

Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient

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This publication has been produced by the American College of Emergency Physicians under its contract 98-0347(P) with the US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient

This document was created under the leadership of the American College of Emergency Physicians (ACEP). The intent was to prepare a set of useful and practical recommendations that will standardize the evaluation and management of sexual assault patients. The following individuals participated in this process. The organizations they represent are identified. ACEP extends its greatest appreciation to each of these individuals as well as the organizations they represent for participating in this extremely important project.

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Overview

Preface

To minimize unnecessary variations in care, the American College of Emergency Physicians (ACEP), in concert with a broad range of clinical, legal, forensic, judicial, advocate, and other organizations, has developed the following consensus approach to assist in the care of the patient with the complaint of sexual assault or sexual abuse (Module–Methodology of Developing this Handbook).

Introduction

The evaluation of the sexually assaulted or abused patient is a challenge for health care professionals, particularly for the patient with developmental issues such as cognitive impairment or young age. Appropriate management of the patient requires a standardized clinical evaluation, an effective interface with law enforcement for the handling of forensic evidence, and coordination of the continuum of care with a community plan. Appropriate management of the sexually assaulted patient requires the clinician to address the medical and emotional needs of the patient while addressing the forensic requirements of the criminal justice system. Medical issues include acute injuries and evaluation of potential sexually transmitted disease and pregnancy. Emotional needs include acute crisis intervention and referral for appropriate follow-up counseling. Forensic tasks include thorough documentation of pertinent historical and physical findings, proper collection and handling of evidence, and presentation of findings and conclusions in court.

How to use this document

This handbook has been written to provide a consensus-based set of recommendations. When possible, evidence-based recommendations are incorporated. The main document contains the core elements. Modules are attached that provide additional information and instructional guidance in greater detail. Appropriate portions of the handbook should be adapted to the circumstances of the individual community consistent with federal, state, and local laws.

Definitions

For this handbook, **sexual assault** is defined as the sexual contact of one person with another without appropriate legal consent. This definition includes, but is not limited to, the range of behavior classified by state and federal law as rape, sexual abuse, and sexual misconduct (Module–Your State/Local Laws). Practitioners should refer to their state statutes for precise definitions of these terms in their particular jurisdictions.

Vulnerable target populations for sexual assault include children, adolescents, elders, developmentally delayed persons, patients with physical and/or mental impairments, and persons under the influence of drugs or alcohol. Persons in these groups may become involved in unlawful sexual activities because they do not understand what is happening, or they may lack the ability to give informed consent. **Sexual abuse** is often used as a term for the sexual assault of children and adolescents.

Development of a Community Response Plan

Sexual assault is a serious societal problem that creates significant challenges to local communities as they attempt to create an overall plan for meeting the medical, emotional, physical safety, and legal needs of the patient. Well-planned multidisciplinary community response plans have been demonstrated to be cost effective while diminishing further harm to the patient and providing comprehensive care (Module–Societal Costs of Sexual Assault). Sexual assault response/resource teams (SARTs) have also enhanced public safety by increasing public awareness, increasing reporting, and facilitating investigation.

Many different organizations and public agencies are crucial participants in an effective community-based sexual assault response plan. Key participants include, but are not limited to, medical and nursing

personnel, patient advocates, college and school administrators, prosecutors, protective services personnel, law enforcement personnel, and forensic scientists (Module–Coordinated Community Response Plan). The SART creates a plan that addresses issues pertaining to the immediate response to sexual assault, but this is only the first step (Module–SART Development). Additional resources and planning for overall patient care, safety, and patient well-being are necessary. Each community will need to consider options that work best for their setting, geography, and local resources.

At a minimum, professionals caring for sexual assault patients should be proficient in the core content of the evaluation and management of cases of sexual assault (Module–Core Content of Knowledge for Community Response Workers). The responsibilities and activities of each portion of the community plan should be clearly identified (Modules–Victim-Centered Responsibilities Matrix; Federal Funding and Violence Against Women Grant Information).

Clinical Considerations

Identification of sexual assault or sexual abuse

Identification of sexual assault is often difficult for many reasons. The sexually assaulted or abused patient often delays seeking medical evaluation due to feelings of shame, fear, or lack of understanding that they are victims of a crime. Delayed reporting may also result from the effect of drugs and/or alcohol ingested during a substance-facilitated sexual assault. Recent studies suggest that the majority of sexual assaults are perpetrated by acquaintances, not strangers, so emphasis must be given to documenting injuries that reflect lack of consent. Sexual assault by a person known to the patient tends to be underreported (Module–Issues of Sexual Assault by a Person Known to the Patient). Adults who are sexually assaulted may seek medical care out of fear of infection or pregnancy. Alternatively, the adult patient may have nonspecific symptoms, such as sleep disturbance, nightmares, emotional lability, fatigue, self-blame, shame, fear, or sexual dysfunction. Children who are sexually assaulted or abused may display variable nonspecific symptoms and/or physical findings. Children who are sexually abused most often delay reporting, do not willingly disclose the abuse, and if the incident is disclosed, facts are often incomplete or conflicting (Module–Pediatric/Adolescent Patient).

Recent sexual assault is usually defined as within 72 hours. However, this interval may be extended as technology such as DNA analysis advances (Module–Forensic Laboratory Testing). Because some drugs can be found in the serum up to 1 week after ingestion, for the patient with drug-facilitated rape, the collection of evidence can be performed up to 96 hours. If the patient is in the out-of-hospital setting and the sexual assault is recent, the patient should be encouraged to go immediately to the emergency department, local rape crisis center, or other designated facility suitable for an evidentiary examination to collect physical evidence. The patient should be instructed to not engage in activities that may destroy important evidence that can be used to identify the perpetrator, such as urinating, defecating, vomiting, douching, removing/inserting a tampon, wiping/cleaning genital area, bathing, showering, gargling, brushing teeth, smoking, eating, drinking, chewing gum, changing clothes, or taking medications. Nonevidentiary examinations may or may not be emergent. Non-emergent cases may be referred to appropriate local resources for collection of appropriate evidence or for follow-up care once the patient's immediate needs are met.

Clinical evaluation (Modules–Pediatric/Adolescent Patient; and Adult/Adolescent Patient)

Policies and procedures for the evaluation and management of the patient with the complaint of sexual assault should be established by all sexual assault evaluation facilities (Module–References). Sexual assault nurse examiner (SANE) programs are an excellent option for acute and chronic sexual assault evaluations, because they standardize the sexual assault evaluation and collection of evidence (Module–SANE Development and Operation Guide). Special attention and supervision must be provided if resident physicians are involved in sexual assault evaluations to best ensure timely, efficient, and standardized

treatment. Standardized programs that include a competency assessment (reviewing local, legal, clinical, and follow-up issues) should be established in training institutions and should include a minimum number of supervised examinations (Module–Minimum Core Content).

If present, life-threatening injuries must be treated first. The lack of physical injury does not necessarily indicate consensual sexual contact. Once stabilized, the patient should be placed into a private room as soon as possible. A specially trained individual who can provide crisis intervention, such as a rape crisis advocate, mental health professional, social worker, or pastoral caregiver, should be available for emotional support. If desired by the patient, a friend or relative may be present. Throughout the encounter, privacy, safety, and confidentiality must be ensured (Module–Confidentiality). Ideally, the information in the medical record should be available to outside authorities only with the consent of the patient. However, disclosure of the medical record may be mandated by law in some jurisdictions.

In most states, the sexually assaulted patient is not required to report the assault to law enforcement authorities. In contrast, in many states, medical personnel are required by law to report all cases of sexual assault. Most states mandate the reporting of sexual abuse of children to police or to the child protection agency. However, in many jurisdictions, police coordinate and oversee the collection of evidence. Thus, if they determine that sexual assault has not occurred or if the patient is uncertain about pressing charges, no evidence is collected.

Informed consent or refusal should be obtained for each of the following components of the sexual assault evaluation.

- Medical evaluation and treatment
- Reporting the crime
- Performing a physical examination
- Photodocumentation
- Evidence collection: The patient has the right to decline the collection of any and all specimens. However, to give the patient the ability to make an informed decision, it is important to explain to the patient that this is the only time to gather certain forensic evidence
- Transferal of evidence to law enforcement personnel

In many jurisdictions, hospitals are not required by law to perform examinations on suspected perpetrators without a court order or alternative means of legally mandating such an examination. Persons placed under arrest do not have the right to refuse an examination for the collection of evidence if the officer has a court order. Because states vary in requirements, check your local statutes.

In pediatric cases, check local and state laws regarding obtaining parental consent to provide treatment. In some states, if parental abuse is suspected (e.g., the child is brought by a child care worker or teacher) the examination may be performed without parental consent.

Determination of consent to perform a sexual act is a legal principle and therefore not part of the assessment. One of the fundamental tenets of the forensic examination is objectivity. The goal of a forensic examination is to comprehensively and objectively document all findings.

History (Modules–Pediatric/Adolescent Patient; and Adult/Adolescent Patient)

Whenever possible, use open-ended (nonleading) questions and encourage free narrative. Special care is needed in obtaining the history of the pediatric patient (Module–Pediatric/Adolescent Patient). Document the following:

1. Specifics of the incident: Document direct quotes from the patient describing the incident
 - a. Time, date, and place of the sexual assault or abuse

- b. The patient's ability to give consent to the reported sexual activity
 - c. Use of force, threats of force, weapons, coercion, or drugs and/or alcohol to facilitate sexual assault
 - d. Types or means of assault
 - e. The occurrence of penetration of any body part with a penis or other object
 - f. Did the patient urinate, defecate, vomit, douche, remove/insert a tampon, wipe/clean the genital area, bathe, shower, gargle, brush teeth, smoke, eat, drink, chew gum, change clothes, or take medications after the incident?
 - g. Did the patient bite the perpetrator, or was the patient bitten?
2. Medical history
 - a. Allergies
 - b. Medications
 - c. Immunizations
 - d. Past medical history
 3. Additional pertinent history
 - a. Use of contraceptives and what type
 - b. Last menstrual period
 - c. Last voluntary intercourse
 - d. Is the patient pregnant?
 - e. Recent anogenital surgery

Physical examination: The examiner should prevent cross-contamination of evidence by changing gloves whenever cross-contamination could occur. Clearly document all findings.

1. Before the patient undresses, place a clean hospital sheet on the floor to be a barrier for the collection paper (Module–Adult/Adolescent Patient).
2. Allow the patient to remove and place each piece of clothing being collected in a separate paper bag. Handle all clothing with gloved hands to prevent contamination of evidence (Module–Adult/Adolescent Patient).
3. Simultaneously identify the presence of any physical injury, biological evidence, or foreign debris, but **do not disturb**.
4. Recover any trace evidence, including sand, soil, leaves, grass, and biological secretions. Note the body location of the collection. Identify moist secretions.
5. Note all injuries by documenting the location, size, and complete description of any trauma, including bite marks, strangulation, or areas of point tenderness, especially those occurring around the mouth, breasts, thighs, wrists, upper arms, legs, back, and anogenital region (Module–Bite Mark Guidelines).
6. Perform appropriate photodocumentation of collection sites before collection, as well as of other suspect areas (Module–Medicolegal Photography in Sexual Assault).
7. Recover moist secretions with a dry swab. Look for areas of debris and dried secretions on the skin; flake them off onto folded paper. Recover any remaining material on these areas with a swab moistened with one drop of water (tap water is acceptable).
8. Document the Tanner Stage of the patient and describe the level of physical maturity (Module–Pediatric/Adolescent Patient).
9. Follow the sexual assault evidence collection instructions (Module–Adult/Adolescent Patient).
 - Toluidine blue dye may be used to identify minor external genital and anal injuries, but it may cause discomfort (burning) in prepubertal children (Module–Use of Toluidine Blue).
 - When the vaginal examination is performed, the speculum should be lubricated with tap water because other lubricants may affect test results and decrease sperm motility. A vaginal speculum is never used in prepubertal children without general anesthesia.

- When drug/alcohol-facilitated sexual assault is suspected, blood and/or urine should be collected.¹
- If alcohol was ingested, use the law enforcement blood alcohol collection kit or collect three fluoride (gray top) tubes. Check with local law enforcement for the kit.
- If a drug was ingested within 36 hours of examination, collect three full fluoride (gray top) tubes of blood and 100 ml of nonprepped, first-void urine. If a drug was ingested more than 36 hours before the examination, collect 100 ml of nonprepped, first-void urine. Do NOT place urine or blood in the sexual assault kit. Package each item separately, label and seal, and initial each package.
- A colposcope may be used as an adjunctive examination tool. Anogenital examination findings are enhanced through illumination, magnification, and photodocumentation (Module–Use of Colposcope).
- The collection of known samples (standards) from the patient may be indicated (buccal smear, blood, or hair). Depending on laboratory preferences, these samples can be collected later.

Hospital Laboratory and Radiographic Data

Consider tests that are appropriate for a given patient:

1. Serum or urine pregnancy test.
2. Cultures and syphilis testing: In cases where prophylaxis will be given and chronic abuse is not suspected, cultures and syphilis testing are not necessary. This area is very controversial (Module–Adult/Adolescent Patient).
3. Hepatitis B surface antibody: To check for the immune status in the previously immunized patient. Hepatitis B testing is not indicated in the nonimmunized patient (Module–Sexually Transmitted Disease in Adult and Child Patients Who Have Been Sexually Assaulted/Abused).
4. Laboratory and radiographic studies as indicated.
5. HIV counseling and follow-up testing (Module–Human Immunodeficiency Virus). Referral is strongly encouraged. Patients may be referred to a center that provides confidential counseling and testing or to the primary care provider within 72 hours of the exposure to establish the HIV status at the time of the assault or abuse.

Chain of Evidence/Chain of Custody

Note: If the urine sample is not officially part of the rape kit, take special caution to maintain the chain of evidence.

Document all historical and physical findings. Properly seal and initial all specimens and label with:

- Hospital name, patient name, and patient identification number
- Date and time of collection of evidence
- Description and location of the body part of origin of the evidence
- Name and signature of the person collecting the evidence

All transfers of custody of evidence must be accountable by keeping a written record of:

- Name and signature of the person receiving the evidence
- Date and time of the transfer

1. LeBeau M, Andollo W, Hearn WL, et al. Recommendations for toxicological investigations of drug-facilitated sexual assaults. *J Forensic Sci* 1999;44(1)227-230.

Medical treatment

Consider offering the following interventions depending on the circumstances:

1. Antibiotic prophylaxis for sexually transmitted diseases (Modules–Sexually Transmitted Disease in Adult and Child Patients Who Have Been Sexually Assaulted/Abused; and Pediatric/Adolescent Patient).
2. Hepatitis B immunization is indicated if the patient has not been previously immunized (Modules–Sexually Transmitted Disease in Adult and Child Patients Who Have Been Sexually Assaulted/Abused; and Pediatric/Adolescent Patient).
3. HIV prophylaxis based on risk assessment of exposure (Module–Human Immunodeficiency Virus)
4. Pregnancy prevention (Module–Emergency Pregnancy Prophylaxis).

Coordination of Care

1. The patient should be given referrals to local resources for follow-up counseling and advocate services (Module–State Sexual Assault Coalitions).
2. The patient should be referred for follow-up examinations in 2 weeks, 3 months, and 6 months for evaluation of pregnancy and sexually transmitted diseases (Module–Sexually Transmitted Disease in Adult and Child Patients Who Have Been Sexually Assaulted/Abused).
3. Provide written documentation to the patient of tests performed, treatment received, follow-up appointments, community resources, and what to expect in terms of test results and the legal process.

Methodology of Developing this Handbook

1. Background

- Building on the commitment of ACEP to address violence and its impact on health
- Building on ACEP's commitment for the primary prevention of violence
- An ACEP Council Resolution was adopted
- ACEP Board voted to support the resolution and financing
- ACEP developed the Task Force/Subcommittee of Emergency Medicine Practice Committee to develop National Protocols for Care of the Sexual Assault Patient.

2. Purpose/Mission/Vision

- Improve the response to the sexually assaulted patient
- Increase community and health care provider awareness
- Improve quality of patient care
- Reduce unnecessary variations in care
- Attempt to create a consensus on core content of care
- Foster interdisciplinary communication and coordination of care
- Use the expertise of the Task Force/Subcommittee in evaluating the latest information and technology

3. Sponsor/Funding

- ACEP provides support and coordination
- The Department of Health and Human Services, Maternal and Child Health Bureau, EMS-C Program provides funding

4. Participating Organizations

- American Academy of Pediatrics
- American College of Emergency Physicians
- American College of Obstetricians and Gynecologists
- American Medical Association
- American Prosecutors Research Institute
- American Psychological Association
- American Society of Crime Laboratory Directors
- Centers for Disease Control and Prevention
- Emergency Nurses Association
- Federal Bureau of Investigation
- International Association of Chiefs of Police
- International Association of Forensic Nurses
- National Alliance of Sexual Assault Coalitions
- National Network Childrens Advocacy Center
- Public Health Service/Office on Women's Health
- STOP Violence Against Women Grants Technical Assistance Project

Methodology of Developing this Handbook

5. Process

- Invitations were extended to key organizations
- Individuals met at a face-to-face meeting
- Three subgroups were identified
- Members individually reviewed pertinent medical literature provided by committee members
- Members reviewed existing sexual assault protocols
- Subgroups conducted much of their work through regularly scheduled conference calls and by e-mail
- At a second face-to-face meeting, the entire draft document was reviewed
- A consensus was reached with input from all organizational representatives during the above processes

6. Secondary Review

- Secondary reviewers were chosen based on recommendations of members of the group
- An attempt was made to include a wide range of practice types and locations
- An attempt was made to include major organizations that interface on the subject

Your State/Local Laws

Please gather information regarding your state and local laws and insert it under this tab:

The following agencies can be a source of obtaining your state and local laws:²

1. Local police department
2. Local sheriff's department
3. Department of public safety
4. Local district attorneys office
5. Local protective and regulatory agency
6. State attorney general's office
7. State protective and regulatory agency (family code for children, disabled, and elderly)
8. National Association of Attorneys General (NAAG): www.naag.org

2. Code of criminal procedures, penal code, and family code pertaining to sexual assault or abuse.

Societal Costs of Sexual Assault

Rape in the United States	
Patient Cost	
• Productivity	\$ 2,200
• Medical care	500
• Mental healthcare	2,200
• Police/fire services	37
• Social/victim services	27
• Property loss/damage	100
• Quality of life	81,400
Total (per patient)	<hr/> \$ 86,464

Source: Miller, Cohen, Weirsema. Victim Costs and Consequences: A New Look. National Institute of Justice, January 1996.

Although placing a dollar value on the suffering that results from sexual violence may seem cold and impersonal, such information is useful in the public policy arena. Overall, rape has the highest annual victim costs at \$127 billion per year (excluding child sexual abuse), and is much higher than other crimes. Crimes impose different kinds of losses on both victims and society. Costs to society include expenses to the criminal justice system; social costs associated with fear of crime; and private security expenditures. Society also directly bears the costs of crime, which are reimbursed by insurance coverage. To the victims, many of the costs are nonmonetary losses, such as fear, pain, suffering, and lost quality of life.

The establishment of a victim-focused multidisciplinary, multiagency approach to the treatment and evaluation of victims of sexual violence can help to minimize the physical and psychological trauma sustained by these victims. Programs embracing a team approach to sexual assault exist across the country. Research indicates these programs contribute to: (a) increased reporting in the community; (b) improved quality of evidence collected; (c) decreased waiting time for the victims to be examined; and (d) an increase in the cases settled by plea bargaining.

Coordinated Community Response Plan

Coordinated Community Response

Coordinated community response (CCR) may be defined as a community plan that incorporates all aspects of sexual assault response, often beginning with the SART and moving on to post-event needs such as victim safety and well-being, and effective criminal prosecution of perpetrators. A CCR must be configured to meet the needs of the area it serves. Any organization or agency with an interest or a responsibility for sexual assault victims or for the successful prosecution of sexual assault victims should be considered for membership in the CCR group or its subordinate advisory committee.

Group members may include support organization representatives as well as individuals who have relevant expertise or experience. The formation of advisory committees may be useful to provide the CCR group with unique insights into the problems of a specific victim population such as individuals with disabilities or gay and lesbian sexual assault victims. An advisory committee can also provide guidance in such areas as dealing with the media or drawing on the resources available through religious institutions, computer technology, or other medical service areas.

Responsibilities of Community Response

- **Education:** Educate the general public about sexual assault, with a focus on how males can prevent sexual assault, how females and males can reduce their risk of sexual assault, and the existence of available services for survivors.
- **Training and Technical Assistance:** Assist all involved sexual assault response professionals to treat survivors from all backgrounds with compassion and respect.
- **Protocol Development:** Establish procedures through which all involved agencies are accountable for their participation in the CCR.
- **Services:** Ensure that survivors of all backgrounds, sexual orientations, and cultures have access to services that include a minimum of 24-hour crisis intervention, short-term counseling, and advocacy in legal, medical, and other systems.
- **Public Policy Advocacy:** Work toward policy and legislative changes to eliminate sexual assault, ensure justice and safety for survivors, and hold offenders accountable. This includes the amending of state statutes, protocols, or memoranda of understanding to best protect the needs and rights of survivors of sexual assault.
- **Dissemination of Materials:** Develop and distribute materials tailored to different cultural/language/religious groups with the goal of making the general public aware of available services.
- **Evaluation:** Assess the community response, including the effectiveness of the SART, by soliciting input from survivors and reviewing data, with the goal of improving the existing systems. This helps communities to identify the strengths and weaknesses of their particular sexual assault response plan.

Who should be involved in a coordinated committee response?

Coordinated community response teams should be multidisciplinary and multiagency. The team may be composed of the following groups or organizations:

- Victim advocates
 - Community-based rape crisis center
 - Court-based (prosecutor's office)
 - Office for victim compensation
 - State sexual assault coalition

Coordinated Community Response Plan

- Survivors
- Health care workers: physicians, registered nurses, SANEs, and forensic odontologists
- Law enforcement personnel: municipal, county, state, and federal levels
- Prosecutors: city and state prosecutors, US attorneys
- Judiciary personnel
- Defense attorneys (both public and private)
- Forensic laboratory personnel (including toxicologists and pharmacologists)
- Corrections/probation personnel
- Sex offender treatment providers
- Mental health organizations
- Educators
 - College, high school or elementary school because of statistically high risk of age group³
 - Medical schools and nursing organizations, emergency medical services organizations, physician assistants, nurse practitioners
- Legislators and government policy makers
 - State/municipal legislators
 - Public health agency
 - Criminal justice agency
- Other groups
 - Members of community hospital associations
 - Religious leaders
 - Racial and cultural groups in community
 - Organizations that assist runaways
 - Media and business community
 - Specialty groups, including senior citizens and the disabled (mental, physical)
 - Commission on Women

3. In the Rape in America study conducted in 1992 by the Crime Victims Research and Treatment Center, the majority of rapes (32%) reported by participants surveyed occurred when they were between the ages of 11 and 17, and 22% occurred when the victim was between the ages of 18 and 24.

SART Development

Sexual Assault Response/Resource Team Development

What persons and agencies should be members of a SART?

Ideally, core **SART** members consist of:

1. **Sexual Assault Forensic Examiners:** A registered professional nurse, physician, or forensic odontologist licensed in the state who has successfully completed a course of training in the performance of evidentiary examinations
2. **Law Enforcement Officers**
3. **Patient Advocates**
4. **Prosecutors**
5. **Forensic Laboratory Personnel**

Once the key players have been identified and are involved, the following items will need to be addressed:

- Medical facility (facilities) that will participate in the SART process
- Resources and equipment that will be needed by the SART team members (i.e., standardized evidence collection kits, ultraviolet light source, camera, colposcope)
- Identification of available state and local funding sources
- Assessment of other SART or SANE programs in your state and across the country that currently exist in other jurisdictions

Initial Assessment of the Current Situation

It is important that the involved parties critically evaluate the current response to sexual assault patients before initiating a new program. Important factors to consider include:

- Comparison of crime statistics within the community as captured by the various represented agencies (this will capture both sexual assaults reported to law enforcement and those *not* reported)
- Consideration of the adequacy of policies and protocols pertaining to each aspect of the existing response plan
- Review of feedback from survivors about their experiences and satisfaction with the response by police, advocates, and medical providers
- Review of specific problems or systemic breakdowns that have occurred
- Assessment of the capacity of each discipline to support a coordinated response
- Assessment of the effectiveness of the current response to patients of underserved populations or in certain types of cases (i.e., nonstranger versus stranger assaults)
- Assessment of the adequacy of agency and multidisciplinary training and resource materials
- Assessment of the adequacy of medical facilities
- Review of current mechanisms to communicate, monitor cases, and problem solve among the agencies

How does a SART process facilitate the immediate response to sexual assault situations?

As noted above, sexual assault forensic examiners, law enforcement officers, and patient advocates are participants in the immediate response team, or SART. At a minimum, the SART process should ensure the coordination of the following activities:

- Contact with each team member to alert him or her to the need for services (i.e., the 911 operator calls the police officer, the officer calls the hospital and on-call staff, and hospital staff calls the advocate)
- Patient transportation to and from the medical facilities in a timely manner
- Prompt response of the team to patient
- Initial communication between the members to share case information and determine evidence collection needs, address special concerns, and reduce the need to duplicate questions
- Patient interviews with police and medical personnel
- Medical examination and forensic evidence collection
- Provision of support, information, and materials to the patient, plus assistance with safety planning
- Patient accompaniment by other support person during interviews, medical examination, and evidence collection should be considered with the consent of the patient and the health care provider
- Communication among the involved SART members at the close of the examination to discuss follow-up concerns and action plans and findings
- Provision of clothing and toiletries for the patient
- Transportation of patient to a safe place
- Support and information to the patient's significant others, as appropriate
- Proper and timely storage and delivery of forensic evidence
- Contact with other SART members (judiciary personnel and forensic laboratory personnel) to discuss their involvement in the case
- Follow-up contact and assistance to the patient
- Trouble shooting on specific issues (e.g., crime victim compensation)
- Communication on individual case progress and the overall effectiveness of the SART process
- The patient typically reports to hospital, where process is begun

An example of a SART process

- With permission of the adult patient, law enforcement is notified of the sexual assault. After the response of law enforcement, the SART process is initiated.
- The SANE and SART advocates are advised of the sexual assaults.
- The forensic examination process begins.
- The patient advocate provides hospital accompaniment and gives referrals for community resources, crisis counseling, and patient-witness assistance.
- Initial closure is completed between hospital staff and patrol officer or detectives.
- Disposition of evidence is made to appropriate agencies.
- The case is referred for investigation.
- Depending on case facts, the investigation is referred to the district or city attorney's office.
- Judicial proceedings begin.

Keys to keeping the system working

In addition to working toward constant improvement in responses to individual patients, coordinators of the SART should undertake any necessary ongoing steps to refine and change the system:

- Develop multidisciplinary/multiagency protocols that define the roles and responsibilities of the members and that support the SART function
- Initiate training, supervision, and professional development of team members
- Develop forms/checklists to standardize documentation, evidence collection, and patient notification of rights
- Create mechanisms to increase communication among agencies during the immediate response
- Develop mechanisms to promote monitoring and problem solving in individual cases
- Create brochures and written materials for the community and patients to explain the SART process (written in understandable terms and in multiple languages)
- Effect specialized outreach programs to encourage patients from underserved populations to seek SART services
- Provide mechanisms to build professional and public support for the SART to increase patient referrals
- Create a mechanism to obtain patient feedback to evaluate SART process effectiveness
- Develop patient assistance programs beyond the immediate response

Core Content of Knowledge for Community Response Workers

- **Education**: Educate the general public about sexual assault, with a focus on how males can prevent sexual assault, how females and males can reduce their risk of sexual assault, and about the existence of available services for survivors.
- **Training and Technical Assistance**: Assist all involved sexual assault response professionals in treating survivors from all backgrounds with compassion and respect.
- **Protocol Development**: Establish procedures through which all involved agencies are accountable for their participation in the Coordinated Community Response (CCR) plan.
- **Services**: Ensure that survivors of all backgrounds, sexual orientations, and cultures have access to services that include a minimum of 24-hour crisis intervention, short-term counseling, and advocacy in legal, medical, and other systems.
- **Public Policy Advocacy**: Work toward policy and legislative changes to eliminate sexual assault, ensure justice and safety for survivors, and hold offenders accountable. This includes the amending of state statutes, protocols, or memoranda of understanding to best protect the needs and rights of survivors of sexual assault.
- **Dissemination of Materials**: Develop and distribute materials tailored to different cultural/language/religious groups with the goal of making the general public aware of available services.
- **Evaluation**: Assess the community response, including the effectiveness of the sexual assault resource/response team (SART), by soliciting input from survivors and reviewing data, with the goal being to improve the existing systems. This helps communities to identify the strengths and weaknesses of their particular sexual assault response plan.

Victim-Centered Responsibilities Matrix

CRITICAL ELEMENTS FOR SEXUAL ASSAULT CRIME RESPONSE									
<p style="text-align: center; margin: 0;"><u>INSTRUCTIONS</u></p> <ol style="list-style-type: none"> 1. Place a “P” in the column where the <u>primary</u> responsibility exists. 2. Place a check mark (✓) under any other column that may share or possess follow-up responsibility. 3. If you have a critical element that is not being adequately addressed or inherently causes problems, or you would like to more fully discuss this element, place an asterisk (*) in the “problem area” column. 	A	M	L	P	V	C	C	P	
	D	E	A	R	I	O	C	O	R
	V	I	C	I	S	T	E	I	R
	O	C	C	E	I	M	S	C	O
	C	A	N	F	U	T	W	T	I
	A	T	L	O	R	O	I	O	N
	T	E	F	O	R	C	E	M	S
	E		M	E	N	T			
Receive Victim Report of Sexual Assault									
9-1-1/police department									
Rape crisis									
Third party reporting: friends, schools, etc.									
Hospital emergency department									
Prosecutor’s office									
First Responder									
Ensure safety									
Educate on options: reporting, care, legal									
Determine need/willingness for emergency medical care									
Arrange transportation to/from hospital									
Advise victim of evidence preservation steps									
Determine if assailant is still nearby									
Determine if victim wants crisis counseling									
Determine if victim wants victim assistance									
Work with secondary victims									
Medical Intake									
Record victim’s statement/condition accurately									
Determine extent of injuries requiring medical attention									
Inform victim about evidence collection procedures and receive authorization									
Determine if victim wants advocate support during examination									
Forensic Examination									
Collect and preserve evidence in accord with established protocol: rape kit									
Provide clothing at hospital									

CRITICAL ELEMENTS FOR SEXUAL ASSAULT CRIME RESPONSE						
INSTRUCTIONS	A	M	P	V	C	P
	D	L	R	C	O	R
	V	E	I	O	R	O
	O	A	S	S	T	R
	C	C	E	E	R	E
	A	E	I	M	S	L
	T	L	F	C		E
	E	O	U	T		M
		R	W	O		A
		C	I	R		R
		E	N	T		E
		M	E	S		S
		E	N	S		A
Minimize patient discomfort						
Medical Concerns Related to Sexual Assault						
Pregnancy						
Sexually transmitted diseases (STDs)						
HIV/AIDS						
Administer pregnancy prevention treatment with consent						
Administer prophylactic treatment for STD with consent						
Obtain blood sample for HIV baseline status with consent						
Referral for further medical care						
Referral for psychological counseling						
Review financial issues (victim's compensation, etc.)						
Initial Interview						
Determine interview information needed						
Develop strategy to avoid multiple interviews						
Ask victim preference of interviewer gender						
Determine if victim requires interpreter						
Provide comfortable, private setting for interview						
Determine if victim wants to file a complaint and move toward prosecution						
Investigation						
Provide private setting for interview						
Determine location of crime						
Crime scene/victim evidence: fingerprints, trace evidence, photographs, clothing, sheets, etc.						
Search warrants						
Suspect kit						
Keep victim informed of case status						

CRITICAL ELEMENTS FOR SEXUAL ASSAULT CRIME RESPONSE							
<u>INSTRUCTIONS</u>	A D V O C A T E	M L D E A D W I C E A N F O R C E M E N T	P R I S T E I M S	V I C T I M S	C O U R T S	C O R R E C T I O N S	P R O B L E M A R E A
1. Place a "P" in the column where the <u>primary</u> responsibility exists.							
2. Place a check mark (√) under any other column that may share or possess follow-up responsibility.							
3. If you have a critical element that is not being adequately addressed or inherently causes problems, or you would like to more fully discuss this element, place an asterisk (*) in the "problem area" column.							
Address victim's concerns of safety							
Arrestment/initial appearance							
Notify victim of time and place of hearing							
Discuss desired conditions of release with victim before bail hearing							
Request any release on bail include protection orders for victim							
Pretrial							
Inform victim of pretrial hearings/motions							
Include victim's participation in all hearings in which defendant has a right to be present							
Consider needs of victim in scheduling proceedings							
Plea Negotiations							
Inform victim of reasons to consider a negotiated plea							
Describe optional courses of action							
Determine what action the victim wants to take							
Consider the needs of the victim in accepting a plea							
Sentencing							
Ensure opportunity for victim impact statement as part of sentence considerations							
Include victim needs as part of sentence (i.e. restitution, protection, emotional security)							
Incarceration							
Notify victim about changes in offender status							
Notify victim of scheduled parole hearings							
Provide opportunity for victim testimony at parole hearings							
Notify victim of release and status of release (i.e. parole, discharge, etc.)							

Adapted from: Looking back, moving forward: A program for communities responding to sexual assault. National Center for Victims of Crime, 1992.

**Federal Funding and Violence Against Women:
A Guide to Programs Which May be Used to Address Domestic Violence, Sexual Assault, or Stalking**

Revised 1/99

*Initially prepared by Mary B. Malefyt, Esq. for the STOP Violence Against Women Grants Technical Assistance Project.
Updated by Carmen Rivera, Esq. for the National Resource Center on Domestic Violence. Call NRC Information Line (800-537-2238) for additional materials.*

Grant Programs Created or Enhanced by the Violence Against Women Act				
Grant	Administering Agency	Purposes	Eligibility	Amounts
STOP Violence Against Women Formula Grants STOP = <ul style="list-style-type: none"> •services •training •officers •prosecutors 	Violence Against Women Grants Office, Office of Justice Programs, U.S. Dept. of Justice, 810 7th St., N.W., Washington, D.C. 20531 Contact: Roberta Valente at (202) 616-3580 Fax: (202) 305-2589 www.ojp.usdoj.gov/vawgo	The purpose of the STOP Grants program is to promote a coordinated, multidisciplinary approach to improving the criminal justice system's response to violence against women by assisting States, Indian Tribal Governments, and units of local government develop and strengthen effective law enforcement and prosecution strategies to combat violent crimes against women, and to develop and strengthen victim services in cases involving crimes against women. Emphasis is placed on the criminal justice system and victim services working together to establish a coordinated response to violence against women.	Funds are limited to all States, Territories, and the District of Columbia. Funds may be further subgranted to units of local government, non-profit non-governmental victim services programs, and Indian Tribal Governments.	FY95 appropriation: \$26 million FY96 appropriation: \$130 million FY97 appropriation: \$145 million FY98 appropriation: \$172 million, inc. \$12 million for a civil legal assistance program and \$7 million for research and evaluation. FY99 appropriation: \$206 million
Rural Domestic Violence and Child Victimization Enforcement Grant Program	Violence Against Women Grants Office, Office of Justice Programs, U.S. Dept. of Justice, 810 7th St., N.W., Washington, D.C. 20531 Contact: Jacqueline Agtuca at (202) 307-6026	The Rural Grants program supports collaborative ways to improve victims safety and access to services and is intended to implement, expand, and establish cooperative efforts and projects between law enforcement officers, prosecutors, victim advocacy groups, and other related parties to investigate and prosecute crimes of domestic violence and child abuse; provide treatment and counseling to victims of domestic violence and child abuse; and work in cooperation with the community to develop education and prevention strategies directed at these issues.	All States, Indian Tribal Governments, as well as local governments and public and private entities in rural states; rural and/or non-rural States may submit joint applications for projects to be implemented in more than one State; Indian Tribal Governments individually, as consortiums, or on behalf of non-Indian governmental orgs.	FY96 appropriation: \$7 million FY97 appropriation: \$8 million FY98 appropriation: \$25 million FY99 appropriation: \$25 million

**Updated by the National Resource Center on Domestic Violence (1/99)
800-537-2238 TTY 800-553-2508**

Grant Programs Created or Enhanced by the Violence Against Women Act (continued)

Grant	Administering Agency	Purposes	Eligibility	Amounts
Grants to Encourage Arrest Policies	<p>Violence Against Women Grants Office, Office of Justice Programs, U.S. Dept. of Justice, 810 7th St., N.W., Washington, D.C. 20531</p> <p>Contact: Nadine Neufville or Catherine Pierce at (202) 307-6026</p> <p>Fax: (202) 305-2589</p> <p>www.ojp.usdoj.gov/vawgo</p>	<p>The purpose of this grant program is to encourage jurisdictions to implement mandatory arrest or pro-arrest policies as an effective intervention to domestic violence, including mandatory arrest programs and policies for protection order violations; to develop strategies between probation/parole and police departments to improve tracking of cases involving domestic violence; to coordinate computer tracking systems to ensure communication between police, prosecutors, and both criminal and family courts; to strengthen legal advocacy service programs for victims of domestic violence; and to educate judges in criminal, tribal, and other courts about domestic violence and to improve judicial handling of these cases; and to centralize and coordinate police enforcement in groups or units of police officers, prosecutors, or judges.</p>	<p>Eligible applicants include States, Indian Tribal Governments, and units of local government.</p>	<p>FY95: no appropriation</p> <p>FY96 appropriation: \$28 million</p> <p>FY97 appropriation: \$33 million (123 grants awarded in FY97)</p> <p>FY98 appropriation: \$59 million</p> <p>FY99 appropriation: \$34 million</p>
Violence Against Women Discretionary Grants for Indian Tribal Gov'ts (STOP Violence Against Indian Women Grants)	<p>Violence Against Women Grants Office, Office of Justice Programs, U.S. Dept. of Justice, 810 7th St., N.W., Washington, D.C. 20531</p> <p>Contact: Jacqueline Agtuca or Terri Henry at (202) 307-6026</p> <p>Fax: (202) 305-2589</p> <p>www.ojp.usdoj.gov/vawgo</p>	<p>The purpose of this discretionary grant program is to assist Indian Tribal Governments in developing and strengthening effective law enforcement and prosecution strategies to combat violent crimes against Indian/Native American women, and to develop and strengthen victim services in cases involving crimes against Indian/Native American women.</p> <p>Indian Tribal Government not entitled to funds unless it incurs the full out-of-pocket costs of forensic medical examination for victims of sexual assault.</p> <p>NOTE: The annual funding level for this program is set at 4% of the funding level appropriated for the STOP Grants program.</p>	<p>Three categories of eligible recipients are:</p> <p>(1) the 14 Tribal Governments selected for funding in FY95 with supplemental awards in FY96;</p> <p>(2) the 23 Tribes which applied and did not receive funding in FY96;</p> <p>(3) VAWGO will reach out to the 381 federally recognized Tribes that have not yet applied for funding.</p> <p>The 53 Tribes that received initial funding in FY96 will be eligible to receive continuation funding in FY98.</p>	<p>FY95 appropriation: 14 awards totaling \$1,021,594</p> <p>FY96 appropriation: 68 awards totaling approximately \$4.6 million</p> <p>FY97 appropriation: \$5.8 million</p> <p>FY98 appropriation: \$6.8 million</p> <p>FY99 appropriation: \$8.27 million</p>

Grant Programs Created or Enhanced by the Violence Against Women Act (continued)

Grant	Administering Agency	Purposes	Eligibility	Amounts
Domestic Violence Civil Legal Assistance Grants (1998)	<p>Violence Against Women Grants Office, Office of Justice Programs, U.S. Dept. of Justice, 810 7th St., N.W., Washington, D.C. 20531</p> <p>Contact: Roberta Valente at (202) 616-3580</p> <p>Fax: (202) 305-2589</p> <p>www.ojp.usdoj.gov/vawgo</p>	<p>The Domestic Violence Victims' Civil Legal Assistance Discretionary Grant Program is designed to strengthen civil legal assistance for victims of domestic violence. The core components of projects sponsored by this grant program include training, mentoring and collaborative relationships. Funds may be used to support or provide direct legal services on behalf of victims of domestic violence in civil matters directly related to domestic violence, including but not limited to protection orders, divorce, support, custody, housing, employment, and benefits. Legal services organizations applying for funding through this program are encouraged to formally collaborate with domestic violence victim advocacy groups within the community to develop and implement a civil legal services program.</p>	<p>Eligible applicants include law schools and non-profit organizations, either public or private, that support or provide direct legal services to domestic violence victims; such entities as law school legal clinics, legal aid or legal services programs, shelter and advocacy programs for battered women; and Bar Associations.</p>	<p>FY98 appropriation: \$12 million These funds are part of the \$172 million authorized for the STOP Violence against Women Formula Grants</p> <p>FY99 appropriation: \$23 million</p>
Violence Against Women Grants Office Technical Assistance Program	<p>Violence Against Women Grants Office, Office of Justice Programs, U.S. Dept. of Justice, 810 7th St., N.W., Washington, D.C. 20531</p> <p>Contact: Stephanie Condon or Catherine Pierce at: (202) 307-6026</p> <p>Fax: (202) 305-2589</p> <p>www.ojp.usdoj.gov/vawgo</p>	<p>The Violence Against Women Grants Office administers four major grant programs, the STOP Violence Against Women Formula Grants, The Grants to Encourage Arrest Policies, the Rural Domestic Violence and Child Victimization Enforcement Grants, and STOP Violence Against Indian Women grants. VAWGO funds a range of national technical assistance projects to support the activities of its grantees under these programs. In addition, TA projects designed to support the professional development of victim advocates and criminal and civil justice system personnel, including judges, will be supported. Finally, technical assistance projects focusing on special issues, such as the enforcement of intrastate, interstate, and tribal protection orders, initiatives addressing the needs of diverse and often underserved populations, business partnerships, collaboration between domestic violence/child protection/criminal justice agencies, and others will be supported.</p>	<p>Eligible applicants are public or private, non-profit victim advocacy organizations, national criminal justice constituency organization, judicial organization or other agencies expertise in the technical assistance categories or subcategories described in the program announcement.</p>	<p>FY98 appropriation: \$9 million</p> <p>FY99 appropriation: Technical Assistance funds are already committed. Additional funds may become available in FY2000.</p>

Grant Programs Created or Enhanced by the Violence Against Women Act (continued)

Grant	Administering Agency	Purposes	Eligibility	Amounts
Family Violence Prevention and Services: Grants to States and Indian Tribes	Office of Community Services, Administration for Children and Families, Dept. of Health and Human Services, 370 L'Enfant Promenade, S.W., 5th Flr., Washington, D.C. 20447 Contact: James Gray at (202) 401-5705 or William Riley at (202) 401-5529	These funds are used by States for grants to local public agencies and non-profit private organizations to prevent incidents of family violence and to provide immediate shelter and related assistance to victims of family violence. States must give special emphasis to the support of community-based projects of demonstrated effectiveness carried out by non-profit organizations, particularly those projects for which the primary purpose is to operate shelters for victims of family violence, and those which provide counseling, advocacy, and self-help services to victims and their children.	All 50 States are eligible, as well as the District of Columbia, Puerto Rico, Guam, American Samoa, the Virgin Islands, Northern Mariana Islands, Palau, and certain federally recognized Tribes. Each state has a designated agency administering these funds.	FY97: States and Territories: \$50.96 million Tribes and Tribal Organizations: \$7.28 million FY98 appropriation: States: \$60.76 million Tribes: \$8.68 million FY99 appropriation: States: \$62.16 million Tribes: \$8.88 million
Family Violence Prevention and Services: Grants to State Domestic Violence Coalitions	Office of Community Services, Administration for Children and Families, Dept. of Health and Human Services 370 L'Enfant Promenade, S.W., Washington, D.C. 20447 Contact: James Gray at (202) 401-5705 or William Riley at (202) 401-5529	The purpose of this program is to provide funding for state domestic violence coalitions. State domestic violence coalitions may be engaged in a range of activities that further the purposes of domestic violence intervention and prevention including: working with local domestic violence programs, judicial and law enforcement agencies and other direct service providers to encourage appropriate responses to domestic violence, implementing public education campaigns regarding domestic violence through the use of PSAs and other vehicles of information including information aimed at underserved populations, and participating in planning and monitoring the distribution of Family Violence Prevention and Services grants and grant funds.	Eligible applicants must be statewide non-profit State Domestic Violence Coalitions.	FY97 appropriation: \$7.28 million FY98 authorization: \$8.68 million FY99 appropriation: \$8.88 million These funding levels represent 10% of the total appropriation for grant programs authorized under the Family Violence Prevention and Services Act.

Grant Programs Created or Enhanced by the Violence Against Women Act (continued)

Grant	Administering Agency	Purposes	Eligibility	Amounts
<p>Family Violence Prevention and Services: Discretionary Funds Program</p>	<p>Office of Community Services, Administration for Children and Families, Dept. of Health and Human Services 370 L'Enfant Promenade, S.W., Washington, D.C. 20447</p> <p>Contact: James Gray at (202) 401-5705 or William Riley at (202) 401-5529</p>	<p>The purpose of the program is to assist States in supporting the establishment, maintenance, and expansion of programs and projects to prevent incidents of family violence and provide immediate shelter and related assistance for victims of family violence and their dependents.</p> <p>Each year program priority areas are determined by the Office of Community Services based on the needs identified by those working in the field of domestic violence. In FY97, applications were sought for projects focusing on one of four priority areas: (1) the development and enhancement of services and supports available to immigrant and migrant battered victims of domestic violence; (2) the development of effective strategies for integrating domestic violence services into State/local or Tribal welfare systems; (3) the establishment of a special issue resource center for Indian Tribes and Tribal Organizations; and (4) the provision of training grant stipends to Historically Black, Hispanic-Serving, and Tribal Colleges and Universities.</p> <p>In FY1998, priority areas included (1) and (4) listed above, as well as grants to support community-based public education and awareness projects.</p>	<p>Eligible applicants are State and local public agencies, Territories, Federally recognized American Indian Tribes and Tribal Organizations, and Native American communities; public and private non-profit agencies providing services to immigrant, migrant or refugee communities; domestic violence advocacy organizations, and State and local domestic violence coalitions.</p> <p>Funding levels are determined each year by the Office of Children and Families based on the priority areas.</p>	<p>FY97: The following are maximum funding levels for programs funded under each of the four priority areas. (1) \$50,000 (2) \$75,000 (3) \$600,000 (4) \$75,000.</p> <p>FY98 priority areas and grant amounts: Developing and enhancing services for immigrant, migrant, and refugee battered women (\$50,000); public information and community awareness campaign projects (\$35,000); and training grant stipends in domestic violence for historically black/hispanic-serving and Tribal Colleges and Universities (\$100,000).</p>
<p>Grant for a National Domestic Violence Hotline</p>	<p>See above</p>	<p>The purpose of this grant is to establish and operate a national, toll-free telephone hotline providing information and assistance to victims of domestic violence.</p>	<p>In September, 1995, a five-year grant was awarded to the Texas Council on Family Violence to establish and operate the National Domestic Violence Hotline. The Hotline number is: (800) 799-SAFE (7233).</p> <p>TTY: (800) 787-3224</p>	<p>FY95 appropriation: \$1 million FY96 appropriation: \$400,000 FY97 appropriation: \$1.2 million FY98 appropriation: \$1.2 million FY99 appropriation: \$1.2 million</p>

Grant Programs Created or Enhanced by the Violence Against Women Act (continued)

Grant	Administering Agency	Purposes	Eligibility	Amounts
Family Violence Prevention and Services Act Information and Technical Assistance Centers	Office of Community Services, Administration for Children and Families, Dept. of Health and Human Services 370 L'Enfant Promenade, S.W., Washington D.C. 20477 Contact: William Riley (202) 401-5529	To establish and maintain one national resource center and not more than seven special issue resource centers. These centers will provide resource information, training and technical assistance to Federal, State and Indian Tribal agencies, as well as to local domestic violence programs and to other professionals who provide services to victims of domestic violence. In 1994, one national resource center and three special issue resource centers were established and funded under this grant program. These centers are: the National Resource Center on Domestic Violence (800-537-2238); the Health Resource Center on Domestic Violence (888-792-2873); the Resource Center on Domestic Violence: Child Protection/Custody (800-527-3223), and the Battered Women's Justice Project (800-903-0111). In 1997, Sacred Circle, a national resource center to end domestic violence against Indian women was established (877-733-7623).	These programs were awarded 3-year grants in 1993. In 1996, these programs were re-funded and awarded 5-year grants.	5% of the total Family Violence Prevention And Services Act appropriations is used to fund these programs. FY98 appropriation \$3.5 million FY99 appropriation: \$4.4 million
Education and Prevention Grants to Reduce Sexual Assaults Against Women	Centers for Disease Control and Prevention, National Center on Injury, Prevention and Control, U.S. Dept. of Health and Human Services, 4770 Buford Highway NE, MS K60, Atlanta, GA 30341 Contact: The Family and Intimate Partner Violence Prevention Team at (770) 488-4410	This program provides funds for rape prevention and education programs conducted by rape crisis centers or similar non-governmental, non-profit organizations. Fundable services include rape crisis hotlines operated by rape crisis centers, victim counseling, professional training and education of police officers and investigators to address the needs of victims, education programs in colleges and secondary schools, and offender rehabilitation by prison systems. States must ensure that at least 25% of awarded funds are devoted to education programs for middle school, junior high school, and high school students.	All 50 States are eligible, as well as the District of Columbia, Puerto Rico, Guam, American Samoa, the Virgin Islands, Northern Mariana Islands, and Palau.	FY96 appropriation: \$28.5 million FY97 appropriation: \$35 million FY98 appropriation: \$45 million FY99 appropriation: \$45 million

Grant Programs Created or Enhanced by the Violence Against Women Act (continued)

Grant	Administering Agency	Purposes	Eligibility	Amounts
Grants to Educate Youth About Domestic Violence	Office of Community Services, Administration for Children and Families, Dept. of Health and Human Services 370 L'Enfant Promenade, S.W., Washington, D.C. 20447 Contact: James Gray at (202) 401-5705 or William Riley at (202) 401-5529	This program authorizes the Secretary of Health and Human Services, in consultation with the Secretary of Education, to select, implement and evaluate four model programs for the education of young people about domestic violence and violence among intimate partners. The model programs must address four different audiences: primary schools, middle schools, secondary schools, and institutions of higher education, and shall be selected, implemented and evaluated in consultation with educational experts, legal and psychological experts on battering, and victim advocate organizations such as battered women's shelters, State coalitions, and resource centers.	A contract was awarded to a national advisory group, which is conducting the evaluations.	FY96 appropriation: \$400,000
National Criminal History Improvement Program (NCHIP)	Bureau of Justice Statistics, Office of Justice Programs, U.S. Dept. of Justice, 810 7th St., N.W., Washington, D.C. 20531 Contact: Stephanie Evans at (202) 514-9012 or Carol Kaplan at (202) 307-0759	The goal of this discretionary grant program is to improve public safety by assisting States in meeting evolving requirements concerning criminal histories and related records such as protective orders and sex offender registries to support interstate exchange of records through the FBI.	Awards will be made to the agency designated by the Governor to administer the NCHIP program. One application per state. Application Deadline TBA.	FY96 appropriation: \$26.5 million (\$1.5 million under the Stalker/Domestic Violence Reduction provisions of VAWA; \$25 million under Brady/NCPA) FY97 appropriation: \$51.75 million (\$1.75 million under the Stalker/Domestic Violence Reduction program; \$50 million under Brady/NCPA) Up to \$14 million of the FY97 appropriation will be awarded for Stalking/Domestic Violence. FY98 appropriation: \$47.75 million (\$2.75 million for purposes relating to Domestic Violence/Stalker Reduction; \$45 million for criminal records improvement under Brady/NCPA). FY99 appropriation: \$45 million encompasses both NCHIP and National Sex Offender Registry Assistance Programs.

Non-VAWA Programs Which May Be Used to Fund Projects Addressing Violence Against Women

Grant	Administering Agency	Purposes	Eligibility	Amounts
<p>Coordinated Community Response Program</p>	<p>Centers for Disease Control and Prevention, National Center on Injury, Prevention and Control, U.S. Dept. of Health and Human Services, 4770 Buford Highway NE, MS K60, Atlanta, GA 30341</p> <p>Contact: The Family and Intimate Partner Violence Prevention Team (FIVPT) at (770) 488-4410</p> <p>http://www.cdc.gov/ncipc</p>	<p>The purpose of this program is to establish projects in local communities involving many sectors of each community to coordinate intervention and prevention of domestic violence.</p> <p>In 1997, \$3 million was appropriated under two parts:</p> <ul style="list-style-type: none"> • Part I funding was for applicants from rural communities, American Indian populations, and Tribes and Tribal Councils (Three projects in rural communities were funded in FY96). • Part II funding is for applicants from towns, cities, and rural communities. The applicants must provide evidence of a functioning intimate partner violence prevention coalition that is broad-based in the community, represents a cross-section of community actors and underserved populations including American Indians, Alaska Natives, Asian/Pacific Islanders, Blacks and Hispanics, and whose participants' roles, responsibilities, and activities are well-defined and documented. Part II applicants must demonstrate that the award will enhance the community coalition and broaden the existing prevention efforts, activities, and services (Three projects were funded in FY96). <p>Nine community-based primary prevention projects were funded for three years in FY1998. These projects are designed to develop, implement, and evaluate primary prevention programs that prevent family and intimate violence including dating violence prevention, children and adolescents who witness intimate partner violence in the home, and public awareness and community education. Most of these projects focus on intimate partner violence among ethnic and racial minority populations.</p>	<p>Applicants must be tax-exempt, non-profit, community-based organizations.</p> <p>* Cost of Intimate Partner Violence Study. The Assistant Secretary for Planning and Evaluation (ASPE) and FIVPT co-funded a project at the University of California, San Francisco, to assess the consequences and costs of intimate partner violence using the NVAWS data for some of its analyses. The final analysis is scheduled to be completed in 1998, and materials will be prepared for publication and presentation to Congress in 1999.</p>	<p>FY95: no appropriation</p> <p>FY96 appropriation: \$3.1 million (\$100,000 for the Cost of Intimate Partner Violence Study*).</p> <p>FY97 appropriation: \$6 million</p> <ul style="list-style-type: none"> • Awards under Part I were between \$200-250,000. • Awards under Part II were between \$700-780,000. • Awards were for a 3-year period. <p>FY97 appropriation:</p> <p>\$3 million</p> <ul style="list-style-type: none"> • Awards were made to programs funded in FY96. <p>\$3 million for community-based primary prevention projects.</p> <p>FY98 appropriation: \$6 million</p> <p>FY99 appropriation: \$6 million</p>

Non-VAWA Programs Which May Be Used to Fund Projects Addressing Violence Against Women (cont.)

Grant	Administering Agency	Purposes	Eligibility	Amounts
<p>Edward Byrne Memorial Formula Grant Program</p>	<p>Bureau of Justice Assistance, U.S. Dept. of Justice, 810 7th St. Indiana Ave., N.W., Washington, D.C. 20531</p> <p>Contact: BJA Response Center at (202) 307-1480 or (800) 421-6770 M-F 8am-5pm ET.</p> <p>www.ojp.usdoj.gov/BJA</p>	<p>The purpose of the Byrne program is to enforce State and local laws that establish offenses similar to offenses established in the Federal Controlled Substance Act (21 U.S.C. 801 <i>et seq.</i>) and to improve the functioning of the criminal justice system, with emphasis on violent crime and serious offenders. Funds will be awarded for use in specific programs in the following areas: Law Enforcement, Crime Prevention, Adjudication-Related programs, Corrections-Related programs, Comprehensive programs and Special Initiatives, Technology and Systems Improvement, Evaluation, and Technical Assistance projects.</p> <p>Byrne funds may be used to improve the criminal and juvenile justice system's response to domestic and family violence, child abuse, and abuse of the elderly. There are several specifically-delineated purpose areas which address violence against women. For example, Byrne Formula funds in the Law Enforcement Program area may be used for the purpose of improving the criminal and juvenile justice systems' response to domestic and family violence, child abuse, and abuse of the elderly.</p> <p>Additionally, you may submit a proposal for a program that addresses violence against women, even if the purpose area under which you are applying does not specifically mention domestic violence or sexual assault. For example, several purpose areas in the Adjudication-Related Program area may be used to address sexual assault or domestic violence, including fast track prosecution, pretrial services delivery, the Community Courts initiative, improvement of interaction among Tribal, State, and Federal courts, and victim-witness assistance programs.</p>	<p>States and territories. They in turn make subgrant awards to local units of government.</p>	<p>FY96-2000 authorizations: \$550 million</p> <p>FY97 appropriation: \$500 million</p> <p>FY 8 appropriation: \$505 million</p> <p>FY99 appropriation: \$505 million</p>

Non-VAWA Programs Which May Be Used to Fund Projects Addressing Violence Against Women (cont.)

Grant	Administering Agency	Purposes	Eligibility	Amounts
<p>Crime Victim Assistance Formula Grant Program</p>	<p>Office for Victims of Crime, Office of Justice Programs, State Compensation and Assistance Division, U.S. Dept. of Justice, 810 7th St., N.W., Washington, D.C. 20531</p> <p>Contact: (202) 307-5983</p>	<p>Funds under this program shall be used by States and Territories to provide direct services to crime victims, including victims of domestic violence. Services that are eligible for VOCA funding support include: crisis intervention, hospital accompaniment, hotline counseling, domestic violence shelter services, advocacy services, notification to victims of trial dates, and forensic exams for sexual assault victims.</p> <p>5% of the grant may be retained by the State for administrative purposes, such as improving coordination efforts on behalf of crime victims with other Federal, State, and local agencies and organizations, providing training on crime victim issues to state, public, and non-profit organizations that serve or assist crime victims (such as law enforcement, prosecutors, judges, and corrections personnel) and coordinating and developing protocols, policies, and procedures that promote systemic change in the ways crime victims are treated and served.</p> <p>The guidelines have been modified to allow subgrantees discretion in providing victims of domestic violence with legal assistance such as child custody and visitation proceedings when such actions are connected to family violence cases and pertain to the health and safety of the victim.</p> <p>The confidentiality of information shared between VOCA-funded counselors and clients must be maintained, as required by State and Federal law. This information is immune from legal process absent consent of the person furnishing the information. See Sec. 1407(d) of VOCA at 42 U.S.C. 10604.</p>	<p>All States, as well as the District of Columbia, all Commonwealths, and any other Territory or Possession of the U.S. are eligible if they have established crime victim compensation programs which meet the VOCA eligibility requirements.</p> <p>State grantees will be required to give assurances that priority will be given to victims of sexual assault, spousal abuse, and child abuse. A minimum of 10% of each Federal Fiscal Year's grant must be allocated to victims of these crime categories. Additionally, 10% of each grant must be allocated to victims from previously underserved populations.</p> <p>Application Deadline: December 31, 1998</p>	<p>Each State grantee receives a base amount of \$500,000 (Northern Mariana, Guam, and American Samoa receive \$200,000). The remaining amount is distributed among the States, based upon the State's population in relation to all other States.</p> <p>In FY96, Victim Assistance awards totaled \$127 million to 57 States, Territories, and the District of Columbia.</p> <p>In FY97, awards totaled approximately \$397 million</p> <p>In FY98, awards totaled \$275 million</p> <p>FY99 awards total \$240 million</p>

Non-VAWA Programs Which May Be Used to Fund Projects Addressing Violence Against Women (cont.)

Grant	Administering Agency	Purposes	Eligibility	Amounts
Crime Victim Compensation Formula Grant Program	Office for Victims of Crime, Office of Justice Programs, State Compensation and Assistance Division, U.S. Dept. of Justice, 810 7th St. N.W., Washington, D.C. 20531 Contact: (202) 307-5983	Funds under this program shall be used by the States for awards of compensation benefits to crime victims. Eligible crime victim compensation programs include those offering compensation to victims and survivors of domestic violence for: (a) medical expenses attributable to a physical injury, including expenses for mental health counseling and care; (b) loss of wages attributable to a physical injury; and (c) funeral expenses.	Eligible applicants include States, the District of Columbia, Puerto Rico, and any other Possession or Territory of the U.S. who have established eligible crime victim compensation programs. Application Deadline: November 30, 1998	In FY96, 51 participating States received a total of \$84 million to support crime victim comp initiatives In FY97: \$74 million In FY98: \$67 million FY99 appropriation: \$67 million Each State receives a federal grant equal to approximately 40% of its prior year payout of State Compensation Funds.
Crime Victim Assistance/ Discretionary Grants	Office of Justice Programs, Office for Victims of Crime, Special Projects Division, U.S. Dept. of Justice, 810 7th St., N.W., Washington, D.C. 20531 Contact: Marti Speights at (202) 616-3582 or Marilyn Keel at (202) 616-3575 or Joye Whatley at (202) 305-1715	Funds are available specifically for national scope training and technical assistance or demonstration projects to eligible crime victim assistance programs and for the financial support of services to victims of Federal crime by eligible crime victim assistance programs. Examples of funded projects include development of training for victim assistance providers and other allied practitioners to improve services to victims of crime, including victims of domestic violence and sexual assault. For FY98, grants were available in several topic areas, including: Field Generated National Impact Projects, Action Partnerships with Membership Organizations, Law Enforcement Resource Kit, Law Enforcement Training Programs, Assisting International Tourist Victims, Victim Assistance in Indian Country, Indian Country TRIAD Demonstration Program, and other projects developed in Concept Papers.	Eligible applicants are public and private non-profit agencies and organizations.	Awards range from 6 to 24-month time periods. Award amounts range from approximately \$5,000 to \$200,000. In FY97, approximately \$14.5 million was available. In FY98: \$5.6 million In FY99, it is estimated that \$4.86 million for training and technical assistance discretionary grant projects will be available.

Non-VAWA Programs Which May Be Used to Fund Projects Addressing Violence Against Women (cont.)

Grant	Administering Agency	Purposes	Eligibility	Amounts
Local Law Enforcement Block Grants (LLEBG)	<p>Bureau of Justice Assistance, U.S. Dept. of Justice, 810 7th St., N.W., Washington, D.C. 20531</p> <p>Contact: BJA Response Center at (202) 307-1480 or (800) 421-6770</p>	<p>These block grants are administered to local government units to reduce crime and enhance public safety through hiring, training and continued employment of law enforcement officers, paying overtime, procuring equipment and technology, enhancing security measures in the community, establishing or supporting drug courts, enhancing the adjudication process of cases involving violent offenders, establishing a multi-jurisdictional task force - particularly in rural areas, establishing crime prevention programs involving cooperation between community residents and law enforcement.</p> <p>The funds may be used to support projects aimed at reducing crimes of domestic violence and sexual assault. One example of an LLEBG-funded program that addresses domestic violence is a prevention/education program housed in the Parks and Recreation Department in Phoenix, Arizona, in which peer trainers facilitate informational and training seminars at youth camps and after-school programs.</p>	<p>Units of local government (towns and townships, villages, cities, and Puerto Rico) are eligible to apply. Indian Tribes and Alaskan Native villages that carry out substantial governmental duties and powers are also eligible.</p>	<p>FY96 appropriation: \$503 million</p> <p>FY97 appropriation: \$523 million</p> <p>FY98 appropriation: \$485 million</p> <p>FY99 appropriation: Not available</p>
Grants for Intimate Partner Violence Prevention Research	<p>Centers for Disease Control and Prevention, National Center on Injury, Prevention and Control, U.S. Dept. of Health and Human Services, 4770 Buford Highway NE, MS K60, Atlanta, GA 30341</p> <p>Contact: The Family and Intimate Partner Violence Prevention Team at (770) 488-4410</p>	<p>The purposes of the Prevention Research Center are to: (1) support violence against women research; (2) encourage professionals to undertake and collaborate in research & evaluation; (3) foster collaboration to develop models about the nature of violence against women, its relationship to other forms of violence, and prevention strategies; (4) integrate research on child maltreatment & other forms of violence into a study; (5) foster creative and innovative approaches to collaborative research & evaluation; (6) develop a knowledge base for evaluating current and new programs, strategies, and policies; (7) create training programs that develop interdisciplinary knowledge and expertise among young investigators; (8) provide technical assistance; and (9) provide a national focus for public fora designed to disseminate research knowledge about violence against women.</p>	<p>Eligible applicants include all non-profit and for-profit organizations, including State and local health departments, State and local governmental agencies, universities, colleges, research institutions, and other public and private organizations including small, minority and/or woman-owned businesses.</p>	<p>FY97: \$675,000 was appropriated to fund a VAW Prevention Research Center.</p> <p>A VAW Prevention Research Center was funded at \$541,000/year for 5 years in FY98.</p>

Issues of Sexual Assault by a Person Known to the Patient

Traditionally, the medical, law enforcement, and prosecution communities have thought of sexual assault as rapes committed by strangers. However, recent studies have dramatically demonstrated that sexual assaults are generally committed by someone known to the victim.

"Friends and acquaintances committed about half of all rapes and sexual assaults. Intimates committed an additional 26%. Altogether, offenders known to the victim accounted for three-quarters of all rapes and sexual assaults against women. Strangers committed [ONLY] 18% of such assaults." (emphasis added)

Bureau of Justice Statistics Special Report, National Crime Victimization Survey, Violence against Women: Estimates from the Redesigned Survey, by Ronet Bachman, PhD, Bureau of Justice Statistics, Statistician, and Linda E. Saltzman, PhD, Centers for Disease Control and Prevention, Senior Scientist; August 1995, NC 154348, p. 6.

Negating consent: The majority of sexual assaults are committed by someone known to the victim. Therefore, medical, law enforcement, and prosecution personnel, in addition to gathering evidence pointing to the identification of the offender, must gather evidence that would eliminate the potential "consent defense" used by the offender. Examples of such evidence include bumps to the back of the head, strangulation evidence, and abrasions all over the body.

Sexual assault can strike anyone regardless of sex, race, ethnicity, creed, sexual orientation, or physical, emotional, or mental capability. Many myths exist pertaining to sexual assault. Professionals working in the area of sexual assault must be able to distinguish these myths from the realities. An example of one such myth is that a husband cannot rape his wife. Spousal rape is a crime in most US jurisdictions. As the following statistic suggests, it is not an uncommon occurrence.

"Eighty-one percent of the women who were stalked by a current or former husband or cohabiting partner were also physically assaulted by the same partner, and 31 percent of the women who were stalked by a current or former husband or cohabiting partner were also sexually assaulted by the same partner... . Thus, husbands or partners who stalk their partners are six times as likely than husbands and partners in the general population to sexually assault their partners."

Source: National Institute of Justice, Centers for Disease Control and Prevention, "Stalking in America: Findings From the National Violence Against Women Survey," by Patricia Tjaden and Nancy Thoennes, April 1998, p. 8.

Issues of Sexual Assault by a Person Known to the Patient

Drugs/alcohol used in sexual assault

There has been an increase in sexual assaults involving the use of drugs and alcohol. The most common substance used is alcohol; others are benzodiazepines, flunitrazepam (Rohypnol [*ro-hyp'-nol*]), GHB (gamma hydroxybutyrate), ketamine, cocaine, methamphetamine, and marijuana.

Drug-and Alcohol-Facilitated Rapes

Drugs and alcohol can result in a loss of consciousness and an inability to resist. Some drugs cause memory loss and incapacitation. The effects of all drugs are enhanced when taken with alcohol. Patients of these drug and alcohol administrations often do not remember the assault itself and therefore may not immediately report the assault.

The response team must be aware of drug-and alcohol-facilitated rapes to be able to quickly identify these situations as sexual assaults and to provide the necessary care to the patient. In a drug-facilitated rape case, the likelihood of detecting the drug used to facilitate the rape diminishes each time the patient urinates. Therefore, in many cases, it is imperative that immediate action be taken to preserve evidence.

If within 36 hours of assault, 30 ml of blood should be properly collected; if it is determined that ingestion of the drug may have occurred within the past 96 hours (4 days), immediate action should be undertaken to have a health care provider obtain a urine specimen from the patient. The clinician should consider collecting 100 ml of urine regardless of the elapsed time due to variations in excretion. Information that this might be a drug/alcohol-assisted rape must be given to the forensic laboratory so a full drug screen is done. A full drug screen for these purposes includes testing for alcohol, amphetamines, antihistamines, barbiturates, benzodiazepines, cocaine, GHB, ketamine, marijuana, muscle relaxants, opiates, scopolamine and sleep aids. Positive results must always be confirmed by gas chromatography/mass spectrometry (GC/MS).

Additional information on such evidence collection is provided in the Module—Adult/Adolescent Patient.

Urine: Specimen containers with tight lids; if available, use sterile urine specimen containers. If possible, collect 100 ml.

Blood: Gray topped blood-collection tubes; the gray top signifies that the tube contains potassium oxalate and sodium fluoride to preserve the blood. If ingestion of the drug occurred within the past 36 hours, 30 ml of blood should be collected in addition to the urine. Three 10 ml gray top blood-collection tubes should be used.

Issues of Sexual Assault by a Person Known to the Patient

Signs that You May Have Been Drugged

If you remember taking a drink but cannot recall what happened for a period of time after you consumed the drink.

If you feel as though someone had sex with you, but you cannot remember any or all of the incident.

If you feel a lot more intoxicated than your usual response to the amount of alcohol you consumed.

If you wake up very hung over, feeling “fuzzy,” experiencing memory lapse, and cannot account for a period of time.

Note: Some symptoms may still be present when the patient speaks with the health care provider, law enforcement officer, or rape crisis professional.

Courtesy of the Rape Treatment Center of the Santa Monica-UCLA Medical Center.

Pediatric/Adolescent Patient

Normal Physical or Congenital Findings that Can Be Confused with Child Sexual Abuse

Hymen Note: All females have a hymen. Stating “no hymen present” is incorrect per Reese et al. (Module–References)

- Imperforate hymen (classically appears as blue-domed mass at puberty)
- Annular (80% in the study by Berenson of 468 neonates) (Module–References)
Of note in the study by Berenson, anterior clefts in the hymen were common in normal patients but **NO** posterior clefts were noted. This supports the tenet that posterior clefts are caused by trauma.
- Crescentic
- Fimbriated (19% in the study by Berenson)
- Septate
- Cribriform

Vagina

- Distal vaginal atresia
- Vaginal septum (associated with other urogenital abnormalities)
- Ambiguous genitalia
- Urethral prolapse

Conditions and Injuries that Can Be Confused with Child Sexual Abuse

Anogenital erythema, excoriation, pruritus

- Fecal contamination, retained urine, restrictive clothing (tights), chemical irritants (bubble bath soaps)
- Atopic dermatitis, lichen sclerosis, scabies, nonspecific vaginitis, pinworms, perianal streptococcal cellulitis, inflammatory bowel disease, Kawasaki syndrome

Anogenital bruising

- Straddle injuries (bicycle crossbar, balance beam, or jungle gym): hymenal membrane should not be traumatized, but presence of bruising to labia majora or periurethral area is common; motor vehicle accidents, impaling injury
 - traumatized lichen sclerosis, phyto dermatitis, bleeding disorders, vascular nevi, Mongolian spots

Anogenital bleeding and vaginal bleeding or discharge

- Foreign bodies to vaginal area: toilet paper or facial tissue may be irritant and cause vaginal discharge
- Atopic or seborrheic dermatitis
- Precocious puberty, hormone-producing tumors, vaginal polyps, vulvar hemangioma, sarcoma botryoides

Nonbloody vaginal discharge

- Leukorrhea, vulvovaginitis, varicella, measles, scarlet fever, typhoid
- Congenital abnormalities of genitourinary tract (ectopic ureter), rectovaginal fistula, prolapsed urethra

Other

- Phimosi s/paraphimosis, hair tourniquet syndrome, hematocolpos, mucocolpos

Physical Findings in Child Sexual Abuse

Likelihood of finding physical evidence of abuse depends on the following factors:

- Whether force was used
- The size and age differences of the perpetrator and the patient
- Whether a foreign object was placed/forced into the mouth, vulva, or anus
- Positioning of the child and use of lubricants during the abuse
- Type of abuse and its frequency and chronicity (McCann, 1992, found that in children with genital injury from sexual assault, healing occurred rapidly and little scar formation resulted; irregular hymenal edges and narrow rims at the point of injury were the most persistent findings) (Module–References)
- Whether the child resisted

Physical Examination Findings Consistent with Child Sexual Abuse (occur in approximately 25% of cases)

Findings consistent with abuse but not diagnostic (Guidelines for the Evaluation of Sexual Abuse in Children, *Pediatrics*, 1999; 103:186-190) include the following:

Female patient

NOTE: The size of the hymenal opening is based on relaxation, position, technique used, and anatomic structure and thus is not useful information to be included.

- Vaginal discharge; urethral inflammation; lymph gland inflammation; pregnancy; recurrent atypical abdominal pain; blood stains on underwear; genital bleeding; genital pruritis; genital bruising
- Abrasions, chafing or bruising to medial thighs
- Bite marks to the thighs, breasts, or other areas
- Scarring, tears or distortion to the hymen
- Injury to or scarring of the fossa navicularis or posterior fourchette
- Scars or tearing of the labia minora

NOTE: Nonintentional trauma (straddle injury or falls) often results in injury to anterior structures such as the periurethral area or labia minora or majora; the hymen is rarely affected. Intentional trauma usually results in injury to posterior structures such as the hymen, posterior fourchette, fossa navicularis, and anus.

Male patient

- Chafing or bruising to the genital region, anus, or back
- Penile discharge, painful urination, penile swelling
- Bite marks to the genital region, anus, or back

Male and female patients

- Bruises, scars, or anal tears
- Other anal findings include: the loss of rugal pattern to anus, loss of sphincter tone, scars, anal dilatation (without stool present), edema, venous congestion, skin tags, or contusions to natal cleft or perianal tissues
- Tears to the labial frenulum or palatal petechiae
- STDs, enuresis, encopresis

NOTE: Sixty-six percent of patients with a history of anal penetration have normal exams (Muram, 1989), and reflexive dilatation is controversial because it can be found in 49% of children without abuse (McCann, 1989).

A normal physical examination is most often what is found and can be consistent with abuse!

Guidelines for Interviewing Children

The medical interview has become a critical component of the diagnostic, therapeutic, and legal aspect of child sexual abuse. Although interviewers must adapt to the individual and variable needs of children, care must be taken to prevent undermining the child's credibility by improper questioning. In many communities, the role of the specialized or forensic interviewer has been established by multidisciplinary, interagency agreements. This may mean the child will be referred to another agency, a children's advocacy center, or a medical facility. When specialized procedures have been developed, the medical interview may serve as a major component of the forensic interview coordinated with law enforcement and child protection. In specialized medical settings, children can feel safe and comfortable with intimate discussions. The child can provide very specific details regarding what happened to his or her body through responses to a series of questions that are carefully constructed so the question does not contain the answer. Some or all of the following questions can be used to meet the individual needs of the child.

<ul style="list-style-type: none"> • Perform initial procedure. • Obtain information from caretaker/social worker/law enforcement separate from child. 	<ul style="list-style-type: none"> • Include past medical, developmental and behavioral history. • Ask about exposure to violence, drugs, and pornography.
<ul style="list-style-type: none"> • Interview child alone in a safe environment that is comfortable for the child. • Establish rapport with the child. • Determine child's verbal and cognitive abilities, level of comfort, and attention. • Establish rules: If I ask questions you don't know, "I don't know" is an OK answer. If I make a mistake or misunderstand you please correct me. If you need a break, please ask. 	<ul style="list-style-type: none"> • What's your name? How old are you? • Where do you live? Who else lives with you? • Do you have any pets? Names? • What grade are you in? What do you like best about school?
<ul style="list-style-type: none"> • Ask about daily living and intimate relationships. 	<ul style="list-style-type: none"> • Where do you sleep? Where do mommy/daddy sleep? • Who gives you a bath?
<ul style="list-style-type: none"> • Determine if child knows the difference between truth and lies and remind the child to tell the truth. 	<ul style="list-style-type: none"> • If I told you that this rabbit was an elephant, what would that be? (truth or lie) • Let's only talk about things that are true, that really happened.
<ul style="list-style-type: none"> • Ask the child to identify body parts, including names for genitalia and anus (use a diagram). • Use child's name for the body part. • Ask about different types of touch; include kisses, hugs, tickles, spankings, and pinches or bites. 	<ul style="list-style-type: none"> • Identify hair, eyes, nose, mouth, belly button, breasts, and private parts. • Who gives you kisses? Hugs? Spankings? Etc.? • Show me where kisses go? Hugs? Spankings? • How do hugs make you feel? Kisses? Spankings?
<ul style="list-style-type: none"> • Try to determine what happened. • Begin with open-ended questions. • Use more focused questions for younger or reluctant children. 	<ul style="list-style-type: none"> • Do you know why you came to see me today? • Did something happen to you? • A focused question is, Have you had a touch on your bottom (use child's name for body part) that hurt or bothered you? • Can you tell me about that?

<ul style="list-style-type: none"> • If child begins to disclose, ask easier questions first. • Work up gradually to the harder details. • Ask younger child to show you what happened. • Avoid questions that contain the answer. • Avoid questions that can be answered yes or no. 	<ul style="list-style-type: none"> • Where were you when that happened? • Where was Mommy? Daddy? Was anyone else there? • Who did it? What did he/she do? • How did it make you feel? How did it make your peepee feel? • Did he/she say anything? • Did you tell anyone? Whom? • What did he/she say when you told?
<ul style="list-style-type: none"> • Elicit the details of the abuse from the child. • Use the diagram to ask about all possible abusive touches and ask about any other times (places) it happened. 	<ul style="list-style-type: none"> • Ask the child specifically about the penis. • Who has one? What is it for? What did it look like? • What did you see/feel it do? Where did it go? • Anything come out of it? What? Where did it go? • Who cleaned it up?
<ul style="list-style-type: none"> • For the older child or adolescent, questions can be more specific. 	<ul style="list-style-type: none"> • Obtain date and time of assault. • Oral, breast, rectal, or genital contact or penetration. • Ask about ejaculation and bathing, brushing teeth, urinating, defecating, douching, changing clothes since assault, and saving clothes or bedding. • Obtain menstrual history and whether patient is sexually active and/or uses contraceptives. • Were any lubricants or a condom used?
<ul style="list-style-type: none"> • Conclude the interview. 	<ul style="list-style-type: none"> • Tell the child he/she did a good job and that it was good that he/she told so we can help. • Assure them that they are not in trouble.
<ul style="list-style-type: none"> • Document; we prefer videotape to capture the child's expression and demonstrations. 	<ul style="list-style-type: none"> • Document questions asked and answers given. • Try to record exact words, phrases, and emotional reactions.
<ul style="list-style-type: none"> • Explain the examination. • Ask the child during the examination to show you what they told you happened. • If there was no disclosure, ask if anyone has hurt or touched the genital or anal parts being examined. 	<ul style="list-style-type: none"> • Now I'm going to do a check up— • Listen to your heart and lungs and feel your tummy and to look at your private parts to make sure they are OK. • Conclude by reassuring child that his/her body is OK; minimize any findings during discussion with child.

Pediatric/Adolescent Patient

Pediatric/Adolescent Sexual Abuse Forensic Medical Report

Adapted from Forensic Medical Report: Suspected Child/Adolescent Sexual Abuse
State of California, Office of Criminal Justice Planning – OCJP 925

PATIENT DEMOGRAPHIC INFORMATION

Name of patient	Age
Patient ID number	Date of birth
Address	Gender
City	Ethnicity
County	Race
State	Date/time of arrival
Telephone number	Date/time of examination
	Date/time of discharge
Mother	
Father	Presence of interpreter?
Stepmother	If so, Name?
Stepfather	Language?
Guardian	

REPORTING AND AUTHORIZATION

Telephone report made to:
Name, agency ID number (if applicable), and telephone number of law enforcement and/or child protective services

Responding personnel to medical facility:
Name, agency ID number (if applicable), and telephone number of law enforcement and/or child protective services

Authorization for examination from requesting law enforcement agency, if required:
Name, ID number, and agency of law enforcement officer

CONSENT FOR EXAMINATION BY PATIENT/PARENT/GUARDIAN (Module—Your State/Local Laws)

Parental consent may not be required in some states; check your state family code

HISTORY OF ENCOUNTER (Module—Pediatric/Adolescent Patient)

Provide the time frame
Document if there were multiple incidents over time
Describe the incident using patient’s own words; identify historian as child or other adult accompanying child, (please put statement in direct quotes as applicable)
For acts described by other historians:
Provide name of historian, relationship to patient, and telephone number
Provide a detailed history of encounter (denote whether a penis, finger, or other object was used)

Vulvar penetration/contact
 Anal penetration/contact
 Oral penetration/contact to genitals (not object or finger)
 Oral copulation of genitals
 Oral copulation of anus
 Anal/genital fondling
 Did ejaculation occur (if so, where?)
 Was lubricant or jelly used?
 Was a condom used?
 Did you bite? Were you bitten?
 Fondling, kissing, licking, biting, suction injuries?
 Was force or threat(s) used? (Describe)
 Were pictures or videotapes taken or shown?
 Please describe other acts not otherwise listed
 Elaborate on patient's description of symptoms of pain or bleeding
 Describe demeanor of patient or emotional response while taking the history
 Ask about postassault hygiene activity; document if the patient:
 Urinated
 Defecated
 Vomited
 Douched
 Removed/inserted tampon
 Bathed/showered
 Wiped/cleaned genital area
 Gargled/brushed teeth
 Smoked
 Ate/drank
 Chewed gum
 Changed clothes
 Took medication

MEDICAL HISTORY PERTINENT TO THE ENCOUNTER

Document from whom the history was taken
 Relate pertinent prior surgeries, diagnostic procedures, medical treatment and anogenital injuries
 Provide history of other physical or sexual abuse incident(s)
 Provide history of recent or current medication(s) and contraceptives
 Describe other sexual activities by adolescent only (provide details of the activity)
 Menstruation
 Age of menarche and date of last menstrual period
 Symptoms disclosed by patient
 Abdominal pelvic pain
 Pain on urination
 Genital discomfort or pain
 Genital itching
 Rectal discomfort or pain
 Rectal itching
 Rectal bleeding
 Constipation

GENERAL PHYSICAL EXAMINATION

Vital signs, height, weight, Tanner Stage (Module–Pediatric/Adolescent Patient)

Demeanor/behavior of child during examination (Module–Pediatric/Adolescent Patient)

Record any statements by patient during the examination pertinent to the encounter

Document physical findings by photography (Module–Medicolegal Photography in Sexual Assault)

Document and draw the number of injuries/findings on Figure 1 and use legends to describe physical findings. Please provide a legend if abbreviations or numbers are used. Use Figure 1 to document injuries to back, face, buttock, arms, and so on.

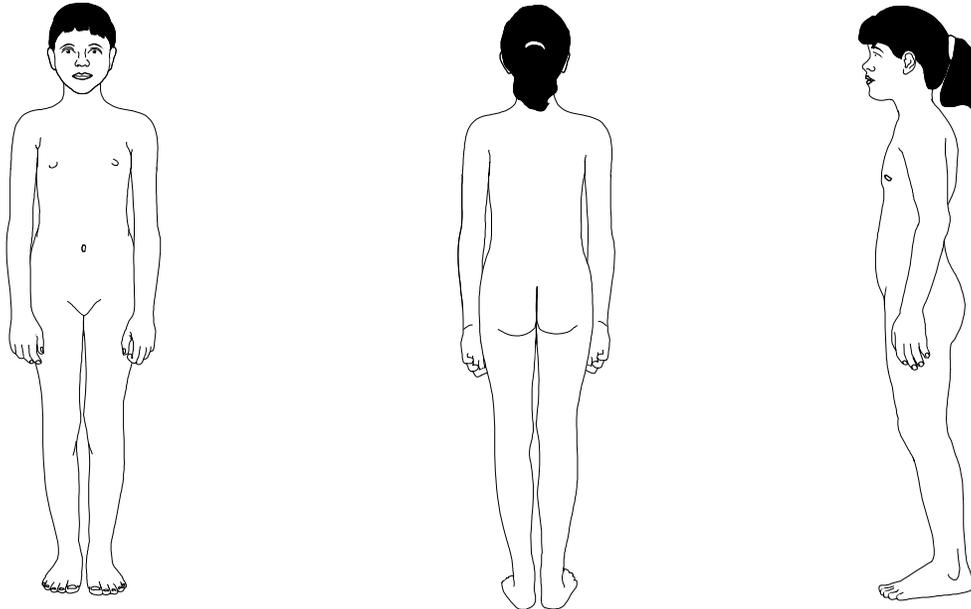


Figure 1

PHYSICAL EXAMINATION

Anogenital findings

Use legend to describe anogenital/perineal injuries.

Document position the child was in during the physical examination (Figure 2).

A. Dorsal recumbent position B. Frog-leg position C. Knee-chest position

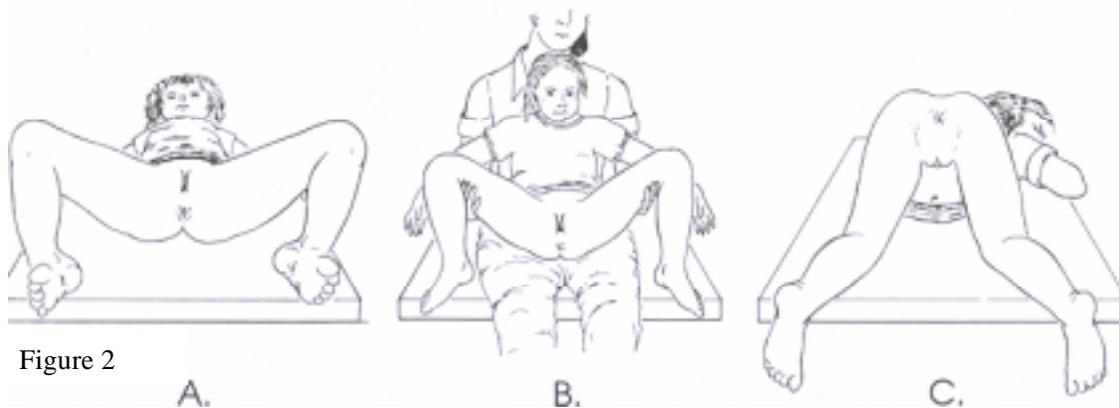


Figure 2

ANOGENITAL DOCUMENTATION

Examination methods

- Direct visualization
- Colposcope (Module–Use of Colposcope)
- Other magnification techniques

General

Female genital examination

- Document examination position and methods (Figure 2)
- Document examination and describe if separation and traction were used
- Document if toluidine blue was used (Module–Use of Toluidine Blue)
- Document description of the following structures (Figure 3)

1. Clitoris
2. Labia majora
3. Clitoral hood
4. Labia minora
5. Fossa navicularis
6. Posterior fourchette
7. Periurethral/meatus
8. Hymen
9. Vagina

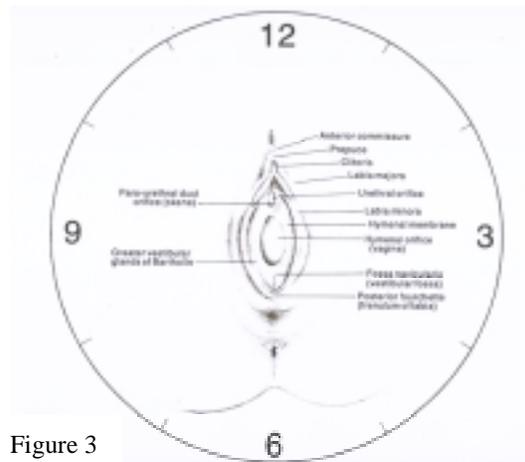


Figure 3

Male genital findings

- Document all findings to the following (Figure 4)

1. Penis (Is patient circumcised?)
2. Urethral meatus (Is a discharge present?)
3. Glans
4. Shaft
5. Scrotum/testis

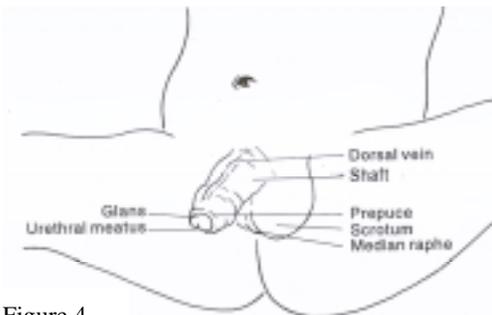


Figure 4

Female/male anus

- Document all findings

- Examination position (supine, knee-chest position, lateral recumbent)
- Examination methods (define: traction, etc.)
- Use of toluidine blue
- Buttocks
- Perianal skin
- Anal folds
- Anal dilatation

Document if stool is present in the ampulla; it may be helpful to have the patient defecate and reexamine the patient

It is possible that further invasive procedures may be required such as anoscopy, vaginoscopy or a speculum examination under anesthesia if it is suspected that injuries to deeper structures are present.

SUMMARY OF FINDINGS

It is important to note that a normal examination is a common finding in cases of sexual abuse. It is important that your conclusion summarize and integrate the physical findings in light of the history of sexual abuse, and a normal genital examination can neither confirm nor negate sexual abuse incidents. In cases with obvious physical findings, one can state that the examination is consistent with the history of sexual abuse.

MEDICAL LABORATORY TESTS ORDERED

NOTE: Cultures should be deferred until after biological evidence is collected. Actual cultures should be taken versus the use of rapid detection kits.

Document all laboratory tests ordered as indicated (Module–Pediatric/Adolescent Patient)

Document when the following laboratory tests were obtained (if applicable):

Gonorrhea culture (document source of culture: oral, cervical, vaginal, anal, penile)

Chlamydial culture (document source of sample as above)

Wet mount

Serology

 Syphilis

 HIV

 Hepatitis

Pregnancy test (document whether blood or urine test was sent)

PHOTODOCUMENTATION (Module–Medicolegal Photography in Sexual Assault)

Document the use of colposcope (still photographs: 35 mm film, video) for attainment of photodocumentation of findings. Specify the body area of the pictures taken.

EXAMINATION PERFORMED BY PERSONNEL

Document the names of persons completing the examination, license number (if applicable), signature, credentials, and telephone number.

EVIDENCE SUBMITTED TO THE FORENSIC LABORATORY

Document all evidence sent to the forensic laboratory (Module–Adult/Adolescent Patient)

Document the following:

 Clothing

 Foreign body on material, including:

 Blood

 Dried secretion

 Fiber/loose hairs

 Vegetation soil/debris

 Swab for suspected semen

Swab for suspected saliva
Swabs from areas denoted positive by alternative light source (Wood's lamp)
Control swabs (reference samples) of area adjacent to alternative light source
Fingernail scrapings
Matted hair cuttings
Pubic hair combing/brushing
Feminine hygiene products
Document oral/genital samples sent from the following regions:
 Oral
 Vaginal
 Vulvar
 Vestibule
 Cervical
 Anal
 Penile
Document attainment of reference samples

DISTRIBUTION OF EVIDENCE

Identify the agency, name of individual accepting the following evidence, and date and time
Clothing
Sexual assault kit (evidence kit)
Reference blood sample or buccal swab
Toxicology samples
Urine sample, if not officially part of the sexual assault kit

SIGNATURE OF OFFICER RECEIVING EVIDENCE

Signature of officer
Name
Agency ID number

DOCUMENT DISTRIBUTION OF FORENSIC MEDICOLEGAL REPORT

Copies of medical report should be available for law enforcement, the forensic laboratory, the child protective agency, and medical facility records.

The medicolegal record should be maintained separately from the patient's other medical records to ensure limited access.

DISCHARGE INFORMATION

Minor discharged under the care of (name):
Telephone number:

Developmental Staging

Tanner Staging

Documentation of sexual development (Tanner Stages) is important because a young, preadolescent girl or boy may physically mature by the time of the trial.

Pubic Hair

- Stage 1: Preadolescent. No pubic hair or hair in pubic region is fine, like that over other areas of the body
- Stage 2: Appearance of few, long, lightly pigmented hairs. Straight or curled hair develops at the base of the penis or along the labia
- Stage 3: Hair increases in density, becomes coarse and curled, and darkens
- Stage 4: Hair of adult color and texture but covering a smaller area, with no spread to the medial thighs
- Stage 5: Adult-like pattern

Breast Development

- Stage 1: Preadolescent
- Stage 2: Breast bud stage
- Stage 3: Further enlargement and elevation of breast areola
- Stage 4: Projection of areola and papilla to form secondary mound above the level of the breast
- Stage 5: Adult stage, projection of papilla only, areola even with breast

Male Genitalia

- Stage 1: Preadolescent
- Stage 2: Enlargement of scrotum and testes, without enlargement of penis; scrotum reddens and changes texture
- Stage 3: Continued enlargement of scrotum and testes, now with lengthening of penis
- Stage 4: Increase in size of penis and glans
- Stage 5: Adult stage

Huffman Sexual Maturity Rating

Chronologic age does not accurately reflect the developmental changes seen in the female external genitalia. Most of these developmental changes are directly influenced by the response to various levels of estrogen found in the female at different times of her childhood and adolescence. Because many cases of sexual assault are not heard in court for years after their alleged occurrence, it is important to document this information at the time of presentation. The court should be advised of any likely significant developmental changes that may have occurred since the actual assault. This information should be given in the form of Tanner and, if necessary, Huffman Staging changes so as to be consistent and reproducible from one professional to another.

1. Stage 1
 - 1.1. Occurs after birth for the first couple of months of life. Due to maternal estrogen effects.
 - 1.2. Hymen typically appears
 - 1.2.1. Thick
 - 1.2.2. Pink in color
 - 1.2.3. Moist in appearance
 - 1.2.4. Actual secretions may be present. It is not unusual for a small amount of blood to be noted as the maternal estrogen dissipates
2. Stage 2
 - 2.1. This is a period of low estrogen effect.

- 2.2. It typically occurs from about 2 months to about 6 or 7 years of age. Hymen typically appears
 - 2.2.1. Thin
 - 2.2.2. Translucent or whitish in color
 - 2.2.3. Minimal secretions present
 - 2.2.4. Hymen typically appears dry
3. Stage 3
 - 3.1. This is the period during which the body begins producing more estrogen. Usually, Tanner Staging will give indications of estrogen effect at this time as well.
 - 3.2. Typically, this stage occurs between the ages of 7 and 12.
 - 3.3. Hymen appears
 - 3.3.1. Increasingly pinkish in color
 - 3.3.2. Thicker
 - 3.3.3. Somewhat lubricated
4. Stage 4
 - 4.1. This is the premenarcheal stage.
 - 4.2. Genitalia become much more adult like in appearance.
 - 4.3. Hymen appears
 - 4.3.1. Lubricated
 - 4.3.2. Thick
 - 4.3.3. Pink in color
 - 4.3.4. Tanner Staging typically demonstrates clear evidence of endogenous estrogen production

Clinical Evaluation Summary

Clinical Evaluation	Child	Adolescent	Adult
Sexual assault kit \leq 72 hours ¹	\pm ¹	+ ¹	+
Sexual assault kit >72 hours ¹	-	\pm	\pm
Cultures—recent (\leq 72 hours) ²	-	-	-
Cultures—chronic ³	+	+	+
Use of colposcope (Use of Colposcope)	\pm	\pm	\pm
Use of alternative light source (such as a Wood’s lamp)	\pm	\pm	\pm
Antibiotic prophylaxis for STDs ⁴	-	+	+
HIV prophylaxis ⁵	\pm	\pm	\pm
Hepatitis B vaccine: patient immunized ⁶	-	-	-
Hepatitis B vaccine: patient not immunized ⁷	+	+	+
Tetanus: patient immunized >5 years or underimmunized	<7 years old—DaPT	\geq 8 years old—DT	Td

¹. Selective completion of the sexual assault kit in the child may be most appropriate. This would allow the health care professional to complete those parts of the sexual assault kit that are pertinent to the history and clinical findings of the patient. This management strategy is most applicable to the pediatric patient who is often frightened by the examination and may suffer emotional trauma as a result. The sexual assault kit should be completed in cases of sexual assault occurring in less than 72 hours. After 72 hours, new technology, such as DNA, may identify the perpetrator in cases in which evidence is present in the vagina for 3 weeks or more and on clothing for years; therefore, in selected cases, the kit may be completed after 72 hours (Module—References).

². Initial STD testing is a controversial issue. In most instances, the results of the culture will be negative, and if positive, they may or may not indicate new infection. Because these specimens are not forensically indicated, one management strategy is that no culture be taken acutely unless obvious signs of STDs are present. For chronic sexual abuse cases, obtain cultures because chronic infection may be asymptomatic.

³. After 3 to 7 days, it may be helpful to take cultures that might indicate an infection that was introduced at the time of the sexual assault. Cultures should be taken if there is a high prevalence of STD and for patients for whom there is physical evidence of infection with a STD.

⁴. Patients in whom there has been vaginal or anal penetration with or without ejaculation or oral penetration with ejaculation should be considered for antibiotic prophylaxis. For nonchronic sexual abuse in the asymptomatic prepubescent child, two options exist: 1) to provide prophylaxis based on the history as above or in the presence of another STD; and 2) do not provide prophylaxis but schedule the child for a 2-week return visit, when cultures would be taken for children based on the history (as above or at high risk for STDs in the community or perpetrator) and if symptomatic. All patients should be given instructions to return immediately if symptoms develop (Module—Sexually Transmitted Disease).

⁵. HIV prophylaxis is not universally accepted as a standard of practice but may be considered in selected cases. The risks and benefits of the medication regimen must be considered. HIV prophylaxis may be given in cases in which there has been anal or vaginal penetration or oral penetration with ejaculation. In addition, other information can be used to evaluate the risk of HIV transmission to patient, such as history of repeated abuse, multiple perpetrators, perpetrator known to be HIV positive, and high prevalence of HIV in the area in which the sexual assault occurred (Module—HIV).

⁶. If patient is surface antibody negative, then proceed with hepatitis B vaccination. If the patient has not received the complete hepatitis B vaccine series, complete the series.

⁷. Provide hepatitis B vaccine at time zero and at 1 and 6 months.

Behavioral Indications of Child Sexual Abuse

CLINICAL PRESENTATION

The patient may present with a behavioral complaint or a physical complaint. Signs and symptoms of sexual abuse can range from subtle (nightmares) to obvious (vaginal discharge). A partial list of signs and symptoms of sexual abuse is outlined in the following table:

Behavioral	Physical
Aggressive behavior	Abdominal pain
Clinging behavior	Anorexia
Insomnia	Constipation
Excessive masturbation*	Painful defecation
Sudden change in behavior	Encopresis
Phobias; fears	Pregnancy
Sexualization of play*	Rectal bleeding
Attempted suicide	Sexually transmitted disease
	Vaginal itching, discharge, or bleeding
	Urethral discharge
	Urinary symptoms

*Possibly indicative of sexual abuse.

Forensic Laboratory Testing

Forensic—relating to, used in, or appropriate for courts of law or for public discussion or argumentation; from the Latin *forensis*—public, of a forum.

Collection and preservation of evidence should be done in such a way that the evidence is in the same form when it arrives at the laboratory as it was at the crime scene. Add nothing, subtract nothing. The exception is that wet stains or samples should be air dried.

Quality begins at the crime scene.

In sexual assault, there are at least **two crime scenes**: the **patient** and the **place of the assault**.

General rules for forensic evidence collection (Module–Adult/Adolescent Patient)

The examiner must be careful to prevent evidence transfer. This is prevented by changing gloves whenever cross-contamination can occur. Clearly document all findings.

- There is only one chance to collect
- When in doubt, collect
- Air dry, no heat (heat degrades)
- If once living, such as blood and body fluids, refrigerate
- Use no plastic; use paper or glass only (plastic does not breathe, and it causes mold)
- Label, seal, and initial everything (chain of custody). Do not lick envelopes to moisten
- Separate items collected (so there is no transfer of trace evidence)
- Do not touch items that may contain fingerprints (knife, gun, bullet, cartridge case, etc.); package to preserve prints
- The 72-hour presumptive guideline of collection may change because it was a function of the sensitivity of forensic tests
- Suspect's DNA from epithelial cells has been found in the vaginal vault of patients for as long as 3 weeks (Module–References) and on clothing for years
- Buccal swabs are good as known samples in lieu of blood
- Collect samples without water if possible—ease off stain and place in a bindle (paper folded in thirds and thirds again); if needed, place one drop of tap water (not saline) on a swab to collect
- Sterile collection is not necessary (sterile refers to the absence of microorganisms; DNA is neither bacteria nor virus); however, it is necessary to change gloves between sites to avoid cross-contamination

Core evidence needed consists of oral, vaginal, and anal samples, as appropriate. If not already part of the kit, collect urine when it is possible the assault was substance facilitated.

Collect urine in drug-and/or alcohol-facilitated sexual assaults if not already part of the official rape kit (Module–Adult/Adolescent Patient).

Evidence collection changes as technology changes. Consult your local forensic laboratory and work with their scientists to ensure that the evidence you collect is feasible to test and that your protocol is in step with the newest technology.

Use and Quality Control of Desiccant Packs¹

Multiform desiccant packs are used to dry swabs that have been used to collect biological evidence; this includes items such as blood, semen, and saliva stains. The desiccant rapidly dries the sample so as to prevent microorganism growth and sample degradation.

Quality Control

If the blue Drierite indicating mesh at the bottom of the desiccant stock bottle turns purple, the packs are spent and should be discarded. This color change occurs when moisture has been absorbed. Leaving the lid off the jar or numerous reopenings of the jar can allow moisture in. It is particularly important to check the Drierite when getting near the bottom of the desiccant bottle. Drierite should be changed when refilling a bottle with new desiccant packs.

Possible Vendors

Multiform Desiccants, Inc.

960 Busti-at-Niagara
Buffalo, NY 14213
800-445-9890

Bite Mark Scale

ABFO #2 scale (Catalog # 6-3875)
The Lightning Powder Co., Inc.
1230 Hoyt St. SE
Salem, OR 97302
800-852-0300

¹ Wilson JT. Dessicant drying of physiological fluids. Presented at Midwestern Association of Forensic Scientists, Kansas City, MO, 1991.

References

Sexual Abuse (General)

Adams JA. Sexual abuse and adolescents. *Pediatr Ann* 1997;26(5):299-304.

American Academy of Pediatrics. Adolescent assault victim needs: A review of issues and a model protocol (RE9643). *Pediatrics* 1996;98(5):991-1001.

American Academy of Pediatrics, Committee on Adolescence. Sexual assault and the adolescent. *Pediatrics* 1994;94(5):761-765.

American Academy of Pediatrics, Committee on Child Abuse and Neglect. Guidelines for the evaluation of sexual abuse of children: Subject review. *Pediatrics* 1999;103(1):186-190.

Bays J, Chadwick D. Medical diagnosis of the sexually abused child. *Child Abuse Negl* 1993;17:91-110.

Blumenthal I. Medical aspects of child sexual abuse. *Br J Hosp Med* 1991;45:364-374.

Botash AS. Examination for sexual abuse in prepubertal children: An update. *Pediatr Ann* 1997;26(5):312-320.

Christoffel KK, Barlow B, Bell C, Dowd D, Godbold LT, Kitchen A, Reynolds M, Staggers BC. Guidelines for the evaluation of sexual abuse of children. *Del Med J* 1997;69(8):405-412.

De Jong A, Finkel MA. Sexual abuse of children. *Curr Probl Pediatr* 1990;495-567.

De Jong AR, Rose M. Frequency and significance of physical evidence in legally proven cases of child sexual abuse. *Pediatrics* 1989;84(6):1022-1026.

Dubowitz H, Black M, Harrington D. The diagnosis of child sexual abuse. *Am J Dis Child* 1992;46:688-693.

Faulkner N. The sexual abuse recognition and non-disclosure inventory (SARANDI) for young adolescents. 1998.

Ferrell J. Foley catheter balloon technique for visualizing the hymen in female adolescent sexual abuse victims. *J Emerg Nurs* 1995;21:585-586.

Finkel MA, DeJong AR. Medical findings in child sexual abuse, in Reece RM (ed). *Child Abuse: Medical Diagnosis and Management*. Lea & Febiger, Malvern, PA, 1994.

Gardner JJ. Comparison of the vaginal flora in sexually abused and nonabused girls. *J Pediatr* 1992;120(6):872-877.

Gausche M. Robbed of innocence: *Emerg Med Serv* 1997;3:41-62.

Giardino AP, Finkel MA, Giardino ER, Seidl T, Ludwig S (eds). *A Practical Guide to the Evaluation of Sexual Abuse in the Prepubertal Child*. Sage, Newbury Park, CA, 1992.

Guidelines for the evaluation of sexual abuse of children. *Pediatrics* 1991;87(2):254-260.

Heger A, Emans SJ, et al. Evaluation of the Sexually Abused Child: A Medical Textbook and Photographic Atlas. New York, Oxford University Press, 1992.

Heger AH. Twenty years in the evaluation of the sexually abused child: Has medicine helped or hurt the child and the family? *Child Abuse Negl* 1996;20:893-897.

Kellogg ND, Parra JM, Menard S. Children with anogenital symptoms and signs referred for sexual abuse evaluations. *Arch Pediatr Adolesc Med* 1998;152:634-641.

Levitt CJ. Medical evaluation of the sexually abused child. *Primary Care* 1993;20:343-354.

Palusci VJ, Cox EO, Cyrus TA, Heartwell SW, Vandervort FE, Pott ES. Medical assessment and legal outcome in child sexual abuse. *Arch Pediatr Adolesc Med* 1999;153:388-392.

Paradise JE. The medical evaluation of the sexually abused child. *Pediatr Clin North Am* 1990;37(4):839-862.

Reece RM (ed). Child Abuse: Medical Diagnosis and Treatment. Lea & Febiger, Malvern, PA, 1994.

Sexual Abuse (Anatomic Findings)

Adams JA, Harper K, Knudson K, Revilla J. Examination findings in legally confirmed child sexual abuse: It's normal to be normal. *Pediatrics* 1994;94:310-317.

Adams JA, Wells R. Normal versus abnormal genital findings in children: How well do examiners agree? *Child Abuse Negl* 1993;17:663-675.

Bays J, Jenny C. Genital and anal conditions confused with child sexual abuse trauma. *Am J Dis Child* 1990;144:1319-1322.

Berenson AB. Appearance of the hymen at birth and 1 year of age: A longitudinal study. *Pediatrics* 1993;91:820-825.

Berenson AB. A longitudinal study of hymenal morphology in the first 3 years of life. *Pediatrics* 1995;95:490-496.

Berenson A, Heger A, Andrews S: Appearance of the hymen in newborns. *Pediatrics* 1991;87(4):458-465.

Berenson A, Heger A, Hayes J, Bailey R, Emans B. Appearance of the hymen in prepubertal girls. *Pediatrics* 1992;89:387-394.

Emans SJ. Sexual abuse in girls: What have we learned about genital anatomy? *J Pediatr* 1992;120:258-260.

Girardin B, Faugno D, Seneski P, Slaughter L. Color Atlas of Sexual Assault. St. Louis, Mosby, 1997.

Heger A, Emans SJ. Introital diameter as the criterion for sexual abuse. *Pediatrics* 1990;85(2):222-223.

Kerns D, Ritter M, Thomas R. Concave hymenal variations in suspected child sexual abuse victims. *Pediatrics* 1992;90:265-272.

McCann J, Kerns D. The anatomy of child and adolescent sexual abuse. CD-ROM Atlas/Reference 1999.

McCann J, Voris J, Simon M, et al. Perianal findings in prepubertal children selected for nonabuse: A descriptive study. *Child Abuse Negl* 1989;13:179-193.

McCann J, Voris J, Simon M. Genital injuries resulting from sexual abuse: A longitudinal study. *Pediatrics* 1992;89(2):307-317.

McCann J, Wells R, Simon M, et al. Genital findings in prepubertal girls selected for nonabuse: A descriptive study. *Pediatrics* 1990;86(3):428-439.

Muram D. Child sexual abuse: Relationship between sexual acts and genital findings. *Child Abuse Negl* 1989;13:211-216.

Muram D. Anal and perianal abnormalities in prepubertal victims of sexual abuse. *Am J Obstet Gynecol* 1989;161(2):278-281.

Sexual Abuse (Behavioral Issues)

Dubowitz H, Black M, Harrington D, Verschoore A. A follow-up study of behavior problems associated with child sexual abuse. *Child Abuse Negl* 1993;17:743-754.

Friedrich WN, Grambsch P, Broughton D, et al. Normative sexual behavior in children. *Pediatrics* 1991;88(3):456-464.

Wells RD, McCann J, Adams J, Voris J, Ensign J. Emotional, behavioral and physical symptoms reported by parents of sexually abused, nonabused, and allegedly abused prepubescent females. *Child Abuse Negl* 1995;19:155-163.

Sexual Abuse (Sexually Transmitted Diseases in Children/Adolescents)

General

American Academy of Pediatrics. Sexually transmitted diseases. in Peter G (ed) 1997 Red Book: Report of the Committee on Infectious Diseases, 24th ed. Elk Grove Village, IL, American Academy of Pediatrics, 1997, pp. 108-116.

American Academy of Pediatrics, Committee on Adolescence. Sexually transmitted diseases. *Pediatrics* 1994;94:568-572.

Anderson C. Childhood sexually transmitted diseases: One consequence of sexual abuse. *Public Health Nursing* 1995;12(1):41-46.

Argent AC, Lachman PI, Hanslo D, Bass D. Sexually transmitted diseases in children and evidence of sexual abuse. *Child Abuse Negl* 1995;19(10):1303-1310.

- Centers for Disease Control and Prevention. 1998 Guidelines for treatment of sexually transmitted diseases. *MMWR* 1998;47 (No. RR-1).
- De Jong AR. Sexually transmitted diseases in sexually abused children. *Sex Transm Dis* July-September 1986, pp. 123-126.
- De Villiers FPR, Prentice MA, Bergh AM, Miller SD. Sexually transmitted disease surveillance in a child abuse clinic. *SAMJ* 1992;81(18):84-86.
- Forster GE. STDs and the sexual abuse of children. *Br J Hosp Med* 1994;51(5):206-208.
- Gardner JJ. Comparison of the vaginal flora in sexually abused and nonabused girls. *J Pediatr* 1992;120(6):872-877.
- Goth BT, Forster GE. Sexually transmitted diseases in children: Chlamydial oculo-genital infection. *Genitourin Med* 1993;69:213-221.
- Hammerschlag MR. Sexually transmitted diseases in sexually abused children. *Adv Pediatr Infect Dis* 1988;3:1-18.
- Hanson RM. Sexually transmitted diseases and the sexually abused child. *Pediatrics* 1993;5:41-49.
- Hymel KP, Jenny C. Child sexual abuse. *Pediatr Rev* 1996;17(7):236-249.
- Ingram DL, Everett VD, Lyna PR, White ST, Rockwell LA. Epidemiology of adult sexually transmitted disease agents in children being evaluated for sexual abuse. *Pediatr Infect Dis J* 1992;11:945-950.
- Jenny C. Sexually transmitted diseases and child abuse. *Pediatr Ann* 1992;21(8):497-503.
- Lowy G. Sexually transmitted diseases in children. *Pediatr Dermatol* 1992;9(4):329-334.
- Neinstein LS, Goldenring J, Carpenter S. Nonsexual transmission of sexually transmitted diseases: an infrequent occurrence. *Pediatrics* 1984;74:67-76.
- Siegel RM, Schubert CJ, Myers PA, Shapiro RA. The prevalence of sexually transmitted diseases in children and adolescents evaluated for sexual abuse in Cincinnati: rationale for limited STD testing in prepubertal girls. *Pediatrics* 1995;96:1090-1094.
- Shapiro RA, Schubert CJ, Myers PA. Vaginal discharge as an indicator of gonorrhea and chlamydia infection in girls under 12 years old. *Pediatr Emerg Care* 1993;9(6):341-345.
- White ST, Loda FA, Ingra DL, et al: Sexually transmitted diseases in sexually abused children. *Pediatrics* 1983;72:1:16-21.
- 1989 Sexually transmitted diseases treatment guidelines: Extracted from the Centers for Disease Control guidelines. *Pediatr Infect Dis J* 1990;9(6):379-382.

Sexual Abuse (Sexually Transmitted Diseases in Children/Adolescents)

Gonorrhea

American Academy of Pediatrics, Committee on Child Abuse and Neglect. Gonorrhea in prepubertal children. *Pediatrics* 1998; 168-169.

Ingram DL. *Neisseria gonorrhoeae* in children. *Pediatr Ann* 1994;20:341-345.

Ingram DL, Everett D, Flick LAR, Russell TA, White-Sims ST. Vaginal gonococcal cultures in sexual abuse evaluations: Evaluation of selective criteria for preteenaged girls. *Pediatrics* (Electronic Abstracts) 1997;99:863-864.

Whittington WL, Rice RJ, Biddle JW, Knapp JS. Incorrect identification of *Neisseria gonorrhoeae* from infants and children. *Pediatr Infect Dis J* 1988;7:3-10.

Human Papilloma Virus

Boyd L. Condylomata acuminata in the pediatric population. *Am J Dis Child* 1990;144:817-824.

Davis AJ, Emans SJ. Human papilloma virus infection in the pediatric and adolescent patient. *J Pediatr* 1989;115(1):1-9.

Goldenring JM. Condylomata acuminata: Still usually a sexually transmitted disease in children. *Am J Dis Child* 1991;145:601-602.

Gutman LT, Herman-Giddens ME, Phelps WC. Transmission of human genital papillomavirus disease: Comparison of data from adults and children. *Pediatrics* 1993;91:31-38.

Ross JD, Scott GR. Condylomata acuminata in pre-pubertal children. *Med Sci Law* 1993;33(1)78-82.

Gardnerella

Bump RC, Buesching WJ III. Bacterial vaginosis in virginal and sexually active adolescent females: Evidence against exclusive sexual transmission. *Am J Obstet Gynecol* 1988;4:935-939.

Emans SJ. Significance of *Gardnerella vaginalis* in a prepubertal female. *Pediatr Infect Dis J* 1991;10:709-710.

Ingram DL, White ST, Lyna PR, et al. *Gardnerella vaginalis* infection and sexual contact in female children. *Child Abuse Negl* 1992;16:847-853.

Genital Mycoplasmas

Ingram DL, Shite ST, Lyna P, et al. *Ureaplasma urealyticum* and large colony mycoplasma colonization in female children and its relationship to sexual contact, age and race. *Child Abuse Negl* 1992;16:265-272.

Syphilis

Bays J, Chadwick D. The serologic test for syphilis in sexually abused children and adolescents *Adolesc Pediatr Gynecol* 1991;4:148-151.

Horowitz S, Chadwick DL. Syphilis as a sole indicator of sexual abuse: Two cases with no intervention. *Child Abuse Negl* 1990;14:129-132.

Lande MB, Richardson AC, White KC. The role of syphilis serology in the evaluation of suspected child abuse. *Pediatr Infect Dis J* 1992;11:125-127.

Siqueira LM, Barnett SH, Kass E, Gertner M. Incubating syphilis in an adolescent female rape victim. *J Adolesc Health Care* 1991;12:459-461

Chlamydia

Dattel BJ, Landers DV, Coulter K, Hinton J, Sweet RL, Schachter J. Isolation of chlamydia trachomatis from sexually abused female adolescents. *Obstet Gynecol* 1988;72(2):240-242.

Hughes EG, Mowatt J, Spence JE. Endocervical chlamydia trachomatis infection in Canadian adolescents. *CMAJ* 1989;140:297-301.

HIV

Centers for Disease Control and Prevention. 1998 Guidelines for treatment of sexually transmitted diseases. *MMWR* 1998;47(No. RR-1):1-116.

Centers for Disease Control and Prevention. Management of possible sexual, injecting-drug-use, or other nonoccupational exposure to HIV, including considerations related to antiviral therapy. Public Health Services Statement. *MMWR* 1998;47(No. RR-17):1-15.

Dominguez KL, Simonds RJ. Postexposure prophylaxis, in Zeichner S, Read J (eds). *Handbook of Pediatric Care*. 1998:1-43.

Dyson C, Hosein IK. The role of the microbiology laboratory in the investigation of child sexual abuse. *J Med Microbiol* 1996;45:313-318.

Fost N. Ethical considerations in testing victims of sexual abuse for HIV infection. *Child Abuse Negl* 1990;14:5-7.

Gellert GA, Durfee MJ, Berkowitz CD, Higgins KV, Tubiolo VC. Situational and sociodemographic characteristics of children infected with human immunodeficiency virus from pediatric sexual abuse. *HIV Pediatr Sexual Abuse* 1993;91(1):39-44.

Gellert GA, Durfee MJ, Berkowitz CD. Developing guidelines for HIV antibody testing among victims of pediatric sexual abuse. *Child Abuse Negl* 1990;14:9-17.

Gutman LT, St Claire KK, Weedy C, et al. Human immunodeficiency virus transmission by child sexual abuse. *Am J Dis Child* 1992;146:1185-1189.

Gutman LT, Herman-Giddens ME, McKinney RE. Pediatric acquired immunodeficiency syndrome: barriers to recognizing the role of child sexual abuse. *Am J Dis Child* 1993;147:775-780.

Mok JY. When is HIV an issue after child sexual abuse? *Arch Dis Child* 1996;75:85-87.

Murtagh C, Hammill H. Sexual abuse of children: A new risk factor for HIV transmission *Adolesc Pediatr Gynecol* 1993;6:33-35.

Rimsza ME. Words too terrible to hear: sexual transmission of human immunodeficiency virus to children. *Am J Dis Child* 1993;147:711-712.

Siegel R, Christie C, Myers M, Duma E, Green L. Incest and pneumocystis carinii pneumonia in a twelve year old girl: A case for early human immunodeficiency virus testing in sexually abused children. *Pediatr Infect Dis J* 1992;11:681-682.

Yordan EE, Yordan RA. Sexually transmitted diseases and human immunodeficiency virus screening in a population of sexually abused girls. *Adolesc Pediatr Gynecol* 1992;5:187-191.

Sexual Assault (General)

Aiken MM, Speck PM. Confidentiality in cases of rape: A concept reconsidered. *J Clin Ethics* 1991;2(1):63-71.

Dwyer BJ. Psychological, medical, and forensic aspects of emergency management. *Emerg Med Rep* 1995;16(12):105-116.

Elders MJ, Albert AE. Adolescent pregnancy and sexual abuse. *JAMA* 1998;280(7):648-649.

Geist RF. Sexually related trauma. *Emerg Med Clin North Am* 1988;6(3):439-466.

Gold CR. Sexual assault, in Rosen P, Barkin R (eds). *Emergency Medicine Concepts and Clinical Practice*, 4th ed. St. Louis, Mosby, 1998, pp. 2319-2326.

Hampton HL. Care of the woman who has been raped. *N Engl J Med* 1995;332(4):234-237.

Hochmeister M, Ferrell J. Sexual assault: The health care response. A complete guide to the forensic examination and evidence collection of the adult sexual assault patient. 1998. Video.

Hoelzer M. Sexual assault. *MMWR* pp. 398-402.

Holmes MM. The clinical management of rape in adolescents. *Contemp OB/GYN* May 1998, pp. 62-78.

Ledray LE. The sexual assault examination: Overview and lessons learned in one program. *J Emerg Nursing* 1992;18(3):223-232.

Lipscomb GH, Muram D, Speck PM, Mercer BM. Male victims of sexual assault. *JAMA* 1992;267(22):3064-3066.

Mechanic MB, Resick PA, Griffin MG. A comparison of normal forgetting psychopathology & information-processing models of reported amnesia for recent sexual trauma. *J Consult Clin Path* 1998;66(6): 948-957.

Pettifer S, Bicher M, Torge J. Sexual Assault. *Montreal Health Press* Winter 1997, pp. 1-48.

Pharris MD, Ledray LE. Sexual assault: Clinical issues: Consent and confidentiality in the care of the sexually assaulted adolescent. *J Emerg Nursing* 1997;23(3):279-281.

Pharris MD. Allegations of sexual assault on the inpatient unit: How to respond. *J Emerg Nursing* 1998;24(1):98-99.

Rambow B, Adkinson C, Frost TH, Peterson GF. Female sexual assault: Medical and legal implications. *Ann Emerg Med* 1992;21(6):727-731.

Scott DL, Schelbe DT, White LJ. An important question in the evaluation of sexual assault victims. *Acad Emerg Med* 1997;4(4):329-330.

Voelker R. Experts hope team approach will improve the quality of rape exams. *JAMA* 1996;25(13).

Medicolegal Issues of the Sexually Assaulted or Sexually Abused Patient

Alexander ER. Misidentification of sexually transmitted organisms in children: Medicolegal implications. *Pediatr Infect Dis J* 1988;7(1):1-2.

US court in Massachusetts holds that rape crisis center lacks independent standing to assert its client's privilege when rape victim voluntarily waives her confidentiality rights to in camera review of records. *HLD* 1997;25(2):49.

Pharris MD, Ledray LE. Sexual assault: Clinical issues. *J Emerg Nursing* 1997;23(3):279-281.

Sexual assault and the adolescent (RE9433). *Pediatrics* 1994;94(5):761-765.

Public disclosure of private information about victims of abuse (RE9201). *Pediatrics* 1991;87(2):261.

Adolescent assault victim needs: A review of issues and a model protocol (RE9643). *Pediatrics* 1996;98(5):991-1001.

Emergency Contraception with Sexual Assault

Wells E, Crook B, Muller B. Emergency contraception: A resource manual for providers. *Pathology* May 1997.

An emergency contraceptive kit. *Medical Lett* 1998;40(1038):102-103.

Sexual Assault (Sexually Transmitted Diseases in Adults)

General

Glaser JB, Hammerschlag MR, McCormack WM. Epidemiology of sexually transmitted diseases in rape victims. *Rev Infect Dis* 1989;11(2):246-254.

Glaser JB, Schachter J, Benes S, Cummings M, Frances CA, McCormack WM. Sexually transmitted diseases in postpubertal female rape victims. *J Infect Dis* 1991;164:726-730.

Glaser JB. Sexually transmitted diseases in victims of sexual assault. *N Engl J Med* 1987;316(16):1023-1024.

Hughes EG, Mowatt J, Spence JEH. Endocervical chlamydia trachomatis infection in Canadian adolescents. *CMAJ* 1989;140:297-301.

Kellogg ND, Parra JM. The progression of human papillomavirus lesions in sexual assault victims. *Experience and Reason* December 1994, pp. 1163-1165.

Lacey HR. Sexually transmitted diseases and rape: the experience of a sexual assault centre. *Int J STD AIDS* 1990;1:405-409.

Schwarz SK, Whittington WL. Sexual assault and sexually transmitted diseases: Detection and management in adults and children. *Rev Infect Dis* 1990;12(6):S682-S690.

1998 Guidelines for treatment of sexually transmitted diseases. *MMWR* 1998;47(No. 44).

Management of possible sexual, injecting-drug-use, or other nonoccupational exposure to HIV, including considerations related to antiretroviral therapy. *MMWR* 1998;47(No. RR-17):1-14.

Sexual Assault (Sexually Transmitted Diseases in Adults)

HIV

Gostin LO, Lazzarini Z, Alexander D, Brandt AM, Mayer KH, Silverman DC. HIV testing, counseling, and prophylaxis after sexual assault. *JAMA* 1994;271(18):1436-1444.

Gutman LR, Herman-Giddens ME, McKinney RE Jr. Pediatric acquired immunodeficiency syndrome: Barriers to recognizing the role of child sexual abuse. *Pediatr AIDS* 1993;147:775-780.

Katz MH, Gerberding JL. Postexposure treatment of people exposed to the human immunodeficiency virus through sexual contact or injection-drug use. *N Engl J Med* 1997;336(15):1097-1100.

Royce RA, Sena A, Cates W Jr, Cohen MS. Sexual transmission of HIV. *N Engl J Med* 1997;336(15):1072-1078.

HIV prophylaxis after sexual exposure. *Emerg Med Acute Care Essays* 1998;21(8):1-4.

Management of possible sexual, injecting-drug-use, or other nonoccupational exposure to HIV, including considerations related to antiretroviral therapy. *MMWR* 1998;47(No. RR-17)1-14.

Sexual Assault Nurse Examiners (SANE)

Hohenhaus S, Ledray L. Sexual assault: Clinical issues: SANE legislation and lessons learned. *J Emerg Nursing* 1998;24(5):463-464.

Jaeger B. Sexual assault nurse examiners. *J Emerg Nursing* 1998;24(5):440-441.

Ledray LE. Sexual assault nurse examiner development & operation guide. Department of Justice, Office for Victims of Crime, Washington, DC, 1999.

Ledray LE, Simmelink K. Sexual assault: Clinical issues. Efficacy of SANE evidence collection: A Minnesota study. *J Emerg Nursing* 1997;23(1):75-78.

Ledray LE, Barry L. Sexual assault: Clinical issues. SANE expert and factual testimony. *J Emerg Nursing* 1998;24(3):284-287.

O'Brien C. Sexual assault: Clinical issues: Light staining microscope: Clinical experience in a sexual assault nurse examiner (SANE) program. *J Emerg Nursing* 1998;24(1):95-97.

Smith K, Holmseth J, MacGregor M, Letourneau M. Sexual assault: Clinical issues: Sexual assault response team: Overcoming obstacles to program development. *J Emerg Nursing* 1998;24(4):365-367.

Voelker R. Experts hope team approach will improve the quality of rape exams. *JAMA* 1996;25(13).

Forensic Issues in Sexual Assault

American Prosecutors Research Institute. The prosecution of rohypnol and GHB related sexual assaults. Video and manual, 1999.

Armstrong R. When drugs are used for rape. *J Emerg Nursing* 1997;23(4):378-381.

Collins KA, Rao PN, Hayworth R, Schnell S, Tap MP, Lantz PE, Geisinger KR, Pettenati MJ. Identification of sperm and non-sperm male cells in cervicovaginal smears using fluorescence in situ hybridization: Applications in alleged sexual assault cases. *J Forensic Sci* November 1994, pp.1347-1355.

LeBeau M, Andollo W, Hearn WL, et al. Recommendations for toxicological investigations of drug-facilitated sexual assaults. *J Forensic Sci* 1999; 44(1):227-230.

Ledray LE, Netzel L. Forensic nursing: DNA evidence collection. *J Emerg Nursing* 1997;23(2):156-158.

Nagesh P, Collins KA, Geisinger KR, Parsons LH, Schnell S, Hayworth-Hodge R, Tap MP, Lantz PE, Pettenati MJ. Identification of male epithelial cells in routine postcoital cervicovaginal smears using fluorescence *in situ* hybridization. *Anat Path* 1995;104(1):32-35.

Smock WS. The forensic aspects of caring for victims of domestic assault: Identification of pattern injuries. *PVS* September-October 1997.

Toluidine Blue

Bays J, Lewman LV. Toluidine blue in the detection at autopsy of perineal and anal lacerations in victims of sexual abuse. *Arch Pathol Lab Med* 1992;116:620-621.

Hochmeister MN, Whelan M, Borer UV, Gehrig C, Binda S, Berzlanovich A, Rauch E, Dirnhofer R. Effects of toluidine blue and destaining reagents used in sexual assault examinations on the ability to obtain DNA profiles from postcoital vaginal swabs. *J Forensic Sci* 1997;42(2):316-319.

Hochmeister M, Ferrell J. The health care response: A complete guide to the forensic examination and evidence collection of the adult sexual assault patient. Video 1998.

Lauber AA, Souma ML. Use of toluidine blue for documentation of traumatic intercourse. *Obstet Gynecol* 1982;60(5):644-648.

McCauley J, Gorman RL, Guzinski G. Toluidine blue in the detection of perineal lacerations in pediatric and adolescent sexual abuse victims. *Pediatrics* 1986;78(6):1039-1043.

McCauley J, Guzinski G, Welch R, Gorman R, Osmer F. Toluidine blue in the corroboration of rape in the adult victim. *Am J Emerg Med* 1987;5:105-108.

Use of Colposcope

McCann J. Use of colposcope in childhood sexual abuse examinations. *Pediatr Clin North Am* 1990;37(4):863-880.

Muram D. Child sexual abuse: Relationship between sexual acts and genital findings. *Child Abuse Negl* 1989;13:211-216.

Teixeira WR. Hymenal colposcopic examination in sexual offenses. *Am J Forensic Med Pathol* 1980;2:209.

Wooding BA, Hager A. The use of the colposcope in the diagnosis of sexual abuse in pediatric age group. *Child Abuse Negl* 1986;10:111.

Policy Resources

American Academy of Pediatrics (AAP)

141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1098
847-228-5005
847-228-5097 (Fax)
<http://www.aap.org>

American Board of Forensic Odontology (ABFO)

<http://www.abfo.org>

American College of Emergency Physicians (ACEP)

1125 Executive Circle
Irving, TX 75038-2522
972-550-0911
972-580-2816 (Fax)
<http://www.acep.org>

American College of Obstetricians and Gynecologists (ACOG)

409 12th Street SW, PO Box 96920
Washington, DC 20090-6920
202-638-5577
<http://www.acog.org>

American Medical Association (AMA)

515 N State Street
Chicago, IL 60610
312-464-5000
312-464-4184 (Fax)
<http://www.ama-assn.org>
<http://www.ama-assn.org/public/releases/assault/sa-guide.htm#acute>
(Guide: Acute management of sexual assault victims)

American Professional Society on the Abuse of Children (APSAC)

<http://www.apsac.org/>

American Prosecutors Research Institute (APRI)

99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
<http://www.ndaa-apri.org/>

American Psychological Association (APA)

750 First Street NE
Washington, DC 20002
<http://www.apa.org/>

American Society for Testing & Materials (ASTM)

100 Bar Harbor Drive

West Conshohocken, PA 19428-2959

<http://www.astm.org/>

[http://www.astm.org/cgi-](http://www.astm.org/cgi-bin/SoftCart.exe/DATABASE.CART/PAGES/E1843.htm?L+mystore+knyv3058)

[bin/SoftCart.exe/DATABASE.CART/PAGES/E1843.htm?L+mystore+knyv3058](http://www.astm.org/cgi-bin/SoftCart.exe/DATABASE.CART/PAGES/E1843.htm?L+mystore+knyv3058)

(ASTM Standard Guide for Sexual Assault Investigation, Examination, and Evidence Collection)

American Society of Crime Laboratory Directors (ASCLD)

ASCLD c/o NFSTC

SPJC Allstate Center

3200 34th Street South

St. Petersburg, FL 33711

<http://www.asclcd.org>

Centers for Disease Control and Prevention (CDC)

1600 Clifton Road NE

Atlanta, GA 30333

404-639-3311

<http://www.cdc.gov>

Office of Womens Health Violence and Injury Prevention page

<http://www.cdc.gov/od/owh/whvio>

Federal Bureau of Investigation (FBI)

J Edgar Hoover Building

935 Pennsylvania Avenue NW

Washington, DC 20535-0001

<http://www.fbi.gov/>

International Association of Chiefs of Police (IACP)

515 N. Washington St

Alexandria, VA 22314-2357

Ph: 703-836-6767

<http://www.theiacp.org>

International Association of Forensic Nurses (IAFN)

<http://members.aol.com/COCFCI/index.html>

National Alliance of Sexual Assault Coalitions (NASAC)

<http://www.connsacs.org/alliance.htm#alliance>

National Coalition Against Sexual Assault (NCASA)

125 N Enola Drive

Enola, PA 17025

Ph: 717-728-9764

<http://ncasa.org>

National Network Childrens Advocacy Center (NNCAC)

236 State Capital

Salt Lake City, UT 84114

<http://www.nncac.org/>

Other Resources

<http://www.ojp.usdoj.gov/search97cgi/vtopic>

(US Department of Justice statistics on sexual assault)

American Bar Association

The ABA recommends calling the local bar association for legal assistance and requesting the lawyer referral service.

National Victims Center

800-FYI-CALL

703-276-2880

Sexual Assault Crisis Centers in the US

Published by VAASA Virginians Aligned Against Sexual Assault

508 Dale Avenue, Suite B

Charlottesville, VA 22903-4547

804-979-9002

(lists sexual assault services by state)

National Resource Center Against Domestic Violence

800-537-2238

National Clearinghouse on Marital and Date Rape

510-524-1582 fee-based telephone service

National Resource Center on Child Sexual Abuse

2204 Whitesburg Drive, Suite 200

Huntsville, AL 35801

800-543-7006

Direct contact with information specialist

205-534-6868

The National Clearinghouse on Child Abuse and Neglect Information compiles a state statute series each year. It covers reporting laws, central registries, investigations, child witness information, crime definitions, and permanency planning. Approximate cost is \$100.

It can be ordered through:

PO Box 1182

Washington, DC 20013-1182

800-FYI-3366 or 703-385-7565

<mailto:statutes@calib.com>

<http://www.calib.com/nccanch>

National Organization of Victim Assistance (NOVA)

1757 Park Road North West

Washington, DC 20010

202-232-6682

Kendal Hunt Publishing Co.

Book of Victim Assistance Resource Programs

1-800-228-0810 (I.D. no 9460)

(contains local and national mental health and legal resources)

Rape, Abuse and Incest National Network (RAINN)

800-656-HOPE, ext. 2

<http://www.rainn.org>

RAINN provides contact information for the nearest rape crisis center. More than 700 rape crisis centers participate in RAINN.

Regional Children's Advocacy Centers

Midwest Regional Children's Advocacy Center

(Ohio, Indiana, Michigan, Illinois, Wisconsin, Missouri, Iowa, Minnesota, Kansas, Nebraska, South Dakota, and North Dakota)

The Midwest Children's Resource Center

360 Sherman Street, Suite 200

St. Paul, MN 55102

888-422-2955

or 651-220-6750

Southern Regional Children's Advocacy Center

(Maryland, Virginia, North Carolina, South Carolina, Alabama, Georgia, Florida, Mississippi, Louisiana, Tennessee, Kentucky, Arkansas, Texas, District of Columbia, Delaware, Oklahoma, and West Virginia)

70 Woodfin Place, Suite 408

Asheville, NC 28801

800-747-8122

or 704-285-9588

Northeast Regional Children's Advocacy Center

(Maine, New Hampshire, Vermont, New York, Massachusetts, Connecticut, Rhode Island, Pennsylvania, and New Jersey)

4000 Chestnut Street

Philadelphia, PA 19104

800-662-4124

Western Regional Children's Advocacy Center

(Montana, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada, Idaho, Oregon, Washington, Alaska, Hawaii, and California)

301 W. 13th

Pueblo, CO 81003

800-582-2203

or 719-543-0380



Sexual Assault Nurse Examiner

SANE



Development
&
Operation Guide

SANE Development and Operation Guide

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 the most recent update 86 SANE programs were identified (Ledray: 96b). 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 fifty-nine programs responding, three were established between 1976 and 1979; 10 between 1980 and 1989; and 46 were developed between 1990 and 1996. While the initial SANE development was slow, with only three programs in existence at the end of the 70s, program development today is progressing rapidly.

This current flurry of interest is to a great extent a result of the media attention created by the 1994 recognition of the Tulsa SANE program when they 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 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 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), Department of Justice (DOJ), recognized the need for additional information and technical assistance when they funded this project. It was OVC's goal, and it is the goal of this project, to facilitate SANE program development by providing state-of-the-art 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 they are utilizing the most current information and standards.

It is our goal to provide in this manual all the information necessary 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.

SANE Development and Operation Guide

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 began with a complete review of the SANE literature. The information available is included in this guide, with references, for your use. In addition, it is based on the information from the 59 (68%) programs who responded to the survey of the 86 programs identified in the 1996 *JEN* survey (Ledray: 96b). Follow-up 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 judgement 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 to refer to the victim population in this guide. This decision was made based on the fact that the majority of victims 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 involving the sexual organs of one person 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 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 the completeness and utility of this manual. The questionnaire consists of two pages that are designed to be torn out of the manual, folded in half with the address visible, stapled and put into the mail.

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.

SANE Development and Operation Guide

CHAPTER 2

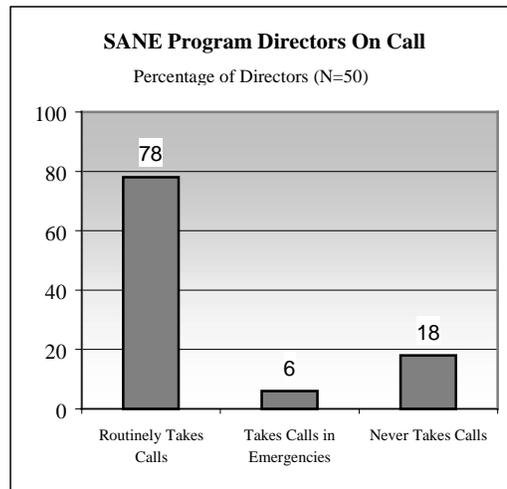
SANE HISTORY AND DEVELOPMENT

Even though rape has likely occurred for as long as man has existed (Brownmiller: 75), there has only been a concerted effort to better understand the issue and better meet the needs of survivors since the early 1970s. One of the first researchers to systematically study the impact and needs of this population was a nurse, Dr. Ann Burgess (Burgess & Holmstrom: 73). She identified a pattern of response which she referred to as Rape Trauma Syndrome (Burgess & Holmstrom: 74). Dr. Burgess has remained 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% decrease in reported rapes from 1994, and a 9% decrease from 1991. Even though the numbers 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% of the 1995 forcible rapes occurred in the most heavily populated southern states, 25% in the midwestern states, 23% in the western states, and 13% in the northeastern states.



The two-year trend indicates there was a decline in all regions of the country, especially in large metropolitan areas. In the ten-year period that the rate of reported forcible rapes declined 10% in large metropolitan areas, the rate actually increased 70% in smaller suburban cities and 40% in rural areas. The northeast and midwest states experienced a 6% decline, the south a 5% decline, and the west a 2% decline in reported forcible rapes. The highest reporting rate occurred in August and the lowest reported rate was in December (Uniform Crime Report: 96).

SANE Development and Operation Guide

SANE GUIDE: CHAPTER 2

HISTORY AND DEVELOPMENT

It is important to remember that the actual rate remains unknown. We can only speculate that this increase outside of metropolitan areas represents an actual increase in crime. It 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 program, while approximately 20% of victims are uncertain about reporting when they first came to the emergency department (ED), working through their fears and concerns with a knowledgeable SANE has allowed 95% 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 interestingly higher for rape than for any other index crime. In 1995, 8% of forcible rapes were determined by law enforcement to be "unfounded", compared with 2% of all other index crimes (Uniform Crime Report: 96). The assumption is that all "unfounded" cases are false reports, deceitfully reported even though no actual rape occurred. However, this is not necessarily the case. Reported rape cases are actually classified by police as "unfounded" for a variety of reasons.

While the use of this classification varies greatly from one community to another, it is often used in the following situations:

- 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 the difference between an untrue rape 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% 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% of rapists go to jail either as the result of guilty pleas or guilty verdicts (Minneapolis Police Chiefs Report: 89). This is true even though 51% of reported forcible rapes in metropolitan areas are cleared by arrest and 52% in rural and suburban areas. The arrest rate for forcible rapes declined in 1995 by 4% in metropolitan areas, 6% in suburban areas and 14% in rural areas (Uniform Crime Report: 96). The results were slightly better in an earlier Detroit report which indicated warrants were issued for 18% of 372 reported rapes and convictions resulted in 13% of these cases (Tintinalli, Hoelzer & Michigan: 85).

SANE Development and Operation Guide

SANE GUIDE: CHAPTER 2

HISTORY AND DEVELOPMENT

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 if further evaluation is required (Sheridan: 93). When violence such as rape is identified, trained staff need to be available to provide service. Only in 1992 did the guidelines of the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) first require emergency and ambulatory care facilities to have protocols on rape, sexual molestation and domestic abuse (Bobak: 92).

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 be treated the same as stranger rape, this act made \$800 million dollars available for training and program development over a six-year period, with \$26 million appropriated for the first year. This was an important recognition of the need for additional services for crime victims.

Fortunately, womens' groups had 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 1970s, 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.

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 across the country. It was obvious to these individuals that services to sexual assault victims were inadequate, and not at the same high standard of care as 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 four to twelve hours in a busy, public area, their wounds seen as less serious than the other trauma victims, competing unsuccessfully for staff time with 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 the survivor was blamed for the rape by the ED staff (Kiffe: 96).

Typically, the rape survivor 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

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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: 96).

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: 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: 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: 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 follow-up of rape victims, nurses and other professionals realized the importance of providing the best ED care possible (Lenehan: 91). For 75% of these victims the initial ED contact was the only known contact they had with medical or professional support staff (Ledray: 92). Nurses were also 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: 86) (Ledray: 92). 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

As a result of this identified goal to better meet the needs of this underserved population, the first Sexual Assault Nurse Examiner (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 1980s. 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 for the first time at a meeting hosted by the Sexual Assault Resource Service and the University of Minnesota School of Nursing in Minneapolis. It was at that meeting that the International Association of Forensic Nurses (IAFN) was formed (Ledray: 96b). 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 1970s, development today is progressing much more rapidly. We are now aware of ten 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.

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After years of effort on the part of SANEs, 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 ten years the JCAHO would require every hospital to have a forensic nurse available (Marullo: 96).

Summary

While the growth of the SANE concept was slow in the 1970s and 1980s, it is anticipated that the development of SANE programs in the 1990s will continue to be rapid. This concept has proven itself effective both in terms of cost savings and especially in the quality of service provided to the rape victim. It is important that programs that are beginning today have access to the lessons learned by the programs that were developed more than twenty years ago. It is the purpose of this manual to make that information readily available in hard copy as well as over the Internet, the communications method of the next century.

Minimum Core Content

At a minimum, health care professionals practicing in the area of sexual assault should receive instruction on the following topics, especially as they relate to specific local, legal, clinical, and follow-up issues:

- Multidisciplinary Team Concept
- Dynamics of Sexual Assault
 - Myths and realities
 - Rape Trauma Syndrome, Post-traumatic Stress Disorder (PTSD)
- Sexual Assault Forensic Examination
 - Communication skills
 - History
 - Physical assessment
 - Detailed genital examination
 - Physical evidence collection
 - Forensic photography
 - Documentation
- Criminal Justice System

Source: Curriculum excerpts based on the “Sexual Assault Nurse Examiner Education Guidelines” of the International Association of Forensic Nurses. (Complete curriculum outline on adult and children available from the IAFN on request.)

- Anatomy and physiology as it relates to sexual assault/abuse
 1. Normal male and female genital structures, from birth to reproductive age to the aged adult
 2. Effect of hormones on the genital structures
 3. Effects of the human sexual response cycle on the body
 4. Anatomic sequelae of nonconsenting sexual acts plus associated physical trauma
 5. Medical conditions, anomalies, or pathology that may influence the physical examination
- Psychological aspects of sexual assault
- Medicolegal forensic examination
 1. Patient assessment/patient history
 2. Evidence collection: physical examination/enhanced visualization/evidence collection kits/preservation of evidence
- The role of the forensic examiner in the criminal justice system
- Medical management of sexually transmitted diseases, HIV, and pregnancy
- Referral services available for the victim

Source: Curriculum based on the “Sexual Assault Nurse Examiner Development and Operations Guide” of the US Department of Justice, Office on Womens Health (Module–SANE Development & Operation Guide).

Confidentiality

Sample confidentiality statement

All information and evidence related to this investigation are privileged, confidential, and proprietary. The substance and content are exempt from disclosure to anyone, except its intended recipients, or as clearly compelled under applicable local, state, or federal law.

ACEPs policy on patient confidentiality:

American College of Emergency Physicians

Reaffirmed by the ACEP Board of Directors, October 1998

Patient Confidentiality

The American College of Emergency Physicians believes that all physicians have an important ethical and legal duty to guard and respect the confidential nature of the personal information conveyed during the patient-physician encounter. Emergency physicians implicitly promise to preserve patient confidentiality, a promise that in turn promotes patients' autonomy, privacy, and trust in their emergency physicians.

ACEP believes patient confidentiality is an important but not absolute principle. Confidential patient information may be disclosed when patients or their legal surrogates agree to disclosure, when mandated by law, or when there exist overriding and compelling grounds for disclosure, such as the prevention of substantial harm to identifiable other persons.

ACEP also acknowledges that there are circumstances in which no societal consensus exists about whether to disclose patient information. Specific problem areas include but are not limited to cases involving minors, drug testing, employee health, perpetrators and victims of violent crimes, medical records, the media, and communicable and sexually transmitted diseases. Such cases can require an extraordinary degree of sensitivity, discretion, and judgment on the part of emergency physicians.

Adult/Adolescent Patient

Adult/Adolescent Sexual Assault Forensic Medical Report

Adapted from the Forensic Medical Report Suspected Acute Adult/Adolescent Sexual Assault
State of California, Office of Criminal Justice Planning
OCJP 923

PATIENT DEMOGRAPHIC INFORMATION

Name of patient	Age
Patient ID number	Date of birth
Address	Gender
City	Ethnicity
County	Race
State	Date/time of arrival
Telephone number	Date/time of examination
	Date/time of discharge
Presence of interpreter?	
If so, name?	
Language?	

LAW ENFORCEMENT INFORMATION

Law enforcement information will be dictated by local protocol and may document:

- Name of officer who took the report and the responding office
- Agency
- ID number
- Telephone number

PATIENT NOTIFICATION

Patients may be notified about duty of medical personnel to report to law enforcement in cases of sexual assault (as dictated by local protocol). Patients should be informed that victims of crime are eligible to submit crime victim compensation claims and that Family Code sections address the ability of minors to consent to medical examination treatment and evidence collection related to sexual assault without parental consent, as dictated by state and local laws.

PATIENT CONSENT

- Consent for the following:
 - Medical legal examination for evidence of sexual assault
 - Collection of evidence including photographs
- Consent for release of information to health authorities and qualified persons
- Consent for patient advocate to attend
- Other consent as dictated by local needs/requirements

DISTRIBUTION FORM OR FORENSIC MEDICOLEGAL REPORT

Multiple legible copies of the medical report should be made available to law enforcement, forensic laboratory, and the medical facility. The medicolegal record should be maintained separately from the patient's other medical records to ensure limited access.

PATIENT HISTORY

Name of person providing history (document relationship to patient)

Document if an interpreter is used, including name and language

Pertinent medical history

 Last normal menstrual period (document any recent anogenital injuries, operations, diagnostic procedures, or medical treatment that may affect physical findings)

Other pertinent medical condition(s)

Preexisting physical injuries

Pertinent history related to the encounter

 History of other intercourse within the past 72 hours (document time course in detail, such as when did ejaculation occur and whether a condom was used)

 Drug and alcohol use before the assault?

 Drug and alcohol use after the assault?

Post-assault hygiene activity: Document whether the patient did any of the following after the encounter:

 Urinated

 Defecated

 Vomited

 Douched

 Removed/inserted tampon/diaphragm

 Wiped/cleaned genital area

 Bathed/showered

 Gargled/brushed teeth

 Smoked

 Ate or drank

 Chewed gum

 Changed clothing

 Took medications

ASSAULT HISTORY

Document patient's description of the encounter in direct quotes if at all possible:

- Date of assault(s)
- Time of assault(s)
- Physical surrounding of assault(s)
- Lapse of consciousness
 - Anterograde amnesia
- Nongenital injury, pain, and/or bleeding
- Anogenital injury, pain, and/or bleeding
- Verbal coercion (No threats, but fear of injury experienced by patient)
- Force or coercion used
 - Weapons: threatened or used
 - Physical assault
 - Grabbing/holding/pinching
 - Physical restraints
 - Drugs used to facilitate sexual assault; Voluntary ingestion; Clandestine drugging of patient
 - Choking
 - Burns
 - Threat(s)
 - Target of threat
 - Ingestion of a substance (including alcohol or suspected drugs)
- Injuries inflicted on assailant(s) during assault (Describe.)
- Acts described by patient (Note that any penetration, however slight, constitutes the act)
- Oral copulation requires only contact
- If more than one assailant, identify by number

Document the following acts and whether a penis, finger, or other object was used:

- Penetration of labia majora (vulva or deeper structures)
- Penetration of anus or deeper structures
- Oral copulation of genitals
- Oral copulation of anus
- Nongenital acts
 - Biting of patient or by patient on perpetrator
 - Licking
 - Kissing
- Other acts
- Did ejaculation occur? If yes, note location:
 - Vulva or deeper structures
 - Anus or deeper structures
 - Body surface
 - Clothing
 - Bedding
 - Mouth
 - Other

Contraceptives or lubricant products used

- Document use of foam, jelly, lubricant, and/or condom, and the brand, if known
- Recent consensual intercourse

GENERAL PHYSICAL EXAMINATION AND FINDINGS

- Vital signs
- Date and time of examination
- General physical appearance
- General demeanor/behavior/orientation
- Description of clothing on arrival
- Conduct physical examination and document, draw, number injuries/findings, including size and appearance, on a diagram (Figure 5) and use a legend for abbreviations or numbers (be specific)

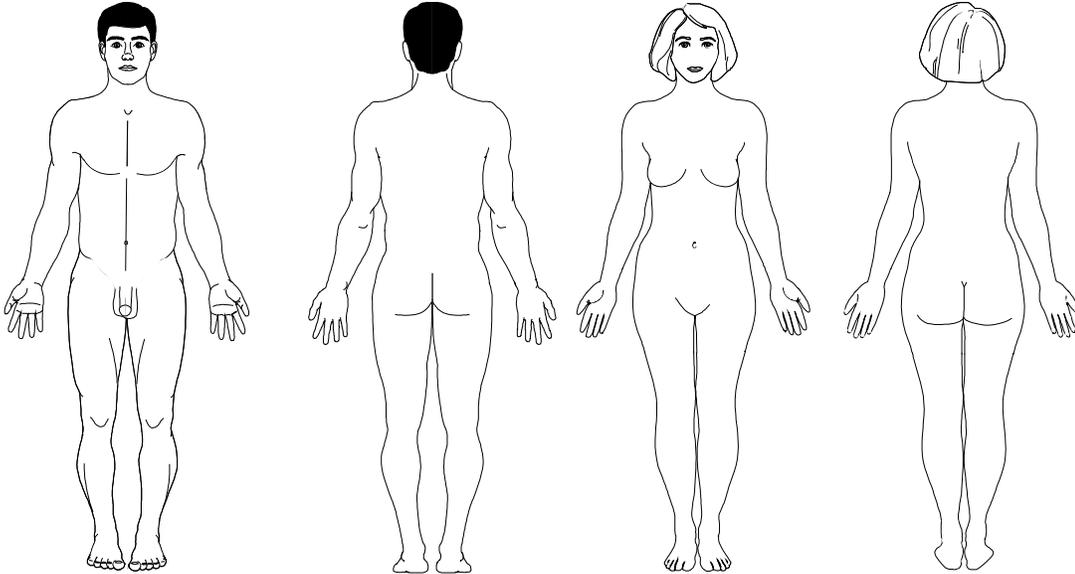


Figure 5

- Alternative light source examination (such as Wood's lamp)
- Collect dry and moist secretions, stains, and foreign materials from the body, including head, hair, and scalp
- Collect fingernail scrapings or cuttings according to local policy
- Examine the oral cavity for injury
- Collect dried and moist secretions, stains, and foreign materials from the lips, perioral region, and nares
- Collect reference samples per local protocol (Module–Adult/Adolescent Patient)
- Swab the areas the suspect kissed, licked, or sucked

GENITAL EXAMINATION—FEMALE

Perform an external examination and document findings (Figure 6) of the external genitalia and perineal area specifically for injury, foreign materials, and other findings in the following areas:

Abdomen
Thighs
Perineum
Labia majora
Labia minora
Clitoral hood and surrounding area
Periurethral tissue/urethral meatus
Perihymenal tissue (vestibule)
Hymen
Fossa navicularis
Posterior fourchette

Follow procedure noted in the sexual assault kit or evidence collection kit

Examine the vagina and cervix for injury, foreign materials, and foreign bodies. Use colposcope or other magnification, if available (Module—Use of Colposcope)

Examine the buttocks, perianal skin, and anal folds for injury, foreign materials, and other findings
Consider anoscopy if rectal injury is suspected

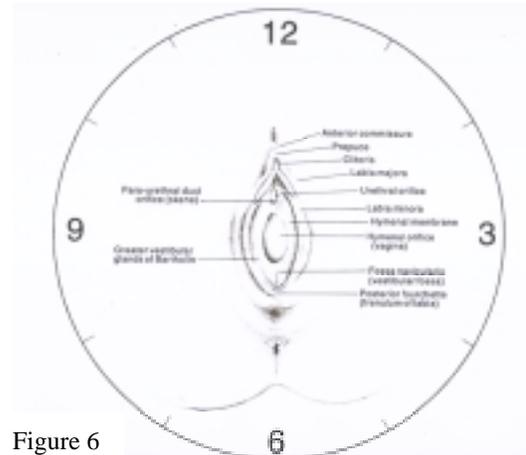


Figure 6

GENITAL EXAMINATION—MALE

Examine the external genitalia and perineal area (Figure 7) for injury, foreign materials, and other findings; include the following body areas:

Abdomen
Buttocks
Thighs
Foreskin
Urethral meatus
Shaft
Scrotum
Perineum
Glans
Testes

Document whether the patient is circumcised

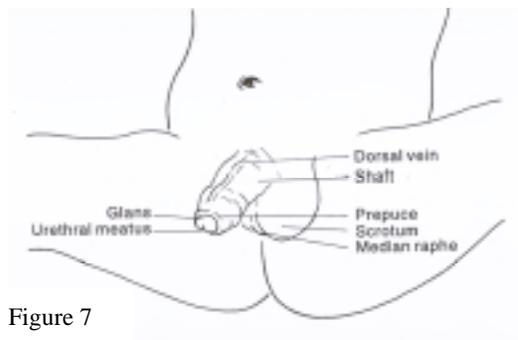


Figure 7

DOCUMENT EVIDENCE SUBMITTED TO THE FORENSIC LABORATORY

Document all materials sent to the forensic laboratory, including the following:

Clothing
Foreign materials on the body
Blood
Dried secretions

Fiber/loose hairs
Vegetation
Soil/debris
Swabs of suspected semen
Swabs of suspected saliva
Swabs of areas highlighted by alternative light source (such as Wood's lamp)
Body cavity samples
Oral sample
Vaginal/anal sample
Fingernail scrapings/cuttings
Matted hair cuttings
Pubic hair combing/brushing
Intravaginal foreign body
Intrarectal foreign body
Oral genital samples
Reference samples
 Buccal swabs/blood
 Toxicology samples: blood and/or urine
Photodocumentation (Module–Medicolegal Photography in Sexual Assaults)
Document use of toluidine blue (Module–Use of Toluidine Blue)
Document all examination methods used

PERSONNEL INVOLVED IN SEXUAL ASSAULT EVALUATION

Document all personnel involved in taking the history, performing the physical examination, and handling specimens, including times.

OVERALL CLINICAL ASSESSMENT

Please note that history of sexual assault with no physical findings may still be consistent with the sexual assault. Avoid legal terms such as “rape” or “abuse.”
Please accurately document the assessment of the patient, remembering that the lack of obvious injuries does not preclude the possibility that sexual assault took place.
Name of health care provider
Signature of health care provider performing the examination

LAW ENFORCEMENT INFORMATION

Document the name and ID number of the officer to whom the kit is given and the officer's agency and the date the kit is transferred to the officer. Include a comprehensive list of the evidence collected.

At the conclusion of the examination, brief the law enforcement person on findings, interpretation, and assessment. Anything found during the examination, such as foreign fibers like dirt, carpet, and so on, should be discussed.

Sexual Assault Kit

Before a kit is designed and samples are collected, a dialog among the health care, forensic, and legal entities involved should occur. **Samples and collection techniques vary from jurisdiction to jurisdiction in type and amount and will change as technology advances. Basic collection must include oral, vaginal, and anal samples, as appropriate.**

Preparation:

- If labels are not provided in the kit, make 20 to 40 labels with the patient's name, hospital record number, date and time, and signature or initials of health care professional collecting the evidence
 - Have extra examination paper/swabs and (optional) slides
 - Pair of sterile forceps
 - Culture materials
 - Water to moisten swabs
 - 3 ml syringe and plastic catheter (only if vaginal wash is collected)
 - Urine cup (if not included/required in kit)
 - Wood's lamp or alternative light source, especially on all bite marks and bruises
 - Speculum (moisten with warm tap water; avoid lubrication because it dilutes the foreign sample)
 - Swab drying box or drying agents (Module–Forensic Laboratory Testing)
- Use only paper to package evidence
 - Air dry wet evidence for at least 60 minutes
 - Use an alternative light source (such as Wood's lamp) on clothing and skin; record all Wood's lamp (WL) findings on the diagrams and label as WL
 - Dried stains should be either flaked off into a bindle or wiped with a moistened (one drop of water) swab
 - Wet stains should be wiped with a dry swab. NOT all semen fluoresce; collect all suspicious stains
 - Dry all wet specimens
 - Photograph as appropriate (Module–Medicolegal Photography in Sexual Assault)
 - Use a wet gauze to moisten sticky seals, do not lick them

Step 1: Clothing

- Place a clean hospital sheet on the floor as a barrier. Then place collection paper on barrier sheet. Examiner must be careful to prevent evidence transfer. This is prevented by changing gloves whenever cross-contamination could occur. Clearly document all findings. Have the patient first remove the shoes and then undress (if someone assists, they should also wear gloves) over collection paper to catch any debris that is dislodged
- Collect only clothing pertinent to the assault. Place each piece of clothing and collection paper in separate paper bags, label, seal and initial seal. Collect shoes, if pertinent (depending on local statutes)
- If additional bags are needed, use grocery-style paper bags only
- Tape/seal bag(s) closed; label, seal, and initial seal
- Barrier sheet is **not** submitted as evidence

Debris

- Collect obvious debris on patient's body (plant material, fibers, hair, soil, grass, and so on) on the sheet of paper provided—bindle, label, seal, and initial seal
- Optional—If fingernail scrapings are collected, place fingernail scrapings and tool used to obtain sample in a paper bindle, label, seal, and initial seal. If fingernails are broken, cut the remaining jagged edge for later comparison. Collect decorated fake nail as known sample if one fake nail is missing
- Place the patient in an examination gown

Step 2:

Dried secretions

Inspect the body carefully for dried secretions, bruises, bite marks, and burns

- Flake dried secretions into a paper bindle or swab dried secretions with a swab moistened with one drop of water
- Optional—Smear swabs onto two microscope slides
 - Air dry all specimens, label, place in envelope, seal, and initial seal
 - Photograph all bite marks and swab bite marks for trace evidence using the double-swab technique (Module—Bite Mark Guidelines)
 - Swab not just bite marks but also all areas the perpetrator kissed, licked, or sucked

Step 3:

Oral sample

- Place two swabs together to collect specimen from oral cavity between gums and cheeks and under tongue; remove dentures and swab with same swabs
- Optional—Smear swabs onto two microscopic slides
- Air dry slides and swabs
- Place slides in holder and swabs in carton; place in envelope
- Label and seal envelope, and initial seal

Step 4:

Head hair combing

- Remove paper and comb provided in envelope; Patient can do the combing
- Unfold and place paper under patient's head. Using comb provided, comb head hair toward the paper
- If hair is matted because of stains, cut matted hair and place on collection paper
- Place comb in center of paper and fold into bindle with comb inside
- Label, place in envelope, seal, and initial seal

Concerning steps 5 and 7: The sexual assault examiner is responsible for the collection of evidence from every appropriate part of the body. However, collection of hair standards (head or pubic) may be delayed until requested by the forensic laboratory. Protocols vary in number (25 to 100), method (plucking versus cutting), and timing (immediate versus delayed). There are times when plucking 100 pubic hairs immediately may be inappropriate compared with initially obtaining a fewer number of hairs, some cut, and delay further collection. It is suggested that all local protocols be requested, with the understanding that as with any other part of the examination after being informed, it can be declined by the patient.

Step 5:

Optional—Pulled head hair (may be delayed at the discretion of law enforcement and the patient). Patient can collect hairs.

- Remove paper bindle and unfold
- Use fingers; do not use forceps or tweezers
- Pull, do not cut, a minimum of eight full length head hairs from top, front, back, left side, and right side (40 total)
- Collect unusually colored hairs, such as purple, and so on. Collect hairs from wigs and hairpieces; place in separate bindle, label, and place in collection paper
- Place hairs in bindle and refold
- Label and seal envelope; initial seal
- In a young child, hairs may be cut close to the scalp to avoid additional discomfort (if cut, indicate on the envelope)
- It is best to get a random sampling of hairs from various parts of the head

- Step 6: Pubic hair combing*
- Place collection paper under patient's buttocks and comb hair toward the paper (patient can do this)
 - Collect secretions dried on the pubic hair by cutting the matted hair and placing on the collection paper
 - Fold comb with debris/matted hair into paper; place folded paper in envelope
 - Place in envelope, label, seal, and initial seal

- Step 7: Pulled pubic hair (may delay collection until requested by the forensic laboratory)*
- Remove paper bundle and unfold
 - Pull the hair; DO NOT CUT (patient can do this)
 - Use fingers only; tweezers or forceps crimp the hair
 - Pull a minimum of 25 hairs from all areas of the pubis
 - If debris or semen is matted in the hair, cut it out and add to the pubic hair sample bundle
 - Place hairs in the bundle and refold
 - Place in envelope, label, seal, and initial seal

- Step 8: External genital sample (especially important in children)*
- Swab external genital area with two swabs, rolling swabs together as you collect
 - Smear the swabs on the two microscope slides
 - Air dry swabs and slides for 60 minutes. If drying or desiccant agents are used, swabs must be packaged immediately. Package swabs and two desiccant packs in an airtight container (15-ml tube size) or glassine envelope folded over to be airtight (Module–Forensic Laboratory Testing)
 - Place slides in holder and swabs in cartons
 - Place in envelope, label, seal, and initial seal

- Step 9: Toluidine blue dye/colposcopy/photodocumentation (Modules–Medicolegal Photography in Sexual Assaults; Use of Toluidine Blue; Use of Colposcope)*

Concerning step 10: The examiner must consider local policy, potential issues of patient needs and wants, and the need for collection of evidence from appropriate parts of the body. There are times, however, when a patient will deny anal touching or penetration because of embarrassment, and valuable evidence would be lost. It is suggested that a routine anal swab be requested of each sexual assault patient, at the same time making it clear that, as with any other part of the examination, it can be declined after the patient is informed. The examiner must also consider the likelihood of a positive test, potential trauma to the patient, and the need to collect immediate evidence.

- Step 10: Anal sample*
- Use alternative light source (such as Wood's lamp) on anal area and flake off or swab areas of dried secretions; place on slide (optional); air dry; and place in envelope labeled "perianal"
 - Use two swabs together to collect a sample from the anal cavity (avoid contact with external skin surfaces)
 - Air dry, place in holders, and place in envelope
 - Label and seal envelope, and initial seal

- Step 11: Vaginal/penile sample*
- Use two swabs together to collect specimen from vaginal pool

- Optional—Smear one swab on slide for wet mount; slide is prepared by placing one drop of normal saline onto slide. Roll swab into drop and cover with a coverslip. View for presence of motile sperm under 400x (within 10 minutes). Package this swab and slide separately and label as “wet mount”
- Optional—Smear other swabs onto slides
- Air dry all swabs and slides, place in appropriate holders (wet mount slide goes into single slide holder), and place in envelope
- Label and seal envelope, and initial seal
- In a prepubertal female, swabs may be premoistened with sterile, nonbacteriostatic saline or water to avoid discomfort

Step 12:

Optional—vaginal washings

- Use 3 ml of sterile saline or water for vaginal lavage (use plastic catheter and 3 ml syringe)
- Aspirate and place in tube provided
- Tightly secure cap
- Label, place in envelope, and seal envelope; initial seal

Step 13:

Toxicology—for best accuracy of toxicology evaluation, urine should be collected on all patients up to 72 hours.

Urine sample if drug and/or alcohol ingestion is suspected

- If possible, perform the vaginal examination (if applicable) before collecting the urine sample
- Collect urine in a specimen cup
- If only 40 ml, collect two specimens, but 100 ml is recommended per LeBeau et al.
- Label, seal, and initial the seal
- **DO NOT PUT URINE SAMPLE IN KIT; PACKAGE SEPARATELY,** depending on local protocol

Blood sample (if drug ingestion up to 12 hours)

- Collect three gray top (fluoride) tubes, 30 ml total

Step 14:

Optional—known reference sample

Buccal swab may be used instead of blood sample

- Remove sterile swab from envelope
- Have patient rinse their mouth with tap water, and then expose buccal (inner) area of cheek
- Swab with gentle pressure
- Place in envelope, label, seal, and initial seal

Optimal collected reference sample

Collect a saliva reference sample at the time if required by the local forensic laboratory

Patient may do this with his/her fingers

- Using forceps (clean), place clean gauze, filter paper, or pledget under tongue and allow it to remain there until saturated; handle sample only with tweezers
- Air dry and place in envelope as provided, label, seal, and initial seal

Step 15:

Optional—known blood sample

Dry sample

- Using an alcohol prep pad or a betadine swab, wipe the tip of the left or right ring finger
- Using the sterile lancet provided, prick the finger

- While holding the finger over one of four circles on the blood collection card, milk the finger, allowing two drops of blood to fall in a circle. Repeat this procedure for the remaining circles
- Allow blood on card to air dry. FILL OUT VICTIM NAME ONLY ON THE FIRST LINE
- Return blood collection card to envelope
- Seal envelope with evidence, label, seal, and initial seal

Liquid sample for DNA purposes

- *Collect blood in EDTA powder (lavender top tube)*
- *Invert 10 times to mix*
- *Place patient's name, date and time of collection, and collector's initials on tube label*
- *Place in envelope*
- *Label, seal envelope, and initial seal*

Step 16: Other items collected

- Examples include a condom or tampon; swab them and include (Dry them before placing in paper bag)

Medical report

- Complete appropriate documentation.

Place appropriate envelopes and specimens in container

Label and seal with evidence seal provided, and initial seal

Document the name and ID number of the officer, the officer's agency and the date. Also retain a comprehensive list of the evidence collected

Clinical Evaluation Summary

Clinical Evaluation	Child	Adolescent	Adult
Sexual assault kit \leq 72 hours ¹	\pm ¹	+ ¹	+
Sexual assault kit >72 hours ¹	-	\pm	\pm
Cultures—recent (\leq 72 hours) ²	-	-	-
Cultures—chronic ³	+	+	+
Use of colposcope (Module—Use of Colposcope)	\pm	\pm	\pm
Use of alternative light source (such as a Wood’s lamp)	\pm	\pm	\pm
Antibiotic prophylaxis for STDs ⁴	-	+	+
HIV prophylaxis ⁵	\pm	\pm	\pm
Hepatitis B vaccine: patient immunized ⁶	-	-	-
Hepatitis B vaccine: patient not immunized ⁷	+	+	+
Tetanus: patient immunized >5 years or underimmunized	<7 years old—DaPT	\geq 8 years old—DT	Td

¹ Selective completion of the sexual assault kit in the child may be most appropriate. This would allow the health care professional to complete those parts of the sexual assault kit that are pertinent to the history and clinical findings of the patient. This management strategy is most applicable to the pediatric patient who is often frightened by the examination and may suffer emotional trauma as a result. The sexual assault kit should be completed in cases of sexual assault occurring in less than 72 hours. After 72 hours, new technology, such as DNA, may identify the perpetrator in cases in which evidence is present in the vagina for 3 weeks or more and on clothing for years; therefore, in selected cases, the kit may be completed after 72 hours (Module—References).

² Initial STD testing is a controversial issue. In most instances, the results of the culture will be negative, and if positive, they may or may not indicate new infection. Because these specimens are not forensically indicated, one management strategy is that no culture be taken acutely unless obvious signs of STDs are present. For chronic sexual abuse cases, obtain cultures because chronic infection may be asymptomatic.

³ After 3 to 7 days, it may be helpful to take cultures that might indicate an infection that was introduced at the time of the sexual assault. Cultures should be taken if there is a high prevalence of STD and for patients for whom there is physical evidence of infection with a STD.

⁴ Patients in whom there has been vaginal or anal penetration with or without ejaculation or oral penetration with ejaculation should be considered for antibiotic prophylaxis. For nonchronic sexual abuse in the asymptomatic prepubescent child, two options exist: 1) to provide prophylaxis based on the history as above or in the presence of another STD; and 2) do not provide prophylaxis but schedule the child for a 2-week return visit, when cultures would be taken for children based on the history (as above or at high risk for STDs in the community or perpetrator) and if symptomatic. All patients should be given instructions to return immediately if symptoms develop (Module—Sexually Transmitted Disease).

⁵ HIV prophylaxis is not universally accepted as a standard of practice but may be considered in selected cases. The risks and benefits of the medication regimen must be considered. HIV prophylaxis may be given in cases in which there has been anal or vaginal penetration or oral penetration with ejaculation. In addition, other information can be used to evaluate the risk of HIV transmission to patient, such as history of repeated abuse, multiple perpetrators, perpetrator known to be HIV positive, and high prevalence of HIV in the area in which the sexual assault occurred (Module—HIV).

⁶ If patient is surface antibody negative, then proceed with hepatitis B vaccination. If the patient has not received the complete hepatitis B vaccine series, complete the series.

⁷ Provide hepatitis B vaccine at time zero and at 1 and 6 months.

Bite Mark Guidelines

These guidelines are the result of a collective effort of a bite mark workshop of the American Board of Forensic Odontology. The collection method is that of Sweet and Lorente (Module–References). These guidelines are considered dynamic, not static, and should be modified as significant developments evolve. Careful use of these guidelines in any bite mark case will enhance the quality of the investigation and conclusion.

I. Description of bite mark

A. Demographics

1. Name of patient
2. Case number
3. Date of assault
4. Date of examination
5. Referring agency
6. Age of patient
7. Race of patient
8. Sex of patient
9. Name of examiner

B. Location of bite mark

1. Describe anatomic location
2. Describe surface contour: flat, curved, irregular
3. Describe tissue characteristics
 - a. Underlying structure: bone, cartilage, muscle, fat
 - b. Skin: relatively fixed or mobile

C. Shape

Describe as essentially round, ovoid, crescent, irregular, double

D. Color

Note the color, such as red, purple, and so on

E. Size

Vertical and horizontal dimensions of the bite mark should be noted, preferably in the metric system. The distance between canines should be documented, if clear. The circular arc should be documented (preferably with a metric scale such as the ABFO #2 scale; if a metric scale is not available, a quarter next to the wound in one picture can be substituted). The presence or absence of suction applied to the bite area should be documented when possible.

F. Type of injury

1. Petechial hemorrhage
2. Contusion (ecchymosis)
3. Abrasion
4. Laceration
5. Incision
6. Avulsion
7. Artifact

G. Other information

Note whether the skin surface is indented or smooth

¹. ABFO #2 scale is available from the Lightning Powder Co, 800-852-0300, Catalog number 6-3875.

II. Collection of evidence from patient

Gathering bite mark evidence should be done with authorization from the patient (and/or the proper authorities). Note whether the bite mark has been affected by washing, contamination, lividity, change of position, and so on.

A. Photography

1. Orientation and close-up photographs with and without a metric scale marker, and containing identifying information (case number, date, initials, and so on)
2. Photographic resolution should be of high quality (a macro lens with ring and point flash)
3. If color film is used, accuracy of color balance should be ensured
4. In using the scale, ensure that it is on the same plane and adjacent to the bite mark. It is desirable to include a circular and a linear scale. The ABFO #2 scale incorporates both of these elements. Ultraviolet light can be used to photograph bite wounds months after they occur even when the overlying skin appears totally normal. This method should be used when historically indicated.
5. The most critical photographs should be taken in a manner that will eliminate distortion. Some high-end 35 mm cameras have interchangeable focusing screens. Use of an architectural grid screen in conjunction with the ABFO #2 scale will help reduce distortion.
6. It is beneficial to obtain serial photographs of the bite mark over a period of time

B. Salivary swabbing

1. Whenever possible, salivary trace evidence should be collected as guided by the patient history and/or the use of an alternative light source such as a Wood's lamp
2. Use the double-swab technique to collect the saliva
 - a. Immerse the tip of the first swab in water
 - b. Roll the tip of the swab over the skin using moderate pressure and circular motions
 - c. Air dry the swab for 60 minutes
 - d. Do not moisten the second swab, but use it dry
 - e. Roll the tip of the swab over the skin using moderate pressure and circular motions
 - f. Air dry the swab for 60 minutes
 - g. Package both swabs together in a paper envelope, label, and seal
 - h. Do not lick the evidence envelope because it will contaminate the sample

Medicolegal Photography in Sexual Assault

One picture is worth a thousand words.
A few pictures, taken well, leaves one speechless.
Film is cheap. Document. Document. Document.
Be familiar with the camera and flash.

- I. Medicolegal photography: the camera is the extension of the brain and eyes.
The photograph will make a statement; control every element in the photograph to produce a clearer, more powerful statement. Be efficient, limit the patient's psychological and physical discomfort while being photographed. Always respect the patient's modesty. You will not have a second chance to photograph the injuries. Polaroid pictures are strongly discouraged. Detail in these photographs is not good. Photograph all visible injuries, such as bruising on back or strangulation marks.
 - A. Why photography?
 - Permanent record
 - Can be accessed at any time
 - Communicates quickly and clearly
 - More accurate than the written word
 - Reduces subjectivity and confusion
 - Adds credibility to the patient's statements
 - Do not fade as memories do
 - Refreshes memory
 - Accurate documentation of the event
 - B. Uses of photography
 - Provides true and accurate record
 - May be useful in obtaining a restraining order
 - Reduces likelihood of medical personnel having to testify
 - Produces a powerful statement
 - C. Understanding photography
 1. Light spectrum
 - a. Visible
 - i. Color
 - ii. Black and white
 - b. Ultraviolet (UV)
 - c. Infrared (IR)
 2. Film
 - a. Color/black and white
 - b. Prints/slides
 - c. Speed
 - d. Matching film to light source

II. Basic supplies

Camera(s)

Lenses: normal, wide angle, close-up¹

Filters

Electronic flash(es)

Remote or sync cord for above

Extra batteries for camera and flash

Light meter

Owner's manuals for camera and flash

Ruler

Gray card/color bar

Tripod

Film

Locking cable release

III. The camera

A. Description digital: Olympus D-500L

B. Nikon N50 autofocus/Nikkor 35 f/45.6D AF lens for injury

close-ups: Nikkor 60 mm macro AF lens

C. Lens: normal, wide angle, close-up

D. Shutter speed

E. Focus

F. Care and maintenance

Cleaning lens and cameras

Camera repair

Protection from extreme heat, cold, and humidity

IV. Taking the photograph

A. Obtain patient's consent

B. Before beginning, print the patient's name, the date, and your name or initials on a plain piece of paper. Photograph this at the beginning and end of each roll of film to identify the film. Many cameras have the ability to enter a case number so the face of the patient is not on the film. Many states allow patient's paperwork and court papers to be "Jane Doe." Check with local law enforcement.

C. What you see is what you get (photograph skin against a blue background)

1. Exposure is controlled by the shutter speed and lens aperture.

a. Automated cameras and flash units can be fooled and give incorrect exposures

b. Front, side, and back lighting

c. Light meters

d. Gray card

e. Bracketing exposures

2. Depth of field is the area in a photograph in which objects are in sharp focus

a. Control the depth of field

b. Zone focusing

3. Photograph must have a good perspective and be free from distortion

a. Use a normal focal length lens whenever possible

b. Keep the camera as level as possible

c. Photograph into the camera at eye level whenever possible

4. Sharp focus

a. Keep the camera steady

b. Focus carefully and use maximum depth of field

c. Look at the frame of your scene

¹ A macro lens, preferably 90 mm, to prevent distortion. Nonmacro "close-up" lenses give distorted images, especially along the edges.

D. Scale: An inch scale or ruler should be used

Take at least two photographs: one with and one without the scale

1. Prove that the scale was not concealing anything important
2. Do not alter the scene
3. Do not photograph fingers holding the scale in the photographs

E. Orientation of shots

Rule of Three: Take at least two shots (one with scale, one without) at three orientations

1. Full-body images with patient's face visible and clearly identifiable, showing all injuries: anterior, posterior, and lateral.
 - a. Position patient 2 feet from corner of room, using walls to reflect and diffuse the flash illumination
 - b. When photographing the back of the patient, turn the face toward the camera so the patient can be recognized
2. Medium-range photos of each separate injury inclusive of cuts, bruises, swelling, lacerations, and abrasions. Work from one side to the other and then top to bottom or design a workable method. Be consistent.
3. Close-up images of particular injuries; use the scale, see IV D above
 - a. When photographing a wound, show its relationship to another part of the body for orientation
 - b. Take at least three photographs involving the wound area
 - c. Shield uninvolved breast or genital areas with clothing or a sheet when possible
 - d. Highly graphic or erotic photographs may be deemed inadmissible in court and make the case less credible
 - e. All injuries should be recorded with a close-up lens attachment
 - f. Try to capture subtleties in texture and color
 - g. Document pattern injuries caused by object that might later be compared with the object
 - h. Use no external light source around an injured eye; further retinal damage could be caused secondary to repeated flashing of the strobe

F. Skin

1. Close-up photographs of hands and fingernails may show traces of blood, skin, or hair; damage to the nails or missing nails will be evident
2. Photograph marks of restraint or bondage around wrists, ankles, or neck; close-ups of these marks might later be compared with the rope or object in question that made the marks

G. Photograph transfer evidence that may be present on the body or clothing, such as dirt, gravel, or vegetation

V. Colposcope

- A. Use of 35 mm camera is preferable to Polaroid. Videoscopy light factor = flashes, halogens. (Module–Use of Colposcope)

VI. Accountability

- A. Take two photographs of each injury, one with and one without an inch scale
- B. Know the proper procedure for development of the film in collaboration with local law enforcement
- C. Ensure that proper chain of custody procedures are followed

Use of Toluidine Blue

Toluidine blue dye (TBD, 1% aqueous solution) is used in sexual assault examinations to aid in the identification and documentation of lacerations. Toluidine blue does not stain the surface layer of skin but will dye nucleated squamous cells in deeper layers of the epidermis exposed by even superficial lacerations. It has increased detection of trauma in children, adolescents, and adults. It can be applied in cases suspicious for both genital and anal trauma.

If used as part of the female genital examination, it should be applied by cotton swab before any internal digital or speculum examination. This is to ensure that any injuries noted are not induced by the examiner. Although DNA evidence will be preserved, care should be taken to avoid dye entering the vaginal vault. The vaginal application of the dye should occur after the anal application has been completed (if indicated) to avoid any cross-contamination. Excess dye may be blotted away with 1% acetic acid solution (1% vinegar/water) or lubricating jelly. Specific injuries identified at the posterior fourchette are most consistent with trauma from recent sexual intercourse. Use of toluidine may be unnecessary if a colposcope is available or if obvious trauma is visible. Toluidine cannot separate consensual from nonconsensual lesions. Nontraumatic inflammatory or infectious lesions will be positive. Toluidine may be useful in illuminating injuries for the nonmedical person (i.e., judge, jury).

PROCEDURE

SUPPLIES

Toluidine blue dye 1% aqueous solution
1% Acetic acid (1% vinegar/water) or lubricating jelly
Cotton swabs or 4x4 gauze pads

PROCEDURE

1. Collect all external genital specimens as indicated by examination protocol before TBD application
2. Photodocument area, if available
3. Apply TBD by using a sterile cotton swab to the genital area in question (avoid insertion of dye into vaginal vault). Dye application may be used on the labia majora, labia minora, posterior fourchette, perineal body, and perianal area
4. Gently blot away excess TBD with 1% acetic acid (1% vinegar/water) or lubrication jelly
5. Photodocument area after TBD application, if available
6. Speculum examination and other procedures

PATIENT TEACHING

Advise the patient that small traces of TBD may shed in their clothing over the next 2 days.

Use of Colposcope

Use of the Colposcope in Assessing Sexually Abused Children

The use of a colposcope is beneficial in any patient. This particular module highlights the specific use in children.

The colposcope provides:

- Optimal illumination
- 4x to 30x magnification
- Photographic or videotape documentation of the examination and findings

The colposcope:

- Enhances findings of the pediatric anogenital examination
- Has achieved widespread acceptance as the instrument for optimal visualization
- Was adapted from the gynecologic examination of the cervix (Teixeira, 1981; Wooding and Heger, 1986)
- 96% agreement between colposcopic and unaided eye examination findings (Muram, 1989)
- Can be equipped with 35 mm camera and a light source or videotape
- Can capture the entire magnified, illuminated examination (videotape), or selected parts of the examination (colposcopic photographs).

The colposcopic photograph or videotape:

- Can be reviewed by consultants for interpretation of findings
- Can prevent the child from being reexamined
- Can be reviewed by peers to achieve improved quality of performance
- Provides the basis of a national consensus regarding interpretation of findings

Regardless of the method used for the anogenital examination:

- There is significant variation in the experience of the examiner
- There is variation in the technique used for positioning and visualization of the hymen or anus
- Complete relaxation of the child optimizes the accuracy of the examination; to encourage cooperation, it is important not to touch the hymen of a prepubertal child
- Children are examined in the supine and/or knee-to-chest (buttocks up) position with labial separation and labial traction (Module—Pediatric/Adolescent Patient, Figure 2)
- The application of warm water to sticky mucosal tissues and/or gravity supplied by the knee-to-chest position can aid visualization of the hymen
- The examiner's finger, a cotton applicator, or the balloon of a Foley catheter may be placed behind the estrogenized hymen in adolescents for better visualization of findings

When colposcopes are not available:

- Illuminate with head lamp or other good light source
- Magnify with optivisor or otoscope
- Document with hand-held camera with macro lens or new high-resolution digital camera

Sexually Transmitted Disease in Adult and Child Patients Who Have Been Sexually Assaulted/Abused

Adults

There are a number of sexually transmitted diseases that must be considered as potential pathogens in patients who have been sexually assaulted. Trichomoniasis, bacterial vaginosis, chlamydia, and gonorrhea are the most frequently diagnosed infections in these adult patients. Hepatitis B and human immunodeficiency virus (HIV) infections may also be transmitted through sexual assault. Antibiotic, vaccine, and/or antiretroviral administration must be considered as part of a regimen to provide prophylaxis for patients against these potential pathogens.

The Centers for Disease Control and Prevention (CDC) recommends the following antibiotic regimen: ceftriaxone 125 mg IM in a single dose plus metronidazole 2 g PO in a single dose plus azithromycin 1 g PO in a single dose or doxycycline 100 mg PO.

The hepatitis B vaccine should be administered intramuscularly to patients not previously immunized (Module–Adult/Adolescent Patient).

HIV prophylaxis is a complex issue that remains controversial (Module–HIV). Health care personnel must weigh the risk of HIV transmission to the patient against the interval since the assault occurred, the side effects of the medications, the likelihood of patient compliance, and the overall emotional impact of the exposure to the patient.

Children

The CDC states that “the identification of a sexually transmissible agent from a child beyond the neonatal period suggests sexual abuse.”

Everett, et al. found STDs in 2973 children evaluated for sexual abuse: 1.7% gonorrhea (5% of these without discharge), 1.3% chlamydia trachomatis, 0.2% syphilis, <1% trichomoniasis, 1.7% condyloma acuminata, and 0.3% HSV. (Module–References)

Gonorrhea

- Wide range of rates of infection (2.5% to 28%)
- Incubation period 2 to 7 days
- Within 6 months, 90% of infected children are free of the infection
- Confirmatory tests in laboratory imperative (culture mandatory: nonculture gonococcal tests, such as Gram’s stain, DNA probes, or enzyme immunoassay of oropharyngeal, rectal, or genital tract cannot be relied on in children and should not be used)
- **Must be reported; link to sexual abuse is certain**

Treatment

- Child <45 kg: ceftriaxone 125 mg IM or spectinomycin 40 mg/kg (max 2 g) IM (unreliable for treatment of pharyngeal infections)
- Child >45 kg: ceftriaxone 125 mg IM or cefixime 400 mg PO x 1 or ciprofloxacin 500 mg PO or ofloxacin 400 mg PO x 1 or spectinomycin 2 g IM
- Adolescents: ceftriaxone 125 mg PO x 1 or cefixime 400 mg PO x 1 or ciprofloxacin 500 mg PO x 1 or ofloxacin 400 mg PO x 1 **PLUS** azithromycin 1 g PO x 1 or doxycycline 100 mg PO BID x 7 days
- For the penicillin-allergic patient, consider fluoroquinolone (ciprofloxacin).

Chlamydia

- Occurs in 1% to 2% of sexually abused children; most chlamydia infections produce no symptoms; may see perinatally acquired infections for up to 3 years
- Must use culture technique to obtain organism (recovery 50% to 90%); enzyme immunoassay (Chlamydiazyme) and direct fluorescent antibody (Micro Trak) tests are unreliable for children and should not be used for evaluation of sexually abused children for chlamydial infection; **use culture only**
- **Must be reported; link to sexual abuse is probable**

Treatment

- Infants < 6 months: erythromycin 50 mg/kg/day divided QID x 10 to 14 days
- Child who weighs <45 kg: erythromycin 50 mg/kg/day divided QID x 10 to 14 days
- Child >45 kg, but <8 years: azithromycin 1 g PO x 1
- Child ≥ to 8 years: azithromycin 1 g PO x 1 or doxycycline 100 mg PO BID x 7 days

Syphilis

- Occurs in about 0.2% of cases of sexual abuse
- Nontreponemal tests (VDRL, RPR) used for screening but must be confirmed by treponema tests (FTA-ABS or MHA-TP); false-positive rate about 1% to 2%
- **Must be reported; link to sexual abuse is certain**

Treatment:

- Acquired (first and second degree): benzathine penicillin 50,000 U/kg IM (maximum 2.4 million U)

Herpes genitalis HSV-2 (or HSV-1 in the genital area)

- Risk for acquiring it from sexual abuse is unknown
- HSV-1 or HSV-2 can be found in the oral or genital region; viral cultures should be done on all suspicious lesions
- **Must be reported; link to sexual abuse is probable for HSV-2 and possible for HSV-1**

Treatment

- Adolescents: acyclovir 400 mg PO TID for 7 to 10 days or acyclovir 200 mg PO 5 times a day for 7 to 10 days or famciclovir 250 mg PO TID x 7 to 10 days or Valacyclovir 1 g PO BID x 7 to 10 days
- Children: acyclovir 80 mg/kg/day divided QID x 7 to 10 days

Trichomoniasis

- Uncommon in prepubertal girls
- Diagnosis made on wet mount of vaginal discharge (50% to 75% detection rate)
- **Must be reported; link to sexual abuse is possible**

Treatment

- Adolescents: metronidazole 2 g PO x 1 or metronidazole 500 mg PO BID x 7 days
- Children: metronidazole 15 mg/kg/day (maximum 250 mg) TID for 7 days

Human papilloma virus (HPV)

- Condyloma acuminata (anogenital warts); transmitted via sexual contact or perinatally
- **Must be reported; link to sexual abuse is probable (if not perinatally acquired)**
- Refer to gynecologist or dermatologist for biopsy

Treatment

- Podophyllin 10% to 25% topically followed in 1 to 4 hours by bathing, every week for 4 weeks
- Trichloroacetic acid (TCA) applied topically to warts
- Imiquimod 5% cream (Aldara) applied by the patient at bedtime three times a week for up to 16 weeks
- May require laser surgery or cryotherapy

Bacterial vaginosis

- Caused by a combination of organisms, including *Gardnerella vaginalis* and other anaerobic organisms
- Thin, yellow discharge is noted and detection of infection by wet mount of discharge; clue cells noted (epithelial cells with bacteria adhering to the surface); whiff test may be performed (10% KOH to secretions that release a fishy odor); vaginal fluid pH > 4.5 in a postpubertal child
- **May be reported if history or other findings indicate sexual abuse; link to sexual abuse is uncertain**

Treatment

- Adolescents: metronidazole 500 mg PO BID x 7 days
- Children: metronidazole 15 mg/kg/day divided TID x 7 days

Mycoplasma/ureaplasma

- Hammerschlag et al. (1987) found *M.hominis* present in 23% (anorectal) and 34% (vaginal) of sexually abused children; *U. urealyticum* in 19% (anorectal) and 30% (vaginal) of sexually abused children and 3% (anorectal) and 8% (vaginal) controls (Module–References)
- **May be reported if history of other findings indicate sexual abuse; link to sexual abuse is uncertain (no published guidelines present to date)**

Treatment

- Erythromycin 50 mg/kg/day PO divided QID x 14 days

Hepatitis B

- Sexual transmission accounted for approximately 30% to 60% of the estimated 240,000 new HBV infections in the United States
- Fully vaccinated patient should not be revaccinated; if not vaccinated, then administer hepatitis B vaccine; if vaccination status is unclear, send hepatitis serology for immune status and if not immune treat the patient with hepatitis B vaccine

Human immunodeficiency virus (HIV)

- Guidelines for when to test for HIV (ELISA test followed by Western blot, if positive)
 - Repeated abuse OR multiple perpetrators
 - Perpetrator known to be HIV positive or have HIV risk factors
 - High prevalence in the area
- Testing done again at 3 and 6 months
- **May be reported if neonatal transmission or other risk factors are not present; link to sexual abuse is probable in selected cases**
- **Treatment:** Referral to pediatrician and/or infectious disease consultant for possible therapy
 - When to provide prophylaxis for HIV is unclear; some authors recommend prophylaxis in the following cases:
 - Unprotected anal or vaginal intercourse, receptive oral intercourse with ejaculation, or sharing of needles with HIV-infected partner
 - Rape/sexual abuse victims
 - Zidovudine (AZT) 200 mg PO tid (available as 100-mg capsules or 50 mg/ml syrup) or 160 to 180 mg/m²/dose TID for 4 weeks plus lamivudine 150 mg dose TID, 150 mg/dose BID, or 8 mg/kg/dose BID for 4 weeks

Other STDs, such as LGV and chancroid, not reported in sexually abused children.

Human Immunodeficiency Virus (HIV)

Evaluation and Management of Patients with a Possible Exposure to Human Immunodeficiency Virus (HIV) after Sexual Assault or Sexual Abuse

The use of antiretroviral agents after exposure through sexual assault or abuse must balance the potential benefits of the treatment with the risks. This decision must be made in the emergency department (ED) or sexual assault center by the emergency physician or other health care professional, often with very little information to guide the decision to begin treatment. The decision to begin or withhold treatment is made by the health care professional and the patient after the patient has been adequately informed of the risks and benefits of the treatment options. It is also important to realize and inform patients of the diverse opinions related to the efficacy of postexposure prophylaxis for HIV in cases of sexual assault/abuse.

There are a number of factors that may influence the decision to begin treatment:

- Time since the exposure occurred
 - Likelihood that transmission could occur from the sexual assault or abuse
 - Prevalence of HIV in the locale of the sexual assault/abuse or the probability that the perpetrator is infected with HIV
 - The efficacy and side effects of the drug regimen prescribed
 - Likelihood of patient compliance with the regimen
 - Availability: Costs and medical expertise
- The risk of transmission of HIV per episode of receptive vaginal exposure is estimated at 0.1% to 0.2%; that of penile-anal exposure is 1% to 2%; and the risk of oral transmission has not been quantified, although reports of transmission have occurred.
 - Studies in animals and humans have shown up to a 67% reduction in risk of transmission of HIV in cases of occupational exposure and in cases of perinatal transmission. These results may not be applicable to the patient who has been sexually assaulted.
 - As many as 50% to 75% of health care workers receiving zidovudine (ZDV) and up to 90% of those receiving combination therapy for possible HIV exposure report side effects and 35% do not complete the regimen. Side effects of antiretroviral medication include nausea, vomiting, diarrhea, and other gastrointestinal effects. Protease inhibitors may cause lipid abnormalities, diabetes mellitus, and hyperglycemia and lead to diabetic ketoacidosis in previously diagnosed diabetics. Combination therapy has led to serious side effects, including hepatitis, nephrolithiasis, and pancytopenia.

Recommendations

The health care professional must consider all the factors related to possible transmission of HIV for each patient.

- Health care professional unfamiliar with risks associated with the exposure or postexposure therapeutic agents should consult with an expert in the field if at all possible
- History related to the exposure and information known about the perpetrator should be obtained and documented in the chart
- Informed consent for initiation of therapy and all discussions pertaining to the decision for providing therapy or not with the patient and, in the case of minors, with the legal guardian should be documented in the patient's chart
- Patients should also be alerted to possible signs and symptoms of primary HIV infection (fever, fatigue, sore throat, lymphadenopathy, rash) and instructed to seek care if these symptoms arise

- Patients may be referred to voluntary counseling and testing centers or to their primary care provider within 72 hours of the exposure to establish their HIV status at the time of the assault/abuse. It is important to understand that HIV testing may lessen the psychological burden for the patient; however, it is imperative that the testing be done in a setting where appropriate counseling can be offered to explain the results and implications of test results. Testing is anonymous in some states.
- Possible treatment regimens:
 - Adults: ZDV 200 mg TID or 300 mg BID and lamivudine 150 mg BID for 4 weeks. A protease inhibitor nelfinavir 750 mg q8h (with meals) or indinavir 800 mg q8h (on an empty stomach) for high-risk exposure such as when the perpetrator is known to be HIV infected. Refer to the Centers for Disease Control and Prevention web site <http://www.cdc.gov/> for the most recent recommendations
 - Children: ZDV (10 mg/ml syrup) 90 to 180 mg/m² q8h and lamivudine (10 mg/ml solution) 4 mg/kg every 12 hours. Protease inhibitors are not FDA approved for use in children younger than 2 years. May use indinavir 500 mg/m² every 8 hours for high-risk exposures.
 - All patients should receive follow-up with their primary care provider within 1 week of initiation of therapy

In Canada, the British Columbia Centre for Excellence in HIV/AIDS recommends in its published guidelines that patients who have been sexually assaulted receive postexposure antiretroviral therapy. Kits are provided to EDs to get the therapy with ZDV and lamivudine (3TC) started immediately.

Emergency Pregnancy Prophylaxis

The following are tables to aid in prescribing prophylaxis medications. Specific information about this practice may be found within the patient “Informed Consent¹ Form” on the next page. The clinician should ensure they are familiar with this form and the relative contraindications for the various types of pregnancy prevention. Some clinicians have found it helpful to provide the patient with an antiemetic before giving oral pregnancy prevention medications. The second table provides potential options for this practice. **This information is for information only and should not serve as the sole source for prescribing information or clinical decision making.**

Table 1

Brand	Pills per Dose²	Ethinyl Estradiol per Dose (µg)	Levonorgestrel per Dose (mg)
Preven Kit ³	2 blue pills	100	0.50
Ovral	2 white pills	100	0.50
Alesse	5 pink pills	100	0.50
Nordette	4 light-orange pills	120	0.60
Levlen	4 light-orange pills	120	0.60
Lo/Ovral	4 white pills	120	0.60
Triphasil	4 yellow pills	120	0.50
Tri-Levlen	4 yellow pills	120	0.50
Ovrette	20 yellow pills	0	0.75

Table 2

Medication⁴	Dose⁵	Repeat Dosing if Required
Metoclopramide	10 mg	6 h
Meclizine	25 to 50 mg	24 h
Diphenhydramine	25 to 50 mg	4 to 6 h
Trimethobenzamide	200-mg suppository	6 to 8 h
Promethazine	25-mg suppository	8 to 12 h
Dramamine	25 to 50 mg	6 to 8 h

¹ If using an “off-label” drug, informed consent may be protective in cases where rare but possible side effects occur such as bleeding, pulmonary embolism, or continued pregnancy despite “prophylaxis.” Informed consent ensures proper patient education has occurred and ensures that her values and ethics are taken into account in what may be a very emotionally charged decision. An informed decision is always better than a misinformed one.

² First dose should be given within 72 hours of alleged event. Second dose should be taken 12 hours after the first dose. If an antiemetic is being used, it should be given 1 hour before the oral emergency pregnancy prevention tablets.

³ Although commonly used “off-label,” none of the above, with the exception of Preven, are FDA approved for postcoital pregnancy prophylaxis.

⁴ Other medications may be equally effective.

⁵ Dose may need to be altered based on patient age, weight, or concurrent medications.

Source: Adapted from Trussell J, Koenig J, Ellertson C, et al: Preventing unintended pregnancy: The cost-effectiveness of three methods of emergency contraception. *Am J Public Health* 1997;87(6):932-937.

INFORMED CONSENT FORM FOR EMERGENCY PREGNANCY PREVENTION PILLS

Name _____ Age _____
Address _____
Medical Record # _____ Telephone # _____

This form is being given to you to provide information on postcoital pregnancy prevention. Your signature below indicates your understanding of the material contained in this form, that you have received a copy of this form, and that you have had the opportunity to discuss the issues contained within this form with the clinician. After reading through this information and discussing it with the clinician, it is recommended that you take some time to consider your options. Should you decide to use the postsexual intercourse pregnancy prevention pills or an IUD, you should contact your primary care physician, your gynecologist, or Planned Parenthood at once. Should you be unable to do so or if you need further referral, it can be obtained free of charge 24 hours per day via the emergency contraception hotline at 1-888-NOT-2LATE.

Instructions to Patient:

Please initial if you understand and agree with the statement. DO NOT SIGN the form until the clinician is with you and can witness your signature.

Informed Consent

- _____ I understand that ECPs (emergency contraceptive pills) contain a combination of hormones that act to prevent pregnancy, as defined by the American College of Obstetricians and Gynecologists. These pills are to be taken after unprotected vaginal sex (sex without birth control). They are to be used as an emergency treatment only and not as a routine method of contraception.

- _____ I understand that ECPs may or may not actually prevent conception, the combining of egg with sperm.

- _____ I understand that Pennsylvania law states that life begins at conception.

- _____ I understand that the American College of Obstetricians and Gynecologists defines pregnancy as beginning after the implantation of the human embryo into the tissue of the uterus. This definition is controversial as many believe life begins at conception, the combining of the egg with the sperm (see above).

- _____ I understand that ECPs may work by preventing or delaying the release of an egg from the ovary, preventing the combining of the egg and sperm, or causing changes in the lining of the uterus or womb that prevent the implantation of a human embryo. I understand that if the zygote is already implanted into the uterus, these medications will not stop the pregnancy.

- _____ I understand that ECPs are regular birth control pills taken differently.

- _____ I understand that the US Food and Drug Administration has recently approved birth control pills for this use and has stated that they are safe and relatively effective for emergency contraception.

- _____ I understand that the medication should be started as soon as convenient after unprotected sex and should be started within 3 days (72 hours) of that sex. Should the 72-hour window not be met, an IUD may be placed with similar results up to 5 days (120 hours) after sex. Neither of these options should be chosen without informed consent and serious consideration of how the individual's belief system fits with the proposed mechanism with which these medications work.

INFORMED CONSENT FORM FOR EMERGENCY PREGNANCY PREVENTION PILLS

_____ I understand that ECPs are effective if used within 72 hours in about 75% of the cases. Effectively, this lowers the risk of pregnancy from about 8 per 100 to about 2 per 100.

_____ I understand that should the pregnancy continue despite the use of these medications, there is no data to suggest they could have any adverse effects on the unborn child.

_____ I understand that some reactions to the medication may include:

- Nausea and vomiting
- Fatigue
- Dizziness
- Breast tenderness
- Early or late menstrual period

_____ I understand that I should see my primary care physician or do a home pregnancy test if my period has not started within 3 weeks after taking the medications.

_____ I understand that emergency contraceptive pills may not prevent an ectopic pregnancy in the tubes or abdomen, a potentially serious condition. Therefore, should I develop abdominal pain in the first few months after taking the medication, I should see my primary care physician immediately.

_____ I understand that I should use condoms, spermicides, and/or a diaphragm or continue taking certain birth control pills to prevent pregnancy if I have sex before my next period. After that, I can use any regular method of contraception.

_____ I understand that if I see a physician for any reason before I get my period, I should tell him or her that I have taken ECPs.

_____ I understand that ECPs will not protect me from or treat sexually transmitted diseases and that I should see a physician for diagnosis and treatment if I am concerned about this.

_____ I understand that a clinician is available to answer any questions I may have.

_____ No guarantee or assurance has been made to me as to the results that may be obtained if I use ECPs. I have given a complete and accurate history to those taking care of me.

_____ I will follow the guidelines set forth above.

_____ I understand that I assume all risk and responsibility for pregnancy should it occur.

SIGNATURE OF PATIENT _____
Date

I witnessed the fact that the patient received the above-mentioned information and said she read and understood the same.

SIGNATURE OF WITNESS _____
Date

SIGNATURE OF PHYSICIAN/NURSE PRACTITIONER _____
Date

Source: Adapted from Planned Parenthood of Western Washington. Morning After Treatment Consent form, June 1996.

State Sexual Assault Coalitions

Alabama

Alabama Coalition Against Rape
PO Box 4091
Montgomery, AL 36102-4091
Office: 334-264-0123
Fax: 334-264-0128

Alaska

Alaska Network on Domestic Violence and
Sexual Assault
130 Seward Street, Suite 209
Juneau, AK 99801
Office: 907-586-3650
Fax: 907-463-4493

Arizona

Arizona Sexual Assault Network
P O Box 7634
Phoenix, AZ 85011
Office: 602-254-6400
Fax: 602-258-7390

Arkansas

Arkansas Coalition Against Sexual Assault
PO Box 1953
Harrison, AR 72601
Office: 870-741-1328
Fax: 8700-741-3084

California

California Coalition Against Sexual Assault
1611 Telegraph Avenue, Suite 1515
Oakland, CA 94612
Office: 510-839-8825
Fax: 510-839-3110

Colorado

Colorado Coalition Against Sexual Assault
PO Box 18663
Denver, CO 80218
Office: 303-832-7033
Fax: 303-832-7067

Connecticut

Connecticut Sexual Assault Crisis Services, Inc.
110 Connecticut Blvd.
East Hartford, CT 06108
Office: 860-282-9881
Fax: 860-291-9335

Delaware

Delaware Rape Crisis CONTACT
P O Box 9525
Wilmington, DE 19809
Office: 302-761-9800
Fax: 302-761-4280

District of Columbia

DC Rape Crisis Center
P O Box 34125
Washington, DC 20043
Office: 202-232-0789
Fax: 202-387-3812

Florida

Florida Council Against Violence
306 E. Park Avenue #109
Tallahassee, FL 32301
Office: 850-224-4878
Fax: 850-425-3091

Georgia

GNSA
100 Edgewood Avenue, Suite 518
Atlanta, GA 30303
Office: 404-659-6482
Fax: 404-659-6383

Hawaii

HI Coalition for Prevention of Sexual Assault
741-A Sunset Avenue
Honolulu, HI 96816
Office: 808-733-9038
Fax: 808-733-9032

Idaho

ID Coalition Against Sexual & Domestic
Violence
815 Park Boulevard, Suite 140
Boise, ID 83712
Office: 208-384-0419
Fax: 208-331-0687

Illinois

Illinois Coalition Against Sexual Assault
123 S. 7th Street, Suite 500
Springfield, IL 62701
Office: 217-753-4117
Fax: 217-753-8229

Indiana

Indiana Coalition Against Sexual Assault
2511 E. 46th St, Suite N-13
Indianapolis, IN 46205
Office: 317-568-4001
Fax: 317-568-4045

Iowa

Iowa Coalition Against Sexual Assault
2603 Bell Street, Suite 102
Des Moines, IA 50321
Office: 515-244-7424
Fax: 515-244-7417

Kansas

Kansas Coalition Against Sexual & Domestic
Violence
820 SE Quincy Street, Suite 600
Topeka, KS 66612
Office: 785-232-9784
Fax: 785-232-9937

Kentucky

Kentucky Association of Sexual Assault
Programs, Inc.
PO Box 602
Frankfort, KY 40602-0602
Office: 502-226-2704
Fax: 502-226-2725

Louisiana

Louisiana Foundation Against Sexual Assault
685 W Railroad Ave, Suite A
Independence, LA 70443
Office: 504-747-8815
Fax: 504-747-8879

Maine

Maine Coalition Against Sexual Assault
3 Mulliken Court
Augusta, ME 04330
Office: 207-626-0034
Fax: 207-626-5503

Maryland

Maryland Coalition Against Sexual Assault
7257 Parkway Drive, Suite 208
Hanover, MD 21076
Office: 410-712-0955
Fax: 410-712-0959

Massachusetts

Jane Doe, Inc.
14 Beacon Street, Suite 507
Boston, MA 02108
Office: 617-248-0922
Fax: 617-248-0902

Michigan

MI Coalition Against Domestic & Sexual
Violence
3893 Okemos Road, Suite B-2
Okemos, MI 48864
Office: 517-347-7000
Fax: 517-347-1377

Minnesota

Minnesota Coalition Against Sexual Assault
2344 Nicolett Avenue S, #170A
Minneapolis, MN 55404
Office: 612-872-7734
Fax: 612-872-0929

Mississippi

Mississippi Coalition Against Sexual Assault
5455 Executive Place Drive
Jackson, MS 39296
Office: 601-987-9011
Fax: 601-987-9166

Missouri

Missouri Coalition Against Sexual Assault
PO Box 1925
Columbia, MO 65205
Office: 573-875-3058
Fax: 573-441-1517

Montana

Montana Coalition Against DV/SV
PO Box 633
Helena, MT 59624
Office: 406-443-7794
Fax: 406-443-7818

Nebraska

Nebraska Domestic Violence & Sexual Assault
Coalition
825 M Street, Suite 404
Lincoln, NE 68508
Office: 402-476-6256
Fax: 402-476-6806

New Hampshire

New Hampshire Coalition Against Domestic & Sexual Violence
PO Box 353
Concord, NH 03302-0353
Office: 603-224-8893
Fax: 603-228-6096

New Jersey

New Jersey Coalition Against Sexual Assault
1 Bethany Road, Bldg 3, Suite 42
Hazlet, NJ 07730
Office: 732-264-4111
Fax: 732-888-4776

New Mexico

NM Coalition of Sexual Assault Programs, Inc.
4004 Carlisle NE, Suite D
Albuquerque, NM 87107
Office: 505-883-8020
Fax: 505-883-7530

New York

NY State Coalition Against Sexual Assault
784 Washington Avenue
Albany, NY 12203
Office: 518-482-4222
Fax: 518-482-4248

North Carolina

North Carolina Coalition Against Sexual Assault
174 Mine Lake Court, Suite 1000
Raleigh, NC 27615
Office: 919-676-7611
Fax: 919-676-1355

North Dakota

North Dakota Council on Abused Women's Service-Coalition Against Sexual Assault in ND
418 East Rousser, #320
Bismarck, ND 58501
Office: 701-255-6240
Fax: 701-255-1904

Ohio

OH Coalition on Sexual Assault
4041 N High Street, Suite 408
Columbus, OH 43214
Office: 614-268-3322
Fax: 614-268-0881

Oklahoma

Oklahoma Coalition Against DV & SA
2525 Northwest Expwy, Suite 208
Oklahoma City, OK 73112
Office: 405-848-1815
Fax: 405-848-3469

Oregon

Oregon Coalition Against DV & SA
520 NW Davis Street, #310
Portland, OR 97209
Office: 503-223-7411
Fax: 503-223-7490

Pennsylvania

Pennsylvania Coalition Against Rape (PCAR)
125 N. Enola Drive
Enola, PA 17025
Office: 717-728-9740
Fax: 717-728-9781

Rhode Island

The Rhode Island Rape Crisis Center
300 Richmond Street Suite 205
Providence, RI 02903
Office: 401-421-4100
Fax: 401-454-5565

South Carolina

SC Coalition Against DV & SA
PO Box 7776
Columbia, SC 29202
Office: 803-256-2900
Fax: 803-256-1030

South Dakota

SD Coalition Against DV & SA
PO Box 141
Pierre, SD 57501
Office: 605-945-0869
Fax: 605-945-0870

Tennessee

Tennessee Coalition Against Sexual Assault
P O Box 120972
Nashville, TN 37212
Office: 615-386-9406
Fax: 615-383-2967

Texas

Texas Association Against Sexual Assault
One Commodore Plaza
800 Brazos, Suite 810
Austin, TX 78701
Office: 512-474-7190
Fax: 512-474-6490

Utah

CAUSE – Coalition of Advocates for Utah
Survivors' Empowerment
366 South 500 East Suite 204
Salt Lake City, UT 84102
Office: 801-322-1500
Fax: 801-322-1250

Vermont

Vermont Network Against DV & SA
PO Box 405
Montpelier, VT 05601
Office: 802-223-1302
Fax: 802-223-6943

Virginia

Virginians Aligned Against Sexual Assault
508 Dale Avenue, Suite B
Charlottesville, VA 22903-4547
Office: 804-979-9002
Fax: 804-979-9003

Washington

Washington Coalition of Sexual Assault
Programs
2415 Pacific Avenue, SE
Olympia, WA 98504
Office: 360-754-7583
Fax: 360-786-8707

West Virginia

West Virginia Foundation for Rape Information
& Services
112 Braddock Street
Fairmont, WV 26554
Office: 304-366-9500
Fax: 304-366-9501

Wisconsin

Wisconsin Coalition Against Sexual Assault
123 E. Main Street, 2nd Floor
Madison, WI 53703-3315
Office: 608-257-1516
Fax: 608-257-2150

Wyoming

Wyoming Coalition Against DV & SA
152 N 2nd
P O Box 236
Laramie, WY 82073
Office: 307-755-5481
Fax: 307-755-5482