



**Report to Congress**

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# **Medical Examination and Treatment for Victims of Sexual Assault: Evidence-based Clinical Practice and Provider Training**

**Agency for Healthcare Research and Quality  
U.S. Department of Health and Human Services**



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## Acknowledgments

The focus of this report has inspired the passions and commitment of multiple organizations whose assistance was essential. Among the organizations that provided copies of policy statements, training materials, curricula, and other resources are:

### AARP

American Academy of Child and Adolescent Psychiatry  
American Academy of Pediatrics  
American Academy of Pediatric Dentistry  
American Academy of Physician Assistants  
American Association of Critical Care Nurses  
American Association of Health Plans  
American College of Emergency Physicians  
American College of Obstetricians and Gynecologists  
American College of Physicians/American Society of Internal Medicine  
American Medical Association  
American Osteopathic Association  
American Professional Society on the Abuse of Children  
American Society for Testing and Materials  
California Medical Center, Department of Emergency Medicine  
California Medical Training Center, University of California-Davis Medical Center  
California Office of the Governor  
Emergency Nurses Association  
Family Violence Prevention Fund  
Forensic Nursing Services  
Health Education Alliance  
Hennepin County Medical Center, Sexual Assault Resource Services  
International Association of Forensic Nurses  
National Board of Medical Examiners  
National Center for Victims of Crime  
National Children's Advocacy Center (National Children's Alliance)  
National Indian Justice Center  
National Sexual Violence Resource Center  
Physicians for a Violence-Free Society  
Texas Attorney General's Office  
Victim Intervention Prevention Center, Parkland Hospital

Valuable assistance was also provided by many colleagues at the U.S. Department of Justice and components of the U.S. Department of Health and Human Services.

This report was prepared under the direction of Marcy L. Gross, (former) Senior Advisor, Women's Health, at the Agency for Healthcare Research and Quality.

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## **I. Executive Summary**

### **Purpose and Background**

Section 916 (d) of the Healthcare Research and Quality Act of 1999 (P.L. 106-129) charged the Agency for Healthcare Research and Quality (AHRQ) with developing and disseminating a report on: (A) evidence-based clinical practices for the examination and treatment of victims of sexual assault; and (B) the training of health professionals on performing medical evidentiary examinations of victims of child abuse or neglect, sexual assault, elder abuse, or domestic violence. The legislation did not establish a due date for the report, and no funds were appropriated. This report provides an overview of current systems for training and practice in the provision of medical evidentiary examinations to victims of sexual assault and other abuse. It discusses major gaps in service and training, summarizes the current scientific evidence-base, summarizes Federal and State activities, and identifies further opportunities for improvement in training, practice and systems of care.

Estimates of the number of victims of sexual assault and other abuse in the United States vary considerable from study to study. By any estimate, however, the number is substantial and affects all strata of society, all geographic regions, all populations, and all ages. Recurrent findings regarding rape and sexual assault indicate that most victims are young women, most incidents are not reported, and most assaults are perpetrated by husbands or other intimate partners, friends, or relatives.

A medical evidentiary examination is an examination done by a health professional that includes attention to the medical needs of the victim as well as to the gathering of evidence for law enforcement purposes. It typically includes: medical evaluation and crisis intervention; forensic evidence collection; evaluation of emotional needs; and referral for follow-up care.

A medical evidentiary examination can be a key element in the successful prosecution of sexual assault and other violent crimes. When examining a victim, providers must systematically gather evidence that will document injuries and assist in identifying the assailant, yet must also avoid or reduce further psychological distress and retraumatization of the patient. Discussions with the patient about the assault, gathering and storing of specimens that may eventually link the assailant to the crime, and documentation of injuries must be done in a painstaking, yet respectful way. Evidence must be preserved and stored without contamination or risk of tampering. As a scientist serving law enforcement, the provider may be asked to testify in court about any statements made by the victim and their demeanor at the time of the examination, and about the evidence collected.

To do an examination correctly and to ensure that the process meets the test of reliability required by a court, a health provider needs training and experience in what procedures are needed and how they should be done. Unfortunately, most providers are not routinely trained or

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familiarized with the management of victims of sexual assault and other abuse or in the performance of evidentiary examinations.

## **Study Methods and Approach**

In developing this report, AHRQ staff conducted an extensive search of the peer-reviewed literature, as well as an Internet search of national clearinghouses and other relevant sites. In addition, letters inviting submission of any relevant training materials, practice guidelines, policy statements, or position papers were sent to a large number of professional organizations and individuals thought to be knowledgeable about or having professional training or clinical practice standards related to sexual assault. As a result of these efforts, training materials, protocols and position statements were received from over 40 organizations including the major professional societies as well as providers, public health agencies, advocacy organizations and research institutions.

Information was also obtained from telephone discussions with experts from around the country or site visits to a number of professional or training organizations and through exchanges at relevant meetings and conferences. Experts in the legal system were consulted and information about the study was presented to the National Advisory Council on Violence and Abuse, and the International Association of Forensic Nurses. There was substantial consultation with staff and Committee members at the National Academy of Sciences' Institute of Medicine (NAS/IOM), who developed a 2002 report on the adequacy of training for health professionals in family violence: *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence*. Finally, a number of components within the Department of Health and Human Services (DHHS) and at the U.S. Department of Justice (USDOJ) were consulted.

## **Health Professions Education, Training, Professional Standards and Guidelines**

There is very little known about who and how many health professionals have received training in the examination and treatment of victims of sexual assault and other forms of abuse, nor the content, duration and scientific basis for the training. There is no central source of data on this skill, and no specific credentialing requirements.

Although little factual information is available on what programs exist, it is evident that the number of programs and support for training in forensic sciences is growing. This is attributed to expanded State reporting requirements. Nonetheless, based on a recent review performed by the IOM Committee on training for family violence, there currently exist only a handful of university-based academic training programs for health professionals that include significant content related to performing medical evidentiary examinations. The IOM committee concluded, moreover, that those that exist are frequently inadequate.

There are a number of organizations that offer continuing education or training and related materials to health professionals already in practice. A training model that is growing rapidly and bringing substantial change to the field is the Sexual Assault Nurse Examiner (SANE)/Sexual Assault Response Team (SART) program described in Section III of the report.



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Through these programs, trained nurses may receive supplemental certification as nurse examiners. These programs are often integrated into a Sexual Assault Response Team (SART) model in which medical and mental health providers, law enforcement, prosecutors, and victim assistance agencies and public health organizations work together to facilitate continuity and quality of care. The number of these programs across the country has grown from 20 in 1991 to over 400 in 2001 (Ledray, 2001).

Other organizations that offer continuing education (CE) programs to develop the skills needed to perform medical evidentiary examinations include a handful of State-funded programs. Prominent examples include the California Medical Training Center at UC-Davis that provides specialized multidisciplinary training and distance learning facilities (see Section V,B,5) and the Texas Office of the Attorney General, which provides financial support and technical assistance for development of SANE/SART training programs throughout Texas, and has a full-time unit to encourage these programs.

Several professional organizations have developed materials, policies, and course offerings related to sexual assault, including the American College of Obstetricians and Gynecologists (ACOG). The American College of Emergency Physicians has developed a detailed examination protocol, as well as other materials and training.

Distinct from educational programs that are offered at a particular time and place, and which are part of a formal training process, guidelines, professional standards and clinical practice protocols are developed by professional organizations or quality improvement bodies to help guide practicing providers toward improved health outcomes. In recent years, the development of guidelines and protocols has grown, as evidence-based medicine has become a dominant force in the way medicine is practiced.

A number of specialty-specific professional organizations and accrediting bodies have developed clinical protocols, training materials, professional standards and policy statements to assist their members in practice. These organizations include: the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); the AAP; American College of Emergency Physicians (ACEP); ACOG; AMA; the American Professional Society on the Abuse of Children (APSAC); the American Academy of Child and Adolescent Psychiatry (AACAP), the American Society for Testing and Materials (ASTM); and the U.S. Centers for Disease Control and Prevention (CDC).

### **Clinical Practice: Issues of Cost, Quality, and Access**

The Agency's discussions with experts in the field pinpointed a number of issues in cost, quality, and access to services for victims of sexual assault and other forms of abuse in urban, suburban, and rural areas.

There are few studies of the short- or long-term medical costs associated with sexual assault and other forms of abuse. The most recent study to assess both immediate and long-term costs was published by the National Institute of Justice (NIJ) at the Department of Justice in 1996. The report indicated that costs associated with non-fatal rape and sexual assault averaged \$87,000 per

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incident for adults, and \$99,000 per incident for children. The estimates consider both immediate use of medical care and mental health services, lost productivity, and permanent disability, as well as the cost of less tangible impacts such as pain, suffering, fear, and lost quality of life. Interestingly, the researchers estimated that between 5 and 10 percent of all mental health expenditures in the U.S. might be attributable to victims of child abuse (all forms) who receive treatment as adults.

Issues with respect to quality of care and variations in practice include: lack of standardized protocols, procedures, and rape testing kits in use; lack of trained providers and expert consultants; uneven quality of examination facilities and technologies available; and poor quality and limited capability to test for drugs and DNA.

What little data exists suggests wide variations in access to and quality of services received by victims of sexual assault, including: length of waiting times; provision of information or testing for sexually transmitted diseases; the availability of nurse examiners or other providers with specialized expertise in evidentiary examinations; the presence of extraneous personnel during the examination; the availability or referral to other community resources such as advocacy organizations or social service agencies; and the availability of private waiting areas, examination rooms, showers, or the provision of clothing.

Access to medical evidentiary examinations is not uniform across the United States and access can be compromised by payment issues. Although numerous Federal and State laws have been enacted to ensure that victims of sexual assault do not have to pay for medical evidentiary examinations, some States limit payment to victims who indicate a willingness to report the assault, a decision the victim may not want or be able to make immediately. Even when the victim is willing to commit to formally filing a report and cooperating with prosecution, the law enforcement agency or prosecutor still may not be willing to approve payment for an examination if they feel the case is weak, a decision that is made in the early stages of an investigation. In addition, it is the opinion of many experts working in the field that despite legal prohibitions, billing of the patient/victim continues to be widespread.

### **Federal and State Activities**

There are a number of Federal and State activities that address issues in research, training, and practice related to the examination and treatment of victims of sexual assault and other forms of abuse.

#### ***DHHS***

The DHHS Violence Against Women Act Steering Committee includes representatives from DHHS Agencies and Offices and from the USDOJ. It promotes the exchange of information and collaboration on issues related to intimate partner violence. CDC collects surveillance data, supports community development and research on prevention, and offers technical assistance. HRSA collects data and conducts analyses related to health professions training programs. The Division of Nursing, in particular, has funded initiatives to develop improved curriculum and training programs related to violence against women. In addition, there are a variety of programs

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aimed at improving prevention and care for violence victims among primary care providers and in community care settings. CDC and HRSA also joined forces in supporting the American College of Emergency Physicians (ACEP) in development of a consensus-driven national training protocol for performing medical evidentiary examinations.

The Administration on Aging funds a long-term care ombudsman program to address abuse of residents in nursing homes and other facilities. SAMHSA is currently sponsoring a 5-year study on integrated service models for women who have experienced trauma. NIH established the Child Abuse and Neglect Working Group in 1997, which coordinates research efforts in child abuse and neglect across all the major research Institutes and offices at NIH. NIMH sponsors a broad array of research related to the psychosocial impact of sexual and physical assault; development and testing of treatment protocols and training programs; research on preventive interventions to reduce posttraumatic mental disorders; training of mental health researchers; and research on the organization, delivery and effectiveness of care to victims. AHRQ is funding four research grants on the outcomes, effectiveness, and cost effectiveness of programs for early identification and treatment of domestic violence, and recently released a Web-based tool to assist hospitals in assessing the quality and effectiveness of their domestic violence programs.

### USDOJ

The USDOJ is the source for national statistics on crime, criminal justice and crime victimization. It also supports research on sexual violence, including a current evaluation of the Sexual Assault Response Team (SART) model in Rhode Island. USDOJ also oversees programs to support the victims of crime and supports training programs to educate criminal justice and allied health professionals regarding rights and needs of victims, including a comprehensive program of training, technical assistance and publications related to rape and sexual assault. The USDOJ also funds grants to state, tribal and local governments and community agencies for development of programs and training related to sexual assault. The USDOJ has been in the forefront of promoting expansion of SANE/SART programs and is currently developing national recommendations for a protocol for sexual assault forensic examinations. Finally, USDOJ funds States to hire additional personnel in order to eliminate backlogs in the processing and analysis of DNA samples.

### State Activities

Almost all states have mandatory reporting requirements for child abuse and elder abuse. Over three fifths have, or are developing, practice protocols on sexual assault and 45 States have, or are developing, standardized evidence collection kits. A few States have established mandatory educational requirements for health professionals. Approximately half of the States have SART/SANE programs and a few States have well-developed training models, including the California Medical Training Center which provides specialized clinical training for examination and treatment of victims of sexual assault and other abuse, and uses advanced medical technology to link rural providers with specialized consultation services.

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## **Opportunities for Further Improvement**

### **A. Consolidate and Enhance the Evidence Base for Practice**

1. Promote Cross-Collaboration to Enhance Research, Education and Practice
2. Encourage Federal, State and Community Involvement in the Development, Standardization, Evaluation, and Dissemination of Evidence-based Training Materials
3. Encourage Access to Evidence-based Training and Education Through the Use of Distance Learning and other Medical Technologies

### **B. Improvements in the Organization and Delivery of Care**

1. Encourage Coordination at the Community and State Levels Among Law Enforcement, Social Service, Specially Trained Health Providers, State and Local Public Health Agencies, Mental Health Providers and Community Advocates
2. Encourage Investment in Needed Facilities and Equipment

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## II. Background

### A. Charge to the Agency for Healthcare Research and Quality

The Agency for Healthcare Research and Quality (AHRQ) is an operating division within the U.S. Department of Health and Human Services (DHHS). AHRQ is charged with enhancing the quality, appropriateness, and effectiveness of health care services, and access to such services. AHRQ accomplishes these goals through scientific research and promotion of improvements in clinical practice and in the organization, financing, and delivery of health care services (42 U.S.C. 299-299c-7, as amended by P.L. 106-129 (1999)). Over the last decade, the Agency has pioneered the development of evidence-based medicine, which promotes improvement in clinical practice based on rigorous review and assessment of relevant scientific evidence.

#### 1. Legislative Mandate

This report was prepared in response to Section 916 (d) of the Healthcare Research and Quality Act of 1999 (P.L. 106-129), which reads as follows:

##### MEDICAL EXAMINATION OF CERTAIN VICTIMS–

- (a) IN GENERAL – The Director shall develop and disseminate a report on evidence-based clinical practices for–
- (1) the examination and treatment by health professionals of individuals who are victims of sexual assault (including child molestation) or attempted sexual assault; and
  - (2) the training of health professionals, in consultation with the Health Resources and Services Administration, on performing medical evidentiary examinations of individuals who are victims of child abuse or neglect, sexual assault, elder abuse, or domestic violence.
- (b) CERTAIN CONSIDERATIONS – In identifying the issues to be addressed by the report, the Director shall, to the extent practicable, take into consideration the expertise and experience of Federal and State law enforcement officials regarding the victims referred to in paragraph (a), and of other appropriate public and private entities

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(including medical societies, victim services organizations, sexual assault prevention organizations, and social services organizations).

The legislation did not establish a due date for the report, and no funds were appropriated.

## **2. Purpose of the Study**

The legislative mandate from Congress requires AHRQ to review the scientific evidence that supports the immediate clinical care for victims of sexual assault, and to examine the evidence base for training providers to perform the specialized clinical procedures that make up a medical evidentiary examination<sup>1</sup>. Given the dual nature of the task, AHRQ staff consulted with an array of professional and service-oriented individuals to assure that we identified information about the most important aspects of the examination and immediate treatment of adult and child victims of sexual assault and the training of clinicians in the provision of medical evidentiary examinations for victims of sexual assault, child abuse, domestic violence and elder abuse.

The report presents a picture of current practices and systems of care for the examination and treatment of victims of sexual assault and child molestation. The report also addresses what is known about the training of providers who may be called upon to conduct medical evidentiary examinations, whether for victims of sexual assault, or for other forms of abuse including child abuse, elder abuse, and domestic violence. The data is insufficient to permit an evaluation of the many response systems in place across the country. However, the report:

- Discusses the major weaknesses and gaps in service and training as identified in discussions with providers, law enforcement officials, policymakers, researchers and others who are active in responding to the needs of victims and society;

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<sup>1</sup> The need for evaluation, referral, and follow-up care for the mental health needs of victims is critical, as is the importance of minimizing potential retraumatization related to forensic examinations. While the importance of including initial evaluation and referral for mental health needs in the forensic examination is addressed, an assessment of evidence regarding the effectiveness of interventions and systems of care for the ongoing mental health needs of victims was considered to be outside the scope of this report.

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- Summarizes the science which provides the foundation for clinical practices used in providing medical evidentiary examinations to victims of sexual assault and other forms of abuse;
  - Describes existing State and Federal activities; and
  - Identifies additional opportunities for improvements in terms of training, practice and systems of care.

Sexual assault, including rape and attempted rape, is a common problem in our society. Estimates of the prevalence of rape and other forms of sexual assault vary from study to study, but even the most narrowly focused estimates provide a sense of the breadth of the problem. In 2000, almost 147,000 persons over age 12, male and female, were victims of rape or attempted rape (USDOJ, Bureau of Justice Statistics, 2001). Thousands of children were also molested, many by their own parent(s). Elder abuse, including sexual abuse, is also very prevalent, though there are few reliable studies available. Victims need a health care system which can provide timely, competent, and compassionate care that will help them recover.

### **3. What is a Medical Evidentiary Examination?**

A medical evidentiary examination is given to victims of sexual assault and other forms of abuse and is performed to collect physical evidence and document findings that can be used to identify, prosecute and convict an assailant. While an evidentiary examination includes an array of medical components, including assessment of injuries and crisis intervention, its main purpose is to meet the needs of the legal system. It may also be called a “medico-legal examination,” or a “sexual assault forensic examination” (SAFE). Basic components usually include:

- ***Medical evaluation and crisis intervention*** Recognition and treatment of physical injuries, risk evaluation and counseling for sexually transmitted diseases (STDs) and pregnancy.
- ***Forensic evidence collection*** Evaluation, collection and preservation of evidence, interpretation of findings, and the documentation of examination results for law enforcement purposes.

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- ***Evaluation of emotional needs*** Assessment of psychological functioning, response to the immediate emotional needs of the victim, and referral for appropriate follow-up mental health evaluation and treatment.
  - ***Referral for follow-up care*** Assessment of the need for follow-up treatment and services, with written instructions for the patient on recommendations for further treatment of injuries, laboratory testing and mental health services, and the names and phone number of referral organizations.

Optimally, the examination is based on an integrated clinical approach that considers and responds to cultural issues for victims of diverse racial, ethnic, and economic backgrounds. Culturally congruent care includes sensitivity to victims who may be intimidated by police, such as an immigrant or homeless person; to victims who need translation services; or to women who cannot admit being 'violated' without being ostracized from family and community.

An evidentiary examination is not a linear process. The way it is conducted is affected by such varied factors as: the clinical protocols used in a particular facility, the type and contents of the "rape kit" that is available at the hospital, the length of time elapsed since the attack (which affects the viability of some types of evidence), whether police believe that drugs may have been used in the attack, the nature of the attack, whether the victim has bathed or changed clothes, and many other factors. Examination of young children presents special challenges, as do the frail elderly and others having physical or mental limitations which make cooperation with procedures difficult.

#### **4. The Importance of Medical Evidentiary Examinations to Victims and Prosecutors**

Sexual assault and child abuse crimes often go unpunished. Many cases are not reported, and even when victims do come forward, it can be a difficult crime to prosecute. A recent study which looked at survey figures for the years 1992-2000 found that only about 36 percent of forcible rapes experienced by females over age 12 were reported to law enforcement officials (Rennison, 2002; USDOJ,



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Bureau of Justice Statistics, 2001). Studies by other researchers indicate that of reported assaults, only about one-fifth actually result in arrest, prosecution, and successful conviction (Langan and Farrington, 1998).

It takes courage for the victim of a sexual assault to report the crime. A rape is physically and emotionally traumatic, often leaving the person who is assaulted both frightened and ashamed, and sometimes even feeling that they are responsible for the abuse or assault that occurred. Reporting a sexual assault can be even more difficult, and sometimes dangerous, when the assault was committed by a person the victim knows, which is often the case. One study found that in about three out of four assaults, the victim and offender are acquainted, an intimate partner, or from the same family (Greenfeld, 1997). In another study of police-recorded data on children under age 12, some 90 percent of the children raped knew the offender (USDOJ, Bureau of Justice Statistics, 1993).

A medical evidentiary examination is often a key element in the successful prosecution of sexual assault, and is also used to eliminate suspects. One reason the examination can be pivotal is that there are seldom witnesses to a sexual assault and officials may be reluctant to pursue and prosecute an assailant unless forensic evidence is available. The examination needs to be done well if the evidence gathered is to stand up in an adversarial court proceeding that may occur weeks, months, and sometimes years, after an assault<sup>2</sup>.

***Provider as caregiver and scientist*** When doing a medical evidentiary examination, the physician, nurse, physician's assistant or other health professional caring for a victim takes on the dual roles of caregiver treating a patient as well as that of a scientist working for law enforcement purposes.

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<sup>2</sup>

The extent to which forensic evidence actually influences legal outcomes, and which components of an examination are most essential, are separate questions discussed later in this report.

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The patient-provider relationship can be especially problematic in States and jurisdictions that have mandatory reporting laws that require physicians, and often nurses, other health professionals, and clergy, to report actual or suspected sexual assault and other types of abuse and neglect. In 48 States, physicians and other health care professionals are required to report known or suspected instances of actual or suspected child abuse and most states also require physicians to report if they believe that elder abuse has occurred (US DHHS Children's Bureau, 2002.) Four States (California, Colorado, Rhode Island, and Kentucky) specifically require physicians to report intimate partner abuse, even if the victim's wishes are otherwise (Stobo, 2002.) A much larger number of States (42) require physicians to report injuries resulting from firearms, knives, and other weapons (Houry, Sachs et al, 2002).

In talking with victims and providers, one finds that many favor medical reporting of abuse injuries to police, but not if the reporting is a mandatory requirement (Rodriguez, 1998). Reasons for opposing mandatory laws that are often mentioned include: (a) mandatory reporting may expose a victim to retaliation, since many know their assailant; (b) a lack of informed consent around the reporting issue compromises the patient-provider relationship; (c) and it takes away the autonomy of sexual assault victims, for whom a sense of regained control over their life can be an important step to recovery. There may also be a discrepancy between the legal requirements and the provider's personal threshold of what they feel constitutes abuse.

When examining a victim of rape or sexual assault, the provider must systematically gather evidence that will document injuries and assist in identifying the assailant, yet must also avoid or reduce further psychological distress and retraumatization of the patient. Discussions with the patient about the assault, gathering and storing of specimens that may eventually link the assailant to the crime, and documentation of injuries, all must be done in a painstaking, yet respectful and compassionate way. Evidence must be preserved and stored without contamination or risk of tampering. As a scientist serving law enforcement, the provider may be asked to testify in court about any statements made by the victim and their demeanor at the time of the examination, and about the evidence collected.

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To do an examination correctly and to ensure that the process meets the test of reliability that a court will one day demand, a health provider needs training and experience in what procedures are needed and how they should be done. However, most providers are not routinely trained or familiarized with the management of sexual assault victims and the performance of an evidentiary examination (Stobo, 2002; Voelker, 1996).

## **B. Scope of the Problem**

### **1. Definitions**

As noted previously, estimates of the number of rapes and other types of sexual assault vary substantially and depend on how terms are defined and what types of sexual assaults are included. In addition, there are usually differences in the time frame during which the data was collected, in the sampling methods used, and in the age and gender of the population being studied.

**What is being counted?** As a general matter, rape is a term that refers to forced or attempted sexual intercourse with a male or female, by an offender that may be of the same sex or a different sex from the victim. Sexual assault is usually defined to encompass rape, attempted rape, forced oral and anal sex, penetration with objects, touching of intimate parts, and other types of threats or coercion in which unwanted sexual contact is attempted or occurs between the victim and offender.

Most research studies and surveys count rape and attempted rape as one of several types of sexual assault. However, the largest national household survey does not: the National Crime Victimization Survey (NCVS) instead defines sexual assault to mean “a wide range of victimizations *separate from* rape or attempted rape.” Thus, the survey findings on the number and rate of sexual assaults will be quite different from those in most other studies, since rape/attempted rate is excluded.

In legal terms, rape and sexual assault are defined by each state. States differ in terms of what specific acts are included or excluded, how terms like “unwanted,” “threat,” and “sexual contact” are used, what the age of consent for sexual

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intercourse is, and in other details that affect prosecution, penalties, and sentences.

The key Federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA), which views any person under age 18 (or the age specified by the child protection law of the State in which the child resides), as a child. Child sexual assault, one of several forms of child abuse, is defined in the law as the use, persuasion, inducement, enticement, or coercion of a child to engage in sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or, the rape, .... statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children. Beyond this threshold definition, each State provides further definition and elaboration of terms. While sexual abuse of young and adolescent girls has been well studied, there has been less attention paid to the sexual abuse of boys. Nonetheless, sexual abuse of boys appears to be common, though under reported, under recognized and under treated (Holmes, 1998).

Elder abuse is generally defined broadly to encompass not only sexual abuse (nonconsensual sexual contact of any kind), but also physical abuse (use of force, violence, unwarranted use of drugs and physical restraints, force-feeding, and physical punishment,) and emotional abuse (insults, threats, intimidation, humiliation, and isolation). Abuse is often lumped with elder neglect (the failure of responsible parties to provide life necessities), abandonment, and financial and material exploitation. The studies available indicate that most incidents are by family members and go unreported.

Table I, which follows, provides a snapshot of data available on rape, sexual assault, and child and elder abuse, and is followed by narrative which provides further detail. Recurrent findings indicate that most sexual assault victims are young women; most rapes and other assaults are not reported; and most assaults are perpetrated by husbands, intimate partners, friends, or relatives.

## 2. Summary of Data from National Studies

Table I: Data on Rape, Sexual Assault, and Child and Elder Abuse in the United States

Name of Study/Survey	Sponsoring Agency(s)	Survey Focus	Selected Findings
FBI Uniform Crime Report 2001	FBI, USDOJ	Forcible rapes (defined as carnal knowledge) & attempted rapes of females, any age reported to police in 2001. (Excludes statutory rape and rape of males).	90,491 forcible/attempted female rapes. Rate: 62.2 rapes per 100,000 women
National Crime Victimization Survey 2000	Bureau of Justice Statistics, USDOJ	Survey-based estimates of the number of reported & unreported rapes/attempted rapes of men and women over age 12.	147,000 rapes/attempted rapes, men and women. The figure is down from 201,000 rapes estimated in 1999 survey.
National Violence Against Women Survey  Nov 1995 thru May 96	CDC/DHHS and National Institute of Justice, USDOJ	Survey-based estimates of the number of rapes or attempted rapes (defined to include vaginal, oral, and anal sex), physical assault, and stalking of men and women over age 18. Queried lifetime incidence and in 12 months prior to study.	302,000 completed or attempted rapes of women in prior 12 months. Because some women were victims of multiple rapes, estimates indicate that a total of 876,000 rapes occurred during the year. The study also estimates that 93,000 men were raped, and a total of 111,000 rapes occurred during the year.
National Women's Study 1989 thru 1993	National Institute of Drug Abuse, NIH, DHHS	Physical & sexual assault of women, w/ info on other traumatic events, (e.g., Post-traumatic stress disorder, alcohol and drug abuse).	683,000 women raped over 12 month period. Eighty-four percent of rapes not reported.
National Child Abuse and Neglect Data System 2000	Children's Bureau, Adm. on Children and Families (ACF), DHHS	All types of abuse and neglect of children under age 18.	879,000 cases of abuse & neglect substantiated. Ten percent (87,900 cases) were related to child sexual abuse.
Third National Incidence Study of Child Abuse and Neglect (NIS-3) 1993	National Center on Child Abuse and Neglect, DHHS	Reported and unreported cases of child abuse and neglect.	1.6 million children abused & neglected, including 300,000 victims of sexual abuse.
National Elder Abuse	Administration on	Abuse and neglect (financial,	Estimated 450,000 cases of

Incidence Study  1996	Children and Families; Administration on Aging, DHHS	emotional, sexual, and physical abuse or neglect, excluding self-neglect) of non-institutionalized persons over age 60, as reported to adult protective services agencies and 'sentinel' community agencies.	elder abuse occurred in 1996. This includes 71,000 cases reported and substantiated by Adult Protected Services (APS) agencies, and 379,000 cases that occurred, but were not reported. The number of reported cases is 150 percent higher than in 1986. Females and persons over age 80 at highest risk.
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### 3. Rape and Sexual Assault

- (a) **The FBI Uniform Crime Report (UCR) 2001** This FBI/U.S. Department of Justice (USDOJ) annual report summarizes the number of rapes and attempted rapes of females of any age, as reported to U.S. law enforcement agencies. Because data relates to cases *reported* to police, the data base captures only a portion of the number of rapes that actually occurred. Statutory rape, rape of men, and other types of sexual assault also are accounted for elsewhere.

The UCR report indicates that 90,491 forcible rapes/attempted rapes of females were reported in 2001, a slight increase over the previous year (USDOJ, FBI, 2002). However, the rate of rapes continued a downward trend and declined from 70.3 rapes per 100,000 females in 1997 to 62.2 per 100,000 females reported in 2001.

- (b) **The National Crime Victimization Survey (NCVS)** This survey is conducted by the Bureau of Justice Statistics at USDOJ and provides information on the violent victimization of men and women over age 12, including rape, robbery and physical assault. It is one of the largest randomly selected household surveys conducted in the U.S. NCVS results indicate that about 147,000 persons were victims of rape or attempted rape in the year 2000. This represents a 33.3 percent decrease from the previous year's estimates, and continues a long-term decline (Rennison, 2002). As noted earlier, figures related to sexual assault are not comparable to those

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used in other national surveys because the number of rapes/attempted rapes are not included with the sexual assault category.

(c) **National Violence Against Women Survey (NVAWS)** This national telephone sample survey gathered information from 8,000 women and 8,000 men on their experiences with violent victimization. It took place between November 1995 through May 1996 and was jointly sponsored by the National Institute of Justice (NIJ) and the Centers for Disease Control and Prevention (CDC), and conducted by the Center for Policy Research (Tjaden and Thoennes, 2000).

- An estimated 302,000 women experienced at least one rape or attempted rape in the 12 months preceding the survey. Three-fourths of the women were assaulted by a husband, former husband, cohabiting partner, or date, and many were assaulted multiple times. The findings indicate that approximately 876,000 rapes occurred in 12 months prior to the survey, reflecting the fact that victims are sometimes raped repeatedly over time.

- An estimated 93,000 men were raped within the previous 12 months, most often by a stranger or acquaintance, rather than by an intimate partner.

- The survey found that 31.5 percent of adult female rape victims and 16 percent of men were injured, most often suffering scratches, bruises or welts. However, 25 percent had other types of injuries, including knife wounds, broken bones, dislocated joints, head and spinal injuries, internal injuries and broken teeth.

- Rates of intimate partner violence (IPV) vary significantly by ethnic group: Reports of IPV are lower for Asian/Pacific Islander women and men, while rates for African-Americans and American Indians/Alaskan Native women and men are higher. Differences diminish when socioeconomic status is considered.

- Only one-fifth of all rapes against women were reported to police, and the percentage of male rapes reported was even lower.

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- (d) **National Women's Study (NWS)** The NWS was a longitudinal study of risk factors for substance abuse that was funded by the National Institute on Drug Abuse, NIH/DHHS. The study ran from 1989 through 1993 and sampled some 4,000 women age 18 and older, including an over-sample of women between age 18 and 34. The women were asked about any history of physical and sexual assault, other traumatic events, post-traumatic stress disorder, alcohol and drug abuse, depression, suicidal ideation and attempts, and related topics. Three waves of assessment were conducted via telephone: an initial assessment and further assessments at one year and two years later.

The NWS estimates indicate that 683,000 women were forcibly raped during the one year period between the initial assessment and the follow-up assessment. Most women (84 percent) did not report the offense to police. About 61 percent of assailants were husbands, boyfriends, or other relatives or friends; 24 percent were strangers (Kilpatrick, 1993).

#### 4. **Child Abuse, Neglect and Maltreatment**

- (a) **The National Child Abuse and Neglect Data System (NCANDS)** This information system collects data from states annually on the number of child abuse and neglect cases reported to Child Protective Services (CPS) agencies in the United States. The most recent report, *Child Maltreatment 2000: Reports from the States to the National Child Abuse and Neglect Data System*, indicates that approximately 2.8 million reports of abuse and neglect were referred to CPS agencies, and 879,000 cases of child abuse and neglect were substantiated (USDHHS, ACYF, 2002).

Most children (83 percent) were abused by one or both birth parents. Ten percent of the substantiated cases involved sexual abuse.

The NCANDS system is sponsored by the Children's Bureau, a component of the Administration for Children, Youth and Families (ACYF), in the Administration on Children and Families (ACF), DHHS. The data collection had been a voluntary effort on the part of the States until the *Child Abuse Prevention and Treatment Act Amendments* of 1996 (P.L. 104-235), which required to the extent practicable that States submit seven new elements not previously included in the voluntary effort.



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**(b) Third National Incidence Study of Child Abuse and Neglect (NIS-3)**

This 1993 study was sponsored by the National Center on Child Abuse and Neglect, a part of ACYF at DHHS. The findings are based on reports from Child Protective Service (CPS) agencies, and reports from community professionals who saw cases that were not reported to CPS or which were screened out by CPS without investigation (Sedlak and Broadhurst, 1996). The study found:

- About 1.6 million children in the United States were harmed by abuse or neglect of all types in 1993, including an estimated 300,000 cases of sexual abuse and 614,000 cases of physical abuse. Most of those children who were injured or harmed were victims of their birth parents, including about one-fourth of those children subjected to sexual abuse (75,000 cases).

- The 1993 estimate was a 67 percent increase over an earlier study done in 1986, and a 149-percent increase over the first such survey conducted in 1980.

- Researchers considered whether the dramatic increase in child abuse was due to an actual increase in the number of cases which occurred, or whether they reflected an increased sensitivity by providers to signals that abuse is occurring. They concluded that there was greater sensitivity, but that a real increase in the level of abuse had also occurred.

**5. Elder Abuse and Neglect**

There are few national estimates of the prevalence or incidence of elder abuse and neglect and none provide national estimates specific to sexual abuse in older populations.

In October 2000, the Attorney General brought together public health and law enforcement professionals, prosecutors, health care providers and forensic experts to discuss research and training needs related to elder abuse (USDOJ, NIJ, 2002). The participants noted the scarcity of data on the prevalence and incidence of elder abuse and neglect, as well as on all aspects of the topic, and agreed that there was a “desperate need” for basic research on elder abuse and neglect.

**(a) National Elder Abuse Incidence Study (NEAIS)** This 1996 study is the primary source of national data on elder abuse occurring in domestic (non-institutionalized) settings. The estimates are based on information drawn from a nationally representative sample of Adult Protective Services (APS)

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agencies and reports from professionals working in community agencies having frequent contact with the elderly living at home.

The study suggests that an “iceberg” effect occurs in reporting, i.e., many more cases of abuse and neglect occur than are reported to APS agencies. This theory is based on the substantial number of additional cases they found in this study that were reported to the sentinel community professionals, but not to APS.

The best estimate from the study indicates that about 450,000 cases of elder abuse and/or neglect occurred in 1996. This includes 71,000 cases reported to APS agencies and substantiated, and an estimated 379,000 cases that were derived from reports from the community-based sentinel agencies. However, the standard error for the study indicates that between 211,000 to 689,000 elders could have been victims that year.

The NEAIS found that females over age 60 were abused at a higher rate than males over age 60, and that persons over age 80 are at highest risk of abuse and neglect. Results indicate that ninety percent of the known perpetrators are family members, and two-thirds are adult children or spouses.

The number of cases of elder abuse reported to APS agencies grew by 150 percent in the ten years from 1986 to 1996, while the population of persons over age 60 grew by only ten percent. It is unclear how much of the incremental increase in APS reports represents an increase in the incidence of abuse and how much is attributed to an increase in the proportion of abuse cases that are actually reported to APS agencies (Cook-Daniels, 1999).

The study was requested by Congress and conducted in 1996 by the National Center on Elder Abuse at the American Public Human Services Association and Westat, Inc. It was prepared for the ACF and the Administration on Aging (AOA) at the DHHS (US DHHS, AOA, ACF, 1998).

- (b) Pilot Study – Sexual Abuse of Nursing Home Residents** There are few studies of abuse issues affecting residents of nursing homes, and most that have been done focus on physical and psychological forms of abuse. In a rare pilot study of 20 sexually abused nursing home residents, researchers Burgess, Dowdell, and Prentky found that about half of those abused had reported the sexual assault directly (Burgess et al., 2002). Cognitive and

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neurological disorders limited the ability of many victims to report sexual assaults; physical and communication impediments also limited the ability of many to undergo a physical and forensic examination. More than half of the patients studied died within a year. While many were medically compromised at the time of the assault, the authors speculate that the rape trauma may also have been a contributing factor to some of these deaths.

- (c) **Report from the National Research Council's Committee on National Statistics - Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America** This study was commissioned by the NIH National Institute on Aging, and cosponsored by AHRQ (Bonnie et al., 2002). It provides a review of conceptual, methodological, logistical and other issues related to developing a health research agenda. While several sources of data on elder abuse and neglect were identified, for the most part, sexual abuse was not separately addressed. However, it references a study based on 1998 data from the AOA's National Ombudsman Reporting System which found that physical abuse was one of the five most frequent allegations filed on behalf of nursing home residents. They also note that one researcher identified 1,700 complaints of sexual abuse filed with an Ombudsman over a two-year period.

## 6. Sexual Violence Against People with Disabilities

There has been very little research available on the incidence and prevalence of sexual assault among women with disabilities. Much of what is available is out of date. In 1999, researchers at the CDC published an on-line fact sheet which summarized the findings that could be gleaned from a review of about 15 studies on sexual violence against non-institutionalized adults with disabilities. Most were published in the early to mid-1990's, though the review period runs from 1984 through 1996 (NCIPC, CDC, 1999). The review of the study findings indicates that:

- Disabled women appear to be at high risk of sexual assault. The lifetime incidence of sexual assault of disabled women was between 51 and 79 percent, depending on the study.

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- Among disabled adults with cognitive impairments such as mental retardation and learning disabilities, the lifetime rate of sexual assault ranged from 25 percent to 67 percent, depending on the study.

- The studies reviewed indicate that most assailants of disabled persons are male and are known to the victim. Assailants are frequently family members, acquaintances, others with disabilities, and health care providers (especially for the institutionalized disabled). In most sexual assault cases (75 to 81 percent), the victim was assaulted more than once.

### **C. AHRQ Study Approach**

This report responds to a specific request to AHRQ from Congress for information on evidence-based clinical practices for the examination and treatment of victims of sexual assault and child molestation, and training related to performance of medical evidentiary examinations for victims of sexual assault and other forms of abuse. As a usual matter, the Agency seeks to identify evidence-based practices through systematic reviews of the scientific literature that attempt to minimize bias. Reviews include a comprehensive and reproducible search and selection of articles, an assessment of the methodological quality of articles, and an evaluation of the overall strength of the resulting body of evidence.

Unfortunately, in this instance, the research base is very thin. A review of the peer-reviewed literature identified few studies that were strong in terms of methodology and study design, and almost none that were of experimental or quasi-experimental design. Most articles that turned up in the search were descriptive studies or other reports that present opinions based on clinical experience or on the work of expert panels, committees, or other authorities.

This report summarizes survey data and the findings from the handful of published studies available. However, we also turned to health and law enforcement experts in the field to describe current knowledge and practice. Our goal was to determine if a reliable scientific basis exists for existing clinical practice or for the development of training programs, and to identify remaining research gaps and the priorities for future study and improved training for practitioners in the field.

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- 1. Literature Review** AHRQ staff conducted a MEDLINE search of peer-reviewed medical journals and a HealthSTAR review of nonclinical journals related to medicine, as published through April 2001. Search terms included population-based terms, including sexual assault, child abuse, child molestation, and elder abuse; and procedure and program related terms, including forensic, medical evidentiary, Sexual Assault Nurse Examiner (SANE), and Sexual Assault Forensic Examination (SAFE). Articles on intimate partner violence were included if they were linked to sexual assault or forensic examination.

In addition, an Internet search of national clearinghouses and other sites yielded excellent data, articles, training materials and unpublished protocols related to sexual assault and child abuse, and on legal and clinical examination issues related to examination and treatment. The USDOJ site was searched for health terms, forensics, multidisciplinary training, and sexual assault, as well as for data on incidence, conviction rates, and other issues related to law enforcement aspects. The attached bibliography also contains a handful of studies published more recently which were flagged for our attention by individuals working in the field, or which otherwise came to our attention.

- 2. Consultation with the Public and Professional Communities**

AHRQ staff wrote to the principal health professions organizations that represent medical, nursing, social work, dental and other specialty disciplines in the field. The letters described the Agency's legislative mandate and invited each to give AHRQ copies of any training materials, practice guidelines, policy statements, or position papers about the topic. Interested organizations were invited to have a representative contact AHRQ staff to discuss policies, issues, or programs sponsored or initiated by the organization.

Over 30 individuals from more than 18 professional and advocacy organizations contacted the Agency's staff. They were generous with their time, providing extensive materials for the Agency's use, and many insights on clinical practice and training issues. In addition, many provided the Agency with the names of individual experts that they recommended we contact for additional information.

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As a result of the literature search as well as consultation with the relevant professional, health care, and other organizations, training materials, protocols, and position papers were received from over 40 organizations including the major professional societies as well as providers, public health agencies, advocacy organizations and research institutions.

The Agency also sought to contact experts in the legal system for expertise and perspectives on practice and training issues. We consulted with Federal law enforcement experts in USDOJ, and with the Police Education and Research Foundation (PERF), a non-profit agency in Washington, DC which focuses primarily on law enforcement issues. PERF is evaluating interdisciplinary community training programs in which law enforcement and health professionals work together to prevent homicides by working together to intervene early in the cycle of domestic violence. Local law enforcement agencies contacted included the Napa County District Attorney's Office in Napa, California.

AHRQ staff presented information on the study to the National Advisory Council on Violence and Abuse, which is composed of representatives from the American Medical Association (AMA), the American Academy of Pediatrics (AAP), state medical societies, and other member organizations. AHRQ staff also met with several groups at the first National Sexual Violence Prevention Conference, "Coming Together to End Sexual Assault," convened in Dallas, Texas. Representatives of the International Association of Forensic Nurses (IAFN) convened a special roundtable on the development and scientific standards for Sexual Assault Nurse Examiner (SANE) programs.

AHRQ staff benefited from consultation with staff and Committee members at the National Academy of Science/Institute of Medicine (NAS/IOM) responsible for a study on the adequacy of training for health professionals in family violence that was mandated by Congress and sponsored by the CDC. The report presents the most comprehensive analysis available of education and training on family violence. Although the emphasis of the report is on training and education of providers in relationship to family violence, the study includes a useful discussion of the need for providers to have competency in forensic services, and suggests a model for providing training that would establish core competencies for various

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types of professionals. Their final report is entitled *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence* (Stobo, 2002).

AHRQ staff visited training and clinical service sites and talked with academic faculty, medical and nursing practitioners, and law enforcement experts who work with sexual assault victims and the legal justice system. Programs and facilities visited included the State-funded California Medical Training Program at the University of California-Davis, which offers training and consultation to providers, emergency medical technicians, social workers, law officers, and others who work with the victims of child and adult sexual assault, elder and dependent adult abuse, and domestic violence.

Staff also visited the Victim's Intervention and Prevention Center (VIP), a fairly new facility based at Parkland Hospital in Dallas, Texas. The Center serves an unusual cross-section of victims of violence, including victims of sexual assault, domestic violence, and survivors of torture. It is structured to respond to the needs of a culturally and economically diverse population, and maintains both education and research components that involve hospital staff and close connections to community agencies.

Others organizations visited included the Napa/Solano Sexual Assault Response Team (SART)-Sexual Assault Nurse Examiner (SANE) Program at Queen of the Valley Hospital in Napa, CA, the Forensic Nursing Services in Santa Cruz, CA, and the Family Violence Prevention Fund in San Francisco, CA.

### **3. Consultations with DHHS and Other Federal Agencies**

AHRQ staff also consulted with a number of DHHS components, including the Administration on Aging, the Centers for Disease Control and Prevention, and the Health Resources and Services Administration, as well as with the U.S. Department of Justice. Existing Federal as well as State activities are summarized in Section V.

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### **III. Health Professions Training Programs, Professional Standards and Guidelines**

Little is known about who and how many health professionals have received training or education in the examination and treatment of victims of sexual assault or other forms of abuse, nor the content, duration and scientific basis for the training. However, as noted in Section II, most States have mandatory reporting laws that require health professionals to report known or suspected child maltreatment and elder abuse, and a few require providers to report injuries from domestic violence. A much larger number of States (42) require physicians to report injuries resulting from firearms, knives, and other weapons (Houry et al., 2002).

Only a few States also have established mandatory educational requirements for health professionals, and the requirements principally focus on reporting requirements and mechanisms, rather than on development of clinical skills. California, Iowa and New York require health providers to receive training on identification and reporting of child abuse and neglect; Alaska, Florida, and Kentucky require training to familiarize providers with intimate partner violence and community resources; and Iowa mandates two hours of training every five years on identification and reporting of elder maltreatment (Stobo, 2003).

A recent review of the literature conducted by the IOM found no formal evaluations of the impact of mandated family violence education for providers (Stobo, 2002). They note that studies demonstrate that providers who have taken continuing education on child maltreatment are no more likely to report abuse; and that some samples indicate that continuing education courses make it less likely that providers will report. They recommend evaluation research on whether instruction – didactic or other – increases knowledge or changes behavior, whether changes are sustained, and whether there are positive outcomes in terms of such factors as costs of care, severity of presentation, and mortality.



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## A. Academic Training Programs

There appear to be few university-based, academic training programs for health professionals that include curricula to develop clinical skills for performing forensic or medical evidentiary examinations. However, a handful of degree-granting programs in medicine and nursing are known to exist, and a small number of colleges and universities have recently added course work to existing programs in nursing and medicine.

The IOM Report *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence* identified seven pediatric medicine fellowship programs affiliated with medical schools in the United States that include one to two years of training on child abuse and neglect or child forensics (Stobo, 2002). They also noted a few medical and nursing schools that offer one to four month elective courses or other clinical rotations related to child abuse or domestic violence. However, the degree to which the courses build clinical skills related to medical evidentiary examinations is unknown. Referring to curricula on family violence in general, the report concluded generally that the “content is incomplete, instruction time is generally minimal, the content and teaching methods vary, and the issue is not well integrated throughout the educational experience. Moreover, studies indicate that health professionals and students in the health professions often perceive curricula on family violence to be inadequate or ineffective (Stobo, 2002).”

The nursing profession is moving to develop new academic programs which train students to perform evidentiary examinations for victims of sexual assault, child abuse, elder abuse and domestic violence. In November 2002, the SANE/SART Internet site ([www.sane-sart.com](http://www.sane-sart.com)) listed some six colleges and universities that offer graduate, undergraduate and/or certificate programs in forensic nursing. The newest program was developed through the nursing and law schools at Duquesne University in Pittsburgh, PA, which offers both a Masters of Science in Nursing (Forensic Nursing) or a Post Masters Certificate in Forensic Nursing.

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A few nursing schools have applied for federal funding to support development of programs, though only one program has been funded by HRSA's Division of Nursing. The College of Nursing at Seton Hall University in New Jersey received funds to strengthen the primary care component of their adult nurse practitioner program. The College will develop a new specialty in violence prevention that will educate students to become Sexual Assault Forensic Examiners. The Division of Nursing has also supported development of training materials for nurse-midwife program faculty and providers on caring for survivors of sexual assault, elder abuse or child abuse.

HRSA and others in DHHS also have worked with schools of nursing to assist development of improved curriculum content related to violence against women. The curriculum is primarily focused on identifying and assisting victims of domestic violence, and only lightly touches on issues related to sexual assault. In addition, HRSA reports that some Area Health Education Center Program and Geriatric Education Center Program grantees are offering education programming related to sexual assault and elder abuse. In 1996, HRSA funded the first General Preventive Medicine residency program to teach physicians preventive strategies in correctional health, developed at the University of Texas Medical Branch (Galveston). The curriculum offered elective rotations in forensic psychiatry and medical management.

## **B. Certification and Continuing Education Programs**

### **1. Sexual Assault Nurse Examiner/Sexual Assault Response Team (SANE/SART)**

A training program that is growing rapidly and bringing substantial change to the field is the Sexual Assault Nurse Examiner program. The growth of these programs across the country has established forensic nurses as the dominant provider of medical evidentiary examinations in many communities. SANE programs are often integrated into a Sexual Assault Response Team model for the delivery of emergency medical care to survivors of sexual assault. Within a local community, SARTs bring together providers, law enforcement, prosecution, and victim advocacy and public health organizations to promote more coordinated, comprehensive, effective, and efficient care. In addition to its multidisciplinary focus, the SART

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model features use of specially trained forensic nurses who conduct evidentiary exams, most often with the supervision of a physician medical director.

The basic SANE program is available to trained registered nurses (RNs), and offers certification as a nurse examiner on completion of classroom and clinical training. Typically, programs require 40 or more hours of classroom instruction, along with clinical training and subsequent continuing education.

There are a handful of programs with a long history, but most programs are less than five years old. The first programs were established in 1976 (Memphis, TN) and 1977 (Minneapolis, MN), and the initial development was slow until the mid-1990's. By 1998 the number had grown to 117, and by March of 2001 there were over 400 programs (Ledray, 2001).

The programs may be based at community locations or in hospitals. Hospitals have often been willing to donate space, supplies and equipment, though resources can vary considerably. Many programs operate on a fee-for-service basis receiving reimbursement from hospitals, police, or county prosecutors.

The development of an integrated community approach through the SANE/SART model offers the potential for reducing fragmentation and duplication, and improved efficiency in the delivery of services. The costs and other factors affecting programs have not yet been systematically assessed and compared, and will be difficult to evaluate as programs differ in how they are structured and in the cost of doing business. Reimbursement is available through funding from State victim compensation programs, supported partially through the Federal Victims of Crime Act, and varies according to State policies and resources.

The growth in the number of SANE programs is influenced by the fact that many physicians prefer to avoid seeing sexual assault victims because they don't feel they have the specialized expertise required for evidentiary examinations, and they are reluctant to get caught up in time-consuming legal proceedings. In addition, emergency physicians may be precluded from serving the immediate needs of

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sexual assault victims because of delays and interruptions due to more severely injured patients (Voelker, 1996).

The growth of these programs has also been facilitated by the support of the USDOJ Office for Victim Services, which has promoted development of programs by making materials and training available through the Web, and via regional workshops. Many States have vigorously adopted the program as well, including Texas, Wisconsin, Colorado, and Pennsylvania.

## **2. Other Professional Training Programs**

Many programs offered on sexual assault or domestic violence provide the learner with an overview of issues related to violence and abuse, but few are intended to teach skills related to evidentiary examinations and therefore most lack technical content related to forensic evidence collection. The emphasis tends to be on screening, management, and referral of victims to social service organizations.

However, the programs vary in this regard. Programs that offer detailed clinical education on sexual assault and examination of victims include:

- The National Health Service Corps (NHSC), a program managed by BHP at HRSA, developed and provides a detailed clinical training module on **Child Abuse, Neglect, and Domestic Violence** (Jenny, 1996) as part of an ongoing educational program for students and providers practicing in rural and urban, inner-city areas.

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- ACOG, AAP, AMA, and other professional groups offer training programs of various lengths that provide training related to medical-legal aspects of family violence and sexual assault.
  - The Violence Against Women Act of 2000 amended the STOP Violence Against Women Formula Grants Program, administered by USDOJ, to add a purpose area for training of sexual assault forensic medical examiners in the collection and preservation of evidence, provision of expert testimony, treatment of trauma, and prevention related to sexual assault.

In general, however, the lack of detailed material on sexual assault and training on performing medical evidentiary examinations in programs on family violence is somewhat puzzling, given that rape is a common component of family violence. Most sexual assaults are perpetrated by husbands, boyfriends and other current or former intimate partners. Yet, a review of materials on family violence will reveal that rape, child molestation, or other sexual assault is seldom mentioned in screening or management of patients who are victims of family violence. Rather, course work tends to focus on physical assault—broken arms, bruises, concussions, strangulation, and the like, and future safety planning and community resources. Evidence collection skills tend to be limited to a mention of the usefulness of taking notes on victim statements and use of a body map or photograph to document injuries.

Aside from the issue of whether the content related to sexual assault and evidentiary examination is adequate, many of the programs offered do not appear to be solidly constructed. The IOM review of educational offerings concluded:

“There are few scientific underpinnings to support the content, instructional methodologies, or extent of education now being provided in these training programs ... Curricula content is incomplete, instruction time is generally minimal, the content and teaching methods vary and the issue is not well integrated throughout their educational experiences (Stobo, 2002, p. 6).”

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The IOM report recommends that core competencies for health professional training on family violence be developed and tested, and concludes that the core competencies needed include the identification, assessment and documentation of abuse and neglect. They point to the limited evidence base in family violence generally. Additional barriers to development of improved academic training programs include a lack of interest among faculty, competing pressures for curriculum time, and the limited availability of developmental resources.

### **3. Clinical Practice Guidelines: A Tool for Practitioners**

Clinical guidelines, professional standards and practice protocols are developed by professional organizations or quality improvement bodies to help guide practicing providers toward improved health outcomes. They are distinct from educational programs that are offered at a particular time and place as part of a formal academic training program. The development of guidelines and protocols has grown in recent years as evidence-based medicine has become a dominant force in the way medicine is practiced.

At the heart of evidence-based practice is the systematic review of a body of research which can evaluate what clinical practices work best, for whom, and at what cost. It is only possible, however, if there is a body of rigorous study to support conclusions. In the case of medical evidentiary examinations, the necessary evidence base is sparse.

In reality, most medical care is not solely based on evidence from carefully designed studies, and variations in practice are common. Much medicine derives from experience and common wisdom handed down; where clear evidence is not available, practitioners rely on experienced-based clinical judgment. However, in the last two decades or so, the movement to evidence-based practice has brought about further improvements in the outcomes of care provided, and works to conserve resources by eliminating unnecessary or ineffective health care services. In general, the lack of research on the outcomes and effectiveness of the components of the evidentiary examination process can be expected to hamper

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efforts to improve existing training programs and establish effective practice protocols.

A well-written guideline presents a synthesis of the available scientific evidence on a topic relevant to clinical practice. Ideally, the synthesis is presented in a structured format that facilitates the ability of providers and patients to make decisions about health care services to be provided. To be viewed as solid and reliable guidance, the guideline must be based on a systematic literature search and review of existing scientific evidence published in peer-reviewed journals.

**Guidelines for Performing Medical Evidentiary Examinations** Although a number of States and locations have adopted protocols or clinical guidelines for conducting medical evidentiary or forensic examinations related to sexual assault and child abuse, few are based on systematic reviews of the literature, nor have they been compared or tested in terms of outcomes for patients and/or the purposes of criminal justice.

The largest national repository of clinical guidelines is the National Guideline Clearinghouse ([www.ngc.gov](http://www.ngc.gov)). It is an Internet-based, collaborative public resource that is sponsored by AHRQ in partnership with the AMA and the American Association of Health Plans (AAHP). It accepts science-based clinical care guidelines developed under the auspices of medical specialty associations, professional societies, government agencies, public or private organizations, and integrated health care organizations and plans.

The science that undergirds those guidelines that are accepted varies according to the topic and the available research base, but each is evaluated by the NGC to assess whether development of the guideline was based on a rigorous scientific process.

As of August 2002, six guidelines in NGC referenced forensic or medical evidentiary examination. Two are specifically intended to guide practitioners/examiners in how to conduct such examinations.

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- *Practice Parameters for the Forensic Evaluation of Children and Adolescents Who May Have Been Physically or Sexually Abused* (American Academy of Child and Adolescent Psychiatry)
  - *Practice Parameters for Child Custody Evaluation* (American Academy of Child and Adolescent Psychiatry)

The other guidelines are less specific about procedures related to performing evidentiary examinations, but describe key elements in a general way:

- *National Guideline for the Management of Adult Victims of Sexual Assault* Association for Genitourinary Medicine and Medical Society for the Study of Venereal Diseases
- *Care of the Adolescent Sexual Assault Victim* (AAP, Committee on Adolescence)
- *Practice Guideline for Psychiatric Evaluation of Adults* (American Psychiatric Association)
- *Domestic Violence* (Institute for Clinical Systems Improvement; 2001 Nov. 39 p., June 1996, Revised 2001 Nov)

#### **4. Professional Policies and Standards**

In addition to guidelines, specialty-specific professional organizations and accrediting bodies often develop clinical protocols, training materials, professional standards and policy statements to assist their members. Many organizations have policies and protocols related to identification, treatment, and or reporting of family violence, but few are specific in terms of the mandate of this report: training of health professionals to perform medical evidentiary examinations. Among the organizations that appear to have developed materials



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or policies that are specifically related to sexual assault, child molestation and/or medical evidentiary examinations are:

**American Academy of Pediatrics (AAP)** The AAP's Committee on Child Abuse and Neglect (COCAN) has developed an excellent series of practice guidelines, policy statements and technical bulletins which focus on the physical, sexual, and mental abuse and neglect of children and adolescents. The journal *Pediatrics* published a guideline in 1999 outlining the basic skills needed when examining a child for possible abuse, including details on taking history, performing a physical examination, recording data, and treatment (AAP, 1999).

The AAP recommends that pediatric residency training programs and continuing medical education programs incorporate education on family violence and child abuse. Resources developed by AAP include guidelines and teaching materials related to care for the adolescent sexual assault victim, CD-ROM courses on child abuse and other self-teaching materials, and technical information on oral and dental aspects related to child abuse and neglect, a joint product of the AAP and the American Academy of Pediatric Dentistry.

**American Association of Colleges of Nursing (AACN)** Recommends that schools of nursing ensure there is a curriculum with content related to domestic violence across the lifespan. They also recommend that students be provided opportunities to practice in clinical settings to learn screening, assessment, and caring for victims of violence. It is unclear whether training related to caring for victims of sexual assault is encompassed by this policy statement.

**American College of Emergency Physicians (ACEP)** The ACEP has actively sought to develop policies and protocols related to sexual assault that will be helpful to front line providers. In 1997, the ACEP and more than a dozen partner organizations worked collaboratively to develop a handbook on the evaluation and management of sexually assaulted patients. The handbook addresses the medical and emotional needs of the patient, as well as the forensic requirements of the criminal justice system.

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The effort was supported in part by MCH at HRSA, and involved more than a dozen public and private health and law enforcement organizations, including ACOG, the AMA (including the AAP), CDC, the FBI, the International Association of Chiefs of Police, the Emergency Nurses Association, IAFN, and the American Society of Crime Laboratory Directors. Advocacy organizations included the National Alliance of Sexual Assault Coalitions, the National Network of Children's Advocacy Center, and the STOP Violence Against Women Technical Assistance Project.

Although there were areas of disagreement among the participants, the resulting document, the *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient* (ACEP, 1999), provides a basic protocol for conducting medical evidentiary examinations of adult and pediatric/adolescent patients. It also includes technical assistance tools such as information on how to develop a coordinated community response plan, a guide to development and operation of a SANE Program and a list of key organizations in the field.

The materials developed included a guide to Federal grant programs related to domestic violence, sexual assault, and stalking. Most of the Federal grant programs at the time were applicable to development of community sexual assault prevention programs, and training for law enforcement and social services personnel. Among the programs are grants to States to provide limited compensation for the medical expenses of sexual assault and other victims of crime. There was no Federal assistance for development of curricula, training, or forensic capabilities associated with evidentiary examinations.

The ACEP Board of Directors recommended in 1997 that emergency departments have written protocols on the recognition and treatment of elder abuse, which include appropriately educated staff and referral mechanisms. Notably, the ACEP opposes mandatory reporting of elder abuse and neglect, but encourages voluntary referrals. Other policy statements seek to educate providers about recognition of child abuse and family violence.

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**American College of Obstetricians and Gynecologists (ACOG)** ACOG has mounted a sustained effort to educate their membership about the identification and management of Intimate Partner Violence (IPV) and sexual assault among patients. They publish materials designed to promote effective screening and management of patients, including a slide lecture presentation (ACOG, 2000), available in hard copy and CD-ROM, to be used in training residents, Fellows, medical students and other health care providers (<http://www.cdc.gov/nccdphp/drh/violence/ipdvp.htm>), and offer related continuing education sessions in conjunction with their annual meeting. The College also maintains updated information on their Web site. A technical bulletin for members provides practical direction related to the incidence of sexual assault, use of assessment kits, conduct of a medical evaluation, legal concerns, patient counseling and follow-up treatment.

**American Dental Association (ADA)** Recommends development of educational programs for training dental providers on how to recognize and report abuse and neglect of children, women, elders, people with developmental disabilities, physically challenged, and others who might be the object of abuse or neglect. Also seeks educational collaborations with other professional organizations, including the AMA and the American Psychological Association.

**American Medical Association (AMA)** The AMA publishes and offers for sale a series of diagnostic and treatment guidelines that address the basics of a patient interview and examination, as well as documentation, legal issues, testimony and trends in treatment and prevention. Specific guidelines are available on child physical abuse and neglect (AMA, 1992); child sexual abuse (AMA, 1992); domestic violence (AMA, 1992); and sexual assault (AMA, 1995). The guideline on elder abuse is less specific but also includes a discussion of ethical and legal issues around detection and reporting (AMA, 1992).

The organizational visibility of family violence was raised significantly in calendar 2000, when the AMA House of Delegates approved a resolution (419)

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calling for a committee of representatives from the National Advisory Council on Violence and Abuse and its Committee on Medical Education to identify the knowledge and skills needed by physicians to identify and respond to violence and abuse; to identify where in medical education these skills could be included; and to investigate continuing education needs. The resolution also called on the AMA to advocate for hospital and community support of violence survivor programs, as well as for equitable coverage and reimbursement for all health and mental health related to family violence.

**American Professional Society on the Abuse of Children (APSAC)** APSAC has five data-based guidelines on key areas of practice related to child maltreatment. The guidelines were developed by expert task forces, and then reviewed by other experts, legal counsel and APSAC leadership. The guidelines address:

- Psychological evaluation of suspected sexual abuse in children
- Descriptive terminology in child sexual abuse in medical evaluations
- Use of anatomical dolls in child sexual abuse assessments
- Photographic documentation of child abuse
- Psychological evaluation of suspected psychological maltreatment of children and adolescents

APSAC also offers week-long forensic interview training clinics with both classroom and clinic-based sessions. Topics include forensic interviewing techniques, legal issues, and other practical skills needed for both investigative and therapeutic purposes. The training targets mental health professionals, as well as professionals in child protective services, law enforcement, social services, medicine, and law.

The guidelines have not been systematically tested or compared in terms of how well they support the dual purposes of a medical evidentiary examination: providing medical care and collecting evidence for use in prosecution.

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**American Psychological Association (APA)** APA has developed a guide on the education and training of psychologists on issues of child abuse and neglect that is designed to facilitate development of semester-long courses. The association has developed educational materials for graduate-level programs as well.

**American Society for Testing and Materials (ASTM)** ASTM has a standard guide for sexual assault investigation, examination, and evidence collection which calls for using trained forensic examiners in the setting of a multi-disciplinary team. The ASTM guide requires facilities to have written procedures for providing information on the treatment plan, evidentiary and medical examinations, documentation and evidence collection, transmittal of evidence and the chain of custody and post-examination procedures. Agencies conducting child sexual assault investigations are required to develop special protocols appropriate for the examination of children.

**Joint Commission on Accreditation of Healthcare Organizations (JCAHO)** JCAHO is a non-profit entity which evaluates and accredits more than 17,000 hospitals, health care networks, home care and other health care organizations in the United States. Its guidelines require that hospital organizations have observable, objective criteria for identifying victims of physical assault, rape or other sexual assault, domestic abuse, and abuse of elders and children. In addition, the hospital is required to have a staff education plan and to maintain a list of organizations that provide or arrange for assessment and care of alleged or suspected victims of abuse and neglect, in order to aid in making appropriate referrals.

JCAHO specifies that medical assessment of victims of abuse must be conducted with the consent of the patient, meet legal responsibility for the collection, retention, assessment and safe keeping of evidentiary material, and include the notification and release of information to the proper authority when legally required.

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#### **IV. Clinical Practice: Issues of Cost, Quality, and Access to Sexual Assault Services**

The Agency's discussions with experts in the field pinpointed a number of issues in cost, quality and access to services for victims of sexual assault in urban, suburban and rural areas.

##### **A. Costs Associated with Sexual Assault**

There are few studies of the economic or medical costs associated with sexual assault, and little data on the use of medical services, either immediately, or over the long term. The studies that are available indicate that the long-term costs may be quite substantial in terms of ongoing visits to providers, missed work, and treatment for trauma (Rennison, 2002).

A 1996 NIJ Report (NIJ, 1996) supplements information obtained from the NCVS, which collects information only on short-term, out-of-pocket losses due to victimization. The NIJ report provides cost estimates for various types of violent crime that include longer range costs (e.g., those due to permanent disability and for mental health treatment) and intangibles such as pain, suffering, fear, and lost quality of life. The findings of the report include:

- Between 10 and 20 percent of mental health care expenditures in the United States may be attributable to crime victims who seek treatment as a result of their victimization. About half of these expenditures are for victims of child abuse who receive treatment as adults.
- Total costs per incident of non-fatal rape and sexual assault are estimated at \$87,000, including \$2,200 in productivity losses, \$500 for medical care expenses, \$2,200 for mental health care, and \$81,400 associated with reduced quality of life.
- The average total cost per incident of child abuse is \$60,000, including \$2,200 in lost productivity, \$430 in medical care costs, \$2,500 for mental health care, and \$52,371 in reduced quality of life. The greatest losses are associated with sexual

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abuse (\$99,000 per incident), followed by physical abuse (\$67,000) and emotional abuse (\$27,000).

Note: The quality of life estimates were derived from the analysis of 1,106 jury awards and settlements to assault, rape and burn survivors to compensate for pain, suffering and lost quality of life (excluding punitive damages).

- Total annual losses in the United States associated with child abuse (including sexual, physical, and emotional abuse) are estimated at \$56 billion, including \$23 billion specifically for rape and sexual assault.
- Total annual losses associated with rape and sexual assault of adults are estimated at \$127 billion, including \$4 billion in medical costs, \$3.5 billion in other tangible costs, and \$119 billion in quality of life.
- Total annual losses associated specifically with adult domestic violence (including fatalities, rape, other assaults and robbery) are estimated at \$67 billion, including \$1.8 billion for medical care, \$7 billion for other tangible costs, and \$58 billion for quality of life (these figures overlap substantially with those reported above for rape and sexual assault).

The 1995-96 NVAWS, a telephone sample survey that collected information on medical services provided to adult victims of rape, found that:

- About one-third (31 percent) of female rape victims reported physical injuries. Almost three-quarters of the injuries (73 percent) were minor (e.g., scratches, bruises or welts).
- About one third (36 percent) of those injured received some type of medical care. The majority of injured female victims who received care were treated in a hospital (82 percent). While most of those treated in a hospital were seen in the emergency room or an outpatient department, about 13 percent stayed for at least

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one night, with an average stay of 3.6 nights for those admitted on an inpatient basis.

- About half (55 percent) of all women who received medical care were treated by a physician outside of a hospital and averaged 4.8 office visits related to the injury. Somewhat less than a fifth received dental care (16.9 percent). A similar proportion visited a physical therapist (16.7 percent).

## **B. Variations and Deficiencies in the Quality of Care**

Among the issues identified with respect to quality of care and variations in practice are the following:

- **Lack of standardized protocols, procedures, and rape testing kits in use**  
A number of protocols and procedures have been developed, but there is considerable overlap and many States end up reinventing well accepted standards. However, there remain important differences among the protocols in use and none have been compared or rigorously assessed. Even components which are fairly standardized have neither been systematically taught nor thoroughly evaluated.
- **A lack of trained providers and expert consultants** There are curricula for teaching how to perform a medical evidentiary examination, but programs have reached only a few, self-selected providers (National Academy Press, 2002; Voelker 1996). While there have been notable efforts by States to extend and support forensic training programs to health professionals already in practice, the sheer number and types of providers who may see a sexual assault victim is daunting. The IOM report, *Confronting Chronic Neglect* (National Academy Press, 2002) makes the point that all providers need basic competencies. Specific training needs will vary by profession, specialty and practice setting. In particular, special training and skills are required for addressing the needs of child victims as compared to adults.



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- **Uneven quality of examination facilities and technologies available**

Most victims who seek medical care, though not all, are examined in a hospital setting. Many hospitals have developed special areas and separate facilities for examining patients, to provide a place where the lengthy examination will not impede care for other types of patients coming into an emergency room, to make available the special equipment and storage facilities used in such examinations, and to provide the victim a sanctuary that protects her or him from further traumatic experiences. Quiet, age-appropriate environments are thought to be especially important when examining children, who are particularly vulnerable to retraumatization and who also need examiners who are trained to meet the specialized needs of child victims.

Specialized and separate sexual assault units within or near a hospital are viewed by many as ideal from a patient's perspective, but such facilities are not available in all hospitals. Reasons include lack of space; too few patients to make it an effective use of reserved space; an unwillingness or inability to spend the resources needed to establish and maintain a dedicated sexual assault unit; and a lack of understanding by administrators and/or the community about the importance of specialized care. Equipment and space are expensive resources, and smaller, rural hospitals may have particular difficulty creating a viable program, facility and trained staff.

- **Poor quality and limited capability to test for drugs and DNA** Most hospitals do not routinely test for the full range of drugs (including substances used in drug-facilitated rape). Even fewer have the skills and technology to handle DNA testing, which has assumed additional importance with the advent of State DNA banks.

DNA evidence can easily be compromised by untrained providers who are involved in the collection and preservation process. The sample can be

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contaminated if someone sneezes or coughs over the evidence, or even if the examiner touches his/her own hair or body and then touches the area to be tested. It is also affected by heat and humidity, and is easily degraded (Turman, 2001).

Forensic DNA testing is a lengthy and expensive process, but one which is often paid for by the police department or prosecutor's office. However, even police labs often lack adequate forensic testing capabilities.

In partial response to these issues, a Federal law, the Paul Coverdell National Forensic Sciences Improvement Act, was enacted in 2000 (42 U.S.C. §§ 3797j et seq. (2002)). The Act authorizes about \$500 million in Federal funds over a five-year period to be used by States to: improve procedures for testing DNA samples; hire and train personnel; modernize laboratory equipment; and improve the quality and timeliness of forensic science services.

### **C. Access to Services**

There are only sketchy descriptions available of the types and quality of services available to sexual assault victims. The reports available indicate wide variations in the types and quality of services received.

The NWS (described in Section II) found that 55 percent of rape victims surveyed had not been given information on HIV testing and that one-third were not given information about other STD testing. The practice of immediate testing for STDs is controversial because any infection found would reflect prior exposure, and not all assaults will expose a patient to STD risks. However, others favor it as baseline information, and virtually all experts agree that the provider should stress the need for follow-up STD evaluation and treatment for patients at risk (CDC, 2002).

A 1996 survey of 130 Florida hospitals also provides a startling picture of the high degree of variation in services provided to sexual assault victims (Maxwell and Soubielle, 1996). Highlights of the findings from the 64 hospitals responding (49 percent) include:

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- Most of the Florida hospitals surveyed (88 percent) saw rape victims through the emergency room.

- Some hospitals (six) reported that law enforcement personnel assist in the exam, a violation of the State's evidence collection protocol. Most experts in the field agree that, except in rare cases, there is no medical or legal reason for law enforcement representatives, male or female, to be present during the exam. Maintaining the chain of custody during the examination is a function and responsibility of the attending medical personnel and one that should not require outside assistance.

- Although the JCAHO requirements call for ongoing in-service training, only about one-fourth of hospitals reported that they provided such training for the personnel conducting examinations. (Information on follow-up activity initiated in response to findings about adherence to JCAHO requirements is not available.)

- Most hospitals only involve the local rape crisis center personnel if requested to do so by the victim, many of whom do not know that such services exist.

- Fewer than half of the hospitals reported that they provide written material on common rape reactions and community resources as a usual practice. Fifteen percent said they do not provide the victim with any information on resources.

- Just over half of the hospitals set aside separate rooms for rape victims and some provide showers for the rape victims after the exam, or maintain a clothing closet, or provide underwear or paper jump suits to patients whose clothing was collected.

- Most hospitals (82 percent) discussed HIV screening with patients and dispensed prophylactic drugs for sexually transmitted diseases (88 percent).

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While interesting, these data, collected from 130 hospitals in Florida, may not be entirely reflective of national practices.

### **Access Issues Involving Payment for Evidentiary Exams**

When a sexual assault victim presents to a hospital or clinic, medical staff will typically assess and respond to serious or life-threatening injuries. However, the decision to do a formal evidentiary examination is dependent on the patient who must give written consent, and is affected both by State laws and the judgment of local law enforcement officials or prosecutors as to whether an examination will be useful and can be justified.

Numerous Federal and State laws have been enacted to ensure that victims of sexual assault do not have to pay for medical evidentiary examinations. However, some States limit payment only to victims who are willing to report the assault to police and/or to cooperate in any prosecution. If the assault is not reported, or the case is not prosecuted, the victim may be unable to obtain a full examination, or may have to pay for the costs of an examination.

A number of States place responsibility for payment on the county where the sexual offense occurred, or on the entity who requests the examination, most often the investigating law enforcement agency or the prosecuting attorney. If the county official, police officer, or prosecutor is told that the victim does not plan to formally report the assault (a decision that the victim may not want or be able to make immediately, and a decision which sometimes changes), they may not approve payment for an examination. Similarly, if they believe that the victim's account is weak or that successful prosecution is unlikely, they may act to preserve limited resources and not provide approval for payment.

Even when State laws mandate that victims not be charged for the expense of evidentiary exams, there are cases in which claims may be submitted to third party insurance companies, compromising the victims' privacy, as insurance companies may not only be informed of the sexual assault but may also learn about exposure to HIV or other aspects of treatment that could affect insurance

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coverage in the future. Victims may also be forced to disclose the assault to the primary person on the insurance, such as a family member or even an employer.

Victims of crime are not generally required to cover the costs of evidence collection incurred in the investigation of their cases. Despite the fact that most States have laws that designate payment sources to cover the costs of forensic exams for sexual assault victims, and some even specifically prohibit billing of victims, billing of sexual assault victims continues to be widespread (National Center for Victims of Crisis, 2003; National Center for Victims of Crisis, 2001). Victims need to be informed of their rights and of avenues of recourse when rights are violated.

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## V. Federal and State Activities

### A. Federal Programs and Initiatives

#### 1. Administration on Aging ([www.aoa.gov](http://www.aoa.gov))

The AOA provides home and community-based services to millions of older persons through the programs funded under the Older Americans Act. They are well-known for management of programs which provide home-delivered meals programs or nutrition services in congregate settings, adult day care, and other social services to older Americans. However, they also fund the long-term care ombudsman program, which is designed to prevent abuse of residents in nursing homes and similar facilities by investigating complaints, and by providing a regular community presence in facilities.

#### 2. Centers for Disease Control and Prevention (CDC) ([www.cdc.gov](http://www.cdc.gov))

CDC provides surveillance data, supports community development and research on prevention of sexual assault, and offers technical assistance. The CDC published a comprehensive compendium of training materials for health professionals: *Intimate Partner Violence and Sexual Assault: A Guide to Training Materials and Programs for Health Care Providers* (Osatlin and Short, 1998). The authors identified 36 sets of training materials intended to show providers how to identify and treat partner violence and sexual assault. Few of the programs are sufficiently detailed to be useful to providers in performing medical evidentiary examinations.

CDC staff at the National Center for Injury Prevention and Control (NCIPC) have substantial experience in the field of sexual assault.

Injury Center staff work with their counterparts at the National Institute of Justice and in other offices within USDOJ on a variety of projects. They supported the first National Violence Against Women Survey, which provides estimates of

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intimate partner violence, sexual violence, and stalking, and are now developing a pilot test for an ongoing national survey.

For several years, CDC has provided national leadership in the effort to improve the consistency and comparability of data on violence against women. They are pilot testing uniform definitions and recommended data elements on intimate partner violence, and are working to develop similar standards for sexual violence.

The Injury Prevention Center has an active research and dissemination program and agenda that includes attention to prevention of sexual violence and child maltreatment. Beginning in FY 2000, the CDC initiated projects to implement and evaluate culturally appropriate early intervention and prevention programs to prevent intimate partner and sexual violence among racial and ethnic populations. They also administer funding and technical assistance for health departments in states and territories to develop rape prevention and education programs, that will include training programs for professionals.

The Injury Center is promoting development of a public-private network of training and technical assistance resources, many of which proved useful in the development of this report. In 1999, the CDC awarded a grant to the Pennsylvania Coalition Against Rape to establish the National Sexual Violence Resource Center (NSVRC). The Center provides resources, training materials, and information to State and national sexual assault organizations and coalitions, as well as to community-based programs. Its extensive collection of materials is easily accessible online ([www.nsvrc.org](http://www.nsvrc.org).)

CDC, along with more than a dozen partner organizations, supported the American College of Emergency Physicians (ACEP) in the development of a basic protocol for conducting medical evidentiary examinations of adult and pediatric/adolescent patients.

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### **3. Health Resources and Services Administration ([www.hrsa.gov](http://www.hrsa.gov))**

#### **Bureau of Health Professions**

The Health Resources and Services Administration's (HRSA) Bureau of Health Professions (BHP) has extensive data and analytic initiatives related to the number and type of health professions training programs and students.

Most data on health professions training programs is obtained from relevant professional organizations, including the Association of American Medical Colleges (AAMC), the American Association of Colleges of Nursing (AACN), and other professional entities. For the most part, the data from professional associations is insufficiently detailed to provide a picture of what course-work related to sexual assault or medical evidentiary exams is available to students in a given type of training program.

The National Health Service Corps (NHSC) offers a detailed clinical training module on Child Abuse, Neglect and Domestic Violence for students and providers in rural and urban, inner-city areas. Funding for a General Preventive Medicine residency program at the University of Texas Medical Branch included elective rotations in forensic psychiatry and medical management.

The Division of Nursing obtained survey data collected by the AACN in 1999 that provides information on the curriculum content of baccalaureate nursing programs. The information was used by a DHHS consortium to examine how women's health and sex/gender issues are taught in the academic and clinical course of study for baccalaureate nursing students. HRSA and others in DHHS have worked with schools of nursing to assist development of improved curriculum content related to violence against women.

The Division of Nursing funded the College of Nursing at Seton Hall University in New Jersey to develop a new specialty in violence prevention that will educate students to become Sexual Assault Forensic Examiners. The Division has also



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supported development of training materials for nurse-midwife program faculty and providers on caring for survivors of sexual assault, elder abuse or child abuse.

Some Area Health Education Center Program (AHEC) and Geriatric Education Center Program (GEC) grantees are offering education programming related to sexual assault and elder abuse.

### **Maternal and Child Health Bureau**

In 1997, HRSA's Maternal and Child Health (MCH) Bureau supported the American College of Emergency Physicians (ACEP) in an effort to develop a consensus-driven national training protocol for performing medical evidentiary examinations of victims of sexual assault. The ACEP worked in collaboration with more than a dozen other public and private entities in drafting material, and subsequently published a protocol in 1999. The protocol continues to be widely used within the emergency medicine community (ACEP, 1999) and as a guide for many of the protocols being developed by states.

HRSA's MCH Bureau also supports program interventions to prevent child maltreatment, including child abuse and neglect. It funds the Children's Safety Network (CSN), which provides training, technical assistance and resources to state and local departments of public health, maternal and child directors and staff, injury prevention and control directors, and health professionals. Available resources include a state-by-state statistical summary of costs associated with child sexual, physical, and mental abuse and related deaths. The CSN Web site is [www.csneirc.org](http://www.csneirc.org).

### **Bureau of Primary Health Care**

Another HRSA activity related to domestic violence is the Bureau of Primary Health Care, Office of Minority and Women's Health profile of programs that addresses domestic violence at community health care organizations supported by the Bureau of Primary Health Care. The February 1992 publication *Healing Shattered Lives: An Assessment of Selected Domestic Violence Programs in Primary Health Care Setting* is designed to encourage primary health care

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providers to treat domestic violence among their client base and to engage providers, administrators, policymakers and others in a coordinated, community-wide response to domestic violence.

### **Other HRSA Resources and Initiatives**

There are two additional HRSA activities that, while related to domestic violence issues, provide good prototypes for possible future work related to sexual assault and medical evidentiary examinations.

- The HRSA Action Plan to Prevent Family and Intimate Partner Violence trains managers and program officials on domestic violence to heighten awareness of family, and to pave the way for changes to be made in health care and professional training settings.
- In 2000, HRSA's Office of Minority Health worked with the Bureau of Primary Health Care and others to coordinate delivery of two satellite provider training programs that were targeted to providers in the Community and Migrant Health Center Programs and others serving rural and inner-city areas. The training featured an inter-cultural approach and was designed to raise awareness, build provider skills, define resources, and develop community partnerships.<sup>3</sup>

4. **Substance Abuse and Mental Health Services Administration (SAMHSA) ([www.samhsa.gov](http://www.samhsa.gov))** SAMHSA is currently sponsoring the Women, Co-Occurring Disorders and Violence (WCDV) Study, which began in 1998 and will be completed in September, 2003. This study is the first Federal effort to address the significant lack of appropriate models of integrated services for women with co-occurring substance abuse and mental health disorders who have experienced trauma. The study is generating empirical knowledge on the

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<sup>3</sup> These training sessions on domestic violence are available from the HRSA Information Center or 1-888-ASK-HRSA.

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development of trauma focused comprehensive, integrated service approaches and the effectiveness of these approaches for women.

**5. National Institutes of Health/National Institute of Mental Health**

**(NIH/NIMH) ([www.nih.gov](http://www.nih.gov)) ([www.nimh.nih.gov](http://www.nimh.nih.gov))** In 1997, in response to a Congressional request, NIH established an NIH Child Abuse and Neglect Working Group (CANWG) consisting of the major research Institutes and Offices supporting research in the field. CANWG has worked to review NIH research efforts in child abuse and neglect, clarify Institute responsibilities to differentiate areas of overlap, identify accomplishments and future research needs, coordinate child abuse-related research across NIH, plan conferences and workshops, and develop funding mechanisms. The CANWG has met with representatives of other Federal agencies including the Administration for Children and Families, National Institute of Justice, Office of Juvenile Justice and Delinquency Prevention, Department of Education, and the Department of Defense. The Committee's review revealed that \$33.7 million is devoted primarily to child abuse and neglect research and another \$48 million is relevant to understanding the precursors and consequences of abuse and neglect.

NIMH sponsors a broad array of research related to the psychosocial impact of sexual and physical assault; development and testing of treatment protocols and training programs; research on preventive interventions to reduce posttraumatic mental disorders; training of mental health researchers; and research on the organization, delivery and effectiveness of care to victims. In 1995, NIMH issued a Program Announcement to solicit research on Violence and Traumatic Stress. One of the three major areas addressed was victims of child abuse, rape, sexual assault, family violence, and other kinds of interpersonal violence and crime. NIMH has issued fact sheets on Post-Traumatic Stress Disorder and Helping Children and Adolescents Cope with Violence and Disasters.

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## **6. Agency for Healthcare Research and Quality (AHRQ)**

**([www.ahrq.gov](http://www.ahrq.gov))**

AHRQ has awarded \$5.5 million for four extramural research projects to evaluate health care interventions with the purpose of improving treatment and outcomes for victims of domestic violence. This research should assist health care organizations with evidence-based findings about the most effective treatment approaches for domestic violence victims. The studies are intended to develop new knowledge in the prevention of domestic violence, improve the identification of female patients at risk, and evaluate outcomes and effectiveness of health care interventions designed to treat domestic violence victims.

AHRQ has also issued a new evaluation instrument that hospitals can use to assess the quality and effectiveness of their domestic violence programs (<http://www.ahrq.gov/research/domesticviol/>). Hospitals can use this instrument to assess how well hospital-based programs provide training for health care professionals in recognizing domestic violence, patient screening to determine their risk of domestic violence and future injury, and interventions, including medical treatment and victim advocacy services and follow-up.

## **7. DHHS Violence Against Women Act Steering Committee**

The DHHS Violence Against Women Act Steering Committee meets bimonthly and is managed by the DHHS Office on Women's Health in the Office of the Secretary. Meetings are attended by staff from DHHS Agencies and Offices, as well as by staff from USDOJ. The Committee's primary focus is promoting exchange of information and collaboration on issues related to intimate partner violence, but most members share a strong interest in sexual assault and child abuse as well.

## **8. Stop Family Violence Fundraising Stamp**

The Stop Family Violence postal stamp was unveiled by the Secretary, DHHS on June 14, 2003 to raise awareness and generate money for the victims of domestic violence. The price of the stamp is 45 cents, with the difference

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between the sales price of the stamp and the underlying postage consisting of a tax-deductible contribution. By using this stamp on their cards, letters, and packages, customers will contribute to a nationwide fight against domestic violence.

**9. U.S. Department of Justice ([www.usdoj.gov](http://www.usdoj.gov))**

USDOJ has developed an impressive and useful array of scientific papers related to sexual assault and forensic issues. These include published survey findings and statistical analyses, white papers, conference summaries, and other reports and training materials. The primary resources on sexual assault at the Office of Justice Programs (OJP) are managed by the following offices:

**(a) National Institute of Justice (NIJ)** NIJ is the research, development, and evaluation agency of the USDOJ, and is solely dedicated to researching crime control and justice issues. NIJ funds a range of research, including an annual solicitation for Research on Sexual Violence, that allows for awards of up to \$1,000,000 to support research on sexual violence in understudied populations, drug-facilitated sexual assault, and the effect of criminal justice reforms (including use of DNA evidence) on the outcomes of sexual assault cases.

The NIJ is currently funding an evaluation of the Sexual Assault Response Team (SART) model in Rhode Island. Outcomes for victims and perpetrators will be compared in communities that have SART programs and those that do not. The study will be completed at the end of 2004.

The NIJ also supports a number of projects in collaboration with the CDC, including development and analysis of the National Violence Against Women Survey.

**(b) Bureau of Justice Statistics (OJS)** OJS is the source for national police statistics on sexual assault and conviction rates used in this report. Its mandate within USDOJ is to compile and analyze data on crime, criminal justice, and

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crime victimization. Its *Sourcebook of Criminal Justice Statistics, 2000* compiles statistics from more than 100 sources to profile all aspects of criminal justice in the United States and is published in hard copy, CD-ROM format, and online (USDOJ, NCJ, 2001).

**(c) Office for Victims of Crime (OVC)** OVC was established under the 1984 Victims of Crime Act (VOCA) to oversee programs that benefit victims of crime. It funds state victim assistance and compensation programs, and supports training programs to educate criminal justice and allied professionals regarding the rights and needs of crime victims. It operates a comprehensive program of training, technical assistance materials, and publications related to rape and sexual assault, and manages a Speakers Bureau for contacting experts on sexual assault issues. In 1999, the OVC published an online and hard copy guide for development of SANE programs (Ledray, 1999). A more recent publication, *Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims*, provides an overview of SANE programs and their contributions to improving community response to victims, and identifies promising practices and practical guidelines for establishing a SANE program (USDOJ, NCJ, 2001).

**(d) Office on Violence Against Women** This Office works with others in the Office of Justice Programs to implement a variety of programs authorized by the Violence Against Women Act. One of these is the STOP Violence Against Women Formula Grant Program, which provide funds to state, tribal, and local governments, and to community-based agencies. States may choose to use the funds for any of a number of listed purposes, including development of specialized domestic violence and sexual assault units, and for the training of sexual assault forensic medical personnel examiners in the collection and preservation of evidence, analysis, prevention, provision of expert testimony, and treatment of trauma related to sexual assault. The Office supports a limited program of research on sexual assault issues.

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Under the Violence Against Women Act of 2000, the Attorney General is required to develop national recommendations for a protocol for sexual assault forensic examinations. The Violence Against Women Office has convened national experts and solicited advice from technical sources and the public. The Office is working with medical experts, advocates, experts from the criminal justice system, forensic scientists, and with others at USDOJ and DHHS, in the development of a protocol. The recommended national protocol is anticipated to be completed in December, 2003 (USDOJ, 2003).

**(e) The DNA Analysis Backlog Elimination Act**

The DNA Analysis Backlog Elimination Act of 2000 (42 U.S.C. § 14135 (2000)) provides Federal funding of \$45 million over 3 years to States for DNA sample analysis. The money is intended to enable labs to hire the additional personnel needed to eliminate backlogs and to decrease processing times. To be eligible, States must promise to implement a comprehensive plan for the expeditious analysis of DNA samples, including those collected but not analyzed prior to enactment.

**B. State Programs and Activities**

**1. Reporting Requirements** In 48 States, physicians and other health professionals are required to report known or suspected instances of actual or suspected child abuse and most states also require physicians to report if they believe that elder abuse has occurred (Children's Bureau, DHHS, 2002). Four States (California, Colorado, Rhode Island, and Kentucky) specifically require physicians to report intimate partner abuse (National Academy Press, 2002).

**2. Practice Protocols and Standardized Evidence Collection Kits**

Background research conducted by the Department of Justice, derived from State and professional materials, has documented that there are approximately

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35 States which have or are developing practice protocols on sexual assault for use in the State, and approximately 45 States that have or are developing State standardized evidence collection kits and forms.

- 3. Mandatory Educational Requirements** A few States have established mandatory educational requirements for health professionals. California, Iowa and New York require health providers to receive training on identification and reporting of child abuse and neglect. Alaska, Florida, and Kentucky require training to familiarize providers with intimate partner violence and community resources; and Iowa mandates two hours of training every five years on identification and reporting of elder maltreatment (National Academy Press, 2002).
- 4. Promotion of SART/SANE Programs** Facilitated by the support from the USDOJ Office for Victim Services, SART programs now reach into at least two dozen States. Many states have vigorously adopted SART/SANE programs, including Texas, Wisconsin, Colorado, and Pennsylvania. For example, Texas provides financial support and technical assistance for development of SANE/SART training programs and has a full time unit to encourage SANE training programs. The State of Rhode Island is participating in a study funded by NIJ to evaluate the effectiveness of their SART program.
- 5. State Supported Training Models** Training models have been developed with State support in Alaska, California, Ohio and Texas. As an example, the California Medical Training Center at the University of California (UC)-Davis is a product of the State legislature, which passed laws which mandate reporting of sexual assault and abuse by health professionals, and which also acted to provide financial support for a statewide system. The program is



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based at the UC (Davis) Medical School, and provides specialized clinical training for examination and treatment of four types of victims (sexual assault, child abuse and molestation, domestic violence, and elder abuse). The CMTC offers training to physicians, nurses, emergency responders and other professionals. Training is offered on site, in hospitals and other facilities around the State, and through distance learning facilities available through college, hospital or law enforcement training networks. Trainees include physicians, nurses, law enforcement officers, Emergency Medical Service (EMS) personnel and others. Medical technology is used to link rural providers with specialized consultation services, and faculty are able to offer their services as expert witnesses.

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## **VI. Opportunities for Further Improvement**

### **A. Consolidate and Enhance the Evidence Base for Practice**

#### **1. Promote Cross-Collaboration to Enhance Research, Education & Practice**

Efforts to improve the quality and outcomes of medical evidentiary examinations could be facilitated by consolidating and enhancing the existing knowledge base through the promotion of cross-collaboration and communication among the various disciplinary and organizational entities involved in education, research, and practice. Current efforts are frustrated by a lack of a coherent body of research in the field, i.e., a comprehensive evidence base to provide an integrated framework for what is taught to students and providers. This problem is related to all forms of violence, but is particularly acute for the evidence base related to sexual assault.

Several factors are thought to contribute to this problem. Support for research available from Federal, State, foundation, or private industry sources is sparse and fragmented. Thus, sexual assault as a field does not represent a viable career path for many academic clinicians who might otherwise be attracted to it.

In addition, there is limited demand for teaching faculty who are expert in sexual assault. There are few courses, and little prestige connected with this expertise within the academic setting. This, combined with meager research funding, has created a dearth of experienced researchers and university-based clinical faculty with the skills needed to advance the field. For many, work in the field of sexual assault is as much a personal cause as it is an academic pursuit.

Further, greater collaboration and communication is needed among researchers and practitioners in order to integrate, consolidate, and enhance the baseline descriptive information available on issues related to quality, outcomes, cost and

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access to medical evidentiary examinations and related treatment services. Basic questions include:

- Who is currently performing medical evidentiary examinations for victims of rape and other sexual assaults? How are they trained? What services do they provide? What are the variations in practice, and in the related quality, effectiveness and outcomes of care?
- What is the experience of victims, including the types of settings where they receive care, waiting times, and access to services? To what extent are special provisions made for children who are sexually molested?
- What are the immediate and long-term costs associated with sexual assault, including the cost to providers and the health care system of an involvement with legal proceedings?

Another set of questions concern the relationship between the services that are provided, the training received by providers, and the outcomes, costs and effectiveness of care. Decisions about when and under what circumstances an evidentiary examination should be performed continue to be controversial, as is the issue of who decides. Sometimes the decision is based on the believability of the victim and/or the likelihood of prosecution, as assessed by the law enforcement officer on the scene. In addition, technological innovations are changing the practice of forensic science. The time frame during which useable evidence can be recovered is being extended and new techniques are improving the range and reliability of other testing.

The assessment of under what circumstances examinations should be undertaken is further complicated by the fact that examination results are frequently not actually used in criminal proceedings. Arrests may not be possible or assailants may plead guilty, although examination results may increase the likelihood of a guilty plea.

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To date, study results of the usefulness in subsequent legal proceedings of evidence from evidentiary examinations are mixed. A few studies seem to indicate that evidentiary examinations do not strongly influence the outcomes of court proceedings, but that outcomes tend to turn on factors such as the credibility of the victim and the demeanor of the accused. Other studies show a selective impact, i.e., that parts of the examination are useful. Still others conclude that examination results provide pivotal information for prosecutors. In particular, DNA results are often key, resulting in the conviction or confession of some accused persons, but also conclusively exonerating other suspects.

Since evidentiary examinations are emotionally difficult for most patients to undergo, as well as costly, further study is needed on questions such as:

- When are evidentiary exams indicated? How is the decision about whether an evidentiary exam is conducted affected by the judgments of police and prosecutors?
- What contributes to their effectiveness both in terms of meeting patient care needs and leading to successful prosecutions?
- How are services best organized and delivered?
- What are the costs and effectiveness of different models of care?
- What is the impact of enhanced training on practice and outcomes?

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A variety of strategies have been recommended by experts in the field to consolidate, integrate and enhance the infrastructure for collaboration and communication in research and training on issues related to the examination and treatment of sexual assault.

The IOM report on training for health professionals in family violence recommends development of multidisciplinary education and research centers that would be charged initially with conducting research to:

- Understand the magnitude and impact of family violence on society and the health care system.
- Evaluate existing training curricula and educational approaches.
- Expand scientific research on the magnitude of health effects and effectiveness of interventions for family violence.

The vision is that, over time, such centers would develop training programs based on scientific evidence, and work with others to test, evaluate and disseminate education and training programs. They might also provide training directly and undertake a range of other activities to advance the field.

The idea of creating “Centers of Excellence” to focus on work in a specific field has been used in many areas with considerable success. It is an approach that, perhaps as part of centers with a more general focus on women’s health or family violence, may be useful for advancing the training and care provided to victims of sexual assault. Support for such centers could come from a variety of sources including existing Federal programs, States (which already support educational programs in State schools of medicine, dentistry and nursing), and private foundations. The California Medical Training Center at the University of California (UC)-Davis, described in Section V, is an example of such a comprehensive program created by a State.

A research and educational focus on examination and treatment of sexual assault could also be built into other current multidisciplinary programs with a

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women's health or family violence focus funded by Federal agencies such as DHHS, USDOJ, and DOD.

There are few existing opportunities for individuals to advance their skills in the field of sexual assault examination and treatment. Such opportunities could be enhanced by modifying or supplementing existing Fellowship and training programs at the State or Federal level, and encourage additional foundation support for such training. For example, there are existing research fellowships—public and private—that tend to focus on disease-specific topics, that could be opened to persons interested in the field of sexual assault.

## **2. Encourage Federal, State, and Community Involvement in the Development, Standardization, and Dissemination of Evidence-based Training Materials and Protocols**

The USDOJ has played an active role in refinement and dissemination of the SANE programs for practicing health professionals, which now reach into more than 24 States. There are also training models developed with State support in Alaska, California, Texas, Ohio, and elsewhere that could be evaluated and adopted by professional groups.

There is precedence for the Federal Government to encourage development of specialized curricula and training programs through its role as convener and coordinator. When legislative authority and funds are available, it can also provide financial support for special projects of this nature.

As described in Section V, under the Violence Against Women Act of 2000, the Attorney General is required to develop national recommendations for a protocol for sexual assault forensic examinations, and a number of States are developing practice protocols and standardized evidence collection kits and forms.

The exercise of developing national recommendations will require a comparison of protocol components, with the goal of identifying optimum approaches agreed upon by practitioners in the field. A useful follow-on project would be to compare and test alternative models, and to convene a

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group of national experts to establish a research agenda that targets areas of uncertainty.

In partnership with State, Federal, and professional organizations, community organizations can also contribute by providing training and awareness-building for health care organizations.

**3. Encourage Access to Evidence-based Training and Education Through the Use of Distance Learning and Other Medical Technologies**

A relatively untapped resource is the use of Federal and State distance learning facilities associated with colleges, universities, Federal facilities, and law enforcement to provide rural and small town hospitals and professionals with relevant training programs over time. Studies show that one-time continuing education programs are likely to have little impact, but consistent reinforcement and interaction with peers can change practice.

Problems with the compatibility of live video training hookups may place limits on what can be done, though the possibilities have not yet been explored in a systematic way across the country. These programs need to be assessed, and a source of funding identified.

Since it is not feasible for every physician and every nurse to acquire and maintain skill levels in an area as complex and changing as forensic medicine, other approaches are needed to assure skills are available to sexual assault patients in rural and small town areas by fostering regional capabilities and training.

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**B. Improving the Organization and Delivery of Care for Victims of Sexual Assault**

**1. Encourage Coordination at the Community and State Levels Among Law Enforcement, Social Service, Specially Trained Health Providers, State and Local Public Health Agencies, Mental Health Providers, and Community Advocates**

The SART approach, advocated by many and adopted in an increasing number of communities, brings together police, prosecutors, nurses, physicians, hospital administrators, public health agencies, mental health providers, and victim advocates to collaborate on a sustained basis in providing coordinated care to sexual assault victims. A more coordinated approach can help minimize burdens for the victim associated with long waits at the hospital, repetitive police and medical interviews, poorly trained or inexperienced providers, inappropriate or inadequate facilities, and uncoordinated treatment and follow-up services. Coordination is thought to help overcome fragmentation of resources and offer improved efficiency and effectiveness in the delivery of needed services to sexual assault victims. Community organizations can play an important role in contributing to the viability of coordinated community response efforts, by providing services as well as training and awareness-building activities. Programs to encourage coordinated systems of care can be initiated at the local, State, and Federal levels. As described in Section V, the NIJ is currently funding an evaluation of the SART model in Rhode Island.

**2. Encourage Investment in Needed Facilities and Equipment**

There have been quantum leaps in the sophistication of camera and examination equipment and tests and testing procedures. This has led to sharp disparities in the quality and accessibility of services from city to city, State to State, and between urban and rural areas. At the same time, there has been little investment in upgrading crime labs that process evidentiary material, and in the training for health and law enforcement personnel in the use of technical advances.

Many of the improvements available have great potential for extending consultation services to rural and isolated areas. For instance, in the Sonoma Valley, a rural area of California, a local hospital has purchased



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digital cameras and colposcopes that link directly to medical consultants at the UC Davis California Training Center. It is possible for nurse examiners to show consultants images of victims, and then discuss interpretation and follow-up with university-based experts. Consultants can then also provide expert testimony on issues as needed, and more consultations can be offered because the need for travel time is less.

There is considerable concern about the use of digital cameras because of the difficulty of detecting alterations. Digital cameras are appealing because images can be transmitted quickly to law enforcement and technical consultants. The image clarity is also greater, especially in poor light conditions and for persons of dark complexion. They enable the kind of distance consultation described above. However, some jurisdictions prohibit use of images from digital cameras as evidence. Hospitals and forensic investigative teams should explore this issue before investing in equipment and training. In addition to the security issues, diffusion is also hampered by the initial high cost of equipment and training.

**Appendix A**

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## Appendix A: Bibliography

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## **Appendix B**

# **Inventory of Training Programs, Policy Statements and Practice Protocols**

**Training Program/Policy Statement/Practice Protocol:** 7474747411

Practice Parameters for the Forensic Evaluation of Children and Adolescents Who May Have Been Physically or Sexually Abused

**Source:** American Academy of Child and Adolescent Psychiatry

**Address:** 3615 Wisconsin Ave., N.W.  
Washington, D.C. 20016

**Description:**

These practice parameters describe the forensic evaluation of children and adolescents who may have been physically or sexually abused. The recommendations are drawn from guidelines that have been published by various professional organizations and authors and are based on available scientific research and the current state of clinical practice. They consider the clinical presentation of abused children, normative sexual behavior of children, interview techniques, the possibility of false statements, the assessment of credibility, and important forensic issues.

**Audience:**

Mental health professionals who may be called upon to: 1) provide forensic evaluations; 2) to conduct mental health assessments or to provide treatment, and 3) to provide consultations regarding public policies.

**Dissemination/Usage:**

Published in the October, 1997 Journal of the American Academy of Child and Adolescent Psychiatry, 36(10 supplemental): 37S-57S.



**Training Program/Policy Statement/Practice Protocol:** 7474747422

Care of the Adolescent Sexual Assault Victim

**Source:** American Academy of Pediatrics, Committee on Adolescence

**Address:** 141 Northwest Point Blvd.  
PO Box 927  
Elk Grove Village, IL 60009-0927

**Telephone:**

**Web site:**

**Description:**

Guideline on the care of the adolescent sexual assault victim, developed by the American Academy of Pediatrics, Committee on Adolescence. The guidelines recommend that pediatricians should:

- be knowledgeable about the epidemiology of sexual assault in adolescence;
- be knowledgeable about the current reporting requirements for sexual assault in their communities;
- be knowledgeable about sexual assault and rape evaluation services available in their communities and when to refer adolescents for a forensic examination;
- screen adolescents for a history of sexual assault and potential sequelae;
- be prepared to offer psychological support or referral for counseling and should be aware of the services in the community that provide management, examination, and counseling; and
- provide preventive counseling to adolescent patients regarding avoidance of high-risk situations that could lead to sexual assault.

**Audience:**

Pediatricians

**Dissemination/Usage:**

Published in the June, 2001 issue of Pediatrics 107(6): 1476-9.

**Training Program/Policy Statement/Practice Protocol:** 7474747433

Child Abuse and Forensic Pediatric Medicine Fellowship Curriculum Statement

**Source:** American Academy of Pediatrics (AAP) Section on Child Abuse and Neglect, and the Forensic Pediatrics Physician Leadership Group, Committee on Fellowship Curriculum

**Description:**

This is a model curriculum developed by a joint working group of the American Academy of Pediatrics Section on Child Abuse and Neglect and the Forensic Pediatrics Physician Leadership Group, Committee on Fellowship Curriculum. The purpose is to expand the number of training programs and to standardize curricula in existing fellowships to prepare physicians for the diagnosis and treatment of victims of child abuse and neglect, and to provide expert consultation at the request of medical, investigative and legal professionals.

**Dissemination/Usage:**

Published in the February 2000 issue of Child Maltreatment, Vol. 5, No. 1, pp. 58-62,

**Training Program/Policy Statement/Practice Protocol:** 7474747444

Educational Activities of the American Academy of Pediatrics.

**Source:** American Academy of Pediatrics (AAP)

**Address:** 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007-1098

**Telephone:** (847) 434-4000

**Web site:** www.aap.org

**Description:**

The Committee on Child Abuse and Neglect (COCAN) provides an educational forum for AAP members to discuss problems and treatments relating to child abuse.

COCAN is also active in developing resources to assist in diagnosing and preventing child abuse. The AAP has developed the following educational materials with the assistance of COCAN .

\$ The Visual Diagnosis of Child Abuse

The most common physical injuries from child abuse are presented in 150 vivid photographic slides, accompanied by a detailed study guide. An effective tool for enhancing diagnostic skills or educational presentations. Developed with the C. Henry Kempe National Center.

\$ Visual Diagnosis of Child Sexual Abuse

This unique, comprehensive presentation uses slides and a study guide to assist in diagnosing cases of child sexual abuse and in medical evaluation of abuse accusations. 166 powerful photographic slides show examples of abuse, as well as normal anatomy and non-abusive injury. Study guide enables self-teaching and review of visual material.

\$ A Guide to References and Resources in Child Abuse and Neglect 2<sup>nd</sup> Edition

Knowing where to find the facts to enhance your ability to help children in crisis is the focus of this manual. Resource includes annotated bibliographies, summary, US child abuse and neglect programs and AAP policy statements.

\$ Focus on Child Abuse: Resources for Prevention, Recognition's and Treatment 2<sup>nd</sup> Edition CD-ROM

CD-ROM technology, including high-speed navigator search and integration functions, makes it easy to access vital data. Key components include: more than 200 color slides; the Visual Diagnosis of Child Physical Abuse; visual self-assessment; parent and patient education/information; results of 50-state child abuse survey; AAP policies; manual experts; full-text articles from *Pediatrics*, and AAP Speaker's Kit of slides, lecture notes, and handouts.

In addition to the above materials, COCAN also sponsors educational sessions at the AAP's National Conference and Exhibitions Sessions.

**Audience:**

Physicians, primarily pediatricians.

**Dissemination/Usage:**

The educational materials were developed by the AAP with assistance from COCAN and are available for purchase through the AAP publications catalog and the AAP web site.

**Additional Comments:**

COCAN also publishes a newsletter which is distributed to section members.

**Training Program/Policy Statement/Practice Protocol:** 7474747455

Gonorrhea in Pre-Pubertal Children Policy Statement

**Source:** American Academy of Pediatrics, Counsel of Child and Adolescent Health

**Address:** 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007-1098

**Telephone:** (847) 434-4000

**Web site:** [www.aap.org](http://www.aap.org)

**Description:**

A policy statement by the Committee on Child Abuse and Neglect (COCAN) of the American Academy of Pediatrics concerning gonorrhea in pre-pubertal children. The purpose of the guideline is to remind physicians that sexual abuse should be strongly considered when gonorrheal infection is diagnosed in a child after the newborn period and before the onset of puberty. Frequently a sexually-transmitted disease may be the only evidence of sexual abuse. The Centers for Disease Control (CDC) and Prevention states, "the identification of a sexually-transmitted agent from a child beyond the neonatal periods suggests sexual abuse." While the risks of acquiring sexually-transmitted diseases as a result of sexual abuse is unknown reported rates of gonococcal infection have ranged from 3 to 20 percent among sexually abused children.

The policy statement discusses clinical findings and laboratory findings and also provides a list of references.

**Audience:**

Pediatricians.

**Dissemination/Usage:**

The material is on the AAP Web site and was published in the *Journal of the American Academy of Pediatrics*.

**Training Program/Policy Statement/Practice Protocol:** 7474747466

Guidelines for the Evaluation of Sexual Abuse of Children: Subject Review

**Source:** American Academy of Pediatrics

**Address:** 141 Northwest Point Boulevard, Elk Grove Village, Illinois 60007-1098

**Telephone:** (847) 434-4000

**Web Site:** www.aap.org

**Description:**

The guidelines are prepared and approved by the Committee on Child Abuse and Neglect (COCAN), of the American Academy of Pediatrics. Focus is on the physical, sexual, and mental abuse and neglect of children and adolescents. This is one of a number of current policy statements which has been developed by COCAN to provide advice to practicing pediatricians. The guidelines point out that few areas of clinical pediatric practice have expanded as much as sexual abuse in the last 25 years.

Sexual abuse occurs when a child is engaged in sexual activities that they cannot understand, for which they are not developmentally prepared, or that violate either laws or social taboos of society. Besides seeing possibly abused children in the normal course of practice, pediatricians may see the potentially abused child when 1) the child is brought in by parents for evaluation of possible sexual abuse, 2) the child is brought to the pediatrician by child protective services or law enforcement professionals for a medical evaluation of possible sexual abuse or 3) the child is brought to an emergency department after a suspected episode of sexual abuse for evaluation, evidence collection, and crises management.

The guidelines provide information and guidance on the following topics:

1. Taking a history and interviewing the child
2. Physical examination
3. Laboratory data
4. Diagnostic considerations
5. Record
6. Treatment
7. Legal issues

It is important that interviews be conducted by the designated agency or person to avoid repetitive questioning of the child. The American Academy of Child and Adolescent Psychiatry and the American Professional Society on Abusive Children have published specific guidelines for interviewing sexually abused children.

The guidelines were prepared by the Committee on Child Abuse and Neglect in 1998 and 1999, and published in *Pediatrics* 1999. The guidelines include a bibliography.

**Target Audience:**

These guidelines are intended for all health professionals caring for children. In addition to these guidelines, the Academy has also produced guidelines for dealing with the sexually abused adolescent.

**Dissemination/Usage:**

Available on the AAP web page. Published in Academy Journal, Pediatrics.

**Training Program/Policy Statement/Practice Protocol:** 7474747477

Oral and Dental Aspects of Child Abuse and Neglect  
Joint Statement of the American Academy of Pediatrics and the American Academy of  
Pediatric Dentistry

**Source:** American Academy of Pediatrics and American Academy of Pediatric Dentistry

**Address:** 141 Northwest Point Boulevard, Elk Grove Village, Illinois 60007-1098

**Telephone:** (847) 434-4000

**Web Site:** [www.aap.org](http://www.aap.org)

**Description:**

A joint policy statement designed to aid the pediatrician in identifying oral or dental aspects of child abuse and neglect. The policy statement points out that, physicians receive limited education in oral health and dental injury and therefore may have difficulty in identifying child abuse in the oral cavity.

The oral cavity is a frequent site of sexual abuse in children. The presence of oral and perioral gonorrhea or syphilis in pre-pubertal children is pathognomonic of sexual abuse. When gonorrhea or syphilis are diagnosed in a child, public health authorities must be notified and a multi-disciplinary child abuse evaluation should be undertaken.

The policy statement describes the specific cultures and tests that need to be conducted in the case of suspected gonorrhea. The statement also indicates that during the examination of the child suspected of experiencing oral sex, cotton swabs should be used to obtain samples with the swabs preserved for laboratory analysis of the presence of semen. The policy statement also advises the physician to look for unexplained erythema or petechiae of the pallet, particularly at the junction of the hard and soft pallet since this may be indicative of forced oral sex.

**Target Audience:**

Pediatricians.

**Dissemination/Usage:**

Distributed by the academy and also published in *Pediatrics*, volume 104, number 2, in August 1999.

**Training Program/Policy Statement/Practice Protocol:** 7474747488

Policy Statements Regarding Sexual Assault and Abuse of Children.  
American Academy of Pediatrics

**Source:** American Academy of Pediatrics (AAP)  
Committee on Child Abuse and Neglect (COCAN)

**Address:** 141 Northwest Point Boulevard, Elk Grove Village, Illinois 60007-1098

**Telephone:** (847) 434-4000

**Web site:** [www.aap.org](http://www.aap.org)

**Description:**

The Committee on Child Abuse and Neglect (COCAN) is responsible for policy development and related issues concerning the physical, sexual, and mental abuse and neglect of children and adolescents. The COCAN has developed a number of policy and educational statements related to the sexual abuse of children. The following policy statements developed by COCAN and approved by the American Academy of Pediatrics relate to treatment and diagnosis of the sexually assaulted or physically abused child.

- Distinguishing sudden infant deaths syndrome from child abuse (February 2001)
- The medical necessity for the hospitalization of the abused and neglected child (April 1998)
- Shaken Baby Syndrome (Inflicted Cerebral Trauma, December 1993, currently being revised)
- Investigation and Review of Unexpected Infant and Child Deaths (November 1999)

**Audience:**  
Pediatricians

**Dissemination/Usage:**

The material is on the AAP web page and was published in the AAP Journal, Pediatrics.

**Training Program/Policy Statement/Practice Protocol:** 7474747499

Sexual Assault and the Adolescent: Policy Statement

**Source:** American Academy of Pediatrics (AAP)

**Address:** 141 Northwest Point Boulevard, Elk Grove Village, Illinois 60007-1098

**Telephone:** (847) 434-4000

**Web site:** www.aap.org

**Description:**

The current policy statement on sexual assault and the adolescent was developed in 1994 and published in November 1994, volume 94, no. 5 *Pediatrics*. The Committee on Adolescents is in the process of revising the policy statement which briefly outlines the problem of rape and provides various definitions. The policy statement points out that while there is a common perception of rape as something perpetrated by strangers, about half of adolescent sexual assaults are committed by acquaintances.

The policy indicates that victims of rape have a difficult adjustment to the assault since they tend to blame themselves, frequently suffer diminished self-esteem, and may have difficulty establishing trust in future relationships. The policy statement describes the appropriate management of the rape victim and identifies the goals of rape intervention to include identification and treatment of injury and infection, pregnancy prevention, evidence collection, and psychological assessment with referral for counseling. Findings must be carefully and accurately documented in the medical record.

The position paper recommends that when a pediatrician is consulted about a possible sexual assault within 72 hours of the event, the adolescent should be evaluated by a pediatrician knowledgeable in forensic procedures or referred to a rape crisis center or an emergency facility.

The American Academy of Pediatrics recommends that pediatricians: 1) be knowledgeable about the incidence of stranger and acquaintance sexual assault; 2) participate in the establishment of rape protocols; 3) understand the legal aspects of forensic examination; and 4) be prepared to offer preventive counseling, immediate medical referral, and psychological support to the adolescent patients in their practice who may be victims of sexual assault.

The policy statement includes a sexual assault and rape protocol and an extensive bibliography.

**Target Audience:**

Pediatricians

**Dissemination/Usage:**

Widely disseminated by the American Academy of Pediatrics. The policy statement was published in the *Journal of Pediatrics*, and was made available electronically.



**Training Program/Policy Statement/Practice Protocol:** 747474741010

Organization: American Academy of Physician Assistants  
Address: 950 N. Washington Street, Alexandria, VA 22314  
Website: [www.aapa.org](http://www.aapa.org)  
Contact: Bob McNellis  
Director of Clinical Affairs & Clinical Education  
Telephone: 703-836-2272

Description:

The American Academy of Physical Assistants (AAPA) has a number of policy statements relating to various aspects of violence and violence education and training.

- PA programs are encouraged to include in their curricula techniques of violence prevention, assessment and intervention.
- AAPA supports educational programs concerning the prevention, recognition, reporting and treatment of child abuse.
- The AAPA recognizes family violence as a public health problem and supports medical care of battered individuals.
- The examination for PA certification and re-certification may include questions on both child abuse and domestic violence.

Target Audience:

Physician assistants

**Training Program/Policy Statement/Practice Protocol:** 747474741111

Advancing Women's Health: Health Plans' Innovative Programs in Domestic Violence

**Source:** American Association of Health Plans and The Commonwealth Fund

**Description:**

A report developed by the American Association of Health Plans in partnership with HealthPartners Research Foundation (Minneapolis, MN) with support from The Commonwealth Fund. The report summarizes the key findings from AAHP's assessment of four health plans that have implemented innovative practices, including provider training, patient education, philanthropic efforts, community awareness programs, and public policy advocacy, to address the health issues arising from domestic violence and other forms of violence against women. Lessons learned include:

- Reach out to other concerned clinicians within the health plan
- Build relationships with community-based nonprofit agencies
- Invite the participation of a diverse group including providers, community leaders and advocates
- Provide education to health care professionals during natural meeting times, such as staff meetings and lunches

**Audience:** AAHP member health plans, consumers, and organizations in women's health, public health, and maternal and child health.

**Training Program/Policy Statement/Practice Protocol:** 747474741212

Child Abuse  
ACEP Policy Statement

**Source:** American College of Emergency Physicians

**Address:** 1125 Executive Circle, Irving, TX 75038-2522

**Telephone:** (972) 550-0911  
(800) 798-1822

**Web Site:** [www.acep.org](http://www.acep.org)

**Description:**

This Policy Statement, approved January 2000 by the ACEP recommends that:

1. Emergency physicians be familiar with signs and symptoms of child abuse.
2. Evaluations of pediatric patients include assessments for child abuse in appropriate physical and psychosocial settings.
3. Emergency medical services, medical school, and emergency medicine residency curricula include training in recognition, assessment and interventions in child abuse.
4. Hospitals be encouraged to participate in interdisciplinary approaches to child abuse that include policies; protocols for recognition, assessment, and intervention; and reporting and referring victims and their families.
4. An interdisciplinary approach should be used to collect data on various forms of child abuse and to promote and develop research on child abuse.

**Target Audience:**

Emergency Medicine Physicians

**Training Program/Policy Statement/Practice Protocol:** 747474741313

Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient --  
A handbook

**Source:** American College of Emergency Physicians

**Address:** Sales and Service, PO Box 619911, Dallas, Texas 75261-9911

**Telephone:** (800)-798-1822, Touch 6

**Web site:** www. acep.org

**Description:**

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.

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.

**Target Audience:**

Physicians and other health care providers who may examine and treat victims of sexual assault including child molestation.

**Dissemination/Usage:**

Widely distributed and also available on the Internet.

**Other Comments:**

The Handbook was developed by a task force under the direction of the American College of Emergency Physicians. Representatives of the following organization participated in the project:

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

List of Key Elements of Family Violence Protocols

**Training Program/Policy Statement/Practice Protocol:** 747474741414

**Source** American College of Emergency Physicians

**Address:** 1125 Executive Circle, Irving, TX 75038-2522

**Telephone:** (800) 798.1822

**Web Site:** [www.acep.org](http://www.acep.org)

**Description:**

The 1993-94 Emergency Medicine Practice Committee's Subcommittee on Key Elements of Domestic Violence Protocols developed a list of the key elements which should be covered in emergency department domestic violence protocols for both practice and reporting purposes. This list was based on a review of a variety of organizational and hospital protocols and on comments received from the Domestic Violence Task Force.

Major topics addressed include:

- 1) Criteria for Identification
- 2) Procedure for evaluation
- 3) Consideration of patients and provider staff safety
- 4) Referral to other locations and organizations as appropriate
- 5) After care
- 6) Medical record documentation
- 7) Plans for staff education
- 8) Prevention
- 9) Quality assessment and management

The protocols cover physical assaults, sexual assault, as well as abuse and neglect.

**Training Program/Policy Statement/Practice Protocol:** 747474741515

Management of Elder Abuse and Neglect  
ACEP Policy Statement

**Source:** American College of Emergency Physicians

**Address:** 1125 Executive Circle, Irving, TX 75038-2522

**Telephone:** (972)550.0911  
(800) 798.1822

**Web Site:** [acep.org](http://acep.org)

**Description:**

This statement, approved October 1997 replaces a previous statement by the ACEP on the same subject.

ACEP recommends that emergency departments should have written protocols on recognition and treatment of elder abuse; that hospitals should have appropriate staff to aid victims of elder abuse and neglect; that hospitals and emergency departments should establish relationships with agencies that oversee the management and investigation of elder abuse; that professionals subject to mandatory reporting should be immune from liability for good faith efforts to comply, and; that further research should be done in the field of elder abuse and neglect.

The ACEP opposes mandatory reporting of elder abuse and neglect but encourages voluntary referrals to social services, victims' services, the criminal justice system, or any other appropriate resource agency.

**Target Audience:**

Emergency Medicine Physicians

**Other Comments:**

As an adjunct to the policy statement, ACEP's Emergency Medicine Practice Committee has developed a Policy Resources and Education Paper (PREP) entitled, "Guidelines for the Recognition and Management of Elder Abuse."

**Training Program/Policy Statement/Practice Protocol:** 747474741616

Management of the Patient with the Complaint of Sexual Assault  
ACEP Policy Statement

**Source:** American College of Emergency Physicians

**Address:** P.O. Box 619911, Dallas, TX 75267-9911

**Telephone:** (972) 550.0911

**Web Site:** [www.acep.org](http://www.acep.org)

**Description:**

This policy statement was reaffirmed by the ACEP Board of Directors in June 1999. The policy states that the sexual assault patient, whether adult or child, has special medical, psychological, and legal needs. All patients who report a sexual assault are entitled to prompt access to emergency medical care and competent collection of evidence that will assist in the investigation and prosecution of the incident.

The guidelines provide that: 1) each county, State, or other appropriate political jurisdiction should establish a community plan to deal with the sexually assaulted patient. The plan should provide capable, trained personnel and appropriate equipment. 2) Each plan should address the medical, psychological, safety and legal needs of the sexually assaulted patient. 3) Each hospital should provide access to appropriate medical, technical and psychological support for the patient. 4) Specially trained non-physician medical personnel should be allowed to conduct evidentiary examinations where evidence collected in such manner is admissible in criminal cases. 5) Health professionals who collect evidence in good faith and follow protocols should be immune from civil or criminal penalties. 6) The community plan should provide for a primary referral center for pediatric patients. 7) Emergency department staff should be provided with ongoing training and education in the management of the sexually assaulted patient.

**Audience:**

Emergency medicine physicians and others involved in the care and treatment of sexually assaulted patients.

**Dissemination/Usage:**

The policy statement and the handbook are both available from ACEP's customer service department and on ACEP's web site.

**Additional Comments:**

In addition to the policy statement, ACEP's emergency medicine practice committee developed a handbook entitled, "Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient."

**Training Program/Policy Statement/Practice Protocol:** 747474741717

**Organization:** Recognition and Management of Elder Abuse  
Policy Resource and Education Paper

American College of Emergency Physicians

**Address:** 1125 Executive Circle, Irving, TX 75038-2522

**Telephone:** (972) 550.0911

**Contact:** Margaret Montgomery  
(972).550.0911, Ext. 3230

**Description:**

The purpose of this paper is to increase awareness by emergency health care providers and to provide a format for the development of individual emergency department protocols. The paper defines physical, sexual, and behavioral abuse, identifies indicators of abuse and suggests possible interventions.

**Target Audience:**

Emergency medicine physicians and other health care professionals involved with treating victims of sexual or physical abuse.

**Dissemination/Usage:**

Available on the ACEP web site: [www.ACEP.org](http://www.ACEP.org)



**Training Program/Policy Statement/Practice Protocol:** 747474741818

ACOG Educational Bulletin: Adolescent Victims of Sexual Assault

**Source:** American College of Obstetricians and Gynecologists (ACOG)

**Address:** 409 12<sup>th</sup> Street, SW  
PO Box 96920  
Washington, D.C. 20090-6920

**Description:**

This Educational Bulletin was developed under the direction of the Committee on Adolescent Health Care of the American College of Obstetricians and Gynecologists (ACOG) as an educational tool presenting current information as an aid to obstetricians and gynecologists. The bulletin addresses: definitions; prevalence; adolescent perceptions; identification of adolescent sexual assault victims; behavioral and psychological sequelae suggestive of history of sexual assault; physical health problems suggestive of history of sexual assault; and intervention and prevention.

**Audience:**

Obstetricians and gynecologists

**Training Program/Policy Statement/Practice Protocol:** 747474741919

Domestic Violence: The Role of the Physician in Identification, Intervention, and Prevention –  
A Slide Lecture Presentation

**Source:** American College of Obstetricians and Gynecologists (ACOG)

**Address:** 409 12<sup>th</sup> St., S.W.  
Washington, D.C. 20024-2188

**Description:**

A 30 to 60 minute slide lecture presentation developed by the ACOG Family Violence Work Group, a body of respected physician/educators, many of whom have implemented domestic violence education programs at their respective institutions. The slide presentation is designed to:

- provide background information on the definition, epidemiology, and demography of woman battering;
- encourage and support physician's routine inquiry about battering to all patients in the office, clinic, or hospital;
- help physicians identify presenting symptoms and signs of abuse through history and examination;
- aid in formulating action plans to support battered women returning to unsafe environments;
- identify components of long-term support and intervention in the community; facilitate access to community support services;
- create clinical environments conducive to women learning more about battering;
- identify barriers that prevent physician recognition of woman battering; and
- eliminate abuse in clinical settings.

**Audience:**

Obstetric and gynecology residents; ACOG Fellows and Junior Fellows; third year medical students on obstetric-gynecology clinical rotation; first and second year medical students; other health providers, including emergency department personnel, dentists, nurse midwives, nurse practitioners, and mental health providers.

**Training Program/Policy Statement/Practice Protocol:** 747474742020

Intimate Partner Violence During Pregnancy: A Guide for Clinicians (Slide Lecture)

**Source:** American College of Obstetricians and Gynecologists (ACOG) and Centers for Disease Control and Prevention (CDC)

**Address:** 409 12<sup>th</sup> Street, SW  
Washington, D.C. 20024-2188

**Description:**

This 30 to 60 minute slide presentation on intimate partner violence during pregnancy is designed as an introductory or supplementary training tool for clinicians to increase understanding of the important role they can play in identifying, preventing, and reducing intimate partner violence. It also emphasizes the critical window of opportunity that prenatal care provides for the screening and referral of pregnant women. Included with the slide set are a bibliography and resource lists.

**Audience:**

Obstetrics and gynecology residents; ACOG Fellows and Junior Fellows; third-year medical students on obstetric-gynecologic clinical rotation; first and second year medical students for whom the content is integral to courses such as "Introduction to Clinical Medicine" and "Medical Ethics;" other health care providers, including emergency department personnel, dentists, nurse-midwives, nurse practitioners, and mental health care providers

**Training Program/Policy Statement/Practice Protocol:** 747474742121

Book on Ambulatory Medicine

**Organization:** American College of Physicians;  
American Society of Internal Medicine

**Address:** 190 N. Independence Mall West, Philadelphia, PA 19106-1572

**Web Site:** <http://www.acponline.org>

**Contact:** Patrick C. Alguire  
Director, Education and Career Development  
(215) 351-2845

**E-Mail:** [palguire@mail.acponline.org](mailto:palguire@mail.acponline.org)

**Description:**

As part of its continuing education program, the American College of Physicians produces written material to allow internists to assess their current state of knowledge and update their knowledge in key areas.

The book on ambulatory medicine has brief sections on domestic violence, elder abuse and adolescent sexual abuse.

**Target Audience:**

Internists

**Distribution:**

Available from the American College of Physicians Book Division

**Training Program/Policy Statement/Practice Protocol:** 747474742222

Diagnostic and Treatment Guidelines on Child Physical Abuse and Neglect

**Source:** American Medical Association

**Address:** 515 North State Street, Chicago, IL 60610

**Telephone:** (312) 464-5000

**Web Site:** [www.ama-assn.org](http://www.ama-assn.org)

**Description:**

The Guideline describes symptoms of child abuse and neglect and the diagnosis of abuse or neglect. The role of historical, behavioral and physical findings as well as the interview and examination of the victim are discussed. The Guideline also addresses the ethics of reporting an abuser who is known to the physician, how to document the examination, obtaining an order of temporary custody, giving testimony, risk management, and trends in treatment and prevention. The Guidelines reflect the views of scientific experts and reports in scientific literature as of March 1992.

**Dissemination/Usage:**

Published and distributed by the AMA. Available for sale on their web site.

**Training Program/Policy Statement/Practice Protocol:** 747474742323

Diagnostic and Treatment Guidelines on Child Sexual Abuse

**Source:** American Medical Association

**Address:** 515 North State Street, Chicago, IL 60610

**Telephone:** (312) 464-5000

**Web Site:** [www.ama-assn.org](http://www.ama-assn.org)

**Description:**

The Guideline is intended to familiarize the physician with facts about sexual abuse: the ethical considerations of reporting parents who are known to the physician; how abused children present; the interviewing process; and the physical exam. The Guideline discusses documenting the examination, reporting requirements for the examiner, how to obtain an order of temporary custody, giving testimony, risk management, and trends in treatment and prevention. The Guideline reflects the views of scientific experts and reports in the scientific literature as of March 1992. State reporting agencies are listed.

**Target Audience:**

Physicians

**Dissemination/Usage:**

Published and distributed by the AMA. Available for sale on their web site.

**Training Program/Policy Statement/Practice Protocol:** 747474742424

Diagnostic and Treatment Guidelines on Domestic Violence

**Source:** American Medical Association

**Address:** 515 North State Street  
Chicago, Illinois 60610

**Telephone:** (312) 464-5000

**Web site:** [www.ama-assn.org](http://www.ama-assn.org)

**Description:**

These guidelines are intended for physicians in all practice settings. They are intended to:

- Familiarize physicians with the magnitude of the problem
- Describe how to identify abuse and violence through routine screening and recognition of clinical presentations
- Help physicians assess the impact of abuse and violence on patients' health and well-being
- Provide examples of how to ask questions in ways that can elicit meaningful responses and help women explore their options and take action
- Provide information on appropriate resources for referral and address frequently encountered obstacles
- Familiarize physicians with the legal aspects of medical care, including reporting requirements

**Audience:**

Physicians in all practice settings

**Dissemination/Usage:**

Published in 1992 and distributed by the AMA. Available for sale on their web site.

**Training Program/Policy Statement/Practice Protocol:** 747474742525

Diagnostic and Treatment Guidelines on Elder Abuse and Neglect

**Source:** American Medical Association

**Address:** 515 North State Street, Chicago, IL 60610

**Telephone:** (312) 464-5000

**Web Site:** [www.ama-assn.org](http://www.ama-assn.org)

**Description:**

The purpose of the Guideline is to:

- 1) Sensitize clinicians to the fact that elder abuse and neglect occur commonly and that the problem is likely to be encountered in their medical practices.
- 2) Present information on the epidemiology, clinical manifestations and history of elder mistreatment.
- 3) Describe barriers to the proper identification and management of elder mistreatment.
- 4) Outline an approach that physicians can use to facilitate recognition of elder abuse and neglect in a variety of clinical settings.
- 5) Identify strategies for the management and prevention of elder mistreatment.
- 6) Discuss relevant ethical and medicolegal issues surrounding the detection and reporting of elder abuse and neglect.

References and resources are also listed.

**Target Audience:**

Physicians

**Dissemination/Usage:**

Published in 1992 and distributed by the AMA. Available for sale on their web site.



**Training Program/Policy Statement/Practice Protocol:** 747474742626

Prevention of Violence and Abuse Resolution

**Source:** American Medical Association

**Address:** 515 North State Street, Chicago, IL 60610

**Telephone:** (312) 464-5000

**Web Site:** [www.ama-assn.org](http://www.ama-assn.org)

**Description:**

The AMA House of Delegates approved in 2000 a resolution (# 419) dealing with violence. The resolution called upon the AMA to establish a committee of representatives from the National Advisory Council on Family Violence and its Committee on Medical Education to: 1) identify knowledge and skills needed by physicians to identify, respond to and prevent violence and abuse; 2) identify appropriate places within the medical education system for the training and development of those skills; 3) explore ways to include the necessary training within the current medical education system; and 4) establish a mechanism to respond to proposals from the IOM "Committee on Training Needs of Health Care Professionals to Responding to Family Violence."

The resolution also called upon the AMA to advocate for hospital and community support of violence survivor programs and to advocate for equitable coverage and appropriate reimbursement for all health care (including mental health) related to family and intimate partner violence.

**Audience:**

AMA members and other physicians and health care providers concerned with domestic violence. Policy makers concerned with health policy and legislation.

**Training Program/Policy Statement/Practice Protocol:** 747474742727

Strategies for the Treatment and Prevention of Sexual Assault

**Organization:** American Medical Association

**Address:** 515 North State Street, Chicago, IL 60610

**Telephone:** (312) 464-5000      **Fax:** (312) 464-4184

**Web Site:** [www.ama-assn.org](http://www.ama-assn.org)

**Description:**

This is one of a series of guideline booklets put out by the AMA to aid physicians in the examination and treatment of victims of violence. The guide was developed by staff and consultants with the oversight of an expert advisory group. Members of the expert advisory group represented a number of medical specialties including ob/gyn, pediatrics, family medicine, and emergency medicine as well as non-medical groups and AMA members. The guideline reflects the state of knowledge as of October 1995.

The guide provides advice on how the physician should examine a victim of sexual assault, both in an acute care setting (Emergency Department) and in a primary care setting. The guide describes in detail the evidence exam and the use of the rape kit. The guide also discusses STD prophylactics and pregnancy counseling in acute care settings. The booklet also includes a discussion of treating special populations (males and adolescents), a discussion of symptoms reported by sexually assaulted patients and references and recommended readings and resources.

**Target Audience:**

Physicians in practice who may encounter patients who are victims of sexual assault, either in an acute care or primary care setting.

**Training Medium:**

Written guide; 46 pages including appendices and references

**Training Program/Policy Statement/Practice Protocol:** 747474742828

Position Papers on Sexual Assault and Other Types of Violence

**Source:** American Osteopathic Association  
**Address:** 142 East Ontario Street, Chicago, IL 60611  
**Telephone:** 800-621-1773  
**Contact:** Sharon L. McGill, M.P.H.,  
Director Division of Minority and Women's Health  
(312) 202-8150  
**Web Site:** [www.aoa-net.org](http://www.aoa-net.org)

**Description:**

The American Osteopathic Association has published several position papers about sexual assault, domestic violence and child abuse. These include:

- Violence-Development of Progress to Reduce: Urges that Federal and local governments develop educational and preventive programs to reduce abuse of all kinds, especially sexual and domestic (revised 1996).
- Abused Persons: Public health agencies should provide training in advocacy for abused persons, assessment and intervention techniques to aid those in abuse situations, legal procedures, and attention to the special needs of the young and elderly (reaffirmed 1997).
- Child Abuse: AOA urges its members to participate in national education programs relative to child abuse, to cooperate with state and local authorities in reporting suspected child abuse, and to be vigilant in recognizing child maltreatment wherever they encounter it (revised 1995).
- Domestic Violence: The AOA supports the efforts of the United States Department of Health and Human Services to develop and foster programs that prevent domestic violence (revised 1999).

In addition to the position papers, there have also been several editorials in the Journal of the American Osteopathic Association, including "Increasing Awareness of Sexual Abuse" (May, 1989), "Join the Battle Against Domestic Violence" (April 1989); and "Breaking The Cycle of Family Violence" (July, 1994).

**Target Audience:**

Osteopathic physicians and health policy makers.

**Dissemination/ Usage:**

In the Journal of the American Osteopathic Association

**Training Program/Policy Statement/Practice Protocol:** 747474742929

Forensic Interview Training Clinic

**Source:** American Professional Society on the Abuse of Children (APSAC)

**Address:** Post Office Box 26901 CHO3B-3406, Oklahoma City, Oklahoma 73190

**Telephone:** (405) 271-8202

**Web Site:** [www.apsac.org](http://www.apsac.org)

**Description:**

Training clinics are 40-hours in length and include both didactic and practicum sessions. In the interview practicum students have an opportunity to conduct interviews with actual children in a supportive environment where feedback can help develop confidence and skills. The topics covered in the clinic include: forensic interviewing techniques and types of interviews; legal issues affecting interviews; child development and issues of linguistics; cultural competency; the investigative versus the therapeutic interview; problems and pitfalls in interviewing; and effective performance as a witness in legal proceedings.

**Target Audience:**

Professionals from the fields of mental health, child protective services, law enforcement, social services, medicine, and law.

**Dissemination and Usage:**

The clinics are put on by APSAC and have been held for a number of years.

**Other Comments:**

Currently the clinic planning committee is reviewing the curriculum and there is a temporary postponement of scheduled clinics.

**Training Program/Policy Statement/Practice Protocol:** 747474743030

Guidelines for Practice

**Source:** The American Professional Society on the Abuse of Children

**Address:** PO Box 26901 CHO3B-3406, Oklahoma City, OK 73190

**Telephone:** (405) 271-8202

**Web Site:** [www.apsac.org](http://www.apsac.org)

**Description:**

The APSAC National Interdisciplinary Guidelines task forces have produced five data based guidelines on key areas of practice in the field of child maltreatment. These guidelines, after being developed by task forces, are reviewed by subject matter experts not on the task force, the members of APSAC, legal counsel, and the board of directors. The five guidelines which have been published are as follows;

- 1) Psychological evaluation of suspected sexual abuse in children. The guideline is produced by the task force on psycho-social evaluation of suspected child abuse in children. The topics covered include characteristics of the evaluator, components of the evaluation, interviewing procedure, the interview and the report.
- 2) Descriptive terminology in child sexual abuse in medical evaluations. The guideline was prepared by the terminology subcommittee of the APSAC task force on medical evaluation of suspected child abuse. The guideline covers description of anatomical structures, including the hymen and peri-anal anatomy, as well as other structures and findings.
- 3) Use of anatomical dolls in child sexual abuse assessments. Guideline was prepared by the APSAC task force in the use of anatomical dolls in child sexual abuse assessments. The guideline provides a summary of current research findings and describes how to interpret behavior with dolls, the efficacy of anatomical dolls and inappropriate use of the dolls.
- 4) Photographic documentation of child abuse. These Guidelines were produced by the photo-documentation subcommittee of the APSAC task force on medical evaluation of suspected child abuse. The topics include the necessary equipment and lighting, legal considerations and documentation.
- 5) Psychological evaluation of suspected psychological maltreatment of children and adolescents. Guideline was produced by the psychological maltreatment consortium and the APSAC task force on psychological maltreatment. The guidelines discuss the prevalence of psychological maltreatment and it's short and long-term effects. The guidelines also discuss important considerations in assessing a child and reporting the findings.

**Target Audience:**

Psychologists, social workers, attorneys, physicians, nurses, researches, law enforcement officials and protective services administrators involved with the evaluation and treatment of victims of child abuse.

**Dissemination/ Usage:**

The guidelines are available for purchase from APSAC. Details are available on their website.

**Training Program/Policy Statement/Practice Protocol:** 747474743131

Handbook on Child Maltreatment

**Source:** American Professional Society on the Abuse of Children

**Address:** P.O. Box 26901 CH03B-3406, Oklahoma City, Oklahoma 73190

**Telephone:** (405) 271- 8202

**Web Site:** [www.apsac.org](http://www.apsac.org)

**Description:**

The Handbook on Child Maltreatment is published by Sage Publications in cooperation with the American Professional Society on the Abuse of Children. The handbook covers physical and sexual abuse, all forms of neglect, and psychological maltreatment. The major topic areas include:

- Overview: aspects of child maltreatment
- Psychological treatment
- Medical aspects of child maltreatment
- Legal aspects
- Reporting and prevention
- Organization and delivery of services

**Target Audience:**

All professionals working with maltreated children.

**Dissemination/Usage:**

The handbook is for sale from APSAC.

**Training Program/Policy Statement/Practice Protocol:** 747474743232

Standard Guide for Sexual Assault Investigation, Examination, and Evidence  
Printed Guide.

**Source:** American Society for Testing and Materials

**Address:** 100 Barr Harbor Drive, West Conshohocken, PA 19428

**Telephone:** (610) 832-9500

**Contact:** Gloria Collins, Staff Manager  
(610) 832-9715

**Web Site:** [www.astm.org](http://www.astm.org)

**Description:**

The Guide was prepared by the sub-committee on Criminalistics under the jurisdiction of the ASTM Committee (E-30) on Forensic Sciences. The ASTM (organized in 1898) is the largest voluntary standards development organization in the world, with more than 32,000 members. The current Guide was approved on November 10, 1996.

The Guide covers the basic requirements for the development of a sexual assault investigation protocol. The Guide calls for using trained forensic examiners in the setting of a multidisciplinary team and indicates that this is the current standard of care.

The Guide indicates that every facility dealing with victims of sexual assault should have written procedures that provide information on the treatment plan, the evidentiary and medical examinations, the documentation and evidence collection, the transmittal of evidence and the chain of custody, and post examination procedures. The Guide states that agencies undertaking child sexual assault investigations should develop special protocols. The Guideline also calls for the development of protocols for the recognition, treatment and prevention of the transmission of sexually transmitted diseases arising from sexual assault investigations.

The Guide has an appendix that lists evidence kit specifications.

**Target Audience:**

Organizations involved in investigating sexual assaults. Besides non-health organizations, the Guide is addressed to every treatment facility that deals with victims of sexual assault (as well as suspects.)

**Dissemination/ Usage:**

The Guide is voluntary. It is legally binding only when adopted by a government body or incorporated into a contract.

**Other Comments:**

According to ASTM policies, the Guide must be revised and re-approved at least every five years.

Advanced Training in Domestic Violence for Healthcare Providers  
Training course with extensive participant manual.

**Training Program/Policy Statement/Practice Protocol:** 747474743333

**Source:** California Medical Training Center, UC Davis

**Address:** 3300 Stockton Boulevard, Sacramento, CA 95820

**Telephone:** (916) 734-4143

**Fax:** (916) 734-4150

**Email:** [mtc@umdc.ucdavis.edu](mailto:mtc@umdc.ucdavis.edu)

**Contact:** Connie Mitchell, MD  
(916) 734-3540

**Web Site:** [www.ucdmc.ucdavis.edu/medtrng](http://www.ucdmc.ucdavis.edu/medtrng)

**Description:**

An advanced level, one-day course with audio/visual material accompanied by an extensive participant manual. Attendees should have a basic knowledge of the dynamics of domestic violence, as well as basic skills regarding interviewing of victims who have been traumatized.

**Course Goals:**

1. To understand current epidemiological data in the field of domestic violence.
2. To recognize current theories and dynamics of domestic violence.
3. To understand the behaviors which impede or promote the identification of victims of domestic violence.
4. To understand the use of routine and in-depth inquiries to identify victims of domestic violence.
5. To understand the basic injury assessment skills needed for evaluation of domestic violence victims.
6. To know the components of a forensic evaluation for victims of domestic violence.
7. To know the components of a comprehensive care plan for victims of domestic violence.
8. To have an in-depth understanding of California law and the legal process as it relates to domestic violence.

**Target Audience:**

Forensic examiners, members of hospital/clinic based response teams and emergency personnel.

**Dissemination/ Usage:**

Course has been conducted at various locations within California. There is no tuition for California residents. Out of state attendees are charged tuition and admitted if space is available.

**Other Comments:**

One of a number of courses on sexual abuse, domestic violence, elder abuse and child molestation conducted by the California Medical Training Center.



**Training Program/Policy Statement/Practice Protocol:** 747474743434

Advanced Training in Elder Abuse (version 1.0)

**Source:** California Medical Training Center

**Address:** 3300 Stockdon Boulevard, Sacramento, CA 95820

**Telephone:** (916) 734-4141

**Web Site:** [www.ucdmc.ucdavis.edu/medtring](http://www.ucdmc.ucdavis.edu/medtring)

**Contact:** Connie Mitchell, MD

**Description:**

A one-day course designed to provide training for the conduct of a comprehensive evaluation and forensic examination of victims of elder abuse. The course is intended for the health care providers who have some experience in the normal aging process and geriatrics. It assumes a basic knowledge about elders and their health care issues. The goals of the course include: 1) developing appreciation that elder abuse is a prevalent health care problem, 2) learning how to recognize elder abuse in the office setting, 3) learning how to document suspected cases of elder abuse, 4) learning the role of adult protective services, and 5) learning how to manage suspected cases of abuse in the nursing home setting.

**Target Audience:**

Primarily physicians.

**Dissemination/ Usage:**

Course was taught by the California Medical Training Center as one of a series of courses on elder abuse, sexual abuse, domestic violence and child abuse.

As with other programs put on by the California Medical Training Center, the course is intended primarily for health care workers in the state of California though others have been allowed to attend by paying tuition if space was available.

**Other Comments:**

The course is currently being revised to add modules on dependent adults, financial abuse and sexual assault of the elderly.

**Training Program/Policy Statement/Practice Protocol:** 747474743535

Elder and Dependent Adult Abuse Training for Community Health Care Providers  
(Introductory Course)

**Source:** California Medical Training Center, UC Davis

**Address:** 3300 Stockton Boulevard, Sacramento, California 95820

**Contact:** Connie Mitchell, MD

**Telephone:** (916) 734-4141

**Web Site:** [www.ucdmc.ucdavis.edu/medtrng](http://www.ucdmc.ucdavis.edu/medtrng)

**Description:**

A one to two hour overview course to familiarize clinicians with the epidemiology and variety of elder mistreatment. To familiarize the clinician with how to detect elder abuse and with the reporting requirements and procedures in California. The course is also intended to increase the ability of the clinician to assess and manage suspected abuse cases.

The goals of the course are to: 1) provide information on the normal aging process; 2) provide appreciation that elder and dependent adult abuse is a prevalent medical problem; 3) provide the clinician with the ability to recognize elder and dependent adult patients during office visits; 4) provide information on the importance of the cognitive assessment; 5) provide information on how to appropriately document cases of elder and dependent adult abuse; 6) identify and manage suspected cases of elder abuse in nursing homes or other institutional settings; and 7) gain an appreciation of the issue of self neglect as it pertains to elder and dependent adults.

**Target Audience:**

Adult primary care providers, including physicians in general practice, family medicine and internal medicine, as well as advanced practice nurses and physicians assistants.

**Dissemination/Usage:**

The course is taught in California as part of a series of courses on elder abuse, domestic violence, sexual assault, and childhood sexual and physical abuse presented by the California Medical Training Center at the University of California, Davis.

**Training Program/Policy Statement/Practice Protocol:** 747474743636

Forensic Examination for Victims of Domestic Violence

**Organization:** California Medical Training Center

**Address:** 3300 Stockton Boulevard, Sacramento, CA 95820

**Contact:** Connie Mitchell, MD

**Telephone:** 916-734-4143

**Website:** [www.usdmc.ucdavis.edu/medtrng](http://www.usdmc.ucdavis.edu/medtrng)

**Description:**

This is a module in the training course “Advanced Training in Domestic Violence for Healthcare Providers.” The goal of the module is to teach the components of a forensic evaluation for victims of domestic violence. The comprehensive forensic evaluation includes: forensic history; mental status evaluation; forensic evidence collection; and injury assessment.

**Target Audience:**

Physicians who may encounter domestic abuse patients in their practices

**Dissemination/Usage:**

One of a series of courses prescribed by the California Medical Training Center

**Training Program/Policy Statement/Practice Protocol:** 747474743737

Pediatric Sexual Abuse Evidentiary Exam Training Course with extensive participant manual. Classroom training with extensive use of audio/visuals and class handouts.

**Source:** California Medical Training Center, UC Davis

**Address:** 3300 Stockton Boulevard, Sacramento, CA 95820

**Telephone:** (916) 734-4143

**Fax:** (916) 734-4150

**Email:** [mtc@umdc.ucdavis.edu](mailto:mtc@umdc.ucdavis.edu)

**Contact:** John McCann, MD  
(916) 734-3691

**Web Site:** [www.ucdmc.edu/medtrng](http://www.ucdmc.edu/medtrng)

**Description:**

Training to conduct evidentiary examinations on children and adolescents suspected of being victims of sexual abuse or assault. Special emphasis is placed on training examiners to follow the guidelines for conducting evidentiary examinations as outlined in the California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims. Four-day course with a wide range of faculty representing all organizations involved in child sexual assault cases.

The goal of the training is to provide participants with:

1. understanding of California law on the medical/legal aspects of child/adolescent sexual abuse;
2. understanding of how to conduct a forensically defensible medical interview;
3. opportunity to recognize differences between normal and abnormal genital findings;
4. in-depth understanding of how to effectively conduct an evidentiary examination;
5. understanding of current methods of performing and interpreting anal/genital examination;
6. understanding of emotional and behavioral responses;
7. understanding of how to evaluate, identify, prophylax and interpret STD's;
8. understanding of the California judicial system including the types of hearings, the roles of personnel within the judiciary, how to respond to subpoenas and how to testify;
9. understanding of the importance of identifying and developing self-care strategies; and,
10. opportunity to develop clinical assessment skills.

**Target Audience:**

Physicians, registered nurses, nurse practitioners, and physician assistants.

**Dissemination/ Usage:**

Courses are conducted throughout California at a minimal or no cost to residents; out of state participants are charged tuition and accepted if space is available.

**Other Comments:**

Part of an extensive curriculum of training programs in sexual abuse, child molestation, elder abuse and domestic violence conducted by California Medical Training Center.

Sexual Assault Evidentiary Exam Training for Health Care Providers

**Source:** California Medical Training Center

**Training Program/Policy Statement/Practice Protocol:** 747474743838

**Address:** UC Davis, 3300 Stockton Boulevard, Sacramento, California 95820

**Telephone:** (916) 734-4141

**Contact:** William Green, MD

**Web Site:** [www.ucdm.edu/medtrng](http://www.ucdm.edu/medtrng)

**Description:**

This is a three-day course focusing on fundamental forensic examination techniques for adult and adolescent victims of sexual assault. The course is designed for the inexperienced examiner and teaches basic knowledge, skills, and attitudes. The course is built around the Office of Criminal Justice Planning (OCJP) form 923 Medical Protocol for Examination and Treatment of Sexual Assault Victims.

The goals of the course are to teach: 1) an appreciation of the advantages of using a Sexual Assault Response Team; 2) an understanding of legal issues involved in sexual assault crimes; 3) how to obtain a sexual assault history with precise and complete documentation; 4) a basic understanding and skills in crisis intervention; 5) an understanding of the essential elements of rape trauma syndrome, and the role of a rape crisis advocate; 6) ability to perform a sexual assault forensic examination with adequate and appropriate documentations; 7) ability to recognize and properly manage the collection of evidence in the forensic examination; 8) recommended strategies for the treatment, referral, and follow-up of the sexual assault victim; 9) advanced exam techniques involving colposcopy, forensic photography, and videography.

**Target Audience:**

Nurses, physicians, nurse practitioners, physician assistants, and law enforcement personnel involved with the interface with health care providers.

**Dissemination/Usage:**

This is one of a series of courses taught by the California Medical Training Center. The courses are intended for California health professionals who will serve as medical, i.e., sexual assault forensic examiners. Others, including out of State personnel are accepted upon payment of tuition if there is space available.

**Training Program/Policy Statement/Practice Protocol:** 747474743939

Clinical Forensic Medicine in the ED: A Training Video

**Source:** Jayne J. Batts, M.D.

**Address:** Carolinas Medical Center, Department of Emergency Medicine, Charlotte, NC 28232

**Contact:** Jayne J. Batts, M.D.  
(704) 643-7709

**E-mail:** [JayneBatts@aol.com](mailto:JayneBatts@aol.com)

**Description:**

A brief 7-minute training video for emergency physicians and others involved with forensic medicine in the emergency department.

The brief film depicts a gunshot victim arriving by ambulance in the emergency department and then traces the steps through the emergency department until the patient is being discharged to an inpatient bed. The 7-minute film depicts 17 forensic errors, e.g., the failure to keep the chain of evidence, failure to keep the potentially valuable evidentiary material, failure to conduct the evidentiary exam until after the victim has been contaminated, etc.

**Target Audience:**

Emergency department physicians and others involved with treating of forensic evidence in the emergency department.

**Additional Comments:**

The film was prepared by Dr. Batts for the training of emergency department residents and forensic nurses in issues surrounding emergency forensic medicine.

**Training Program/Policy Statement/Practice Protocol:** 747474744040

Sexual Assault and STDs: Sexually Transmitted Diseases Treatment Guidelines 2002.

**Source:** Centers for Disease Control and Prevention (CDC)

**Description:**

The guideline includes recommendations on the identification, prophylaxis, and treatment of sexually transmitted infections and conditions commonly identified in the management of such infections. Examination of survivors of sexual assault should be conducted so as to minimize further trauma to the survivor and should be performed by an experienced clinician. The decision to obtain genital or other specimens for STD diagnosis should be made on an individual basis. Mechanisms to ensure continuity of care (including timely review of the results of any tests obtained) and to monitor compliance with and adverse reactions to any therapeutic or prophylactic regimens should be in place in any setting where survivors of sexual assault are examined. Laws in all 50 states strictly limit the evidentiary use of a survivor's prior sexual history, including evidence of previously acquired STDs, as part of an effort to undermine the credibility of the survivor's testimony. Evidentiary privilege against revealing any aspect of the examination or treatment is enforced in most states. In unanticipated, exceptional situations, STD diagnoses may later be accessed, and the survivor and clinician may opt to defer testing for this reason. However, collection of specimens at initial examination for laboratory STD diagnosis gives the survivor and clinician the option to defer empiric prophylactic antimicrobial treatment. Among sexually active adults, the identification of sexually transmitted infection after an assault is usually more important for the psychological and medical management of the patient than for legal purposes, because the infection could have been acquired before the assault. Furthermore, a post-assault examination is an opportunity to identify or prevent sexually transmitted infections, regardless of whether they were acquired during an assault.

**Audience:**

Clinicians who examine or treat victims of sexual assault.

**Dissemination/Usage:**

Published in the May, 2002 issue of MMWR, 10;51 (RR-6):69-74.

**Training Program/Policy Statement/Practice Protocol:** 747474744141

Sexual Assault Protocol, Departments of Social Service and Emergency Medicine

**Source:** Children's Hospital Medical Center

**Address:** 3333 Burnet Avenue, Cincinnati, Ohio 45229

**Telephone:** (513) 636-4200

**Web Site:** [www.cincinnatichildrens.org](http://www.cincinnatichildrens.org)

**Description:**

The protocol is for children who are victims of alleged sexual assault. The protocol indicates that the child and family should be provided with the following services:

- Emotional support
- Medical assessment and treatment of injuries
- Documentation of the alleged assault by collection of evidence
- Referral to appropriate counseling services
- Expert medical testimony in subsequent litigation

The protocol points out two aspects of child sexual assault which present difficulty in recognition and management:

1. Since the child is usually assaulted by a relative or acquaintance there is likely to be denial or blame of the child.
2. There is frequently little physical evidence to corroborate the child's story.

The remainder of the protocol describes the functions of the individuals involved in the treatment of the victim of child sexual abuse. These include the triage nurse, the social worker, the nurse in attendance, the physician, the protective service worker, and the police officer.

The protocol contains a number of appendices including the following:

- The vaginal exam in pre pubertal girls
- Culturing for sexually transmitted diseases
- Interpretation of the genital examination
- Post coital contraception
- Venereal disease prophylaxis
- Treating the uncooperative patient
- The social and medical clinic

**Target Audience:**

Physicians and other health workers who may need to examine and treat victims of childhood sexual assault.

**Additional Comments:**

The protocol is available from the Children's Hospital Medical Center of Cincinnati or on the web site listed above.



**Training Program/Policy Statement/Practice Protocol:** 747474744242

Police Response to Crimes of Sexual Assault: A Training Curriculum

**Source:** Produced by Connecticut Sexual Assault Crisis Services, Inc.  
Funded by Police Office Standards and Training Council under a STOP grant.  
Available from- Violence Against Women Online Resources, U.S. Department of Justice,  
Office of Justice Programs

**Web Site:** [www.vaw.umn.edu](http://www.vaw.umn.edu)

**Description:**

A training curriculum for law enforcement professionals involved in sexual assault issues. The curriculum includes the following six modules:

- An overview of sexual assault
- Definitions of sexual assault and related statutes
- Procedures for police investigations including collection of evidence
- Services available to victims of sexual assault
- Information for sex offenders
- Legal issues

While intended for police professionals, the material provides a good general overview of issues surrounding the crime of sexual assault, and provides insight into the issues which are critical in police investigations.

**Target Audience:**

Police professionals dealing with sexual assault issues.

**Dissemination/Usage:**

Material can be downloaded from Violence Against Women Online Resources available at the Department of Justice, Office of Justice Programs web site.

While the material is specifically designed for Connecticut police, it could be modified for other police jurisdictions.

**Training Program/Policy Statement/Practice Protocol:** 747474744343

Care of Sexual Assault Victims  
Position Statement

**Source:** Emergency Nurse Association

**Address:** 915 Lee Street, Des Plaines, IL 60016-6569

**Telephone:** (847) 460-4000

**Web Site:** [www.ena.org/services/posistate/data/tresex.htm](http://www.ena.org/services/posistate/data/tresex.htm)

**Description:**

This position statement reflects the ENA's belief that a need exists for improving treatment and care of sexual assault victims. It further states that improved and comprehensive care requires extensive preplanning, education, and the collective expertise of emergency care and other team members. The position statement establishes objectives for emergency nurses which, when achieved, will further the goal of comprehensive competent care.

The objectives include:

- 1) all personnel involved with sexual assault victims should have an empathetic and non judgmental attitude
- 2) emergency nurses should conduct a brief mental assessment of needs and support necessary to prevent further trauma
- 3) provide internal crisis intervention and assist in further intervention as needed
- 4) provide treatment for physical injury and conduct evidence collection in a private setting with only a limited number of people in attendance
- 5) provide access to rapid assessment, testing and disease prophylaxis
- 6) conduct or assist with the conduct of the physical examination
- 7) perform or assist with the performance of evidence collection and documentation
- 8) facilitate follow-up care
- 9) provide appropriate referrals to community resources
- 10) understand the special diagnostic and treatment needs of sexually assaulted or abused children.

**Target Audience:**

Emergency room nurses

**Training Program/Policy Statement/Practice Protocol:** 747474744444

Domestic Violence & Child Maltreatment  
Position Statement

**Source:** Emergency Nurse Association

**Address:** 915 Lee Street, Des Plaines, IL 60016-6569

**Telephone:** (847) 460-4000

**Web Site:** [www.ena.org/services/posistate/data/tresex.htm](http://www.ena.org/services/posistate/data/tresex.htm)

**Description:**

This position paper states ENA's belief that the emergency nurse is an advocate for the survivor of domestic violence. Additionally, ENA believes that the survivor has a right to be treated in a physical and social environment conducive to compassionate and unbiased care; and to that end recommends the development and use of routine protocols/procedures for assessment, identification and referral for survivors of domestic violence. As part of the position paper, the ENA supports extending use of protocols for routinely identifying, treating and referring victims of sexual assault in hospital emergency departments.

In an addenda to the position paper entitled "Child Maltreatment," ENA states its support for increased public education for prevention, detection, treatment, reporting and follow-up of child maltreatment/abuse. It also calls for the development of a national format for reporting child maltreatment.

**Training Program/Policy Statement/Practice Protocol:** 747474744545

Forensic Evidence Collection  
Position Statement

**Source:** Emergency Nurse Association

**Address:** 915 Lee Street, Des Plaines, IL 60016-6569

**Telephone:** (847) 460-4000

**Web Site:** [www.ena.org/services/posistate/data/forensic](http://www.ena.org/services/posistate/data/forensic)

**Description:**

This position paper state:

ENA's belief that it is within the nurse's role not only to provide physical and emotional care to patients, but also to help preserve the "chain" of evidence collected in the Emergency Department. ENA encourages nurses to become familiar with the concepts and skills of evidence collection and documentation, and that nurses should have basic skills or access to resources to obtain photo documentation in the emergency care setting. ENA also believes that nurses should work collaboratively with the emergency physicians, social services and law enforcement personnel to develop guidelines for forensic evidence collection and documentation in the emergency care setting.

The position statement includes a rationale and a bibliography of key journal articles.

**Training Program/Policy Statement/Practice Protocol:** 747474744646

Catalog of Training and Education Materials on Domestic Violence

**Source:** Family Violence Prevention Fund

**Address:** 383 Rhode Island Street, Suite 304  
San Francisco, CA 94103-5133

**Telephone:** 415/252-8900

**Web site:** [www.fvpf.org](http://www.fvpf.org)

**Description:** Catalogue of education and training materials developed by the Family Violence Prevention Fund as part of a National Health Initiative on Domestic Violence, to provide health care professionals and institutions with training and information required to effectively meet the needs of battered women. The materials have been widely used in hospitals, clinics and doctors' offices. In addition to information on best practices and training manuals, the catalogue features practical tools such as laminated reference cards for busy practitioners, patient brochures, and items that can be utilized for raising public awareness such as t-shirts and mugs.

**Training Program/Policy Statement/Practice Protocol:** 747474744747

Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health

**Source:** Family Violence Prevention Fund

**Address:** 333 Rhode Island Street, Suite 304  
San Francisco, CA 94103-5133

**Telephone:** (415) 252-8900

**Web site:** [www.endabuse.org](http://www.endabuse.org)

**Description:**

These guidelines were developed by the Family Violence Prevention Fund, in partnership with: the American Academy of Family Physicians (AAFP); the American Academy of Pediatrics (AAP); the American College of Obstetricians and Gynecologists (ACOG); the Child Witness to Violence Project at Boston Medical Center; and the National Association of Pediatric Nurse Practitioners (NAPNAP). The development of the guidelines was funded by the U.S. DOJ Office for Victims of Crime, with support from the US. DHHS Administration for Children and Families and the Conrad N Hilton Foundation. The guidelines offer specific recommendations for screening and responding to domestic violence in child health settings which provide a unique and important opportunity to screen for domestic violence and to educate parents about the impact of such violence on children. The guidelines also speak to the need for child health providers to engage in, model, and take leadership in delivering effective primary prevention of domestic violence and other types of family and community violence, by highlighting violence prevention during well child and other routine visits as a component of routine anticipatory guidance.

The report includes appendices with position statements on domestic violence by medical and health professional associations; abstracts of studies on provider and patient attitudes toward screening; indicators of abuse; reporting requirements and State code information; resources for providers and patients; and safety plans and instructions.

**Training Program/Policy Statement/Practice Protocol:** 747474744848

Improving Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers

**Source:** Family Violence Prevention Fund

**Address:** 383 Rhode Island St., Suite 304, San Francisco, CA 94103-5133

**Telephone:** (415) 252-8900

**Web Site:** [www.fvpf.org](http://www.fvpf.org)

**Description:**

A 250 page loose leaf resource manual for health professionals developing and implementing comprehensive domestic violence prevention and treatment programs in emergency departments, primary care and ob/gyn settings. The manual provides information on the dynamics of domestic violence; identification, screening, assessment and interventions with victims of domestic violence; and responding to batterers. The manual also provides resource material for both patients and providers including model protocols, screening and discharge material and additional clinical tools.

**Target Audience:**

Physicians, medical social workers, nurses, health educators and domestic violence advocates.

**Dissemination/ Usage:**

Sold by the Family Violence Prevention Fund.

**Training Program/Policy Statement/Practice Protocol:** 747474744949

Improving the Health Care Response to Domestic Violence  
A training manual for health care providers

**Source:** Family Violence Prevention Fund

**Address:** 383 Rhode Island St., Suite 304, San Francisco, CA 94103-5133

**Telephone:** (415) 252-8900

**Web Site:** [www.fvpf.org](http://www.fvpf.org)

**Description:**

The training manual is a companion document to the resource manual and provides complete step by step instructions on how to teach each of the modules. Areas covered include the dynamics of domestic violence, developing clinical skills, understanding legal issues and identification of community resources. The training manual also includes a special section on developing cultural competency in providing help to diverse populations.

**Target Audience:**

Physicians, nurses, medical social workers, health educators and violence advocates.

**Dissemination/ Usage:**

Sold as part of a package with the resource manual by the Family Violence Prevention Fund.



**Training Program/Policy Statement/Practice Protocol:** 747474745050

Preventing Domestic Violence: Clinical Guidelines on Routine Screening

**Source:** Family Violence Prevention Fund (FVPF)

**Address:** 383 Rhode Island Street, Suite 304  
San Francisco, CA 94103-5133

**Telephone:** 415/252-8900

**Web site:** [www.fvpf.org](http://www.fvpf.org)

**Description:**

The guideline includes recommendations for how screening for domestic violence should occur within the health care system. Recommendations are based on an extensive literature review and a conference with expert health practitioners in the field of domestic violence screening, intervention and prevention and advocates in the domestic violence community.

The guideline recommends:

- Routine screening for domestic violence victimization for all female patients over the age of fourteen in primary care, obstetric/gynecology and family planning, emergency department in-patient, pediatrics and mental health settings.
- That all practitioners and health organizations within these settings implement culturally competent programs to ensure routine screening
- That screening be carried out in private settings and through the use of straight-forward, non-judgmental questions in a culturally competent manner
- Confidential documentation of screening outcomes
- 

**Audience:**

All health care institutions and practitioners

**Dissemination/Usage:**

FVPF works with national health and medical associations and state organizations to jointly encourage the widespread implementation of these guidelines.

**Training Program/Policy Statement/Practice Protocol:** 747474745151

SART/SANE Institute

**Source:** Forensic Nursing Services

**Address:** P.O. Box 2512, Santa Cruz, CA 95063-2512

**Telephone:** (831) 465-9826

**Contact:** Sandra Goldstein, R.N., M.S.  
(831) 465-9826

**Web Site:** [www.Forensicnursing.com](http://www.Forensicnursing.com)

**Description:**

A one-week multi-disciplinary training program on how to implement a Sexual Assault Response Team/Sexual Assault Nurse Examiner (SART/SANE) program with assistance from the staff of Forensic Nursing Services and materials designed by them. The training meets the educational guidelines of the International Association of Forensic Nurses (IAFN).

The Forensic Nursing Services provides, as part of the Institute package the following:

- Participants manual, including an overview of the Institute
- Outlines of the presentations by various speakers
- Articles related to sexual assault
- Abstracts of sexual examination research
- Sample diagrams and terminology definitions

The entire Institute curriculum includes the daily agenda, presentation content outlines, presentation objectives and evaluation forms. The program also includes a preceptorship instructor and a SART/SANE Preceptorship Guide for each person. Forensic Nursing Services also provides an introduction to the preceptorship, suggestions for selecting preceptors, sample preceptor recruitment letters and sample letters to preceptors, instructions for preceptor nurse examiners, the identification of goals for each preceptor area and evaluation forms for each preceptor.

**Target Audience:**

Nurses, health care providers, advocates for assault victims, law enforcement personnel, and district attorney's interested in developing SART or SANE programs in a community.

**Dissemination/ Usage:**

The program has been operational since the early 1990's. The references and other materials are updated as techniques and technology change.

**Other Comments:**

Information on the SART/SANE Institute can also be obtained from Sherry Arndt, R.N., M.P.H. at 40758 100<sup>th</sup> Street, Comfrey, MN 56018-4011. Telephone (507) 877-3663. Fax (507) 877-6011.

**Training Program/Policy Statement/Practice Protocol:** 747474745252

The SART/SANE Orientation Guide

**Source:** Forensic Nursing Services

**Address:** P.O. Box 2512, Santa Cruz, CA 95063

**Telephone:** (831) 465-9826

**Contact:** Sandra Goldstein, R.N.,M.S.  
(831) 465-9826

**Web Site:** [www.Forensicnursing.com](http://www.Forensicnursing.com)

**Description:**

The Sexual Assault Response Team/Sexual Assault Nurse Examiner (SART/SANE) Orientation Guide provides a step by step outline to aid a community in developing a Sexual Assault Response Team (SART). Chapters discuss developing a task force, identifying funding, development of the multi-disciplinary team and the preparation for a SART/SANE institute.

The orientation guide contains community assessment worksheets to determine the readiness for developing a program, it includes discussions on how to introduce the concept of a SART/SANE program to community leaders and includes a slide presentation with accompanying text.

The orientation guide also includes sections on the following topics:

- developing goals and objectives for the task force
- developing a budget
- selection of staff
- role development and description of team activities
- setting up exam rooms, including information on location design, décor and equipment.

**Target Audience:**

Nurses and other community leaders interested in establishing a SART/SANE program in their community.

**Dissemination/ Usage:**

Sold through Forensic Nursing Services web site.

**Other Comments:**

Information on the SART/SANE Orientation Guide and other services provided by the Forensic Nursing Services can also be obtained from Sherry Arndt, R.N.,M.P.A. at 40758 100<sup>th</sup> Street, Comfrey, MN 56018-4011. Telephone (507) 877-3663. Fax (507) 877-6011.

**Training Program/Policy Statement/Practice Protocol:** 747474745353

Injuries and Evidence  
Sexual Assault: Documenting the Trauma for Trial (A Video and Workbook)

**Source:** Health Education Alliance

**Address:** 2611 Garden Road, Monterey, CA 93940

**Telephone:** (831)-333-0300

**Description:**

In sexual assault cases, forensic evidence may be useful in two ways. It may establish facts or corroborate testimony by showing links between the victim, her attacker and the scene of the crime. These links consist of physical traces exchanged during violent acts. Today, exploitation of this kind of evidence is possible, but frequently not done. This unsatisfactory situation derives from a lack of forensic knowledge by some of the crucial actions involved in the investigation: physicians, investigators and magistrates. Also, taking into account the high level of recidivism in this kind of crime, systematic forensic investigation can point to links between cases having no obvious relation in terms of time or location. Physicians and other health care providers have to know how to handle the cases optimally in order to guarantee that all potentially useful information is available.

The program is divided into three main areas: Overview; Documentation of Injuries and Evidence; and Assessment Instrument.

The overview section is divided into two parts:

1. Sexual Crimes: The Importance of Forensic Investigation, and
2. Bite Mark Evidence on Crimes Against Persons.

The Documentation of Injuries and Evidence section consists of the following:

1. Investigation of Microtrauma after Sexual Assault,
2. Genital Injury and Implied Consent to Alleged Rape,
3. Cervical Findings in Rape Victims,
4. Colposcopy to Establish Physical Findings in Rape Victims,
5. Use of Toluidine Blue for Documentation of Traumatic Intercourse, and
6. Toluidine Blue in the Corroboration of Rape in Adult Victims.

The Assessment Instrument section presents a case study of a sexual assault with the relevant reporting forms.

**Target Audience:**

Physicians and Nurse Examiners

**Dissemination/Usage:**

For sale from the Health Education Alliance

**Training Program/Policy Statement/Practice Protocol:** 747474745454

Sexual Assault Response Teams;  
A training video

**Source:** Health Education Alliance

**Address:** 2611 Garden Road, Monterey, CA 93940

**Telephone:** 800-404-3258

**Description:**

A 30-minute video explaining basic facts about Sexual Assault Response Teams (SART), their development, organization and function. The major topics discussed include:

- Who should examine rape victims?
- What are the benefits of a SART?
- What are the barriers to creating a SART in a community?
- What are the responsibilities of various team members?
- What is the District Attorney's role?
- What are the resources necessary for getting started?
- How to initiate a SART?

**Audience:**

Those individuals interested in organizing a Sexual Assault Response Team. Also suitable to show to community groups to explain the SART concept.

**Dissemination/Usage:**

Available from Health Education Alliance

**Training Program/Policy Statement/Practice Protocol:** 747474745555

Save the Evidence, Save a Life!

Sexual Assault: The Medical-Legal Exam (A Video and Workbook)

**Source:** Health Education Alliance

**Address:** 2611 Garden Road, Monterey, CA 93940

**Telephone:** (831)-333-0300

**Description:**

Much of the information in the video and workbook was taken from the California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims and the California Medical Protocol Informational Guide.

The workbook and video are divided into three main sections and, in addition, the workbook has an extensive Appendix. The main sections are: Overview; Examination Procedures; and Multicultural Issues.

The Overview section addresses: the Rape Trauma Syndrome; The Behavior-Oriented Interview of Rape Victims; The Key to Profiling and Sexual Assault; and Guidelines for Clinicians.

The Examination Procedures section covers the following topics: Patient Consent for Examination, Treatment, and Evidence Collection; Special Considerations in the Collection & Preservation of Evidence; Adult Female Patients (Psychological Reactions, Evidential Examination, Possibility of Pregnancy); Adult Male Patients (Psychological Reactions, Evidential Examination); Pediatric Patients (Psychological Reactions & Behavioral Indicators, Evidential Examination); Treatment of Sexually Transmitted Diseases; and Follow-up Patient Care.

The Multicultural Issues section covers the following: Cultural Considerations in the Treatment of Asian Sexual Assault Victims; Providing Support Services to Black Sexual Assault Survivors; and Medical Protocol for the Latina Survivor.

**Target Audience:**

Physicians and Nurse Examiners

**Dissemination/Usage:**

For sale from the Health Education Alliance

Sexual Assault Nurse Examiner Education Guidelines  
Minimum requests for training programs.

**Source:** International Association of Forensic Nurses

**Training Program/Policy Statement/Practice Protocol:** 747474745656

**Address:** East Holly Avenue, Box 56, Pitman, NJ 08071-0056

**Telephone:** (856) 256-2425

**Web Site:** [www.forensicnurse.org](http://www.forensicnurse.org)

**Description:**

The booklet briefly defines the goals of a Sexual Assault Nurse Examiner (SANE) intervention and the practice area of the SANE. The goals of the Sexual Assault Nurse Examiner Guidelines are to

- Describe a standardized body of knowledge for the comprehensive evaluation and forensic examination of the sexual assault patient
- Ensure that the content meets the definitions of practice area set forth in the IAFN SANE Standard of Practice
- Describe the concept, development and collaboration of the multidisciplinary team
- Provide awareness of professional nurse practice issues in forensic nursing.

The Guidelines recommend that the training be conducted by a SANE with demonstrated expertise in the field and that the training include both a didactic component and a clinical preceptorship. The target topics of the didactic component include:

1. The multidisciplinary team concept
2. Forensic nursing
3. Roles and responsibilities of the SANE
4. The dynamics of sexual assault
5. Components of the Sexual Assault Forensic Examination
6. Role of the criminals in evidence evaluation
7. Nursing management
8. Criminal justice system
9. Ethics
10. Evaluation

The clinical preceptorship requires the practice of clinical skills in conducting a Sexual Assault Forensic Examination (SAFE) including: detailed genital examination; speculum examination; and visualization. The required clinical skills must be practiced until proficiency is demonstrated. The preceptorship experience includes forensic photography and observation of procedures and processes in: crime lab; law enforcement agency; advocate agencies; and other local agencies.

**Target Audience:**

Individuals and organizations interested in conducting or receiving SANE training.

**Training Program/Policy Statement/Practice Protocol:** 747474745757

Scope and Standards of Forensic Nursing Practice

**Source:** International Association of Forensic Nurses

**Address:** East Holly Avenue, Box 56, Pitman, NJ 08071-0056

**Telephone:** (856)-256-2425

**Web Site:** [www.forensicnurse.org](http://www.forensicnurse.org)

**Description:**

Forensic nursing is the application of forensic science combined with the bio-psychological education of the registered nurse, in the scientific investigation, evidence collection and preservation, analysis, prevention and treatment of trauma and/or death related medical legal issues. The forensic nurse functions as a staff nurse, nurse scientist, nurse investigator, or as an independent consulting nurse specialist to public and/or private operations and/or individuals in the medical-legal investigation of injury and/or death of victims of violence, criminal activity, and traumatic accidents.

Evolving professional and societal demands have necessitated this statement clarifying the scope of forensic nursing practice. The "Standards of Clinical Nursing Practice" are the basic standards which apply to all nurses. The IAFN has utilized the "Standards of Clinical Nursing Practice" to develop specific criteria for defining expectations within the parameters of forensic nursing.

The Scope and Standards of Forensic Nursing Practice consist of "Standards of Care" and "Standards of Professional Performance", which include the following:

Standards of Care: Assessment, Diagnosis, Outcome Identification, Planning, Evaluation

Standards of Professional Performance: Quality of Care, Performance Appraisal, Education, Collegiality, Ethics, Collaboration, Research, Resource Utilization

The Standards are primarily intended to assist the forensic nurse in providing safe and effective services and to pursue professional development.

**Target Audience:**

Forensic nurses and organizations that employ them.

**Dissemination/Usage:**

Available for sale from the association.



**Training Program/Policy Statement/Practice Protocol:** 747474745858

Sexual Assault Nurse Examiner Resource Guide for Michigan Communities

**Source:** Michigan Coalition Against Domestic and Sexual Violence

**Address:** 3893 Okemos Rd., Suite B2, Okemos, MI 48864

**Telephone:** (517) 347-7000

**Contact:** Maria Chickering  
(517) 347-7000 ext. 10

**Description:**

A resource Guide for communities considering the development of Sexual Assault Nurse Examiners/Sexual Assault Response Team (SANE/SART) programs. The Guide describes SANE and SART program models, how to assess the community feasibility to develop a program, development of a task force, and developing and operating a program. Major chapters describe:

- What are SANE and SART programs?
- Program benefits
- Program feasibility
- Convening a task force
- Identifying and overcoming obstacles
- Appropriate program location
- Developing a budget and identifying sources of funding
- Issues of consideration for communities developing SANE programs

The Guide also contains a bibliography and extensive appendices ranging from sample position descriptions, sample forms, etc.

**Target Audience:**

Communities considering starting a SANE/SART program.

**Dissemination/ Usage:**

Available for sale from the Michigan Coalition Against Domestic and Sexual Violence.

**Training Program/Policy Statement/Practice Protocol:** 747474745959

Looking Back– Moving Forward: A Guide Book; Program and Workbook for Communities Responding to Sexual Assault.

**Source:** National Center for Victims of Crime

**Address:** 2111 Wilson Boulevard, Suite 300, Arlington, Virginia 22201

**Telephone:** (703) 276-2880

**Web Site:** [www.ncvc.org](http://www.ncvc.org)

**Description:**

The Guidebook for Communities Responding to Sexual Assault reviews the past two decades of success by law enforcement, prosecutors, and emergency care providers in improving the sexual care for sexual assault victims. It describes the development of rape crisis centers and other victim services that focus on meeting the needs of the individual victim. The guide stresses the need to merge the case focus of the criminal justice system with the victim focus of victim service providers. The approach to achieving this unification is through the creation of a Community Sexual Assault Interagency Council through which representatives of law enforcement agencies, prosecution, the medical community and victim services can meet and coordinate the community's response to victims. An interagency council operates under a set of multi-agency, multi-disciplinary guidelines or protocols which define the role of each participating agency. The Guides stress that services must be victim centered, expanding the role of the victim from that of an important witness, to an active participant in the decision-making.

The Training Guide provides the details for a three-day training program to prepare representatives of the various organizations for the development of a Sexual Assault Interagency Council (SAIC). The training guide works in consort with a process in which the community develops an inventory of existing services, a victim satisfaction survey, and a community needs assessment. The training is designed to: 1) familiarize the participants with the eight step process of developing and implementing a multi-agency/multi-disciplinary, victim centered protocol; and 2) develop multi-disciplinary communication and team work.

The Workbook is designed to complement the materials in the guide book and to assist the interagency council in organizing and carrying out the steps for developing and implementing a multi-disciplinary, multi-agency, victim centered protocol.

The entire package of material is designed to develop victim centered methods of investigating, prosecuting and adjudicating sexual assault cases through the development of Community Sexual Assault Interagency Councils.

**Target Audience:**

Communities desiring to develop a coordinated approach to services for victims of sexual assault.

**Dissemination/Usage:**

For sale from the National Center for Victims of Crime.

**Training Program/Policy Statement/Practice Protocol:** 747474746060

Forensic Evaluation Training

**Source:** National Children's Advocacy Center (National Children's Alliance)

**Address:** 200 Westside Square, Suite 700, Huntsville, AL 35801

**Telephone:** 256-533-0531

**Web Site:** [www.ncac-hsv.org](http://www.ncac-hsv.org)

**Description:**

A training program developed for treating children who are too young or frightened to give clear information at the initial investigative interview. The protocol is conducted over six sessions- one with the non-offending caregiver, and five with the child. It includes forensic assessment for possible sexual abuse, and clinical assessment and treatment needs. Results of a pilot test of the model demonstrated it to be effective in obtaining credible statements from children, and that the evaluations were supported in legal proceedings. Training is conducted over a three day period and covers all aspects of the forensic evaluation protocol. Major components include:

- Rapport building and assessing the developmental level of the child
- Social, clinical, and behavioral assessment of the child
- Forensically sound interviewing techniques

**Target Audience:**

Degreed mental health clinicians interested in conducting extended forensic evaluation of children when sexual abuse is suspected. Training is appropriate for clinicians with some experience and those just beginning this activity.

**Dissemination/ Usage:**

Information is available on the NCAC web site and on the web site of the National Children's Alliance.

**Training Program/Policy Statement/Practice Protocol:** 747474746161

Manuals and videos from National Children's Alliance

**Source:** National Children's Alliance

**Address:** 1612 K Street, NW, Suite 500, Washington, DC 20006

**Telephone:** (202) 452-6001

**Web Site:** [www.nncac.org](http://www.nncac.org)

**Description:**

The National Children's Alliance (formally the National Network of Children's Advocacy Centers) is a not for profit organization whose mission is to provide training, technical assistance and network opportunities to communities desiring to establish or improve Child Advocacy Centers (CAC).

Among the materials available are the following manuals and video tapes:

Manuals

- *Best Practices*, 3<sup>rd</sup> Edition- Describes the fundamental concepts that must be addressed when developing a CAC.
- *Organizational Development for CACs*- A how-to guide of specific techniques and tools necessary to develop a CAC.
- *Intake and Forensic Interviewing in the CAC Setting*- Guidelines for multi-disciplinary teams and CAC employed forensic interviewers.
- *Fundraising Manual for CACs*- A how-to guide for fundraising.
- *Fundraising Guide for Native American CACs*- A reference and research tool for Native American groups desiring to fund CACs
- *Safe and Savvy Volunteer Services*- Guidelines and suggestions
- *Putting Standards into Practice: A Guide to Implementing NCA Standards for CACs*- A handbook for meeting NCA standards and preparing for full membership.

Videotapes

- *Child Advocacy Centers*- a brief video over-view of the CAC model.
- *Changing the System for Children*- A brief video addressing the basic questions professionals ask when developing a CAC
- *One Child at a Time*- Addresses the need for medical personnel to conduct the forensic medical assessment following the allegations of child abuse.

**Target Audience:**

Child welfare workers, physicians, and other health professionals interested in developing a coordinated community program to assist sexually abused children.

**Dissemination/ Usage:**

Materials are available on the National Child Alliance Network.

**Other Comments:**

In addition to the materials described above the center also provides a wide variety of technical assistance packages and has training programs available.

**Training Program/Policy Statement/Practice Protocol:** 747474746262

**Source:** The National Indian Justice Center (NIJC)

**Address:** The McNear Building, #7, 4<sup>th</sup> Street, Petaluma, CA

**Telephone:** (707) 762-8113

**Web Site:**

**Description:**

The training manual provides both substantive and procedural information on handling child abuse cases in Indian country. The manual has chapters on the following topics:

- 1) overview of child sexual abuse;
- 2) reporting policies and procedures;
- 3) law enforcement investigation of child sexual abuse;
- 4) child protective services and victims services;
- 5) interviewing child sexual abuse victims;
- 6) tribal/ federal coordination of child sexual abuse cases;
- 7) child sexual abuse cases in tribal court;
- 8) witness and evidentiary considerations in child sexual abuse cases;
- 9) roles in child sexual abuse cases;
- 10) sentencing, treatment and resource development; and
- 11) problem areas in child sexual abuse.

**Target Audience:**

Health professionals, legal professionals, and police and criminal justice system representatives who are involved with child sexual abuse cases involving Native Americans.

**Dissemination/ Usage:**

The manual is available for sale from the National Indian Justice Center.

**Training Program/Policy Statement/Practice Protocol:** 747474746363

**Source:** Ohio Pediatric Sexual Abuse Protocol, August 2000

Protocol developed by the Committee on Child Abuse and Neglect of the Ohio Chapter of the AAP, the Ohio Department of Health and the Ohio Attorney General's Office

**Address:** 3333 Burnet Avenue, Cincinnati, Ohio 45229

**Telephone:** (513) 636-7966

**Web Site:** [www.cincinnatichildrens.org/programs](http://www.cincinnatichildrens.org/programs)

**Description:**

The protocol is intended to provide comprehensive, standardized, non-judgmental, equitable treatment to pediatric victims of sexual abuse. The protocol is modeled on the Ohio Department of Health Protocol for the Treatment of Sexual Assault Survivors and provides for emotional, social, and crisis intervention as well as providing information about available referral services in the community. The protocol addresses issues of the legal system and evidence collection and recommends that where possible children be examined at a children's hospital, child abuse clinic or child advocacy center.

It is also hoped that the protocol will increase cooperation and communication between the various organizations which provide services to child sexual abuse victims. The protocol urges all communities to establish a specialized service team where children who allege sexual abuse can receive an expert evaluation. Members of the team may include representatives from the hospital child abuse program, emergency department, pediatrics, sexual assault nurse examiners, and pediatric nurse practitioners, law enforcement, the prosecutors office, and social services. The protocol indicates only physicians trained and experienced in the evaluation and treatment of the sexual abuse patient, or a health professional who is under the supervision of experienced physician, such as a pediatric sexual assault nurse examiner, resident, or fellow should perform the evaluation. The protocol includes sections on:

- patient triage
- support
- abuse history, medical history, examination and evidence collection
- photo documentation
- treatment and tests
- referrals and follow up
- written documentation
- handling of the completed evidence kit
- patient discharge

The protocol also has a series of appendices including handouts for the child victim and adult companions dealing with what will happen during the evaluation, after care, and common reactions and follow up services. The appendices also provide information on reporting, dealing with drug facilitated rape, billing issues, crime victim compensation, and detailed instructions for completing the Ohio Department of Health Sexual Assault/Abuse Evidence Collection Kit.

**Target Audience:**

Physicians, forensic nurse examiners, and institutions which will have responsibility for the evaluation, examination, and treatment of child sexual abuse victims.

**Dissemination/Usage:**

Available from Children's Hospital, Medical Center of Cincinnati, the Ohio Academy of Pediatrics, and on the web site listed.

Ohio Protocol for the Treatment of Sexual Assault Survivors

**Training Program/Policy Statement/Practice Protocol:** 747474746464

**Source:** Ohio Department of Health, Division of Prevention, Bureau of Health Promotion and Risk Reduction, Women's Health Section/Rape Prevention Program

**Address:** 246 North Hyde Street, P.O. Box 118, Columbus, Ohio 43216-0118

**Telephone:** (614) 466-3543

**Web Site:** [www.odh.state.oh.us](http://www.odh.state.oh.us)

**Description:**

The protocol was originally developed in 1991, revised in June 1999, and is currently undergoing another revision. The protocol was developed to provide comprehensive, standardized, non-judgmental, equitable treatment of survivors of sexual assault. It is intended to facilitate the provision of consistent, comprehensive healthcare treatment to include emotional, social, and crisis intervention as well as providing information about available referral services in the community.

The protocol stresses the basic requirements of the legal system and evidence collection. It is critical that evidence be properly collected and analyzed so that prosecution can be conducted and the necessary evidence provided to the appropriate law enforcement officials. Another important purpose of the protocol is to develop cooperation and communication among the different organizations providing assistance to rape victims. The State of Ohio encourages all communities to establish Sexual Assault Response Teams (SART) and Sexual Assault Nurse Examiner (SANE) programs.

The actual protocol contains sections on:

- Support
- Patient Assault and Medical History
- Evidence Collection
- Procedure Checklist
- Detailed Instructions for Evidence Collection
- Drug Facilitated Sexual Assault
- Release
- Billing/Payment for Evidence Collection
- Reporting to Police
- Crime Victims Compensation

The protocol also contains numerous appendices ranging from sample billing forms, to sample consent forms plus an outline of the criminal justice system, to a discussion of cultural sensitivity and cultural competency in assisting survivors of sexual assault and an adult protocol on sensitivity developed by the Illinois Attorney General's Office under a grant from the U.S. Department of Justice.

**Target Audience:**

Physicians and other health care workers in the State of Ohio who may provide examination and treatment to victims of sexual assault.

**Dissemination:**

To all hospitals and rape crisis centers in the State of Ohio. Available on request from the Department of Health.

**Training Program/Policy Statement/Practice Protocol:** 747474746565

Ohio Sexual Assault Protocol Training Packet

**Source:** Ohio Department of Health, Women's Health/Rape Prevention Section,  
Bureau of Health Promotion and Risk Reduction

**Address:** 246 North Hyde Street, P.O. Box 118, Columbus, Ohio 43216-0118

**Telephone:** (614) 466-3543

**Web Site:** www.odh.state.oh.us

**Description:**

The training packet, which was distributed to all hospitals and rape crisis programs in the State, contains:

- The Ohio Protocol for the Treatment of Adult Sexual Assault Survivors,
- The video on responding and treating sexual assault patients,
- The sexual assault training guide for medical personnel,
- A sample rape evidence collection kit.

The training materials are designed to be used at a local level to provide education to medical personnel on the sexual assault protocol and to aide in the implementation of the protocol in hospitals throughout the State of Ohio. The training material is designed to facilitate the provision of consistent, comprehensive and sensitive medical treatment and evidence collection for sexual assault survivors.

The objectives of the training material include the following:

- To implement a standardized sexual assault protocol
- Provide understanding of the crime of rape and other sexual offenses
- Increase awareness about rape crisis intervention and the importance of cultural sensitivity
- To learn about the rape trauma syndrome and the impact of sexual assault on the victim
- To develop coordination among service providers in both treatment and referral
- To familiarize health care professionals with the legal issues of sexual assault
- To explain in detail the documentation of the medical exam
- To describe proper evidence collection and chain of evidence procedures

**Target Audience:**

Physicians and other health professionals who will be conducting the medical examination and treatment of victims of sexual assault.

**Dissemination/Usage:**

The training packet was distributed to all hospitals and rape crisis programs in the State, and the training guide is available to other health professionals on request.

**Other Comments:**

The training guide as well as the Ohio Protocol for the Treatment of Adult Sexual Assault Survivors is currently being revised. There is also a companion protocol for children which was developed in 2000, and is currently distributed widely within the State.



**Training Program/Policy Statement/Practice Protocol:** 747474746666

PVS Abuse Assessment Response Course: Systems Approach to Partner Violence Across the Life Span – A Train the Trainer Course

**Source:** Physicians for a Violence-Free Society

**Description:**

This comprehensive 'train-the-trainer' course was developed by a multi-disciplinary, multi-specialty collaborative of domestic violence health care providers, educators, and researchers to address family violence with an emphasis on intimate partner violence. Physicians for a Violence-Free Society (PVS) in collaboration with Allina Hospitals and Clinic, United Behavioral Health, and the Family Violence Prevention Fund developed the course. It features a variety of resources for instructors including: scripted power point presentations and accompanying instructor notes; participant handouts; small group discussion case scenarios; role playing exercises; a standardized patient vignette; quizzes; and rationale and strategies to integrate family violence training into academic as well as private settings. The presentations employ case-based learning and educational resources to encourage problem solving rather than memorization. The course is presented on a CD-ROM with multimedia components including sound, video-streaming and supplemental handouts to enhance learning.

Core modules focus on: dynamics; screening; assessment; forensics; documentation and medical-legal aspects. Supplemental modules include: elder abuse; teen dating violence; coding and documentation of domestic violence; family violence and firearms; and making the business case for a health care response to domestic violence. The program also includes tools to facilitate integration of family violence training into academic and private settings and for developing and implementing clinical protocols for abuse assessment as part of a comprehensive health care response to intimate partner violence.

**Audience:**

Health care providers and educators, community advocates who provide health care training and key hospital and clinic staff who are interested in providing and integrating family violence training, curricular and protocol development in their individual academic or private health care setting.

**Training Program/Policy Statement/Practice Protocol:** 747474746767

Sexual Trauma: Dilemmas for the Primary Care Practitioner

**Source:** Society of General Internal Medicine: 20<sup>th</sup> Annual Meeting, May 1, 1997, Washington, D.C.

**Description:**

Program materials for workshop on Sexual Trauma for the Primary Care Practitioner. Contains: description of course coordinators and faculty; stories of sexual assault survivors; description of the long-term physical and mental health sequelae of sexual assault; effective therapeutic interventions in the primary care and mental health settings; asking about sexual trauma; implications of gender mismatches between provider and patient; traumatic effects of patients' stories on caregivers; avoiding burn-out; management, referral, and coordination of interdisciplinary care; and dealing with patient projections of the rapist/rescuer role onto the caregiver.

**Training Program/Policy Statement/Practice Protocol:** 747474746868

Standards For Providing Services to Survivors of Sexual Assault

**Source:** State of New Jersey  
Department of Law and Public Safety  
Division of Criminal Justice

**Address:** 25 Market Street, P. O. Box 85, Trenton, New Jersey 08625

**Contact:** James A. Gilson  
Deputy Attorney General  
N. J. Division of Criminal Justice  
(609) 984-1956

**Description:**

These standards have been written to develop a victim centered approach, defined as: the systematic focus on the needs and concerns of a sexual assault victim to ensure the compassionate and sensitive delivery of services in a nonjudgmental manner. The standards provide direction for professionals, counselors, law enforcement officers and other individuals in the State of New Jersey who deal with adult and child victims of sexual assault and also provide a framework for the evaluation of their efforts. These standards were developed pursuant to an amendment to a provision of New Jersey law that ensures the rights of crime victims. The amendment requires the Attorney General to coordinate the establishment of standard protocols for the provision of information and services to victims of sexual assault and make these protocols available to victims upon request.

The Standards contain the following chapters:

1. The Physical, Emotional, and Psychological Well Being of a Survivor
2. Evidence Collection
3. Reporting a Sexual Assault and Seeking Immediate Help
4. Quality of Assistance and Treatment
5. Survivor Comment on Services Provided
6. Law Enforcement Officers
7. Rape Care Advocates
8. Prosecutors
9. The Special Needs of Survivors
10. Child Victims of Sexual Assault

The standards are designed around the concept that the medical evidentiary examination will be done by a SANE and each county should develop a Sexual Assault Response Team (SART). In addition to the standards there are a series of recommendations that describe how services should be developed, what activities should be undertaken, and what types of training should be provided.

**Target Audience:**

All members of the community that provide services to victims, or investigate or prosecute sexual assault cases, including professionals and individuals in the public and private sectors.

**Training Program/Policy Statement/Practice Protocol:** 747474746969

Child and Adolescent Sexual Offense: Medical Protocol

**Source:** State of New York, Depts. of Health and Social Services

**Address:** Rape Crisis Program, New York State Department of Health, ESP-Corning Tower  
Albany, NY 12237

**Telephone:** (518) 474-3368

**Description:**

A detailed manual for health care providers who examine and treat child or adolescent victims of sexual abuse. The protocol was originally issued in 1991 and is currently being revised. The protocols are coordinated with the New York State Sexual Assault Evidence Collection Kit and the State's Public Health law which requires all hospitals to provide treatment to victims of sexual abuse and to collect and properly maintain evidence related to sexual offenses. The state of New York requires that hospitals provide staff orientation continuing education, and designate a staff member to coordinate compliance with state law concerning child abuse and maltreatment. The manual was developed with the help of a multi-disciplinary task force. The protocol recommends a team approach to the treatment of sexual assault victims and suggests that communities develop interagency agreements or protocols to establish these teams.

The protocol is intended to assist health care practitioners in minimizing the physical and psychological trauma to victims of sexual assault by ensuring appropriate and consistent treatment in hospital emergency rooms. It should also facilitate proper collection and preservation of physical evidence for potential use in the legal system if there are subsequent criminal proceedings. The protocol offers information on ways to improve sensitivity to the special needs of sexual assault victims, and background and reference materials that should help to integrate improved care with existing hospital procedures.

The Guidelines are intended to provide health care practitioners with:

- The standard of care for the treatment of sexually abused children and adolescents;
- An overview of the dynamics of sexual abuse;
- Comprehensive clinical information to diagnose and evaluate sexual abuse;
- Information to facilitate proper collection and maintenance of forensic evidence;
- Procedures for proper documentation;
- The resources needed to conduct sensitive, coordinated and comprehensive sexual abuse evaluation;
- Information needed to facilitate compliance with New York State reporting requirements;
- Clarification of the purpose and responsibilities of the multi-disciplinary team in child sexual abuse cases.

The protocol has eight chapters dealing with the multi-disciplinary team, documentation, triage, the interview, medical evaluation, case management, reporting and testifying in courts.

There are extensive appendices and a comprehensive index.

**Dissemination/ Usage:**

Disseminated to all hospitals in New York State along with the Sexual Assault Evidence Collection Kit. Training was provided on use of the kits and implementation of the protocol.

**Other Comments:**

In addition to the complete protocol which is provided to hospitals in a three-ring binder, a brief outline (16 pages) is provided in a separate document which can be used as check list by experienced clinicians.

**Training Program/Policy Statement/Practice Protocol:** 747474747070

Building Alliances: A Guide for Health Care Providers, 1996

**Source:** State of Rhode Island Rape Crisis Center

**Address:** 300 Richmond Street, Suite 205, Providence, RI 02903

**Telephone:** (401) 421-4100

**Training Program/Policy Statement/Practice Protocol:** 747474747171

**Web Site:** [www.satrc.org](http://www.satrc.org)

**Description:**

The guidebook is designed to provide healthcare practitioners with information in responding to victims of domestic violence and sexual assault. In addition to materials on domestic violence, the guide contains a chapter on acute sexual assault. The chapter describes appropriate medical treatment for victims of acute sexual assault. The chapter also describes the use of the Rhode Island sexual assault evidence collection kit. The "rape kit" is used with all sexual assault patients seen within 72 hours following the assault.

- The patient does not have to be ready to report to the police to have the exam completed.
- The kit contains detailed instructions for conducting the examination
- Any expenses incurred in conducting the exam, not covered by the patients insurance, will be paid for by RI Department of Health.
- The patient should never be billed for expenses not covered by insurance.

**Target Audience:**

Health care providers in the state.

**Dissemination/ Usage:**

Health care providers who treat victims of sexual assault or domestic violence.

**Training Program/Policy Statement/Practice Protocol:** 747474747272

Coming Together to End Sexual Assault: Conference Proceedings

**Source:** U.S. Centers for Disease Control and Prevention (CDC)

**Description:**

CD-ROM of the proceedings of the First National Sexual Assault Prevention Conference held in Dallas, Texas in May, 2000.

**Training Program/Policy Statement/Practice Protocol:** 747474747373

Sexual Assault Care: A Training Video

**Source:** University of Bern, Institute of Legal Medicine

**Address:** Buhlstrasse 20, CH-3012  
Switzerland

**Telephone:** (00-41) 31-631-84-12

**Web Site:** [www.cx.unibe.ch/irm](http://www.cx.unibe.ch/irm)

**Description:**

The video documents the state-of-the-art techniques in forensic examination and evidence collection involving the sexual assault victim. It provides a detailed, step-by-step guide for the recognition, collection, and preservation of evidence.

The video is designed to maximize the two main purposes of the examination, i.e., providing health benefit to the patient , and providing law enforcement with the greatest amount of information possible.

The video is available in a medical and non-medical version. The latter does not include the actual genital examination.

**Target Audience:**

First responders, physicians, nurses, forensic pathologists, law enforcement professionals, laboratory personnel and other members of the team involved in the investigation of a sexual assault.

**Dissemination/Usage:**

Available though the International Association of Forensic Nurses or the University of Bern, Institute of Legal Medicine.



**Training Program/Policy Statement/Practice Protocol:** 747474747474

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**U.S. Department of Health and Human Services**  
Public Health Service  
Agency for Healthcare Research and Quality



**AHRQ Publication No. 03-R210**  
**September 2003**

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