- ☐ 6. Divorced
- ☐ 7. Widowed

15. What is your parenting situation: (Check all that apply)

- ☐ 1. Parenting alone
- ☐ 2. Parenting with child's other parent
- ☐ 3. Parenting with help from your parents
- ☐ 4. Parenting with help from another relative
- ☐ 5. Parenting with help from a nonrelative
- ☐ 6. Other:_____

Goal Attainment Scaling

T.J. Kiresuk
&
R. Sherman

Purpose: To assist individuals in setting personal goals and to measure individual as well as group goal attainment.

Target Population: Older adolescents and adults

Description: Found within description on proceeding pages.

Scoring: Found within the proceeding pages.

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GUIDE TO GOALS

WOMEN HAVE MANY DIFFERENT CONCERNS. PLEASE USE THIS FORM, "GUIDE TO GOALS," TO HELP IDENTIFY YOUR CONCERNS AND TO DETERMINE WHAT YOU THINK COULD BE REASONABLY ACCOMPLISHED IN THE FUTURE.

YOUR CONCERNS MAY BE DIRECTLY RELATED TO THE ASSAULT, OR RELATED TO OTHER PARTS OF YOUR LIFE.

ON THE NEXT TWO PAGES, YOU WILL FIND SAMPLE GOALS COMPLETED ON A GOAL ATTAINMENT FOLLOW-UP GUIDE.

GOAL ATTAINMENT SCALING

(Kiresuk, T. J., & Sherman, R. (1968). Goal attainment scaling: A general method of evaluating comprehensive community mental health programs. *Community Mental Health Journal, 4* (6). Adapted from Practical Program Evaluation: Examples from Child Abuse Prevention, 1990, Pietrzak, J., Ramler, M., Renner, T., Ford, L., & Gilbert, N.)

DESCRIPTION OF GOAL ATTAINMENT SCALING

Goal Attainment Scaling (GAS) was developed in the early 1960s by evaluators at the Hennepin County Mental Health Service. They developed GAS as a measurement to avoid the inflexibility of standardized measures and the vagueness of unstructured observation. Benefits of GAS include:

- clients select and define their own problems or challenges;
- clients and helping professionals work together on GAS;
- clients are their own comparison of success; and
- different types of programs or services can be compared.

There are several steps in using GAS. Briefly:

1. During intake the client and the helping professional identify problems or challenges that are being experienced by the client.

2. They identify target goals for each problem area. The goals are then placed in the middle of a five-point scale which ranges from *most unfavorable outcome thought likely* to *best anticipated outcome*.

3. The client and the helping professional should agree on a date for a follow-up meeting in which they determine the client's progress toward his or her goals.

4. Finally, the helping professional scores the results of GAS.

The remainder of this document will describe each of these steps in greater detail.

USING THE GOAL ATTAINMENT SCALE

1. Identify goal areas.

Choose at least two, but no more than five, broad areas that are problematic or challenging to the client. Typical areas common for people participating in child abuse prevention programs include stress management, discipline, relationships, or coping. If there are more than five problem areas, it will be necessary for the helping professional and the client to choose those goals that are most important.

Certain authors (Bloom & Fisher, 1982 and Gambrill, 1983) suggest the following guidelines for determining which areas are of primary importance to work on:

- Begin with a goal area identified by the client.
- Identify goal areas which are amenable to change.
- Choose goal areas that are appropriate for the agency.
- Identify goal areas that need immediate attention.
- Select goal areas that take priority in comparison to other goal areas. (i.e., working on marital communication may be premature if one or both spouses has an active drinking problem.)
- Choose goal areas that result in changes that are observable and measurable.
- Choose goal areas that will increase the client's motivation to work on other goal areas.
- Identify goal areas that the client and the helping professional see as directly related to the client's needs.

2. Rank each of the goal areas.

The client and the helping professional will work together to rank the importance of each goal area. More important goals should be assigned ***higher*** numbers. Goals of equal importance should be assigned ***equal*** numbers. These numbers will be used later to calculate the summary goal attainment score.

Example:

This client's goals (not drinking, reducing stress, and using appropriate discipline) could be ranked in the following ways:

Not drinking = 3 (most important goal), reducing stress = 2 (more important than appropriate discipline but less important than not drinking) and using appropriate discipline = 1 (least important of these goals)

or

Not drinking = 2 (most important goal), reducing stress = 1 and using appropriate discipline = 1 (reducing stress and using appropriate discipline are equal in importance to each other, however they are less important than not drinking).

3. Translate Goal Areas into Goal Statements

For each goal area, a practical, specific statement should be developed to measure outcomes. Most goals areas will have a variety of statements that can be developed. For example, if the goal is stress management, one good statement might be "number of relaxation exercises performed each day," or "number of times per week that parent exercised." Both indicators are appropriate, measurable and specific.

The center of the scale (see Form 1) is the "expected level of outcome." The center of the scale represents the most likely level of success reached by the client by the follow-up interview. The "expected level of outcome" ought to reflect what realistically *could* be attained, considering the strengths and limitations of the client, and the time frame imposed by the follow-up interview, rather than what *should* be attained.

Form 1

Goal Attainment Scale

Family ID# _____ **Intake date** _____

Program # _____ **Follow-up date** _____

Circle a number→ 5 is most important Please indicate a Goal Area→	Rank 5 4 3 2 1 Goal Area A	Rank 5 4 3 2 1 Goal Area B	Rank 5 4 3 2 1 Goal Area C	Rank 5 4 3 2 1 Goal Area D	Rank 5 4 3 2 1 Goal Area E
Much less than expected					
Somewhat less than expected					
Expected level of outcome					
Somewhat more than expected					
Much more than expected					

Mark the Starting Position with *. **Mark the Ending Position with ✓.**

With the "expected successful outcome" level completed, the four remaining outcome levels on the scale can be filled in (see Form 1). All levels on the scale for each problem area should use the same progress indicator. The "expected level of outcome" should be the most likely outcome that the client can achieve within the time frame. "Much less than expected " and "Much more than expected" levels are the most unlikely outcomes for the client with "Somewhat less than" and the "Somewhat more than" levels falling in between the ends of the scale.

The following suggestions will assist the client and the helping professional review the goal areas and goal statements (Adapted from Gambrill, 1983):

- Goal statements are clearly described (what, where, when, how often, and who).
- Goal statements are stated in positive terms whenever possible.
- Goal statements are attainable.
- Goal statements are clearly related to the client's goals.
- Goal statements focus on behaviors and/or environmental changes.
- Goal statements do not confuse outcomes (stress is managed better by parent) with processes (parent attends stress management classes).
- Goal statements build on client assets.
- Progress can be easily assessed through the statements.

4. Note Client's Current Level of Functioning

Indicate the client's level of functioning when goals are set by placing an asterisk (*) in the appropriate box. Noting the client's current level of functioning enables the helping professional or the evaluator to determine two things: (1) whether or not the "expected level of outcome" has been achieved and (2) whether or not any changes occurred for the client between baseline and follow-up interviews.

5. Conduct a Follow-up Interview

At the specified follow-up date, the helping professional and the client will determine the progress of the client. Mark the client's level of functioning at the follow-up interview with a check mark (✓). The client's baseline and follow-up levels of functioning will be used (in the following sections) to calculate results.

SCORING THE GOAL ATTAINMENT SCALE AND INTERPRETING THE RESULTS

There are two different types of analysis possible using the Goal Attainment Scale.

1. Individual client scores can be analyzed.

2. Groups of client scores can be analyzed.

The Meaning of the GAS Summary Score

The GAS summary score is a single number that represents the findings from several diverse observations. A score of 50 indicates that the client has, on the average, exactly attained "expected level of outcome" on his or her goals. A score of less than 50 indicates less than expected success and a score of greater than 50 indicates better than expected success. See Form 2 for a step-by-step breakdown of calculating the GAS summary score. (Examples using Form 1 and 2 are located at the end of this section, Forms 3, 4, and 5.)

Using the GAS Summary Score

After the summary score has been calculated, the helping professional has a number (the GAS summary score) that indicates how closely the client has met his or her goals. This number can tell you several things. For example, a less than satisfactory GAS summary score (less than 50) should not necessarily be considered a failure. It may mean one of the following things:

1. It may signal that the program or service may be ineffective for a particular type of problem or client;

2. It may indicate that the goals are unrealistically ambitious for the client; or

3. It may indicate that more attention needs to be paid to the original assessment of client needs to ensure that the goals are relevant and desirable to both the client and the helping professional.

When GAS summary scores are consistently above expected success rates (greater than 50), this should also be interpreted carefully. While positive feedback is important for all involved (the client, the helping professional, and the program), the helping professional may need to reassess his or her involvement with the goal setting process to ensure that appropriately challenging outcomes are sought.

The Meaning of the Goal Attainment Change Score

A GAS Change Score indicates how much difference there is between the baseline assessment (Starting Position) and the follow-up interview (Ending Position). Before you can calculate the GAS Change Score you need two GAS Summary Scores (one using Ending Position Scores and one using Starting Position Scores). You already calculated the Ending Position Summary Score on Form 2. To calculate the Starting Position Summary Score you simply need to use Form 2 inserting the Starting Position numbers (marked with *). Once you have these two summary scores you simply subtract the Ending Position Summary Score from the Starting Position Summary Score (see the bottom of Form 2). A negative score indicates movement in the wrong direction, a score near zero indicates little or no change, and a positive score indicates progress. A ten-point change indicates that a client has moved about one outcome level (Hagedorn et al., 1976).

The Second Type of Analysis: Analyzing Information For All Clients

At this level of analysis, the scores from all the clients are examined so that you can make statements about the success of the program, the service, or the agency as a whole. The most basic question that you may want to answer is, "What percentage of our clients reach their individual goals?" In order to answer this question, you must collect the individual GAS Summary Scores from all of the clients served by the program or agency. Next, do a simple tally to determine what percentage of those clients have GAS Summary Scores of 50 or

better. In addition, it might be useful for the agency to know what the mean and median scores were, or how the program clients were distributed on the range of scores (i.e., the percentage of clients who had scores below 40, what percentage had scores of 40-60, and the percentage who had scores of 60 or more).

The GAS Summary Score can also be the basis for a comparative analysis, answering the question, "Are certain programs or services within our agency more successful than others in meeting the goals of their clients?" In this case, the clients could be separated into groups of clients who received services from different programs (i.e., parents in education classes or parents in home visiting programs). The mean GAS Summary Scores of these clients could then be compared to tell you if one program was more successful than the other in meetings client's goals.

In this type of analysis, comparing programs or services, it is important to remember that *success* is defined individually for each client. so that there is nothing in the analysis process that ensures that the difficulties of the problem areas are comparable between groups. The analysis process determines if one program is more successful than another at meeting the goals defined on the GAS forms, not if one program is better than another in a universal sense.

ASSESSING YOUR AGENCY'S USE OF GOAL ATTAINMENT SCALING

It is important to practice using the GAS method when it is a new approach for the agency, the helping professionals, and the clients. One way of practicing is to use the GAS with a smaller number of clients and then have a few staff review the cases.

The program staff participating in the testing process should pay particular attention to the following:

- Goal areas selected should be appropriate for the agency or the program.
- Expectations should be at an appropriate level of difficulty. Other helping professionals working with a similar client population can provide good checks and balances in assuring that there is consistency throughout the agency with respect to level of difficulty.
- Program staff participating in the pilot testing process should agree that progress indicators chosen for particular goal areas are meaningful and provide a relevant measure of progress.

When follow-up interviews for the pilot cases have been completed, the group can calculate the GAS summary scores and modify their construction of the goal scales accordingly. If the first batch of scores is consistently low, the helping professionals need to construct more realistic goal scales. If the scores are consistently high, more challenging expectations are required.

It is important to review discrepancies and make adjustments in a group setting because this ensures that the helping professionals have comparable expectations. Therefore, scores will reflect differences in outcomes rather than differences among staff.

Another benefit of pilot testing this process is that preferred methods of measuring frequently chosen goals will accumulate over time. These can be catalogued into a kind of scale library for the agency, which could serve as a reference to the helping professional. When common goal areas are selected as a focus of work with a new client, the helping professional can consult the library of previously constructed scales to see if they can be modified for use in his or her particular case, and avoid the time burden of reinventing new scales. Utilizing the historical files can also help refine practices used in achieving goals.

Form 2

Calculating the GAS Summary Score

1. Use the following table to assign points to the client's starting and ending positions for each goal area:

Much less than expected	-2
Somewhat less than expected	-1
Expected level of success	0
Somewhat more than expected	1
Much more than expected	2

2. Fill out the following table using information from the Goal Attainment Scale (Form 1).

   a. In the first row, each "starting position" or "ending position" score should be placed in the column corresponding to its Goal Area.

   b. In the second row, place the rank assigned to that goal.

   c. In the third row, place the value obtained for the square of the rank (rank x rank).

   d. In the final row, place the value obtained by multiplying the rank of the particular goal area with its respective "starting position" or "ending position" score.

Form 2 p. 2 **Calculating the GAS Summary Score**

3. In boxes A, B, and C, fill in the total obtained by adding the values in each row.

score						
rank						
rank x rank						
score x rank						

4. Find the square of the value in box C and put that number on line D. ___ (C) x ___ (C) = ___ (D)

5. Multiply the value in box B by 0.7 and place that number on line E. ___ (B) x 0.7 = ___ (E)

6. Multiply the value in line D by 0.3 and place that number on line F. ___ (D) x 0.3 = ___ (F)

7. Add lines E and F and place total on line G. ___ (E) + ___ (F) = ___ (G)

8. Take the square root of line G and place that number on line H. $\sqrt{\ }$ (G) = ___ (H)

9. Multiply the number in box A by 10 and put that number on line I. ___ (A) x 10 = ___ (I)

10. Divide the number on line I by the number on line H and put that number on line J. ___ (I) ÷ ___ (H) = ___ (J)

11. J + 50 = GAS summary score ___ (J) + 50 = ___ GAS summar score

Ending Position summary score – Starting Position summary score = Change Score

_____ – _____ = _____

GAS page 7

GUIDE TO GOALS III

This member of the Guide to Goals Series is designed to enable women who are victims of sexual assault to construct their own Goal Attainment Follow-up Guide with minimal assistance.

Special thanks are extended to the staff of Sexual Assault Resource Service for their help in producing this revised format.

This series constitutes a technical aid to the process of Goal Attainment Scaling as developed by Dr. Thomas J. Kiresuk and Dr. Robert Sherman.

This series is produced by the Sexual Assault Resource Service
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in collaboration with Program Evaluation Resource Center
Director: Thomas J. Kiresuk, Ph.D.

Form 3 **Example of Form 1**

Goal Attainment Scale

Family ID# 789 **Intake date** 10/4/94

Program # 234 **Follow-up date** 11/4/94

Circle a number → 5 is most important Please indicate a Goal Area →	Rank 5 4 3 ② 1 Goal Area A *Stress Management*	Rank 5 4 3 2 ① Goal Area B *Discipline*	Rank 5 4 3 2 1 Goal Area C	Rank 5 4 3 2 1 Goal Area D	Rank 5 4 3 2 1 Goal Area E
Much less than expected	*Client never performs relaxation exercises in response to stress at home.* *	*Client spanks child once a day at home or in public.*			
Somewhat less than expected	*Client performs relaxation exercises in response to stress 1 time a day at home.*	*Client spanks child 3 times a week at home or in public* *			
Expected level of outcome	*Client performs relaxation exercises in response to stress 2 times a day at home.* ✓	*Client spanks child once a week at home or in public.*			
Somewhat more than expected	*Client performs relaxation exercises in response to stress 3 times a day at home.*	*Client spanks child once a month at home or in public.* ✓			
Much more than expected	*Client performs relaxation exercises whenever experiencing stress at home.*	*Client never spanks child at home or in public.*			

Mark the Starting Position with *. **Mark the Ending Position with ✓.**

GOAL ATTAINMENT GUIDE

Level of Results Expected	Concern: Importance =	Strategies to Reach Goal: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
Much More Than Expected Results		
Somewhat More Than Expected Results		
Expected or Most Likely Results in_____		
Less than Expected Results		
Much Less Than Expected Results		

Present Level of Goal Attainment

1) X _____ date written
2) ✓ _____ date
3) 0 _____ date
4) ⊕ _____ date
5) ♂ _____ date

HIS PAGE SHOWS HOW CLIENT MIGHT COMPLETE ER OWN GUIDE TO OALS. YOUR GUIDE TO OALS WILL HAVE DIF- ERENT CONCERNS AND UMBERS, BUT SHOULD E FILLED-IN GENERALLY IKE THIS ONE. THIS OOKLET WILL GIVE YOU STEP-BY-STEP INSTRUC- TIONS ON HOW TO FILL IN YOUR OWN PERSONAL GOALS.

Guide to Goals	SCALE 1: Criticize Others ($w_1 = 1$)	SCALE 2: Friends ($w_2 = 1$)	SCALE 3: Self-Concept ($w_3 = 3$)	SCALE 4: Social Activities ($w_4 = 2$)	SCALE 5: Smoking ($w_5 = 2$) - 1 -
much less than the expected level of results	I criticize others about something 20 or more times per day.	I have no friends.	I don't even like myself and no one else does either. (Admire me for myself)	No social activities per week.	Smoke more than one and one-half packs of cigarettes per day.
somewhat less than the expected level of results	I criticize others about something 13 - 19 times per day.		Only one of these people really like me myself, my mother, my therapist, my brother my boss, my roommate.	Only one social activity per week out side my house (like movie, dinner out, dancing, club, church so on).	Smoke one and one-half packs of cigarettes per day.
expected level of results in____ months	I criticize others about something 12 - 9 times per day.	I have 2 or 3 friends (People I can talk to about feelings and problems.)	2 or 3 of the above people like me.	2 to 4 social activities per week.	Smoke one pack of cigarettes per day.
somewhat more than the expected level of results	I criticize others about something 6 - 8 times per day.		4 of the above people like me.		Smoke one-half pack of cigarettes per day.
much more than the expected level of results	I criticize others about something 5 or less times per day.	I have 7 to 10 friends.	5 or more of the above people like me	6 or more social activities per week.	Smoke less than one-half pack of cigarettes per day.

SARS Research Study

Patricia Frazier
University of Minnesota

&

Linda Ledray
Sexual Assault Resource Service

Purpose:	To document and assess the effects of a sexual assault on the individual
Target Population:	Sexually assaulted females and males.
Description:	Multiple sections using a diverse range of scales. The inventory assesses several areas, including the individual's feelings about the assault, symptoms, coping and the impact it has on their life.
Copyright:	Permission is granted to copy and administer any or all parts of this survey.
Comments:	A good tool to give to assault victims to help them work through their situation.

CONSENT FORM

You are invited to participate in a study of the impact of rape on women. We hope that the information we obtain will allow us to provide better services for rape victims in the future.

If you decide to participate, you will be asked to fill out questionnaires regarding your rape experience. You will fill out these questionnaires at three points in time: about one week following the assault, 1 to 3 months following the assault, and 6 to 12 months following the assault. You will be paid $10.00 for completing each questionnaire. While it would be helpful if you completed all three questionnaires, you are free to end your involvement in this part of the study at any time.

If you decide to participate, you will also be agreeing to make the information in your hospital, police, and court records available to us. These records contain information collected as a routine part of your treatment at SARS and the investigation of your case by the legal system.

Any information obtained in connection with this study that can be identified with you will remain confidential. In any written reports or publications, no one will be identified or identifiable. All data will be presented in terms of group scores. Individual scores will remain confidential. There are no known risks to you for participation.

Your decision whether or not to participate will not affect your future relations with SARS in any way. If you decide to participate, you are free to discontinue participation at any time without affecting your relationship with SARS.

You will be offered a copy of this form to keep

By signing below, you are indicating that you have read the information provided above and have decided to participate in this study. You may withdraw from the study at any time after signing this form without penalty.

Signature _____ Date _____

Signature of Witness _____ Date _____

SARS ID _____ Date _____

3 to 10 days ____, 2 months ____, 6 months ____, 12 months ____

SECTION 1. THIS SECTION ASKS ABOUT HOW YOU ARE FEELING SINCE THE ASSAULT.

A. Below is a list of problems and complaints that people sometimes have. Read each one carefully, and select the number that best describes how much discomfort that problem has caused you during the past week. Place that number in the space before each item.

0	1	2	3	4
Not at all	A little bit	Moderately	Quite a bit	Extremely

HOW MUCH WERE YOU DISTRESSED BY:

_____ 1. Nervousness or shakiness inside

_____ 2. Feeling easily annoyed or irritated

_____ 3. Thoughts of ending your life

_____ 4. Feeling afraid in open spaces

_____ 5. Suddenly scared for no reason

_____ 6. Temper outbursts that you could not control

_____ 7. Feeling fearful

_____ 8. Feeling afraid to travel on buses, subways, or trains

_____ 9. Having to avoid certain things, places, or activities because they frighten you

_____ 10. Feeling tense or keyed up

_____ 11. Feeling lonely

_____ 12. Having urges to beat, injure, or harm someone

_____ 13. Feeling blue

_____ 14. Having urges to break or smash things

_____ 15. Feeling no interest in things

_____ 16. Feeling uneasy in crowds

_____ 17. Spells of terror or panic

_____ 18. Feeling hopeless about the future

_____ 19. Getting into frequent arguments

_____ 20. Feeling nervous when you are left alone

_____ 21. Feeling so restless you couldn't sit still

_____ 22. Feelings of worthlessness

B. Below are symptoms often experienced by women who have been assaulted. Please place a check next to any symptoms you have experienced <u>in the past week</u>.

_____ 1. I have upsetting memories of the assault that happen over and over.

_____ 2. I often have bad dreams about the assault.

_____ 3. Sometimes I suddenly feel like the assault is happening all over again.

_____ 4. I feel very uncomfortable in situations that are similar to the assault.

_____ 5. I try to avoid thoughts or feelings about the assault.

_____ 6. I stay away from activities or situations that bring back memories of the assault.

_____ 7. Sometimes I can't remember important things about the assault.

_____ 8. I have lost interest in activities I enjoyed before the assault.

_____ 9. Since the assault, I feel more disconnected from others.

_____ 10. I feel more emotionally numb than I did before the assault.

_____ 11. Since the assault, I often feel that I don't have much of a future.

_____ 12. I have trouble falling asleep or staying asleep since the assault.

_____ 13. I feel more grouchy or have more outbursts of anger than before the assault.

_____ 14. Since the assault, I have trouble concentrating.

_____ 15. Since the assault, I'm always on the lookout for danger.

_____ 16. I am more easily startled than I was before the assault.

_____ 17. I have physical reactions when I am reminded of the assault (heart beats faster, palms feel sweaty, etc.).

A. Please read each item below and determine the extent to which you used it in handling the assault during the past week. Mark your answer in the space before each item, using the following scale:

1	2	3	4	5
Not at all	A little	Somewhat	Much	Very much

____ 1. I tried to get a new angle on the situation.

____ 2. I found ways to blow off steam.

____ 3. I slept more than usual.

____ 4. I hoped the problem would take care of itself.

____ 5. I tried to keep my feelings to myself.

____ 6. I looked for the silver lining, so to speak; tried to look on the bright side of things.

____ 7. I did some things to get it out of my system.

____ 8. I went along as if nothing were happening.

____ 9. I hoped a miracle would happen.

____ 10. I spent more time alone.

____ 11. I told myself things that helped me feel better.

____ 12. I let my emotions go.

____ 13. I tried to forget the whole thing.

____ 14. I wished that I never let myself get involved with that situation.

____ 15 I avoided my family and friends.

____ 16. I looked at things in a different light and tried to make the best of what was available.

____ 17. I let out my feelings to reduce the stress.

____ 18. I didn't let it get to me; I refused to think about it too much.

____ 19. I wished that the situation would go away or somehow be over with.

____ 20. I avoided being with people.

____ 21. I asked myself what was really important, and discovered that things weren't so bad after all.

____ 22. I let my feelings out somehow.

____ 23. I decided that it was really someone else's problem and not mine.

____ 24. I wished that the situation had never started.

____ 25. I didn't talk to other people about the problem.

____ 26. I convinced myself that things aren't quite as bad as they seem.

____ 27. I let my emotions out.

____ 28. I avoided the person who was causing the trouble.

____ 29. I had fantasies or wishes about how things might turn out.

____ 30. I spent some time by myself.

____ 31. I stepped back from the situation and put things into perspective.

____ 33. I made light of the situation and refused to get too serious about it.

____ 34. I hoped that if I waited long enough, things would turn out OK.

____ 35. I kept my thoughts and feelings to myself.

____ 36. I reorganized the way I looked at the situation, so things didn't look so bad.

____ 37. I got in touch with my feelings and just let them go.

____ 38. Every time I thought about it I got upset; so I just stopped thinking about it.

____ 39. I wished I could have changed what happened.

____ 40. I didn't let my family and friends know what was going on.

____ 41. I went over the problem again and again in my mind and finally saw things in a different light.

____ 42. I was angry and really blew up.

____ 43. I avoided thinking or doing anything about the situation.

____ 44. I thought about fantastic or unreal things that made me feel better.

____ 45. I did not let others know how I was feeling.

Please list any other things you are doing to try to deal with the assault.

_____

_____

_____

SECTION 3. THIS SECTION ASKS ABOUT VARIOUS CHANGES THAT MIGHT HAVE OCCURRED IN YOUR LIFE AS A RESULT OF THE ASSAULT.

A. An assault often brings about a lot of changes in a person's life. Some changes may be positive, while others may be negative. Thinking about your life *now* compared to your life before the assault, please check the appropriate column. Please check only one.

_____ My life is completely worse now.
_____ My life is a lot worse now.
_____ My life is a little worse now.
_____ My life has not changed.
_____ My life is a little better now.
_____ My life is a lot better now.
_____ My life is completely better now.

Please use the following scale in answering the next set of questions.

1	2	3	4	5
strongly disagree	disagree somewhat	neither agree nor disagree	agree somewhat	strongly agree

____ 1. I am afraid that I will be assaulted again.

____ 2. The assault is going to affect me for a long time but there are things I can do to lessen its effects.

____ 3. I have changed certain behaviors to try to avoid being assaulted again.

____ 4. It is not very likely that I will be assaulted again.

____ 5. I don't feel there is much I can do to help myself feel better.

____ 6. Since the assault, I try not to put myself in potentially dangerous situations.

____ 7. Now that I have been assaulted, the odds are it won't happen again.

____ 8. I know what I must do to help myself recover from my assault.

____ 9. I do not take any special precautions since the assault occurred.

____ 10. I feel pretty sure that I won't be assaulted again.

____ 11. I am confident that I can get over this if I work at it.

____ 12. I have taken steps to protect myself since the assault.

____ 13. No matter what steps I take, I could be assaulted again.

____ 14. I feel like the recovery process is in my control.

____ 15. I have made a change in my living situation since the assault.

B. Please circle the number 1 to 5 that best describes your feelings.

1. To what extent was the assault caused by something you could have controlled?

1	2	3	4	5
Completely out of my control				Completely under my control

2. To what extent do you have control over your recovery process?

1	2	3	4	5
Completely out of my control				Completely under my control

3. How likely is it that you will be assaulted again?

1	2	3	4	5
Not at all likely				Extremely likely

4. To what extent have you changed your behaviors to avoid being assaulted again?

1	2	3	4	5
Not at all				A great deal

5. How often do you think about why you were assaulted?

1	2	3	4	5
Not at all				A great deal

SECTION 4. THIS SECTION ASKS FOR YOUR THOUGHTS OR HUNCHES ABOUT WHY THE ASSAULT OCCURRED.

A. Below are statements describing thoughts women often have about why an assault occurred. Please indicate how often you have had each of the following thoughts in the past week.

Never	Rarely	Sometimes	Often	Very Often
1	2	3	4	5

How often have you thought: I was assaulted because...

_____ 1. Society doesn't do enough to prevent violence against women.
_____ 2. I used poor judgment.
_____ 3. I am just the victim type.
_____ 4. It was just bad luck.
_____ 5. The rapist thought he could get away with it.
_____ 6. Men are taught not to respect women.
_____ 7. I should have resisted more.
_____ 8. I am a careless person.
_____ 9. I was in the wrong place at the wrong time.
_____ 10. The rapist wanted to feel power over someone.
_____ 11. Men are socialized to be violent.
_____ 12. I should have been more cautious.
_____ 13. Things like this happen to people like me.
_____ 14. Things like this happen at random.
_____ 15. The rapist was sick.
_____ 16. In our society, women are sex objects.
_____ 17. I just put myself in a vulnerable situation.
_____ 18. I am unlucky.
_____ 19. I was a victim of chance.
_____ 20. The rapist was angry at women.
_____ 21. The media encourages violence against women.
_____ 22. I didn't do enough to protect myself.
_____ 23. I am too trusting.
_____ 24. Bad things like this are just a part of life.
_____ 25. The rapist wanted to hurt someone.

Please list any other reasons why you think the assault occurred.

_____

_____

_____

B. Please circle the number 1 to 5 that best describes your feelings.

1. To what extent was the assault caused by something you could have controlled?

1	2	3	4	5
Completely out of my control				Completely under my control

2. To what extent do you have control over your recovery process?

1	2	3	4	5
Completely out of my control				Completely under my control

3. How likely is it that you will be assaulted again?

1	2	3	4	5
Not at all likely				Extremely likely

4. To what extent have you changed your behaviors to avoid being assaulted again?

1	2	3	4	5
Not at all				A great deal

5. How often do you think about why you were assaulted?

1	2	3	4	5
Never				All the time

6. To what extent do you have control over being assaulted in the future?

1	2	3	4	5
Completely out of my control				Completely under my control

SECTION 5. THIS SECTION ASKS ABOUT VARIOUS STRESSES IN YOUR LIFE.

A. Thinking back over all the things you have experienced in life, please list the 5 most stressful things you have experienced. Keep in mind that stressful experiences can be both good and bad. After listing the stressful experience, rate how stressful that experience was for you at the time, with 10 being as much stress as you can imagine being under, and 0 being no stress. The 5 experiences do not have to be in any particular order.

The stressful experience:		Stress rating: (circle one) No stress → Highest stress										
1. _____	Date_____	0	1	2	3	4	5	6	7	8	9	10
2. _____	Date_____	0	1	2	3	4	5	6	7	8	9	10
3. _____	Date_____	0	1	2	3	4	5	6	7	8	9	10
4. _____	Date_____	0	1	2	3	4	5	6	7	8	9	10
5. _____	Date_____	0	1	2	3	4	5	6	7	8	9	10

B. If you did not list your most recent assault as one of your 5 most stressful experiences, how would you rate it on the same 0 to 10 scale used above?

0 1 2 3 4 5 6 7 8 9 10
No stress → Highest stress

SECTION 6. THIS SECTION ASKS ABOUT THE SUPPORT YOU MAY HAVE RECEIVED SINCE THE ASSAULT.

A. Who was the first person you confided in about the assault? (Circle one)

Mother Father Spouse Female friend Male friend

Sister Brother Nurse Counselor Other (specify) _____

B. Please rate the extent to which you feel this first person in whom you confided provided a caring and helpful reaction to you and your situation (Please circle your response).

0 1 2 3 4 5 6 7 8 9 10
Not at all caring and helpful → Very caring and helpful

C. Thinking about all the people who have provided you with support since the assault, how would you rate them overall? (Please circle your response.)

0 1 2 3 4 5 6 7 8 9 10
Not at all caring and helpful → Very caring and helpful

D. How much support have you wanted or desired since the assault? (Please circle your response.)

0 1 2 3 4 5 6 7 8 9 10
No support → A lot of support

E. How much support have you actually received? (Please circle your response.)

0 1 2 3 4 5 6 7 8 9 10
No support → A lot of support

If you have not received as much support as you've wanted, why do you think this is?

_____

_____

_____

_____

SECTION 7. THIS SECTION ASKS YOU ABOUT YOUR FEELINGS ABOUT GOD AND RELIGION.

Our past research indicates that some people turn to God or religion when dealing with traumatic events. Do you believe in God? ___ Yes ___ No. If you believe in God, please continue with the next set of questions. If you do not believe, please skip to Section 8 below.

A. What do you think God/religion has provided you during the period since the assault?

_____

_____

_____

_____

_____

B. The following items describing ways of coping by turning to God/religion. Please read each item and determine the extent to which you used it in handling the stress of the assault.

Not at all	A little	Somewhat	Much	Very much
1	2	3	4	5

1.____ I sought God's help in dealing with the situation.

2.____ I trusted that God would handle the situation.

3.____ I tried to find the lesson from God in the event.

4.____ I let God solve my problems for me.

5.____ I accepted that the situation was not in my hands but in the hands of God.

6.____ I focused on the divine world rather than the problems of this world.

7.____ I waited for God to provide solutions to my problems.

8.____ With God's help I was able to see the situation in a different light.

9.____ I took control over what I could and let God help me with the rest.

10.____ I used my faith to help me reorganize how I looked at the situation, so things seemed more manageable.

QUESTION #2:

A. Was your most recent assault the only non-consensual sexual activity you've experienced after the age of 12? Yes _____, No ____.

If you checked "yes", you are done with the questionnaire.

If you checked "no", please answer the following questions with regard to the non-consensual sexual experience (since the age of 12) that had the greatest impact on you. Please do not comment on your most recent assault.

B. Who was the experience with? A stranger _____, friend _____, relative (specify) _____, other (specify) _____.

C. How old were you at the time? _____

D. How old was the other person? _____ (If you don't know, please guess).

E. Was the person male _____ or female _____.

F. Please briefly describe the incident.

_____

_____

_____

_____

_____

_____

_____

_____

_____

G. Thinking about all the non-consensual sexual activities you've had, did the most recent assault have a greater emotional effect on you than any of the other experiences? Yes _____, No _____. Please explain.

_____

_____

_____

THANK YOU VERY MUCH FOR YOUR TIME!

SELF ESTEEM SCALE

Rosenberg

Uses: To measure an individual's self attitudes and general self esteem.

Source of Instrument: Rosenberg, M. (1965) Society and the Adolescent Self-Image. New Jersey: Princeton University Press.

Languages: English and Spanish

Reliability: No information available

Scoring: For questions 3, 5, 6, 7 and 8 apply the following points:

a	1
b	2
c	3
d	4

For questions 1, 2, 4, 9 and 10 apply the following:

a	4
b	3
c	2
d	1

After assigning the appropriate number of points for each question, add up the total number of points and divide by the number of questions for the final score. Higher scores indicate greater self esteem.

SELF ESTEEM SCALE

Rosenberg

Please read each statement. Then circle the number indicating how much you agree or disagree with the statement.

4 Strongly Disagree

3 Disagree

2 Agree

1 Strongly Agree

1.	I feel that I am a person of worth. I am as good as anybody else.....	1	2	3	4
2.	I feel that there are a lot of good things about me.	1	2	3	4
3.	I feel that I fail a lot.	1	2	3	4
4.	I can do things as well as most other people.	1	2	3	4
5.	I do not have much to be proud of.....	1	2	3	4
6.	I wish I had more respect for myself.	1	2	3	4
7.	I feel useless at times.....	1	2	3	4
8.	Sometimes I think I am no good at all.	1	2	3	4
9.	I like myself.	1	2	3	4
10.	I am happy with myself.	1	2	3	4

Al Describirme

	1 Estoy muy de acuerdo	2 Estoy de acuerdo	3 No estoy de acuerdo	4 No estoy muy de acuerdo
1. Yo siento que soy una persona de valor. Soy tan bueno/buena como cualquier otra persona.....	1	2	3	4
2. Yo siento que hay muchas cosas buenas de mi.....	1	2	3	4
3. Yo siento que fracaso mucho.....	1	2	3	4
4. Puedo hacer las cosas tan bien como otras personas.....	1	2	3	4
5. No tengo mucho de que puedo sentirme orgulloso/orgullosa.....	1	2	3	4
6. Quisiera tener más respeto por mi mismo/misma.....	1	2	3	4
7. A veces, me siento inútil.....	1	2	3	4
8. De vez en cuando, pienso que no valgo nada.....	1	2	3	4
9. Me gusta como yo soy.....	1	2	3	4
10. Estoy contento/contenta con mi mismo/misma.....	1	2	3	4

SANE Job Impact Survey

by

Michael G. Luxenberg, Ph.D., Julie Rainey, Holly Miller, Linda Ledray, Ph.D.

Instructions:
Please circle the number of the response that best describes your feelings about each statement.

	1 Strongly Agree	2 Agree	3 Uncertain	4 Disagree	5 Strongly Disagree	6 Doesn't Apply
1. I am often late for meetings and/or have trouble getting into the ED within a reasonable amount of time.	5	4	3	2	1	0
2. I feel physically exhausted.	5	4	3	2	1	0
3. I regularly allow time for my own hobbies and favorite leisure activities.	5	4	3	2	1	0
4. Lately I haven't been as productive at work as I usually am.	5	4	3	2	1	0
5. When I go home, I have a difficult time leaving my work behind.	5	4	3	2	1	0
6. My work has had a negative impact on my own sexuality.	5	4	3	2	1	0
7. I have a strong and healthy support network.	5	4	3	2	1	0
8. I find that I cannot stop thinking about the increasing amount of violence in the world.	5	4	3	2	1	0
9. I have difficulty concentrating and find it hard to stay on task.	5	4	3	2	1	0
10. I find that I am significantly increasing my use of alcohol or other drugs.	5	4	3	2	1	0
11. It is hard for me to find enough time away from work to enjoy my family and friends.	5	4	3	2	1	0
12. I get angry more easily and more often than I used to.	5	4	3	2	1	0
13. I am generally happy with my job.	5	4	3	2	1	0
14. I set and maintain healthy boundaries that allow me to work closely with victims without becoming too personally involved.	5	4	3	2	1	0

	5 Strongly Agree	4 Agree	3 Uncertain	2 Disagree	1 Strongly Disagree	0 Doesn't Apply
15. I no longer get pleasure from sexual activity.	5	4	3	2	1	0
16. I am often troubled by thoughts and recollections of the traumatic experiences I hear about at work.	5	4	3	2	1	0
17. I feel emotionally drained.	5	4	3	2	1	0
18. I believe that the world is generally a safe place and I don't feel personally at high risk for assault.	5	4	3	2	1	0
19. I have a difficult time getting up emotionally to go in when I am paged.	5	4	3	2	1	0
20. I experience feelings of emotional isolation, just as the victims I examine often do.	5	4	3	2	1	0
21. I get a lot of satisfaction from my work and from the assistance I give to victims.	5	4	3	2	1	0
22. I seldom have trouble sleeping.	5	4	3	2	1	0
23. I have consistently been unable to meet deadlines at work.	5	4	3	2	1	0
24. This job has blurred my ability to differentiate between consensual and nonconsensual sexual activity.	5	4	3	2	1	0
25. I exercise or engage in physical activity on a regular basis.	5	4	3	2	1	0
26. I have become afraid to walk alone at night.	5	4	3	2	1	0
27. I have difficulty becoming aroused.	5	4	3	2	1	0
28. I no longer feel much empathy towards the victims I treat.	5	4	3	2	1	0
29. I cry uncontrollably more often than I used to.	5	4	3	2	1	0
30. I have identified successful coping strategies that I know work well for me when I begin to feel burned out.	5	4	3	2	1	0

SANE Job Impact Survey
Scoring Sheet

Missing Values
When there are three or more missing items (items marked '0' or left blank) in any subscale, then that subscale *should not be scored.*

Reverse Scoring
Some of the items need to be reversed before scoring. These items are marked with an asterisk (*) below. Use the following method to reverse scores when indicated:

5=1 4=2 3=3 2=4 1=5 6 = missing

Cognitive Impact (CI) Score
Include items 4, 8, 9, 12, 13*, 18*
[Sum of responses _____]
divided by
[number of non-missing items _____ * 5] * 100 = CI Score: _____

Emotional Impact (EI) Score
Include items 14, 17, 20, 21*, 26, 28, 29
[Sum of responses _____]
divided by
[number of non-missing items _____ * 5] * 100 = EI Score: _____

Sexual Impact (SI) Score
Include items 6, 15, 16, 24, 27
[Sum of responses _____]
divided by
[number of non-missing items _____ * 5] * 100 = SI Score: _____

Behavioral Impact (BI)
Include items 1, 2, 10, 19, 22*, 23
[Sum of responses _____]
divided by
[number of non-missing items _____ * 5] * 100 = BI Score: _____

Overall Score
[Sum of CI, EI, SI and BI scores _____]
divided by 4 = Overall Score: _____

Reduction of Impact through Leisure and Support (LS) Score
Include items 3*, 5, 7*, 11, 25*, 30
[Sum of responses _____]
divided by
[number of non-missing items _____ * 5] * 100 = LS Score: _____

*** Items need to be reversed before scoring.**

INTERPRETATION: Scores may range from 20 to 100.

- Overall score and CI, EI, SI and BI subscale scores: Higher scores indicate higher levels of burnout.
- Reduction of Impact through Leisure and Support (LS) score: Higher scores indicate greater levels of participation in activities which contribute to stress reduction.

This survey is currently being piloted; the development of reliability information and gathering of normative data is in progress.

SANE Job Impact Survey
Sample Scoring Procedure

Cognitive Impact (CI) Score
Include items 4, 8, 9, 12, 13*, 18*

The respondent marked the following answers:

Item #	Response	Scoring
4.	0	missing
8.	5	5
9.	4	4
12.	left blank	missing
13.	5	1 (item #13 must be reversed)
18.	4	2 (item #18 must be reversed)

[Sum of responses 12]
divided by
[number of non-missing items 4 * 5] * 100 = CI Score: 60

SANE Job Impact Survey

Michael G. Luxenberg, Ph.D.
Julie Rainey
Holly Miller
Linda Ledray, Ph.D.

Response Format:
Strongly Agree Agree Uncertain Disagree Strongly Disagree NA

SCALE CONSTRUCTION

Cognitive Impact

4. Lately I haven't been as productive at work as I usually am.

8. I find that I cannot stop thinking about the increasing amount of violence in the world.

9. I have difficulty concentrating and find it hard to stay on task.

12. I get angry more easily and more often than I used to.

13. I am generally happy with my job.

18. I believe that the world is generally a safe place and I don't feel personally at high risk for assault.

Emotional Impact

14. I set and maintain healthy boundaries that allow me to work closely with victims without becoming too personally involved.

17. I feel emotionally drained.

20. I experience feelings of emotional isolation, just as the victims I examine often do.

21. I get a lot of satisfaction from my work and from the assistance I give to victims.

26. I have become afraid to walk alone at night.

28. I no longer feel much empathy towards the victims I treat.

29. I cry uncontrollably more often than I used to.

Sexual Impact

6. My work has had a negative impact on my own sexuality.

15. I no longer get pleasure from sexual activity.

16. I am often troubled by thoughts and recollections of the traumatic experiences I hear about at work.

24. This job has blurred my ability to differentiate between consensual and nonconsensual sexual activity.

27. I have difficulty becoming aroused.

Behavioral Impact

1. I am often late for meetings and/or have trouble getting into the ED within a reasonable amount of time.

2. I feel physically exhausted.

10. I find that I am significantly increasing my use of alcohol or other drugs.

19. I have a difficult time getting up emotionally to go in when I am paged.

22. I seldom have trouble sleeping.

23. I have consistently been unable to meet deadlines at work.

Reduction of Impact through Leisure and Support

3. I regularly allow time for my own hobbies and favorite leisure activities.

5. When I go home, I have a difficult time leaving my work behind.

7. I have a strong and healthy support network.

11. It is hard for me to find enough time away from work to enjoy my family and friends.

25. I exercise or engage in physical activity on a regular basis.

30. I have identified successful coping strategies that I know work well for me when I begin to feel burned out.

GLOSSARY

GLOSSARY OF ACRONYMS

ACP - Acid Phosphatase

ACOG - American College of Gynecologists

ANA - American Nurses' Association

APSAC - American Professional Society on the Abuse of Children

BCA - Bureau of Criminal Apprehension

BSN - Bachelor of Science in Nursing

CEU - Continuing Education Units

CISPA - Critical Item Suicide Potential Assessment

CODIS - Combined DNA Index System

CNS - Central Nervous System

CPS - Child Protective Services

CSAAT - Comprehensive Sexual Assault Assessment Tool

DEA - Drug Enforcement Agency

DNA - deoxyribonucleic acid

ED - Emergency Department

FNE - Forensics Nurse Examiner

GHB - gamma hydroxy butyrate

HCMC - Hennepin County Medical Center

IAFN - International Association of Forensic Nurses

JCAHO - Joint Commission on the Accreditation of Healthcare Organizations

JEN - Journal of Emergency Nursing

MSW - Master of Social Work

NCASA - National Coalition Against Sexual Assault

NOVA - National Organization of Victim Assistance

OVC - Office for Victims of Crime

PA - Physician's Assistant

PAP - Prostatic Acid Phosphatase

PSA - Prostatic Specific Antigen or Public Service Announcements

PTSD - Post-Traumatic Stress Disorder

RN - Registered Nurse

SAFE - Sexual Assault Forensic Examiner

SANC - Sexual Assault Nurse Clinician

SANE - Sexual Assault Nurse Examiner

SARS - Sexual Assault Resource Service

SART - Sexual Assault RESPONSE/RESOURCE Team

S-T-O-P - Services, Training, Officers, and Prosecutors

UPT - Urine Pregnancy Test

VAWA - Violence Against Women Act

VAWGO - Violence Against Women Grants Offices

VOCA - Victims of Crime Act

WNS - Western Nurse Specialists

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EVALUATION

SANE GUIDE EVALUATION

Your feedback is an important and essential part of making this guide an effective tool. We ask that you please take the time to complete the following questionnaire at this time. OVC is interested in learning what information in this guide was useful and what additional information you would like included in revisions. Your honest response will help us improve this guide. Once completed, tear the questionnaire from the manual, fold it in half and staple it with the return address to the Sexual Assault Resource Service (SARS) on the outside and put it in the mail.

1. What kind of agency do you work for? *(Check all that apply)*

   ☐ 1. Police

   ☐ 2. Hospital

   ☐ 3. Prosecutor's office

   ☐ 4. Rape center

   ☐ 5. Existing SANE program

   ☐ 6. Other_____(specify)

2. What is your academic background? Please list degrees, certifications, areas of study:

   _____

3. a. Do you currently have an operating SANE program in your area? ☐ 1. Yes ☐ 2. No ☐ 3. Uncertain

   b. Do you have a SART program in your area? ☐ 1. Yes ☐ 2. No ☐ 3. Uncertain

4. a. Is there interest in starting a SANE program in your area? ☐ 1. Yes ☐ 2. No ☐ 3. Uncertain

b. Is there interest in starting a SART program in your area?
- ☐ 1. Yes
- ☐ 2. No
- ☐ 3. Uncertain

5. a. Are you currently working to develop a SANE program?
- ☐ 1. Yes
- ☐ 2. No
- ☐ 3. Uncertain

b. Are you currently working to develop a SART program?
- ☐ 1. Yes
- ☐ 2. No
- ☐ 3. Uncertain

If you are working to develop a new SANE or SART program, please answer the items in the following section. If not, please go to Question 9.

6. What development work have you done prior to receiving this guide?

_____

_____

_____

7. How helpful do you believe this guide will be?
- ☐ 1. Very helpful
- ☐ 2. Moderately helpful
- ☐ 3. Not very helpful
- ☐ 4. Not at all helpful

8. How do you plan to use this guide?
- ☐ 1. Start a SANE program
- ☐ 2. Improve a program
- ☐ 3. Influence legislation
- ☐ 4. Reference Guide
- ☐ 5. Interagency collaboration
- ☐ 6. Other_____

9. Is there anything you would have done differently if you had this guide before you started working to develop your SANE/SART program?

   ☐ 1. No

   ☐ 2. Yes, please explain: _____

   _____

10. Do you want to work in a SANE program?

   ☐ 1. Yes

   ☐ 2. No, because_____

   ☐ 3. Uncertain, because_____

11. Did you share this information with anyone else?

   ☐ 1. No

   ☐ 2. Yes, the information was shared with _____

12. Do you believe you could start a SANE program with the information in this guide alone?

   ☐ Yes

   ☐ No... I would also need: _____

   _____

   _____

13. If the following technical assistance was available, would you utilize it?

   a. SANE program development WEB page ☐ Yes ☐ No ☐ don't have computer

   b. e-mail assistance ☐ Yes ☐ No ☐ don't have e-mail

   c. Telephone assistance ☐ Yes ☐ No ☐ Unsure

   d. Regional workshop/SANE development conference ☐ Yes ☐ No ☐ Unsure

At what location would you prefer to attend_____

e. Other, please specify_____

_____

14. If there was a possibility to share SANE/SART information with other programs (e.g., providing local program statistics such as the number of cases seen, convictions, etc. to a central national center and getting other area and compiled national statistics in return) would you be willing to participate?

☐ 1. Yes

☐ 2. No

☐ 3. Uncertain, I would need more information about: _____

_____

For each item below, please circle the number that represents your opinion about that section.

	1 Very Useful	2 Moderately Useful	3 Minimally Useful	4 Not Useful
1. SANE History and description of current program operation	1	2	3	4
2. SANE program model information	1	2	3	4
3. SART information	1	2	3	4
4. Needs assessment	1	2	3	4
5. Overcoming obstacles	1	2	3	4
6. Program costs and funding	1	2	3	4

7. Starting a SANE program	1	2	3	4
8. Program staff	1	2	3	4
9. SANE Training	1	2	3	4
10. Establishing and maintaining coverage	1	2	3	4
11. Program operation	1	2	3	4
12. The pediatric SANE exam	1	2	3	4
13. Policies and procedures	1	2	3	4
14. Maintaining a healthy program	1	2	3	4

15. Which of the above items was the **LEAST** helpful? _____

16. Which of these items was the **MOST** helpful? _____

17. What would make this guide more useful?_____

_____

18. Would you recommend this guide to a colleague?

☐ 1. Yes

☐ 2. No

☐ 3. Uncertain

For updated information and to be on our mailing list:

Agency Name_____

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