FOUNDATION TO PROVIDE SEXUAL ASSAULT PATIENT CARE IN THE EMERGENCY ROOM

By: Jaclyn Jackson BSN, BS, RN, SANE-A
State SANE Coordinator, Office of the Illinois Attorney General
Agenda

- Why are we here?
- Sexual Assault Survivor Emergency Treatment Act (SASETA)
- Neurobiology of Trauma
- Medical-Forensic Examination
- Drug Facilitated Sexual Assault
- Strangulation
- Discharge Instructions and Medical Treatment
- Vicarious Trauma
- SART
Why are we here?
Women and girls are most at risk of violence from men they know, particularly in the family.

Rape and sexual torture are used as weapons of war.

Violence against women has serious mental, physical and sexual health consequences.

Violence against women is a public health problem. It can be prevented.
There is no shame when a loved one dies. When a home is lost. When a car is stolen.

There is **comfort and support**.

There is **respect and sympathy**.
Yet when someone is sexually assaulted...

There can be a very different response.
STEUBENVILLE, OHIO
A 16-year old girl, unconscious from alcohol, is sexually assaulted and ferried from party to party by members of the high school football team.

The party starts at an assistant coach’s house.
The victim learns of the **assault when pictures and videos are posted on social media.**

She contacts police.

"We’re not gonna let dumb s - - - like this mess up our state championship goal," one football player Tweets.
Police urge students and parents to come forward.

The response: “mostly silence.”
Two suspects are ultimately convicted for rape of a minor.

Media coverage focuses on how the young men’s lives are “destroyed.”

“This will haunt them for the rest of their lives.”
Ohio Attorney General Mike DeWine announces the *indictment of four adults* for obstruction of justice and tampering with evidence.

"While this started out being about the kids, it is also just as much about the parents, about the grown-ups, about the adults."
The school technology director is the first adult charged for the cover-up.

Charges against the school superintendent are related to the prior rape of a 14-year old girl by several Steubenville baseball players.
CLEVELAND, TEXAS
21 suspects are charged with the videotaped gang rape of an 11-year old girl in an abandoned trailer.

Residents say the victim wore makeup and dressed like a 20-year old.

“What was her mother thinking?” one neighbor asked.
The defense likened the victim to a spider:

“Wasn’t she saying, ‘Come into my parlor, said the spider to the fly?’”

The lead investigator answered:

“I’d say she was just an 11-year old girl.”
21 people are convicted:

7 juveniles, 7 years probation.

14 adults, 7 years to life.
A 54-year old former high school teacher is sentenced to **30 days in jail** for raping a student.

Montana District Judge G. Todd Baugh explains the **14-year old victim** was “older than her chronological age” and “as much in control” as the teacher.
"I think that people have in mind that this was some violent, forcible, horrible rape ... but it wasn’t this forcible beat-up rape.”

The victim took her own life at 16.
Sara Reedy reports being robbed and raped at gunpoint.

The detective fails to investigate or connect it with his other case – the only other rape reported that year.

Sara is arrested for filing a false report, theft, and receiving stolen property. Five months pregnant, she spends 5 days in jail.
When arrested, the suspect confesses to 12 sexual assaults, 10 after Sara.

Sara later wins a 1.5 million dollar settlement and testifies before the Senate Judiciary Committee.

“If my story can bring about change, I owe it to people to tell it.”
MARYVILLE, MISSOURI
Two high school seniors supply 14-year old Daisy Coleman with alcohol. One sexually assaults her while the other videotapes it.

They leave her on her porch, unconscious, in freezing temperatures.

Her mother wakes to find Daisy scratching at the door.
Within hours, deputies execute a search warrant, seize evidence, conduct interviews, and make arrests.

The suspects confess on videotape.

The Sheriff says the case will “absolutely” result in prosecutions.
Daisy is read her Miranda rights and questioned by the prosecutor and defense attorney in a "tag-team" deposition.

She is asked 690 questions ... nearly 500 by the prosecutor.

The suspect's interview with a detective lasts 17 minutes.
The District Attorney drops all charges.

“There wasn’t any prosecuting attorney that could take that case to trial. It had to be dismissed.”
Months of torment follow. Daisy’s mother is fired. The family moves.

Their unsold home in Maryville burns to the ground under mysterious circumstances.

Three skinned rabbits are found at their new home.
Finally, a special prosecutor is appointed.

Only one suspect is convicted for misdemeanor child endangerment.
Daisy recovers from her **third suicide attempt**.

“I refuse to be a victim of cruelty any longer. That is why I am saying my name. That is why I am not shutting up. I am not done fighting yet.”
CLEVELAND, OHIO
Police discover the **decomposing bodies** of 11 **women** inside the home of convicted sex offender Anthony Sowell.
The year before, a victim escaped Sowell and ran to police, bleeding and screaming for help.

Her injuries required more than a dozen stitches.
Police interviewed the woman, collected her clothing, and took pictures of her injuries. Hospital personnel conducted the exam.

At Sowell’s home, police found signs of a struggle and blood. They interviewed Sowell and took pictures of injuries on his shoulder and legs.
Prosecutors said there was insufficient evidence to charge, indicating the "detective did not believe the victim was credible."

The detective noted: "Clean up report – Unfounded."
Sowell is sentenced to death for 11 murders.
Police now believe a woman they accused of lying about a rape in 2008.

They doubted “her ever-changing story,” and charged her with false reporting.

She was fined $500.
Marc Patrick O’Leary is arrested for a series of sexual assaults in Colorado. Investigators discover hundreds of pictures, including the Lynnwood victim.

Lynnwood Police apologize to the woman and return her money.

She wins a $150,000 settlement against the department.
One after another, teenagers take their own lives after being sexually assaulted and tormented on social media.

15-year old Rehtaeh Parsons, April 2013

19-year old Lizzy Seeberg, November 2010

15-year old Audrie Pott, September 2010
“I was raped thirty years ago. There was so much shame then, and there still is now.”

—Bonnie Quillin

The Voices and Faces Project
voicesandfaces.org
It doesn’t have to be this way.
Because **your** response ... **Our** response ... Makes the difference.
“When someone says ‘I’ve been raped’ the most important words in the world to say are ‘I believe you.’ If a survivor doesn’t hear that from anyone else, she or he is going to hear it from me.”

—Karen Carroll

The Voices and Faces Project
voicesandfaces.org
Why Are We Here?

The scope of sexual assault is staggering:

- 1 in 5 women
- 1 in 33 men
- 1 in 7 women in Illinois
- The Illinois Coalition Against Sexual Assault (ICASA) Rape Crisis Centers helped 18,092 survivors of sexual assault in FY2012

Age:

- Highest victim age group are females between 16 – 24 years
- Teenagers under the age of 18 years make up 61% of rapes
  - 32% will occur between the ages of 11-17
Out of 100 rapes...

Less than 1/2, or 42 victims, report their rape to the police

Of the 36 reports filed, approximately 18 arrests are made

Of the 18 arrests, 80%, or 15 cases, result in prosecution

Of the 15 cases prosecuted, 58%, or 8 cases, result in conviction

Of the 8 convictions, 69%, or 5.5 rapists serve any jail time
Why Are We Here?

- Victims more likely to suffer from:
  - Depression: 3 times
  - Post Traumatic Stress Disorder: 6 times
  - Alcohol Abuse: 13 times
  - Drug Abuse: 26 times

- Training:
  - Most nurses do not receive any formalized training in regards to caring for a sexual assault patient. But the statistics show that these patients are part our population
Understanding Rape

Literature describes six “rape scenarios” whereas rape is committed by:

- **Intimate partner**
  - Marital rape did not become a crime in all 50 states until 1993
  - 10 – 14% of married women are raped by their husbands in the United States

- **Date or an acquaintance**
  - Most common, ~60% of all cases

- **Stranger**
  - ~33% of REPORTED cases

- **Family member**

- **Captor or occupying military or militia**

- **Fellow prisoner**
Myths

- Rape is sex
- Rapes are committed by a stranger
- Men cannot be victims of rape
- If she was really a victim she would have injury
- Only young, attractive women or women who engage in risky activities are raped
- Men rape women because they are overly aroused sexually or have been sexually deprived
- Acquaintance rapes are not as serious as stranger rapes
- Victims recant their stories of rape because it didn’t really happen
- If a woman has been sexually assaulted there will be physical/medical/emotional evidence to support it
Frank Video
Forensic Nursing

- “The application of the forensic aspects of health care combined with the bio-psychological education of the registered nurse in the scientific investigation of trauma and/or death related medical-legal issues”

- Types of forensic nurses:
  - Death Investigation- Nurse Coroners
  - Psychiatric Nursing
  - Clinical Forensic Nurse
  - Forensic Nurse Investigators
  - Corrections Nursing
  - Legal Nurse Consulting
  - Sexual Assault Nurse Examiner (SANE)
Basic History of Forensics

- 1986 Virginia Lynch develops first formal forensic nursing curriculum focusing on death investigations
- 1988 McNamara introduces concept of clinical (living) forensics
- 1989 Lynch introduces forensic nursing as a scientific discipline
- 1991 American Academy of Forensic Sciences formally recognizes forensic nursing
- 1992 IAFN founded
- 1995 ANA recognizes forensic nursing as a specialty
Basic History of Forensics

- 1997 Publication of the Scope and Standards of Forensic Nursing
- 1998 Sexual Assault Nurse Examiner Standards of Practice
- 1999 Sexual Assault Nurse Examiner Adult/Adolescent Educational Guidelines
- 2000 Sexual Assault Nurse Examiner Pediatric Education Guidelines
- 2001 Sexual Assault Nurse Examiner Adult Certification Pilot Test
- 2002 Forensic Nursing Certification Board Formalized
- 2002 Sexual Assault Nurse Examiner Adult/Adolescent Certification Test
SANE Programs

- Rape Crisis Centers began to be established in the early 1970’s
- SANE programs were first established in:
  - Memphis- 1976 (Pat Speck)
  - Minneapolis- 1977 (Linda Ledray)
  - Amarillo- 1979 (Edith Rust)
International Association of Forensic Nurses

- Minneapolis, Minnesota August 12, 1992
  - 74 individuals
  - United States and Canada
- 31 SANE programs in 1992
- 117 by 1999
- 452 by 2005
- 2600 members in December of 2005
To develop, promote and disseminate information about the science of forensic nursing internationally. IAFN establishes and improves standards of practice and strives to foster growth and development of forensic nursing as an emerging area of nursing expertise. IAFN promotes the exchanges of ideas and transmission of developing knowledge among its members and to a wide variety of professionals who are dedicated to the development of forensic nursing for the advancement of humanity.
What is IAFN?

- It is the only international professional organization of registered nurses formed exclusively to develop, promote, and disseminate information about the science of nursing.

- [www.iafn.org](http://www.iafn.org)
Sexual Assault Nurse Examiner

- A registered nurse who has been specially trained to provide comprehensive care to sexual assault patients, who demonstrates competency in conducting a forensic exam and the ability to be an expert witness.

- Training includes:
  - Normal/abnormal genitalia
  - Evidence Collection Techniques and Rationale
  - Expert Witness Testimony Techniques
  - Forensic Photography
  - Working Together as a Multidisciplinary Team
Mission

- To avoid further trauma to all sexual assault patients in the health care environment
- Provide a compassionate and sensitive approach
- Provide a timely medical/forensic examination with expert evidence collection
- Provide a consistent care-giver throughout the exam
- Provide referral for follow-up and counseling
- Provide expert courtroom testimony
SANE Supporters

- Illinois Attorney General - Lisa Madigan
- American College of Emergency Physicians
- Emergency Nurse Association
- American Nurses Association
- United States Department of Justice - Office for Victims of Crime
Research Has Proven That SANE Programs Have:

- Improved evidence collection and documentation
- Increased the likelihood of victims reporting the crime to law enforcement
- Increase progression of case through the criminal justice system therefore increasing prosecution rates
  - Allen County Indiana reported an increase in conviction rates from 20% to 60% since the inception of the Fort Wayne Sexual Assault Treatment Center
- Reduces cost of sexual assault to society
- Reduces the re-traumatization of the victims in the health care setting
Data Supports

- Victims treated by Sexual Assault Nurse Examiners:
  - Spent less time in the health care setting
  - Experienced less discomfort
  - Had greater access to support services
  - Received more compassionate and objective care
  - Received victim services in addition to medical treatment
  - Felt better informed about options within the criminal justice system
Benefits of a SANE Program

- **Hospitals:**
  - Opportunity for improved patient care
  - More efficient use of hospital staff

- **Advocacy Center:**
  - Victims have earlier access to advocacy programs
  - Providing liaison between the victims, medical and criminal justice systems

- **Law Enforcement and Prosecuting Agencies:**
  - Improved evidence collection which helps substantiate arrests and yields convictions
Role of SANE

- Practices within the Standards of Care as set forth by the Illinois Nurse Practice Act, Forensic Nursing Standards of Practice and SANE Standards of Practice
- Primary responsibility is compassionate appropriate care of the sexual assault patient in the healthcare setting.
- Comprehensive and objective physical examination with the completion of a forensic examination
- Expert documentation of the medical record
- Liaison between the medical and legal professions
- Ability to be an expert witness
SANE Defined in Illinois Law

- Sexual Assault Survivor Emergency Treatment Act (SASETA) defines SANE in 2002
  - "Sexual Assault Nurse Examiner" means a registered nurse who has completed a sexual assault nurse examiner (SANE) training program that meets the Forensic Sexual Assault Nurse Examiner Education Guidelines established by the International Association of Forensic Nurses.
  - A sexual assault nurse examiner may conduct examinations using the sexual assault evidence collection kits, without the presence or participation of a physician.
Questions?
SASETA

- Mandates healthcare hospitals must provide to victims
- Establishes the statewide evidence collection program for sexual assault victims
- Provides for reimbursement of costs for emergency department care, follow-up healthcare and evidence collection

Section 2: All hospitals required to be licensed by the Department of Public Health which provides general medical and surgical hospital services shall provide either:
  - Transfer services
  - OR
  - Hospital emergency services and forensic services

To all sexual assault survivors

All services shall be provided without the consent of any parent, guardian, custodian, surrogate or agent
Transfer Hospitals

- Provide necessary emergency services
- Respond promptly
- Explain the transfer to the victim
- Notify the receiving hospital
- Send emergency room record with victim
- Maintain chain-of-custody for evidence
- Arrange for/permit victim to go by ambulance or with friend/family/law enforcement
Medical examinations and laboratory tests to ensure the health, safety and welfare of the survivor or which may be used as evidence

Records of these tests, which will be made available to law enforcement as the survivor requests

Appropriate oral and written information concerning the possibility of infection, sexually transmitted disease and pregnancy resulting from sexual assault

Appropriate oral and written information concerning accepted medical procedures, medication, and possible contraindications of such medication for the prevention or treatment of infection or disease
Treatment Hospitals continued

- An amount of medication for treatment at the hospital and after discharge as deemed appropriate
- Evaluation of the survivor’s risk of contracting HIV
- Written and oral instructions indicating the need for follow-up examinations and laboratory tests to determine the presence or absence of STIs
- Referral for appropriate counseling
- When HIV prophylaxis is deemed appropriate, an initial dose or doses of HIV prophylaxis, along with written and oral instructions indicating the importance of timely follow-up healthcare
Section 2.2: Emergency Contraception

Every hospital providing services to sexual assault survivors. . .must develop a protocol that ensures that each survivor of sexual assault will receive:

- Medically and factually accurate written and oral information about emergency contraception
- The indications and contra-indications and risks associated with the use of emergency contraception
- Description of how and when victims may be provided emergency contraception upon the written order of a Physician/APN/PA
Section 5.5: Minimum reimbursement requirements for follow-up healthcare

- Every hospital, health care professional, laboratory or pharmacy that provides follow-up healthcare shall be reimbursed for the follow-up healthcare services provided.

- Services include, but are not limited to:
  - Physical examination
  - Laboratory tests to determine the presence or absence of sexually transmitted disease
  - Appropriate medications, including HIV prophylaxis

- Available for up to 90 days after the initial visit
Section 6.4: Sexual Assault Evidence Collection Program

- Statewide sexual assault evidence collection program to facilitate the prosecution of persons accused of sexual assault
- Administered by Illinois State Police
  - Distribution of sexual assault evidence collection kits
  - Collection of kits from hospitals after the kits have been used to collect evidence
  - Analysis of the collected evidence and conducting of laboratory tests
  - Maintaining chain of custody and safekeeping of the evidence for use in a legal proceeding
  - Comparison of the collected evidence with the genetic marker grouping analysis information maintained by the Department of State Police
Section 6.4 continued

- Kit may not be released without the written consent of the survivor
- Minor 13 years of age and older: Provide their own consent
- Minor under 13 years of age: Consent can be provided by:
  - Parent
  - Guardian
  - Investigating law enforcement officer
  - Department of Children and Family Services

- Adult who has a guardian, health care surrogate or agent acting under a health care power of attorney, do not require the consent of any of those individuals to release evidence and information concerning the assault
  - If unable to provide consent and guardian/surrogate/agent unavailable or unwilling to consent, then investigating law enforcement officer may authorize release.
Section 7: Reimbursement

When any ambulance provider furnishes transportation, hospital provides hospital emergency services and forensic services, hospital or health care professional or laboratory provides follow-up healthcare, or pharmacy dispenses prescribed medications to any survivor who:

- Is neither eligible to receive such services under the Illinois Public Aid Code nor
- Covered as to such services by a policy of insurance

Then those services shall be furnished without charge to the survivor and the provider shall be entitled to be reimbursed for such services by the Illinois Sexual Assault Emergency Treatment Program under the Department of Healthcare and Family Services (the voucher)
How to Use the Attached Authorization for Payment Voucher

The attached form is very important to you for your follow-up care. It is an **Authorization for Payment Voucher** that you can take to the doctor, pharmacy, or healthcare clinic of your choice for important follow-up treatment. It is valid for 90 days from the date of your initial sexual assault examination at the hospital. For your ease of mind, all charges for physician examinations, laboratory services, and prescribed medications for follow-up healthcare related to the sexual assault will be paid by the Illinois Department of Healthcare and Family Services’ Sexual Assault Emergency Treatment Program.

**Why is this so important?**
Follow-up healthcare services are very important to ensure your physical health and well being following a sexual assault. In order to be sure that you have not contracted a sexually transmitted disease, it is important to follow-up with a doctor or healthcare clinic to request laboratory exams within 2 to 6 weeks following the initial examination at the hospital. These providers may also prescribe additional medication that can be obtained from a pharmacy in your community. You will not be charged for these services or medications!

*Please Note: Each healthcare provider, laboratory, or pharmacy will make a photocopy of the attached form so that you may retain the original “Authorization for Payment Voucher” for additional follow-up services during the 90-day period.*

Cómo Usar “La Autorización de Pago” Adjunta

El documento adjunto es muy importante ya que es para el seguimiento de su cuidado médico. Esta es una “**Autorización de Pago**” que puede presentar a su médico, farmacia, o clínica de salud que usted escoja para el seguimiento de su tratamiento. Este documento es válido por 90 días desde la fecha de su examen médico inicial en el hospital debido a la agresión sexual. Para su tranquilidad mental, todos los gastos médicos con relación a la agresión sexual (ejemplo, las facturas del médico o clínica, laboratorio, farmacia, u otros servicios de salud) serán pagados por el Programa de Tratamiento de Emergencia Para Agresión Sexual – Departamento de Cuidado de Salud y Servicios Para Familias.

**¿Por qué esto es tan importante?**
El seguimiento de los servicios del cuidado médico es muy importante para asegurar su buena salud física y bienestar después de una agresión sexual. Para asegurarse de que usted no haya contraído una enfermedad transmitida sexualmente, es importante el seguimiento, vaya a un médico o clínica y pida que le hagan pruebas de laboratorio entre 2 y 6 semanas después del examen inicial en el hospital. Estos proveedores posiblemente le recetarán medicinas adicionales que usted puede obtener en una farmacia de su comunidad. ¡No le cobrarán a Usted por estos servicios o medicinas!

*Por favor tenga en cuenta: Cada médico, laboratorio, o farmacia debe hacer una fotocopia del documento adjunto para que usted pueda retener el original “Authorization for Payment Voucher” para cualquier servicio médico adicional que necesite durante el periodo de 90 días.*
Illinois HFS Sexual Assault Emergency Treatment Program

AUTHORIZATION FOR PAYMENT VOUCHER

Authorization #: __________________________ Date of Hospital Service: __________________________

Patient’s Name: __________________________ Hospital: __________________________

Dear Provider:

This patient has recently received hospital emergency services through the Illinois HFS Sexual Assault Emergency Treatment Program and has been advised to seek follow-up healthcare services. This Authorization for Payment Voucher (Voucher) allows you to provide appropriate follow-up healthcare related to the sexual assault to ensure the patient’s well being and to be reimbursed directly by the Illinois HFS Sexual Assault Emergency Treatment Program for those healthcare services.

If additional follow-up healthcare services are required (e.g., exam, laboratory, pharmacy), please make a copy of this Voucher for your billing purposes and allow the patient to retain the original Voucher. If you directly order laboratory services, please make an additional copy of this Voucher to accompany your request to the laboratory. The patient will keep the original Voucher in case additional follow-up healthcare services related to the sexual assault are needed. This Voucher is valid for 90 days, with the “date of hospital service” above counted as day one. The expiration date for this voucher is: MM/DD/YYYY

Do not bill the sexual assault survivor presenting this Voucher for follow-up healthcare services you render related to the sexual assault. Illinois law requires that healthcare services to a sexual assault survivor covered by the Illinois HFS Sexual Assault Emergency Treatment Program be provided at no charge to the sexual assault survivor. 89 Ill Admin. Code §148.510. Each provider of follow-up healthcare services must send its bill (electronic billing is not available) along with a copy of this Authorization For Payment Voucher to the following address:

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SEXUAL ASSAULT PROGRAM
P.O. BOX 19129
SPRINGFIELD, ILLINOIS 62794-9129
Illinois Mandated Reporting: ILCS 2630/3.2

- It is the duty of any person conducting or operating a medical facility, or any physician or nurse as soon as treatment permits to notify the local law enforcement agency of that jurisdiction upon the application for treatment of a person who is not accompanied by a law enforcement officer, when it reasonably appears that the person requesting treatment has received:
  - Any injury resulting from the discharge of a firearm
  - Any injury sustained in the commission of or as a victim of a criminal offense
Questions?
BREAK 9:45-10:00
Neurobiology of Trauma

Dr. Rebecca Campbell Research
Dr. Rebecca Campbell started her research looking at sexual assault case attrition and began by talking with detectives, rape victim advocates and victims.

One seasoned detective interviewed about sexual assault patients and stated:

- “The stuff they say makes no sense. So no, I don’t always believe them, and yeah I let them know that.”

He then proceeded to state:

- “Then they say ‘never mind, I don’t want to do this.’ Ok fine.”

Detective documents:

- Complainant refused to prosecute. Case closed.
Rape Victim Advocate stated:

“It’s hard trying to stop what they (police) do to victims. They don’t believe them and treat them so bad they (victims) give up. It happens over and over again”

The Victim perspective when interacting with law enforcement:

“He didn’t believe me and he treated me like sh*t. Didn’t surprise me when he said there wasn’t enough to go on to do anything. Didn’t surprise me, but still hurt.”

These quotes show that sexual assault case attrition happens early on, often in the first interaction with law enforcement.
## Sexual Assault Case Attrition

<table>
<thead>
<tr>
<th></th>
<th>Site 1 (Rural)</th>
<th>Site 2 (Rural)</th>
<th>Site 3 (Mid)</th>
<th>Site 4 (Mid)</th>
<th>Site 5 (Urban)</th>
<th>Site 6 (Urban)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Referred/Not Charged</td>
<td>80%</td>
<td>89%</td>
<td>91%</td>
<td>84%</td>
<td>89%</td>
<td>82%</td>
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<tr>
<td>Charged, but Later Dropped</td>
<td>2%</td>
<td>5%</td>
<td>0%</td>
<td>7%</td>
<td>0%</td>
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<td>Plea Bargained</td>
<td>13%</td>
<td>4%</td>
<td>4%</td>
<td>7%</td>
<td>6%</td>
<td>13%</td>
</tr>
<tr>
<td>Trial: Acquittal</td>
<td>3%</td>
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<td>0%</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Trial: Conviction</td>
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<td>1%</td>
<td>5%</td>
<td>1%</td>
<td>3%</td>
<td>1%</td>
</tr>
</tbody>
</table>

*Source: Campbell et al., 2012*
Why did these cases not move forward?

- Secondary Victimization
  - Attitudes, beliefs and behaviors of social system personnel that victims experience as victim blaming and insensitive.
  - Exacerbates their trauma
  - Makes victim feel like they’re experiencing a second rape

- Behaviors the lead them to feel re-traumatized:
  - Discouraged report= 69%
  - Not serious enough= 51%
  - Dress, behavior, done to provoke assault= 70%
  - Any secondary victimization behavior= 90%
Putting Things Together

- Criminal Justice research studied case attrition
- Psychology and Psychiatry studied neurobiology of trauma

Goal:
- Understand victims’ behavior
- Educate practitioners
- Change how the system responds to victims of sexual assault
Brain Regions Impacted by Trauma

**Corpus callosum**
A large band of nerve fibers through which information flows back and forth between the left and the right hemispheres of the brain.

**Basal ganglia**
A control system for movement and cognitive functions.

**Thalamus**
The relay station for most information going into the brain.

**Hypothalamus**
Regulates sex hormones, blood pressure and body temperature.

**Pituitary gland**
The master gland of the body produces its own hormones and also influences the hormonal production of the other glands in the body.

**Amygdala**
Regulates the heartbeat and other visceral functions and processes the emotion fear.

**Hippocampus**
Helps establish long-term memory in regions of the cerebral cortex.
Brain Regions Impacted by Trauma

- Hormones and emotions
  - HPA Axis

- Encoding, processing and memory
  - Amygdala
  - Hippocampus
Brain Regions Impacted by Trauma

- **HPA Axis:**
  - Hypothalamus
  - Pituitary
- **Adrenals:**
  - Catecholamines
  - Cortisol
  - Opioids
  - Oxytocin
Brain Function

- Normal brain function:
  - Senses detect stimuli that go straight to the thalamus
  - Thalamus sorts the information and sends it to the cortex for memory storage
  - Cortex is the brain’s center for higher functioning

- Brain during a sexual assault:
  - Amygdala detects the threat →
  - Activates the hypothalamus →
  - HPA (hypothalamus/pituitary/adrenal) Axis kicks in hormonal flood →
    - Cathecholamines Increase: Impairs rational thought
    - Opioids increase: Causes flat affect
    - Corticosteroids decrease: Reduces energy
      - Can trigger complete shut down of the body
Fight, Flight or Freeze

- **Tonic Immobility**
  - Rape-induced paralysis
  - Autonomic (uncontrollable) mammalian response in extremely fearful situations
  - Increased breathing, eye closure, paralysis
  - 12-50% of rape victims experience TI during assault
  - Is more common if victims have been assaulted in the past (childhood, adolescence, or adult)
  - Higher levels of self blame
  - Disclosure to family, friends and service providers often associated with hurtful responses
  - Explain and normalize this action
Memory and Cognition

- Stress hormones impair hippocampus
  - Encoding and consolidation difficult
- Memories will be fragmented
  - Recall will be slow and difficult
- Post-it note example
  - Take your notes from today on post-it notes
  - Write down everything you know and have learned
  - Take them to the messiest desk
  - Scatter post-it notes all over the desk
  - Go back the next day, find all the notes and put them in the correct order and tell me everything you learned
- Memories go in accurately and come out accurately, but they come out slow, steady, fragmented and disorganized
  - Exception: Alcohol may prevent encoding, so there may be nothing to retrieve
What Does This Mean?

- When you understand the neurobiology of trauma, you then understand why what the victim states doesn’t make sense.
- Take home lessons:
  - Can lead to flat affect or “strange” emotions or emotional swings.
  - Can make memory consolidation and recall difficult.
  - Tonic immobility is often frightening to victims.
After Effects of Rape

- Rape Trauma Syndrome
  - Attack
  - Acute
  - Outcome Adjustment
  - Resolution and Integration

- Effects on emotional, psychological, physical and behavioral health

- 55% of rape victims develop PTSD
Questions?
Overview of the Medical-Forensic Examination and Evidence Collection
Objectives

- Describe the medical-forensic examination
- Discuss medical and forensic history
- Discuss evidence collection using ISPECK
- Discuss documentation
In 1985, the U.S. Surgeon General, Dr. C. Everett Koop, identified violence as a public health issue that health care providers play a key role in improving.

As of 1992, JCAHO standards require that emergency departments and ambulatory care facilities have protocols in place to provide care for victims of abuse and neglect, including, but not limited to victims of sexual assault, domestic violence and child sexual abuse.
Screening for Violence

- Routine inquiry increases identification and intervention
- Important part of interaction with healthcare provider
- May feel supported even if patient does not choose to disclose
  - May increase chance of reporting in the future
- May lead to reduced morbidity and mortality
How to Screen for Violence

- Ask about current and lifetime exposure to violence and direct questions about physical, emotional and sexual abuse
  - Lifetime exposure may not be possible in an acute care setting
- Conduct orally and include on written or computer-based questionnaires
- Screen all adolescent and adult patients regardless of cultural background
  - Screen parents or caregivers of children in a pediatric care setting
How to Screen for Violence

- Screen as a routine part of health history and standard health assessment
- Conduct in a private setting
- Maintain patient confidentiality
- If unable to screen, note in chart
- Include posters, safety cards and patient education materials in exam, waiting, and/or bathrooms
Screening Methods

- Framing questions:
  - Because violence is so common in many people’s lives, I’ve begun to ask all my patients about it . . .
  - I am concerned that your injuries/symptoms may have been caused by someone hurting you. . .
  - I don’t know if this has even been a problem for you, but many of my patients have experienced violence or been in an abusive relationship, so I have started asking about it at every visit. . .
Screening Methods

- **Direct questions:**
  - Are you in a relationship with someone who physically or emotionally hurts you or threatens you?
  - Have you ever been physically or emotionally hurt by someone important to you?
  - Have you ever been forced to have sex or engage in sexual activities when you did not want to?
  - Do you feel safe at home?
  - Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
  - Since you’ve been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?
Goal = Empowering Care

- “Empowering Care”
  - “Providing healthcare, support and resources; treating patients with dignity and respect; believing their stories; helping them re-instate control and choice; and respecting patient’s decisions.” (Campbell et al., 2008)

- SANE Interventions
  - Introduce self to patient prior to anyone else in the room and prior to providing care
  - Explain what is going to happen next in the exam
  - Ask patient if they have any questions
Upon Arrival to the ED

- Patient is briefly triaged and assigned ESI 2
- Determine if evidence collection is needed, within 7 days of assault
- Identify patient as sexual assault and assign a private room
  - If no room available, temporarily move patient to other private space such as the family waiting room
- Medical screening exam by ED MD to address all urgent medical needs
- Assign/call-in SANE or primary RN
- Call-in medical advocacy if available
- Perform medical-forensic exam
Prior to Medical-Forensic Exam

- The patient should be medically stabilized
  - ABC’s always come first

- Altered level of consciousness, possible fracture, active bleeding, unstable vital signs, history of strangulation are examples of conditions that should be evaluated by a physician first

- If extensive trauma or life-threatening injuries are present, hospital staff should maintain forensic principles to the best of their ability while providing care

- If patient is going to the operating room, exam can be performed while hospital staff are prepping the patient
Components of Medical-Forensic Exam

- Medical and forensic history
- Medical treatment and evaluation
  - Head to toe assessment
  - Detailed genital exam
- Forensic exam and evidence collection
- Exam and documentation should always be “patient-centered”
6 Main Steps of the Medical-Forensic Exam

1. Obtain informed consent
2. Conduct a patient history
3. Head-to-toe physical assessment
4. Perform a detailed genital assessment
5. Collect evidence
6. Administer medication and provide discharge instructions
Step 1: Consent

**Patient Consent/Authorization to Release Information and Evidence to Law Enforcement Agency**

**Patient**

DOB Hospital Patient No.

**CONSENT** (minors 13 years old and over can provide):

I understand that in addition to consent for medical evaluation and treatment, I also give consent for evidence preservation and collection. I understand that the evidence collected in the Sexual Assault Evidence Collection Kit will be sent to the Illinois State Police Forensic Sciences Command for the sole purpose of analysis. I understand that this exam may include reference samples. I also understand that I may withdraw consent at any time for any portion of the exam.

Patient, Parent or Guardian (please circle)

I understand that collection of evidence may include photographing injuries and that those photographs may include the genital area. Knowing this, I consent to having photographs taken.

Patient, Parent or Guardian (please circle)

**RELEASE**

I hereby authorize _______ to release to _______

(Name of Hospital) (City) (Law Enforcement Agency Name)

the following information covering treatment given to me on _______

(Month) (Day) (Year)

**AUTHORIZED FOR RELEASE**

(check those which apply)

1. Copies of Medical/Forensic Documentation Form
2. Sexual Assault Evidence Collection Kit
3. Photographs
4. X-rays or copies of x-rays taken in connection with exam
5. Clothing

Authorized for Release (list clothing or miscellaneous items)

<table>
<thead>
<tr>
<th>Article</th>
<th>Description</th>
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Signature of person authorizing release of information _______

Patient, Parent, Guardian, Investigating Officer or D.C.F.S. (please circle)

**Receipt of Information**

I certify that I have received the following items (check those which apply):

- One sealed evidence collection kit
- X-rays
- Photographs
- Swabs/specimens (if no evidence collection kit is used)
- Sealed paper clothing bag(s) (if more than one sealed clothing bag, please note)
- Other

Signature of person receiving information and/or articles _______ Date _______ Time _______

Officer/Det and rank _______ Representative of _______

Name of hospital representative who is releasing articles _______ (Printed Name) (Signature)

(White copy to hospital; yellow copy to law enforcement agency)
Step 1: Consent

- Informed consent is imperative
- Consent needed for:
  - Examination
  - Collection of evidence
  - Photography
  - Release of evidence to law enforcement
- Patient may withdraw consent at any time. Patient may consent to one part of the exam but not another.
- Consent to complete the kit doesn’t necessarily mean consent to release the kit
- What are the consent guidelines for minors in Illinois?
- Law enforcement cannot be in the room during the exam
Confidentiality

- Reassure patient that information obtained in exam is confidential up to the extent of the law.
- Only information relevant to the investigation will be released to law enforcement.
- HIPPA allows for release of information to law enforcement.
- Discuss possibility of case going to trial if needed.
Who can consent?

- **Any aged person** can consent to their own treatment and evidence collection related to sexual assault.
- Any person 13 years and older can consent to the release of the kit to law enforcement.
- For minors under 13 years, evidence may be released at the written consent of the parent, guardian, investigating law enforcement officer, or Department of Children and Family Services.
Parents and Adolescents

- Can a parent request that a rape kit is done on their adolescent child?
  - NO - just because a parent believes that a child is sexually active, does not mean that a SA kit should be collected
  - Situations can be tricky
    - By law an adolescent has the right to consent to or decline regardless of a parents’ request
  - It is best to separate child and parent to determine what the adolescent wants
Step 2: Patient History

**Patient Name**

**DOB**

**Age**

**Rac**

**Sex**

**Arrival Date**

**Arrival Time**

**Address**

**City**

**County**

**State**

**Zip**

**Phone**

**Hospital**

**ER**

**For Children: Name of Guardian**

**Relationship**

**Person providing history**

**Relationship to patient**

**Persons present during exam**

**For children: Avoid multiple interviews. Take time to establish rapport. Avoid leading or yes/no questions. Use direct quotes. Avoid surprise or negative emotions, while still showing concern and support. (Please provide legible account and attach additional pages if necessary.)**

1. Patient’s Description of what happened.

2. **Did patient scratch/injure assailant(s)?**
   - [ ] Yes
   - [ ] No
   - [ ] Unsure

   See fingernail specimen envelope.

3. **Date of Assault**
   - **Time of Assault**
   - **Location & geographical surroundings of assault**

4. **Number, relationship, name, or general description of assailant(s) if name is unknown**

5. **Sexual acts described by patient/historian**

   **Acts Described**
   - [ ] Yes
   - [ ] No
   - [ ] Unsure

   **Acts Described**
   - [ ] Yes
   - [ ] No
   - [ ] Unsure

   **Penetration of female sex organs by:**
   - **Penis**
   - **Finger**
   - **Foreign object**
   - **Describe object**

   **Penetration of anus by:**
   - **Penis**
   - **Finger**
   - **Foreign object**
   - **Describe object**

   **Other sexual acts**
   - [ ] Yes
   - [ ] No
   - [ ] Unsure

   If applicable, describe location and collect.

   See miscellaneous stains envelope.

   **Was oral sex performed?**
   - If yes, please collect from area described.
   - See miscellaneous stains envelope.

   **Other sexual acts**
   - [ ] Yes
   - [ ] No
   - [ ] Unsure

   If applicable, describe location and collect.

   See miscellaneous stains envelope.

   **Did any of the patient’s body parts, clothing, or objects become involved?**
   - [ ] Yes
   - [ ] No
   - [ ] Unsure

   If yes, please collect from area described.

   See miscellaneous stains envelope.
Step 2: Patient History

- Should you conduct a patient history on every patient?

- Why conduct a patient history as part of the nursing assessment?

- What can you do while taking a patient history to facilitate empowerment?

- What part of the patient history will your facility allow you to take without the physician/NP/PA present?
Step 2: Patient History

- Perform in a private and quiet setting
- Family or friends typically not allowed
- Interpreters should be professionals, not family/friend
  - Document name and title
  - Can be subpoenaed
- Patient should be in clothing that they arrived in
- Make them as comfortable as possible
- Provide tissues or have them available
Step 2: Patient History

- Be on eye level or lower with the patient
- Speak to the patient directly, use their name
- Be relaxed and natural- monitor your body language
- Be supportive and sensitive through: tone of voice, body expression, maintenance of eye contact, turn off cell phone
- Pay attention to the patient
- Allow them time to be emotional
- Be comfortable with silence
- It is ok to comfort the patient. . .just as you would any individual whose care has been entrusted to you
Step 2: Patient History

- Convey to the patient
  - You are safe here
  - I’m sorry this happened to you
  - You did not deserve to be hurt
  - You did not ask to be hurt
  - You did everything right
  - You are very brave
  - Thank you for coming to see me
  - I’m glad I got to meet you

- Always assume that the rape occurred
Step 2: Patient History

- Patient specific information
- Obtain patient demographic information
  - Name, address, telephone number, age, date of birth, gender, race
- Record law enforcement information
  - Agency, officer, case number, telephone number
- Record date/time of SANE exam (always use military time)
Step 2: Patient History

- Patient demeanor
  - Use words that describe outward appearance, visible behavior, speech, eye contact, etc.
    - Looked at floor/examiner
    - Responded only when asked a question
    - Cried during patient history
    - Paced
    - Fidgeting hands when talking
    - Laughed
  - Do not use value statements
    - Good, bad
Step 2: Patient History

- History of the assault in patient’s own words
  - Patient tells clinician what happened
  - Clinician records it
  - Spontaneous information without leading questions
- Detailed questions regarding assault
- Activity/hygiene since assault
- Pertinent medical history
Step 2: Patient History

- Patient Narrative of Assault
  - Verbatim account from the patient
  - Use quotation marks whenever possible
  - Include sequence of events
  - Include perpetrator’s words, actions
  - Include patient’s words, actions, feelings, thoughts
  - Base physical examination and evidence collection on patient account
  - Avoid leading questions or questions that could indicate blame- Why questions
  - If clarification needed, reflect using patient’s own words
  - Use terms that the patient understands
Hearsay (Rule 801 and 803)

- Hearsay means a statement that:
  1. the declarant does not make while testifying at the current trial or hearing; and
  2. a party offers in evidence to prove the truth of the matter asserted in the statement

- Exceptions to hearsay:
  - Present sense impression
  - Excited utterance
  - Then-existing mental, emotional, or physical condition
  - **Statement made for medical diagnosis and treatment**
    - Statement that is made for- and is reasonably pertinent to- medical diagnosis or treatment; and describes medical history; past or present symptoms or sensations; their inception; or their general cause.
Practice as a registered professional nurse means the full scope of nursing, with or without compensation, that incorporates caring for all patients in all settings, through nursing standards recognized by the Division, and includes all of the following and other activities requiring a like skill level for which the registered professional nurse is properly trained:

b) The development of a plan of nursing care to be integrated within the patient-centered health care plan that establishes nursing diagnoses, and setting goals to meet identified health care needs, determining nursing interventions, and implementation of nursing care through the execution of nursing strategies and regimens ordered or prescribed by authorized healthcare professionals.
Step 2: Patient History

- Include any information that will assist in the **diagnosis and treatment** of the patient:
  - Date/time of the assault
  - Physical surrounding during the assault
  - Any loss of consciousness
  - Consumption of drugs/alcohol (how much) by patient
  - Penetration of vagina (labia majora or deeper)
    - With what? (penis, finger, tongue, foreign object)
  - Penetration of anus
    - With what?
Step 2: Patient History

- Did perpetrator orally touch patient? Where?
- Other acts by perpetrator
- Did ejaculation occur? Where?
- Condom used during assault?
  - If yes, where was it discarded?
- Lubrication used?
- Position of the patient and perpetrator during the assault
- Did patient scratch or injure perpetrator during assault?
  - If they didn’t, reassure them that they did what they needed to in order to stay alive.
Step 2: Patient History

- Force or coercion used? By what means?
  - Weapons
  - Grabbing
  - Hitting
  - Biting
  - STRANGULATION vs choking
  - Drugs/Alcohol
  - Burns
  - Held down
  - Torture

- Identifying information about the perpetrator
  - Name
  - Relationship to patient
  - Number of perpetrators if more than one
Step 2: Patient History

- Activity/Hygiene since the assault
  - Bathed/showered
  - Urinated
  - Defecated
  - Vomited
  - Douched
  - Brushed teeth/rinsed mouth
  - Ate/drank
  - Changed clothing
  - Chewed gum/smoked
  - Removed/inserted maxi pad/tampon/diaphragm/sponge
  - Wiped/cleaned genital area
Step 2: Patient History

- Pertinent Patient Medical History
  - Any known allergies
  - Current medications
  - Tetanus and Hepatitis B vaccinations
  - Last menstrual period
  - Current pregnancy status (document result of pregnancy test)
  - Anogenital surgery/procedures
  - Relevant medical conditions
  - History of intercourse within 72 hours (distinguish vaginal, oral, anal)
  - Birth control method used - condom used
  - Pain assessment
Step 3: Head-to-toe Assessment
Step 3: Head-to-toe Assessment

- **Primary assessment**
  - Airway
  - Breathing
  - Circulation
  - Disability/deficit

- **Secondary assessment**
  - Exposure/environment
  - Full set of vital signs
  - Give comfort
  - History/Head to toe
  - Inspect back
  - Jot it down
    - Document, draw and photograph any injuries
    - Include size (in cm), location and description of appearance
Step 3: Head-to-toe Assessment

- Head: pulled hair, scalp trauma
- Eyes: hemorrhages
- Mouth: frenulum, teeth, palate
- Neck: trauma, strangulation injuries
- Extremities: upper and lower
- Breast: licking, biting
- Abdomen

For all areas assess for: TEARS
- Tears, tenderness, bruises, abrasions, redness, swelling

What parts of this assessment can you perform without the physician/NP/PA present?
Step 4: Detailed Genital Exam

- Examine external genitals, anus, vagina and cervix for injury
  - Document, draw and photograph any injuries
  - Include size (in cm), location and description of appearance
- May only be completed by SANE, Physician, Physician Assistant or Nurse Practitioner
Step 5: Evidence Collection

- Collect evidence while conducting physical exam
- Use alternative light source (ALS) and collect any area that fluoresces
- Collect dry and moist secretions, stains, foreign material observed
- Swab any areas that may contain perpetrator DNA (anywhere kissed, licked, sucked, touched)
- Collect reference specimens
- Follow procedure in sexual assault evidence collection kit
- Document all evidence collected, including clothing, swabs, urine and blood
  - If evidence not collected, document why
Evidence Collection 101

- Two crime scenes in sexual assault cases:
  - Place of the assault
  - Patient’s body
- The role of the clinician is to preserve and collect evidence from the patient
- Evidence collection from the patient’s body:
  - Clothes, hair, fingernails, skin, condoms, feminine hygiene products, vaginal secretions, saliva...
- Types of evidence: Physical evidence
  - Physical injury
  - Foreign materials
  - Biological evidence = DNA
- “Keeping in mind the history of the assault”
Biological Evidence

- DNA can be isolated from any specimen that contains cell nuclei
- Types of biological evidence:
  - Semen
  - Blood
  - Vaginal Secretions
  - Saliva- from kissing, sucking, biting, licking. . .
  - Sweat and/or other secretions
  - Epithelial cells- skin to skin contact
- Principles regarding transfer of DNA:
  - Locard Principle: whenever two objects come in contact, there is always a transfer of material
  - Direct transfer vs. indirect transfer
General Rules for Evidence Collection

- There is only one chance to collect: When in doubt, collect it.
- Air dry all samples, do not use heat: Heat degrades DNA.
  - Air dry for 30-60 minutes.
  - If a swab dryer is available, dry for at least 30 minutes in a swab dryer.
- If once living, like blood and body fluids, needs to be refrigerated.
- Do not use plastic, use paper or glass only: Plastic causes mold.
- Separate items that are collected.
General Rules for Evidence Collection

- Once the kit is opened, the clinician cannot leave the specimens to maintain chain-of-custody
  - What is chain-of-custody?
- Every piece of evidence collected must be labeled with the patient’s name, case number, date, clinician’s name
- Seal everything with tape: Staples are not sufficient
- Label, seal and initial everything to maintain chain-of-custody
- Clinicians should follow the policy and procedure of the individual program she/he is practicing when collecting evidence
- Use the kit as a guide
How Not to Contaminate the Evidence

- Make sure you start with a clean room. . .when in doubt wipe it out
- Frequent hand washing- gloves don’t take the place of hand washing
- **Wear gown, mask, hair covering and gloves throughout the evidence collection**
  - Change gloves between sites/samples collected to avoid cross-contamination
- Thoroughly clean exam room and evidence processing areas
- Package unlike samples separately
- Avoid contamination during drying of samples
- Do not lick envelopes

- If you drop it. . .can you say “bye-bye”?
Illinois Sexual Assault Evidence Collection Kit
Debris and Clothing Collection

- Place a clean cloth sheet on the floor to prevent contamination of specimen, then place the enclosed paper sheet or exam mat over the cloth sheet
- Have patient stand over paper sheet while undressing to collect debris evidence
- Ask patient to undress one article of clothing at a time
- Collect each article and place in separate bag
- Collect paper sheet by folding in a bindle and place in envelope
- Nurse should witness the patient undress, but always remember to protect patient privacy
Clothing Collection

- Collect clothing worn during the assault
  - Shoes, coat, belts only needed if pertinent
- If the patient has not changed clothing, perform miscellaneous/debris collection cloth
- If patient has changed clothes and brings clothing to exam, collect it
  - Document that clothing brought to exam by patient
- If patient has changed clothes, still collect underwear worn at time of exam
- Label each bag with what article of clothing is contained within
- Place clothing in paper bags (should be available through local law enforcement or hospital supply)
  - Place underwear and bra in bags in IL SAECK
  - Do not use grocery bags
Clothing Collection

- Document stains/tears in clothing in writing

- If clothing torn or significant stain present, photograph first prior to removing and collecting
Other Debris Collection

- Collect any debris found on patient’s body
- Photograph debris prior to collection
- Collect using a swab to pick up or your fingers (get new gloves prior)
  - In general, do not use forceps/tweezers
- Place each item collected in a separate bindle and place in envelope (including glass, hair, fibers, etc…)
- Label where debris found on body and description of debris
- Document debris location and collection on body map
Bindle

- Piece of paper folded in thirds

- And folded in thirds again

- Can get new printer paper to make bindles
Oral Specimens

- Oral swabs: evidence collection for oral sodomy
- Use two swabs at a time – collect a total of four swabs
- Swab oral cavity of patient, concentrate on area between lower cheek and gums, under tongue and around teeth, particularly behind incisors and front molars
- If tongue ring present, swab around base
  - Ask patient if they would like to remove the ring and submit for evidence
- Place in box in envelope, seal and label
Includes swabbing any area where perpetrator’s saliva could be found (anywhere the perpetrator’s mouth touched the patient), that glows under the alternative light source, where dried secretions/stains noted, etc…

Also includes anywhere the assailant grabbed, touched the patient

Includes all bite marks

- Photograph bite mark
  - Consider contacting a crime scene investigator for additional photos
- Swab entire bite mark, concentrating on center
- 2 swabs (1 wet, 1 dry)
To collect the SANE way:

- Use the double-swab technique:
  - Moisten one sterile cotton swab with distilled water (sterile water is okay)
  - Roll gently over the area on the patient’s body (if too much pressure is applied you will get too much of the patient’s DNA)
  - Repeat with one dry swab
  - Place in envelope, label with where the specimen was collected and seal
  - Note where the specimen was collected on the body map

- Place both swabs from the same area in the same box

- What about wet stains?
Fingernail Specimens

- Remove two specimen envelopes (right hand, left hand)
- Place bindle under patient’s hand on flat surface
- Scrap nails while holding nails over bindle so that debris falls into bindle
- Place scraper in center of bindle and refold
- Place in envelope, seal and label
- Repeat steps for other hand
- Collect if patient states that she/he scratched perpetrator, if there was a struggle during assault or a broken nail is noted
- What about fingernail swabs/cuttings?
Head Hair Combings

- Remove paper bindle and comb
- Unfold paper bindle
- Comb head hair so that any loose hair/debris falls into bindle
- Place comb in center of bindle if possible
- Refold bindle and place bindle and comb in envelope
- Label and seal
Pubic Hair Combing

- Remove paper bindle and comb
- Unfold paper bindle
- Place under patient’s buttocks
- Comb pubic hair in a downward motion so that any loose hair/debris falls into bindle
- Place comb in center of bindle if possible
- Refold bindle and place bindle and comb in envelope
- Label and seal
- What if pubic hair matted or not present?
Anal Specimens

- SANE, Physician, Physician Assistant or Nurse Practitioner only
- Moisten two swabs
- Place inside anus so that entire cotton tip is within
- Move in circular motion and withdraw
- Then repeat with two additional moisten swabs
- Place in box in envelope, label and seal
- May use knee-chest position to help facilitate collection
- Not necessary unless anal penetration reported or determine necessary due to assessment
  - May collect swab of external anus if no anal penetration reported in an attempt to get vaginal secretions with perpetrator DNA
Penile Specimens

- SANE, Physician, Physician Assistant or Nurse Practitioner only
- Needed on all male patients that report any penile contact with perpetrator
- Needed on all male suspects
- Moisten four swabs with distilled/sterile water
- Swab exterior of penile shaft and glans and area of scrotum closest to shaft
  - Do not swab urethra
- Place in box in envelope, label and seal
- May consider using miscellaneous envelope if ALS used and fluorescence occurs on another part of the scrotum
Vaginal/Cervical Specimens

- SANE, Physician, Physician Assistant or Nurse Practitioner only
- Only needed if vaginal penetration during sexual assault
- Conduct external assessment for injury and swab external genitalia first
- Use other tools to further evaluate for external injury (TB dye, fox swabs, foley catheter)
- Perform speculum exam
- Using two swabs, swab posterior fornix of vagina/vaginal vault
  - Avoid touching vaginal walls
- Place swabs in box in envelope, label and seal
- Repeat above steps for cervical swabs
- Insert one (or two if able) swab at a time into cervical os, twist and remove
  - Cervical swab more important the longer the timeframe from the assault
Blood on Filter Paper

- Used for reference specimen
- Write patient’s name and date on filter paper
- Only touch bottom of filter paper
- Don’t allow to lay on the counter – place on a clean paper towel
- Can use blood obtained for medical purposes/blood draw or finger stick
- Fill five circles with drops of patient’s blood
- Allow filter paper to air dry
- Place filter paper in envelope
Other: Jewelry Collection

- Collect if significant:
  - Did perpetrator come in contact with the jewelry during the assault?
  - Think genital/oral jewelry
  - Earrings if history of kissing/sucking on the ear
  - Ring if patient scratched perpetrator
  - Necklace used as ligature for strangulation

- Broken during assault (photograph as well)

- Always ask for patient consent prior to collecting

- Place in a envelope or bag, label and seal
Other: DFSA

- Collect urine if DFSA suspected
- Do not package inside ISPECK
- How do you package/seal?

- Swab all orifices and collect fingernail scrapings if patient cannot recall the assault
  - Also consider body surface swabs such as neck, breast or inner thighs
Other: Collection of Knots

- If knot still intact and present on patient:
  - NEVER UNTIE KNOT
  - Photograph the restraint and knot
  - Tie strings in two locations on opposite end of knot
  - Cut in between two strings, leaving knot intact
  - Take pictures of your actions throughout the process
  - Place in a bag or envelope, label and seal
Other: Collection of Bullets

- Do not write or mark the bullet
- Do not grab with forceps or anything that could damage the bullet
- Wrap in gauze and place in envelope
- Mark container with description of item, from whom, location, who removed, date/time removed
- Label and seal, give to law enforcement
Other: Suspect Exams

- SANE, Physician, Physician Assistant or Nurse Practitioner only
- Use ISPECK
  - LE may provide a collecting standards ISP kit
- Collect pulled hair standards- place in head/pubic hair combings envelopes
  - 50 head hairs
  - 25 pubic hairs
- Collect reference DNA- blood on filter paper or buccal swabs
- Swab penis (if male suspect)
- Look for debris/stains- collect
- Use ALS for fluoresced stains- collect
- Collect clothing
- Head-to-toe assessment and detailed genital assessment for injury-photograph
Step 5: Evidence Collection

- Document a summary of findings
  - Nursing Diagnosis
  - Any injury noted (body or genital)
  - Any tenderness noted
  - Any ALS findings
  - Trace evidence
  - Patient reports sexual assault or patient evaluated for sexual assault
  - Sexual Assault Evidence Collection Kit completed
  - Urine sample obtained for DFSA
  - Never document a conclusion of sexual assault/rape or consent
Step 6: Medication and Discharge

- Discuss treatment options with patient
  - Treat prophylactically for STIs (including HIV) and pregnancy
- Administer other medications as needed
- Provide discharge instructions, including wound care and recommendations for follow-up
- Provide referral for counseling, advocacy services
- Ensure patient is discharged to a safe place
- Refer back to ER physician if not stable for discharge
- Complete patient discharge materials form provided in IL SAECK or hospital equivalent
Receipt of Information

- Package and seal all evidence maintaining chain-of-custody
- Sign documentation
- Law Enforcement Officer signs as receiving information
- SANE signs as releasing information
- White copy- patient medical record
- Yellow copy- include in evidence collection kit
- Copy for law enforcement?
General Exam Information

- Sexual assault exam usually take between 1 ½ to 3 hours for the patient
- Final diagnosis NEVER Alleged Sexual Assault
  - Sexual assault
  - Sexual assault by history
  - Evaluation of sexual assault
  - Patient states
- It is ok to use humor during the exam (when appropriate)
Documentation

- Legible
- Thorough and consistent
- No medical abbreviations/jargon
- Proper spelling and grammar
- Military time

- Avoid the word “like”
  - “bite-like”, “hand-like”
  - Do not group injuries

- Objective comments only
  - Do not use subjective language like “very” or “extremely”

- Use patient quotes whenever possible
Questions?
LUNCH
Drug Facilitated Sexual Assault
Assault upon someone who was delivered in any fashion drugs for the purpose of incapacitating the intended victim or rendering the intended victim incapable of understanding the nature of the act or able to give knowing consent to the act.

Reports increase about 2% each year for the last several years.

Drugs can be taken knowingly by the victim OR

Drugs can be given without knowledge of the victim.
DFSA

- Ideal “date rape drug”
  - Has a short half life (out of the system fast)
  - Potent (effective at low doses)
  - Tasteless, colorless, odorless
  - Soluble in liquids (alcohol in particular)
  - Interacts synergistically with alcohol (1+1 >2)
  - High therapeutic index
  - Causes sedation
  - Causes memory impairment
DFSA

- **Ideal**
  - Any benzodiazepine
  - **Alcohol**
  - Any other depressant

- **Less ideal**
  - Opiates
  - GHB
  - Cannabis
  - PCP
  - Antihistamines
    - No so much amnesia, but confusion as to what happened
  - Tetrahydrozaline (in Visine)
    - Can cause CNS depression, cardiovascular collapse and coma
Alcohol

- Found in nearly 40-65% of drug facilitated sexual assault participants
- Seen in both victim and suspect
- This is a drug often knowingly consumed by the victim
- Sometimes, the victim does not know how much they are drinking
Victim may have impaired memory of event
Victim may be confused about events
Victim may suspect drugs (only one drink, but passed out)
Significant time may have passed between incident and presentation due to recovery and time taken to figure out what happened
Highly Publicized Drugs

- **Rohypnol**
  - Brand name Flunitrazepam
  - Roofies, forget me pill
  - $T_{1/2} = 18-26$ hours
  - Metabolite $T_{1/2} = 36+$ hours
  - Dosage- 1 or 2mg per tablet
  - Not approved for use in US
  - Can cause retrograde amnesia, unconsciousness, coma and death at increasing dosages
  - After effects include dizziness, visual disturbances, dry mouth and “hangover” side effects
  - Now has a dye added to it
Highly Publicized Drugs

- **GHB- gamma-hydroxybutyric acid**
  - Somatomax, liquid ecstasy, grievous bodily harm
  - $T_{\frac{1}{2}} = 0.3-1$ hour
  - Dosage- 1000mg or higher
  - Lethal dosages start at about 3000mg
  - Nearly undetectable in urine at 12 hours
  - Can be made with over the counter materials
  - Is being researched as a medication for narcolepsy
  - Can cause unconsciousness within 15 minutes after administration
  - Very little after effects when (if) individuals regain consciousness
Highly Publicized Drugs

- **Ketamine**
  - Special K, cat valium, kit kat, vitamin K
  - $T_{1/2} = 2.5$ hours
  - Dosage - 100mg or higher
  - Used by veterinarians as an animal tranquilizer
  - Can cause hallucinations and delirium
  - Can cause dissociative amnesia, unconsciousness, seizures and death at increasing dosages
  - Is similar to PCP in side effects but less psychotic episodes
Rapid metabolism of these drugs by the body make detection very difficult.

“In a drug-facilitated rape case, the likelihood of detecting the drug used to commit the rape diminishes each time the victim urinates”

- American Society of Crime Laboratory Directors

Time limits for detection:
- GHB- 12 hours
- Ketamine- 48 hours
- Rohypnol- 72 hours
What Can You Do

- Collect a urine sample as soon as possible
- Sample should be collected while maintaining the dignity of the victim
  - You do not need to be in the bathroom with them
- Collect as much urine as possible initially
  - Do not mix subsequent voids
  - Collect at least 30-50mls
- Seal and mark the sample
  - DO NOT PUT THE SAMPLE IN THE EVIDENCE COLLECTION KIT
- No need for preservative or anticoagulant
- Clean, dry urine cup
What Can You Do

- Obtain consent
  - Informed consent
  - Victim has 48 hours after signing to revoke consent
  - Make sure that patient is aware that urine will be tested for ALL drugs
    - Hospital labs are not able to perform this testing
- Patient does not have to consent immediately
  - Can obtain sample
  - Provide to law enforcement
  - Patient has 30 days to follow-up with law enforcement and provide consent
Questions?
Strangulation
Strangulation and Domestic Violence

- Strangulation is a lethality risk factor - ultimate form of power and control short of homicide
- 68% of women in abusive relationships report strangulation by partner as a component of DV
  - Average length of abuse prior to strangulation is 3.1 years
  - Children witness strangulation in 41% of cases
- 10% of violent deaths per year in U.S. due to strangulation
Strangulation

- **Strangulation vs. choking**
  - Strangulation- lack of oxygen due to external pressure on the neck
  - Choking- lack of oxygen due to airway blockage by a foreign object

- Implies pressure to the neck and as such has great forensic importance

- It is a squeezing of the neck that is independent of the gravitational weight or suspension of the head; it may be circumferential or placed specifically

- **Categories:**
  - Manual strangulation- use of the hands or arms to apply pressure to the neck
  - Ligature strangulation- use of a ligature to apply pressure to the neck
  - Postural strangulation- neck placed over an object and the weight of the body applies pressure to the neck
What does it take?

- Ten pounds of pressure to the carotids for ten seconds causes loss of consciousness.
- Once this pressure is released it takes ten seconds to regain consciousness.
- Four pounds of pressure to the jugular veins for 30-60 seconds causes loss of consciousness.
- Thirty-three pounds of pressure obstructs the trachea, in an adult, causing death in 4-5 minutes.
Four Variables

- In general:
  - The quantity of applied force
  - The exact location where it is applied
  - The duration of the force
  - The surface area of the applied force

- Most of the victim’s either die or survive without consequential brain damage. A fact that has been called “the all or nothing law of strangulation.” (Jacob, et al., 1957)
Asphyxia

- A condition in which an extreme decrease in the concentration of oxygen in the body accompanied by an increase in the concentration of carbon dioxide leads to loss of consciousness or death.
- Asphyxia can be induced by choking, strangulation, drowning, electric shock, injury or the inhalation of toxic gases.
- Absence of oxygen to tissues.
- Does not occur equally throughout the body, not even equally in the brain.
Etiology of Asphyxia

- Mechanical constriction of the jugular veins by squeezing the soft tissues of the neck
- This is the most common type of strangulation asphyxia
- Consists of:
  - Compression of the jugular veins
  - Very little pressure required <4.5 lbs of pressure
  - Leads to reduced outflow of blood as the veins are occluded
  - Cerebral vessels quickly engorge blocking further blood inflow
  - Oxygen flow to the brain is halted and cerebral CO₂ increases
  - Loss of consciousness occurs in 30-60 seconds if jugulars are blocked
Etiology of Asphyxia

- **Mechanical constriction** of the carotid arteries by squeezing the soft tissues of the neck

- **Consists of:**
  - Compression of the carotid arteries
  - More pressure required than with jugulars ~ 10 lbs of pressure
  - Leads to reduced blood flow to the brain
  - Cerebral tissues quickly expend all available oxygen
  - Cerebral CO\(_2\) increases dramatically causing vascular spasms
  - Spasms block even small amounts of blood inflow
  - Loss of consciousness occurs in 10 seconds
  - After release of constriction... 10 seconds to regain wakefulness
Etiology of Asphyxia

- **Airway obstruction** due to external pressure applied to the neck

- Consists of:
  - Pressure is applied to the neck
  - C-clamp/both hands around neck/across front of neck with forearm from front with patient supine; or with patient standing and attacker from behind
  - The hyoid bone and tongue are pushed upward and backward blocking the laryngo-pharynx
  - Painful and panic inducing
  - Tremendous air hunger
  - Victim may have multiple injuries from struggle
Cardiac Arrest

- In rare cases, strangulation may cause immediate cardiac dysrhythmia and/or cardiac arrest
- Due to pressure applied to nerves in carotid arteries
- Force applied to specific, localized anatomic area in neck
Immediate Signs and Symptoms

- Difficulty breathing, especially when talking, or walking/airway compromise
  - “Sniffing position” - a posture where they stand and lean forward to maintain optimal airway
- Loss of consciousness/memory loss
- Change in their voice quality, tone, or volume (hoarseness)
- An inability to sing, even if they can speak
- Neck pain/swelling/sore throat
- Difficulty swallowing/feeling of a lump in their throat
- Dizziness
- Shaking
Immediate Signs and Symptoms

- Headache
- Vision changes
- Ringing in ears
- Nose bleed
- Vomiting
- Loss of bowel/bladder function
- Miscarriage
- Neurological sx:
  - One-sided weakness, facial droop, paralysis
Mental Status Changes

- Hypoxia/Asphyxia can lead to temporary or permanent mental status changes
- Often noted as a change in personality by family or the patient
- Typically increased irritability, combative, hostile, anxious, panic, restless
- Psychosis can occur if oxygen deprivation is severe, includes:
  - Hallucinations- auditory, visual, olfactory, tactile
  - Delusions- paranoid, persecution
Psychiatric Effects

- Psychosis
- Amnesia
- Depression
- Anxiety
- PTSD
- Suicidal Ideation
Cognitive Stages

- **Disbelief** - “I can’t believe he is doing this!”
- **Realization** - “Yes, this IS happening!”
  - Pain and fear
- **Survival** - “I’ve got to make him stop!”
  - Terrible struggle to preserve airway and life
- **Resignation** - “This is how I will die.”
  - “Who will take care of my children?”
- These stages evolve quickly as hypoxia worsens and CO$_2$ increases
- Important to document mental and emotional status of patient and their perceptions of what happened
Long Term Health Risks

- At risk for developing serious health problems and/or fatal outcomes up to two weeks post strangulation:
  - CVA/Stroke- inflammatory process due to damaged blood vessels
  - Aspiration pneumonia
  - Pulmonary edema
  - Progressive degeneration of brain function
  - Progressive dementia
Strangulation Injury

- 50% of strangulation victims have NO visible injury to the neck
- No external evidence of injury may be present on fatal strangulation victims - autopsy needed
- If injury present, most common site on head, neck and face
- Consists of:
  - Bruising
  - Ligature marks
  - Petechiae to eyes, scalp, skin and ears
  - Defensive injuries - fingernail marks from victim trying to escape
Petechiae

- Small pinpoint areas of bleeding caused when small capillaries rupture and bleed into the surrounding tissues.
- These areas are not raised; they rest flat against the skin.
- Petechiae do not blanch.
- The configuration will follow vessels- if you see petechiae on the face or neck, track the vessel into the scalp.
- They may also be present in and around the eyes, ears and hairline.
- Petechiae are located above (superior) to the constriction.
- Other causes?
As First Responders

- Victims often seen as unstable, drunk, drugged, hysterical and/or hyperventilating and may not receive the appropriate medical care and evaluation

- ALL STRANGULATION VICTIMS NEED IMMEDIATE MEDICAL ATTENTION

- The Journal of Emergency Medicine recommends hospital admission for evaluation and observation for worsening signs and symptoms for 24 hours

- Refer to healthcare provider if strangulation within two weeks
Medical-Forensic Exam

- Separate strangulation assessment required
- Refer to and consult with physician prior to discharge
- Specific discharge instructions
Questions?
Discharge Instructions and Medical Treatment
Objectives

- Discuss the emergency contraception pill (ECP) and its use
- Outline the treatment guidelines per SASETA
- Summarize the appropriate referral and follow-up recommendations for the sexual assault patient
Basic Medical Guidelines

- Emergency Contraception
- STI Prophylaxis
- HIV Prophylaxis
- Other Medical Treatment
- Follow-up
In 1996, ACOG recommended that all OB/GYN physicians, clinics and hospitals offer EC as part of a standard of care.
Emergency Contraception

- Estimated as many as 25,000 rape-related pregnancies occur each year (Stewart & Frussell, 2000)
- Method of contraception to prevent pregnancy AFTER an unprotected sexual encounter
- Not an abortive agent
Mode of Action

- May inhibit or delay egg from being released from ovary if client is in first half of her cycle
- May prevent sperm and egg from uniting
- May prevent fertilized egg from attaching to uterine lining (alters the endometrial lining and cervical mucus)
  - New research suggests that this is not true
- If taken during an established pregnancy - no affect
- Stress that ECP is NOT an abortion agent
- Recent studies suggest top 2 MOA’s
  - Does not affect endometrium
  - Levonorgestrel does not interfere with post-fertilization events
Forms of Emergency Contraception

- Progestin only pills
  - Next Choice One Dose or My Way (generic Plan B One Step)- 1 dose of 1.5mg levonorgestrel
  - Plan B One Step- 1 dose of 1.5mg levonorgestrel

- Ella- Rx only, up to 120 hours, 1 dose 30mg ulipristal acetate

- Combination estrogen-progestin oral contraceptives
  - 100mcg of estrogen and 0.50mg of progestin

- Copper Intra-Uterine Device (IUD)
  - Most effective form of emergency contraception
Progestin Only Pills

- Reduce risk of pregnancy by 88% (7 out of 8 pregnancies that would have otherwise occurred)
  - If taken within 24 hours, risk reduced by up to 95%
- Less likely to have side effects
- Available over-the-counter
- Cost:
  - Plan B One Step- $40-$50
  - Generics (Next Choice One Dose/My Way)- $35-$45
Progestin Only Pills Side Effects

- Generally resolve within 24 hours from taking the medication
- Nausea/vomiting
- Menstrual irregularities
  - Delayed
  - Irregular bleeding
- Fatigue
- Irritability
- Abdominal pain
- Breast tenderness
- Headache
- Dizziness
Ella

- Progesterone receptor modulator
- Believed to be more effective than levonorgestrel ECPs
  - Risk 65% lower than risk after progestin-only within 24 hours
  - 42% lower if taken within 72 hours
- Effective for 5 days after unprotected intercourse
- Depends on where woman is in her cycle
  - Does not appear to work if too close to ovulation or if already ovulated
Combination estrogen-progestin oral contraceptives

- Higher incidence of nausea and vomiting
- Reduce the risk of pregnancy by 75%
Copper IUD

- Reduces the risk of pregnancy by more than 99%
- Can continue to be used for ongoing contraception for at least 10 years
- Can be inserted up to 5 days after unprotected intercourse to prevent pregnancy
- Not recommended:
  - Active gonorrhea or chlamydia infection
  - Pelvic inflammatory disease (PID)
EC and Patient Care

- LMP
- How long ago was unprotected intercourse?
- Collect specimen for preexisting pregnancy
- Follow hospital protocol and procedures
- Know the options for your community
EC Hotline Numbers

- Emergency Contraception Hotline (Association of Reproductive Health Professionals)
  - 1-888-NOT-2-LATE
  - www.not-2-late.com

- Planned Parenthood
  - 1-800-230-PLAN
An empiric antimicrobial regimen for chlamydia, gonorrhea and trichomonas

- **Ceftriaxone (Rocephin) 250mg IM in a single dose** or Cefixime 400mg orally in a single dose, PLUS
- **Azithromycin 1g orally in a single dose** or Doxycycline 100mg orally twice a day for 7 days, PLUS
- **Metronidazole 2g orally in a single dose** or Tinidazole 2g orally in a single dose

Consider an anti-emetic medication
STI Prophylaxis- Hepatitis B

- Post exposure Hepatitis B vaccination (without HBIG) if the hepatitis status of the assailant is unknown and the survivor has not been previously vaccinated.
  - If assailant is know HBsAg-positive: unvaccinated survivors should receive both hepatitis B vaccine AND HBIG.
  - Follow-up doses at 1-2 and 4-6 months
  - Survivors previously vaccinated but did not receive post vaccination testing should receive a single vaccine booster dose.
STI Prophylaxis - HPV

- HPV vaccination recommended for:
  - Female survivors aged 9-26 years
  - Male survivors aged 9-21 years
  - MSM who:
    - Have not received HPV vaccine
    - Have been incompletely vaccinated
    - Can be administered through age 26 years

- Administer at time of the initial examination
  - Follow-up doses at 1-2 months and 6 months
Risk of Acquiring HIV

- Per act risk for HIV transmission in consensual sex:
  - Receptive anal intercourse- 0.5%-3%
  - Vaginal intercourse- 0.1%-0.2%
  - Oral sex substantially lower

- If assailant is HIV-infected, risk could be high dependent upon factors such as:
  - Type of sexual intercourse (oral, anal, vaginal)
  - Presence of oral, anal or vaginal trauma including bleeding
  - Viral load in ejaculate
  - Presence of an STI or other genital lesion in assailant or patient
  - Children may be at greater risk because repeated assaults are more common

- Postexposure prophylaxis with a 28-day course of zidovudine was associated with an 81% reduction in risk for acquiring HIV in a study of health-care workers who had percutaneous exposures to HIV-infected blood.
Risk of Acquiring HIV

- High risks for HIV acquisition include
  - HIV-positive assailant

- If HIV status of assailant is unknown, health care provider should assess available information including:
  - Local HIV/AIDS epidemiology
  - Nature of the assault (vaginal vs. anal vs. oral, genital injury, condom use)
  - Any information about high risk behaviors of assailant, i.e. intravenous drug user, high risk sexual practices, MSM, etc.
When deciding whether to recommend the initiation of PEP, the clinician must assess and carefully weigh the following factors:

- Whether or not a significant exposure has occurred during the assault
- Knowledge of the HIV status of the alleged assailant
- Whether the victim is ready and willing to complete the PEP regimen
Clinicians should recommend HIV PEP to victims when significant exposure may have occurred, as defined by direct contact of the vagina, penis, anus, or mouth with the semen, vaginal fluids, or blood of the alleged assailant, with or without physical injury, tissue damage, or presence of blood at the site of the assault.

PEP should also be offered in cases when broken skin or mucous membranes of the victim have been in contact with blood, semen, or vaginal fluids from the alleged assailant. Similarly, PEP should be offered in cases of bites that result in visible blood.
Recommendations (HIVguidelines.org)

- Unless the identity and HIV status of the alleged assailant have been clearly established to assist with the decision-making, PEP should be promptly initiated and should not be delayed while awaiting test results from the alleged assailant.

- Even when the alleged assailant is known to be HIV-infected, the decision to recommend PEP should be based on the nature of the exposure and the victim’s ability to complete the regimen.

- If PEP has been initiated and HIV screening tests from the alleged assailant are found to be negative, including rapid test and third- or fourth- generation EIA or HIV RNA assay*, then PEP should be discontinued. Decisions to discontinue PEP should be made in consultation with a clinician experienced in HIV PEP.
PEP should be initiated as soon as possible after exposure, ideally within 2 hours. Decision regarding initiation of PEP beyond 36 hours post exposure should be made on a case-by-case basis with the realization that diminished efficacy is a consequence of delay in the timing of initiation.

The recommendation for PEP should be communicated simply and clearly to the patient, considering his/her emotional state and ability to comprehend the nature of antiretroviral treatment.

If a sexual assault victim is too distraught to engage in a discussion about PEP or make a decision about whether to initiate prophylaxis at the initial assessment, the clinician should offer a starter pack of medication and make arrangements for a follow-up appointment within 24 hours to further discuss the indications for PEP.

If a sexual assault victim decides to initiate treatment, a follow-up visit should be scheduled within 24 hours to review the decision, evaluate initial drug tolerability, reinforce the need for adherence to the regimen, and arrange for follow-up care.
Discussions regarding initiation of PEP should include the following:

- Potential benefit of early initiation (asap and up to 72 hours after the assault), unproven efficacy, and potential toxicity of PEP
- Duration of PEP regimen
- Importance of adherence to the treatment regimen to prevent PEP failure or the development of drug resistance should infection occur
- Need to reduce risk and prevent exposure to others
- Clinical and laboratory monitoring and follow-up schedule
- Signs and symptoms of acute HIV infection
Post-exposure Prophylaxis for HIV

- **Medications:**
  - Tenofovir 300mg PO daily + Emtricitabine 200mg PO daily, PLUS
  - Raltegravir 400mg PO twice daily or Dolutegravir 50mg PO daily

- **Provide:**
  - 3-5 day supply of nPEP
  - Schedule follow-up at a time that allows for provision of remains 23 days of medication without interruption of dosing

- What about children? Pregnant patients?
Post-exposure Prophylaxis for HIV

- If PEP is started, perform
  - Baseline rapid HIV testing of the victim
    - PEP should be started without waiting for the results
    - Refusal to undergo baseline testing should not preclude initiation of PEP
  - Baseline CBC and serum chemistry
  - Prophylactic medication to prevent gonorrhea, chlamydia and trichomoniasis/bacterial vaginosis
  - Baseline pregnancy test and emergency contraception
  - Follow-up care
    - Re-evaluate after 3-5 days to determine tolerance of medicine
Resources

- CDC National AIDS Hotline: 1-800-342-2437
- HIV/AIDS Treatment Information Service: [http://www.hivatis.org](http://www.hivatis.org) or 1-800-448-0440
- National Clinicians’ Postexposure Prophylaxis Hotline: 1-888-448-4911 or [http://www.nccc.ucsf.edu/about_nccc/pepline](http://www.nccc.ucsf.edu/about_nccc/pepline)
- HIV Clinical Resource [http://www.hivguidelines.org](http://www.hivguidelines.org)
Discharge Instructions

- Every patient should have the benefit of a discharge plan that addresses:
  - Personal safety
  - Medications
  - Medical follow-up
  - Legal follow-up
  - Financial needs
  - Emotional needs
Follow-up- CDC Recommendations

- Provide an opportunity to:
  - Detect new infections acquired during or after the assault
  - Complete Hepatitis B and HPV vaccinations, if indicated
  - Complete counseling and treatment for other STIs
  - Monitor side effects and adherence to postexposure prophylactic medication, if prescribed

- If initial testing was done, follow-up should be conducted within 1 week
  - Positive test results can be discussed promptly
  - Treatment provided if not given at initial visit
  - Follow-up for the infection(s) can be made
Follow-up - CDC Recommendations

- If initial tests are negative and treatment not provided, examination for STIs can be repeated within 1-2 weeks.

- Patients treated during the initial visit (regardless of testing), post-treatment testing should be conducted only if the patient reports having symptoms.

- Syphilis
  - Repeated 4-6 weeks and 3 months.

- HIV
  - Repeated at 6 weeks, 3 months and 6 months.
Provide to Patient

- Emergency phone numbers for their community
- Name and phone numbers of law enforcement agency
- Rape Crisis Worker
- SANE
- Physician
  - Infectious Disease specialist (if started on PEP)
- Domestic Violence Shelter
Questions?
Vicarious Trauma
Objectives

- Define vicarious trauma
- Recognize signs and symptoms of vicarious trauma
Definition of Vicarious Trauma

- The natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by another; it is the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1995).

- Physical, emotional and/or spiritual fatigue or exhaustion that takes over a person and causes a decline in their ability to care for others (Stonier, 2010).
What is Vicarious Trauma?

- Form of occupational stress for those that work with patients/clients that experience trauma
- Cased by second hand exposure to trauma that diminishes a person’s ability to cope
- Normal response to exposure to trauma of others
- Physical and emotional symptoms similar to direct trauma
- Also called secondary trauma, compassion fatigue or sympathy PTSD
Stressor

- Any event acting as a stimulus which places a demand upon a person (Stonier, 2010)

- Causes of stress:
  - Psychological - past trauma, coping skills
  - Sociological - support system
  - Occupational - professional support
    - Nursing?
    - SANE?
    - Helper stressors
Who is at Risk?

- New workers
- Personal history of trauma
- Personal cumulative stress
- Personality traits
- Gender
- Mental health and health care professionals
- Anyone
Early Warning Signs

- Physical symptoms:
  - Difficulty sleeping
  - Pain - headache, backache, jaw, GI
  - Fatigue
  - Changes in appetite
  - Flu-like symptoms
Early Warning Signs

- Cognitive symptoms:
  - Difficulty concentrating
  - Difficulty communicating
  - Recurring/intrusive thoughts
  - Guilt
  - Decreased work performance
  - Depression
Early Warning Signs

- Emotional symptoms:
  - Irritability
  - Fear
  - Anxiety
  - Hopelessness
  - Anger
Early Warning Signs

- Behavioral symptoms:
  - Dissociation
  - Change in normal routine
  - Change in sexual activity
  - Hyper-vigilance
  - Social isolation
  - Substance use/abuse
What is Burnout?

- Burnout is defined as exhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration (Stamm et al., 2008)

- Compared to vicarious trauma:
  - I don’t care anymore
  - Requires more than a break
  - Loss of ideals and hope
  - Disengagement
  - Emotional/spiritual damage
Is Vicarious Trauma Normal?

YES!!!!!!!!!!

• Recognizing that it is normal to be affected by this type of work is the most important coping skill you can give yourself
• It is ok to feel outrage, shock, anger, horrified, saddened or vulnerable
• It is essential that you be prepared for these reactions and learn how to cope
Importance of Self-Care

- Continuous self awareness, self-assessment and self-care are critical to prevent the toxic buildup of negative and invasive effects.
- Must accept that working as a SANE will take its toll.
- Monitor your reactions as you work as a SANE:
  - Do I over identify with this patient?
  - Am I getting too involved?
  - Am I feeling overwhelmed?
Importance of Self-Care

- Have a strong personal and professional support system in place
  - SANEs must look out for one another
  - Remember that your SANE colleagues are experiencing the same kinds of events and feelings
  - Be supportive of your fellow SANE
  - Share success stories and reach out for help when needed
  - Debriefing is so important

- Find meaning in the work that you do
  - Having the opportunity to help others is so rewarding
  - As a SANE, you will help individual victims of sexual assault and your community

YOU DO MAKE A DIFFERENCE!
Importance of Self-Care

- Most importantly, find time to take care of yourself
- Find meaning in life outside of work
- Laugh
- Enjoy time with family and friends
- Engage in a hobby
- Get a massage, pedicure or take a relaxing bath
- Exercise and nutrition
- Take time off
- Accept duties within the scope of your experience and training - delegate
- Pay attention to your physical needs
- Talk to someone
Self-Care Summary

- Remove stressors
- Change how you perceive and respond to stressors
- Strengthen your self-care and coping mechanisms
- Remove self from stressful environment
Questions?
Multi-disciplinary Teams

- Successful SANE programs do not operate in isolation
- They work closely with:
  - Advocates
  - Law enforcement
  - Prosecutors
  - Judges
  - Forensic lab staff
  - Victim Witness Specialists
  - Other
- Victim/Patient/Survivor
Definition of SART

- SART = Sexual Assault Response Team
- SARTs are multi-disciplinary teams that coordinate and collaborate to:
  - Provide immediate response to sexual assault cases
  - Improve the treatment of sexual assault victims
  - Ensure a victim-centered approach to service delivery
  - Improve the investigation and prosecution of sexual assault cases to hold offenders accountable
  - Explore ways to prevent future victimization
- Victim-centered, Offender-focused
Role of SART Members

- **SANE:**
  - The SANE’s primary role is patient care
  - Conducts the medical and forensic examination
  - Receive 40-hour of classroom training and additional clinical training
  - Experts in evidence collection
  - Trained to provide expert witness testimony
Role of SART Members

- **Victim Advocates:**
  - In Illinois they receive a minimum of 40 hours of specialized training on issues of:
    - Sexual violence
    - The impact on the victim
    - Crisis intervention counseling
    - Special needs populations
    - The medical and criminal justice systems
  - Provide emotional support, medical and criminal justice system advocacy
  - Provide crisis intervention and crisis counseling throughout the victim’s stay in the emergency department
  - Act as a liaison between the victim and medical staff to ensure appropriate services are provided and the victim’s questions or concerns are addressed
  - Whenever possible an advocate should be available throughout the medical and evidence collection procedure
Role of SART Members

- **Law Enforcement:**
  - Protect the lives and property of citizens. They maintain order, investigate and arrest lawbreakers, and work to prevent crimes.
  - Primary role of law enforcement is victim/public safety.
  - Determine if the elements of the reported crime meet the state statute for sexual assault.
  - Conducts the investigation and collects evidence (other than the evidence collected by the SANE).
  - Remember that in some jurisdictions the investigating officer or detective may be different from the responding officer.
Role of SART Members

- **Prosecutor:**
  - Primary role is to prosecute offenders and hold them accountable
  - Decides who will be charged, what charge will be filed, who will be offered a plea bargain, and the type of bargain that will be offered
  - Review police reports and medical reports
  - Interviews the victim and alleged perpetrator
Other Participating Community Agencies

- Schools and Universities
- Child Advocacy Centers
- Social Service Agencies
- City Council
- Department of Public Health
- Substance Abuse Treatment and Prevention Professionals
- Planned Parenthood
- Social and Community Groups
Establishing a SART

- The first step is conducting a needs assessment to determine the scope of the sexual assault problem.

- Sample questions to be included:
  - How many sexual assaults occur within the state and local community?
  - How many sexual assaults are reported to law enforcement?
  - How many medical-forensic examinations are performed at local hospitals?
  - What is the current protocol and response to sexual assault victims and is it adequate?
    - Is evidence collection completed properly?
    - Is medical-forensic documentation thorough and helpful for the investigation and successful prosecution?
    - Does the presence of a sexual assault victim create a strain on the hospital emergency department?
Establishing a SART

- Determine what agencies and individuals will support a SANE program
- It is important to have the support of other community leaders and agencies
  - Including:
    - Colleges, universities, child advocacy centers, social service agencies, city councils, mayors, public health agencies, substance abuse treatment and prevention professionals, Planned Parenthood, and social and community groups
- Where are exams going to be performed?
- Funding?
Developing SART Protocols

- Create joint protocols
  - Define the roles and responsibilities of each entity, program or agency
- Remember that each community differs from one another
  - The development of a protocol for one community is not necessarily a sufficient protocol for another
- Best practices can be used as a guide for developing protocols for the disciplines who participate in the SART
- Meet regularly
Advocate

- 24-hour hotline staffed with a trained live person
- Multi-lingual and multi-cultural capabilities, including American Sign Language and TTY
- 24-hour, in-person medical advocacy
- Two advocates available at time of medical-forensic exam if needed
- Ensure victim's rights are being upheld
- Advocate called at same time as SANE and law enforcement
- Advocate present throughout emergency room visit and whenever the victim requests
- Provide on-going crisis intervention and emotional support
- Facilitate transportation needs
- Plan for victim's safety
- Provide information and referrals, including a resource packet of material
- Maintain confidentiality
- Conduct follow-up contact within three days with victim consent
Law Enforcement Officer

- Responding officer will limit the scope of the investigation to critical needs, including victim safety, scene preservation and evidence collection, confirmation of crime, location of the crime and suspect apprehension.
- Offer medical-forensic examination and other relevant victim rights.
- Explain evidence preservation advisories to victim.
- Direct or transport victim to medical-forensic examination.
- Notify advocacy services and hospital staff immediately if victim en-route to hospital for medical-forensic examination.
- Remain with victim until advocate or SANE arrive at hospital.
- Ensure that advocate present whenever the victim requests.
- Obtain sexual assault evidence collection kit, other evidence and paperwork from SANE maintaining chain-of-custody.
- Deposit evidence at the appropriate location and file report of incident.
- Conduct investigation, including in-depth victim, suspect and eyewitness interviews and request processing of sexual assault evidence collection kit and other evidence.
- Refer case to State's Attorney's Office for defendant charges.
Available 24-hours/7 days a week

Perform medical-forensic examination after triage and medical screening examination complete (SANE may be able to fulfill both functions depending on facility)

Notify any mandated reporting agencies

Provide compassionate and objective patient care

Explain each procedure to the patient and why it is necessary

Obtain patient consent for overall examination and for each step

Document patient medical history and history of the sexual assault

Conduct a head-to-toe physical assessment

Document in writing and with photography any injuries present

Collect and preserve evidence if within one week of sexual assault

Provide discharge instructions and medication to prevent sexually transmitted infections and pregnancy

Assess patient safety

Refer patient for two-week medical follow-up and other services

Work collaboratively with the advocate, law enforcement and other healthcare providers

Provide all evidence collected and paperwork to law enforcement maintaining chain-of-custody with patient consent
Prosecutor

- Meet with victim with advocate present (if requested) to discuss charging decision
- Meet with law enforcement investigator to discuss case and review all reports, including medical-forensic examination before charging decision is made
- If not charging a crime, notify victim to explain decision not to prosecute
- Vertical prosecution (same prosecutor handles the entire case)
- Prepare victim for court proceedings, with victim witness coordinator's assistance if appropriate
- Talk to victim before any plea agreement is offered/accepted
- Solicit victim's input on disposition alternatives
- Acknowledge the victim's rights and range of options for participation in the criminal justice system
- Work to ensure victim safety throughout the process
Sample SART Process

- Law enforcement notification
- Victim to hospital
- Initial medical assessment (medical screening examination)
- Victim advocate support
- Medical and forensic examination
- Closure with the hospital and responding law enforcement
- Disposition of evidence
- Preparation of police report
- Case referred to Investigations
- Forensic analysis
- Review by prosecutor
- Judicial proceedings
Questions?
Evaluation and Questions
References/Resources

- **SASETA (Act)**
  - [http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1531&ChapAct=410%26nbsp%3BLCS%26nbsp%3B70%26F&ChapterID=35&ChapterName=PUBLIC+HEALTH&ActName=Sexual+Assault+Survivors+Emergency+Treatment+Act%2E](http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1531&ChapAct=410%26nbsp%3BLCS%26nbsp%3B70%26F&ChapterID=35&ChapterName=PUBLIC+HEALTH&ActName=Sexual+Assault+Survivors+Emergency+Treatment+Act%2E)

- **SASETA (Administrative Rules)**

- **To view a listing of Illinois treatment/transfer hospitals**
  - [http://www.idph.state.il.us/healthcarefacilities/SASETA/index.htm](http://www.idph.state.il.us/healthcarefacilities/SASETA/index.htm)

- **CDC guidelines for STI treatment**

- **ACEP guidelines and link to Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient**
  - [http://www.acep.org/content.aspx?id=29562](http://www.acep.org/content.aspx?id=29562)