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Sa/Fe Program: A Rural Health Care Response to Sexual Assault

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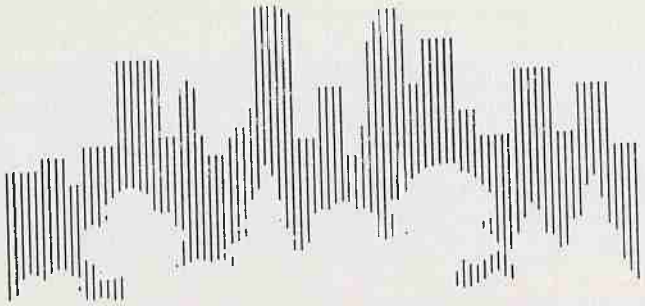
AUGSBURG



C • O • L • L • E • G • E

MASTERS IN SOCIAL WORK THESIS

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Sa/Fe Program: A Rural Health Care Response to Sexual Assault

1999

SA/FE PROGRAM:
A RURAL HEALTH CARE RESPONSE
TO SEXUAL ASSAULT

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CERTIFICATE OF APPROVAL

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"IN OUR CULTURE, POWER IS USUALLY
DEFINED AS CONTROL OVER PEOPLE
RATHER THAN A PROCESS IN WHICH
WE CONTROL OURSELVES AND EMPOWER
OTHERS. THIS UNFORTUNATE SITUATION
CREATES AN ADVERSARIAL SYSTEM RATHER
THAN A CULTURE OF COOPERATION"

JANET MUSEVENI
UGANDA

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Abstract

Governor Arnie Carlson's Minnesota Task Force on Violence found that health care providers lack consistent health promotion for victims of sexual assault, especially in rural settings. Research has shown that efforts to help victims of assault during the initial crisis, and in follow-up care, reduces harmful and expensive residual effects. This study describes the design and implementation of a sexual assault forensic examiner program for rural settings that reduces risks to the victim. A model of health addresses the psycho-social and forensic needs of victims and barriers to expert care, as well as demonstrates ways to reduce costs for health care providers and systems.

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CHAPTER ONE: INTRODUCTION

Statement of the Problem:

Sexual assault is a particularly difficult problem for a victim in a small community. Problems for victims include a lack of access to the expertise of service providers, difficulties preserving confidentiality, and negative attributional judgments. Hospitals that serve these small communities often fall short of addressing these issues effectively from public health, ethical, judicial, and cost-management contexts. The result is unnecessary harm to the well-being of the victim, and subsequently to their families and those around them, as well as to the systems providing their care. In addition, judicial and public health efforts to reduce violence and it's residual effects are thwarted.

Thesis Focus

The primary purpose of this research is threefold:

*To examine the barriers to effective medical-legal services to victims of sexual assault in a rural setting.

*To develop viable options for improving these services in a rural medical setting.

*To design and implement a program that provides viable options to ensure appropriate medical-legal evidence collection, therapeutic care, and health promoting

care for the victim of sexual assault seeking services in a rural setting.

Each of the underpinnings to the identified problems is explored through review of practice guidelines, medical-judicial implications of evidentiary exams, psycho-social implications, preventative education, the physician's role, and cost-efficiency of service provision. Additional underpinnings are explored which address international implications, the role of collaboration, and the moral/ethical dilemmas of use of the "Morning After Pill" in a catholic hospital and the qualifications of a forensic versus nurse examiner. The goal, then, is to integrate the information into a model of health promotion that improves services to sexual assault victims.

Scope of the Problem

In January, 1996, Governor Carlson announced the results of his Task Force on Violence as a Public Health Problem (State of Minnesota, 1996). The recommendations and goals from this Task Force are very timely and offer an effective framework. The Governor's Task Force was developed to deal "specifically with the role of health care providers and organizations in preventing violence and working with victims of violence effectively and appropriately" (p. 1).

The need for such an approach emerges from the alarming statistics that indicate a rise in reported rates of domestic violence and sexual assault with subsequent, and at times, devastating impact on the individual and families. Such persons are most often damaged by this violence psychologically, economically, and/or physically. The

increase in sexual assaults is demonstrated by reviewing the number of reported rapes. In 1987, Minnesota had 1,445 reported rapes. Six years later, 2,713 were reported, revealing an 87% increase (State of Minnesota, 1996). This still under reports those impacted as it is not only the individual and family who are negatively impacted, but also public safety and -- as indicated in the Governor's report -- increased costs to the health care system.

The Task Force, concluding a five-month investigation, defined violence as follows: "Violence is the threatened or actual use of force against a person or a group that either results in or is likely to result in injury, death, emotional damage, or coerced behavior" (Governor's Task Force, 1996, p. 5). On this basis, the Task Force identified relevant statistics indicating increased violence in Minnesota, the costs of violence, and the role of health care organizations and health care professionals in the prevention and treatment of the effects of violence.

The Task Force's "Action Plan" includes the following proposals: A larger coalition on violence to address statewide and regional efforts; data collection and research initiatives on violence-related strategies addressing the workplace; plans to improve health care coverage and payment policies related to services following acts of violence; guidelines for professionals who provide services related to violence; primary violence prevention initiatives; service coordination of health care-related efforts with other violence initiatives; and funding strategies.

The research presented here, draws on those recommendations and strategies for the development of a sexual assault service program within a rural medical setting which would promote effective treatment of victims, provide reliable medical data for the judicial process, and help management of the health care costs. Most importantly, the

distinct needs of the victims and their families will be considered with specific guidelines for implementation of health care services.

It is important to note that the impetus for this project came from "the field," the interdisciplinary service providers who first identified the need for reformatting medical response and psycho-social follow-up to sexual assault victims within Dakota County. Based on their findings, they requested that hospital representatives work with them to develop a plan for health care industry "buy-in" to address the problem and to improve collaborative efforts that address sexual assault as one form of community violence in a public health context.

The proposal in this thesis is for the development of a rural-based program adapted from the Sexual Assault Resource Service (SARS). SARS is a Sexual Assault Nurse Examiner (SANE) model developed in Hennepin County, and now used in other parts of the country, to address the medical, legal, and psycho-social needs of victims of sexual assault. According to Charles Diemer, Chief Deputy in the Dakota County Attorney's Office (1995), it is estimated that approximately only one in ten sexual assaults are reported and only twenty percent of cases reported to law enforcement are prosecuted in Dakota County. One key problem, identified in the County Attorney's Office, is the manner in which medical staff respond to the victims, the quality of evidence collected, and the proper maintenance of "chain of evidence".

In Dakota County, sexual assault cases can be measured and evaluated only by comparative analysis of utilization records of emergency rooms to cases reported to law enforcement, cases charged through the County Attorney's Office, and calls placed to the Sexual Assault Services hotline. Inquiries to these agencies revealed their lack of confidence in hospital emergency rooms to collect evidence effectively that contributes to

an accurate judicial process. Similarly, emergency room physicians and nursing staff indicated concern that they are not meeting the needs of the victims due to time constraints for an effective evidentiary process and infrequent cases requiring evidentiary exams, so that care providers may not remember the chain of evidence, nor effective forensic examination techniques.

The state legislature has recently mandated that each judicial district develop a response plan to address the issue of sexual assaults and responses to victims by the various professionals involved in addressing this crime. Those professionals include law enforcement, county attorney, victim service providers, medical/health care providers, judges, and other court officials. Judge Lynch's (1995) response plan is intended to "improve the quality of the community's response to the crime of sexual assault and to the victims of sexual assault" (p.1).

The key issues to address for improvement of the medical response to sexual assault cases in the emergency room are insufficient assessments and maintenance of a chain of custody for prosecution, the need for improved collaboration with other pertinent agencies, and sensitivity to negative attributional judgment. Good response requires clearly focused and advanced educational training that fosters the ability for health care and other professionals to step beyond their own biases and judgments of the victim's circumstances so that it not harm the quality of service and care offered to the victim. The reality of this problem is well documented (Best, Dansky, & Kilpatrick, 1992; Feild, 1978; Jones & Aaronson, 1973; Pugh, 1983).

One of the goals of this thesis and the actual program implementation is to develop a framework and protocol that ensures accountability on ethical, political, and fiscal levels, given the legislative mandate to address the problem of sexual assault within

the community. The success of such an agenda of accountability can only be ensured by designing a rigorous and practical program. It is important to identify and address the educational needs of the health care providers, the interdisciplinary team of professionals and agencies who are stakeholders in treating victims and making attempts to contribute to crime prevention. Further, successful implementation of such a program depends on clear identification of the problem of sexual assault and how to assess it's residual effects. From this would follow the development of a methodology for treatment of assault cases and a clarification of what factors need to be considered in a health promotion plan.

The role of health care in addressing sexual assault as a public health concern has historically not received adequate attention. It is only in the past twenty-five years that violence against women has been recognized as a public health problem. Such advances were, in large part, due to the successful efforts of the Feminist Movement, and were seen primarily in the professions of law enforcement, social work, education, and public policy. It was not until the early 1980's that the health care industry developed standards of practice for identification, assessment, and provision of care to women who are victims of violence. From this point of view, the role of health care in the forensic (medical-legal) processes must be examined in the context of cost-effectiveness, measures of improved health, and usefulness of the forensic evidence collected. To date, common gaps in service to victims of sexual assault include inadequate forensic evidence collection; the lack of longitudinal studies of the impact of assessment protocols and treatment modalities for the psycho-social needs of victims over time; and lack of research that correlates residual effects of assault with trending and cost-analysis of long-range health care utilization. Understanding the correlation between these gaps in

service and subsequent use of the health care system is a serious challenge to developing cost-effective care.

Planning more effective means of service provision requires current and relevant information to guide local efforts for health care provider-based evidentiary and psycho-social support services for victims of sexual assault. This study is designed to provide pertinent information to planners developing a sexual assault/forensic examiner program in a rural setting. This will improve the chances of successful prosecution while ensuring health-promoting treatment of the victim and service that minimizes the risks of residual effects of sexual assault.

Significance of Thesis Objectives

Health care in the United States, and particularly in Minnesota, is presently experiencing a major paradigm shift for cost-savings via managed care in the form of health promotion and wellness standards, and tighter controls on services rendered, as well as under what circumstances they may be rendered. As a result, there is a growing expectation within this reform for health care providers to accept more responsibility for the health of the communities they serve. The design of this research will explore the role of health care as it addresses an identified public health concern historically not receiving adequate attention, specifically services to sexual assault victims. Attention will focus on cost-effectiveness, measurability of morbidity factors (rates of cases identified through presentation for services, reported to law enforcement, and/or prosecuted judicially), skill development in forensic and psycho-social assessments, collaboration with law enforcement, and providing the judicial system with valid and reliable evidence collection.

These improvements to the judicial process promotes justice. These improvements to the medical process (evidence collection, treatment of injuries, and prophylactic care) positively impact perceptions about accessibility of the services and opportunities for receiving care within a standardized framework that helps reduce risk of disease or untreated injury. It also fosters an improved victim support network which correlates with psycho-social well-being for both the primary victim and secondary victims of sexual assault. The term 'secondary victim' refers to the effect of sexual assault on the family, close friends, coworkers, and others close to the victim. Improved well-being, in turn, reduces risk for disease or somatic, even psycho-somatic, illness. A reduction in the incidences of poor health outcomes result in a more cost-effective utilization of the health care system. In addition, such a program complies with the practice standards set by the legislature, judicial rulings, and health care governing bodies (e.g. American Medical Association, Joint Commission of Accreditation for Health Care Organizations, and International Association of Forensic Nurses).

The need for improved services has been identified, on federal, state, and local levels. Incentive for the health care industry to address psycho-social risk factors within the health care system has evolved more rapidly with the onset of health care reform and managed care directives for health promotion efforts at the local service provider level. The changes in the health care industry can, then, be utilized for the promotion of health for sexual assault victims. Models of care are available, as will be addressed in this thesis, but cost-effectiveness is a challenge. In the following research process, this challenge will be further explored throughout the literature review,

methodology, presentation of findings, summary of actual implementation, and resultant implications. Recommendations for change will be suggested, as well, for further research.

Through the process of examining the existing barriers, exploring and developing viable options for improving services, and designing a program, an actual program was implemented and exists today. Examining barriers resulted in an ongoing process that continues still. These barriers include the following:

*lack of expertise of health care professionals to collect and preserve evidence accurately;

*lack of adequate measures that ensure dignity and confidentiality for sexual assault victims in the current rural health care system;

*time management and reimbursement realities that exist in the ER setting.

Current issues are addressed in Chapter 5: Conclusions and Implications. Each of the points delineated in the 'literature review' and 'presentation and analysis of findings' proved to be significant issues to address and/or barriers to actual implementation of the program. The research and implementation processes spanned five years of seemingly unending work. Volumes of literature were reviewed, as well as interviews conducted, that were not directly utilized in this thesis, but certainly impacted the outcomes of the study and program design.

CHAPTER TWO: REVIEW OF THE LITERATURE

Critical to the understanding of the barriers to an effective health care delivery system and forensic services to sexual assault victims is a comprehensive study of the research literature available. The goal is to integrate the information into a model of health promotion that improves services to sexual assault victims. Barriers specific to a rural setting, or those posing additional challenges due to the variables of a rural setting, may best be resolved through collaborative efforts with other service providers. As the result of collaborative methods, the risk for residual effects, subsequent costs to the health of the individual and society, and avoidable costs of reactionary (versus preventative) medical services may be significantly reduced. Avoiding preventable costs is important in both a managed care health system and a health care system facing the fiscal and service effects of the Balanced Budget Act. The issues identified are described below.

Practice Guidelines

The American Medical Association provides current standards of practice for physicians in the primary, specialty, acute, urgent and emergency care settings. Pediatricians, general practitioners, obstetrician/gynecologists, internists, and emergency medicine physicians are more likely, of all health care providers, to have direct contact with sexual assault victims (American Medical Association, 1995). For this reason, standards have been developed and distributed that address a full scope of medical care, including legal definitions, role of the physician, and general diagnostic and clinical issues. In addition, the AMA guidelines address the acute management of sexual assault

cases including:

* clinical support and history gathering
* meeting the victim's need for a safe environment
* sensitive response and open communication during transitions in the examination process
* guiding questions to pose for gathering health history information
* current protocol for evidentiary exams
* review of rape kit protocol
* guiding questions to ask about the sexual assault

Legal responsibilities and current standards of care are delineated regarding sexually transmitted diseases and pregnancy, as well as treatment in primary care settings, identification of the special needs of males and adolescents, and symptomotologies correlating to the experience of sexual assault. Case histories and a section that is designed to dispel myths are also included in the AMA guidelines on patients presenting as victims of sexual assault (American Medical Association, 1995).

The International Association of Forensic Nurses (IAFN) Sexual Assault Nurse Examiner (SANE) Council has developed standards of practice specific to the field. The standards represent the outcome goals in the areas of medical/nursing, forensic/legal, advocacy/counseling, and educational needs of those receiving SANE services (Sexual Assault Nurse Examiner [SANE] Council, International Association of Forensic Examiners [IAFN], 1996). The Standards set assure that a SANE nurse is providing and meeting a minimum standard of nursing practice in forensic care of the patient. Each forensic nurse must be a registered nurse "with advanced educational and

clinical preparation who practice nursing within the community framework of agency policies and procedures, and with the legal framework of a medically supervised protocol. The forensic nurse must have documentation of Continuing Education or a Certificate of Training in the "Forensic Nursing Evaluation of Victims of Sexual Assault and Abuse" (IAFN, 1996). These standards are delineated in Chapter Four: "Presentation of Findings" in the "Scope of Service" section.

The conceptual framework of forensic nursing models a multi-dimensional and multi-disciplinary approach to care of the victim that is consistent with the systems framework inherent in social work practice. Such collaborative methods are intended to reduce, rather than promote the risk for residual effects. While the focus of the Sexual Assault Nurse Examiner is a brief intervention with follow-up, the role of social work offers a range of services from brief interventions to ongoing follow-up services, based upon the individual program design. Both the SANE and Social Worker should be aware of the local influences upon the care of victims, as well as the broader policy issues and legislation involved. Collaborative efforts should be developed toward reform of systemic barriers facing victims at these levels.

One benefit that the SANE Model offers to the practice of social work is the systematic approach to the rationale, structure, process, and outcomes of each standard of care to the victims served. The result is a focused, measurable, and monitorable service that can provide a sound basis for advancing research in the field.

Ten standards have been developed within a conceptual framework that establishes structure, process and outcome designed for evaluation of quality of care. The first standard applies nursing theory to the SANE model as it's practice framework. This also incorporates "crisis, systems, adaptation, and communication theories, as well as

multidisciplinary sources including nursing and medical, public health, social, behavioral, forensic, and physical sciences, jurisprudence and criminal justice" (IAFN, p. 5). Other standards include data collection, diagnosis, planning, intervention, evaluation, safety, quality assurance, interdisciplinary collaboration, and research.

The mission of the Joint Commission on Accreditation of Healthcare Organizations is to improve the quality of care provided by participating hospitals and affiliated health service providers. This is accomplished through adherence to performance improvement standards while accreditation fosters benefits for the health care facility, as an incentive towards compliance. Standards address such issues as how patients are assessed, provided care and continuity of care, provided education, and ensured overall quality of service through continuous improvement mechanisms from the health care systems that are accredited.

Specific to medical services provided to victims of sexual assault, the Joint Commission on Accreditation of Healthcare Organizations' Patient Assessment standard states that the medical record of such patients must contain evidence of the following: "patient/guardian consent, collection and safeguarding of evidentiary material, legal notification for release of information, and...referrals made to community agencies for victims of abuse" (Paskavitz, Ed., 1996, p.8). Standardized educational materials are to be incorporated into patient education, where appropriate, as means to ensure consistency in the educational process. According to the 1996 intent of JCAHO standards, process improvement efforts must be demonstrated to address high-risk, high-volume, and problem-prone processes.

The new standards set by JCAHO (1996, 1997) for the human resources function within a hospital setting require orientation for forensic staff. Such education

and training is specific to their skills of interaction with forensic patients, but the focus suggests a limited view of forensic staff, as it defines them as 'correctional officers or guards' (1997, HR-13) providing service that may require responding to 'unusual clinical events and incidents...(requiring) clinical, security, and administrative communication' (1997, HR-13). While these standards reflect the need for health care service systems to be prepared for the potentially violent patient, as well as for the need for collaboration with law enforcement and issues of security in the health environment, it does not delineate the human resource need for training specific to ensuring expertise with diagnostics, evidentiary processes, and the unique needs of the victims of interpersonal violence.

This limitation in standards testifies to the current poor outcomes in the medical contributions to victims of interpersonal violence. Social Work can play an important role in agency reform to address such critical issues as access and equitable care for populations at-risk, including victims of rape and other interpersonal violence. Another critical issue for medical social work is public accountability as a means of survival for health care systems in this era of health care reform. Such demands on health care systems may actually pave the way for increased health care responsibility that addresses the bio-psycho-social needs of the community served. With such pressures on a national level, it is anticipated that JCAHO will adjust their standards of measurement accordingly.

Human Resource standards 4.2 through 4.5 do, however, address the need for initial and ongoing evaluation of staff competencies and needs for additional education or training in identified weak areas. This serves to ensure an ongoing process of quality assurance and improvement in the area of staff competency specific to job requirements.

Evidence of staff competency is measured through various means including of in-service and continuing educational records, verification of credentials specific for the job, job descriptions and contracts, policies and procedures, staffing plans, and staff development plans (JCAHO, 1997, p. HR-13).

International Implications

While the focus of this study is to address the needs and tangible responses to those needs of sexual assault victims living in a rural area, the undercurrent of variables involved are, in many aspects, universal issues. Presently, communication mechanisms and accessible transcontinental travel foster a sharing of cultures, economic trades, and even societal ills. That which affects one community may also affect another community, near or far. The interdependence that has developed must be acknowledged and factored into many human development processes.

Violence is one of the social ills that has been identified as transglobal. Many of the sources of violence in one community or nation are also found in other communities and nations. In the international development community, a three tiered concept of violence is identified. These tiers (structural, institutional, and personal) draw from and feed upon the others in a continuous cycle of development. The National Association of Social Workers, in "Overview: Making the Connection between Violence and Development" (1995) identifies structural violence as "avoidable deprivations built into the structure of society based on norms and traditions that subjugate one group in favor of another" (p. 3), while institutional violence represents the damaging effects of organizations and institutions, both official and subsidiary.

Interpersonal violence is identified as acts of violence initiated by individuals upon themselves, individuals or groups of individuals upon another, or organized groups upon others. Various forms of such violence include chemical abuse and suicide, rape and murder, and hate crimes, respectively.

International efforts have been developed through government and private sectors that address the identified needs of 'sustainable human development'. According to the National Association of Social Workers' "Overview: Making the Connection between Violence and Development" (1995), this term has been defined as "meeting the basic needs of all and extending to all the opportunity to fulfill their aspirations for a better life" (p.2). Effective interventions that address issues relating to the occurrence of sexual assault include structural and institutional changes that foster oppression and barriers to access adequate services. These are themes that run through the issues presented in this study, as well. In order to effectively address sexual assault and it's residual effects, change must occur in how and what services are provided to the victims. As will be further explained in this study, effective change includes:

* revision of medical services
* training of medical personnel for forensic examination of sexual assault victims
* collaboration between medical providers, victim advocacy services, law enforcement, and the judicial system
* development of a plan of care that ensures continuity of services

International attention to the subject of violence in general, and sexual assault specifically, suggests a pertinent role for social work. Much can be learned from both the global north (industrialized and wealthy countries) and the global south (poor and underdeveloped nations) pertaining to improvements to individual and social frameworks of 'sustainable human development'. According to the National Association of Social Workers "Overview: Making the Connection between Violence and Development", "violence and poverty obstruct the development of human capital - the term used by economists to describe a nation's collective ideas, labor, knowledge and problem-solving skills" (p. 4). Likewise, the lack of development opportunities is identified as a major contributor to the presence of violence, despite the fact that violence against women is found in many cultures irregardless of socioeconomic status and class. Violence against women is only recently becoming recognized as a worldwide and pervasive problem. This, otherwise known as gender violence, was first raised as a global issue in 1975 at the Mexico City World Conference of the International Women's Year, and refined at the 1980 and 1985 World Conferences.

Gender violence is rooted in belief systems that ensure male domination and female subordination. These belief systems can be found in political, economic and social components of societies and interactions between societies, irregardless of whether the country is from the Global North or Global South. Such beliefs are so pervasive, in fact, that maltreatment of women, including domestic violence and rape, has not historically been recognized as abuse. According to the National Association of Social Workers "Violence Against Women and Children: Beyond a Family Affair", primary factors contributing to the abuse include male domination, militarism, domestic violence, changing political and economic systems, and lack of development opportunities (p. 5).

Theories about male domination as a contributor to violence against women vary. One theory suggests militaristic values shape the framework by which boys are raised to be leaders, using violence as a means of gaining and maintaining control. In "Violence Against Women and Children: Beyond a Family Affair", the National Association of Social Workers suggests that another theory holds value which states that women, at baseline, lack economic resources which increases their vulnerability to violence (p. 5). Militarism, as a primary source of accepted violence against women, includes rape by occupying troops. This is slowly becoming recognized as a war tactic or rite of battle conquest. Recent attention to the post-traumatic effects of sexual assault upon Japanese women from World War II and the women and children from the Bosnia/Croatian war are examples of this use of violence as an unnecessary destructive force that holds long-term residual effects and should no longer be overlooked or tolerated.

Domestic violence is noted by Stark and Flitcraft (1996) to be a strong corollary with sexual assault. In a study they conducted, it was found that half of the rapes identified involved women at risk for domestic violence. Likewise, they found that one third of the women in one two year study who presented at the Emergency Room for sexual assault also had documented histories of domestic violence (p. 11). In "Violence Against Women and Children: Beyond a Family Affair", the National Association of Social Workers identifies the long-term residual effects of such violence, both to the women and their children, when "almost universally, the social impulse is to preserve the family at all costs, even if this compromises a woman's safety" (p. 6).

Changing political and economic systems are catalysts for a disruption of the status quo. In the process of change, individuals, families, communities, and nations are

thrown into a new set of rules to which they must adjust. For women and children, this often poses greater risk than for men due to their lack of resources from the onset. Without the proper resources for meeting basic needs, it is not uncommon for women and children to present as the most vulnerable in the struggle for survival.

When economic development cannot produce opportunity or hope for a community, it creates tension, particularly for men and boys who are identified as the leaders of their families. In "Violence Against Women and Children: Beyond a Family Affair, the National Association of Social Workers identifies "underdevelopment juxtaposed with a fiercely materialistic culture is seen by some as feeding violence in the U.S" (p.6). In many countries, young girls go to the streets for their survival. Each country varies, but in some countries the girls are sold into prostitution with endorsement from their parents as a means of economic contribution to the family.

Clearly, addressing sustainable human development must incorporate the issue of violence against women and the devastating effects. Much research has indicated that the protection and empowerment of women equates in societal improvements. One example is the recognition in the United Kingdom that fostering good for the children must also include care for and protection of the mother.

In addition to the recognition of violence as a global problem, the effects of trauma are likewise global. Post-traumatic stress disorder (PTSD) is an attributed after-effect for survivors of rape, victims of torture, political refugees, alcoholic homes, domestic violence, and veterans of war. Some of the effects of trauma include a flight response, identification with the aggressor, and truncated moral development. Counter-acting these effects, a healing response should include empowerment (developing trust, speaking the truth, and expressing grief), community cooperation,

apology and forgiveness, and conscientization and democracy building efforts. The role of community reflects the support system and sense of connectedness or belonging that a victim has within her community. Isolation, or the sense thereof, can only foster the residual effects of sexual assault and other violent crimes against women.

It is in these opportunities for prevention and early intervention that social work can work within the health care industry to effect change for the sexual assault victim. Therefore, recognizing the globalization of risk factors, the prevalence of sexual assault, and the associated residual effects, lessons can be learned from other communities and countries as we address these same issues in rural U.S. communities.

Medical-Legal Implications of Evidentiary Exams

In a retrospective study conducted by Rambow, Adkinson, Frost, & Peterson (1992), 182 cases were reviewed of women who had agreed to an evidentiary exam when seeking medical attention in one urban hospital following experience of rape. The study focused on associated injuries, evidence of male secretions (sperm and acid phosphatase), venereal disease, pregnancy, and the legal outcomes. One-half of the women had suffered injuries in the assault with 10% sustaining vaginal or perineal injuries, one-third of which appeared asymptomatic on presentation but required treatment. The evidence of physical trauma significantly correlated with successful prosecution, more than the presence of male secretions. The risk for sexually transmitted diseases and pregnancy were also studied. These risks of injury, disease, and pregnancy are the most common physical concerns following a sexual assault. In a study by Ruch, Amedeo, Leon, & Gartrell (1991), four hypotheses about repeated sexual victimization and trauma change were based on the premise that physical trauma affects the level of psychological trauma

for the victim. Ruch, Amedeo, Leon, & Gartrell (1991) further suggest that an initial response of fear, depression, self-blame, (and) pre-existing interpersonal problems also are important factors impacting the post-rape level of trauma experienced by the victim.

Psycho-Social Impact

Rape results in psychological trauma that is often overlooked by health care professionals. Research on these aspects of injury suggest that the present standard emergency room protocol is not cost-effective, as it does not, generally, provide early intervention services critical to prevention of costly long-term residual effects. In a study by Vernon and Kilpatrick (as cited in Santiago, McCall-Perez, Gorcey, & Beigel, 1985), it was found that in the first 24 months following a rape, anxiety, fear, and depression were evident immediately after the rape and at a level consistent with clinical depression. Three to six months later, the clinical symptoms were significantly reduced, but at 12-, 18-, and 24 months post-rape, the women were found to have a significant amount of fear and anxiety as compared to a control group (see Figure 1). The results of this study indicate that the experience of sexual assault has long-term effects.

Santiago, McCall-Perez, Gorcey, & Beigel (1985) tested the effects of sexual assault beyond two years for residual effects. In this study, a control group was matched demographically with a group of sexual assault survivors. Using a standardized interview format, several tests were used to measure levels of depression, anxiety, and fear. The rape victims also completed an "impact interview scale" to measure the impact the trauma of the rape has had on other aspects of the woman's life. The Beck Depression Inventory indicated the rape survivors were significantly more depressed than the control group ($t = 4.80$, $df = 135$, $p < .01$). The Fear Survey Interview indicated a total fear score,

Psycho-social Impact of Trauma Over Time Is Overlooked

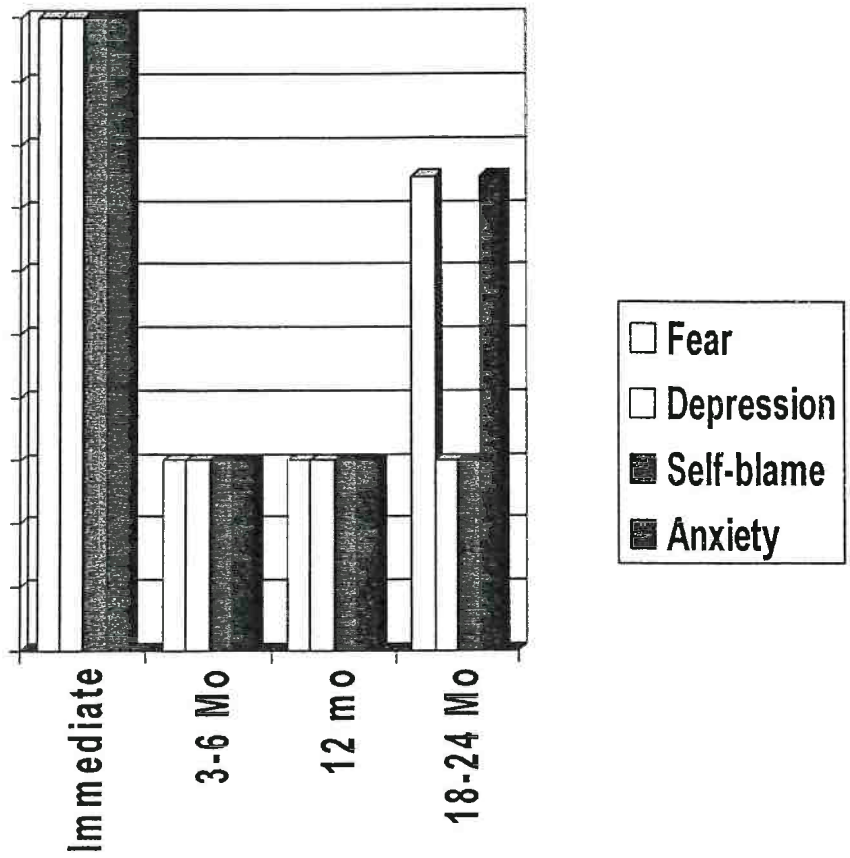

Figure 1.

miscellaneous fear score, failure fears, rape fears, and social fears were significantly higher than the control group scores. The Spielberger interview, A-state scores (measuring the emotional state of the subject at the interview) indicated no difference in anxiety between the research and control groups at the time of interview. But the A-state scores indicated greater anxiety was present in the research group over an extended period of time.

Ten variables were identified that may impact the research group's response to the rape, both in the short- and long-term. Examples were beatings, torture, whether the rape was the victim's first sexual experience, or whether the victim was a prior victim of sexual assault. Through a statistical test (a two-tailed t test), it was determined that prior victimization was the only one that showed significantly higher scores of depression, anxiety, and fear when comparing the research and control groups.

Ruch, Amedeo, Leon, & Gartrell (1991), tested the hypotheses that (1) trauma increases in previously assaulted victims while decreasing in victims of first-time assault; (2) differences in outcomes between the two groups reflected features of the attacks and not of the survivor's sexual victimization history; (3) any differences between the two groups were due to differences in mental health and/or substance abuse history; and (4) prior sexual assault affects short-term trauma change only under certain conditions, i.e., when pre-existing mental health or drug problems exist or when the assailant is known to the victim and/or no physical force is used. Results were determined through a trauma assessment protocol used in the emergency room. The use of an interview schedule provided collection of sociodemographic data, details of the assault, and trauma symptoms presenting at that time. Information was evaluated and discussed at a follow-up meeting with the victim to discuss assessment measuring

behaviors, emotions, and cognition variables of the victims. Inter-rater reliability was considered in the evaluation process. All of the proposed hypotheses were supported with the exception of the second hypothesis.

Ruch, Amedeo, Leon, and Gartrell (1991) focused their study on the risks for and features of revictimization. Over a two-year period, they conducted panel interviews with 184 female victims seeking services at a sexual assault treatment center. Their findings modify the hypotheses of Santiago, McCall-Perez, Gorcey, & Beigel (1985) that suggests a prior sexual assault history is the only rape situation variable notably impacting the psychological state of the woman. Ruch, Amedeo, Leon,& Gartrell (1991) suggest, however, that increased trauma impact correlates with previously assaulted rape victims primarily when there is a preexisting mental health or drug abuse problem and/or when the assailant is known to the victim and/or physical force is not used in the sexual assault. Ruch, et.al., also suggest similarities in trauma level between features of prior victimization and prior mental health or substance abuse problems at the time of the recurrent sexual assault. These are not factors identified in the Santiago, et. al. research findings.

Preventative Education

Hanson and Gidycz (1993) suggest that once a woman is sexually assaulted, she enters a cycle of risk for revictimization for which escape is difficult. They designed and evaluated a sexual assault prevention educational service addressing acquaintance rape on a college campus. They divided 360 female college students into a control and a research group to measure the effectiveness of sexual assault education as a means for reducing risk for future incidence of sexual assault. Their findings indicated that the

education was not effective for women who had a prior history of sexual assault, but it was effective for women without a prior assault history. For those women, high-risk dating behaviors were reported to have decreased as the women's knowledge about sexual assault increased. Hanson & Gidycz (1993) suggest that future research examine factors that create and maintain the cycle. Ruch, Amedeo, Leon, & Gartrell (1991) found their case study results to reveal that prior assault victims with mental health and/or substance abuse problems reported suicide attempts and nervous breakdowns after their initial assault. Ruch, et.al.'s conditional data analysis defends the hypothesis that mental illness and substance abuse can place a woman at risk for critical and long-term suffering with risk increasing with each assault.

Ruch, Amedeo, Leon, & Gartrell (1991) found that more than 50% of victims reporting rape or attempted rape also reported revictimization. Hanson & Gidicz found that women experiencing sexual assault in adolescence are twice as likely than women without such history to experience rape in the college years. Both research groups looked at studies on prevalence rates of revictimization and found different findings. Ruch, Amedeo, Leon, & Gartrell (1991) found Johnson's (1980) research to support a 20-30% prevalence rate, while Hanson & Gidycz (see also Kilpatrick, 1985; Russell, 1984; Sorenson, Stein, Siegel, Golding, & Burnam, 1987) found a 5-22% prevalence rate.

Physician Role

Regarding the role of health care in the prevention, evidentiary collection and treatment of sexual assault victims, one factor to examine is the physician's role, and more importantly, his/her perception of that role in the health promotion process. In a study by Wechsler, Levine, Idelson, Schor, & Coakley (1996), primary care physicians'

perceptions and practices were examined (note: this study was targeted at general practice and, therefore, not specific to the care of patients who have been sexually assaulted) to better understand the response shown by physicians to the Surgeon General's recommendations for health promotion. A comparison was done on surveys completed by primary care physicians practicing in Massachusetts in both 1981 and 1994. The purpose of the study was to examine the extent to which primary physicians agreed with the Surgeon General's recommendations for physician responsibility in health promotion efforts, and the degree to which they perceived themselves and their profession to be competent and in a position of power to influence patients in their self-care practices.

The value of understanding the physicians' role in this context is in the patriarchal structure of health care that has historically given physicians the power to influence the lives of their patients to a degree they may not have fully understood nor appreciated. Similar patriarchal structures or dynamics are common in abusive relationships and incidences, as well (Stark & Flitcraft, 1996). The power physicians often carry in the helping relationship can be a source of revictimization for the woman who has experienced abuse or violence, particularly if the perpetrator was an authority figure to the victim. Negative transference and countertransference, if not acknowledged and addressed, can prove counterproductive to the efforts toward health promotion and disease prevention intended by a well-meaning but unknowing physician. Negative transference refers to hostile "emotional reactions that are assigned to current relationships but originated in earlier, often unresolved and unconscious experiences" (Barker, p. 385). Counter-transference "is identical to transference except that it applies to the feelings, wishes, and defensive operations of the social worker or therapist toward

the client" (Barker, p. 84). Gaining an understanding of the physician's perceptions about professional responsibilities, power, and commitment to the well-being of the patient is a first step towards the commitment to health and well-being of that patient.

A survey was conducted of 800 physicians. Follow-up questionnaires and phone calls were used to maximize the degree of response. Fifty-two percent of those 800 physicians approached responded in the 1994 study. Specific criteria was used to ensure the respondents shared comparable demographic and practice backgrounds.

Findings correlated with respondent variances, including their beliefs about health promotion. The priorities identified in 1994 were identified by a 4-point scale value of 14 health-related behaviors rating importance for health promotion efforts. It is noteworthy, here, that sexual assault and other forms of interpersonal violence were not specifically identified among these priorities. These priorities did differ significantly, however, from 1981 issues to those identified in 1994. The determination of targets for physician prompted health promotion was based on the prioritization values of society at that point in time. Physicians set their priorities based upon the focus and demands of the market economy.

The physicians in this study did show an improved use of routine questions targeting patient health behaviors. Confidence levels also improved for physicians addressing health promotion with patients. Confidence was measured by three means: 1) extent of perceived competency counseling patients; 2) individual level of perceived success effecting change in patient behaviors; 3) perception of physician's ability, as a whole, affecting behavioral change in patients. Overall, physicians surveyed responded that it is their role to educate patients about health-related risk factors. More physicians identified their role as inclusive of talking with patients about personal stressors (e.g.,

sexual assault) providers of emotional support, knowing about or triaging patients to community services/resources or getting families involved in the care process.

The results of Wechsler, Levine, Idelson, Schor, & Coakley's (1996) study point to some of the gaps in service provision to sexual assault victims, even though this patient-type was not specifically identified in the study. For example, considering Hanson & Gidycz's (1993) findings, the perception and practice of physicians that avoids addressing psycho-social needs must be targeted in light of the research findings. In Hanson & Gidycz's (1993) study, indicators of the importance of preventative education regarding sexual assault and skill-building in self-protective behaviors would suggest need for primary care physicians to reconsider their triage role. This correlates with the identification by Wechsler, et.al., that "physicians are in a unique position to influence the behavior of patients" (p. 96), thus suggesting that attaining the national goals for health promotion requires their support and active participation. Likewise, the significant findings of Santiago, et.al., and Ruch, et.al. suggest correlation between sexual assault and residual psychiatric and psycho-social functioning. As noted by Wechsler, et.al. above, the physician is in a powerful and influential position to effect positive change in the lives of patients. Psychiatric problems are as important as physical well-being in the functioning of the individual. It, therefore, should not be ignored in the efforts toward health promotion and preventative medicine.

Cost-Efficiency of Service Provision

In the process of program development, one of the key questions that must be asked is whether or not the proposal can be implemented and managed in a cost-efficient manner. This must be balanced, of course, with a high quality standard.

The following research data addresses one of the key questions in the development of a sexual assault forensic examiner program: "what is the most cost-effective means of housing the program or services"?

Williams (1996) studied a convenience sample of six hospitals in an exploratory study of emergency department charges and costs. Monthly data was reviewed from 1991 to 1993. Initially, the design focused on the ratio of marginal costs to the average cost of services provided. The intent of the study was to determine whether the use of the emergency room for non-urgent needs is cost prohibitive when considered in the context of marginal costs beyond urgent care cases. Due to the significant amount of time involved for physician and nursing personnel in the evidentiary collection process, such cases are a concern from both fiscal and psycho-social perspectives.

The management of the Emergency Department services are carefully monitored in light of managed care reimbursement structures. Cases which are not of an urgent, even of a life-threatening nature are referred to urgent care or primary care clinics whenever possible. While sexual assault evidentiary exams can be performed in a primary care or urgent care clinic, self-blame or shame associated with the assault may limit help seeking when barriers to access are perceived by the victim. Calling for a referral or preauthorization to receive medical help can be an intimidating process for the victim. Likewise, barriers to access may negatively effect the evidence collection needed for successful prosecution, by preventing a victim from seeking help immediately. While awaiting clinic or urgent care hours, she may shower or, otherwise, inadvertently destroy important evidence. Williams' study points out that the marginal cost of adding an additional visit to an already open and staffed ER may actually be more cost-effective

than extending clinic or urgent care hours to a twenty-four hour service. Utilities and wages are an additional cost required of non-urgent service providers if care is to be provided in a timely manner.

Evidentiary exams, by their very nature, require a timely, knowledgeable, and skilled response. Provision of services and information for patients, particularly when trauma is involved, requires consistency, knowledge, and skill by the service provider. Centralizing the evidentiary and triaging process fosters quality and comprehensive service provision. Centralizing services in a setting accessible to patients at all times and in a location easily identified by the patients as the primary source of this type of care enhances the likelihood that victims will seek services they might otherwise not pursue further.

Community Health Collaboration for Program Development and Implementation

Utilization of collaborative relationships with other service providers has become an important means by which health care providers are able to effectively promote health and wellness in the communities they serve. Changes in the health care industry have strengthened managed care organizations and the necessity for cost-containment and cost-effectiveness as a means of survival in an increasingly competitive market. As part of their strategic planning, hospitals now have incentives from managed care organizations, with whom they contract, to promote health and reduce injury and illness rates within the communities served. As a result, programs and services

are developing that address high risk, high volume, and/or high cost diagnoses or health behaviors. According to Boex, Cooksey, and Inui (1998), the current population health-based model promotes stepping beyond traditional disease management toward "mobilizing community resources for success around the determinants of health" (542).

The use of collaborative relationships is recognized as an important mechanism by which providers can attain their health promotion efforts in an industry facing increasing financial restraints. According to a recent Joint Commission publication, Mays, Halverson, and Kalzuny (1998) identify collaboration as "a strategy for improving quality, efficiency, and competitiveness" (p. 518). Mays, et. al further delineate the advantages which include "improving health outcomes, enhancing efficiency, sharing the financial risks of new products and services, and expanding market share" (p. 518). Marketplace incentives are anticipated to increase for hospitals that successfully foster community collaborations toward healthier communities.

The uniqueness of a health promotion and injury/illness reduction model of health is the recognition of the interrelatedness between the physical, cognitive, emotional, social, and environmental components of a whole person and his or her state of health. For this reason, healthcare providers are finding it advantageous to collaborate with service providers from other sectors to pool resources and strengths to reduce injury and illness risks within their targeted populations. Boex, et. al's conceptualization fosters an understanding and the ability to take a proactive, health promoting approach to "the ways that personal behaviors, the environment, social interactions, economic conditions, physical function, psychological state, and susceptibility to disease can all affect health or well-being" (p. 543). Successful reduction of high-risk health problems is dependent, in part, on the recognition that poor health outcomes are inter-related to a

person's environment and social system.

Medical Social Work can be a leader in this collaborative paradigm shift. Incorporating core social work functions into the collaborative process will maximize outcomes and successful attainment of goals. Core social work functions include those listed (see Figure 2). Each of the core social work functions address the critical issues facing the health care industry today (see Figure 3).

Collaborations occur within various healthcare sectors, as well as with other community-based or public service entities. Types of investors and collaborative strategies vary based upon a number of factors, including balance between benefits versus costs for each alliance participant. Mays, Halverson, and Kaluzny (1998) identified six basic activities as the focus of collaborative relationships. Of these, collaborative benefits for program development of a sexual assault forensic examiner program include: (a) improving access for the uninsured and underinsured, (b) implementing population-based strategies to improve the quality and efficiency of medical practice, (c) implementing community-based health promotion and disease prevention efforts, and (d) improving the system of care through policy development, workforce training, and research initiatives. (p. 520). As above mentioned, the role of social work provides expertise to successful execution of these activities.

Models for collaborative relationships do vary, as do the motivations and levels of commitment of the members engaging in them. Hospitals embracing a collaborative relationship together to achieve a common goal are often competitors, in the larger sense, for marketshare in the communities served. While the benefits of collaborating might include the ability to serve a broader based population with enhanced services, one of the challenges may be bureaucratic delays in decision-making processes.

CORE SOCIAL WORK FUNCTIONS

- POPULATION ANALYSIS
- ACCESS MANAGEMENT
- HEALTH PROMOTION
- RISK SCREENING AND MANAGEMENT
- PSYCHO-SOCIAL CARE
- ADVOCACY AND JUSTICE PRESERVATION
- DISEASE MANAGEMENT
- UTILIZATION MANAGEMENT
- CASE MANAGEMENT
- CONTINUITY MANAGEMENT

Figure 2.

CRITIAL ISSUES IN 21ST CENTURY HEALTH CARE

- FINANCING
- PREMIUM DISTRIBUTION†
- COST CONTROL
- ACCESS
- EQUITABLE CARE
- QUALITY MAINTENANCE
- END OF LIFE MANAGEMENT†
- DIVISION OF LABOR†
- INFORMATION MANAGEMENT
- PUBLIC ACCOUNTABILITY

† Not addressed in this thesis

Figure 3.

As strategic planning priorities, systems, and cultures of each organization interface, the organizations themselves must establish boundaries within their new relationships. According to Kettner, Moroney, and Martin (1990), the principal purposes of budgeting within a systems framework include the areas of planning, management, and control. Establishing a state of equilibrium between participating organizations in these areas extends beyond the budgetary process and into the collaborative relationship in general. In a recent study of collaborative relationships completed by Mays, Halverson, and Kaluzny (1998), participating hospitals reported that their experiences with collaboration included "competitive pressures within the alliances [that] can limit the scope of activities to be achieved and slow the pace of decision making and action" (p. 522).

A primary goal of community intervention and improvement of health fosters collaboration between a broad sector of service providers and organizations. Beyond hospitals, other service providers include grass roots organizations; local, state, and federal agencies or service entities; health and human service organizations; advocacy groups; and associations. Specific to addressing the problem of sexual assault, common collaborative relationships exist between hospitals, law enforcement, victim advocacy agencies (specifically state certified sexual assault agencies), and the County Attorney's Office. Secondary collaborations might incorporate mental health agencies, family planning agencies, domestic violence advocacy agencies, schools, county social service departments, victim/witness advocates, public health, spiritual care providers, chemical health intervention services (including Detoxification Centers) and governmental regulatory agencies.

The presence and participation of both primary and secondary collaborative partners is ideal to the benefit of the victim/survivor entering the 'system'. A

comprehensive review and coordination of all optimal services to victims of sexual abuse, both during initial and later stages of adjustment and healing, promotes the greater likelihood that the victim will experience a more complete adjustment to the trauma and associated losses. This accomplished with a sense of wholeness and minimal residual effects for the sexual assault victim is our ultimate goal.

Nurse Examiner VS Forensic Examiner

Throughout the course of this study, the term 'forensic examiner' has been used often. This was intentional in order to shift the possibilities of program staffing to acceptable alternatives other than registered nursing. In the current health care industry, a common response to the demand for reducing expenditures has been to reengineer and/or downsize staffing. Registered nurses have been replaced by unlicensed assistive personnel (UAP) in most hospitals nationwide. Much controversy has been raised as to the true cost-effectiveness and increased liability risks that this alternative brings. The exploration of this alternative for a sexual assault forensic examiner program stems from two factors: the high cost of program implementation and operation as compared to the limited revenue options, and the legal acceptance of a forensic examiner in the judicial process based upon training and expertise rather than educational background. Just as CEO's have implemented reengineering in many hospitals, the program development process for this study has examined similar considerations.

According to the literature reviewed, outcome studies are not yet readily available and much research is still needed. As a result, anecdotal information has been

used to raise the points of support and criticism for this creative option for staffing. The goal, of course, in reengineering, is to develop the skills needed into one person's role rather than maintain several specialty providers to complete these tasks. In the role of forensic examiner for sexual assault cases, the nurse's ideal professional background is in OB/GYN, psychiatry, emergency services, and/or public health (Ledray, 1992). Most of these nurses will require additional training, beyond the scope of the forensic examination, to develop competency in completing pelvic examinations, blood draws, and recognition of normal versus abnormal findings. Because these specialized skills are not inherent strengths in all registered nurses, one might raise the question 'what barriers exist that prevent another professional (e.g. an LISW or LICSW Social Worker with a health care background) from successfully developing these same skills through the same training and, thus, combine their professional expertise into the victim's need for a continuum of services?' Justification can certainly be made for providing a rural community that has low volume/high impact concerns with the most comprehensive package of services at the least cost per full-time equivalents (FTE's).

According to the SANE Council of the International Association of Forensic Nursing (1996), the practice area for forensic examiners falls clearly within the realm of nursing practice, as follows:

> The practice is defined as professional nursing care that assesses, evaluates, diagnoses, and implements care to restore and promote the bio/psycho/social health of the victim throughout the forensic medico-legal evaluation process following a sexual assault. The nursing action includes but is not limited to:
>
> 1. Obtaining the health history and reported criminal act;
> 2. Providing crisis intervention;

3. Performing a physical examination;
4. Inspecting and evaluating of any area of the body of a victim who is reporting sexual assault or molestation;
5. Collecting evidence;
6. Treating (by medical protocol) and/or referring for medical treatment;
7. Documenting objectively the findings by the evaluator that are and are not consistent with the complaint of sexual assault; and
8. Interacting with clients in an objective and neutral manner that promotes informed consent or informed refusal with regard to collection and/or available treatment options (p. 2).

According to Polly Gerber Zimmermann, author of "Increased Use of Unlicensed Assistive Personnel: Pros and Cons", UAP's have been useful to supplement nursing responsibilities with other strengths. However, the extent of cost-savings has been called into question when all factors are figured into the fiscal equation. A forensic examiner who has a background as a mental health provider/social worker, for example, is able to provide skilled crisis intervention and ongoing follow-up services beneficial to the victim's healing process. These are important to the full scope of care that should be accessible to victims during their healing process. However, the needs presented by the victims at the Emergency Department may be more forensic and medically specific. For example, victims may need assessment and treatment for injuries incurred during the assault. Likewise, the fear of becoming pregnant and/or contracting a sexually

transmitted disease may be forefront in the victim's mind (Ledray, 1997). The benefits and problems inherent in the use of alternative staffing must be weighed against each other.

Use of a physician is costly and time-consuming based upon their Emergency Department responsibilities to other patients (Ledray, 1997). Use of a Physician Assistant or Nurse Practitioner is suggested due to their expanded scope of service from nursing, albeit their charges will typically be higher than that of a registered nurse and their services must be supervised by an M.D. However, a registered nurse can provide the skilled services needed for examination of injuries, evaluation for sexually transmitted infections (STI) and pregnancy risk, and assessment for suicide risk and/or mental health crisis as experienced by the victim. According to Linda Ledray (1997), less than 27% of survivors have even minor injuries, less than 3% have injuries requiring treatment, and less than 1% have injuries requiring hospitalization. Thus, a registered nurse would be required to utilize the services of a physician for further examination and treatment of injuries in only about 4% of rape victims, as well as for obtaining prescriptions for the appropriate prophylactic medication.

Use of a mental health provider and/or social worker with forensic experience as the sexual assault forensic examiner may actually prove to be more costly than a registered nurse who has crisis intervention skills as noted above. A mental health provider does not have the professional training for physical assessments afforded to

nurses in their training. As a result, reliance on the E.D. physician may be greater for the benefit of the victim and liability reasons. So while the mental health provider or LISW or LICSW social work background may be able to perform the forensic exam, it would appear that a missing component would be the nursing theory and full scope of service that nursing brings that may best meet the victim's needs, as above stated, surrounding the possibilities of injury associated with sexual assault, pregnancy and contraction of S.T.I.'s, and the side effects associated with prophylactic treatments. This does not, however, preclude social work from providing leadership in service collaboration that ensures continuity in psycho-social support for victims adjusting to survivorship.

Religious-Based Hospitals and the Morning After Pill

Developing a sexual assault forensic examiner program in a rural setting comes with it's own set of unique challenges. For example, a small community that has historically been closely knit will often share common values and religious norms. Factors influencing such shared beliefs and values include the sharing of deep roots in common family histories, as well as the limited resources and options available in a rural setting, and the peer pressure inherent in a small tightly-knit community.

One issue related to care of the sexual assault victim often poses a significant challenge for the health care provider, particularly in a smaller community. Standard rape treatment protocol includes use of the 'Morning After Pill' (the contraceptive Ovral prescribed in a calculated higher dose within a 72 hour period of time). The 'Morning

After Pill' is often misunderstood and confused with the high dose of estrogen called Mifepristone (RU 486) which is abortifacient. In small communities, the hospitals are often tied to a religious group. In many instances, particularly in the Catholic-based hospitals, birth control options are not offered or practiced in accordance with facility bylaws. For many health care providers, standard procedure of care for the rape victim has been challenged by moral or religious beliefs held by the health care facility. Most health care providers are, then, forced to turn the victim away regarding prophylactic care for pregnancy risk. In the American Journal of Hospital Pharmacy (1990, Vol. 47, pp. 395-396), a court case is cited regarding the ethical and legal responsibility of a 'catholic' hospital to, at the very least, inform rape victims of the availability of the 'morning after pill'. In the state of California, (Brown v. Daniel Freeman Memorial Hospital, 256 Cal. Rptr. [1989]), it was found that the patient's (rape victim) right to self-determination in her medical care is compromised when the moral and religious values of the health care facility and/or provider impose those beliefs on the care she receives. According to this case law, when a female patient is at risk for pregnancy as a result of rape, the hospital is not required by law to provide the post-coital prophylactics, but it is required to provide the information necessary for the victim to access the prophylactics elsewhere.

In the "Ethical and Religious Directives for Catholic Health Care Services" (1995), a two-fold purpose was delineated to promote ethical behavior in health care that promotes dignity and to provide leadership on moral issues facing Catholic health care. Specific to the care of the sexual assault victim, it embraces a compassionate and understanding approach, encourages cooperation with law enforcement and care of the victim as a whole person (physical, psychological, and spiritual care). The Directive states support for the victim who chooses to treat the risk of pregnancy prevention within

the boundaries of appropriate medical assessment that ensures the prophylactic treatment is not abortifacient in nature.

Catholic health care facilities (and other religious health care facilities) then have an ethical and legal responsibility to provide the sexual assault victim with adequate information and a thorough assessment to determine pregnancy risk as result of the rape and access to appropriate prophylactic treatment options. The challenge is, then, to educate not only the victim and her family, but also the health care providers and facility leadership about the Church's stance on prophylactics or pregnancy prevention for the sexual assault victim as well as to dispel any myths about pregnancy prophylactics options. In light of the risk for revictimizing the sexual assault victim, as well as incurring undue liability, it is in the best interest of all involved if a common ground can be established by which the victim is provided education, choices and access to appropriate care, whether or not the facility, itself, provides it. An additional risk to the subject of "access" in a rural community is the lack of accessibility of a 24-hour pharmacy that can provide the pregnancy prophylactics for appropriately screened victims in a timely fashion. Rural religious-based hospitals who do not have the policy to distribute pregnancy prophylactics to patients, including sexual assault victims, may need to address the ethical considerations of "accessibility" (or the reasonable lack thereof) for victims of rape. This is particularly a concern for the victim seeking services during night, weekend, or holiday hours. Even during normal business hours, confidentiality issues may exist for the rape victim who must seek pregnancy prophylactics at a rural local pharmacy. The victim who is referred to a neighboring town for pharmacy access may have the barriers of lack of transportation, including a driver's license if the victim is an adolescent. Since the efficacy of pregnancy prevention decreases with an increase in

time, delay in obtaining the medication could result in a pregnancy that could have been prevented. This could result in liability for the hospital.

The cost of the prophylactic medications is an additional ethical issue that the servicing hospital should consider. Victims who are minors and/or without insurance or who do not wish to utilize their insurance for confidentiality reasons are at increased risk of STI and pregnancy as a result of access barriers to the prophylactic medications. The facility should consider the risk management issues inherent in developing service guidelines.

The social work functions of access management, advocacy, and justice preservation are key resources to utilize when faced with such circumstances. A medical social worker within the health care system, particularly one who is respected in the facility with visionary leadership, is well positioned to provide education and advocacy for victims of sexual assault. Multidisciplinary and inter-agency collaboration between invested parties may foster development of a viable option that assures access to prophylactics for those in need. Engagement of social workers from public school systems, county, and/or other relevant agencies may also prove crucial to program success, particularly where medical social workers are not utilized in a rural hospital. While social workers from organizations other than the health care facility may not have the rapport with hospital administration and ED staff, their access to and awareness of alternative community women's services may be necessary.

Summary of the Literature Review

Practice guidelines have developed within the fields of medicine and forensic nursing that address the needs of the sexual assault victim. The Joint Commission on

Accreditation of Healthcare has set credentialing standards for how patients should be provided in the continuum of care, as well as how staff competencies ought to be measured. In these processes, the medical-legal and bio/psycho/social needs of such victims are identified and addressed. The universal factors of sexual assault (prevalence, residual effects, and precipitating factors) are also identified and discussed on an international level. The role of health care reform and the current emphasis on preventative health and wellness in the health care industry are reviewed, particularly as this plays a key role in the development of sexual assault forensic nursing programs in hospitals. Factors affecting program development are reviewed in research literature, specifically cost-efficiency variables, the use of interagency collaborations, the moral and ethical challenges of prophylactic care, physician perceptions about their role in the care of the patient, the role of preventative education and the implications of the forensic sexual assault exam on the medical-legal issues, as well as the psycho-social features commonly associated with sexual assault.

The intent of reviewing such facets of program development is to address the underpinnings to the barriers historically faced by sexual assault victims seeking help from the health care system. Review of the residual effects of interpersonal violence (e.g. sexual assault) provides a catalyst for action in light of the current emphasis of the role of health care prevention and wellness on sexual assault victims and society. Examination of factors inherent in some of the identified barriers to program development and success are of value with the intent to plan strategically how to avoid or minimize their effects. Program development guidelines have been compiled and published on a national level during the course of this study. As a result, the literature review focused on the

subsidiary factors mentioned above, as they pertain to challenges or the need for specially tailored program features that meet the needs of the rural community served.

CHAPTER THREE: METHODOLOGY

Research Focus

1. To examine the barriers and their underpinnings to effective health and forensic services to victims of sexual assault in a rural setting.
2. To develop viable options for improving such services in a rural medical setting.
3. To design and implement a program that provides viable options to ensure forensic validity, therapeutic care and health promoting care for the victim of sexual assault seeking services in a rural setting.

This chapter outlines key concepts and terms used in the research and program development process, defining and describing the target population, the study design, data collection procedures and the editing process. Likewise, the theoretical frameworks (Weick's model of health and a feminist framework) are compared in the context of attaining program development goals and targeted outcomes. Procedures for protection of human subjects are delineated, as experts in the field and reference to case studies are not intended to cause harm or violate the rights of any individual contributing to this thesis project.

Key Concepts and Terms

"Advocate", according to Girardin, Faugno, Seneski, Slaughter, and Whelan, means "a person who aligns themselves with the patient, providing emotional support,

contact with social services, arrangements for transportation, presence in court, and for other needs" (p.187).

"Catholic Health Care", according to the National Conference of Catholic Bishops (1994), promotes the use of ethical and religious directives as means to "reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person, ...(and)...provide(s) authoritative guidance on certain moral issues that face Catholic health care today" (p.1) (Note: Perceptions and interpretations of the Church's stance on the use of prophylactics for pregnancy prevention for sexual assault victims often creates avoidable barriers and revictimizes the victim unnecessarily).

"Chain of Custody", according to Girardin, Faugno, Seneski, Slaughter, and Whelan (1997), is "a continuous succession of persons responsible for the evidence with the purpose to ensure there is no alteration nor loss of evidence; the documentation of the chain of custody is a record of times, places, and personnel who have been responsible for the evidence; transfers of custody of evidence must be logged with the (1) name of the person transferring custody; (2) name of person receiving custody; and (3) date and time of the transfer; the documentation may be attached to the evidence envelope" (p. 188).

"Confidentiality", according to Barker (1996), is defined as "a principle of ethics according to which the social worker or other professional may not disclose information about a client without the client's consent. This information includes the identity of the client" (p. 74).

"Cost Efficiency" is the means by which the goals of the program are met through maximizing existing resources, and minimizing extraneous costs.

"Discharge Planning", according to Barker (1995), is "a social service in hospitals and other institutions that is designed to help the patient or client make a timely and healthy adjustment from care within the facility to alternative sources of care or to self-care when the need for service has passed" (p. 103).

"Expertise Beneficial to the Judicial Process" refers to the level of knowledge, skill, and experience required to know what evidence to collect, how to look for and gather it, how to document it, and how to preserve it and the chain of custody that ensures the evidence will be considered valid in court.

"Forensic", according to the Cambridge Dictionary (1995), is a term used "to discover information about a crime by scientifically examining the objects or substances that are involved in the crime" (p. 549).

"Medical-Legal Examination", according to Girardin, Faugno, Seneski, Slaughter, and Whelan (1997), is "a specialized history and physical examination performed by an examiner specializing in forensics; the purpose of the examination is to properly collect, document, and preserve evidence, as well as maintain the chain of custody; the examiner determines whether the findings support the history and timing of the event and whether there is evidence of sexual contact; standard examination guidelines are published by the American Society for Testing Materials (ASTM; p.190).

"Sexual Assault/Forensic Examiner Program" offers trained and experienced evidentiary examiners to the medical setting, typically emergency rooms, for the purpose of providing expertise in collecting medical evidence that may support the legal charges that sexual assault has occurred for the presenting victim. In addition, psycho-social care

and education are provided to the victim. Comprehensive service provision is intended as a preventative measure to risks of residual health-related problems identified in the research literature.

"Small Community Hospital" is identified for the risks inherent as the victim seeking services in her own community may know the service providers and/or other patients in the emergency room (hereafter called ER or ED) setting. Fear of being associated with assault of a sexual nature may place the victim at additional risk should it deter her from seeking timely medical help, or further traumatize her should she perceive she has been 'found out'.

"Standard of Practice Prophylactic Treatment" refers to the services and medications used to lower the risk of sexually transmitted diseases, pregnancy (as a result of the assault), post-traumatic stress and related long-term residual health-related problems.

"Supportive Care" refers to the psycho-social support provided to the victim during and following the evidentiary process. It also refers to the communication skills of the examiner which conveys a message to the victim that she is believed, respected, not to blame for the assault, safe while in the clinical environment, and that she is being treated by someone who has expertise and ethical standards.

"Sustainable Human Development", according to the National Association of Social Workers in "The Global Crisis of Violence: Common Problems, Universal Causes, Shared Solutions - Overview: Making the Connection between Violence and Development" (1995), is defined as "meeting the basic needs of all and extending to all

the opportunity to fulfill their aspirations for a better life" (p.2).

Definition and Description of Target Population

"Acquaintance Rape" or "Date Rape", according to Barker (1995), is "forced or coerced sexual intercourse by someone who is known to the victim. Typically, the victim is in some social encounter with the perpetrator such as a date or private meeting and is then manipulated into sexual intercourse through physical violence, restraint, threats, or power. The perpetrator ignores protests or interprets them as subtle encouragement. Often victims do not report the event, and frequently they or their assailants do not identify it as rape" (p. 4). This term is more recently identified as 'stranger' VS. 'non-stranger' rape.

"Rape", according to Girardin, Faugno, Seneski, Slaughter, and Whelan (1997) by "legal definition varies from state to state, but typically includes three criteria: (1) unwillingness to engage in an act, (2) force or coercion, or (3) mental or physical inability to communicate; the crime of rape requires only slight penile penetration; full erection and ejaculation is not necessary; rape occurs to males and females (Bureau of Justice statistics, 1995; Burgess, and others, 1995) between married persons, and persons of the same gender; rape is a form of sexual assault" (p. 191).

"Sexual Abuse", according to Barker (1995), is "the exploitation and mistreatment of children and adults in ways that provide erotic gratification for the abuser. Abusers tend to have serious psychological problems such as a personality disorder, paraphilia or another sexual disorder, or psychosis. Victims often cannot or are unwilling to understand or resist the advances of the abuser. Sexual abuse can include

sexual intercourse without consent (or when the victim is younger than the age of consent), fondling genitalia, frotteurism, taking or showing pornographic pictures, and other forms of sexual acting out" (p. 344). The above stated definition of rape is inclusive under the definition of sexual abuse, in addition to seduction, sexual harassment, and sexual coercion.

"Sexual Assault", according to Girardin, Faugno, Seneski, Slaughter, and Whelan (1997), varies in definition by state; in California (1990), sexual assault is: (1) force, threats, or coercion to engage in an unwanted sexual act; (2) contact or penetration of the intimate parts (sexual organs, anus, groin, buttocks, and breasts) of one person with another person; with another person; included is rape, rape with a foreign object, rape by a spouse, forced oral copulation, forced sodomy, attempted rape, and sexual battery" (p. 191). Minnesota Statutes do not specifically define "sexual assault", but do imply it through their definitions of "sexual contact" and "sexual penetration" (see Appendix G).

"Statutory Rape", according to Barker (1995), is "a consenting sexual relationship with someone who is under the legal age of consent in a given jurisdiction" (p. 365).

"Survivor", according to Girardin, Faugno, Seneski, Slaughter, and Whelan (1997), is "a term used most commonly by counselors to indicate that the sexually assaulted patient has attained a certain stage of emotional recovery" (p. 191).

The sexual assault victims that will be served through the proposed program include adolescents thirteen years old and older, as well as adults, including geriatric populations. Children twelve years old and younger will continue to be referred from the ER or clinics to Midwest Children's Resource Center where a specialty unit provides

expertise in medical forensics for children. Due to the validity issues surrounding young children's testimonies, it is believed that the expertise required of the professional to benefit the child and family is beyond the scope of this proposed program. The service population is primarily targeted in Dakota County and surrounding areas. However, service will not be denied of any victim seeking services of the SA/FE Program.

Study Design

Exploratory: The focus of this study is to design and implement a program in planning and administration which clearly explores the adaptation of a sexual assault/forensic examiner program to a rural setting, identifying goals and objectives, assessing alternative approaches, developing a proposal, and demonstrating steps in the implementation process. A needs assessment will be conducted through the gathering of qualitative and quantitative data.

Data Collection Procedures and Editing Process

The prevalence of rape will be identified through existing databases of reported and/or substantiated cases of rape within the county law enforcement system. This information will be compared to the prevalence numbers documented in the county where the model program is implemented. This will help determine potential caseload and subsequent staffing needs. Area hospitals will also contribute by providing data on the number of sexual assault victims presenting at their respective emergency departments. The use of research data will also provide a normative needs assessment.

Data collected by former Governor Carlson's Task Force on Violence will be used to determine service statistics for the needs of sexual assault victims. These expressed needs will be used in support of the identified local needs. Standards of practice set by governing or credentialing bodies have been used as the assessment of need and impetus for the development of a program that promotes health and better supports the judicial process.

Data was collected for development of a program framework based on existing standards and research findings. Such resources beneficial to this study are the following reports: legislative mandates for judicial district responsibilities to victims of violence, the Governor's Task Force on Violence recommendations for an improved health care response to those affected by violence, standards from Joint Commission on Accreditation of Healthcare Organizations, guidelines from the American Medical Association and the International Association of Forensic Nursing and the U.S. Department of Justice SANE Development and Operation Guide. Also, recommendations from research as they pertain to the residual effects of sexual assault, and the subsequent need for services that address these residual needs. Review of existing program models were used to explore options for developing a program design that will meet the needs of the assigned community.

Theoretical Frameworks

The outcomes of the sexual assault for the victim are commonly humiliation,

fear, loss of control and often loss of self-esteem. It is important that, as health care providers, we offer an approach that counters this impact and fosters the strengths of the individual that will be important to their survival and promotes a state of health and well-being. The qualitative human attributes of identity, competence, and autonomy are challenged when one experiences sexual assault.

Weick's health model (1986), highlighting healing and the human body as a self-correcting mechanism, supports capacities and strengths in the victim. This framework is of particular value in the health care setting which historically operates under a biomedical model. In a model of health, a premise is held for the synthesis of physical, cognitive, emotional, social, and spiritual components as inherent in each human being. Weick's model of health is delineated as "emphasizing people's capacity for growth and development", acknowledging this "capacity is a power that must be nurtured" (p. 558). The following is Weick's comparison of the biomedical and health models, as they provide insight into the strengths of the health model that promote health and healing in the victims of sexual assault served through specialized services within the health care system (p.557):

TABLE 1. Assumptions of the biomedical and health models.

	Biomedical model	Health model
Primary emphasis	Study and treatment of disease	Study and promotion of health
Orientation toward disease	Disease as derangement of body	Ill health as expression of imbalance among interacting environments
Orientation toward health	Health as absence of disease	Health as expression of optimal well-being
Causality	Attempt to locate specific cause	Recognition of patterns among

	in biochemical and organic functioning of body (reductionistic)	multiple levels of influence (holistic)
Nature of intervention	Provision of externally instigated treatments	Stimulation of internal capacity for healing
Role of Professional	The agent of externally produced cure	The facilitator of the healing process
Role of patient	Passive but cooperative recipient of medical intervention	Active director of the healing process
Role of society	Disease is a private business; society shoulders some of the costs in its welfare function	Health is the public's business; society is responsible for creating healthy environments

The health model suggested by Weick contributes to the development of a sexual assault forensic examiner program in a health care setting by the very nature that it draws on the capacities of the victim (survivor) for healing while placing responsibility on the community for creating an environment in which healing can flourish. Community, in this context, represents both the health care community and the community-at-large. These principles remain consistent with both the strengths perspective and a systems theory inherent in the practice of social work. As assessments and discharge planning are completed with the victim, it is important that close evaluation is given to the social support and environment from which the victim comes and to which she returns. Individualized tailoring of additional support systems may be necessary for those victims who return to an environment which lacks adequate support to foster the healing

process. For those victims returning to a supportive environment, specialized support services are still beneficial due to the long term residual effects and related issues that are unique to the experience of sexual assault.

The field of health care and medicine have their foundations anchored in the biomedical model which fosters patriarchy, as supported in research literature. As a

result, research priorities in medical practice, treatment options and frameworks for assessment of patients' needs are carried out in the context of a particular world view, specifically from a masculine point of view. Feminist theory, on the other hand, recognizes gender as a significant characteristic that interacts with other factors, including race and class, and influences the structure of those relationships. Hence, a feminist framework is an important link to the present gaps in service to victims of sexual assault. This expands beyond the medical and into the judicial and legal realms, as well. According to Stark and Flitcraft (1996), "it is in the medical system that the most physical and behavioral consequences of assault are seen most vividly" (p. xx). Likewise, they add, "the ways in which male control converges with larger processes of discrimination has enormous importance in identifying who is being victimized, which strategies we define as criminal, where and how we intervene, and how we balance advocacy for women's liberation with the important emphasis on personal safety through police protection and shelter" (p. xx-xxi). For purposes of this research, the term 'feminist' shall be used in it's generic form which recognizes the effects of gender on relationships and processes as above mentioned. For the purposes of this research, 'feminism' has not been further defined, according to Rosser's definitions (1994), as liberal, Marxist, socialist, African-American, lesbian separatist, conservative or essentialist, existential, psychoanalytic, or radical (p. 126).

The framework of a model of health capitalizes on the strengths or capacities of the victim as means for fostering his or her own health and healing. Feminism, on the other hand, recognizes 'gender' as an influential issue of power. Combining the two in an analysis of the current system and format for addressing the needs of the sexual assault victim models a framework of fostering health and a sense of wellness for victims,

irregardless of their gender, in addition to empowering them in the healing process that includes participation in the pursuit of justice. In light of gender influences on justice, one function of a sexual assault forensic examiner program is to improve the forensic evidence collection so that judicial outcomes are improved. Concerted efforts toward interdisciplinary collaboration with law enforcement, the County Attorney's Office, Sexual Assault Advocates and health care providers are means by which policy and practice changes may occur to the benefit of victims of sexual assault.

Procedures for Protection of Human Subjects

This research project has been accepted by a committee for human subjects review in order to prevent harm to or violation of rights of any individual who has provided information necessary for exploring the research problem and alternative solutions to improving service and care to rape victims. Key informants will be used as part of the normative needs assessment. Information gathered from key informants will be used only with signed consent from the informants. Upon such consent, any information used in the research that has been obtained from a key informant will be referenced accordingly, in compliance with APA guidelines.

Summary of the Methodology

The focus of the thesis will be accomplished through an exploratory process that examines options to adapt existing programs to a rural setting. Barriers to the adaptation and implementation processes are also examined through a needs assessment and exploration of alternative approaches that foster accomplishment of identified goals

objectives. The data and options examined are accomplished through a theoretical framework of a model of health and a feminist perspective. The theoretical frameworks used are identified as most consistent with the goals and objectives of design and implementation of a program that promotes health and healing in victims of violence that is most often gender-biased against women. The research, proposal, and program implementation processes are systematic and the protection of human subjects is ensured in the approaches to this process.

CHAPTER FOUR: PRESENTATION OF FINDINGS

Rates of Morbidity

Dakota County is part of the First Judicial District in Minnesota. In this Judicial District's report on sexual assault (1995), Dakota County's totals for reported sex crimes in 1990 to1994 range from 44 to 127. Total sex crimes reported range between 300 and 384. More recently, contact made to each law enforcement office revealed raw data for reported rapes in Dakota County from 1995 through 1997. Eleven police departments and one Sheriff's Department cover Dakota County. Of the twelve, eight responded to the request for data, equaling 172 reported rapes in 1995; 170 in 1996; and 189 in 1997. Each of the four departments not responding to the requests for data are larger departments in Dakota County. At least two of the four are on the border of an urban setting.

Statistics provided by Assistant County Attorney, Charles Diemer (raw data, 5/2/97) reveal that in 1995, 83 counts of rape were prosecuted compared to 119 counts in 1996. Diemer explains that each person prosecuted has an average of one to one and one-half counts against them. It is important, when collecting and interpreting such data, to differentiate between rapes reported, charged, and/or prosecuted. "Cases reported" reflect the number of reports made by victims of the crime to the appropriate police department or sheriff's office. When a victim reports to law enforcement, she will be directed to the police department which has jurisdiction over the location where the rape actually occurred. "Cases charged" are those cases reported which law enforcement has investigated and the county attorney's office has reviewed and determined that enough evidence exists to charge an identified perpetrator with the crime. Cases

successfully prosecuted are those that go to trial and the alleged perpetrator is determined guilty of the crime(s) charged. Cases reported are not charged without sufficient evidence of force (or threat of force) and penetration of an adult or sexual contact of a person under 13 years of age. Mental or physical impairment or incapacitation of the victim are also considered in charging a suspect. Variability's in definition include the type of sexual activity, the relationship between perpetrator and victim, and the condition and response of the victim at the time of the assault (see Minnesota State Statutes 609.341-347 for further details). Cases charged may settle out of court without going to trial.

Literature reviewed for this study revealed that statistical data collected in a formalized manner is very limited. Much of the useful statistical information sought has been identified through raw data available from key informants in the field. In reference to rates of morbidity and program development, one of the key questions in the needs assessment has been how existing programs sustain themselves over time. Two programs contacted revealed a substantial growth in caseload from the beginning of the program to the present. In 1996, one urban midwestern hospital cited 97 cases their first year, 297 cases three years later, and currently average 630 cases annually. This program is approximately twenty years old. The second program contacted, a suburban program located in the midwest, had 23 cases it's first year, 185 cases after eight years, and currently averages more than 200 cases per year. Differentiation must be made regarding an increase in rape statistics as an increase in occurrences and/or an increase in victims seeking help in a formalized manner. Due, in part, to insufficient data collection, this cannot be fully ascertained. However, as the program's advantages to victims, law enforcement, and the county attorney's office reaches these entities, and success stories

become known, the services of the program should be better utilized.

On the subject of morbidity, discussions with key informants substantiated the above stated research literature that correlates victimization by sexual assault with high risks for long-term residual effects. One such case scenario also supported former Governor Carlson's concern about the extensive preventable costs to the health care system. With permission, the following information has been shared regarding the scenario of a female patient with a significant sexual abuse history, as well as a history of seeking medical care for somatic complaints consistent with those somatic illnesses commonly identified with sexual abuse. In one short history with one physician, the patient had the procedures for a chronic upper abdominal pain syndrome (see Figure 4). The total cost of these procedures totaled over $10,000.00 and represented only a brief point in this woman's medical history for the same chronic problem of chronic upper abdominal pain. Source of the upper abdominal pain was not identified, despite the thorough work-up. Such unidentifiable etiology is suggestive of another case of somatic symptoms resulting from the psychological trauma of sexual assault. In a capitated health care system, it is understandable that concern is raised about the long-term residual costs of violence to the health care system. Multiplying this scenario by the recurrency of similar work-ups prior to and likely after this, and then multiplying this one person's experience by the thousands of men, women, and children like her, it is easier to understand the scope of the problem for which former Governor Carlson had concern.

Role of Interdisciplinary Collaboration in Service Provision

Partnership between service providers, whether interdisciplinary or between comparable providers within the same general service areas, is an important factor that

Case Example: Costs Associated With Residual Effects

- Sexual abuse survivor w/ chronic upper-abdominal pain syndrome
  - Cholecystectomy
  - Breath hydrogen test
  - Two colonoscopies
  - Multiple abdominal x-rays
  - Multiple ultrasound imaging
  - Upper GI workup
  - Stool cultures
  - Three upper endoscopies

- **$10.000 +**

Figure 4.

should be explored, particularly in a rural setting where the costs of service delivery may be cost prohibitive when standing alone. Partnerships, from a community health standpoint, are also important in the current health care climate. Collaborative efforts between health care facilities should be seriously examined, as the start-up and maintenance costs can be prohibitive to a single facility in a service area with lower incidences of reported sexual assaults.

Collaborative efforts should also be fostered on an interdisciplinary level between invested parties. These include health care providers (typically emergency room management or staff), law enforcement, county attorney's office, sexual assault advocates, and forensic examiners as a core group. Additional providers might include domestic violence advocates, schools, county social services, mental health providers, and others as identified appropriate and beneficial to working with sexual assault victims. Language interpreters who specialize in sexual assault advocacy, liaisons addressing diversity issues, and primary care providers might also be appropriate members of such a collaboration.

The strengths that each provider brings to the relationship should be examined and maximized for the benefit of comprehensive, high-standard service provision to sexual assault victims. Thorough exploration of the interdisciplinary strengths has strong potential for cost-savings. This is particularly true as the partnership effort strengthens to create an interdependency in service provision. As each sexual assault service provider strengthens it's value of and involvement in a team approach, investment in problem-solving and resource allocation should develop. A team approach may be further strengthened by the achievement of positive, measurable outcomes from their joint efforts on behalf of sexual assault victims (see Figures 5&6).

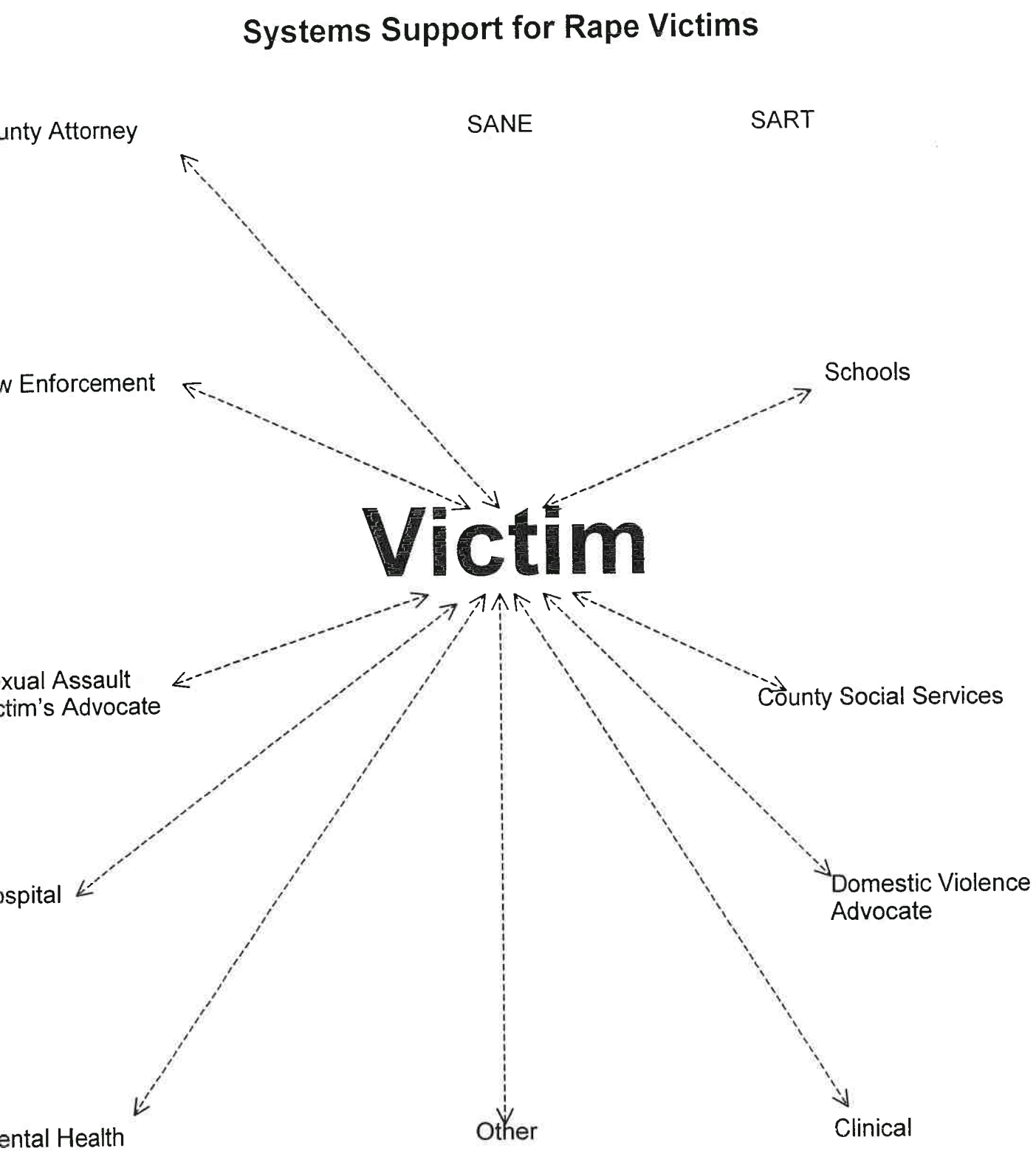
Systems Support for Rape Victims
unty Attorney
SANE
SART
w Enforcement
Schools
Victim
xual Assault
ctim's Advocate
County Social Services
ospital
Domestic Violence
Advocate
ental Health
Other
Clinical

Figure 5.

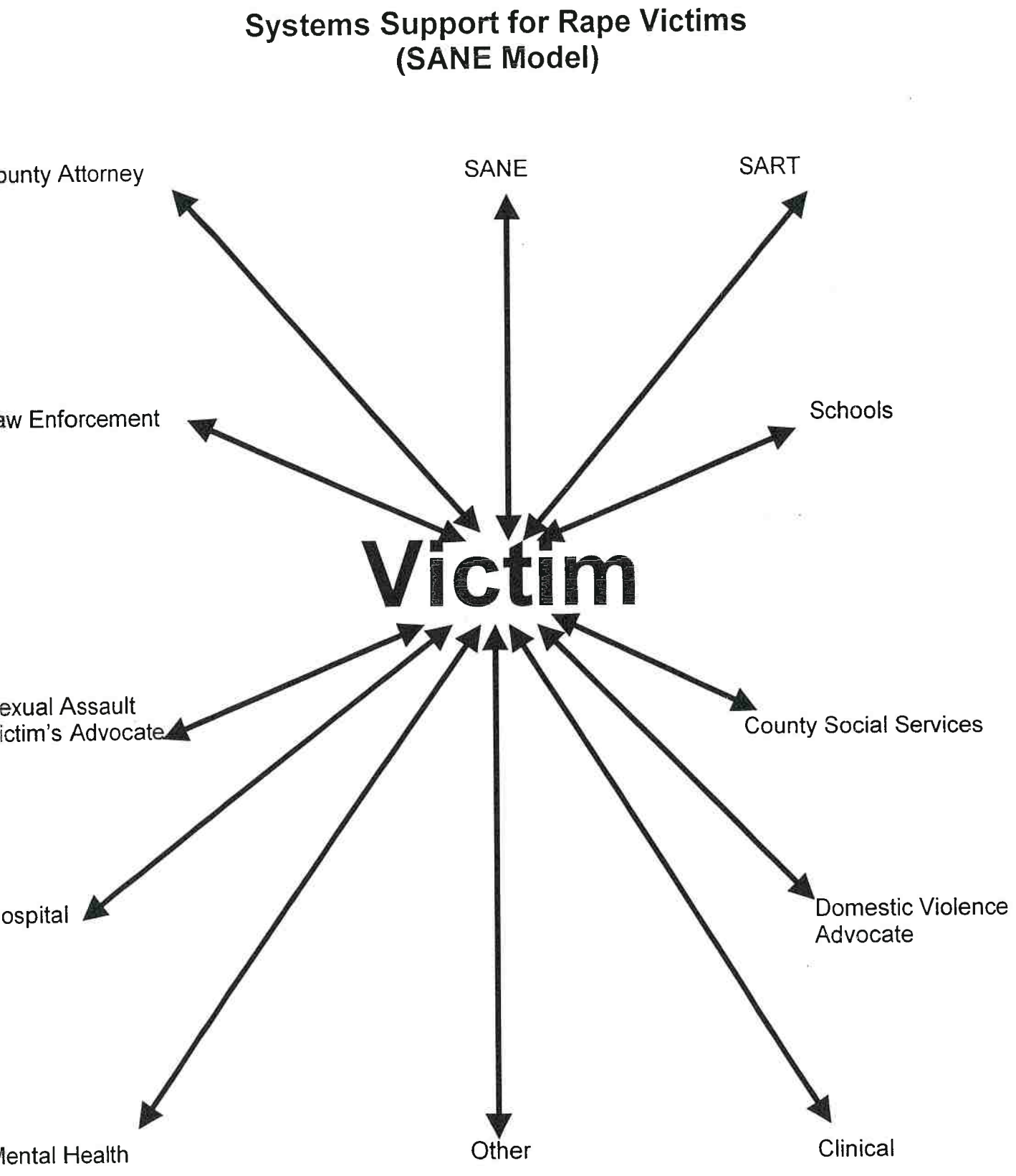
Systems Support for Rape Victims
(SANE Model)
SANE
SART
Schools
County Social Services
Domestic Violence
Advocate
Clinical
Other
Victim

Figure 6.

One example of the value of 'partnership', particularly in a rural setting, is an agreement between the forensic examiner and the sexual assault advocacy provider as to the delineation of psycho-social services to the victims served. It is important for the forensic examiner to utilize existing victim and legal services, providing the service history of each demonstrates competency in their respective fields. For example, the sexual assault advocate must receive at least 40 hours of training in sexual assault issues. Guidelines and standards for the content of this training has been developed in response to the Department of Corrections' (DOC) requirement for minimum standards of staff/volunteer training as a prerequisite to funding sexual assault programs in Minnesota (Sexual Assault Advisory Council, 1992) must be trained and certified through a training process that meets state guidelines. This ensures competency of the advocacy services provided, but it also ensures the benefits of a state-certified advocate which is the exempt status that protects the advocate from getting subpoenaed to testify in court as to observations made of the victim in their service interactions.

An important role of the forensic examiner is to testify should the case go to trial. As part of this, the examiner's role is to collect information from the victim related to the victim's assault history. But there is an equally important role for the advocate who can confidentially listen to and support the victim as she transitions into survivorhood. The process of surviving and healing from the effects of sexual assault, as with any grief process due to significant loss, inherently has stages and phases of understanding about what has happened. The personal growth and understanding accomplished may feel as if it waxes and wanes, at times, in relation to the ultimate goal of accepting the losses inherent in the experience of sexual assault and adjusting to life inclusive of these changes (Worden, 1991). It is the role of the advocate, during this

time, to provide support, education, and, when necessary, triage to a mental health clinician, in order to foster optimal adjustment for the victim/survivor. These are important functions in the prevention of the long-term residual health problems commonly associated with victims of sexual assault.

Another advantage to partnering with other service providers is seen in the relationship with law enforcement and the county attorney's office. Many victims are hesitant to report a sexual assault regardless of the circumstances. They are even more reluctant when the assault occurred in concurrence with illegal activity on the part of the victim (e.g. illicit drug use) or the results of poor judgment on the part of the victim (e.g. intoxication at a party or accepting a ride home from a stranger or someone whom they do not know well). Collaboration with law enforcement and the county attorney's office on how such situations are likely to be handled in that specific service area may be helpful for the forensic examiner to know when working with a hesitant victim on the subject of reporting. Strong communication and buy-in between key investors can serve to enhance both the holistic care of victims and to reduce the prevalence of sexual assault and abuse within the community and surrounding areas.

Organizational Structure for Program Management in Rural Settings

Cost-containment is a critical factor impinging on program development and implementation, particularly in a rural setting. As a result, every aspect of program development and management must be evaluated for cost-effectiveness. One of the most expensive costs to a program is the salaries and benefits section reflected in the financial proforma.

The first task is to identify responsibilities involved in program management,

beyond the scope of services provided by the forensic examiner. The means by which delegation of tasks occur will affect the organizational structure of a program. Clearly, the more responsibilities that can be incorporated into existing job functions of invested staff may conserve on the full-time equivalency (FTE) needed of a program supervisor or director, as the creation of a new leadership role will likely incur more real costs than support staff.

Note, however, that the financial proforma should reflect both real and inkind costs to the program. If costs exist that are not sufficiently reflected in the proforma, then the risk may be financial survival of the program should it, at a later time, be required to assume the hidden costs it was not prepared to cover. Keeping this in mind, the task delegation should be as broad-based as possible to minimize need for program-specific support staff.

Ultimately, however, a central reporting figure is needed for accountability of the program. It is important that this person is qualified for the leadership position in program development and management skills, as well as in demonstrating ability to understand and respond to the broader scope of issues and needs of the victims and service providers involved in each case. It is not sufficient to remain focused on the forensic exam alone, as the victim comes for help as a whole person and seeks help from a 'whole' system made of many parts. Therefore, planning and evaluation on an ongoing basis must occur to ensure the services are working in a manner that promotes health and wellness for that victim as they leave the hospital and move forward into survivorship. Other important features that a program director should have include the flexibility, training, and willingness to cover on-call schedules on the occasions when staffing may be too low, whether due to illnesses, turnover, or otherwise.

At the very core, the number of forensic examiners to recruit and train will need to be determined. This decision should be made based on factors such as estimated caseload, service hours, and payment structure for the examiners. The role or function of the forensic examiner beyond the initial exam and prophylactic care of the victim may also impact staffing. Examples of this include the scope and extent of follow-up services provided by the examiner to the victim, and whether the examiner also functions in another capacity during on-call hours for forensic cases. Based upon lessons learned from other existing programs, (Linda Ledray, personal communications, August 28, 1996) if the program offers services 24 hours per day and 365 days per year, then a staff of seven to ten examiners is an optimal number. This, however, should also be determined in light of the above factors, such as anticipated caseload, employment status of the examiners, and cost-effectiveness of wage base for the examiners, especially if collective bargaining is involved. For example, if the needs assessment in a rural service area indicates planning for 20 cases per year, then a staff of seven to ten nurses would not be cost-effective. Neither would it be beneficial to the nurses who would, as a result of overstaffing, have extremely limited access to cases and the resultant ability to maintain and further develop their forensic skills. However, if the needs assessment in a similar service area suggests planning for 50 cases initially, then employing seven to ten nurses may be appropriate, but would still require evaluation based upon the structure of the examiners' wages and status of employment.

In some circumstances, independent contractor status of the forensic examiners would be most cost-effective for the host facility. This would free the hospital from paying for employee benefits, as well as turning liability risks over to the agency that is sponsoring the independent contractors. The challenges to this option include

identifying a source for sponsorship that is willing to take on the risk. In other situations, hiring the examiners as employees of the facility would prove most efficient fiscally.

Another factor to consider when determining the employment status of the examiners is whether or not, as employees of a medical facility, the examiners would be required to become part of a collective bargaining group (e.g., Minnesota Nurses Association - MNA). Collective bargaining contracts may require that on-call nurses work under such conditions that do not allow for the flexibility needed of staff to run the program affordably. For example, if an MNA contract exists and it requires the hospital to pay, for example $4.00 per hour for each hour a nurse is on-call for the program, annual on-call wages alone would be $28,810.00. If this is the cost for a case load of twenty forensic cases per year, cost-effectiveness is not met.

Should a hospital hosting a sexual assault forensic examiner program also be held to a collective bargaining agreement that is inclusive of the forensic examiners, an important step has been suggested by one expert in the field. Linda Ledray, founder and director of Sexual Assault Resource Service in Minneapolis has suggested approaching the Minnesota Attorney General's Office for support (personal communications, February 10, 1998). Engaging the State Attorney General in the negotiations with the MNA may be beneficial to secure a waiver of the collective bargaining agreement for the forensic examiners and to ensure that violations of that agreement do not occur. It is critical, however, to understand the political climate and who may be supporters for the goal in mind. The recent change in state leadership may now limit the support base for such steps that have been successful in the past. The Federal Wage and Hour Law must also be factored into the equation. Unfortunately, the law is ambiguous and complicated whereby Human Resources personnel may need to provide insight and direction on cost

analysis of on-call staffing options. The argument can be made that, given the scope of service to an at-risk group of patients, combined with the low caseload, the service could not be provided under conditions of the MNA. Multiple factors come into play that may affect the collective bargaining unit's response. But, generally speaking, if the hospital's rapport with the union is not adversarial, it is possible to reach an agreement that will allow for a waiver of some of the requirements for the nurses, provided the nurses agree to this. Such an agreement would allow program management, in service areas that anticipate low caseload, to avoid the on-call pay that may otherwise be cost-prohibitive for program development. The recommendation would then be to transfer the lost benefits to the forensic examiners via a fee-for-service basis that would come out of the revenue produced by actual cases.

Another issue that should be addressed in a collective bargaining agreement for waiver of conditions would be the union dues owed by the forensic nurses. Particularly in a new program, and especially in a setting with lower caseloads, the forensic examiners are not likely to prosper financially from their work. To add requirement of monthly union dues when income is minimal may present a significant challenge to recruitment of nurses.

Certainly, a delicate balance exists between the variables mentioned. Each rural hospital must determine the program structure that will best meet their needs based upon their area needs assessment, collective bargaining status and climate, and options for allocating costs through alternate available resources. The most important component of a rural organization's assessment for program structure is to identify what and whom they already have in place that can be adapted to develop and manage the program. For example, one hospital combined an existing on-call psychiatric nursing program with a

sexual assault forensic examiner program. It required training nurses from one field into forensic nursing, but they combined resources to accomplish the task affordably. One potential risk to this model might be the level of commitment nurses have in one field when required to take on another specialty, particularly one of such a sensitive nature. Another risk may be one of staffing should a nurse receive calls to two service areas at the same time. Again, creative assessment of existing resources may resolve any potential risks. Program design should be unique to each facility based upon it's individual resources, caseload and structure. Do not rule out collaboration with another organization, hospital or otherwise, that might also benefit from sharing costs of an 'on-call' status of nurses.

After review of the above factors, in combination with those specific to this service area, a decision was made to develop a program consisting of nurses as employees of the hospital with exempt status, at least temporarily, from collective bargaining mandates. This was implemented only after receiving permission from the collective bargaining unit to do so. Forensic nurses will be paid per case, rather than an hourly on-call wage. The rate per case will be calculated to help defray some of the difference from on-call pay based upon actual revenue. They will, however, be paid a pre-set, universal hourly wage for time spent at mandatory monthly staff meetings and any other required function related to the program. Leadership and program operations will be inkind as much as possible.

Scope of Services

As SANE programs continue to develop around the country, the effectiveness of each is, in part, based upon it's ability to adapt to the needs of it's particular

community. In addition, however, it must maintain key components of service indigenous to the profession of forensic nursing for sexual assault victims. At the very core, sexual assault nurse examiner services must provide the following, forensic evidence collection, STI evaluation and preventive care; pregnancy risk evaluation and prevention; crisis intervention; and care of injuries (physician) (Ledray, 1997).

According to the "Sexual Assault Nurse Examiner Standards of Practice" (International Association of Forensic Nurses, 1996, p.1), the goal of the SANE is to provide the following: (1) assessment of injury; (2) objective documentation of health history to determine the bio/psycho/social risk and the risk of medical sequelae; (3) objective, non-judgmental documentation of the history of the crime; (4) collection and preservation of forensic data; (5) prevention of potential psychological and physical health risks associated with the assault; (6) facilitation of client control over assault/abuse issues; and (7) facilitation of healthy reorganization and readaptation following a sexual assault. The action taken to assure these goals are met include the following:

1. Obtaining the health history and reported criminal act
2. Providing crisis intervention
3. Performing a physical examination
4. Inspecting and evaluating any area of the body of a victim who is reporting sexual assault or molestation
5. Collecting evidence
6. Treating (by medical protocol) and/or referring for medical treatment
7. Documenting objectively the findings by the evaluator that are and are not consistent with the complaint of sexual assault

8. Interacting with clients in an objective and neutral manner that promotes informed consent or informed refusal with regard to collection and/or available treatment options

Medical Records Documentation

Because the services of this program are forensic in nature, they are inherently designed with the legal and judicial systems in mind. Therefore, the program design must include policy and procedure format, staff training, and forms development that incorporate a focus on data collection and preservation which support a just judicial process. Ledray (1999) delineates the components of forensic documentation, stating it should address, at the very least, consent for services provided, authorization for release of information, scope of services provided, accurate and complete report of the victim's assault history and examination and medical information that address the victim's "immediate physical and psychological needs...as well as to appropriately collect and interpret the physical and laboratory findings" (p.77). In addition, program evaluation documentation ought to be kept for the purpose of trending service populations, risk factors and needs specific to the service population or area, as well as the quality of services provided. These may prove important to funding sources, collaboration efforts, service provider buy-in, and efficacy of the program. Appendices J through R, T, and U are examples of such documentation forms drawn from other programs and incorporated into the "Sexual Assault Nurse Examiner Development and Operation Guide".

Program Budget Outline and Funding Sources

Program budget format, in order to be an effective tool to meet agency goals and objectives, must address an appropriate budgeting purpose. Line-item budgeting,

while addressing control purposes of revenue vs. expenditures, does not provide adequate data for effective program management and evaluation. A comprehensive presentation of the financial budgeting for program management should be inclusive of management data that addresses the productivity of the program. In addition, budgetary data collection that addresses the planning purposes of budgeting can offer critical information that describes the effectiveness of the program.

Once the purpose of budgetary data collection is determined, a framework and model of process must be determined. For the provision of psycho-social services, Kettner, Moroney, & Martin (1990) recommend a systems framework because "collectively, the three principal purposes of budgeting combine to provide a comprehensive picture of the functioning of a social service agency that none of them is capable of providing separately" (p.182). The collective data addresses the financial state, productivity, and effectiveness of the program. In addition, a model of budgetary process must be determined. Of the three options, political, incremental, and rational planning, the latter is identified as most appropriate for a program addressing psycho-social provision of care. The rational planning process addresses budgetary decision-making based upon needs, priorities, plans, goals, and objectives. The process actually provides a needs analysis, establishes goals and objectives, and links resources to those goals and objectives. According to Kettner, Moroney, & Martin (1990), the deterrents to this process are the time consumption involved, resource allocation (that could be otherwise directed to existing programs or services), and the power of 'politics' to override the outcomes and recommendations (p. 184).

In short, Kettner, Moroney, & Martin recommend that the optimal budget set-up will address the following purpose and processes. Control, management, and

planning purposes of budgeting most often are not all accomplished simultaneously. However, when they are collectively utilized, the result is comprehensive. The control function of budgeting attends to the relationship between program resources, attempting to answer the question: " 'What is the financial condition of the agency?' ". The management function looks at program expenditures in relation to products or services, attempting to answer the question: " 'How productive is the program' ". The planning function of a budgetary process is to address the relationship between expenditures and attainment of goals or objectives, attempting to answer the question: " ' How effective is the program' " (p. 182).

Developing an actual budget, the program developers must consider such factors as start-up costs, annual costs, costs per case, charges, billing structure, and reimbursement and/or revenue sources. Start-up costs should include consultant fees, one-time supply and equipment purchases, set-up fees for graphic design of brochures, business cards, and/or applicable forms and literature. Critical to the program is the determination of resources available for effective program development and maintenance by in-kind means versus real costs from the sponsoring facility. In-kind resources, however, must also be evaluated by the extent to which utilization of existing resources might negatively affect other services, possibly requiring additional purchase of resources and/or services in those areas instead. This would simply shift the services from one cost area to another. Evaluation of the efficacy of this method must include close examination of it's cost-effectiveness. In most situations, creating additional costs for another service area will not be cost-effective and, therefore, will not be permissible.

Factored costs for program maintenance include program director salary, forensic examiner wages for casework and staff meetings, restocking supplies as needed,

advertising fees for staff recruitment and public relations, service fees for staff pagers, and utility charges. Anticipated caseload and scope of service area will help determine the full-time equivalency needed of a program director. According to Linda Ledray, (personal communication, August 8, 1996), the time needed for program management is typically five to ten hours per month once the program is operating on a steady course. However, initial efforts will be more labor intensive due to public relations efforts, policy and procedure development and revisement, and inter- and intra-departmental communications inherently needed when implementing a new program or service within the confines of a pre-existing service. Other factored costs anticipated in program maintenance can be minimized with strong emphasis on time and resource management. Staff meetings should be kept to the time limits set, as overtime will be a costly temptation.

Built-in charges per case include the nursing wage for the case; annual projected salary for mandatory staff meetings; camera film (both 35mm and Polaroid); prophylactic medications (will vary per case); supplies (variable); use of ER examination room (facility costs); ER nurse and physician services (need and extent will vary per case); administrative charges for billing, filing, quality assurance, recordkeeping/statistics, and follow-up services; and mileage (paid to nurses when completing simultaneous cases at different examination sites -- infrequent).

Funding and reimbursement mechanisms are critical factors to the survival of the program. Minnesota State Criminal Code 609.35 addresses the cost of the evidentiary examination as follows:

> "No costs incurred by a county, city, or private hospital or other emergency medical facility or by a private physician for the examination

> of a complainant of criminal sexual conduct when the examination is performed for the purpose of gathering evidence for possible prosecution, shall be charged directly or indirectly to the complainant. The reasonable costs of the examination shall be paid by the county in which the alleged offense was committed. Nothing in this section shall be construed to limit the duties, responsibilities, or liabilities of any insurer, whether public or private."

While this statute is interpreted variably from county to county, it is clear that the victim or suspect cannot be personally charged for the evidentiary exam and that the county is responsible to cover the evidentiary charges. The variability of interpretation is noted in what is defined as inclusive in the examination "performed for the purpose of gathering evidence for possible prosecution" (Minnesota State Criminal Code 609.35). For example, one county might pay for the completion of evidence collected for the BCA kit and related pertinent laboratory specimens only while another county might pay for x-rays and diagnostics of additional injuries (that might show force, but do not, in and of themselves, necessarily suggest sexual assault occurred). Some counties will pay for prophylactic care while other counties will not cover these. In addition, some counties will set a fee that they will pay for an evidentiary examination which may be significantly lower than the charges and/or costs of providing the services. Charges for nonevidentiary services that are not covered by the county (e.g., assessment and treatment of injuries and prophylactic medications) can be billed to the victim's insurance, but cannot be billed to the victim. Victims do not, however, necessarily have this information as a factor when they are deciding whether or not to seek help or report

to the police.

Particularly concerning county reimbursement are the conditions that must be met prerequisite to payment for the examination. Some counties will not pay for an evidentiary examination if the victim does not report the crime, reasoning that if there is no report of a crime, then government should not pay for collection of evidence on a crime that, for all practical purposes, did not occur. Other counties take this a step further and do not pay for the examination if the victim, in addition to reporting, does not cooperate with the prosecution in the judicial process against the suspect, which can include testifying at the trial. The first question of justice which arises, here, in that victims may resist seeking help for fear of the financial costs they might incur.

While victims of sexual assault come from all socio-economic levels, cultures, age groups, living environments, and so on, the greatest number of sexual assaults occur to victims in the dating age ranges of 18-29, then 13-17, according to Carolyn Kirkoff, Director of Sexual Assault Services in Dakota County (personal communications, September 4, 1996). Victims who are minors or young adults are less likely to have adequate insurance or personal financial reserve to cover the medical costs. Due, at least in part, to shame and fear, many minors do not want their parents to know of the rape. This limits the ability to bill their insurance which is most often carried by their parents.

The second question of justice arises when the victim who does seek medical help, and may have an evidentiary examination completed under the above interpretations, is forced to make a decision about reporting to law enforcement in the emergency room. Fear of having her story challenged, her motives or own judgment called into question, not being believed, being criticized by others, or fearing retaliation

by the perpetrator are powerful reasons why victims do not report sexual assaults. Should a victim who is experiencing these fears feel coerced to report the crime, especially without opportunity to direct the timing of the report herself, she may also experience a disempowerment that revictimizes her, defeating the purpose of providing health promoting services in the first place.

Financial reimbursement for services rendered and at a rate that, at the very least, covers costs are key to program survival. While the county is accountable to reimburse for evidentiary services intended for use in possible prosecution for a crime of sexual assault, the sexual assault forensic examiner program also has responsibility both to provide services to all clients, irrespective of their ability to pay and to secure alternate funding sources for the costs of provision of such services. (For further exploration of the COBRA - EMTALA guidelines, see MISC-DOC, HEALTH-ARD 150,000, State Operations manual Transmittal No. 2 (May 1998).Responsibilities of Hospitals in Emergency Cases [Added to CCH Online], June 16, 1998. Available: http://www.acep.org/policy/hcfa9807.htm). For example, the forensic examiners should be taught during training how to assess for billing sources in a manner that does not coerce the victim into reporting the crime if resistance to do so is evident. The forensic examiner should also understand and practice educating victims about access and conditions of use of crime victim reparations monies. The latter may help the victim cover additional expenses that arise related to the assault. The forensic examiner must understand and practice therapeutic care of the victim, consistent with the mission and values of the program. This also holds the examiner responsible to ensure that the subject of billing for services does not interfere with the victim's access and use of appropriate services.

Likewise, program management is responsible to explore options for alternate funding sources. Start-up grants are accessible, particularly for programs that address stopping violence or reducing risk to individuals and society for the residual effects of violence that are just as problematic as the violence itself. However, grant availability for program operational costs may be very difficult to find. Developing new services within the scope of the existing program may facilitate access to start-up monies for that particular aspect of service or care.

Collaboration or partnership with other service providers is an option that might reduce the burden of financial costs and losses, as well as broaden the base of service provision. As discussed in an earlier section, incentives for collaboration are strong, particularly in the current economic era of healthcare.

In summary, the financial factors of program development are key to it's survival and must be addressed accordingly. The type of budget and budgeting process chosen will determine what information can be drawn about the program. It is important to choose a budgeting system that will answer questions regarding the financial state of the program, it's productivity, and the effectiveness of it's services in relation to established needs, priorities, plans, goals, and objectives. In addition, a budget should be delineated that addresses the start-up, program maintenance, and per case costs of the program. Funding sources and barriers to access funding that matches or exceeds program costs must be clearly understood prior to program implementation. As each county and state varies on it's interpretation of the statutes that delineate the extent of their financial responsibilities, this must be understood by program management and alternate funding sources must be explored, including grants and collaborative partnerships with other service providers. It is imperative to establish policies and

procedures, as well as to provide training for staff, that will protect the victim from revictimization by the system, particularly regarding inability to pay or requirement to report to law enforcement as conditions for accessing or financing services.

Staff Training and Credentials

Remaining consistent with existing programs in the United States, the forensic examiners are registered nurses or nurse practitioners. Baccalaureate nurses are preferred due to the degree of independent practice required of the position. Because flexibility, strong assessment and decision-making abilities, and knowledge of normal versus abnormal female anatomy are important skills for a forensic nurse in this field, preferable backgrounds in nursing include independent nursing roles such as in psychiatry, emergency room/trauma, obstetrics/gynecology, and/or public health. According to Linda Ledray (1992), a gynecology and psychiatry combination are preferred skills for a forensic nurse in light of the strong assessment skills inherent in each field.

Other important factors in hiring forensic nurses are the willingness and ability to work an on-call schedule that spans days, evenings, nights, and weekends. Flexibility to cover extra shifts when needed, and to adjust well to a lifestyle of carrying a pager and being prepared for a case at any time during their shift is important. Timeliness is imperative to good rapport and credibility with other service providers (physicians, nurses, law enforcement, etc.) and victims. Forensic nurses in a rural program must also be able to accept the position knowing that the caseload and nature of the work are not conducive to providing a steady income. If the nurse is seeking the position for a stable part-time or steady extra income, it must be understood that this will not occur. Hence,

the type of individual who can function well as a forensic nurse, especially in a rural program for sexual assault victims, has very specific skills and goals inherent to their success in this field. Such nurses may be difficult to find, particularly in more remote settings.

Once identified as strong candidates for forensic nursing in a sexual assault examiner program, the nurses, in order to develop expertise and gain credibility in the field, must complete a training course that has been designed specifically for this field of practice (Ledray, 1992). The course includes a 40-hour classroom training (inclusive of lectures, videos, skills demonstration, and interactive dialogue), training and competency demonstration for completing pelvic examinations and phlebotomy skills, and shadowing seasoned nurses on actual cases. The forensic nurses must demonstrate competency in these skills prior to independent practice. In addition, the nurses are provided an extensive reading list in manual format that must be studied for the program. During the training process, the nurses are introduced to other team members such as police officers, county attorneys, physicians, sexual assault advocates, and the Bureau of Criminal Apprehension (BCA). The training process is designed in continuing education format such that CEU's can be offered.

Role of Program Evaluation

Suchman's work on program evaluation (as cited in Kettner, Moroney, & Martin, 1990) suggests six measurement activities for evaluation of programs developed, as follows: "(a) analysis of the problem; (b) identification of the goals to be evaluated; (c) description and standardization of the activities; (d) measurement of the degree of change that takes place; (e) determination of the costs of the program, including costs

associated with achieving results; and (f) determination of whether the observed change is due to the activity or some other cause" (p.189-190). The first three measurement activities should be accomplished during the needs assessment and early program development stages. The fourth, fifth and sixth measurement activities can be accomplished once the program has been implemented and clients have been served. Determination of the costs of the program should be determined during the course of program development, but will require revision during the course of program implementation.

In the evaluation of change, which has occurred since the onset of the program's services, a baseline needs assessment should be implemented to assist in determination of whether the change can be attributed, in part or whole, to the actual services implemented by the program. Unfortunately, forensic examination of sexual assaults have not been well tracked in the health care system prior to this program implementation. Therefore, measurement is dependent on statistical reports from area law enforcement agencies. Measurement of service utilization in the Emergency Departments can only be measured from program onset and forward unless a concerted effort to collect data within the health care system was developed and implemented prior to the 1997 changes in the 1997 ICD-9CM and DRG coding system by which hospitals can track clientele by diagnostic groups.

The program budget outline delineated earlier in this chapter does address program evaluation by developing a budget framework that measures the cost of each unit of service to the total program costs. This incorporates both inkind and real costs of program operation.

Summary

Despite the inconsistencies between and inadequacies of individual provider systems' data collection on sexual assault cases, the numbers that do exist indicate a need for improved forensic and psycho-social support services. The discrepancies between the number of cases occurring VS. those reported to law enforcement VS. those substantiated and charged as a sexual assault VS. those successfully prosecuted is significant. The cost of poor outcomes for victims is significant, as noted in the case study presented. The indications suggest a need for collaboration among involved service providers, including the addition of specialized forensic nursing.

While the need for improved services is identified, the cost factors remain a reality that must be adequately addressed. Collaboration among service providers is one measure by which resources can be brought together, both to provide inkind resources and a united effort to improve processes in the services to victims. Maximizing existing resources and sharing of resources and services can be critical cost-savings for the implementation of a forensic examiner program. Sharing of resources and services may also expand the accessibility of needed services to victims. Issues surrounding 'access' are very relevant to a rural community (or communities). Thus, creativity is important in resource allocation.

Development of an actual forensic examiner program requires attention to many intricate details. Organizational structure must be determined based on whether or not a collaborative effort exists with other medical facilities. Also, delegation of responsibilities should be assigned based, not only on qualifications of personnel, but also on decisions about how much can be handled on an 'inkind' basis, as opposed to hiring

out services. Inkind services and resources should be maximized based upon availability and appropriateness to the needs identified.

Determination of the scope of services offered is an initial step in the program development process. To a large degree, this decision is based upon available resources through collaboration with other services providers. It may also be affected by fiscal constraints. The core functions of a forensic examiner are delineated utilizing the IAFN standards and the SANE Program Development Manual. Forms for program management and the medical record are most efficiently adapted from the program development manual. Examples are shown in the appendices. Training and credentialing staff appropriately is important if they are to be identified as experts in the judicial process.

Administrative functions such as budget development and exploration of funding sources are critical to program development. These are not inherently strength areas for human service professionals, but financing is a critical issue that must be developed within the role of social worker as a leader in program development of this nature. Likewise, developing measurability for seemingly unquantifiable improvements in the lives of victims must be addressed satisfactorily to ensure continued funding and ongoing collaborative support from other service providers. Once identified, the means by which to create measurability is not difficult. However, quantifying improved long-term outcomes in victims has proven, to date, to be difficult due to problems inherent in maintaining longitudinal studies on individuals.

CHAPTER FIVE: CONCLUSIONS AND IMPLICATIONS

Limitations

A needs assessment was conducted, in the course of this study, to determine whether the requests by service providers substantiated the need for specialized sexual assault forensic services in a rural setting. Findings suggested such a service would address a gap in the already existing array of services provided to sexual assault victims. While significant benefits were found for implementing such a program, limitations were also either discovered or further understood through the program design and implementation processes. The primary limitations identified include:

1) the high cost of program implementation compared to the low reimbursement for the services;
2) the significant role that support from other related service providers play in the ultimate success of the program versus how healthcare industry fiscal changes may impact such buy-in or support;
3) the limited availability in a rural setting of mental health/behavioral health services specializing in PTSD and related issues commonly experienced by sexual assault victims;
4) the lack of epidemiological data supporting prevalence of assaults, as well as longitudinal studies supporting the direct correlation to residual effects, and the subsequent costs to the health care industry and to public health;
5) the lack of literature and documented studies on the cost savings involved from a health promotion perspective.

Implications for Social Work Practice

As of September 1997, only one social worker (MSW) was identified in a leadership role of a SANE Program nationwide. Clearly, limitations exist Social Work leadership from the standpoint that a manager who is not a nurse can be trained to provide the skills required in a forensic examination to the extent of an expert in the field. However, unless the social worker also has a nursing license, she will need to rely more heavily upon the Emergency Room physician and nurse to address some medical functions that a forensic nurse could otherwise address. This may compromise the cost-savings needed for such a program to survive, especially in a rural setting.

In contrast, the expertise that a social worker provides is leadership in the systems process of program development, implementation, and evaluation (see Figure 7). In addition, a clinical social worker (see Figure 8) can also provide the crisis intervention and/or ongoing behavioral health support beneficial for some victims whose adjustment to the effects of sexual assault are complicated and problematic. If the social worker is licensed for clinical practice, the services of ongoing mental health support may be reimbursable by insurances, indicating a secondary source of income for the program.

The profession of Social Work has, at its core, been a leader in community initiatives and grassroots administration of needed community social services. In the current health care industry, the function of Social Work can prove invaluable in visionary leadership through identification and delivery of viable services. Social Work services have the capacity to promote equitable care in an age of growing public accountability of health care delivery services. This can be accomplished through core Social Work functions that are critical to health care in the 21st century (see Tables 2 & 3).

Role of Social Work

- Program development and management
  - Implement population based strategies
  - Improve access management
  - Implement community-based health promotion and disease prevention efforts
  - Improve the system of care through policy development, workforce training, and research initiatives

Figure 7.

Role of Social Work

- Clinical services (LISCW)
  - Crisis intervention
  - Advocacy and justice preservation
  - Continuity management
  - Behavioral Health Services

Figure 8.

Clinical Social Work services may be a means of providing mental health services that otherwise can be of limited availability in a rural setting. This is especially true of mental health providers who have expertise in PTSD issues that rape victims may experience. As delineated in Chapter 2, long-term residual effects of sexual assault are common and can have very serious and costly outcomes. Such residual effects are clearly within the realm of service of a mental health provider when the effects are identified as fear, anxiety, depression, suicide ideation and attempts, chemical abuse, low self-esteem, personality disorders, risk for revictimization, and, in some situations, serious and persistent mental illness or personality disorders. In addition, according to the National Association of Social Workers in "Trauma: Survival Is Victory", victims of unresolved trauma are also at risk for developing aggressive behavioral traits that revictimizes themselves or others. In addition, under extended trauma with lack of proper mentors, victims may experience a 'truncated moral development' (p.5), risking further harm to self or others.

Likewise, in the Emergency Room, the Social Worker can have an important role in the education and support of ER staff during the course of a forensic examination. While the ER staff may turn over the primary care of the victim to the forensic examiner, they still have important functions in the overall care and triaging of victims. In a community where sexual assault advocacy services are pre-existing and well-established, the role of the social worker with the victim becomes more complicated. Advocates who can provide 24hour response and provider-client privilege (comparable to a therapist and patient, per Minnesota statutes) must be weighed against the hospital social worker's more limited availability (rural hospitals are less likely to have continuous social work staffing, if social workers are staffed at all) and exemption from the provider-client

privilege by nature of the professional relationship. The advantage, however, is when the primary advocate (or management) in that agency is a Masters-level Social Worker. Each rural program must determine the available resources and weigh the pros and cons. Wherever possible, the utilization of a Social Worker is preferable due to the psycho-social expertise as a mental health professional. Most sexual assault advocates are trained and certified volunteers, but may not have a mental health or social work background. This will limit the depth and scope of services that can be offered to the victim in a most comprehensive package.

Implications for Further Research

The first organized sexual assault nurse examiner's program was implemented during the mid-1970's. Program expansion did not, however, notably occur until the mid-1990's. Cost-effectiveness is one of the important barriers to program implementation and maintenance. This is particularly true in rural settings where service utilization is lower than in a metropolitan or suburban service area. Strategies for program design that incorporate fiscal viability are critical in the current health care industry reform. In the actual program implementation of this thesis proposal, resolution of this issue is critical to the long-term survival of the program (see Figures 14 & 15). Expansion of the service area to further out-lying hospitals might be one alternative for program survival. Logistical problems exist (i.e. SANE response times to the E.D.), but this might create access to other rural communities that, otherwise, would be without such services. Other creative methods of revenue production might be necessary, as well. Providing forensic services for suspect exams is another venue to explore.

Implications for Further Research

- Financial viability
  - Alternative funding sources
  - Expansion of services
  - Cost control
  - Contractual agreements for services rendered
- LICSW as forensic examiner/manager in a rural medical SA/FE program
  - Cost effectiveness of continuum of care

Figure 9.

Implications for Further Research

- Longitudinal studies on outcomes and satisfaction
  - Identify benefits to the health of the community
- Strengthen collaborative efforts with other service providers
- Promote value/benefits of social work role

Figure 10.

Serving a rural population may equate to fewer resources available to provide a comprehensive program. LISW or LICSW social workers who provide clinical and administrative leadership may not be available through a rural hospital. Identifying accessible and adequate mental health services is critical to the promotion of health in most rape victims. In the current health care industry reform, social work positions are being eliminated from most rural hospitals. Further research into the viability of medical social work services is important for servicing a rural population who, inherently, has limited access to most health-related services.

EPILOGUE

The research conducted for this thesis was accomplished with the intention of actually implementing a program. The thesis research began in 1995 during my Master of Social Work coursework. On June 1, 1998, the program proposal became a reality and the Sexual Assault Forensic Examiner Program opened it's doors. This program was developed through collaborative efforts of invested service providers and organizations. Much of the work in this thesis research went into the actual program. However, many issues arose in the 'real' program development that could not have been anticipated at the academic research level. To other communities and organizations who may explore the implementation of such a program, my recommendations would include that provider collaborations and an understanding of the needs and cultures of the individual communities be given great priority.

The SAFE Program, now 1-1/2 years old, continues to grow in volumes of caseload consistent with the growth patterns mentioned earlier of other programs. Enclosed are examples of outcomes from this program that emphasize that, even in it's early stages, this program is making a positive impact on judicial outcomes, changes in perception about services provided to sexual assault victims (by direct service providers such as law enforcement, emergency room staff, victim advocates, and County Attorney's Office) (see Figures 11-15). The past five years have required a very involved process, but, based upon the successful outcomes already seen, the time spent and sacrifices made have been priceless. The concern for the long-term health of the victims continues to be a reality. Tracking victims over time has been a challenge for other providers in the past. Combined with respect for their autonomy and desire to put the assault behind them, it is

often a challenge to access victims in order to measure long-term results. But measurable improvements do exist in tangible and meaningful ways that demonstrate the worth of the program in ways that do promote an environment that sets the foundation for a healthier adjustment for victims in their survival process.

Perceived Changes

	Before	After
Local Accessibility	Low	High
Provider Expertise	Low	High
Time Involvement	High	Medium
Brief Therapeutic Interventions	Low	High
Local Support	Low	High

Figure 11.

Medical-legal Implications

	Before	After
Injury Identi-fication	Low to Medium	Medium to High
Disease Prevention	Low	High
Pregnancy Prevention	Medium	High

Figure 12.

Implications of a SA/FE Model

- Obtaining convictions through
  - Careful collection of the evidence
  - Testimony of observations
  - Documentation of injuries
  - Expertise regarding sexual assault victims and exams
  - Corroboration of victim's report
- Victim
  - Can feel safe
  - Can feel believed
- End result
  - Suspect can no longer hurt others
  - Promotes healing for victim
  - Promotes safety

Figure 13.

SA/FE Case Example - Judicial Implications

- Guilty on one count of criminal sexual conduct in the first degree
- Guilty on two counts of criminal sexual conduct in the third degree
- Guilty on one count of kidnapping
- Acquitted on one alternative count of criminal sexual conduct in the first degree
- All guilty counts are felonies

Figure 14.

SA/FE Case Example - Judicial Implications Continued . . .

- Immediate custody without bail
- Sentencing: 129 months
  - 1 1/2 times typical sentence
- Sanctions
  - +10 yr "conditional release"
  - Register as sex offender
  - Submit DNA
  - No contact with victim
  - No unsupervised contact with juveniles under 18 years old
  - Pay restitution to victim for costs

Figure 15.

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AUGSBURG

C • O • L • L • E • G • E

Appendix A

May 25, 1997

TO: Sheri L. Arnett
307 East Fourth Street
Hastings MN 55033

FROM: Rita R. Weisbrod, Ph.D.
Chair
Institutional Review Board
(612) 330-1227 or FAX (612) 330-1649

Your IRB application: "SAFE Program: Rural Health Care Response to Sexual Assault"

I have now received all portions of your application, which qualifies as exempt under category 5 (Public Service Programs). I am pleased to report that it is approved without conditions.

Your IRB approval number is:
#96-64 -1.

This number should appear on all participant- related material.

If there are substantive changes to your project which change your procedures regarding the use of human subjects, you should report them to me by phone (612-330-1227) or in writing so that they may be reviewed for possible increased risk.

Good luck to you in your research project!

Copy: Rosemary Link, Thesis Adviser

APPENDIX B

1997 Minnesota Statutes

Chapter Title: CRIMINAL CODE

Section: 609.35

Text:

609.35 Costs of Medical Examination

No costs incurred by a county, city, or private hospital or other emergency medical facility or by a private physician for the examination of a complainant of criminal sexual conduct when the examination is performed for the purpose of gathering evidence for possible prosecution, shall be charged directly or indirectly to the complainant. The reasonable costs of the examination shall be paid by the county in which the alleged offense was committed. Nothing in this section shall be construed to limit the duties, responsibilities, or liabilities of any insurer, whether public or private.

APPENDIX C

Chapter Title: CRIMINAL CODE

Section: 609.341

Text:

609.341 Definitions.

Subdivision 1. For the purposes of sections 609.341 to 609.351, the terms in this section have the meanings given them.

Subd. 2. "Actor" means a person accused of criminal sexual conduct.

Subd. 3. "Force" means the infliction, attempted infliction, or threatened infliction by the actor of bodily harm or commission or threat of any other crime by the actor against the complainant or another, which (a) causes the complainant to reasonably believe that the actor has the present ability to execute the threat and (b) if the actor does not have a significant relationship to the complainant, also causes the complainant to submit.

Subd. 4. (a) "Consent" means words or overt actions by a person indicating a freely given present agreement to perform a particular sexual act with the actor. Consent does not mean the existence of a prior or current social relationship between the actor and the complainant or that the complainant failed to resist a particular sexual act.

(b) A person who is mentally incapacitated or physically helpless as defined by this section cannot consent to a sexual act.

(c) Corroboration of the victim's testimony is not required to show lack of consent.

Subd. 5. "Intimate parts" includes the primary genital area, groin, inner thigh, buttocks, or breast of a human being.

Subd. 6. "Mentally impaired" means that a person, as a result of inadequately developed or impaired intelligence or a substantial psychiatric disorder of thought or mood, lacks the judgment to give a reasoned consent to sexual contact or to sexual penetration.

Subd. 7. "Mentally incapacitated" means that a person under the influence of alcohol, a narcotic, anesthetic, or any other substance, administered to that person without the person's agreement, lacks the judgment to give a reasoned consent to sexual contact or sexual penetration.

Subd. 8. "Personal injury" means bodily harm as defined in section 609.02 (7), or severe mental anguish or pregnancy.

Subd. 9. "Physically helpless" means that a person is (a) asleep or not conscious, (b) unable to withhold consent or to withdraw consent because of a physical condition, or (c) unable to communicate nonconsent and the condition is known or reasonably should have been known to the actor.

Subd. 10. "Position of authority" includes but is not limited to any person who is a parent or acting in the place of a parent and charged with any of a parent's rights, duties or responsibilities to a child, or a person who is charged with any duty or responsibility for the health, welfare, or supervision of a child, either independently or through another, no matter how brief, at the time of the act. For the purposes of subdivision 11, "position of authority" includes a psychotherapist.

Subd. 11. (a) "Sexual contact", for the purposes of sections 609.343, subdivision 1, clauses (a) to (f), and 609.345, subdivision 1, clauses (a) to (e), and (h) to (l), includes any of the following acts committed without the complainant's consent, except in those cases where consent is not a defense, and committed with sexual or aggressive intent:

(i) the intentional touching by the actor of the complainant's intimate parts, or

(ii) the touching by the complainant of the actor's, the complainant's, or another's intimate parts effected by coercion or the use of a position of authority, or by inducement if the complainant is under 13 years of age or mentally impaired, or

(iii) the touching by another of the complainant's intimate parts effected by coercion or the use of a position of authority, or

(iv) in any of the cases above, the touching of the clothing covering the immediate area of the intimate parts.

(b) "Sexual contact," for the purposes of sections 609.343, subdivision 1, clauses (g) and (h), and 609.345, subdivision 1, clauses (f) and (g), includes any of the following acts committed with sexual or aggressive intent:

(i) the intentional touching by the actor of the complainant's intimate parts;

(ii) the touching by the complainant of the actor's, the complainant's, or another's intimate parts;

(iii) the touching by another of the complainant's intimate

(iv) in any of the cases listed above, touching of the clothing covering the immediate area of the intimate parts.

(c) "Sexual contact with a person under 13" means the intentional touching of the complainant's bare genitals or anal opening by the actor's bare genitals or anal opening with sexual or aggressive intent or the touching by the complainant's bare genitals or anal opening of the actor's or another's bare genitals or anal opening with sexual or aggressive intent.

Subd. 12. "Sexual penetration" means any of the following acts committed without the complainant's consent, except in those cases where consent is not a defense, whether or not emission of semen occurs:

(1) sexual intercourse, cunnilingus, fellatio, or anal intercourse; or

(2) any intrusion however slight into the genital or anal openings:

(i) of the complainant's body by any part of the actor's body or any object used by the actor for this purpose;

(ii) of the complainant's body by any part of the body of the complainant, by any part of the body of another person, or by any object used by the complainant or another person for this purpose, when effected by coercion or the use of a position of authority, or by inducement if the child is under 13 years of age or mentally impaired; or

(iii) of the body of the actor or another person by any part of the body of the complainant or by any object used by the complainant for this purpose, when effected by coercion or the use of a position of authority, or by inducement if the child is under 13 years of age or mentally impaired.

Subd. 13. "Complainant" means a person alleged to have been subjected to criminal sexual conduct, but need not be the person who signs the complaint.

Subd. 14. "Coercion" means words or circumstances that cause the complainant reasonably to fear that the actor will inflict bodily harm upon, or hold in confinement, the complainant or another, or force the complainant to submit to sexual penetration or contact, but proof of coercion does not require proof of a specific act or threat.

Subd. 15. Significant relationship. "Significant relationship" means a situation in which the actor is:

(1) the complainant's parent, stepparent, or guardian;

(2) any of the following persons related to the complainant by blood, marriage, or adoption: brother, sister, stepbrother, stepsister, first cousin, aunt, uncle, nephew, niece, grandparent, great-grandparent, great-uncle, great-aunt; or

(3) an adult who jointly resides intermittently or regularly in the same dwelling as the complainant and who is not the complainant's spouse.

Subd. 16. "Patient" means a person who seeks or obtains psychotherapy

Subd. 17. "Psychotherapist" means a person who is or purports to be a physician, psychologist, nurse, chemical dependency counselor, social worker, marriage and family counselor, or other mental health service provider; or any other person, whether or not licensed by the state, who performs or purports to perform psychotherapy.

Subd. 18. "Psychotherapy" means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.

Subd. 19. "Emotionally dependent" means that the nature of the former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to know that the former patient is unable to withhold consent to sexual contact or sexual penetration by the psychotherapist.

Subd. 20. "Therapeutic deception" means a representation by a psychotherapist that sexual contact or sexual penetration by the psychotherapist is consistent with or part of the patient's treatment.

APPENDIX D

Functional/Program Budget Work Sheet

	Sexual Assault Forensic Examiner Program	*Indirect Cost Pool*
******** - Salaries		
(1) program director	$********	
(2) clinical supervisor		$******
(3) forensic examiners		
(a) per case @ $***** ea.	$********	
(b) staff meetings, etc.	$********	
(4) administrative support		
(a) secretarial		$******
(b) billing		$******
******** - Employee-related expenses	$********	$*******
******** - Supplies	$********	$*******
******** - Telephone		$*******
******** - Postage & Shipping		$*******
******** - Occupancy		$*******
******** - Equipment	$********	$*******
******** - Travel	$********	
Total Direct Costs	$********	$*******
(Relative Percentage)	%%%%%%%	%%%%%%
Allocated indirect costs	$********	$********
Total program costs	$********	$********

APPENDIX E

Output/Outcome Cost Work Sheet

Sexual Assault Forensic Examiner Program

Unit of Service Cost

unit of service = one evidentiary examination (or one victim seen)
units of service to be provided during fiscal year = ##
(conservative random total based on county needs assessment versus cases actually seen during past year)
*total program costs = $*****

$$\textit{unit of service cost} = \frac{\textit{total program cost}}{\text{units of service}} = \frac{\$\$\$}{\#\#\#} = \$***$$

Cost Per Output (or Service Completion)

service completion = completion of reported evidentiary exam, prophylactic care, crisis intervention, medical care (as needed), and follow-up care for estimated 50 victims

total program costs = $$$$$

$$\textit{cost per outcome} = \frac{\textit{total program cost}}{\textit{service completions}} = \frac{\$\$\$\$\$}{\#\#\#} = \$****$$

Cost Per Outcome

outcome = improved

*total program costs = $*****

$$\textit{cost per outcome} = \frac{\textit{total program cost}}{\textit{program objective}} = \frac{\$****}{\#\#\#\#\#} = \$*****$$

APPENDIX F

CALIFORNIA HOSPITAL MEDICAL CENTER
JOB DESCRIPTION ADDENDUM
CLINICAL NURSE II / SEXUAL ASSAULT NURSE EXAMINER

SUMMARY:
The Sexual Assault Nurse Examiner (SANE) is a Registered Nurse II who, through certification, competency, and experience, provides forensic services for the sexual assault survivor.

ACCOUNTABILITY:
The Sexual Assault Nurse Examiner is accountable to the SART/SANE Program Coordinator for the results of her performance. She is also accountable for maintaining a collaborative relationship with the entire Response Team (SART) involved in the care of the sexual assault survivor.

AUTHORITY:
The SANE nurse has the authority to provide services for the sexual assault survivor in collaboration with the disciplines in the Sexual Assault Response Team.

RESPONSIBILITIES:
Follows the nursing process as outlined in the policies and procedures of the program.

Participates in documentation and evaluation process with the SART / SANE Program Coordinator.

Assures all activities performed as SANE adheres to established guidelines.

Maintains a close working relationship with SART / SANE Coordinator and members of other disciplines involved in the care of sexual assault survivors.

Maintains equipment and supplies in the SART room pre- and post-exam.

Maintains records and statistics as appropriate.

Takes on-call shift as scheduled, responding within 45 minutes of initial call.
Submits work schedule of time available to SART / SANE coordinator as soon as possible in order to facilitate the on-call schedule.

Maintains contact with the SART / SANE coordinator for at least one year after termination of employment in program and responds to any / all subpoenas on cases she examined while employed with the SART / SANE program.

Participates in certification process and maintains skills through SART meetings and interaction with other disciplines participating in program.

Maintains confidentiality of SART and survivor.

QUALIFICATION:

Registered Nurse with background in Emergency, Labor and Delivery, Critical Care, OB/GYN, or Medical-Legal background with acute care experience. Nurse Practitioner a plus.

Previous SANE experience and bilingual a plus.

(Used by permission).

Appendix G

Sexual Assault Nurse Examiner Checklist
Certification to Perform Sexual Assault Evidentiary Exam

Name: _____

Complete SA Exam Following Protocol	Dates	Preceptor Signature
Introduce self and explain the 5 services provided by SANE		
Explain parameters of confidentiality and obtain consent		
Assist in police report decision		
Complete interview		
Collect, mark, and secure appropriate clothing		
Conduct full body exam for injuries		
Woods lamp exam		
Examine oral cavity for injuries and collect DNA specimens		
Examine external genitalia for injuries		
Pubic hair combing		
Collect perineal/skin DNA specimens		
Perform pelvic and bimanual exam		
Collect vaginal DNA specimen		
Perform exam for anal injuries/rectal exam and collect DNA specimens		
Use light staining microscope		
Photograph genital injuries using colposcope		
Photograph injuries using camera		
Collect saliva sample		
Draw victim's blood and prepare DNA swatch		
Label and secure/transport BCA and hospital lab specimens		
Counsel patient about STD/pregnancy risk		
Staff case with physician		
Incorporate the 7 essential components of crisis intervention into discharge teaching		
Arrange follow-up counseling/safe disposition		

Sexual Assault Resource Service Minneapolis, MN June 1998

(Used by permission).

Appendix H

COLUMBIA UNIVERSITY SCHOOL OF NURSING
FORENSIC NURSE SPECIALIST

Preceptorship

Thank you for being a preceptor for Sexual Assault Nurse Examiner. We hope the following information helps enhance the experience for the Nurse Examiners, and makes the preceptorship enjoyable for you as well.

What Is A Sexual Assault Nurse Examiner?

The Nurse Examiners are Registered Nurses or Nurse Practitioners who have an interest in working with sexual assault survivors. They have receive 32 hours of education help them perform four functions.

1. Perform comprehensive health assessments of sexual assault survivors.
2. Collect and document physical and laboratory evidence.
3. Provide information referral to enhance the continuity of care for a sexual assault survivor.
4. Present testimony in court, when required.

Please consult the enclosed information packet for additional background of the SANE Program.

What Can I Expect The Nurse Examiner to Know?

You will find a copy of the curriculum used to educate the Nurse Examiners in the enclosed packet. The Nurse Examiners have completed the classroom portion of their training, and are now ready to gain the clinical experience. You, as health care professionals, are in a unique position to provide nurses with the necessary learning experiences.

What Are The Goals Of the Preceptor?

The Nurse Examiner will be spening time with a variety of agencies. They will complete a preceptorship in the following settings:

1. Law Enforcement Agencies
2. Child Protective Services
3. The District Attorney's Office
4. The Victim/Witness Program
5. Family Planning Clinics
6. Pediatrician's Offices
7. Hospital Emergency Departments
8. Sexual Assault Exam Rooms

Each Nurse Examiner will be contacting the preceptor settings to arrange their time. You will find a list of preceptors in the enclosed packet.

FORENSIC NURSE SPECIALISTS
CERTIFICATION TO PERFORM SEXUAL ASSAULT EXAMINATION

PRECEPTORSHIP CHECKLIST

EXPERENCE	DATE	SIGNWHEN COMPLETED
Agencies		
Law Enforcement		
Case Review		
Police Ride-along		
District Attorneys		
Criminal Court Case		
Advocate Service		
Staff Meetings		
Crime Lab		
Tour		
Hospital Exam Room Order		
Orientation to examination		
Assessment Skills		
Minimum 10-12 pelvic exams: Speculum Bimanual		
Colposcope Time - 1 hour		
Sexual Assault Exams		
Observe Sexual Assault Exams		
Perform Sexual Assault Exam With Assistance		

(Used by permission).

Appendix I

City of Memphis
TENNESSEE

Memphis Sexual Assault Resource Center
CONSENT FOR EXAMINATION

CASE NUMBER _____

I, _____, do hereby authorize the Forensic Nurse Evaluator/Clinician at the Memphis Sexual Assault Resource Center to perform the following:

_____ a. Collect evidence, including hair combings, blood sample, photographs, body fluid samples, scraping of finger nails, and collection of clothing.

_____ b. Pelvic examination.

_____ c. Visual inspection of injuries and possible areas of assault including the oral cavity, the genitalia, and the rectum.

_____ d. Screen for venereal diseases, including cultures, body fluid samples, and/or blood collection.

_____ e. Collect urine and/or blood for drug screen.

_____ f. Collect urine for pregnancy test.

_____ g. Give medication for the intention of preventing pregnancy and/or infection.

_____ h. Other _____

FOR YOUR INFORMATION (PLEASE READ):

The information provided by you about your (your child's) case will be entered into a computer data base. Then the information will be combined with other data to be analyzed. Information about an individual's rape experience is private and shared only on a "need to know" basis. For example, if you are an adult and have given permission to report to law enforcement, the police will have access to the forensic report, evidence, and laboratory test results on the evidence. If the client is a child, the Child Protection Team will have access to the forensic report, evidence, and laboratory test results on the evidence.

The medical information contained in this record is private and protected under state law. It is also confidential, and in most circumstances, the medical record will be released only with your permission and a signed Release of Medical Information. However, there are exceptions: 1. Infrequently, medical information is subpoenaed by a court and must be released. 2. Occasionally the medical information is shared within the MSARC organization or the Child Protection Team on a "need to know" basis.

****

The procedures and services have been explained by the Forensic Nurse. By signing this form, I authorize the Forensic Nurse Evaluator/Clinician to perform the procedures and provide the services that are marked above. I understand that I can withdraw my consent at any time.

_____ Patient Signature

_____ Parent/Guardian

_____ Date

_____ Relationship to Patient

TELEPHONE CONSENT FOR MINORS:

_____ Parent/Guardian

_____ Identifying Information (SS#, DL#, TP#)

_____ Relationship to Patient

_____ Witness - Forensic Nurse Evaluator/Clinician

Original: Clinic
Copy: Client

(Used by permission).

Appendix J

HENNEPIN COUNTY MEDICAL CENTER
Minneapolis, MN 55415

NARRATIVE NOTES

Pt. Med. Rec. #:

Pt. Name:

180-00455 (9/95)

CONSENT FOR POST-COITAL ESTROGEN TREATMENT
(The Morning After Pill)

You must understand certain facts in order to make an informed decision about post-coital estrogen treatment.

I. Your doctor and nurse have determined from your history that you are at risk for getting pregnant from this exposure.

II. Estrogen therapy, if given soon after intercourse, has been shown to be effective in preventing pregnancy, but it is not 100% effective.

III. It is remotely possible that you have an undetected pregnancy from prior consented intercourse, despite your negative pregnancy test today.

IV. If you are already pregnant, or if you get pregnant despite taking post-coital estrogens this cycle, there is significant risk that your fetus will have extremity, heart, neurologic or other birth defects. If you become pregnant this cycle, you would be advised to have an abortion. You should avoid further exposure to pregnancy this cycle by using contraception or avoiding sex until your next period.

V. If you do not have your period within thirty days of taking the morning after pill, you must see your doctor promptly for a pregnancy test and counseling.

VI. Estrogens given in doses to prevent pregnancy cause many women to have nausea, vomiting and breast tenderness. This usually resolves in 24 hours. A rare, but serious and sometimes fatal, side effect is abnormal blood clotting.

VII. The morning-after pill is for emergency use only. It is not recommended for repeated use or as a routine method of contraception. If you do not desire to get pregnant in the future, you should see your doctor to discuss a contraceptive method appropriate for you.

The above information has been reviewed with me by Dr. _____ and I have had the opportunity to ask questions. I understand the nature, risks and side effects of this treatment.

_____ _____
Patient's Name Date

_____ _____
Witness Date

(Used by permission).

Appendix K

City of Memphis
TENNESSEE

SEXUAL ASSAULT RESOURCE CENTER
901/272-2020 (Voice or TDD)

NURSING-MEDICAL EVALUATION-TREATMENT FORM

CASE #: _____ TODAY'S DATE / TIME: _____

IDENTIFYING INFORMATION (please print):

PATIENT'S NAME: _____ PATIENT'S SS#: _____
PATIENT'S DATE OF BIRTH: _____ ATTENDING PARENT/GUARDIAN: _____
PATIENT'S AGE/RACE/SEX: _____ RELATIONSHIP: _____
PATIENT'S ADDRESS: _____ ZIP CODE: _____
CITY-STATE: _____
HOME PHONE: _____ WORK PHONE: _____ MOBILE PHONE: _____
DIGITAL PAGER: _____ OTHER PHONE(S)/RELATIONSHIP: _____
CAN WE CALL YOU AT THE PHONES LISTED ABOVE? YES _____ NO: _____
ANY SPECIAL INSTRUCTIONS? _____

PATIENT/VICTIM MEDICAL HISTORY:

OB/GYN HX: G ____ P____ tAB ____ sAB ____
LMP: _____
AGE OF 1st MENSES: _____
CURRENT MEDICINES: _____

ALLERGIES TO MEDICINES: _____
MEDICAL ILLNESS HX: _____

PAST HOSPITALIZATIONS: _____

SURGICAL HX: _____

SEXUAL ASSAULT/ABUSE HX: ____Y ____N
IF YES, AGE @ ASSAULT(S): _____
IF YES, SEEN AT MSARC? ____Y ____N
DOMESTIC VIOLENCE HX: ____Y ____N

MENTAL HEALTH HX: _____

MEDICAL/TOPICAL TREATMENT/ PROPHYLAXIS (CHECK ALL THAT APPLY):

_____ CEFTRIAXONE 125 MG IM
_____ DOXYCYCLINE 100 MG PO BID X 7 DAYS
_____ METRONIDAZOLE 2 GM PO STAT
_____ CIPROFLOXACIN 500 MG PO STAT
_____ AMOXICILLIN PO (DOSE: _____)
_____ EES PO (DOSE: _____)
_____ OTHER (DESCRIBE): _____
_____ VERBAL ORDER PER MEDICAL DIRECTOR
MEDS: _____

_____ EMERGENCY CONTRACEPTION
_____ VINEGAR DOUCHE
_____ ORAL HYGIENE
_____ TERAZOLE 7
_____ NONOXYNOL 9
_____ METRONIDAZOLE GEL .75%

ORDERING PHYSICIAN'S SIGNATURE: _____

VITAL SIGNS: temp _____ (F)
N/A wt _____ (lbs) ht _____ (inches)

BP _____ BP re✓ _____ (if indicated)
cuff size (circle one) Ch Sm Med LG XLG
Arm (circle one) lt rt

SANE Signature

MSARC FORENSIC NURSE FORM
NURSING/MEDICAL EVALUATION/TREATMENT: Rev. 5/97

(Used by permission).

ADULT

FORENSIC EVALUATION OF ALLEGED SEXUAL ASSAULT

2 copies to Police Officer
1 copy to Clinic

Case # _____

1. Identifying Information:
   Name _____
   DOB _____ Age _____ Sex _____ Race _____

Alleged Assault:
Date: _____
Time: _____

Forensic Exam:
Date: _____
Time: _____

2. General Forensic Exam: (Describe trauma) _____

3. Forensic Genital and Anal Exam: (Describe trauma) _____

4. Post Assault:

Yes	No	
☐	☐	Urination
☐	☐	Douche
☐	☐	Sponge bath
☐	☐	Bath/Shower
☐	☐	Defecation

5. Behavior type demonstrated during exam:

☐ Controlled ☐ Expressed ☐ Mixed

☐ quiet ☐ tearful
☐ tense ☐ sobbing
☐ fidgeting ☐ yelling
☐ trembling ☐ loud
☐ listless ☐ agitated
☐ staring ☐ other _____

Responds to questions:

☐ briefly ☐ reluctantly ☐ readily

7. Summary of Evidence:

Yes	No	
☐	☐	Kit Collected
☐	☐	Pubic hair
☐	☐	Panties/Clothing

Released to: _____

Condition _____

☐ ☐ Other _____

Physical/Genital exam done with:

Yes	No		Yes	No	
☐	☐	Direct visualization	☐	☐	Colposcope exam
☐	☐	Bimanual exam	☐	☐	Pics taken # ___
☐	☐	Speculum exam			

6. Additional Observation or Remarks: _____

8. Testing: Sperm

	SEEN	MOTILE	NON-MOTILE	NOT SEEN	NOT DONE
Vaginal					
Oral					
Anal					

9. Instructions for Follow-up

	Yes	No
A. ORAL	☐	☐
B. WRITTEN		
Agency brochures	☐	☐
Medical follow-up inst.	☐	☐

I hereby authorize use of this report, collected evidence and any other report incidental thereto by the Memphis Police Services and/or other Shelby County cooperating law enforcement agencies.

Person Examined _____
Parent or Guardian _____
Date _____

Examining Clinician _____
Police Officer _____
R&I # _____

CHILDREN

FORENSIC EXAMINATION OF ALLEGED SEXUAL ASSAULT

2 copies to Police Officer
1 copy to Clinic

Case # _____
Sibling Case # _____

1. Identifying Information:
Name _____
Guardian ☐ Parent ☐ _____
DOB _____ Age _____ Sex _____ Race _____
Address _____
City/State _____ Zip Code _____
Phone (home) _____ (other) _____

Alleged Assault:
Unknown: ☐
Date: _____
Time: _____

Forensic Exam:
Date: _____
Time: _____

2. Anal-gential chart

Female/Male General	WNL	ABN	Describe
Tanner stage			
Breast 1 2 3 4 5	☐	☐	
Genitals 1 2 3 4 5	☐	☐	
Medial aspect of thighs	☐	☐	
Perineum	☐	☐	

	Yes	No	
Vulvovaginal/urethral discharge (describe)	☐	☐	
Flat plaques/growths (describe)	☐	☐	

Female	WNL	ABN	Describe
Labia Majora	☐	☐	
Clitoris	☐	☐	
Labia minora	☐	☐	
Periurethral tissue/ urethral meatus	☐	☐	
Perihymenal tissue (vestibule)	☐	☐	
Hymen	☐	☐	
☐ Cresent			
☐ Annular			
☐ Other (describe)			
☐ Unable to determine (describe)			
Diameter of hymenal lumen			
☐ Horizontal _____ mm.			
☐ Vertical _____ mm.			
Posterior fourchette	☐	☐	
Vagina	☐	☐	

Other _____

Exam position used for genital evaluation:
☐ Supine ☐ Mother's lap

Male	WNL	ABN	Describe
Penis	☐	☐	
☐ circumcised ☐ uncircumcised			
Urethral meatus	☐	☐	
Scrotum	☐	☐	
Testes	☐	☐	

Female/Male Anus	WNL	ABN	Describe
Buttocks	☐	☐	
Perianal skin	☐	☐	
☐ feces present			
Anal verge/folds	☐	☐	
Anal shape (describe)	☐	☐	
☐ linear			
☐ circular			
☐ irregular (describe)			
Anal tone	☐	☐	

Method of exam: ☐ Observation ☐ Digital exam
Anal dilation ☐ ☐
☐ No dilation noted ☐ Funneling present
☐ External ☐ Internal Spincter relaxation
☐ Horizontal _____ mm. in _____ seconds
☐ Vertical _____ mm. in _____ seconds
☐ Feces in rectal ampulla

Anal tags ☐ Yes ☐ No Location: _____
Anal fissures ☐ Yes ☐ No Location: _____

Exam position used for anal evaluation:
☐ Supine ☐ Lateral recumbent ☐ Mother's lap
☐ Prone ☐ Knee chest

Summary of Evidence
☐ Kit collected
☐ No kit
☐ Clothing
☐ Other

Released to: _____

Genital exam done with:
Direct visualization ☐
Colposcope ☐
Pictures taken ☐ #

Case # ____________ CHILDREN

3. PERTINENT PAST MEDICAL HISTORY

Menarche age ☐ N/A ______

Date of last menstrual period ☐ N/A ______

Note history of physical injuries ☐ Yes ☐ No ☐ N/A ______

Pertinent medical history of ☐ anal-genital injuries, ☐ surgeries ☐ diagnostic procedures, or ☐ medical treatment? If yes, describe:

Previous child abuse investigation? ☐ Yes ☐ No ☐ Physical ☐ Sexual ☐ Neglect
(describe when and where)

5. Check behaviors observed during exam:

☐ tearful	☐ fidgeting
☐ sobbing	☐ trembling
☐ yelling	☐ controlled
☐ loud	☐ agitated
☐ quiet	☐ listless
☐ tense	☐ fearful
☐ cooperative	☐ other ______

responds to questions:
☐ readily ☐ briefly ☐ reluctantly

4. Symptoms described by patient: ☐ ______
by historian: ☐ ______
not evaluated: ☐

Physical symptom/hx:
- ☐ Abdominal/pelvic pain
- ☐ Vulvar discomfort or pain
- ☐ Dysuria
- ☐ Urinary tract infection
- ☐ Enuresis (daytime or nighttime)
- ☐ Vaginal itching
- ☐ Vaginal discharge
  Describe color, odor, amount ______
- ☐ Vaginal bleeding
- ☐ Rectal pain
- ☐ Rectal bleeding
- ☐ Rectal discharge
- ☐ Constipation
- ☐ Incontinent of stool (day/night)

Other: ______

6. Additional Observation or Remarks: ______

7. Treatment:
Hospitalization:
location ______
Prophylaxis:
pregnancy ______
gonorrhea ______

Testing:
pregnancy ______ VDRL ______
GC culture ______
Referral ______

8. Testing: Sperm

	SEEN	MOTILE	NON-MOTILE	NOT SEEN	NOT DONE
Vaginal					
Oral					
Anal					

9. Instructions for Follow-up

	Yes	No
A. ORAL	☐	☐
B. WRITTEN		
Agency brochures	☐	☐
Medical follow-up inst.	☐	☐

This report of the examination is an investigative report used as evidence by Memphis Police Services, Shelby County law enforcement agencies, Tennessee Department of Human Services, and other cooperating agencies.

Investigating Agency ______

DHS Social Counselor ______

Date ______

MRCC Forensic Evaluator ______

Police Officer ______

R&I # ______

Appendix L

Zigfrids. T. Stelmachers, Ph.D.

GUIDELINES FOR USE OF THE CISPA

1. The CISPA is an instrument used to help determine overall suicide rating. The purpose of the form is twofold: a. To insure needed consultation is obtained; and b. to assist in assessment of suicide potential. It should be filled out in its entirety even if the patient is already classified as needing consultation. Psychiatrists or psychologists may serve as consultants.

2. CISPA is to be completed if suicide is listed as one of the three major problem areas. If suicide is an issue for the client or staff, it should be listed as a problem.

3. Presence or absence of a given factor should be indicated by a "plus" or "minus" sign, respectively. A zero means that the necessary information to check a given item was not or could not be obtained.

4. CISPAs should also be completed for patients who have been placed on a hold (whether issued by CIC or others) on the basis of danger to self even though a hold by itself already dictates consultation by CIC policy. This will assure a uniform and thorough evaluation of seriously suicidal patients and will assist consultants in their evaluation.

5. If the patient meets the criteria for requesting consultation but refuses it, the refusal should be honored and documented. However, if the patient meets the legal criteria for a hold, such hold should be issued and consultation obtained even on an involuntary basis.

6. The first staff member to evaluate the patient should be responsible for filling out the CISPA during the interview. If a patient is not interviewable in the opinion of the responsible staff member, a meaningful evaluation cannot be done at that time, including filling out a CISPA. The evaluation, including the CISPA, should be done when the patient becomes interviewable. If, in the meantime, the patient has been carted and has been transferred to the next shift, it becomes the responsibility of the staff on the next shift to do the evaluation and CISPA. However, the <u>immediate</u> suicide risk <u>at the time of patient's admission</u> to CIC should be recorded on the narrative note based on whatever information is available at that time.

GUIDELINES FOR USE OF THE CISPA

7. If, according to our adopted criteria, the patient requires a consultation but could not be first evaluated by the CIC staff because he or she was not interviewable at the time of admission, it is not acceptable to simply refer this patient to the consultant the next morning without any prior staff evaluation. Excessive workload may occasionally lead to such a practice, but it should be considered an exception to the rule. In those instances, the consultant should fill out the CISPA.

8. Should the patient's mental condition change over time, a new CISPA need not be completed. The next staff member who reevaluates the patient's condition should note the changes on the narrative note. Whether the patient needs a consultation at that time or not will depend on his or her mental condition at that time, not on the original assessment.

9. Determining "moderate to severe" lesion or toxicity is based on staff judgment. If in doubt, consult emergency room personnel or other CIC staff. It may be wise to err in the direction of being more conservative, i.e., to request a consultation if there is any doubt about the severity of injuries.

10. A consultation need not involve the consultant's personal evaluation of the patient. It can be simply a verbal consultation between the CIC staff member and the consultant. The results of this consultation and the name of the consultant should be recorded in the chart.

CISPA – Critical Item Suicide Potential Assessment

ria for requesting consultation by either psychiatrist or doctoral level clinical psychologist (LCP).

ent Name: _____ **Date:** _____ **Time** _____

Current – PRIMARY RISK FACTORS (Obtain consultation if any one of the following is present):

I. **Attempt**

+ = Present - = Absent

____ 1. Suicide attempt with lethal method (such as by firearms, hanging/strangulation, jumping from high places).

____ 2. Suicide attempt resulting in moderate to severe lesions/toxicity.

____ 3. Suicide attempt with low rescuability (such as no known communication regarding the attempt, discovery unlikely because of chosen location and timing, no one nearby or in contact, active precautions to prevent discovery).

____ 4. Suicide attempt with subsequent expressed regret that it was not completed **and** continued expressed desire to commit suicide **or** unwillingness to accept treatment.

II. **Intent:** Includes suicidal thoughts, preoccupation, plans, threats, and impulses, whether communicated by the patient directly or by another person based on observations of the patient.

+ = Present - = Absent

____ 1. Suicidal intent to commit suicide imminently.

____ 2. Suicidal intent with a lethal method selected and readily available.

____ 3. Suicidal intent **and** preparations made for death (such as writing a testament or a suicide note, giving away possessions, making certain business and insurance arrangements).

____ 4. Suicidal intent with time and place planned, **and** foreseeable opportunity to commit suicide.

____ 5. Suicidal intent without ambivalence **or** inability to see alternatives to suicide.

____ 6. Presence of acute command hallucinations to kill self whether or not there is expressed suicidal intent.

____ 7. Suicidal intent with **currently active** psychosis, especially major affective disorder or schizophrenia.

____ 8. Suicidal intent or other objective indicators of elevated suicide risk but mental condition or lack of cooperation preclude adequate assessment.

Mediating – SECONDARY RISK FACTORS:

The following items all significantly contribute to suicide risk but are of a less critical nature. For the purpose of this instrument, all items are considered of equal importance. Obtain consultation if, in addition to suicidal intent, seven of the following items are present:

+ = Present - = Absent 0 = Unknown

____ 1. Recent separation or divorce.

____ 2. Recent death of significant other.

____ 3. Recent loss of job or severe financial setback.

____ 4. Other significant loss/stress/life changes interpreted by patient as aggravating (such as victimization, threat of criminal prosecution, unwanted pregnancy, discovery of illness, etc.).

____ 5. Social isolation.

____ 6. Current or past major mental illness.

____ 7. Current or past chemical dependency/abuse.

____ 8. History of suicide attempt(s).

____ 9. History of family suicide (include recent suicide by close friend).

____ 10. Current or past difficulties with impulse control or antisocial behavior.

____ 11. Significant depression (whether clinically diagnosable or not), especially if accompanied by feelings of guilt, worthlessness, or helplessness.

____ 12. Expressed hopelessness.

____ 13. Rigidity (difficulty with adaptation to life changes).

MAJOR CONTRIBUTING DEMOGRAPHIC CHARACTERISTICS:

Not to be included in the ratings, but considered in the overall assessment of suicide risk.

1. Male (especially older white male).
2. Living alone.
3. Single, divorced, separated, or widowed.
4. Unemployed.
5. Chronic financial difficulties.

Signature: _____ Title: _____

Appendix M

HENNEPIN COUNTY MEDICAL CENTER
Minneapolis, MN 55415

PT. MED. REC. #: D.O.B.

PT. NAME:

SEXUAL ASSAULT LABORATORY RESULTS

INSTITUTE WHERE EXAM PERFORMED _____

"I" ACCOUNT# _____

N 17149 (6/96)

DATE OF EXAM	TIME ☐ AM ☐ PM		DATE OF ASSAULT	TIME ☐ AM ☐ PM	
EXAMINING NURSE			HOURS SINCE LAST PRIOR INTERCOURSE _____	☐ > 72 HOURS	

CHECK (X) APPROPRIATE BOX FOR EACH SPECIMEN SUBMITTED

TEST		"X"	RESULTS AND DATE READ	TEST PERFORMED SIGNATURE/PRINTED NAME/TITLE	
SPERM MOTILITY	VAG				
	ANAL				
	ORAL				
	OTHER				
STAINED SMEAR	VAG				
	ANAL				
	ORAL				
	OTHER				
ACID PHOSPHATASE	VAG				
	ANAL				
	ORAL				
	OTHER				
NEISSERIA GONORRHEA ☐ CULTURE ☐ PROBE	VAG				
	ANAL				
	PHAR-YNGEAL				
	OTHER				
CHLAMYDIA ☐ CULTURE ☐ PROBE	VAG				
	RECTAL				
OTHER					

INSTRUCTIONS: *Verify patient and specimen(s) identification. Pleat-fold this form so that* ***ONLY*** *the Specimen Transaction Record is visible. Bag specimens and send with courier to HCMC lab.*

SPECIMEN TRANSACTION RECORD

EXAMINING NURSE/DEPARTMENT	GIVEN TO: NAME/DEPARTMENT	GIVEN TO: NAME/DEPARTMENT	GIVEN TO: NAME/DEPARTMENT

SPECIMEN ACCEPTED: NAME AND TITLE BY LABORATORY DEPARTMENT

1		4	
2		5	
3		6	

IMPRESSION

PATHOLOGIST: PRINTED NAME DATE

(Used by permission).

Appendix N

City of Memphis
TENNESSEE

DIVISION OF PUBLIC SERVICES
Memphis Sexual Assault Resource Center
901/272-2020(Voice or TDD)

FOLLOW UP INFORMATION AND INSTRUCTIONS
for Victims and their Primary Providers

CASE#:_____ TODAY'S DATE: _____

You may have been exposed to sexually transmitted diseases during your assault. TOMORROW, call your Managed Care Organization or Private Doctor. Make an appointment as soon as possible for tetanus and Hepatitis B immunizations. In addition, make an appointment for one month after your assault date for a follow up blood test for Syphilis, and pelvic tests for N. gonorrhea, Chlamydia trachoma, and other bacteria from the following areas:

☐ Throat ☐ Vaginal Introitus ☐ Cervix ☐ Anus ☐Urethra

We recommend baseline testing for HIV within the 1st week following your assault . In addition, we recommend that you have blood tests for HIV at 1 month, 3 months, 6 months, and 1 year following your assault. *We recommend condom use with your consensual partner until all tests return negative.*

You were prophylactically treated with the following medicines:

☐ Rocephin 125 mg IM (location)
☐ Doxycycline 100 mg po BID x 7 days
☐ Metronidazole 2 gm PO x I STAT dose
☐ Cipro 500 mg Po x I STAT dose
☐ Erythromycin _____ mg po (circle one) BID QID x7 days
☐ Amoxicillin _____ mg po TID x 10 days
☐ You were not treated prophylactically for STDs

In addition to your private doctor or your clinic, these tests are available from the:

Memphis/Shelby County Health Department - STD Clinic
814 Jefferson, Rm 221 Memphis, TN 38103
Call for an appointment: Telephone 576-7552

Medicaid, Medicare, TennCare and Private Insurance is accepted at this clinic. A $10.00 deposit is requested and charges will be carried if you have no insurance. Please speak to your Advocate about reimbursement through Victim's Compensation funds.

Please call for an appointment as soon as possible if you notice any of the following symptoms, such as:

an increase in discharge
burning or pressure duing urination
sores or blisters
"flu-like" symptoms
an "odor" from the vagina
painful intercourse
swollen lymph nodes
stomach pain

If you have any health questions, please call the nurse between the hours of 9:00 AM and 4:00 PM at the Memphis Sexual Assault Resource Center at *272-2020.*

REMEMBER TO TAKE THIS FORM WITH YOU TO YOUR HEALTH CARE PROVIDER ON YOUR *FIRST* FOLLOW UP VISIT.

Your signature means you received a copy of this form.

_____ _____ _____
Signature of Client/Parent/Guardian Date Nurse Examiner

Formerly The Memphis Rape Crisis Center

I-2100.445 (white/canary) 9/97

(Used by permission).

Appendix O

SATISFACTION SURVEY

Based on your experience with our services, please indicate your level of satisfaction using the following scale: (*Please circle only one number per question)*

1 = very poor
2 = poor
3 = adequate
4 = good
5 = very good

1. Do you feel you were given the services that you were seeking? 1 2 3 4 5
   Please explain: _____
   _____

2. Do you feel you were given thorough explanation of treatment options available? 1 2 3 4 5
   Please explain: _____
   _____

3. Do you feel options were offered or given to you as you would have liked or expected? 1 2 3 4 5
   Please explain: _____
   _____

4. At the time of your exam, did you feel that your case would be treated with the confidentiality that you expect? 1 2 3 4 5
   Did you find, after the exam, that confidentiality was upheld? 1 2 3 4 5
   Please explain: _____
   _____

5. Do you feel you were treated with respect by the staff? 1 2 3 4 5
   If no, who (department name, e.g. E.R. nurse, doctor, registration, SAFE nurse, sexual assault advocate, police) do you feel did not offer respect? _____
   _____

SATISFACTION SURVEY
(side two)

6. Do you feel you were treated without judgment by staff regarding your presenting problem or need or circumstances? 1 2 3 4 5
Please explain: _____
_____

7. Did you incur any financial costs as result of the assault? [ ] yes [ ] no
Please explain: _____
_____

8. Is there anything else that is not addressed here that you think we should know to improve our services or that would be helpful for us to know as we work with other victims/survivors of violence? _____
_____

==========

Please answer the following demographic information:

1. As best you can remember, please indicate in what time frame after the assault you sought services at the emergency room?
[ ] 0-12 hours [ ] 13-24 hours [ ] 25-36 hours
[ ] 37-72 hours [ ] after 72 hours

2. How did you hear about our services (sexual assault forensic examiner or nurse)?
[ ] police [ ] sexual assault advocate
[ ] other professional [ ] friend or someone in the community
[ ] did not know about the services until I received them at the hospital
[ ] am not aware that I received services from a sexual assault forensic examiner or nurse.

3. Prior to the assault, did you know or had you ever met the assailant? [ ] yes
[ ] no

4. Please indicate your general age range at the time of the assault:
[ ] 13-15 [ ] 16-18 [ ] 19-22 [ ] 23-30
[ ] 31-35 [ ] 36-45 [ ] 46-60 [ ] 61-75 [ ] 76 or older

Appendix P

SEXUAL ASSAULT RESOURCE SERVICE CHART AUDIT

Client Number_____ SARS Nurse_____ Hospital_____

Required Information	Yes	No	Comments
Page 1 Date & Time of Exam & Assault/CC# documented			
Allergies & Medications documented			
LMP & UPT documented			
Behavior described & comments quoted			
Photos-views, type of camera & dispo noted			
Documentation of involved orifices			
Correct specimens collected/If not collected, reason indicated			
Page 2 If narrative, it is signed, dated & includes pt. quotes			
Page 3 Assessment consistent with documented findings			
Genital injuries drawn & described (measurement/ nature/location/color). Notation of full body inspection for injuries.			
Page 4 If injuries noted, are they included in H & P?, Size, color, nature, location of injuries noted.			
Page 5 CPS assessment marked yes or no (if yes, data filled in)			
Meds documented/if not given, reason indicated			
Staff MD signature present			
Records signed on each page by SANE			
Consent forms signed. Release signed for Ovral (if not, reason indicated			
Does documentation create a detailed picture of patient's emotional & physical presentation and reasoning behind forensic evidence collection/care provided?			

General Suggestions:

_____

_____

(Used by permission).

Appendix Q

SANE Job Impact Survey

by

Michael G. Luxenberg, Ph.D., Julie Rainey, Holly Miller, Linda Ledray, Ph.D.

(Used by permission).

Instructions:
Please circle the number of the response that best describes your feelings about each statement.

	1 Strongly Agree	2 Agree	3 Uncertain	4 Disagree	5 Strongly Disagree	6 Doesn't Apply
1. I am often late for meetings and/or have trouble getting into the ED within a reasonable amount of time.	5	4	3	2	1	0
2. I feel physically exhausted.	5	4	3	2	1	0
3. I regularly allow time for my own hobbies and favorite leisure activities.	5	4	3	2	1	0
4. Lately I haven't been as productive at work as I usually am.	5	4	3	2	1	0
5. When I go home, I have a difficult time leaving my work behind.	5	4	3	2	1	0
6. My work has had a negative impact on my own sexuality.	5	4	3	2	1	0
7. I have a strong and healthy support network.	5	4	3	2	1	0
8. I find that I cannot stop thinking about the increasing amount of violence in the world.	5	4	3	2	1	0
9. I have difficulty concentrating and find it hard to stay on task.	5	4	3	2	1	0
10. I find that I am significantly increasing my use of alcohol or other drugs.	5	4	3	2	1	0
11. It is hard for me to find enough time away from work to enjoy my family and friends.	5	4	3	2	1	0
12. I get angry more easily and more often than I used to.	5	4	3	2	1	0
13. I am generally happy with my job.	5	4	3	2	1	0
14. I set and maintain healthy boundaries that allow me to work closely with victims without becoming too personally involved.	5	4	3	2	1	0

	5 Strongly Agree	4 Agree	3 Uncertain	2 Disagree	1 Strongly Disagree	0 Doesn't Apply
15. I no longer get pleasure from sexual activity.	5	4	3	2	1	0
16. I am often troubled by thoughts and recollections of the traumatic experiences I hear about at work.	5	4	3	2	1	0
17. I feel emotionally drained.	5	4	3	2	1	0
18. I believe that the world is generally a safe place and I don't feel personally at high risk for assault.	5	4	3	2	1	0
19. I have a difficult time getting up emotionally to go in when I am paged.	5	4	3	2	1	0
20. I experience feelings of emotional isolation, just as the victims I examine often do.	5	4	3	2	1	0
21. I get a lot of satisfaction from my work and from the assistance I give to victims.	5	4	3	2	1	0
22. I seldom have trouble sleeping.	5	4	3	2	1	0
23. I have consistently been unable to meet deadlines at work.	5	4	3	2	1	0
24. This job has blurred my ability to differentiate between consensual and nonconsensual sexual activity.	5	4	3	2	1	0
25. I exercise or engage in physical activity on a regular basis.	5	4	3	2	1	0
26. I have become afraid to walk alone at night.	5	4	3	2	1	0
27. I have difficulty becoming aroused.	5	4	3	2	1	0
28. I no longer feel much empathy towards the victims I treat.	5	4	3	2	1	0
29. I cry uncontrollably more often than I used to.	5	4	3	2	1	0
30. I have identified successful coping strategies that I know work well for me when I begin to feel burned out.	5	4	3	2	1	0

SANE Job Impact Survey
Scoring Sheet

Missing Values
When there are three or more missing items (items marked '0' or left blank) in any subscale, then that subscale *should not be scored.*

Reverse Scoring
Some of the items need to be reversed before scoring. These items are marked with an asterisk (*) below. Use the following method to reverse scores when indicated:
5=1 4=2 3=3 2=4 1=5 6 = missing

Cognitive Impact (CI) Score
Include items 4, 8, 9, 12, 13*, 18*
[Sum of responses _____]
divided by
[number of non-missing items _____ * 5] * 100 = CI Score: _____

Emotional Impact (EI) Score
Include items 14, 17, 20, 21*, 26, 28, 29
[Sum of responses _____]
divided by
[number of non-missing items _____ * 5] * 100 = EI Score: _____

Sexual Impact (SI) Score
Include items 6, 15, 16, 24, 27
[Sum of responses _____]
divided by
[number of non-missing items _____ * 5] * 100 = SI Score: _____

Behavioral Impact (BI)
Include items 1, 2, 10, 19, 22*, 23
[Sum of responses _____]
divided by
[number of non-missing items _____ * 5] * 100 = BI Score: _____

Overall Score
[Sum of CI, EI, SI and BI scores _____]
divided by 4 = Overall Score: _____

Reduction of Impact through Leisure and Support (LS) Score
Include items 3*, 5, 7*, 11, 25*, 30
[Sum of responses _____]
divided by
[number of non-missing items _____ * 5] * 100 = LS Score: _____

*** Items need to be reversed before scoring.**
INTERPRETATION: Scores may range from 20 to 100.
- Overall score and CI, EI, SI and BI subscale scores: Higher scores indicate higher levels of burnout.
- Reduction of Impact through Leisure and Support (LS) score: Higher scores indicate greater levels of participation in activities which contribute to stress reduction.

This survey is currently being piloted; the development of reliability information and gathering of normative data is in progress.

SANE Job Impact Survey
Sample Scoring Procedure

Cognitive Impact (CI) Score
Include items 4, 8, 9, 12, 13*, 18*

The respondent marked the following answers:

Item #	Response	Scoring
4.	0	missing
8.	5	5
9.	4	4
12.	left blank	missing
13.	5	1 (item #13 must be reversed)
18.	4	2 (item #18 must be reversed)

[Sum of responses _____]
divided by
[number of non-missing items _____ * 5] * 100 = CI Score: _____

SANE Job Impact Survey

Michael G. Luxenberg, Ph.D.
Julie Rainey
Holly Miller
Linda Ledray, Ph.D.

Response Format:
Strongly Agree Agree Uncertain Disagree Strongly Disagree NA

SCALE CONSTRUCTION

Cognitive Impact

4. Lately I haven't been as productive at work as I usually am.

8. I find that I cannot stop thinking about the increasing amount of violence in the world.

9. I have difficulty concentrating and find it hard to stay on task.

12. I get angry more easily and more often than I used to.

13. I am generally happy with my job.

18. I believe that the world is generally a safe place and I don't feel personally at high risk for assault.

Emotional Impact

14. I set and maintain healthy boundaries that allow me to work closely with victims without becoming too personally involved.

17. I feel emotionally drained.

20. I experience feelings of emotional isolation, just as the victims I examine often do.

21. I get a lot of satisfaction from my work and from the assistance I give to victims.

26. I have become afraid to walk alone at night.

28. I no longer feel much empathy towards the victims I treat.

29. I cry uncontrollably more often than I used to.

Sexual Impact

6. My work has had a negative impact on my own sexuality.

15. I no longer get pleasure from sexual activity.

16. I am often troubled by thoughts and recollections of the traumatic experiences I hear about at work.

24. This job has blurred my ability to differentiate between consensual and nonconsensual sexual activity.

27. I have difficulty becoming aroused.

Behavioral Impact

1. I am often late for meetings and/or have trouble getting into the ED within a reasonable amount of time.

2. I feel physically exhausted.

10. I find that I am significantly increasing my use of alcohol or other drugs.

19. I have a difficult time getting up emotionally to go in when I am paged.

22. I seldom have trouble sleeping.

23. I have consistently been unable to meet deadlines at work.

Reduction of Impact through Leisure and Support

3. I regularly allow time for my own hobbies and favorite leisure activities.

5. When I go home, I have a difficult time leaving my work behind.

7. I have a strong and healthy support network.

11. It is hard for me to find enough time away from work to enjoy my family and friends.

25. I exercise or engage in physical activity on a regular basis.

30. I have identified successful coping strategies that I know work well for me when I begin to feel burned out.