



OVC Bulletin

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SEXUAL ASSAULT NURSE EXAMINER (SANE) PROGRAMS: IMPROVING THE COMMUNITY RESPONSE TO SEXUAL ASSAULT VICTIMS

by Kristin Littel

A SANE is a registered nurse (R.N.) who has advanced education and clinical preparation in forensic examination of sexual assault victims.¹ In the 1990s, sexual assault nurse examiner (SANE) programs sprang up in hundreds of communities across the country to address the inadequacy of the traditional model for sexual assault medical evidentiary exams. Those who work with sexual assault victims have long recognized that victims are often retraumatized when they come to hospital emergency departments for medical care and forensic evidence collection. Not only have victims had to wait for a long time to be examined, but those who perform the exams often lack training and experience in working with sexual assault victims and in gathering forensic evidence. The SANE program can be tailored to the needs of any locality or region to provide a victim-sensitive solution to systemic gaps in the medical-legal response to these victims.

Where they exist, SANE programs have made a profound difference in the quality of care provided to sexual assault victims. SANEs offer victims prompt, compassionate care and comprehensive forensic evidence collection. In addition to helping preserve the victim's dignity and reduce psychological trauma, SANE programs are enhancing evidence collection for more effective investigations and better prosecutions. Particularly in non-stranger sexual assault cases, thorough documentation of evidence corroborating a victim's account of an assault by establishing lack of consent has led to more successful prosecutions.

The Office for Victims of Crime (OVC) has provided strong leadership in promoting the development of SANE programs. Through OVC's funding and resources, the *SANE Development and Operation Guide* was created to assist communities in developing a SANE program, a Web site was established to offer information and technical assistance to SANEs, and

About This Bulletin

In 1997, OVC granted funding to the Sexual Assault Resource Service in Minneapolis to develop a practical "how-to guide," the *SANE Development and Operation Guide*, for starting and administering a SANE program. At that time, only 86 SANE programs existed in this country. Today, there are hundreds of these programs, and new ones are started every month. The OVC-funded *Guide* has been a valuable training and technical assistance tool, but 3 years later, we at OVC believed it was time to pause and take a look at the impact of SANE programs on victims of sexual assault, the practitioners who serve these victims, and their communities. It was time to check back with some of the older, established programs and the newer programs to find out what is working and why. Although most of the data reported in this bulletin are anecdotal, we believe it offers valuable insight into the difference that a SANE program makes to victims and their communities. In addition, as the number of SANE programs has grown, so have the information, technical assistance, and resources that are available to support these programs. This bulletin describes some of the resources that are available through the Office for Victims

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of Crime and other public and professional organizations.

Finally, with every success come new challenges. How can a SANE program find funding to sustain itself after its initial development? What is the role of the SANE within the framework of a sexual assault response team (SART)? What is involved in establishing SANE standards of practice, training, and certification? We believe the information and promising practices presented in this report will assist programs and communities as they address these and many other emerging issues.

One of the global challenges that OVC has embraced is to support, improve, and replicate promising practices in victims' rights and services. Our support of SANE programs moves us, and the field, closer to the goal of ensuring that every victim receives fundamental justice and needed services. In many ways, this bulletin is a salute to the field—to the SANEs and countless others in the victim advocacy, criminal justice, and medical fields who have embraced the SANE model and worked ceaselessly to bring SANE services to their communities.

regional workshops about how to start a SANE program have been presented. This bulletin provides information, ideas, and resources that will encourage individuals and agencies nationwide to explore the possibility of starting a SANE program in their areas.

Victim Benefits

One advocate contended that the SANE program was “the best development in victim services” that she had seen “in the last 10 years.”² SANE

programs address several problems in the medical-legal response to sexual assault victims in hospital emergency departments, including the following:

- Emergency department staff frequently regard the needs of sexual assault victims as less urgent than other patients because the majority of these victims do not sustain severe physical injuries.³
- Sexual assault victims often endure long waits in busy public areas (4- to 10-hour waits are not uncommon).
- Sexual assault victims often are not allowed to eat, drink, or urinate while they wait for a physician or nurse to conduct the evidentiary exam, to avoid destroying evidence.
- Physicians or nurses who perform evidentiary exams often have not been trained in forensic evidence collection procedures or do not perform these procedures frequently enough to maintain proficiency.
- Some physicians are reluctant to perform evidentiary exams because they know that they might be called from the hospital to testify in court and that their qualifications to conduct the exam might be questioned due to a lack of training and experience.
- Emergency department staff may not understand sexual assault victimization (e.g., they may blame victims for their assaults or may not believe a “real rape” occurred) and overlook the need to treat victims with sensitivity and respect.
- Emergency department staff may fail to gather and/or document all available forensic evidence, particularly in nonstranger cases.

With the advent of SANE programs, it became possible for sexual assault victims to consistently receive prompt and compassionate emergency care from medical professionals who understand victimization issues (e.g., SANEs recognize that the majority of victims are assaulted by intimate partners or acquaintances). A SANE can speed up the evidentiary examination process by reducing the time victims have to wait in a hospital's emergency department and the time it takes to complete the examination.⁴ The quality of the examination is usually improved because an experienced SANE is adept at identifying physical trauma and psychological needs, ensuring that victims receive appropriate medical care, knowing what evidence to look for and how to document injuries and other forensic evidence, and providing necessary referrals. Evidence collected by SANEs can help link the victim and suspect to the crime scene, indicate sexual penetration or activity, and establish lack of victim consent (e.g., bumps on the back of the head, abrasions on the back, and nongenital bruising). Establishing lack of consent is particularly important in the prosecution of nonstranger cases.

Recognizing the horror of sexual assault and the devastation it can cause victims and their significant others, SANEs ultimately strive to ensure that victims are not retraumatized by the evidentiary exam and to facilitate the healing process. SANE Program Director Jamie Ferrell, with the Sexual Assault Prevention and Crisis Services Division of the Texas Office of the Attorney General, remarked that “it's incredible to work with victims at possibly their lowest level of functioning and see them walk away with their heads held high.”⁵ SANE Coordinator Suzanne Brown, at Inova Fairfax Hospital in Fairfax, Virginia, noted that it was not uncommon for victims and their families to express

gratitude to SANEs for the caring and efficient treatment they provided. On the few cases she has worked where victims of repeat assaults had evidentiary exams performed at different times by non-SANEs and SANEs, the victims commented that they wished they had been treated by a SANE the first time.⁶

SANE Program Development

Nurses established the first SANE programs in the mid- to late 1970s, in Minneapolis, Minnesota; Memphis, Tennessee; and Amarillo, Texas. It was not until the late 1980s, however, that these programs came together with other groups to promote this role for nurses. By 1991, the *Journal of Emergency Nursing* reported on the existence of 20 SANE programs. SANE programs developed rapidly after the mid-1990s, as localities learned about the benefits SANEs offer. The *Journal of Emergency Nursing* noted that 86 SANE programs were known to exist by 1996. In 1997, the *SANE Development and Operation Guide* identified 116 programs. The *Guide's* author, Linda Ledray, estimated that more than 300 programs had been established by July 1999 and that the number is likely to expand much more rapidly in the years to come.⁷

SANE programs that are not listed in the *Guide* are urged to register on the Sexual Assault Resource Service Web site at www.sane-sart.com—the *Guide* can be viewed through the Web site.

SANEs are forensic nurses; however, not all forensic nurses are trained to be SANEs. Forensic nurses also conduct evidentiary exams in cases involving other types of interpersonal violence, public health and safety, emergencies or trauma, patient care facilities, and police and corrections custody abuse.⁸ To support their

work, SANEs and other forensic nurses have worked to build networking opportunities and to encourage the field to officially recognize the importance of forensic nursing. In 1992, representatives from 31 SANE programs from the United States and Canada met and founded the International Association of Forensic Nurses (IAFN). 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. The American Nurses Association (ANA) recognized forensic nursing as a specialty area in 1995.

Program Operation

While SANE programs may operate differently depending on factors such as community-specific coordinated response protocols and SANE program location, their primary function is to provide objective forensic evaluation of victims of sexual assault. SANEs have embraced the challenge to be technically skilled evidence collectors who display compassion and acknowledge the patient's dignity during every step of the examination.

Most SANE programs use a pool of SANEs who are on call 24 hours a day. The on-call SANE is paged whenever a sexual assault victim enters the community's response system⁹ and usually responds within 30 to 60 minutes.¹⁰ The SANE or other medical personnel (e.g., emergency department physicians or nurses) first assess the victim's need for emergency medical care and ensure that serious injuries are treated. After the victim's medical condition is stabilized or it is determined that immediate medical care is not required, the SANE can begin the evidentiary examination. During the course of exams, SANEs—

- Obtain information about the victim's pertinent health history and the crime.
- Assess psychological functioning sufficiently to determine whether the victim is suicidal and is oriented to person, place, and time.
- Perform a physical examination to inspect and evaluate the body of the victim (not a routine physical exam).
- Collect and preserve all evidence and document findings.
- Collect urine and blood samples and send them to designated laboratories for analysis in cases where drug-facilitated sexual assault is suspected.¹¹
- Treat and/or refer the victim for medical treatment (a SANE may treat minor injuries such as minor cuts and abrasions, but further evaluation and care of serious trauma is referred to a designated medical facility or physician).
- Provide the victim with prophylactic medications for the prevention of sexually transmitted diseases (STDs) and other care needed as a result of the crime.
- Provide the victim with referrals for medical and psychological care and support.

In many jurisdictions, community-based sexual assault victim advocates are involved in the initial medical-legal response to sexual assault victims. SANEs often collaborate with these advocates during examinations to ensure victims receive crisis intervention, help with safety planning prior to discharge, and referrals

for other types of assistance and ongoing support.

SANEs should interact with victims and their families in an objective and neutral manner that promotes informed decisions regarding evidence collection and available treatment options.¹² To facilitate decisionmaking, SANEs provide information regarding evidence collection procedures and reporting options. An exam is never done against the victim's will, no matter what age.¹³ SANEs release evidence to law enforcement agencies only with the victim's consent in cases where the victim has agreed to report or has already reported the crime. SANEs are mandated, however, to report to the proper authorities in cases of sexual assault of vulnerable adults (e.g., an older person dependent on a caregiver); sexual assault of minors by family members, caretakers, or persons in positions of authority over them; or sexual assaults of minors that were the result of parental neglect.¹⁴ Depending on state statutes and local enforcement policies, SANEs may or may not be mandated to report cases of statutory rape if adult perpetrators were not caretakers or were not in positions of authority over minors.¹⁵

In cases where victims are uncertain whether they want to report, the evidence can be collected and held in a locked refrigerator for a specified time, as mandated by state statutes. Victims should be informed of the time period in which they must decide how the evidence will be disposed if they choose not to report. If victims choose not to report and do not have evidence collected, the SANE ensures that they receive appropriate medical treatment and community referrals and are informed about advocacy services.

SANEs also conduct evidentiary examinations of suspects in sexual assault cases.

These exams are usually conducted at local law enforcement agencies or jails. Meticulously collected evidence in suspect exams can be invaluable in case investigation and prosecution because the evidence can corroborate the victim's account of the assault.

If the case goes to trial, SANEs may be asked to provide testimony about forensic evidence they collected during victim and suspect exams. They view testifying as an integral part of their job and will readily adjust their schedules to be in court as needed. Prior to testifying, they often communicate with prosecutors so that they are informed about the issues involved in the case.

Data Collection by SANE Programs

Because SANE programs follow cases from the initial evidence collection through prosecution, they often gather valuable data on the results of the evidence collected. Data can include information such as the likelihood of finding sperm at a specific site at a specific time and the likelihood of a sexual assault victim being injured during the assault.¹⁶ Such data can aid law enforcement and prosecution efforts. For example, the above information can help prosecutors who need to explain that the lack of injuries or the absence of sperm does not mean that a woman was not raped.¹⁷

Data that SANEs collect can also help build a more accurate picture of the nature of specific types of victimization (e.g., drug-facilitated assaults), victims' health care needs, and reasons why victims report or do not report to law enforcement.

The Memphis, Tennessee, Sexual Assault Resource Center has kept frequency data on cases since its inception 25 years ago. Recognizing the importance of this information to ongoing improvement in community response to victims, staff members (which include SANEs, legal advocates, and counselors) are involved in several collaborative research and data-sharing projects. Through a U.S. Department of Justice grant, a community task force is examining situations where adolescent girls are sexually assaulted by an acquaintance after getting into or being forced into the offender's vehicle. The purpose of the project is to identify risk factors and to develop interventions. Another research project through the University of Memphis, Center for Research on Women, is using center data to look more broadly at sexual assault victimization. Center staff members also participate in weekly multidisciplinary case reviews of child sexual abuse cases. The review meetings ensure that all investigative data on each case are considered and have facilitated more cases being accepted by prosecutors and more plea bargains.¹⁸

Given the recent emergence of SANE programs, it is important to gather qualitative and quantitative data to ensure the efficacy of the SANE evidence collection model and victim satisfaction with the quality of care and treatment received. Such data could be useful in garnering support to continue SANE programs and to facilitate ongoing improvements in the SANE response.

The Sexual Assault Resource Service (SARS), a SANE program based in Minneapolis, Minnesota, worked with the State Bureau of Criminal Apprehension in 1996 to complete an audit of rape kits sent to their laboratory for analysis from jurisdictions around the state. Of the 97 kits analyzed, SANEs from SARS completed 24 kits and non-SANEs completed

73 kits (SARS was the only SANE program in the state at the time). SANE kits were significantly more complete and better documented. They maintained the proper chain of evidence more consistently than kits completed by other nurses or physicians. Also, SANEs made no major errors that threatened the integrity of the evidence collected. Evidence from 13 of the 73 kits collected by non-SANEs, however, would not be admissible in court because it was impossible to identify the person who collected the evidence.¹⁹

In addition, SARS periodically conducts patient-satisfaction surveys in conjunction with other studies of treatment outcome. A 1996 study asked 34 patients to rate their satisfaction with the care they received by the police, hospital staff, and SANE on a 5-point Likert scale. The 29 patients (85 percent) who responded rated their satisfaction with the police at 3.4, with hospital staff at 4.0, and with SANEs at 4.4.²⁰

SANEs as Key Responders in a Coordinated Response

Successful SANE programs do not operate in isolation. They work closely with other members of the community sexual assault response system (e.g., advocates from sexual assault crisis centers, law enforcement officers, prosecutors, judges, other court personnel, forensic lab staff, victim/witness specialists based in justice system offices, and child protective services workers) to meet the multiple needs of victims and to hold offenders accountable for their crimes.²¹

Many communities have created multidisciplinary bodies, such as sexual assault response teams (SARTs), to oversee coordination and collaboration related

to immediate response to sexual assault cases, ensure a victim-centered approach to service delivery, and explore ways to prevent future victimization. In localities where SANE programs exist, SANEs must be integral in these community coordination efforts to facilitate comprehensive and effective response.

The SANE program in Madison, Wisconsin, is collaborating with law enforcement agencies, the prosecution office, and child protective services to develop a child-protection team to coordinate response in child sexual abuse cases. The goal is to conduct one videotaped interview with each child, involving all relevant case responders.²² SANEs will continue to conduct child medical-forensic exams at the hospital.

The SANE program in Monmouth County, New Jersey, as a SART member, works with the Women's Center of Monmouth County to educate high school-aged youth about the dangers of drugs used to facilitate sexual assault. These drugs are typically available at all-night "rave" parties.²³

The SART of Memphis, Tennessee, collaborated with the state department of health to develop voluntary standards for response to victims of sexual violence. The standards were developed for use by all counties in the state. They recommend collaboration among law enforcement officers, sexual assault victim advocates, and health care providers for a more systematic approach that ensures every victim in the state receives appropriate services.²⁴

SARTs and other multidisciplinary coordinating bodies can also play a critical role in developing SANE programs and in ensuring their continuance. For instance, part of the program implementation process should include training for

all those involved in the coordinated response to sexual assault cases. In addition to instructing them on revised coordination protocols, training can teach them how SANEs improve emergency victim care and forensic evidence collection and provide credible testimony in court.

The Nurse Examiner Program in Grand Rapids, Michigan, was developed by a multidisciplinary group coordinated through the YWCA sexual assault advocacy program. The group hired a consultant to conduct a feasibility study and formed a task force to implement the program. Chris Dunnuck, Coordinator of the Nurse Examiner Program, noted that the 3-year planning process was critical to overcome obstacles and ensure the program's financial security.²⁵

The Texas Attorney General's Office, the New Jersey Attorney General's Office, and the Colorado Coalition Against Sexual Assault require communities that apply for state funding for SANE training to demonstrate collaboration among agencies that interact with sexual assault victims. Texas also requests that local multidisciplinary teams form to oversee the implementation of their SANE programs.²⁶

Collaboration Between SANEs and Victim Advocates

Community-based sexual assault victim advocacy programs (often called rape or sexual assault crisis centers) have long pushed, at both local and state levels, to eliminate the wide variability in quality of emergency medical care and forensic evaluation for sexual assault victims. Recognizing that SANEs offer a solution to problems with

the medical-legal response, advocates from these programs are now leading efforts in many communities to promote the SANE model. Over time, strong alliances between advocates and SANEs have the potential to facilitate a comprehensive and timely community response to sexual assault that is truly victim centered.

Roles and Limitations

With the emergence of SANE programs in their communities, agencies involved in the community response system to sexual assault must work together to reexamine response protocols and revise them as necessary to ensure effective service delivery. In the course of successfully integrating SANE programs into response systems, some conflicts will arise. These issues must be resolved as early as possible to avoid power struggles. In particular, SANE coordinators and advocacy center directors may need to collaborate to identify past problems in coordinated medical-legal service delivery and areas where blurring of roles could occur. A few issues that should be considered are—

- **Shift in the advocate’s focus of attention.** The need for advocates to monitor the medical-forensic response is greatly diminished when SANEs are conducting evidentiary exams, because of their education, training, and experience. Trusting that SANEs will provide sensitive and competent care and forensic nursing evaluation, advocates can more fully concentrate on providing crisis counseling, emotional support, and information to victims and their families.
- **By profession, SANEs are not victim advocates.** SANEs support victims by providing caring, respectful, and efficient emergency medical-

legal treatment. Victim support provided by SANEs, however, is not a substitute for services offered by advocates. Staff from sexual assault advocacy programs have specialized training, experience, and access to program resources that allow them to address a wide range of victim needs during the emergency medical-legal process and beyond.²⁷

- **Victim use of advocacy services.** Although victims should decide for themselves whether they would like an advocate present during the exam, SANEs can inform victims of opportunities to use advocacy services and can explain the benefits of advocate assistance.
- **Clarification of responsibilities.** SANE programs and sexual assault crisis centers in the same locality may offer a few similar victim services during emergency medical-legal procedures, including crisis intervention or provision of information about reporting options. Agency directors should work together to clearly delineate separate functions, eliminate duplication, and/or determine the appropriateness of collaboratively delivering some services.
- **Support for SANE work.** When advocates provide emotional support for victims during exams, SANEs can more easily maintain a neutral and objective stance. Victims are usually able to talk with advocates in confidence,²⁸ whereas statements they make to SANEs may become part of the medical-forensic report that is passed on to detectives (if the case is reported).
- **Competency of volunteer advocates.** In addition to paid staff, many sexual assault crisis centers

use trained volunteers to provide advocacy services. Volunteers typically receive ongoing supervision from center staff. Any concerns that SANEs have about the quality of services provided by volunteers should be discussed with the local center director or designated contact person.

In Santa Fe, New Mexico, 4 SANEs, a small number of law enforcement officers and detectives, and a pool of 35 advocates respond to sexual assault calls at the hospital emergency department. While nurses and detectives have built good working relationships because they interact frequently, they may only work with each advocate once or twice. Sharon Moscinski, Advocacy Program Coordinator for Santa Fe Rape Crisis Center, Inc., is trying to determine how to better integrate advocates as members of the response team. She is considering one possibility that provides advanced training to a smaller pool of advocates who would respond solely to emergency department calls and function as short-term case managers. These advocates, who ideally would be paid, could help prevent survivors from falling through the cracks in the critical weeks following the assault. They would provide followup crisis intervention, referrals and information, assistance through the initial legal process, and followup with the application for victim compensation.²⁹

SANEs and advocates tend to agree that there is more than enough work for everyone involved in sexual assault victim response. By resolving differences, recognizing the benefits of working collaboratively, and clarifying roles, SANEs and advocates can support one another in their effort to serve victims. Agency-specific and joint trainings are invaluable tools in making sure advocates and SANEs understand each other’s roles and

limitations and avert problems in service delivery. Sara Donohue, Coordinator of the Sexual Assault Resource and Awareness Program in Alexandria, Virginia, also recommends that cooperative agreements be created to standardize response and build commitment of responding agencies to work together.³⁰

After attending a SANE training, Gail Hutchison, the Sexual Assault Services Coordinator for Virginians Aligned Against Sexual Assault in Charlottesville, Virginia, felt better prepared to support the development of SANE programs in localities across the state and to encourage collaboration among advocates, nurses, law enforcement officers, and prosecutors.³¹

Judy Castele, Associate Director of the Women's Resource Center of the New River Valley in Radford, Virginia, attended a SANE training about 4 years ago. Impressed by what she learned, she asked the trainers to present information on SANE programs to law enforcement officers, prosecutors, nurses, emergency room doctors, and other physicians in Radford. An enthusiastic response to the presentation led Castele to urge area hospitals to consider implementing a SANE program. One hospital agreed and subsequently involved Castele in the selection of the SANEs. Castele maintains regular communication with the SANEs and supports them in their work.³²

The Rape, Abuse and Incest National Network (RAINN) and the Santa Fe Rape Crisis Center, Inc., are in the process of surveying RAINN's member agencies (sexual assault crisis centers that take calls routed through the RAINN hotline) regarding the impact of SANE programs in their communities.³³ The Rape Crisis Center initiated, developed, and pilot tested the survey. RAINN will

provide the results of the survey to OVC, to be published on the SANE-SART Web site.

Impact on Law Enforcement and Prosecution

Law Enforcement

SANE programs "have taken response to sexual assault victims at the emergency department out of the dark ages," according to Mark Purcell, a detective with the Sex Crimes Unit of the Alexandria, Virginia, Police Department.³⁴ Purcell noted that SANEs present victims with a positive first impression of the community response system, increasing the likelihood that they will cooperate with law enforcement and prosecution. Officers know that victims are in good hands with SANEs because victims will be treated with kindness and respect. Officers also recognize the increased efficiency that SANEs bring to the evidentiary exam process, and as a result, the time they spend waiting for evidence and waiting to interview victims can often be greatly reduced.

Detectives realize that SANEs can contribute to investigations by providing meticulously collected forensic evidence and extensive documentation that complement crime scene evidence and witness statements. SANEs have greatly improved the quality and consistency of collected evidence, according to Pat Calhoun, a sergeant with the Sex Crimes Unit, Tulsa, Oklahoma, Police Department.³⁵ Pat Groot, with the National Alliance of Sexual Assault Coalitions, noted that because of their forensic expertise and access to equipment such as the colposcope and medscope, SANEs

may obtain evidence in cases involving acquaintance rapes and child sexual abuse that might have gone undetected with less experienced examiners.³⁶ Calhoun remarked that he finds it useful to compare the police report with the nurse's report—sometimes SANEs obtain new or different information. Since the Tulsa, Oklahoma, SANE program office is located at the police department, Calhoun said he counts on the SANE coordinator to answer questions he and other detectives may have about the exam and collected evidence. Ultimately, the work of SANEs increases the chance that law enforcement will be able to move a case forward to prosecution.

Prosecution

SANEs' thorough evidence collection, particularly evidence corroborating lack of consent, and SANE testimony have been critical in helping prosecutors obtain increased numbers of guilty pleas from defendants.³⁷ Recognizing the positive impact SANEs can have on outcomes in sexual assault cases, many local and state prosecution offices are supporting the implementation of SANE programs. In both New Jersey and Texas, for example, statewide efforts to develop SANE programs and SARTs are being led by the states' offices of the attorney general. Endorsement at this level encourages local prosecution offices and law enforcement agencies to support these initiatives.

Prosecutors have found SANEs to be credible witnesses in court as a result of their extensive experience and expertise in conducting evidentiary exams. The Director of a Wisconsin SANE program reported that during a 3¹/₂-year period, they had a 100-percent conviction rate in cases where a SANE testified at trial.³⁸ Patricia A. Smith, Coordinator of the SART/SANE program in Palmer, Alaska,

noted that SANEs also save money at prosecution because the strength of photographic evidence taken by SANEs promotes more plea bargains, thus saving the state the cost of a trial.³⁹

Sandra Sylvester, an assistant commonwealth attorney for Prince William County, Virginia, praised SANE programs in particular for their contributions to child sexual abuse cases. All pediatric SANE exams done in the county are referred to nearby Inova Fairfax Hospital. She said that with SANEs conducting pediatric evidentiary exams, children are less traumatized, evidence gathered has helped increase the number of pleas, and children often do not have to testify. Because the evidence SANEs collect can make a dramatic difference in whether a case gets prosecuted, Sylvester also would like to use forensic nursing in cases involving battered children.⁴⁰

Case Law⁴¹

With the growth of SANE programs throughout the country, court systems are processing greater numbers of cases of sexual assault in which the victim has undergone a forensic exam. As more of these cases go to trial and result in increased numbers of convictions, state and federal appellate courts are reviewing constitutional and evidentiary challenges by defendants. To date, these courts have rejected all defense challenges to convictions based on SANE testimony.

These appellate reviews include evaluating the qualifications of a SANE as an expert witness and analyzing the nature and scope of SANE forensic testimony (both fact and expert testimony). These cases may establish precedent on the weight and admissibility of forensic evidence collected and testimony given by SANEs in particular jurisdictions throughout the country. In turn, these

cases can help guide nurse examiners, prosecutors, defense attorneys, and courts.

For example, *Gonzalez v. State of Texas*, 1991 WL 67061 (Tex. App. Hous. (14 Dist.)), renders an analysis that a court may apply to qualify a SANE as an expert witness. Gonzalez was found guilty of sexual assault in a jury trial and sentenced to 50 years enhanced punishment. He asserted that he was deprived of effective assistance of counsel because his attorney failed to object to the qualifications of the SANE as an expert witness. Gonzalez asserted that the state failed to establish the SANE's qualifications as an expert witness as a predicate to her opinion testimony, and the failure of his counsel to object deprived him of his right to counsel. The Texas Court of Appeals, however, affirmed the conviction, recognizing the expert qualifications of the SANE, and ruled that the trial court properly admitted the opinion testimony.⁴²

Getting Started

OVC Support for Replicating SANE Programs

OVC has been an unwavering proponent of SANE programs. Its efforts to promote program development have focused primarily on the three projects described below. Through a competitive grant solicitation process, Dr. Linda Ledray, Director of the Sexual Assault Resource Service in Minneapolis, Minnesota, was selected by OVC to spearhead these initiatives.

SANE Development and Operation Guide

This publication, released in 1999, facilitates the development of SANE programs in communities across the country by providing comprehensive information based on the collective wisdom of those who have been operating SANE

programs. The *Guide* includes chapters on the history and development of SANE programs, the SANE program model, community approaches to sexual assault response, assessing the feasibility of a SANE program, funding information, program implementation, staffing information, training needs, program coverage and operation, pediatric SANE exams, policies and procedures, and maintaining a healthy program. The *Guide* offers invaluable detailed information not available from any other single source to those interested in starting a SANE program.

Web Site

The Sexual Assault Resource Service (SARS) Web site at www.sane-sart.com offers information and technical assistance to individuals and institutions interested in developing new SANE programs and improving existing ones. The goal of the Web site is to facilitate communication among SANE programs and provide them with resources to help them overcome obstacles. Features include a live chatroom (under construction), an online version of the *SANE Development and Operation Guide* that can be viewed or downloaded, information on upcoming related conferences and training programs, and information about starting a SANE program.

SANE programs can register at the Web site at no cost. If programs agree to provide case information, Web site staff will provide them with program data analysis and comparison data from other registered programs. Ledray is particularly interested in data collection on drug-facilitated sexual assaults.⁴³ By using the data collected through the Web site, she hopes to obtain a better estimate of the occurrence of suspected and confirmed drug-facilitated sexual assaults, in addition to data for the estimated timeframe for SANE collection of a urine specimen and results of the drug analysis.

Regional Workshops

To supplement the technical assistance available through the *Guide* and the Web site, OVC grant funding supported a series of regional workshops during 1998 and 1999 to SARTs interested in developing SANE programs. Ledray, Project Director, trained SARTs from at least three localities at each regional workshop. The workshops' purpose was to help SARTs evaluate the feasibility of a SANE program in their region, to consider how to develop a program that suits the needs of their community, and to brainstorm how to overcome obstacles. These workshops helped SARTs save time, money, and energy that otherwise would have been spent seeking out information and advice. Ultimately, the workshops can help regions more rapidly develop and implement successful SANE programs.

Since grant funding for these workshops has ended, OVC's Training and Technical Assistance Center (TTAC) will continue to assess community interest in developing SANE programs and will offer additional regional training and technical assistance. Contact information for TTAC is available in the Resources section of this bulletin.

Standards, Training, and Certification

Communities interested in starting a SANE program can benefit from the experiences of pioneers in the field who recognized the importance of providing quality medical care and forensic evaluation to every sexual assault victim, no matter the place, time, or circumstance. Based on their early experiences, standards of practice, training curricula, and training and certification requirements have developed.

Standards of Practice

Standards of practice have emerged to ensure that SANEs respond to the medical-legal needs of victims in a consistent and appropriate fashion. The SANE Council of IAFN adopted the first *SANE Standards of Practice* in 1996. Several states have or are in the process of developing state-specific SANE standards. For example, the Virginia State Council of Forensic Nurses created *Standards of Practice for SANEs* in 1997. These standards are based on the IAFN standards but address state policies and standards relevant to the operation of SANE programs in Virginia. Since there is no regulatory body for enforcement, programs are asked to voluntarily adhere to the standards.⁴⁴

Other states have incorporated SANE response into broad standards for the provision of comprehensive services to sexual assault victims. In New Jersey, for example, a multidisciplinary council coordinated through the Office of the Attorney General released *Standards for Providing Services to Survivors of Sexual Assault* in 1998. The protocols are geared to improve provision of information and services to victims; encourage coordination among service providers; enhance the collection, preservation, and transmission of forensic evidence; and contribute to the prosecution of sex crimes. The protocols recommended the development of standardized training and state standards for SANEs and SARTs and a certification process for SANEs in every county.⁴⁵

Training and Certification

SANEs require specialized training. Basic training programs typically consist of at least 40 hours of classroom instruction. Topics can include the definition of the SANE role, collection of evidence, testing and treatment of STDs, evaluation of other care needed, victim

responses and crisis intervention, assessment of injuries, documentation, courtroom testimony, corroborating with community agencies, competent completion of an exam, and forensic photography.⁴⁶ Some programs also specify a designated number of clinical hours to build SANE experience. Continuing education and competency requirements should be routinely met to maintain active SANE status.

IAFN recently published the *SANE Education Guidelines* to serve as a framework for the specialized training and education of SANEs. The document set forth a minimum level of required instruction. To further ensure consistency in practice and credibility in the courtroom, IAFN is also working to establish a national-level certification for SANEs. In the meantime, several states have developed state-level training programs and certification criteria.

In 1997, the Texas legislature passed a bill directing the Sexual Assault Prevention and Crisis Services Division of the state attorney general's office to adopt rules establishing minimum standards for SANE certification. Certification rules were not part of the bill and can be revised without legislative approval. Certification addresses "currency of practice," meaning the formal process by which training and continuing education and the number of exams performed per year by a SANE are documented. Nurses can seek adult and/or pediatric certification. Several prosecutors have asked their local SANEs how they can help them get certified, since it will further validate SANEs' education and currency of practice in court. A 56-hour SANE training, based on certification rules, is offered at no cost to local multidisciplinary teams willing to make the commitment to start a SANE program.

Nurses are expected to complete clinical hours and to begin program operation within 8 months of classroom training.⁴⁷

The Colorado Coalition Against Sexual Assault (CCASA) offers a 48-hour SANE training to nurses from communities in the state willing to develop a SANE site. Nurses are asked to contribute \$200 toward the training. Interested organizations or communities are asked to apply for training and provide victim-centered care in accordance with clinical and operational standards that have been developed by a multidisciplinary SANE advisory board. The CCASA SANE coordinator will also provide ongoing technical assistance to the sites (e.g., conducting site visits, providing ongoing education, developing evaluation tools, and facilitating networking among SANE programs).⁴⁸

The Wisconsin Coalition Against Sexual Assault is offering free SANE training in various regions of the state. Faculty members come from several Wisconsin SANE programs. Participation requires commitment by the sponsoring hospital or facility to start a SANE program.⁴⁹

Program Location

One of the basic decisions in establishing a new program is determining where it will be located. Considerations for site selection include safety and security for victims and staff, physical and psychological comfort of the victim, access to medical support services that provide care of injuries, access to a pharmacy or medication, access to laboratory services, and access to necessary supplies and equipment to complete an exam.⁵⁰ Rather than basing location decisions on what is convenient for service providers, SANE program planners should develop sites that meet the needs of victims in their community.

Addressing victim needs also requires that, regardless of the location of the program site, SANEs communicate and coordinate their efforts with others involved in the community response system (e.g., through active participation in sexual assault response teams).

Hospital-Based Exam Sites

The majority of SANE exam sites are located in hospital emergency departments. The emergency department offers a secure site, is open 24 hours a day, and provides access to a wide array of medical and support services.⁵¹ Physicians are available to treat victim injuries, and SANEs can conduct evidentiary exams and treat victims for STDs at the same location. Emergency department overhead and physician fees, however, can represent a sizable sum charged to victims, their insurance, SANE programs, or state compensation programs.⁵² To control these costs, some SANE programs have negotiated reasonable fees for use of the emergency department and the department's staff time.⁵³

The SANE program in Madison, Wisconsin, recently became a hospital-based program. The program was moved from the local YWCA to an office in the hospital emergency department where exams were already being performed. While the SANE program is still expected to seek outside funding, Coordinator Jill Poarch hopes that locating in the hospital will offer her program more financial security, a better clinical fit, and easier access to exam supplies and equipment.⁵⁴

SANE programs, like the one in Tulsa, Oklahoma, have opted to locate in hospital-based clinics designed specifically for sexual assault victims that are in close proximity to the emergency department for urgent care and other hospital services.

If victims in Tulsa do not require emergency department treatment, they generally do not have to register as hospital patients.⁵⁵

Other SANE programs perform exams at more than one hospital as well as in places other than hospitals including health departments, women's clinics, and morgues (in cases where the victim is deceased). SANEs may also conduct suspect exams at law enforcement agencies or jails. The SANEs in Minneapolis, Minnesota, go to eight local hospitals.⁵⁶ The SANE Program in Middlesex County, New Jersey, is based out of the county Health Department and uses public health nurses who are SANE trained.⁵⁷ Nurses from the Monmouth County, New Jersey, SANE Program conduct forensic examinations at three local hospital emergency departments. These three hospitals agreed to have expedited registration for sexual assault victims, private waiting areas, and exam rooms stocked with the necessary equipment and supplies.⁵⁸

Numerous programs that do hospital exams base their administrative offices at sites other than hospitals. The Monmouth County SANE program office is located in the prosecutor's office.⁵⁹ The Minneapolis program office is in a health center.⁶⁰ The Tulsa SANE program office is based in the police department.⁶¹

Those interested in starting hospital-based SANE sites should recognize that some hospitals may be reluctant to support such a program. For example, emergency department staff may be uncomfortable with the idea of working collaboratively with SANEs and allowing them to use their resources, particularly if SANEs are not hospital employees. To overcome resistance, planners can

establish dialogue with hospital administrators and emergency department physicians and nurses to explain the benefits of SANE programs, to identify potential problems, and to take action to resolve them. (See also the Funding Issues section of this bulletin for a discussion on building hospital financial support.)

Community-Based Exam Sites

Community-based programs typically offer victims more privacy than hospital exam sites and are not mandated to report felony crimes as hospitals are required to do in some states.⁶² Victims are usually not billed for medical care and services. A community-based program may be more committed to coordinating service provision with other members of the response team. For example, some SANE programs may be one component of a comprehensive response center for sexual assault victims.

The Sexual Assault Resource Center in Memphis, Tennessee, is a community-based program. It employs SANEs, legal advocates, and counselors. SANEs conduct forensic examinations. Legal advocates assist victims who are involved in the criminal justice system. Regardless of whether victims report the assaults to the police, counselors offer short- and long-term counseling. The Memphis Police Department lab is also located on the center's premises. All center staff members participate in weekly meetings to review cases.⁶³

Community-based programs, however, must tackle several difficult issues during the implementation process. Program developers should ensure that individuals with clinical backgrounds, preferably SANEs, administer their programs. They need to work with area hospital emergency departments to create protocols around timely evaluation and treatment

of victim injuries and for medication standing orders. Developers need to consider whether resources and budgets are sufficient to support their SANE programs. Developers also must confer with prosecutors to determine whether forensic evidence and SANE testimony could be perceived as being biased because of the location of the program and then must determine how to overcome this problem.

Val Sievers, SANE Coordinator for the Colorado Coalition Against Sexual Assault, noted that the SANE site requirements and practice standards typically have not been difficult for most hospital-based programs to apply. Hospitals function in accordance with standards of practice and have existing mechanisms for quality improvement, continuing education, and protocol development. In addition, hospital organizations that employ nurses have an understanding of professional licensure and scope of practice. Applying clinical and practice standards is often more challenging for community-based programs, which historically have not worked with licensed registered nurses and are not familiar with issues that influence nursing practice. In order for community-based programs to be successful, Sievers encourages them to work with nurses in their area to ensure that clinical issues are addressed.⁶⁴

The Grand Rapids, Michigan, SANE program is administratively and clinically located in a suite of rooms at the YWCA sexual assault advocacy center. To ensure that all sexual assault victims who go to local hospitals are offered SANE services, the SANE program developed a triage protocol with the hospitals and negotiated with two facilities to allow SANEs to do exams in their emergency departments in cases where victims sustain serious injuries.⁶⁵

Funding Issues

Funding is another important issue to address when considering the feasibility of a SANE program. Existing SANE programs demonstrate that it is possible to obtain needed funding with a sufficient commitment of time, research, fundraising, and creativity. Like many sexual assault crisis centers, SANE programs often must seek out a variety of funding sources to support their work. The sooner a SANE planning team begins to think about how it will cover program startup and ongoing operational costs, the quicker it can seek out assistance from potential partners and funders.

In 1997, a pilot SANE program and SART were implemented in Monmouth County, New Jersey, by the state attorney general's office.⁶⁶ The pilot provided an affordable way to introduce SANEs, evaluate benefits and obstacles, and create a model for statewide duplication.

SANE program startup costs include community and institutional needs assessments, facilities and utilities, office and exam supplies and equipment, staff advertising and selection, staff training, media promotion, and staff salaries for the first year.⁶⁷ Planning teams should be careful in estimating how many trained SANEs are needed to ensure that the program has the capacity to consistently and promptly respond to incoming calls on a 24-hour basis. Otherwise, the program will fail to significantly reduce medical-legal response time to sexual assaults.

Beyond the issue of securing funds for initial expenses, it is critical that planners also consider how the program will be sustained financially over the long term. Stable funding will allow SANE program coordinators to spend more time on day-to-day clinical operations and less time obtaining grants and donations.

Hospital Support

The local medical community is an obvious place to begin seeking financial support. Hospitals may be willing to donate space, supplies, and equipment and to help cover operating costs. Some hospital administrators, however, may be reluctant to develop new programs that they perceive will increase their costs and decrease profits. SANE program planners can help administrators understand how such a program can enhance hospital services in a more cost-effective manner. Part of this task involves revealing the hidden costs involved in treating sexual assault victims in the emergency department without a SANE program. Indirect and overhead costs include physician and nursing time to do the exam and testify in court, supplies, and staff training. It is also important to highlight the less tangible benefits of SANE programs. Planners should stress that not only do SANEs provide quality, patient-centered care, their services often enhance the hospital's reputation, allowing it to stand out among other local medical facilities. SANEs are also invaluable resources for hospital community outreach and education initiatives.⁶⁸

In 1996, The Urban Institute visited 12 states as part of its study of the STOP (Services*Training*Officers*Prosecutors) grant implementation process. It reported that forensic exams cost hospitals about \$800 when a physician conducts the exam and between \$200 and \$300 when a trained nurse, such as a SANE, conducts it.⁶⁹

Reimbursement for Services

Some SANE programs operate on fee-for-service reimbursement from the hospitals served, police department, or county prosecutor's office. They, or the hospital they contract with, are reimbursed for costs associated with forensic exams through funding from state victim

compensation programs, funded partially through the federal Victims of Crime Act (VOCA). Reimbursement varies tremendously from state to state. It is often limited to a set maximum dollar amount for each exam completed, ranging from as little as \$50 per exam to \$750 or more per exam. Compensation to the SANE program for exams often does not cover the majority of costs. Reimbursement gets complicated because only part of the procedure is forensic—it also entails medical components. Some states pay for evidence collection but not follow-up medical care.⁷⁰

Victim Assistance Funds

SANE programs are also encouraged to apply for state VOCA victim assistance grants. In making the decision about whether to fund SANE programs, state VOCA administrators should recognize that SANE programs address critical medical-legal needs of sexual assault victims. Federal final program guidelines for the VOCA Assistance Grant Program permit the use of these funds to purchase colposcopes, and several states have approved requests to purchase colposcopes using VOCA funds. For more information about VOCA funds, visit the OVC Web site at www.ojp.usdoj.gov/ovc.

Other Justice Department Resources

SANE programs may also be able to obtain funding through other U.S. Department of Justice grant projects, such as STOP grants of the Violence Against Women Act (VAWA) and the Edward Byrne Formula Grant Program. Call the U.S. Department of Justice Response Center at 1-800-421-6770 to be placed on their mailing lists to receive updated information on funding resources for violence against women programs.

Other Funding Sources

In addition to the U.S. Department of Justice, there is the potential for

funding from other federal and state agencies, private foundations, community foundations, grant-making public charities, individual donors, and fundraising campaigns. The Foundation Center provides a wide array of information on grant funding resources through its library holdings, publications, and online services. Visit its Web site at www.fdncenter.org.

Local hospitals may be willing to assume SANE program costs that exceed reimbursement for services from grants and donations, especially if the hospital administration understands that it is already assuming hidden costs associated with treating victims in a less efficient manner without SANEs. Community-based programs may have more difficulty absorbing costs because of limited resources and budgets.

Promising Practices

In addition to the innovative strategies being employed to encourage the development and success of SANE programs illustrated earlier in this bulletin, a number of “promising practices” are presented below.

Expanded Role for SANEs

Recognizing the vital service that SANEs provide in sexual assault cases, some hospitals, like St. Mary's Hospital in Richmond, Virginia, have expanded their SANEs' role to include conducting evidentiary exams on domestic violence victims, accident victims, and other populations where forensic evidence may be useful.⁷¹

Use of the Medscope as an Alternative to the Colposcope⁷²

A colposcope magnifies genital tissue and is an important asset for the identification of genital trauma. Photographic

equipment, both still and video, can be attached easily to the colposcope. In the legal arena, the use of the colposcope is well documented as an accepted practice in the examination of both child and adult sexual assault victims. The basic colposcope, without photographic equipment, costs between \$10,000 and \$15,000, although the price is falling as the technology becomes more available.

The medscope is an adapted dental camera and provides photographic documentation that has a greater depth of field than the colposcope and can be used to document injuries elsewhere on the body.⁷³ The complete medscope package is more affordable than the colposcope (\$3,500 for the basic model and \$11,500 including camera, internal lens, camera holder, monitor, printer, foot switch, VCR, and cart). Suzanne Brown, SANE Program Coordinator at Inova Fairfax Hospital, Virginia, noted that the medscope is portable and less cumbersome than the colposcope, is easier to operate, and takes digital prints instead of 35mm prints. Photographic images are taken using the foot instead of the hand, which frees the SANE's hands to conduct the exam and reduces the risk of contaminating the evidence. Digital images can be viewed on the monitor to make sure that they are well focused and clear whereas 35mm prints cannot be viewed prior to development. Digital prints, however, cannot be enlarged or reprinted like 35mm prints. The medscope does not have definite magnification ranges like the colposcope, but Brown indicated that the lack of this feature has not presented problems in court.

Uniform Statewide Colposcope and Forensic Equipment Protocols

New Jersey has recently implemented a statewide funding initiative to acquire identical, state-of-the-art forensic colposcope equipment for SANE programs

participating in a Statewide Sexual Assault Standards Project. The project provides a specially designed forensic colposcope to all exam sites that are part of SANE programs approved and funded by the State Office of Victim/Witness Advocacy. The initiative is designed to maximize the ability to collect competent forensic evidence while supporting the provision of sensitive victim-centered care to sexual assault victims. The equipment consists of a traditional binocular colposcope with an advanced digital image-capturing system to enable the examiner to see the image quality before capture to ensure that high-quality, accurate photographic documentation is part of every forensic examination. Specially designed software has been developed to ensure the highest quality of photo documentation, evidence preservation, and the usefulness of the images for trial.

One of the important aspects of this program involves protocols providing for the strict confidentiality of evidentiary photographs taken, especially photographs of genital injury. The protocols provide that the images are secured with the program and not routinely printed and produced with a patient's forensic file. This helps to reassure victims who may be reluctant to proceed and allows the assurance of confidentiality to victims. Additionally, the security level of the specially developed forensic photo documentation software program eliminates the need to capture facial photographs when there is no injury to that area. The specially designed software provides the ability to securely transmit data and images for child and adolescent forensic sexual assault evaluations. Finally, the design and purchase of specialized equipment on a statewide basis allows for considerable price reduction and improves resource allocation by providing colposcopes to programs with limited funds.

Regional Programs

A regional SANE program is an important alternative to each locality having its own program from a staff training and competency perspective. By serving a larger regional area, SANEs will most likely see more clients, and each SANE will be able to complete a sufficient number of exams to develop and maintain clinical competence. Regional programs may be the only cost-effective way to provide SANE services in rural and remote areas where no one medical facility sees large numbers of sexual assault cases.

When the SANE program of Inova Fairfax Hospital in Virginia began in 1990, it took only adult cases in Fairfax County. It gradually expanded to serve child victims and widened its service area, allowing nurses to increase proficiency because they had more cases. It now serves a region of 20 jurisdictions. While some of these jurisdictions have SANE programs that handle adult cases locally, they tend to refer their cases of child sexual assault to the Fairfax program.⁷⁴

The hospital-based SANE program in Bethel, Alaska, serves a remote region (three people per square mile) approximately the size of Oregon that is 400 miles from the state road system. Victims are transported by plane, boat, or snowmobile to the hospital. Between 130 and 150 exams are conducted each year.⁷⁵ The Matanuska-Susitna Valley SANE program is based at Valley Hospital in Palmer, Alaska, and serves a region the size of West Virginia. Since the region is on the road system, city police or Alaska State Troopers drive most clients to the SART center. The commute may take up to 3 hours. Since the SANEs from Palmer examine fewer than 50 cases per year, they are required to participate in case review meetings and to attend educational

programs to maintain proficiency as forensic examiners.⁷⁶

Child Sexual Abuse Diagnostic System

In rural or remote areas where SANEs may rarely see child victims, more experienced forensic examiners could assist SANEs in properly identifying and evaluating abnormalities. Better quality or more detailed evidence obtained through collaboration of numerous experienced clinicians could increase the likelihood of successful prosecution. The Fairfax, Virginia, SANE program is involved in a pilot project to develop a model regional diagnostic system for forensic examination of children who have been sexually abused. Using camera and computer-imaging equipment that is attached to the medscope, the nurse or physician conducting the forensic exam is able to immediately transmit photographic images of genital trauma to the computers of identified experts for their feedback during the examination. In addition to SANE programs, child advocacy center staff and pediatric emergency medicine specialists are participating in the project.⁷⁷ Although this model is still in the preliminary stages of development, it shows exciting promise. It has the potential to bring clinical expertise to every forensic evaluation of sexually abused children, regardless of the examination location.

Conclusion

SANE programs are emerging in small and large localities across the nation to improve the quality of sexual assault evidentiary exams. All adults and children who are sexually assaulted deserve to receive the prompt and compassionate emergency medical-forensic care that SANEs offer. Thorough evidence collection in each case opens the

door to the possibility of offender conviction. Where SANE programs do not exist, agencies involved in coordinated responses to sexual assault victims should not delay in considering implementing such a promising model in their community. The list of resources that follows this section may help communities organize a SANE program.

Resources

Organizations and Programs

Office for Victims of Crime

U.S. Department of Justice
810 Seventh Street NW.
Eighth Floor
Washington, DC 20531
202-307-5983
Fax: 202-514-6383
Web site: www.ojp.usdoj.gov/ovc

Violence Against Women Office

U.S. Department of Justice
810 Seventh Street NW.
Washington, DC 20531
202-307-6026
Fax: 202-305-2589
Web site: www.ojp.usdoj.gov/vawo

Office for Victims of Crime Training and Technical Assistance Center

2277 Research Boulevard
Rockville, MD 20850
1-800-627-6872
Fax: 301-519-5533
E-mail: TTAC@ovcttac.org

Office for Victims of Crime Resource Center

P.O. Box 6000
Rockville, MD 20849-6000
1-800-627-6872 or 301-519-5500
E-mail for print publication orders: puborder@ncjrs.org
E-mail for questions: askovc@ncjrs.org
Web site: www.ncjrs.org

Sexual Assault Resource Service (SARS)

Web site: www.sane-sart.com

International Association of Forensic Nurses

Web site: www.forensicnurse.org

National Alliance of Sexual Assault Coalitions

Web site: www.taasa.org/coalitions.htm

Rape, Abuse and Incest National Network (RAINN)

Web site: www.rainn.org

Publications, Curricula, and Videos

SANE Development and Operation Guide
Linda E. Ledray, Ph.D, R.N., F.A.A.N.;
Office for Victims of Crime (OVC),
Washington, D.C., 1999. Available on
the Internet at www.sane-sart.com,
through the OVC Web site at
www.ojp.usdoj.gov/ovc, or by contacting
the OVC Resource Center at
1-800-627-6872.

SANE Standards of Practice (1996) and
SANE Education Guidelines (1999)
International Association of Forensic
Nurses (IAFN). For more information on
these publications, contact IAFN at 6900
Grove Road, Thorofare, NJ 08086-9447,
or call 856-848-8356.

Standards for Providing Services to Survivors of Sexual Assault

State of New Jersey, 1998. On the
Web site of the Office of the Attorney
General, New Jersey Division of Crimi-
nal Justice, at [www.state.nj.us/1ps/dcj/
stand.htm](http://www.state.nj.us/1ps/dcj/stand.htm). Deputy Attorney General
James A. Gilson can also be contacted at
609-984-6500 for more information
about the standards.

Standards of Practice for SANEs
Virginia State Council of Forensic Nurses
Contact: Stacey Lasseter, R.N., M.S.N.,
Coordinator, Forensic Nurse Examiners
St. Mary's Hospital
5801 Bremono Road
Richmond, VA 23226
804-281-8574

SANE Currency of Practice Certification Rules
Texas Office of the Attorney General
Sexual Assault Prevention and Crisis
Services Division
Contact: Jo Halligan, C.T.S., Director of
Certification
P.O. Box 12548
Austin, TX 78711
512-936-1272
Fax: 512-936-1650

*Evaluation and Management of the Sexually
Assaulted or Sexually Abused Patient*
American College of Emergency
Physicians (ACEP)
P.O. Box 619911
Dallas, TX 75261-9911
1-800-798-1822
Fax: 972-580-2816
Web site: www.acep.org

This 134-page handbook, released in June 1999, covers topics including the development of a coordinated community response plan; the development of a SART; clinical evaluation and management of pediatric, adolescent, and adult patients who have been sexually assaulted or abused; forensic laboratory testing; development of a SANE program; bite mark guidelines; medical-legal photography; use of toluidine blue; and use of the colposcope. The document also addresses issues relating to STDs, HIV, and emergency treatment. The handbook may be ordered at no cost by calling ACEP (dial phone number, then dial 6) or by downloading the document from the ACEP Web site.

The Sexual Assault Examination: Essential Forensic Techniques
American Forensic Nurses
Faye Battiste-Otto, President and CEO
255 North El Cielo Road, Suite 195
Palm Springs, CA 92262
760-324-1121
Fax: 760-321-2750
Web site: www.amrn.com

The 1-hour video and accompanying training manual cover the following topics: role of SART members, including sexual assault crisis center advocates; role of forensic nurse examiners; the interview process; the medical-legal examination; forensic evidence collection and photography; chain of custody; and followup care. The video and manual can be purchased through the Internet or by phone for \$295.

Sexual Assault: The Health Care Response
Manfred Hochmeister, M.D., and Jamie
Ferrell, R.N., R.S.N.
Institute of Legal Medicine
University of Bern
Buehlstrasse 20, CH-3012
Switzerland
Fax: (0041) 011 31 31 631 84 15

The videotape, released in 1999, is a comprehensive guide to the forensic examination and evidence collection of adult female and male sexual assault clients. One version is available for medical personnel and another version for nonmedical personnel. The video, which costs \$95, can also be ordered directly from the IAFN Web site listed above or by calling 856-256-2425.

Video on the Tulsa SANE Program
Kathy Bell, Coordinator
Tulsa SANE Program
Tulsa Police Department
600 Civic Center
Tulsa, OK 74103
918-596-7608
Fax: 918-596-9330

This free 9-minute videotape provides an overview of the Tulsa, Oklahoma, SANE Program. It discusses sexual assault victims' experiences with the medical-legal system prior to the establishment of the program and how the SANE program improves system response to victims.

Prosecution of Rohypnol and GHB Related Sexual Assault Cases
American Prosecutors Research Institute
(APRI)
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
703-549-4253

This video and binder set was produced as part of the training series *Violence Against Women: The Prosecution of Sexual Assault Cases*. It addresses general characteristics of both drugs, offers investigative suggestions, and provides a checklist for possible charges in these cases. It can be purchased through APRI for \$30.

Contributors

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Mary Szaro, President, New Jersey Chapter of the Association of Forensic Nurses.

Alexandra Walker, Staff, An Agenda for the Nation on Violence Against Women, Center for Effective Public Policy, Silver Spring, MD.

Notes

1. Although the SANE Council of the International Association of Forensic Nurses (IAFN) decided in 1996 to use the title of sexual assault nurse examiner or SANE, different terminology has been used across the country because programs

developed independently. For the purposes of this bulletin, the term SANE is used.

2. Phone interview with Judy Castelee, Associate Director, Women's Resource Center of the New River Valley, Radford, VA, June 25, 1999.

3. Linda E. Ledray, *SANE Development and Operation Guide*, Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice, Washington, DC, 1999, p. 69. In a review of 372 hospital emergency department cases of sexual assault, 68 percent of the victims had no injuries, 26 percent had mild injuries, 5 percent had moderate injuries, and less than 1 percent were severely injured.

4. Linda E. Ledray and Kathy Simmelink, "Sexual Assault: Clinical Issues, Efficacy of SANE Evidence Collection, A Minnesota Study," *Journal of Emergency Nursing*, 23(1), 1997, p. 75.

5. Phone interview with Jamie Ferrell, SANE Program Director, Sexual Assault Prevention and Crisis Services Division, Office of the Attorney General, Austin, TX, July 5, 1999.

6. Phone interview with Suzanne Brown, SANE Coordinator, Inova Fairfax Hospital, Fairfax, VA, December 17, 1999.

7. Phone interview with Linda E. Ledray, Director, Sexual Assault Resource Service, Hennepin County Medical Center, Minneapolis, MN, July 2, 1999.

8. Information drawn from IAFN's Web site, June 1999.

9. Victims usually enter the system by calling law enforcement or the sexual assault crisis hotline or by going directly to the hospital emergency department or SANE facility.

10. An adequate number of SANEs should be available to promptly respond to calls and to handle multiple calls simultaneously.
11. For more information on drug-facilitated assaults, review the training materials produced by the American Prosecutors Research Institute on the prosecution of rohypnol- and GHB-related sexual assaults (see the publications list on page 15 of this bulletin).
12. IAFN, *SANE Standards of Practice*, 1996, p. 2.
13. Ledray, *SANE Development and Operation Guide*, p. 97. See pp. 97–99 for more information on consent, confidentiality, and reporting in cases involving minors.
14. *Ibid.*, p. 114. States have different laws regulating mandatory reporting for child sexual abuse, vulnerable adults, felony sexual assaults of adults, and statutory rape. It is important for SANEs to be aware of these laws and applicable federal laws.
15. *Ibid.*, p. 123–124.
16. *Ibid.*, p. 21.
17. *Ibid.*
18. Phone interviews with Pat Speck, Coordinator of Nursing Services, City of Memphis Sexual Assault Recovery Service, Memphis, TN, June 22, 1999, and Suzanna Parkinson, Coordinator, Rape Crisis Center, City of Memphis Sexual Assault Recovery Service, June 28, 1999.
19. Ledray and Simmelink, “Sexual Assault: Clinical Issues, Efficacy of SANE Evidence Collection, A Minnesota Study,” *Journal of Emergency Nursing*, 23(1), 1997 p. 77.
20. *Ibid.*, p. 76.
21. Other agencies that may be part of the response system include hospitals and other medical facilities; public health departments; mental health agencies; victim compensation offices; battered women’s programs; schools; organizations serving victims from underserved populations; social and human services; civic, faith-based, and neighborhood groups; youth organizations; and sex-offender management programs.
22. Phone interview with Jill Poarch, SANE Program Coordinator, Meriter Emergency Services, Madison, WI, July 5, 1999.
23. Phone interview with Eileen Allen, SANE Program Coordinator, Monmouth County Prosecutor’s Office, Freehold, NJ, June 22, 1999.
24. Phone conversation with Speck, September 13, 1999.
25. Phone interview with Chris Dunnuck, Coordinator, YWCA Nurse Examiner Program, Grand Rapids, MI, June 28, 1999.
26. Phone interviews with Cecelia McKenzie, Director, July 14, 1999, and Jamie Ferrell, July 5, 1999, Sexual Assault Prevention and Crisis Services Division, Office of the Attorney General, Austin, TX; James A. Gilson, Deputy Attorney General and Project Director, New Jersey Sexual Assault Standards Implementation Project; and Val Sievers, SANE Coordinator, Colorado Coalition Against Sexual Assault, CO, June 28, 1999.
27. Some communities may not have a sexual assault victim advocacy program. In these circumstances, SANEs should identify community resources that can help victims through this difficult period (e.g., 24-hour crisis lines, counseling services and support groups, programs that provide financial assistance, and victim/witness programs that guide victims in the justice system). They can also encourage the community to develop an advocacy program with a medical-legal advocacy component.
28. Most community-based sexual assault advocacy programs have internal confidentiality policies that prohibit advocates from disclosing information about victims to third parties without victim consent—a protection based on state statute in some states. If victims oppose sharing requested information, advocates typically will contest attempts to obtain their records. If a subpoena is upheld despite challenges, however, an advocate must disclose the requested information or risk being held in contempt of court. (Exceptions to these policies include cases of sexual assaults of vulnerable adults; sexual assaults of minors perpetrated by family members, caretakers, or persons in positions of authority over them; and sexual assaults of minors that are the result of parental neglect. Confidentiality is also limited in cases with clients who indicate that they are in imminent danger of serious harm to themselves or others.)
29. Phone interview with Sharon Moscinski, Advocacy Program Coordinator, Santa Fe Rape Crisis Center, Inc., Santa Fe, NM, June 25, 1999.
30. Phone interview with Sara Donohue, June 25, 1999.
31. Phone interview with Gail Hutchison, Sexual Assault Services Coordinator, Virginians Aligned Against Sexual Assault, Charlottesville, VA, June 17, 1999.

32. Phone interview with Castele, June 25, 1999.
33. Phone interviews with Debbie Andrews, Executive Director, Rape, Abuse and Incest National Network, Washington, DC, June 24, 1999, and Moscinski, June 25, 1999.
34. Phone interview with Mark Purcell, Detective, Sex Crimes Unit, Alexandria, VA, Police Department, June 24, 1999. Purcell works with the SANE program at Inova Fairfax Hospital in Fairfax, VA.
35. Phone interview with Pat Calhoun, Sergeant, Sex Crimes Unit, Tulsa, OK, Police Department, June 25, 1999. Additional comments by Calhoun in this paragraph come from the interview.
36. Phone interview with Pat Groot, Co-Chair, National Alliance of Sexual Assault Coalitions, Charlottesville, VA, June 29, 1999.
37. Ledray, *SANE Development and Operation Guide*, p. 22.
38. Ledray and Simmelink, "Sexual Assault: Clinical Issues, Efficacy of SANE Evidence Collection, A Minnesota Study," *Journal of Emergency Nursing*, 23(1), 1997, p. 76.
39. Phone interview with Patricia A. Smith of the Matanuska-Susitna Valley Sexual Assault Response Team, Palmer, AK, June 25, 1999.
40. Phone interview with Sandra Sylvester, Assistant Commonwealth's Attorney, Office of the Commonwealth's Attorney, Prince William County, Manassas, VA, June 1999.
41. James A. Gilson, Deputy Attorney General, New Jersey Division of Criminal Justice, Trenton, NJ, provided the information for this section on case law.
42. An upcoming OVC bulletin will further explore case law pertaining to SANE testimony.
43. Phone interview with Ledray, July 2, 1999.
44. Phone interview with Stacey Lasseter, Coordinator, Forensic Nurse Examiners, St. Mary's Hospital, Richmond, VA, June 24, 1999.
45. Phone interview with Gilson, June 23, 1999.
46. Ledray, *SANE Development and Operation Guide*, p. 50.
47. Phone interviews with McKenzie, July 14, 1999, and Ferrell, July 5, 1999.
48. Phone interview with Sievers, June 28, 1999.
49. Phone interview with Poarch, July 5, 1999.
50. Ledray, *SANE Development and Operation Guide*, pp. 35–36.
51. Ledray, "Sexual Assault: Clinical Issues, SANE Program Locations Pros and Cons," *Journal of Emergency Nursing*, 23(2), 1997, p. 183.
52. Ledray, *SANE Development and Operation Guide*, p. 38.
53. *Ibid.*, p. 39.
54. Phone interview with Poarch, July 5, 1999.
55. Phone interview with Kathy Bell, Coordinator, SANE Program, Tulsa Police Department, June 23, 1999.
56. Phone interview with Ledray, July 2, 1999.
57. Communications with Mary Szaro, President, New Jersey Chapter of the Association of Forensic Nurses.
58. Phone interview with Allen, June 22, 1999.
59. *Ibid.*
60. Phone interview with Ledray, July 2, 1999.
61. Phone interview with Bell, June 23, 1999.
62. Ledray, *SANE Development and Operation Guide*, p. 38.
63. Phone interviews with Speck, June 22, 1999, and Parkinson, June 28, 1999.
64. Phone interview with Sievers, June 28, 1999.
65. Phone interview with Dunnuck, June 28, 1999.
66. Phone interview with Allen, June 22, 1999.
67. Ledray, *SANE Development and Operation Guide*, p. 26.
68. *Ibid.*, p. 25.
69. *Ibid.*, p. 32.
70. *Ibid.* In these cases, medical facilities may then either cover the remaining costs or attempt to bill the victim for any additional medical services.
71. Phone interview with Lasseter, June 24, 1999.
72. This section was drawn from a phone interview with Brown, June 23, 1999.
73. Communication between D. McDonald, Inova Fairfax Hospital, Fairfax, VA, and Ledray, September 5,

1997. Information from Ledray, *SANE Development and Operation Guide*, p. 101.

74. Phone interview with Brown, June 23, 1999.

75. Phone interview with Carol Odinzoff, Nurse Coordinator, SART Unit, Bethel, AK, June 28, 1999.

76. Phone interview with Smith, June 25, 1999.

77. Phone interview with Brown, June 23, 1999.

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