DRAFT

Medical/Mental Health Confidentiality in Correctional Settings

Professor Brenda V. Smith

NIC/WCL Project on Addressing Prison Rape

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Guidance on Reporting Obligations

1. **The Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
2. **State Laws**
3. **Case law**
4. **Health Organizations- Professional Codes of Ethics**
5. **Correctional Institution Policies and Procedures**

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- HIPAA's "privacy rule" generally pre-empts state law when state law is not more stringent in the protection of health information.
- An "authorization" is required for disclosing "protected health information" before a disclosure can be made.

HIPAA Questions

- **Under HIPAA, can an inmate prevent a medical provider from reporting a sexual assault to prison authorities for investigation/prosecution?**

No. Although health providers cannot release personal health information of inmates without cause, many exceptions have been provided for, including releasing information to law enforcement during a sexual assault investigation.

HIPAA Questions

- **Can prisoners use HIPAA as grounds for a violation of privacy lawsuit against the correctional institution?**

No. HIPAA does not provide individuals with a private right of action. No prisoner lawsuit has successfully used HIPAA to defend their privacy claim.

HIPAA Questions

- **Can an inmate or health care provider use HIPAA to prevent disclosing information required under PREA?**

No. The information provided by prisons under PREA complies with the HIPAA privacy laws and therefore no objection by an individual is allowed.

HIPAA

- Correctional facilities can disclose health information about inmates without an inmate's authorization for:
  - Providing health care to inmates;
  - The health and safety of the inmate-victim or other inmates;
  - The health and safety of the officers, employees, or others at the correctional institution; and
  - The health and safety of inmates, officers or persons responsible for the transporting of inmates;
  - Law enforcement on the premises of the correctional institution; and
  - The administration and maintenance of the safety, security, and good order of the correctional institution.

HIPAA: So What?

- If state law is not as strict, HIPAA applies
- HIPAA does not prevent a medical provider from reporting a sexual assault to prison authorities for investigation/prosecution
- HIPAA cannot be used to prevent disclosing information for data collection as required under PREA

State Laws

- Confidentiality and Privilege Statutes
  - Physician- Patient
  - Nurse-Patient
  - Sexual Assault Counselor- Patient
  - Rape Crisis Counselor- Patient
  - Clergy
- Mandatory Reporting Statutes
- Vulnerable Adult

Confidentiality and Privilege Defined

- There are three kinds of privilege
  - Absolute
    - Complete protection against disclosure
  - Semi-Absolute
    - Confidentiality is guaranteed except in specific circumstances- harm to self or others, criminal acts committed against a minor, and/or if there is a qualified privilege provision in the confidentiality statute
  - Qualified
    - Privilege can be breached by court order when a judge finds there are countervailing interests

Physician & Patient: Privilege

- **District of Columbia** [D.C. Code § 14-307 (2006)].
  - **Physicians and mental health professionals.**
    - (a) In the Federal courts in the District of Columbia and District of Columbia courts a physician or surgeon or mental health professional as defined by § 7-1201.01(11) may not be permitted, without the consent of the client, or of his legal representative, to disclose any information, confidential in its nature, that he has acquired in attending a client in a professional capacity and that was necessary to enable him to act in that capacity, whether the information was obtained from the client or from his family or from the person or persons in charge of him.

Physician & Patient: Exception

- **District of Columbia** [D.C. Code § 14-307 (2006)].
  - **Physicians and mental health professionals.**
    - (b) This section does not apply to:
      - (1) **evidence** in criminal cases where the accused is charged with causing the death of, or inflicting injuries upon, a human being, and the disclosure is required in the interests of public justice;
      - (2) **evidence** relating to the mental competency or sanity of an accused in criminal trials where the accused raises the defense of insanity or where the court is required under prevailing law to raise the defense;

Sexual Assault Counselor & Victim: Privilege

- **California** [Cal. Evid. Code § 1035.4 (West 2006)].
  - **Confidential communication between the sexual assault counselor and the victim.**
    - As used in this article, "confidential communication between the sexual assault counselor and the victim" means information transmitted between the victim and the sexual assault counselor in the course of their relationship and in confidence by a means which, so far as the victim is aware, discloses the information to no third persons other than those who are present to further the interests of the victim in the consultation or those to whom disclosures are reasonably necessary for the transmission of the information or an accomplishment of the purposes for which the sexual assault counselor is consulted. The term includes all information regarding the facts and circumstances involving the alleged sexual assault and also includes all information regarding the victim's prior or subsequent sexual conduct, and opinions regarding the victim's sexual conduct or reputation in sexual matters.

Sexual Assault Counselor & Victim: Exception

- **California** [Cal. Evid. Code § 1035.4 (West 2006)].
  - **Confidential communication between the sexual assault counselor and the victim.**
    - The court **may compel** disclosure of information received by the sexual assault counselor which constitutes relevant evidence of the facts and circumstances involving an alleged sexual assault about which the victim is complaining and which is the subject of a criminal proceeding if the court determines that the probative value outweighs the effect on the victim, the treatment relationship, and the treatment services if disclosure is compelled.

Confidentiality/Privilege: Clergyman

- **Georgia** [Ga. Code Ann. § 24-9-22 (West 2006)].
  - **Communications to clergyman privileged.**
    - Every communication made by any person professing religious faith, seeking spiritual comfort, or seeking counseling to any Protestant minister of the Gospel, any priest of the Roman Catholic faith, any priest of the Greek Orthodox Catholic faith, any Jewish rabbi, or to any Christian or Jewish minister, by whatever name called, shall be deemed privileged.
    - No such minister, priest, or rabbi shall disclose any communications made to him by any such person professing religious faith, seeking spiritual guidance, or seeking counseling, nor shall such minister, priest, or rabbi be competent or compellable to testify with reference to any such communication in any court.

Confidentiality/Privilege: General Exceptions

- Some jurisdictions carve out exceptions to the general rule of prohibiting the unauthorized disclosure of a patient's confidential health information where prisoners are concerned
- State laws governing medical privacy extend to those treated in correctional facilities except :
  - mandatory reporting requirements for child abuse;
  - certain infectious diseases; or
  - Tarasoff duties ("Once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, [the therapist] bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.") for patients who pose a danger to themselves or others

Exceptions: Texas

- Tex. Rev. Civ. Stat. art. 4495b, § 5.08(h)(9) (1999).
  - Physicians may without obtaining their patients' consent, disclose confidential information if their patient is detained in a "penal or other custodial institution".

Exceptions: California

- Cal. Penal Code § 7501(c) (1995).
  - Correctional health professionals may disclose a prisoner's HIV status to parole or probation officers when an HIV-infected inmate is released from prison.

Exceptions: Idaho

- Idaho Code §§ 39-601, 39-604(1)-39-604(5) (1996).
  - Allows the disclosure to a court of test results for any number of enumerated diseases of prisoners as well as persons charged with an offense.

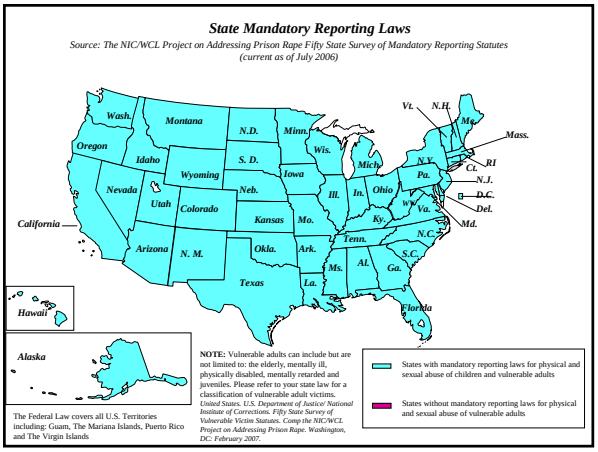
Confidentiality/Privilege--Practicalities

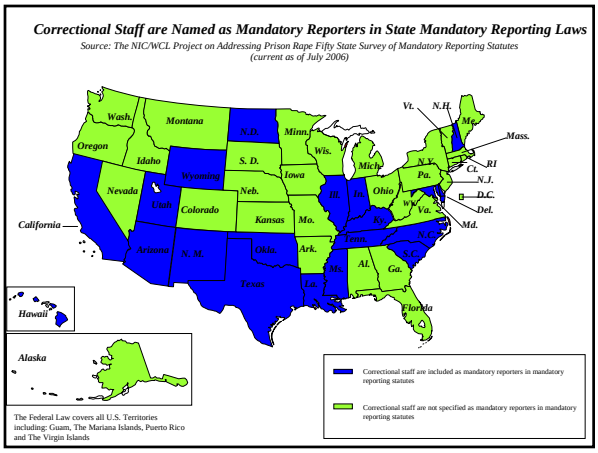
Correctional health professionals may/should fully inform patients about the limits of confidentiality so that patients can make informed decisions in consultation with the health professional, whether to divulge only that information that is necessary for effective patient care.

Jacquiline Moore, *Management & Administration of Correctional Health Care*, Civic Research Institute (2003).

Mandatory Reporting Statutes Defined

- Mandatory reporting laws require certain individuals to report cases of physical or sexual abuse committed against children and vulnerable adults.
- In 20 states correctional staff are mandatory reporters.
  - In 2 states correctional staff are explicitly named
  - In 18 states correctional staff are implicitly covered by the statute using phrases such as "any person"
- In 3 states correctional staff are required to report staff sexual misconduct.
- Often, there is a criminal penalty for the failure to report.





Mandatory Reporting: California

- **Cal. Welf. & Inst. Code § 15630 (West 2006).**
  - (b)(1) Any mandated reporter who, in his or her professional capacity, or **within the scope of his or her employment**, has observed or has knowledge of an incident that reasonably appears to be physical abuse (includes sexual assault).
- **Cal. Welf. & Inst. Code § 15610.23 (West 2006).**
  - (a) Dependent adult means any person between the ages of 18 and 64 years who resides in this state and who has **physical or mental limitations** that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age.

Mandatory Reporting: California

- **Cal. Welf. & Inst. Code § 15630 (West 2006).**
  - (a) Any person who has assumed full or intermittent **responsibility for the care or custody** of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency **or a local law enforcement agency.**

Mandatory Reporting: Florida

- **Fla. Stat. Ann. § 944.35 (West 2006).**
  - (3)(d) Witnessing, or reasonable cause to suspect, that an **inmate or an offender** under the supervision of the department in the community has been unlawfully abused or is the subject of sexual misconduct.
- **Fla. Stat. Ann. §944.35 (West 2006).**
  - (3)(d) **Each employee** who witnesses, or has reasonable cause to suspect, that an inmate or an offender under the supervision of the department in the community has been unlawfully abused or is the subject of sexual misconduct.

Vulnerable Adult Statutes Defined

- Vulnerable adult statutes criminalize the abuse or neglect of a category of adults classified as "vulnerable"
- Vulnerable adults include but are not limited to:
  - the elderly
  - mentally ill
  - physically disabled
  - mentally retarded

Vulnerable Adult: Maryland

- **Md. Code Ann., Crim. Law § 3-604 (2006).**
  - (b) Prohibited. ----(1) A caregiver, a parent, or **other person who has permanent or temporary care or responsibility for the supervision of a vulnerable adult** may not cause abuse or neglect of the vulnerable adult that:
    - (i) results in the death of the vulnerable adult;
    - (ii) causes serious physical injury to the vulnerable adult; or
    - (iii) involves **sexual abuse** of the vulnerable adult.

Vulnerable Victims: Maryland

- **Md. Code Ann., Crim. Law § 3-604 (2006).**
  - (10) "Vulnerable adult" means an adult who lacks the physical or mental capacity to provide for the adult's daily needs.

Immunity Statutes Defined

Immunity statutes protect medical and mental health care providers from lawsuits for reporting confidential medical information.

Immunity: New York

Reporting of endangered adults; persons in need of protective services [N.Y. Soc. Serv. Law § 473-b (McKinney 2006)]

- Any person who in good faith believes that a person eighteen years of age or older may be an endangered adult or in need of protective or other services, pursuant to this article, and who, based on such belief either:
  - (a) reports or refers such person to the department, office for the aging, or any local social services district office or designated area agency on aging, law enforcement agency, or any other person, agency or organization, that such person, in good faith, believes will take appropriate action; or
  - (b) testifies in any judicial or administrative proceeding arising from such report or referral shall have immunity from any civil liability that might otherwise result by reason of the act of making such report or referral or of giving of such testimony.

Immunity: South Dakota

Immunity for reporting abuse or neglect -- Immunity of public officials in investigation of abuse and neglect -- Immunity not available for Alleged abuser [S.D. Codified Laws § 34-12-51 (2006)]

Any institution regulated pursuant to chapter 34-12 and any employee, agent or member of a medical or dental staff thereof who, in good faith, makes a report of abuse, exploitation or neglect of a disabled adult, is immune from any liability, civil or criminal, that might otherwise be incurred or imposed, and has the same immunity with respect to participation in any judicial proceeding resulting from such report. Immunity also extends in a like manner to public officials involved in the investigation of abuse, exploitation or neglect of disabled adults, or to any person or institution provided herein who in good faith cooperates with such public officials in an investigation. The provisions of this section may not be extended to any person alleged to have committed any act of abuse or neglect of a disabled adult.

State Laws: So What?

- Federal laws such as HIPAA can supersede state laws.
- Mandatory reporting laws may require that correctional staff report incidents of sexual abuse of adults in custody if they are defined as vulnerable.
- Confidentiality and privilege are NOT absolute.

Case Law

- **Ruiz v. Estelle, 503 F. Supp. 1265 (1980)**
  - The maintenance of confidential treatment records was one of the six minimum criteria established for adequate prison mental health services.

Case Law: Exceptions

- Communicable Diseases
  - See e.g.
    - Doe v. Couglin, 697 F. Supp. 1234 (1988)
    - St. Hillaire v. Arizona Dep't of Corrections, 1991 U.S. App. LEXIS 11620 (1991)
    - Harris v. Thigpen, 941 F.2d 1495 (1991)

Case Law: So What?

- Confidentiality is part of providing adequate medical and mental health treatment.
- The inmate's right to privacy will be balanced against the correctional facility's need to maintain safety and security.

Medical Health Organizations- Professional Codes of Ethics

- American Academy of Physician Assistants
- American Medical Association
- American Nurses' Association
- American Public Health Association
- National Commission on Correctional Healthcare

Mental Health Organizations- Professional Codes of Ethics

- American Counseling Association
- American Mental Health Counselors Association
- American Philosophical Practitioners Association
- American Society for Philosophy, Counseling, and Psychotherapy
- Association for Addiction Professionals
- National Association of Social workers
- National Commission on Correctional Healthcare

Medical Codes of Ethics

- Generally, confidentiality *is protected* and medical personnel in non-correctional settings are *not* required to report the sexual abuse of non-vulnerable adults.
- Generally, medical personnel *are* mandatory reporters for sexual abuse of vulnerable adults.

American Nurses' Association

- **3.2 Confidentiality**-
  - Associated with the right to privacy, the nurse has a duty to maintain confidentiality of all patient information.
  - The rights, well-being, and safety of the individual patient should be the primary factors in arriving at any professional judgment concerning the disposition of confidential information.

American Medical Association

- **E 5.505 Confidentiality**-
  - The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree.
  - The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.

Medical But…….

- Confidentiality is not applicable in cases where the patient is a harm to himself or to another.
- Communicable diseases should be reported according to applicable statutes.
- Confidentiality may need to be modified in order to protect the patient, other innocent parties and in circumstances of mandatory disclosure for public health reasons.

Special Concerns of Medical Workers in Correctional Settings

- Communicable diseases are generally reportable, but that may go against ethical codes of confidentiality e.g. HIV
- Requires assessment of the importance of state laws, ethical codes and correctional policies and procedures for reporting.

Mental Health Codes of Ethics

- Generally, mental health providers in non-correctional settings *are not required to report* the sexual abuse of non-vulnerable adults.
- Generally, mental health providers in non-correctional settings *are protected* under confidentially and privacy laws in sexual assault situations.

American Mental Health Counselors Association

- **Principle 3- Confidentiality**
  - Mental health counselors have a primary obligation to safeguard information about individuals obtained in the course of practice, teaching, or research.
  - Personal information is communicated to others only with the person's written consent or in those circumstances where there is clear and imminent danger to the client, to others or to society.

American Counseling Association

- **B.1.c. Respect for Confidentiality:** Counselors do not share confidential information without client consent or without sound legal or ethical justification.
- **B.2.a. Danger and Legal Requirements:** Confidentiality does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed.

Mental Health But…..

- Confidentiality can be breached in the free world for three reasons:
  - When the sexual abuse is committed against a minor or another vulnerable victim- then a counselor is a mandatory reporter and by law is required to report the incident;
  - If the client talks about harming themselves or another person; and
  - If a state has a qualified privilege statute and a judge feels that the benefit of the evidence outweighs the victim's privacy.

Special Concerns of Mental Health Workers in Correctional Settings

- Will reporting requirements in correctional settings deter inmates from seeking emotional and psychological assistance after a sexual assault?
- What happens when reporting would do more harm than good?

National Commission of Correctional Healthcare- (NCCH)

- Health care encounters are private, with a chaperon present when indicated, and are carried out in a manner designed to encourage the patients' subsequent use of health services.
- Clinical encounters should be conducted in private and not observed by security personnel unless the inmate poses a probable risk to the safety of the health care provider.

NCCH- Medical Standards

P-G-09 Procedure in the Event of Sexual Assault

- The medical and psychological trauma of a sexual assault are minimized as much as possible by prompt and appropriate health intervention.
- **Compliance Indicator 2d:** A report is made to the correctional authorities to effect a separation of the victim from his or her assailant in their housing assignments.

NCCH- Medical Standards

P-H-02 Confidentiality of Health Records and Information

- The confidentiality of a patient's written or electronic health record, as well as verbally conveyed health information, is maintained.
- **Compliance Indicator 3:** Access to health records and health information is controlled by the health authority.

NCCH- Mental Health Standards

M-G-09 Procedure in the Event of a Sexual Assault

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- **Compliance Indicator 3:** Access to health records and health information is controlled by the health authority.

Ethical and Professional Standards: So What?

- Ethical codes do not supersede state and federal law.
- Ethical codes can provide some guidance in maintaining patient confidentiality.
- Confidentiality is NOT absolute in correctional settings.
- There are special concerns for medical and mental health providers, with regard to privacy and confidentiality of inmates.

Overarching Questions

- Does the safety and security of the institution and those living and working there outweigh the confidentiality rights of the victim?
- What is your responsibility if you believe that disclosure will affect the safety of the patient?

Overarching Questions

- Are inmates a per se vulnerable population?
- What about vulnerable adults in correctional setting?
- What about vulnerable adults in community corrections settings?

Correctional Policies– in general

- Many correctional policies require staff members including health care providers to immediately report allegations of sexual assault.
- Many correctional policies that require reporting also requires a reporter to be discreet.

Correctional Policies– in general

- Policies often don't, but should address information availability regarding post-incident care (both medical and mental health records).
- Most reporting requirements for medical and mental health staff are found in sexual assault procedure policies not in healthcare policies.

Correctional Institution Policy

- **Tennessee Department of Corrections**, Policy, Sexual Assault of Inmates (DOC 502.06)
  - **Section VI. F.1. Procedures: Reporting and Investigations:** "All allegations of sexual assault shall be reported and appropriately investigated in accordance with Policy #103.02. Such allegations shall be treated with discretion and to the extent permitted by law, confidentiality."

Correctional Institution Policy

- **Idaho Department of Corrections**, Policy, Prison Rape and Sexual Activity Elimination (325.02.01.01)
  - **Section 6 Confidentiality:** "The sharing of information regarding a sexual assault and sexual activity should be limited to those who need to know for decision making, investigation, and prosecution. Staff members should refrain from talking openly about such issues. Staff should immediately address inappropriate comments such as taunting or teasing."

Correctional Institution Policy: So What?

- The reporting and confidentiality requirements of medical and mental health staff as written into correctional policy are often contradictory, confusing and unhelpful.
- Most correctional institutions require medical and mental health staff to report sexual abuse of inmates.
- Correctional institutional policy may conflict with state law, and professional and ethical standards.

Summary

- Medical and mental health staff should consult federal and state laws regarding their responsibilities for reporting sexual abuse and maintaining the confidentiality of patient information.
- Professional codes of ethics provide good guidance for reporting and confidentiality of sexual abuse but they are neither absolute nor controlling.

Summary

- Correctional policy should not contradict or conflict with state or federal law.
- Correctional policy should integrate professional codes of ethics.
- If correctional policy deviates from law or professional standards it should articulate a justification.

Additional Resources

- United States. US Department of Justice/ Office for Victims of Crime. "Privacy of Victims' Counseling Communications." Legal Series Bulleting 8. Washington, DC. November 2002.
- United States. U.S. Department of Justice/ National Institute of Corrections. Codes of Ethics from Medical and Mental Health Organizations. Comp the NIC/WCL Project on Addressing Prison Rape Washington, DC: February 2007.
- Allen, Scott et.al. "Dual Loyalties: Our Role in Preventing Inmate Abuse." CorrectCare. Summer 2006.
- Patricia A. Furci, *The Sexual Assault Nurse Examiner: Should the Scope of the Physicial-Patient Privilege Extend That Far?*, 5 Quinnipiac Health L.J. 229 (2002).
- Anna Y. Yoo, *Broadening the Scope of Counselor-Patient Privilege to Protect the Privacy of the Sexual Assault Survivor*, 32 Harv. J. on Legis. 255 (1995).
- Euphemia B. Warren, *She's Gotta Have It Now: A Qualified Rape Crisis Counselor-Victim Privilege*, 17 Cardozo L. Rev. 141 (1995).
- Annette L. Hanson, *Confidentiality in corrections: fact or fiction?*, American Academy of Psychiatry and the Law Newsletter, Vol. 8, No. 3, p. 8 (1999).
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Psychiatric Disorders of Youth in Detention

Linda A. Teplin, Karen M. Abram, Gary M. McClelland, Amy A. Mericle, Mina K. Dulcan, and Jason J. Washburn

The juvenile justice system faces a significant challenge in identifying and responding to the psychiatric disorders of detained youth. In 2001, more than 104,000 juvenile offenders were in custody in juvenile residential placement facilities (Sickmund, Sladky, and Kang, 2004). Understanding the psychiatric disorders of juvenile detainees is an important step toward meeting their needs. Providing such youth with psychiatric services may be critical to breaking the cycle of recidivism. Without sound data on the prevalence of psychiatric disorders, however, defining the best strategies to use and allocating the juvenile justice system's scarce mental health resources are difficult.

Earlier Research

Although epidemiological data are key to understanding the psychiatric disorders of juvenile detainees, few empirical studies exist. Table 1 (page 3) lists studies published in the United States since 1990 that have examined the diagnostic characteristics of incarcerated and detained juveniles. These studies do not provide data that are sufficiently comprehensive to guide juvenile justice policy in this area. Six studies in table 1 present rates of multiple disorders, and four of those examine patterns of psychiatric comorbidity among juvenile detainees (Domalanta et al., 2003; Duclos et al., 1998; Pliszka et al., 2000; Shelton, 2001). However, the studies' findings are inconsistent. The prevalence of major affective disorder in the studies varies from 5 percent to 88 percent; substance use disorders from 20 percent to 88 percent; and psychosis from 12 percent to 45 percent. Such inconsistencies may arise from discrepancies in methodology:

Sampling strategies. Samples varied substantially among the studies. Some studies used random samples. Others relied on nonrandom samples, for example, consecutive admissions over a specified time period. Only a few studies reported racial and ethnic differences; some studies did not report the racial or ethnic composition of the sample. Females were excluded entirely from some investigations.

Small samples. Some severe disorders have low base rates, between 1 and 4 percent. Low base rates require large sample sizes to generate reliable estimates (Cohen, 1988). Sample sizes among the studies varied substantially. Many of the studies sampled too few subjects to generate reliable rates, even for the more common disorders. Most studies did not

A Message From OJJDP

A significant number of youth in detention suffer from psychiatric disorders. To address the needs of such offenders, justice officials need to know the kinds of disorders that are most common and their prevalence among juvenile detainees.

Research indicates that providing detained youth with mental health services may reduce recidivism, but identifying and responding to such mental health needs are challenging.

This Bulletin draws on research conducted by the Northwestern Juvenile Project, which measured the prevalence of alcohol, drug, and mental disorders among youth detained at the Cook County Juvenile Temporary Detention Center in Illinois. The study examined the prevalence of psychiatric disorders among youth by gender, race and ethnicity, and age.

According to the study, nearly two-thirds of males and three-quarters of females met diagnostic criteria for one or more psychiatric disorders. Many of these youth had two or more disorders.

Youth with serious mental disorders should receive appropriate treatment while they are detained. This Bulletin presents information that can help the juvenile justice system detect youth with psychiatric disorders and respond with an integrated system of services.

have enough participants in key demographic subgroups to compare participants by gender, race and ethnicity, or age.

Measurement. Some studies in table 1 used nonstandard or untested instruments, did not assess if the disorder impaired the ability of juveniles to function, or reported data on only one category of diagnoses (e.g., substance use disorders, anxiety disorders, personality disorders).

The Northwestern Juvenile Project

The Northwestern Juvenile Project was designed to overcome these methodological limitations. It includes a random sample of juvenile detainees ages 10–18 and a widely accepted and reliable measurement tool, the Diagnostic Interview Schedule for Children (DISC) Version 2.3 (Shaffer et al., 1996), to measure diagnoses of alcohol, drug, and mental disorders. It also uses accepted criteria for identifying functional impairment (Friedman et al., 1996).

Estimates are presented for demographic subgroups (gender, race and ethnicity, and age) for six categories of disorders: affective (major depressive episode, dysthymia, manic episode); psychosis; anxiety (panic, separation anxiety, overanxious, generalized anxiety, obsessive-compulsive disorders); attention-deficit/hyperactivity disorder (ADHD); disruptive behavior (oppositional-defiant and conduct disorders); and substance use (alcohol and drug disorders).

Methods

Subjects were a randomly selected sample of male and female youth who were arrested and subsequently detained at the Cook County Juvenile Temporary Detention Center (Cook County Detention Center) in Illinois between November 20, 1995, and June 14, 1998. The sample was stratified by gender, race and ethnicity (African American, non-Hispanic white, Hispanic), age (10–13 or 14–18 years old), and legal status (processed as a juvenile or an adult). The final sample (N=1,829) comprised 1,172 males (64.1 percent) and 657 females (35.9 percent), 1,005 African Americans (54.9 percent), 524 Hispanics (28.7 percent), 296 non-Hispanic whites (16.2 percent), and 4 detainees of other racial and ethnic groups (0.2 percent). The mean age of participants was 14.9 years old.

Similar to national trends for juvenile detainees, approximately 90 percent of the Cook County Detention Center detainees were male and most were racial or ethnic minorities: African American (77.9 percent), Hispanic (16.0 percent), non-Hispanic white (5.6 percent), and other racial or ethnic groups (0.5 percent). Their age and offense distributions were also similar to other U.S. juvenile detainees (Sickmund, Sladky, and Kang, 2004).

Although no single site can represent the nation, Illinois' criteria for detaining juveniles are similar to other states'. Pretrial detention is allowed if a juvenile needs protection, is likely to flee, or is considered a danger to the community (Grisso, Tomkins, and Casey, 1988; Illinois Criminal Justice Information Authority, 1997). Details of the data collection and sampling procedures can be found in Teplin et al., 2002, and Abram et al., 2003.

Statistical Analysis

Because the sample was stratified by gender, race and ethnicity, age, and legal status, prevalence estimates were weighted to reflect the detention center's population. A simplified version of the results are presented in this Bulletin. Details of the statistical analyses and the results can be found in Teplin et al., 2002, and Abram et al., 2003.

Psychiatric Diagnoses

The DISC Version 2.3 assesses affective disorders, anxiety disorders, disruptive behavior disorders, substance use disorders, and psychosis within the past 6 months (Bravo et al., 1993; Shaffer et al., 1996).

Diagnoses of psychosis and ADHD required special management. The psychosis module of the DISC is a broad symptom screen and does not generate a specific diagnosis. Instead, it flags subjects if they indicate any essential symptoms of psychosis or at least three associated symptoms. More than one-quarter of the subjects scored positive on the screen. To minimize false positive diagnoses, these subjects were counted as psychotic only if their symptoms persisted for at least 1 week; they had not used alcohol, drugs, or medication during this time; and the psychiatrist or clinical psychologist who reviewed the case judged that the symptoms were probably indicative of psychosis. Twelve subjects met these criteria. The study counted as psychotic another eight subjects who, although they denied symptoms, appeared to have auditory hallucinations, thought disorders, or delusions during their interviews.

ADHD among youth is difficult to assess via self-report and is particularly challenging to diagnose among delinquent youth (Schwab-Stone et al., 1996; Thompson et al., 1996). The *Diagnostic and Statistical Manual of Mental Disorders*, third edition, revised *(DSM–III–R)* (American Psychiatric Association, 1987), requires that ADHD symptoms be present before age 7. Most subjects who reported symptoms of ADHD could not remember when their symptoms began. To reduce the risk of underreporting ADHD, rates were calculated in the conventional manner (requiring that the subject report that symptoms were present before age 7) and by counting the disorder as present regardless of the reported age of onset, as long as the duration criterion was met. (This Bulletin presents only the latter rates; the former are available from the authors.) Details on the DISC can be found in Teplin et al., 2002, and Abram et al., 2003.

Rates of disorder using *DSM–III–R* criteria with and without diagnostic-specific or global functional impairment were examined. The rates were substantially similar. (Tables are available from the authors.) Rates of *DSM–III–R* diagnoses without impairment are presented in the following tables.

Findings

Table 2 (page 7) shows that nearly two-thirds of males and nearly three-quarters of females met the diagnostic criteria for one or more of the disorders listed. Overall rates excluding conduct disorder were also calculated because many of its symptoms are related to delinquent behaviors. Excluding conduct disorder, overall rates decreased only slightly.

Prevalence by Gender

The most common disorders among males and females were substance use and disruptive behavior. One-half of males and almost one-half of females met criteria for a substance use disorder; more than 40 percent of males and females met the criteria for disruptive

Table 1: Published Studies of Psychiatric Disorders in Incarcerated, Detained, and Secured Juvenile Populations in the United States, From 1990 to 2003

Author(s)/Year	Sample*	Diagnostic Measures*	Major Findings*
Davis et al., 1991	**Participants:** Youth in a state residential facility ***N:*** 173 **Age:** N/R **Gender:** N/R **Race/ethnicity:** Equally divided between white and nonwhite	Clinical interview (*DSM–III–R* criteria)	**Affective:** Dysthymia: 17%; MDD: 15% **SUD/AUD:** Alcohol abuse disorder: 34%; alcohol dependence disorder: 12%; drug abuse disorder: 45%; drug dependence disorder: 19% **CD:** 81% **Other:** ADD: 19%; adjustment disorder: 18%; any developmental disorder: 17%; any PD: 17%; ODD: 5%
Forehand et al., 1991	**Participants:** Youth in a juvenile prison ***N:*** 52 **Age:** 16 **Gender:** Male **Race/ethnicity:** African American: 63%; white: 37%	DISC–2	**Affective:** MDD: 33% **CD:** Group delinquency: 58%; solitary aggression: 23% **Anxiety:** Overanxious: 40% **Other:** ADD: 27%
Eppright et al., 1993	**Participants:** Youth in a juvenile detention center ***N:*** 100 **Age:** 14.6 **Gender:** 21 females; 79 males **Race/ethnicity:** African American: 32%; white: 68%	DICA–R; SCID–II	**CD:** 87% **Other:** Antisocial PD: 75%; avoidant PD: 4%; borderline PD: 27%; dependent PD: 7%; histrionic PD: 3%; narcissistic PD: 8%; obsessive-compulsive PD: 2%; paranoid PD: 17%; passive aggressive PD: 14%; schizoid PD: 1%; schizotypal PD: 0%; self-defeating PD: 2%
Rohde, Mace, and Seeley, 1997	**Participants:** Youth in a secure detention facility ***N:*** 60 **Age:** 14.9 **Gender:** 16 females; 44 males **Race/ethnicity:** African American: 2%; Asian/Pacific Islander: 2%; Hispanic: 7%; American Indian: 5%; white: 83%; other: 2%	K–SADS–PL (additional items added for *DSM–III–R* criteria)	Lifetime (%) / Current (%) **Affective** Dysthymia 8 / 8 MDD 40 / 23 **SUD/AUD** Alcohol abuse 7 / 2 Alcohol dependence 42 / 18 Hard drug abuse 7 / 2 Hard drug dependence 33 / 17 Marijuana abuse 5 / 3 Marijuana dependence 43 / 23 **CD** 73 / 73 **Anxiety** 18 / 10 **Other** ADHD 17 / 13 ODD 17 / 2
Steiner, Garcia, and Mathews, 1997	**Participants:** Violent incarcerated youth ***N:*** 85 **Age:** 16.6 **Gender:** Male **Race/ethnicity:** African American: 38%; Hispanic: 27%; white: 30%; other: 5%	Psychiatric Diagnostic Interview–Revised	**Anxiety:** 20% met "partial criteria" for PTSD; 32% met full criteria.
Timmons-Mitchell et al., 1997	**Participants:** Institutionalized delinquents ***N:*** 50 **Age:** 15.7 for females; 15.9 for males **Gender:** 25 females; 25 males **Race/ethnicity:** N/R **Other:** Of the total sample of 173 subjects, 50 were interviewed using DISC.	DISC (modified)	Male (%) / Female (%) **Psychosis** 16 / 12 **Affective** 72 / 88 **SUD** 88 / 56 **CD** 100 / 96 **Anxiety** 52 / 72 **Other** ADHD 76 / 68 Eating disorder 0 / 16 Sleep disorder 68 / 72

(continued)

Table 1—*Continued*

Author(s)/Year	Sample*	Diagnostic Measures*	Major Findings*
Cauffman et al., 1998	**Participants:** Incarcerated wards ***N:*** 189 **Age:** 17.2 for females; 16.6 for males **Gender:** 96 females; 93 males **Race/ethnicity:** African American: Male (%) 38; Female (%) 21 Hispanic: 27; 29 White: 30; 23 Other: 5; 27	Psychiatric Diagnostic Interview—Revised (PTSD module only)	**Anxiety:** PTSD: 32% (male); 49% (female)
Duclos et al., 1998	**Participants:** Youth in a detention facility ***N:*** 150 **Age:** 15 (median) **Gender:** 65 females; 85 males **Race/ethnicity:** 100% American Indian, specific group(s) N/R **Other:** 77% status offenders	DISC 2.3; CIDI	Male (%) / Female (%) / Total (%) **Affective** Dysthymia: 0 / 0 / 0 MDD: 6 / 16 / 10 **SUD/AUD**: 37 / 39 / 38 **CD**: 21 / 11 / 17 **Anxiety (any)**: 2 / 13 / 7 Generalized: 0 / 8 / 3 Overanxious: 0 / 13 / 5 PTSD: 2 / 0 / 1 **Other** ODD: 1 / 3 / 2 ADHD: 6 / 11 / 8 **Comorbidity**†: 17 / 27 / 21
Atkins et al., 1999	**Participants:** Youth in a detention facility ***N:*** 75 **Age:** 15.5 **Gender:** 4 females; 71 males **Race/ethnicity:** African American: 77%; non-Hispanic white: 23%	DISC 2.3	**Psychosis:** 45% **Affective:** 24% **SUD:** 20% **CD:** 40% **Anxiety:** 33% **Other:** ODD: 15%; ADHD: 1% **Comorbidity:** Mean of 2.4 diagnoses per youth
Erwin et al., 2000	**Participants:** Youth in a secure juvenile treatment facility ***N:*** 51 **Age:** 17.5 **Gender:** Male **Race/ethnicity:** African American: 28%; Hispanic: 12%; white: 57%	Clinician-Administered PTSD Scale for Children and Adolescents	**Anxiety:** Lifetime PTSD: 45%; current PTSD: 18%
Pliszka et al., 2000	**Participants:** Youth in a detention center ***N:*** 50 **Age:** 15.4 **Gender:** 5 females; 45 males **Race/ethnicity:** N/R	DISC 2.3	**Affective (any):** 42%; MDD: 20%; mania: 20% **SUD:** Alcohol dependence: 28%; marijuana dependence: 46%; other: 14% **CD:** 60% **Other:** ADHD: 18%; ODD: 24% **Comorbidity**‡
Aarons et al., 2001	**Participants:** Adjudicated youth ***N:*** 419 **Age:** 16.9 **Gender:** 34% female; 66% male **Race/ethnicity:** African American: 21%; Asian/Pacific Islander: 9%; Hispanic: 29%; non-Hispanic white: 34%; biracial: 4%; other: 3% **Other:** Participants from a subsample (*n*=1,036) of a larger study titled "Patterns of Care"; age and race based on the total subsample	CIDI (SUD module only)	Lifetime (%) / Past Year (%) **SUD/AUD (any)**: 62 / 37 AUD: 49 / 28 Amphetamine: 23 / 10 Cannabis: 46 / 15 Cocaine: 2 / 0.5 Hallucinogen: 9 / 3 Opiate: 0.5 / 0

(continued)

Table 1—*Continued*

Author(s)/Year	Sample*	Diagnostic Measures*	Major Findings*
Garland et al., 2001	**Participants:** Adjudicated youth ***N:*** 478 **Age:** 16.9 **Gender:** 74 females; 404 males **Race/ethnicity:** African American: 21%; Asian/Pacific Islander: 6%; Hispanic: 26%; white: 39%; mixed: 5%; other: 3% **Other:** Participants from a subsample (*n*=1,618) of a larger study titled "Patterns of Care"; age and race based on total subsample	Computer-assisted DISC–IV	**Affective (any):** 7%; dysthymia: 0%; hypomania: 1%; MDD: 5%; mania: 2% **CD:** 30% **Anxiety (any):** 9%; generalized anxiety: 1%; obsessive-compulsive: 2%; panic: 0%; PTSD: 3%; separation anxiety: 4%; social phobia: 2% **Other:** Any DBD: 48%; ADHD: 13%; ODD: 15%
Shelton, 2001	**Participants:** Youth in commitment and detention facilities ***N:*** 312 **Age:** 12–20 (mean or median N/R) **Gender:** 60 females; 252 males **Race/ethnicity:** African American: 57%; Hispanic and other: 17%; white: 26%	DISC; C–GAS	**Psychosis:** 32% **Affective:** 17% **SUD:** 37% **Anxiety:** 58% **Other:** Any DBD: 40%; miscellaneous disorders: 18% **Comorbidity:**§
McCabe et al., 2002	**Participants:** Adjudicated youth ***N:*** 625 **Age:** 16.2 **Gender:** 112 females; 513 males **Race/ethnicity:** African American: 19%; Asian/Pacific Islander: 12%; Hispanic: 30%; white: 29%; biracial/other: 9% **Other:** Participants from a larger study titled "Patterns of Care" (*n*=1,715)	Computer-assisted DISC–IV (selected modules); CIDI Substance Abuse Module	Male (%) / Female (%) **Affective (any)** 5 / 16 MDD 3 / 14 Mania 1 / 3 **SUD** 37 / 28 **CD** 33 / 38 **Anxiety (any)** 8 / 15 PTSD 2 / 7 Separation 4 / 10 **Other** Any DBD 49 / 64 ADHD 15 / 21 ODD 30 / 42 **Comorbidity** 38 / 28
Wasserman et al., 2002	**Participants:** Youth in secure facilities ***N:*** 292 **Age:** 17 **Gender:** Male **Race/ethnicity:** African American: 54%; Hispanic: 16%; white: 28%; other: 2%	Voice DISC–IV	**Affective (any):** 10%; dysthymic: 1%; hypomanic: 1%; MDD: 8%; manic: 2% **SUD (any):** 50%; alcohol abuse: 17%; alcohol dependence: 13%; marijuana abuse: 15%; marijuana dependence: 26%; other substance abuse: 4%; other substance dependence: 13% **CD:** 32% **Anxiety (any):** 20%; agoraphobia: 5%; generalized anxiety: 2%; obsessive-compulsive: 5%; panic: 5%; PTSD: 5%; specific phobia: 9%; social phobia: 2% **Other:** Any DBD: 33%; ADHD: 2%

(continued)

behavior disorders. More than one-fourth of females and almost one-fifth of males met the criteria for one or more affective disorders.

Table 2 reports the female-to-male odds ratios. Females had significantly higher odds than males of having any disorder, any disorder except conduct disorder, any affective disorder, major depressive episode, any anxiety disorder, panic disorder, separation anxiety disorder, overanxious disorder, and substance use disorder other than alcohol or marijuana.

Significantly more females (56.5 percent) than males (45.9 percent) met criteria for two or more of the following disorders: major depressive, dysthymic, manic, psychotic, panic, separation anxiety, overanxious, generalized anxiety, obsessive-compulsive, ADHD, conduct, oppositional defiant, alcohol, marijuana, and other substance use. Approximately one-fifth of females (17.3 percent) and males (20.4 percent) had only one disorder (Abram et al., 2003).

Figures 1 and 2 (page 8) indicate substantial comorbidity for females and males. (Psychoses were omitted from this analysis because there were so few cases.) Patterns of overlap differ somewhat by gender. Nearly one-third of females (29.5 percent) and males (30.8 percent) had substance use disorders and ADHD or

Table 1—*Continued*

Author(s)/Year	Sample*	Diagnostic Measures*	Major Findings*
Domalanta et al., 2003	**Participants:** Youth in a detention center ***N:*** 1,024 **Age:** 14.9 for females; 15.3 for males **Gender:** 274 females; 750 males **Race/Ethnicity:** African American: Male (%) 42, Female (%) 33 Hispanic: Male (%) 35, Female (%) 37 White: Male (%) 19, Female (%) 23 Other: Male (%) 4, Female (%) 7	Patient health questionnaire	Male (%) / Female (%) / Total (%) **Affective (any)** 26 / 31 MDD 10 / 10 Mood NOS 12 / 13 Other mood 4 / 8 **SUD** 43 / 36 **AUD** 27 / 27 **Anxiety** Other 8 / 12 Panic 5 / 8 Somatoform 12 / 22 **Comorbidity**** 38

Notes: Treatment studies are not included; only diagnoses reported by each study are displayed. Percentages are rounded to the nearest whole number. Mean age in years is reported unless unavailable or otherwise indicated.

*ADD = attention-deficit disorder; ADHD = attention-deficit/hyperactivity disorder; AUD = alcohol use disorder; CD = conduct disorder; C–GAS = Children's Global Assessment Scale; CIDI = Composite International Diagnostic Interview; DBD = disruptive behavior disorder; DICA–R = Diagnostic Interview for Children and Adolescents–Revised; DISC = Diagnostic Interview Schedule for Children; *DSM = Diagnostic and Statistical Manual of Mental Disorders;* K–SADS–PL= Kiddie-Schedule for Affective Disorders, Present and Lifetime Version; MDD = major depressive disorder; NOS = not otherwise specified; N/R = not reported; ODD = oppositional-defiant disorder; PD = personality disorder; PTSD = posttraumatic stress disorder; SCID = Structured Clinical Interview for *DSM;* SUD = substance use disorder

† Of the 21% with two or more disorders, 83% had SUD and DBD.

‡ Among those with mania, 82% had CD, 36% had alcohol dependence, 64% had marijuana dependence, and 45% had other substance dependence. Among those with MDD, 80% had CD, 20% had alcohol dependence, and 60% had marijuana dependence.

§ Anxiety and DBD: 28%; anxiety and psychotic: 21%; anxiety and affective: 14%; anxiety and SUD: 25%; DBD and psychotic: 14%; DBD and affective: 9%; DBD and SUD: 19%; psychotic and affective: 1%; psychotic and SUD: 15%; affective and SUD: 7%.

** Among those with MDD, 49% had substance abuse and 39% had alcohol abuse. Among those with alcohol abuse, 14% had MDD and 83% had substance abuse. Among those with substance abuse, 12% had MDD and 55% had alcohol abuse.

disruptive behavior disorders; approximately half of these also had anxiety disorders, affective disorders, or both. Significantly more females (47.8 percent) than males (41.6 percent) had two or more of the following types of disorders: affective, anxiety, substance use, and ADHD or disruptive behavior. Significantly more females (22.5 percent) than males (17.2 percent) had three or more types of disorders. Additional information is available in Abram et al., 2003.

Prevalence by Race and Ethnicity

Tables 3 and 4 (pages 9 and 10) show the prevalence rates of disorders for males and females by race and ethnicity. Table 3 indicates that among males, non-Hispanic whites had the highest rates for many disorders and African Americans had the lowest. Compared with African Americans, non-Hispanic whites had significantly higher rates of any disorder, any disorder except conduct disorder, any disruptive behavior disorder, conduct disorder, any substance use disorder, and substance use disorder other than alcohol or marijuana. The only disorder for which African Americans had significantly higher rates than non-Hispanic whites was separation anxiety disorder. Hispanics had significantly higher rates than non-Hispanic whites of any anxiety disorder and separation anxiety disorder. Compared with African Americans, Hispanics had higher rates of panic disorder, obsessive-compulsive disorder, and substance use disorder other than alcohol or marijuana. Non-Hispanic whites had higher rates than Hispanics of any disorder, any disruptive behavior disorder, conduct disorder, and substance use disorder other than alcohol or marijuana.

Table 4 compares prevalence rates among females by race and ethnicity. Compared with African American females, non-Hispanic white females had significantly higher rates of any disorder, any disorder except conduct disorder, any disruptive behavior disorder, conduct disorder, and all substance use disorders. Compared with Hispanic females, non-Hispanic white females had higher rates of any disorder except conduct disorder. Hispanic females had higher rates of generalized anxiety disorder than either African American or non-Hispanic white females. Compared with African American females, Hispanic females had higher rates of all disruptive behavior disorders, alcohol use disorder, substance use disorder other than alcohol or marijuana, and alcohol and drug use disorders.

Among females, significantly more non-Hispanic whites (63.1 percent) had two or more types of disorders than African Americans (42.6 percent). Among males also, significantly more non-Hispanic whites (53.1 percent) had two or more types of disorders than African Americans (40.7 percent). The odds of having comorbid disorders were higher than expected for most racial and ethnic subgroups, except when base rates of disorders were already high or when there were few participants in a category (Abram et al., 2003).

Prevalence by Age

Tables 5 and 6 (pages 11 and 12) show the prevalence of disorders for males and females by age. Table 5 indicates that among males, the youngest age group had the lowest rates of many disorders, including any disorder, any disorder except conduct disorder, generalized anxiety disorder, and all the substance use disorders. The 14–15 age group had higher rates of psychotic disorders than the 16-and-older age group. Significantly more males age 16 and older (41.2 percent) had two or more types of disorders than males age 13 and younger (27.0 percent). Similarly, more males age 14 and 15 (45.3 percent) had two or more types of disorders than males age 13 and younger (Abram et al., 2003).

Table 6 indicates that patterns of disorders are different for females than for males. The oldest female age group had significantly lower rates of oppositional-defiant disorder than the younger age groups. Compared with the older age groups, the youngest age group had significantly lower rates of any substance use disorder and marijuana use disorder. Among females, there were no significant age differences in the prevalence of comorbid disorder types.

Comorbidity of Substance Use Disorders and Major Mental Disorders

More than one-tenth of males (10.8 percent) and 13.7 percent of females had a major mental disorder (psychosis, manic episode, or major depressive episode) and a substance use disorder (Abram et al., 2003). These disorders were examined in depth because detention centers are mandated to treat major mental disorders and because comorbidity complicates treatment.

Prevalence of Substance Use Disorders Among Youth With Major Mental Disorders

Compared with participants with no major mental disorder,[1] females and males with any major mental disorder had significantly greater odds of having substance use disorders. Two subcategories of major mental disorder were examined: psychosis or manic episode (combined

[1] Relevant analyses regarding major mental disorders are available from authors.

Table 2: Six-Month Prevalence and Odds Ratios of *DSM–III–R* Diagnoses, by Gender

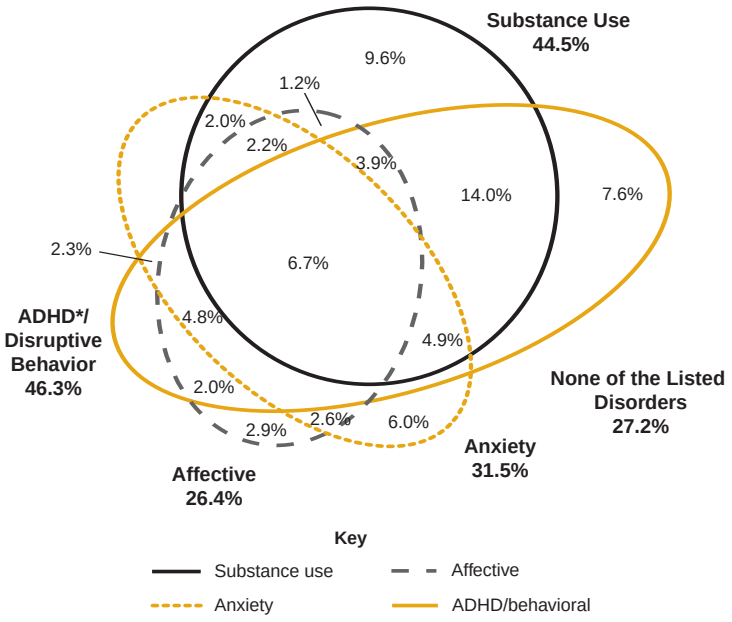
Disorder	Male (%) (*n*=1,170)	Female (%) (*n*=656)	Female-to-Male Odds Ratios
Any of the listed disorders	66.3	73.8	1.43†
Any except conduct disorder	60.9	70.0	1.49†
Any affective disorder	18.7	27.6	1.66†
Major depressive episode	13.0	21.6	1.85†
Dysthymia	12.2	15.8	1.34
Manic episode	2.2	1.8	0.81
Psychotic disorders	1.0	1.0	0.98
Any anxiety disorder	21.3	30.8	1.64†
Panic disorder	0.3	1.5	5.65†
Separation anxiety disorder	12.9	18.6	1.55†
Overanxious disorder	6.7	12.3	1.95†
Generalized anxiety disorder	7.1	7.3	1.03
Obsessive-compulsive disorder	8.3	10.6	1.31
Attention-deficit/ hyperactivity disorder*	16.6	21.4	1.37
Any disruptive behavior disorder	41.4	45.6	1.19
Oppositional-defiant disorder	14.5	17.5	1.25
Conduct disorder	37.8	40.6	1.12
Any substance use disorder	50.7	46.8	0.86
Alcohol use disorder	25.9	26.5	1.03
Marijuana use disorder	44.8	40.5	0.84
Other substance use disorder	2.4	6.9	3.00†
Alcohol and other drug use disorders	20.7	20.9	1.01

Notes: The odds ratios show the relative likelihood of one group having a disorder compared with another group. For the female-to-male odds ratios, odds ratios greater than 1.0 indicate that females had higher odds of having a specific disorder than males; ratios less than 1.0 show that females had lower odds of having the disorder.

*Attention-deficit/hyperactivity disorder is reported without the criterion of onset before age 7 because caretaker information is not available and self-reporting of symptoms before age 7 is unreliable.

† Odds ratios are significant at $p < .05$.

Figure 1: Comorbidity Among Females, by Disorder



Note: Detail may not total 100% due to rounding.
*Attention-deficit/hyperactivity disorder.

Age differences. Among females with major mental disorders, no significant differences existed by age. Among males, nearly 90 percent of those age 16 and older with a major mental disorder also had a substance use disorder, significantly more than males ages 10–13 and 14–15 (55.2 percent and 60.6 percent, respectively).

Prevalence of Major Mental Disorders Among Youth With Substance Use Disorders

Nearly 30 percent of females and more than 20 percent of males with any substance use disorder also had a major mental disorder. Among youth with drug and alcohol use disorders, more than one-third of females and more than one-quarter of males had a major mental disorder. There were no significant differences by gender, race and ethnicity, or age.

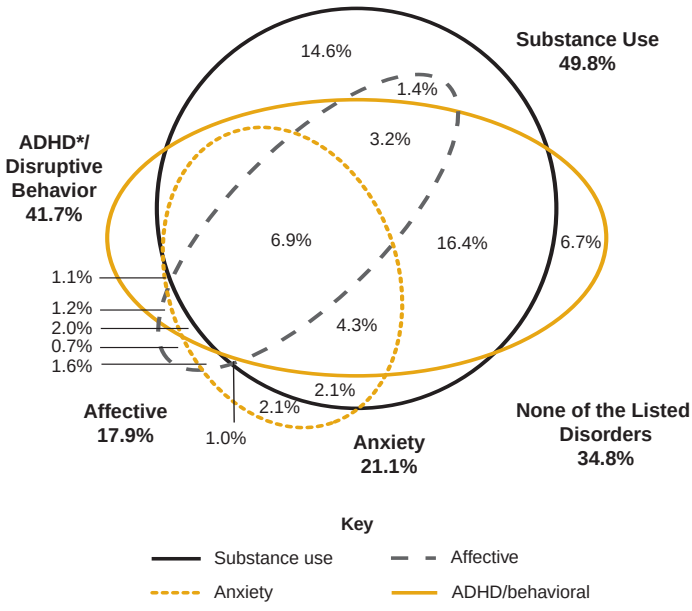
Compared with participants with no substance use disorder (the residual category), females and males with any substance use disorder had significantly greater odds of having any major mental disorder and its subcategory, major

because there were too few cases to analyze separately and because these disorders have similar symptoms) and major depressive episode. Most odds ratios for these subcategories were statistically significant, except when cell sizes were small.

Gender differences. Among youth with major mental disorders (n=305), more than half of females and nearly three-quarters of males had any substance use disorder. Differences between females and males (and the corresponding odds ratios) were not statistically significant.

Racial and ethnic differences. Among females with major mental disorders, significantly more non-Hispanic whites and Hispanics had drug and alcohol use disorders than did African Americans (50.0 percent and 43.4 percent, respectively, versus 21.3 percent). Significantly more Hispanic females had alcohol use disorders than did African Americans (52.5 percent versus 26.6 percent). Among males with major mental disorders, no significant differences existed relative to race and ethnicity.

Figure 2: Comorbidity Among Males, by Disorder



Note: Detail may not total 100% due to rounding.
*Attention-deficit/hyperactivity disorder.

Table 3: Six-Month Prevalence of *DSM–III–R* Diagnoses for Males, by Race and Ethnicity

Disorder	African American (%) (*n*=574)	Non-Hispanic White (%) (*n*=207)	Hispanic (%) (*n*=386)	Overall Significance	Specific Tests*
Any of the listed disorders	64.6	82.0	70.4	< .001	White > African American; white > Hispanic
Any except conduct disorder	59.4	72.9	65.3	.009	White > African American
Any affective disorder	18.6	13.8	21.5	.19	
Major depressive episode	12.5	9.5	16.6	.20	
Dysthymia	12.2	9.5	13.3	.53	
Manic episode	2.5	0.5	1.4	.27	
Psychotic disorders	1.0	2.6	0.7	.19	
Any anxiety disorder	20.9	14.4	25.5	.05	Hispanic > white
Panic disorder	0.1	0.5	1.0	.04	Hispanic > African American
Separation anxiety disorder	12.7	5.9	15.5	.02	African American > white; Hispanic > white
Overanxious disorder	6.9	2.9	7.0	.16	
Generalized anxiety disorder	7.5	2.5	7.2	.08	
Obsessive-compulsive disorder	6.5	9.3	17.0	.01	Hispanic > African American
Attention-deficit/ hyperactivity disorder†	17.0	20.9	13.7	.18	
Any disruptive behavior disorder	39.8	60.3	43.3	< .001	White > African American; white > Hispanic
Oppositional-defiant disorder	14.4	19.4	13.6	.23	
Conduct disorder	35.6	59.9	41.7	< .001	White > African American; white > Hispanic
Any substance use disorder	49.1	62.6	55.4	.01	White > African American
Alcohol use disorder	24.6	30.1	30.8	.28	
Marijuana use disorder	44.4	53.8	45.4	.11	
Other substance use disorder	0.5	21.1	6.0	< .001	White > African American; white > Hispanic; Hispanic > African American
Alcohol and other drug use disorders	20.4	24.0	21.7	.65	

* Specific tests are performed only if the alpha for the overall test is less than .05.
† Attention-deficit/hyperactivity disorder is reported without the criterion of onset before age 7 because caretaker information is not available and self-reporting of symptoms before age 7 is unreliable.

depressive episode. Among males, odds ratios for psychosis or a manic episode were significant for alcohol use disorder and comorbid drug and alcohol use disorders.

Relative Onset of Major Mental Disorders and Substance Use Disorders

One-quarter of females (27.2 percent) and males (25.0 percent) reported that their major mental disorder preceded their substance use disorder by more than 1 year. One-tenth of females (9.8 percent) and 20.7 percent of males reported that their substance use disorder preceded their major mental disorder by more than 1 year. Nearly two-thirds of females (63.0 percent) and 54.3 percent of males developed their disorders within the same year. Findings were similar for subcategories of disorders.

Analysis

Data gathered by the Northwestern Juvenile Project indicate that youth with psychiatric and substance use disorders pose a challenge for the juvenile justice system. Even when conduct disorder was excluded, 60 percent of male and 70 percent of female juvenile detainees met diagnostic criteria for one or more psychiatric disorders. Comorbidity was common. To the extent that Cook County is typical, the findings suggest that on an average day, as many as 72,000 detained youth have at least one psychiatric disorder; 47,000 detained youth have two or more types of psychiatric disorders; and more than 12,000 detained youth have both a major mental disorder and a substance use disorder.

The prevalence of psychiatric disorders among youth entering the juvenile justice system may be greater than that of detainees, as reflected in this study. The

Table 4: Six-Month Prevalence of *DSM–III–R* Diagnoses for Females, by Race and Ethnicity

Disorder	African American (%) (*n*=430)	Non-Hispanic White (%) (*n*=89)	Hispanic (%) (*n*=136)	Overall Significance	Specific Tests*
Any of the listed disorders	70.9	86.1	75.9	.01	White > African American
Any except conduct disorder	67.4	83.9	69.5	.01	White > African American; white > Hispanic
Any affective disorder	26.2	23.4	28.7	.68	
Major depressive episode	19.7	19.0	22.8	.70	
Dysthymia	15.5	17.9	17.2	.80	
Manic episode	1.9	1.1	2.1	.85	
Psychotic disorders	0.9	0.0	2.1	.29†	
Any anxiety disorder	31.2	30.0	32.6	.92	
Panic disorder	0.9	3.4	2.8	.17	
Separation anxiety disorder	18.9	14.5	21.7	.41	
Overanxious disorder	12.5	11.1	13.2	.90	
Generalized anxiety disorder	6.6	4.4	13.1	.03	Hispanic > African American; Hispanic > White
Obsessive-compulsive disorder	10.3	12.4	10.6	.84	
Attention-deficit/ hyperactivity disorder‡	20.0	22.2	29.3	.08	
Any disruptive behavior disorder	39.4	61.6	56.5	<.001	White > African American; Hispanic > African American
Oppositional-defiant disorder	15.8	17.8	26.2	.03	Hispanic > African American
Conduct disorder	34.3	58.9	50.2	<.001	White > African American; Hispanic > African American
Any substance use disorder	42.3	61.9	51.7	.002	White > African American
Alcohol use disorder	21.2	39.2	34.0	<.001	White > African American; Hispanic > African American
Marijuana use disorder	37.8	53.4	44.7	.02	White > African American
Other substance use disorder	0.9	20.0	14.7	<.001	White > African American; Hispanic > African American
Alcohol and other drug use disorders	17.2	35.1	28.3	<.001	White > African American; Hispanic > African American

* Specific tests are performed only if the alpha for the overall test is less than .05.
† Test computed with one degree of freedom because of empty cells.
‡ Attention-deficit/hyperactivity disorder is reported without the criterion of onset before age 7 because caretaker information is not available and self-reporting of symptoms before age 7 is unreliable.

sample included only detainees; it excluded youth who were not detained because their charges were less serious, because they were immediately released, or because they were referred directly to the mental health system. Moreover, under reporting of symptoms and impairments by youth is common, especially for disruptive behavior disorders (Schwab-Stone et al., 1996).

Comparing these findings with studies of youth in the general population is difficult because published estimates for the latter vary widely depending on the sample, the method, the source of data, and whether functional impairment was required for diagnosis (Roberts, Attkisson, and Rosenblatt, 1998). Despite these differences, the overall rates presented here are substantially higher than the median rate (15 percent) reported by Roberts, Attkisson, and Rosenblatt (1998) and the rates of other recent investigations (Costello et al., 1996b; Simonoff et al., 1997; Shaffer et al., 1996; and Turner and Gil, 2002). The rates of comorbidity reported here are also substantially higher than those reported in community samples (Angold, Costello, and Erkanli, 1999; Costello et al., 1996a; Costello et al., 1999; Kessler and Walters, 1998; Lewinsohn, Gotlib, and Seeley, 1995).

Of particular concern are the high rates of depression and dysthymia among detained youth,[2] which are also higher than rates in the general population (Costello et al., 1996a; Costello et al., 1996b; Garrison et al., 1997; Kessler and Walters, 1998; McGee et al., 1992; Simonoff et al., 1997; Turner and Gil, 2002). Depressive disorders, which are a risk factor for suicide and attempted suicide, are difficult to detect and treat in the corrections milieu. Overall, the prevalence rates presented

[2] Although not included in table 2, combined prevalence rates of major depressive episode and dysthymia were 17 percent for males and 24 percent for females.

Table 5: Six-Month Prevalence of *DSM–III–R* Diagnoses for Males, by Age

Disorder	13 and Younger (%) (*n*=315)	14–15 Years Old (%) (*n*=361)	16 and Older (%) (*n*=494)	Overall Significance	Specific Tests*
Any of the listed disorders	52.7	68.0	67.3	.001	14 and 15 years > 13 and younger; 16 and older > 13 and younger
Any except conduct disorder	44.9	63.4	61.8	< .001	14 and 15 years > 13 and younger; 16 and older > 13 and younger
Any affective disorder	13.0	21.2	17.7	.09	
Major depressive episode	7.5	14.8	12.4	.06	
Dysthymia	7.3	14.5	11.2	.08	
Manic episode	1.6	2.6	2.0	.80	
Psychotic disorders	0.0	2.1	0.3	.01†	14 and 15 years > 16 and older
Any anxiety disorder	17.7	23.0	20.6	.42	
Panic disorder	0.8	0.1	0.3	.25	
Separation anxiety disorder	10.0	14.5	12.0	.40	
Overanxious disorder	4.8	5.1	8.4	.25	
Generalized anxiety disorder	1.3	5.9	9.2	.001	14 and 15 years > 13 and younger; 16 and older > 13 and younger
Obsessive-compulsive disorder	6.0	9.4	7.8	.43	
Attention-deficit/ hyperactivity disorder‡	12.5	20.9	13.8	.06	
Any disruptive behavior disorder	32.9	43.5	41.2	.06	
Oppositional-defiant disorder	10.7	18.2	12.1	.08	
Conduct disorder	30.8	41.1	36.4	.10	
Any substance use disorder	28.3	51.3	54.4	< .001	14 and 15 years > 13 and younger; 16 and older > 13 and younger
Alcohol use disorder	12.9	25.6	28.7	< .001	14 and 15 years > 13 and younger; 16 and older > 13 and younger
Marijuana use disorder	25.1	46.9	46.8	< .001	14 and 15 years > 13 and younger; 16 and older > 13 and younger
Other substance use disorder	0.8	2.5	2.6	.01	14 and 15 years > 13 and younger; 16 and older > 13 and younger
Alcohol and other drug use disorders	10.2	21.5	22.0	< .001	14 and 15 years > 13 and younger; 16 and older > 13 and younger

* Specific tests are performed only if the alpha for the overall test is less than .05.
† Test computed with one degree of freedom because of empty cells.
‡ Attention-deficit/hyperactivity disorder is reported without the criterion of onset before age 7 because caretaker information is not available and self-reporting of symptoms before age 7 is unreliable.

here are comparable to rates in other high-risk populations, such as maltreated or runaway youth (Famularo, Kinscherff, and Fenton, 1992; Feitel et al., 1992).

The comorbidity of substance use disorders is also of particular concern. Among the disorders assessed, detainees are more likely to have substance use plus ADHD or disruptive behavior disorders than any other combination. Half of these detainees also have an affective or anxiety disorder. Among adolescent substance users, these internalizing disorders are associated with more severe substance use (Riggs et al., 1999; Whitmore et al., 1997) but better treatment outcomes (Randall et al., 1999).

The data highlight an important paradox regarding race and ethnicity. More than

Table 6: Six-Month Prevalence of *DSM–III–R* Diagnoses for Females, by Age

Disorder	13 and Younger (%) (*n*=56)	14–15 Years Old (%) (*n*=353)	16 and Older (%) (*n*=247)	Overall Significance	Specific Tests*
Any of the listed disorders	66.7	72.2	77.6	.18	
Any except conduct disorder	64.7	67.4	74.8	.13	
Any affective disorder	20.7	27.9	28.8	.50	
Major depressive episode	13.0	21.6	23.4	.27	
Dysthymia	10.4	15.6	17.2	.46	
Manic episode	3.9	1.4	1.9	.45	
Psychotic disorders	0.0	0.6	1.8	.21†	
Any anxiety disorder	26.6	32.6	29.2	.55	
Panic disorder	1.9	1.7	1.0	.75	
Separation anxiety disorder	18.1	19.7	17.2	.77	
Overanxious disorder	7.1	13.8	11.4	.34	
Generalized anxiety disorder	3.8	7.1	8.4	.51	
Obsessive-compulsive disorder	10.4	11.8	8.8	.51	
Attention-deficit/hyperactivity disorder‡	26.6	22.7	18.5	.30	
Any disruptive behavior disorder	44.7	50.0	39.6	.11	
Oppositional-defiant disorder	30.5	20.2	10.7	<.001	13 years and younger > 16 and older; 14 and 15 > 16 and older
Conduct disorder	33.0	45.3	35.7	.06	
Any substance use disorder	30.5	45.8	52.0	.02	14 and 15 years > 13 and younger; 16 and older > 13 and younger
Alcohol use disorder	16.7	25.4	30.3	.16	
Marijuana use disorder	24.8	41.3	43.3	.04	14 and 15 years > 13 and younger; 16 and older > 13 and younger
Other substance use disorder	5.9	5.3	9.5	.52	
Alcohol and other drug use disorders	11.5	21.8	22.0	.20	

* Specific tests are performed only if the alpha for the overall test is less than .05.
†Test computed with one degree of freedom because of empty cells.
‡ Attention-deficit/hyperactivity disorder is reported without the criterion of onset before age 7 because caretaker information is not available and self-reporting of symptoms before age 7 is unreliable.

one-half of the youth in the juvenile justice system are African American or Hispanic. Therefore, most delinquent youth with psychiatric disorders are minorities. The prevalence of many single and comorbid disorders, however, is highest among non-Hispanic whites. Thus, non-Hispanic white youth in the juvenile justice system may, on average, be more dysfunctional (have greater psychiatric morbidity) than minorities.

Females had higher rates than males of many single and comorbid psychiatric disorders, including major depressive episodes, some anxiety disorders, and substance use disorders other than alcohol and marijuana (e.g., cocaine and hallucinogens). These findings confirm those of earlier studies of adult female detainees and females with conduct disorder (Lewis et al., 1991; Teplin, Abram, and McClelland, 1996; Wasserman et al., 2005).

In contrast to the general population, males did not have significantly higher odds of ADHD than females. This may reflect a greater prevalence of attentional problems among females in detention compared with those in the general population, or a possible unreliability of the ADHD diagnosis.

The youngest age group (13 and younger) had the lowest prevalence rates of most disorders, consistent with studies of youth in the general population (Cohen, Cohen, and Brook, 1993; Kandel et al., 1997; Newman et al., 1996; Simonoff et al., 1997). Many youth in the juvenile justice system may develop new or additional disorders as they grow older. Although comorbidity of major mental and substance use disorders is more prevalent among older detainees, this study found no dominant sequence of onset, suggesting that multiple pathways to disorders exist.

Limitations

This study provides a snapshot of the subjects' psychopathology immediately after

arrest and detention. It cannot show whether mental disorder causes delinquency, increases the likelihood of arrest and detention, or is merely a frequent trait among delinquent youth. Some symptoms may be a reaction to detention. Moreover, the rates might differ somewhat using *DSM–IV* rather than *DSM–III–R* criteria. The findings are drawn from one site only and may pertain only to youth in urban detention centers with a similar demographic composition. Finally, because interviewing caretakers was not feasible, the data are subject to the limitations of self-reporting. Despite these constraints, the study has implications for future research on delinquent youth and for the juvenile justice system.

Future Research

Further research is needed to determine the most common pathways to comorbidity, critical periods of vulnerability, and how these factors differ by gender, race and ethnicity, and age. Longitudinal studies that identify the most common developmental sequences would demonstrate when primary and secondary preventive interventions might prove most beneficial (Nottlemann and Jensen, 1995).

Females are increasingly arrested for violent crimes, and they make up a growing proportion of delinquent youth (Office of Juvenile Justice and Delinquency Prevention, 2001; Snyder and Sickmund, 1999). Understanding psychiatric morbidity and associated risk factors among delinquent females could help improve treatment and reduce the cycle of disorder and dysfunction. Earlier studies of conduct-disordered youth (many of whom become delinquent) suggest that females have a greater persistence of emotional disorder and worse outcomes than males (Loeber and Stouthamer-Loeber, 1998; Zoccolillo, 1992). Moreover, problem behaviors among females often persist beyond adolescence. As they grow older, delinquent females may become suicidal, addicted to alcohol or drugs, enmeshed in violent relationships, and unable to care for their children (Lewis et al., 1991; Zoccolillo, 1992). Delinquent females also engage in sexual activity at an earlier age than nonoffenders, placing them at greater risk for unintended pregnancy and the human immunodeficiency virus (Gender-Specific Programming for Girls Advisory Committee, 1998).

Longitudinal studies are needed to examine why some delinquent youth develop new psychopathology and others do not, to investigate protective factors, and to determine how vulnerability and risk differ by key variables such as gender and race and ethnicity. Many youth in the juvenile justice population will develop new disorders as they grow older. Risk factors for the development of disorders are common among delinquent youth (Werner, 1989). These factors include physical and sexual abuse, a troubled family environment, parental substance abuse, poverty, poor education, neighborhood disintegration, and neglect.

Delinquent youth have few protective factors to offset these risks (Cocozza, 1992). Thus, most youth in the juvenile justice system are at great risk for psychopathology, problem behaviors, and even early death (Lattimore, Linster, and MacDonald, 1997; Loeber et al., 1999; Teplin et al., 2005). Longitudinal data on the subjects described in this Bulletin are being collected. Future papers will address persistence and change in psychiatric disorders (including onset, remission, and recurrence), comorbidity, associated functional impairments, and how these disorders affect risk behaviors that may lead to rearrest.

Implications for Juvenile Justice

Research findings indicate that a substantial number of youth in detention need mental health services. Youth with serious mental disorders have a constitutional right to receive treatment while detained. Providing mental health services to youth in detention and redirecting them to the mental health system after release may help prevent their return to the correctional system (Dembo et al., 1997; National Research Council and Institute of Medicine, 2001). However, providing services within the juvenile justice system poses a number of challenges.

Mental health screening. Identifying youth who need mental health services is a significant first step. Experts recommend that youth be screened for psychiatric problems within 24 hours of admission to a juvenile facility. At a minimum, screening should address acute mental health problems (including psychosis), the risk for suicide or harm to self, the use of psychiatric medications, substance abuse, and the risk for assaultive behavior. Youth who disclose such information should have appropriate legal protections (Wasserman et al., 2003).

Many detention centers do not routinely screen for psychiatric problems (Goldstrom et al., 2001). Only recently have specialized screening tools been developed to assess the mental health needs of youth entering the juvenile justice system (Dembo et al., 1996; Grisso, 1999; Grisso et al., 2001); these instruments need further testing and evaluation.

Mental health services. Youth in need of mental health services require access to them while in detention (Costello and Jameson, 1987; Wasserman et al., 2003). Detention centers should train personnel to detect mental disorders that are overlooked at intake or that arise during incarceration (Dembo et al., 1997; Hayes, 2000; Ulzen and Hamilton, 1998). Furthermore, personnel need to know how to make appropriate referrals once they suspect a disorder may be present.

Although fewer in number, females in detention have greater service needs than males. Earlier studies indicate that females with problem behaviors may have worse outcomes than males (Lewis et al., 1991; Loeber and Stouthamer-Loeber, 1998; Zoccolillo, 1992). Services should be developed to address the unique needs of this growing population.

Community services. Youth typically do not remain in detention for long. Most detainees return to their communities within 2 weeks (Snyder and Sickmund, 1999). Ideally, those with mental disorders should be linked to community mental health services prior to their release (Cocozza and Skowyra, 2000; Faenza, Siegfried, and Wood, 2000). However, youth in the juvenile justice system are disproportionately minority, impoverished, and poorly educated, and many lack social networks—characteristics known to limit the type and scope of mental health services provided to youth (Kataoka, Zhang, and Wells, 2002; McKay, McCadam, and Gonzales, 1996). Juvenile justice administrators need to form collaborative relationships with education, child welfare, mental health, and substance abuse service systems to ensure that youth have adequate access to care after their release.

Because many youth in detention suffer from psychiatric disorders and pose a challenge to the juvenile justice system, research is needed to better understand the comorbidity of psychiatric disorders, psychiatric disorders among females involved in the juvenile justice system,

and the long-term outcomes of detained youth with mental disorders. These youth will continue to overburden the juvenile justice system, and eventually the adult justice system, until it is better able to detect them and respond with an integrated system of appropriate services during detention and after release.

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Linda A. Teplin, Ph.D., is the Owen L. Coon Professor of Psychiatry and Behavioral Sciences and Director, Psycho-Legal Studies Program, Feinberg School of Medicine, Northwestern University, Chicago. Karen M. Abram, Ph.D., is Assistant Professor, Feinberg School of Medicine, Northwestern University. Gary M. McClelland is Research Assistant Professor, Feinberg School of Medicine, Northwestern University. Amy A. Mericle, Ph.D., is Postdoctoral Fellow, School of Medicine, Department of Psychiatry, University of California, San Francisco. Mina K. Dulcan, Ph.D., is Professor of Psychiatry and Behavioral Sciences and Pediatrics, Feinberg School of Medicine, Northwestern University, and Head of Child and Adolescent Psychiatry, Children's Memorial Hospital. Jason J. Washburn, Ph.D., is Assistant Professor, Feinberg School of Medicine, Northwestern University.

SURVEY OF SEXUAL ASSAULT COALITIONS ON QUESTION OF OFFERING SERVICES TO PERSON IN CUSTODY

Methodology: In compiling this information, we have used information from RAINN[1] (Rape, Abuse and Incest National Network) to develop the chart below. Additionally, we have made emails to state coalitions and state and local agencies and asked four questions:

- **Do or would your services extend to incarcerated victims of sexual assault;**
- **Do or would you help victims who are now in the community (such as in halfway houses or on parole) who were sexually abused while incarcerated;**
- **Are the services that you provide to incarcerated persons dependent on status (felony vs. misdemeanor offender) or facility (prison vs. halfway house)**
- **Is Violence Against Women Act Funding used in any of your services for incarcerated or formerly incarcerated person**

The information that we are providing you is based on those emails. We have indicated with a ** those agencies that have indicated on either the state or local level that they will serve incarcerated victims. However, most rape crisis agencies have indicated that they will not serve any person who is convicted of a sex crime of any kind. The starred states that have reported that they do or would provide services to incarcerated victims have more often then not taken the position that will not provide services to sex offenders. We are conducting ongoing research in this area in connection with the development of our curriculum on inmate-inmate sexual violence and a future publication.

STATE	STATE AGENCY[2]	LOCAL AGENCIES
Alabama**	Alabama Coalition Against Rape Montgomery, AL 334-264-0123	**Daybreak Crisis Recovery** Anniston, AL 36207 Hotline Phone: 256-231-0654 **Rape Response** Birmingham, AL 35222 Hotline Phone: 205-323-7273 **Rape Response and Prevention Center of Cullman and Winston Counties** Cullman, AL 35056 Hotline Phone: 256-734-6100 **Mental Health Association**

[1] RAINN 24-hour HOTLINE: 1-800-656-4673

[2] Most of these agencies do not offer direct services just referrals to local agencies or providers.

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Decatur, AL 35602 Hotline Phone: 256-353-1160 **House of Ruth** Dothan, AL 36302 Hotline Phone: 334-793-2232 **Rape Response** Florence, AL 35630 Hotline Phone: 256-767-1100 **Crisis Services of North Alabama Rape Response** Huntsville, AL 35804 Hotline Phone: 256-716-1000 **Rape Crisis Center of Mobile** Mobile, AL 36691 Hotline Phone: 251-473-7273 **Standing Together Against Rape** Montgomery, AL 36109 Hotline Phone: 334-213-1227 **Rape Counselors of East Alabama** Opelika, AL 36801 Hotline Phone: 334-745-8634 **Safehouse of Shelby County** Pelham, AL 35124 Hotline Phone: 205-664-4357 **Crisis Center of Russell County** Phenix City, AL 36868 Hotline Phone: 334-297-4401 **The Lighthouse Rape Crisis Center** Robertsdale, AL 36567 Hotline Phone: 251-947-4393 **"SABRA Sanctuary, Inc."** Selma, AL 36702 Hotline Phone: 334-874-8711 **Turning Point**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Tuscaloosa, AL 35403 Hotline Phone: 205-758-0808
Alaska**	Alaska Network on Domestic Violence & Sexual Assault (ANDVSA) Juneau, AK 907-586-3650	**Standing Together Against Rape** Anchorage, AK 99503 Hotline Phone: 907-276-7273 **The LeeShore Center** Kenai, AK 99611 Hotline Phone: 907-283-7257 **Women in Safe Homes** Ketchikan, AK 99901 Hotline Phone: 907-225-9474 **Kodiak Women's Resource & Crisis Center** Kodiak, AK 99615 Hotline Phone: 907-486-3625 **Bering Sea Women's Group** Nome, AK 99762 Hotline Phone: 907-443-5444 **Alaska Family Resource Center** Palmer, AK 99645 Hotline Phone: 907-746-4080 **Seward Life Action Council** Seward, AK 99664 Hotline Phone: 907-224-3027 **Sitkans Against Family Violence** Sitka, AK 99835 Hotline Phone: 907-747-6511 **USAFV** Unalaska, AK 99685 Hotline Phone: 907-581-1500 **Advocates for Victims of Violence** Valdez, AK 99686 Hotline Phone: 907-835-2999 **Arctic Women In Crisis** Barrow, AK 99723

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 907-852-0261 **Tundra Women's Coalition** Bethel, AK 99559 Hotline Phone: 907-543-3456 **Cordova Family Resource Center** Cordova, AK 99574 Hotline Phone: 907-424-4357 **Safe and Fear-Free Environment** Dillingham, AK 99576 Hotline Phone: 907-842-2316 **Emmonak Women's Shelter** Emmonak, AK 99581 Hotline Phone: 907-949-1434 **The Interior Alaska Center for Non-Violent Living** Fairbanks, AK 99701 Hotline Phone: 907-452-2293 **South Peninsula Women's Services** Homer, AK 99603 Hotline Phone: 907-235-0247 **Aiding Women from Abuse & Rape Emergencies (AWARE)** Juneau, AK 99802 Hotline Phone: 907-586-1090
Arizona	Arizona Sexual Assault Network (AzSAN) Phoenix, AZ 602-258-1195	**EMPACT-SPC** Tempe, AZ 85282 Hotline Phone: 480-736-4953 **Southern Arizona Center against Sexual Assault** Tucson, AZ 85716 Hotline Phone: 520-327-7273
Arkansas	Arkansas Coalition Against Sexual Assault Clarksville, AR 501-754-6869	**The Courage House** Arkedelphia, AR 71923 Hotline Phone: 870-246-3122 **Family Violence Prevention**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Batesville, AR 72503 Hotline Phone: 870-793-8111 **Women's Crisis Center of South Arkansas** Camden, AR 71701 Hotline Phone: 888-836-0325 **Ozark Rape Crisis Center** Clarksville, AR 72830 Hotline Phone: 479-754-6869 **Southwest Arkansas Domestic Violence Center** DeQueen, AR 71832 Hotline Phone: 870-584-3441 **Turning Point** El Dorado, AR 71730 Hotline Phone: 888-880-0929 **Crisis Center for Women** Fort Smith, AR 72901 Hotline Phone: 479-782-4956 **Ozark Rape Crisis Center, Inc.2** Harrison, AR 72601 Hotline Phone: 870-741-4141 **Northeast Arkansas Council on Family Violence, Inc.** Jonesboro, AR 72403 Hotline Phone: 870-933-9449 **Options, Inc.** Monticello, AR 71657 Hotline Phone: 870-367-3488 **Rape Crisis: A Program of Family Service Agency** North Little Rock, AR 72114 Hotline Phone: 501-801-2700 **Northwest Arkansas Rape Crisis** Springdale, AR 72764 Hotline Phone: 479-927-1020

STATE	STATE AGENCY[2]	LOCAL AGENCIES
California**	CALCASA Rape Prevention Resource Center Sacramento, CA 916-446-2520	**Tahoe Women Services** King Beach, CA 96143 Hotline Phone: 530-546-3241 **Sutter Lakeside Community Services** Lakeport, CA 95453 Hotline Phone: 707-263-3242 **Sexual Assault Response Services** Lancaster, CA 93534 Hotline Phone: 661-723-7273 **Tri-Valley Haven for Women** Livermore, CA 94551 Hotline Phone: 925-449-5842 **N. County Rape Crisis & Child Protection** Lompoc, CA 93438 Hotline Phone: 805-736-7273 **N. County Rape Crisis & Child Protection** Lompoc, CA 93438 Hotline Phone: 805-928-3554 **Sexual Assault Crisis Agency** **Long Beach, CA 90804** Hotline Phone: 562-597-2002 Business Phone: 562-494-5046 **Rape Treatment Center at Santa Monica-UCLA Medical Center** Los Angeles, CA 90001 Hotline Phone: 310-319-4000 **Los Angeles Commission on Assaults Against Women** Los Angeles, CA 90015 Hotline Phone: 310-392-8381 **Los Angeles Commission on Assaults Against Women** Los Angeles, CA 90015 Hotline Phone: 213-626-3393

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		East Los Angeles Women's Center Los Angeles, CA 90022 Hotline Phone: 323-526-5830 **Center for the Pacific-Asian Family, Inc.** Los Angeles, CA 90036 Hotline Phone: 323-653-4042 **Rosa Parks Sexual Assault Crisis Center** Los Angeles, CA 90062 Hotline Phone: 323-854-4319 **PCIRC SAFE Program, Sierra County** Loyalton, CA 96118 Hotline Phone: 530-283-4333 **Victim Service Center** Madera, CA 93637 Hotline Phone: 559-661-7787 **Mount Crisis Service** Mariposa, CA 95338 Hotline Phone: 209-966-2350 **A Woman Place of Merced County** Merced, CA 95341 Hotline Phone: 209-722-4357 **Haven Women Center of Stanislaus/RCC** Modesto, CA 95354 Hotline Phone: 209-577-5980 **Monterey Rape Crisis Center** Monterey, CA 93942 Hotline Phone: 831-375-4357 **Community Solutions South County Rape Crisis Services** Morgan Hill, CA 95038 Hotline Phone: 408-779-2115 **Volunteer Center of Napa Valley Inc.** Napa, CA 94559 Hotline Phone: 707-258-8000

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Highland Sexual Assault Center Oakland, CA 94602 Hotline Phone: 510-534-9290 **Bay Area Women Against Rape** Oakland, CA 94621 Hotline Phone: 510-845-7273 **Women's Resource Center** Oceanside, CA 92054 Hotline Phone: 760-757-3500 **Coalition To End Domestic & Sexual Violence** Oxnard, CA 93030 Hotline Phone: 805-656-1111 **Coachella Valley Sexual Assault Services** Palm Desert, CA 92260 Hotline Phone: 760-568-9071 **LACAAW -- West San Gabriel Valley Center** Pasadena, CA 91101 Hotline Phone: 626-793-3385 **El Dorado Women's Center** Placerville, CA 95667 Hotline Phone: 530-626-1131 **Project Sister Sex Assault Crisis Services** Pomona, CA 91766 Hotline Phone: 626-966-4155 **Shasta County Women's Refuge** **Redding , CA 96099** **Hotline Phone: 530-244-0117** **Women's Center--High Desert, Inc.** Ridgecrest, CA 93555 Hotline Phone: 760-375-0745
Colorado**	Colorado Coalition Against Sexual Assault	**Alternatives to Violence**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
	Denver, CO 303-861-7033	Loveland, CO 80537 Hotline Phone: 970-669-5150 **Tri-County Resource Center** Montrose, CO 81402 Hotline Phone: 970-249-2486 **Pueblo Rape Crisis Center** Pueblo, CO 81003 Hotline Phone: 719-549-0549 **Advocates Against Battering & Abuse** Steamboat Springs, CO 80477 Hotline Phone: 970-879-8888 **High Plains Sexual Assault Center** Sterling, CO 80751 Hotline Phone: 970-522-8329 **San Miguel Resource Center** Telluride, CO 81435 Hotline Phone: 970-728-5660 **Advocates Against Domestic Assault** Trinidad, CO 81082 Hotline Phone: 719-846-4357
Connecticut	Connecticut Sexual Assault Crisis Services (CONNSACS) East Hartford, CT 860-282-9881	**The Center for Women and Families** Bridgeport, CT 06604 Hotline Phone: 203-333-2233 **The Center for Women and Families** Bridgeport, CT 06604 Hotline Phone: 203-384-9559 **Women's Center of Greater Danbury** Danbury, CT 06810 Hotline Phone: 203-731-5204 **Rape Crisis Center of Milford, Inc.** Milford, CT 06460 Hotline Phone: 203-878-1212 **YWCA of New Britain Sexual Assault Crisis**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Service New Britain, CT 06051 Hotline Phone: 800-656-HOPE **Sexual Assault Crisis Center of Eastern CT** Willimantic, CT 06226 Hotline Phone: 860-456-2789
Delaware	Contact Delaware Wilmington, DE 302-761-9800	**Contact Delaware** Milford, DE 19963 Hotline Phone: 302-761-9100 **Contact Delaware** Wilmington, DE 19809 Hotline Phone: 302-761-9100
Washington, DC**	DC Rape Crisis Center Washington, DC 202-232-0789	
Florida	Florida Council Against Sexual Violence Tallahassee, FL 850-297-2000	**Manatee Glens Rape Crisis** Bradenton, FL 34206 Hotline Phone: 941-708-6059 **Another Way, Inc.** Chiefland, FL 32644 Hotline Phone: 352-493-6742 **Rape Crisis Center** Clearwater, FL 33760 Hotline Phone: 727-530-7273 **2-1-1 Brevard** Cocoa Beach, FL 32931 Hotline Phone: 321-632-6688 **Sunrise of Pasco, Inc.** Dade City, FL 33526 Hotline Phone: 352-521-3120 **Rape Crisis** Daytona Beach, FL 32114 Hotline Phone: 386-254-4106

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		COPE Center DeFuniak Springs, FL 32433 Hotline Phone: 850-892-4357 Abuse Counseling and Treatment (ACT) Fort Myers, FL 33906 Hotline Phone: 239-939-3112 **Bridgeway Center Sexual Trauma Team Program** Fort Walton Beach, FL 32548 Hotline Phone: 850-244-9191 **Victim Services Sexual Assault Treatment Center** Ft. Lauderdale, FL 33301 Hotline Phone: 954-761-7273 **Victim Services and Rape Crisis Center** Gainesville, FL 32641 Hotline Phone: 352-264-6760 **Sexual Assault Response Center** Jacksonville, FL 32206 Hotline Phone: 904-244-7273 **North Central Florida Sexual Assault Center** Lake City, FL 32025 Hotline Phone: 386-623-1708 **Peace River Center** Lakeland, FL 33801 Hotline Phone: 863-413-2707 **Haven of Lake & Sumter Counties, Inc.** Leesburg, FL 34748 Hotline Phone: 352-753-5800 **Crisis Services of Brevard** Melbourne, FL 32941 Hotline Phone: 321-632-6688 **Roxcy Bolton Rape Treatment Center** Miami, FL 33136 Hotline Phone: 305-585-7273

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Project Help, Inc. - Rape Crisis Program Naples, FL 34102 Hotline Phone: 239-262-7227 **Rape Crisis and Spouse Abuse Center** Ocala, FL 34478 Hotline Phone: 352-622-8495 **Quiqley House** Orange Park, FL 32067 Hotline Phone: 904-284-0061 **Crisis Services of Brevard** Palm Bay, FL 32907 Hotline Phone: 321-632-6688 **Salvation Army DV & Rape Crisis Program** Panama City, FL 32401 Hotline Phone: 800-252-2597 **Rape Crisis Center of Northwest Florida** Pensacola, FL 32501 Hotline Phone: 850-438-1617 **Center for Abuse and Rape Emergencies** Punta Gorda, FL 33951 Hotline Phone: 941-627-6000 **Crisis Services of Brevard** Rockledge, FL 32956 Hotline Phone: 321-632-6688 **Safe Place and Rape Crisis Center (SPARCC)** Sarasota, FL 34237 Hotline Phone: 941-365-1976 **Crisis Services of Brevard** Satellite Beach, FL 32937 Hotline Phone: 321-632-6688 **Dawn Center of Hernando County for Sexual & Domestic Violence Assistance** Spring Hill, FL 34611

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 352-799-0657 **Betty Griffin House** St. Augustine, FL 32085 Hotline Phone: 904-824-1555 **Refuge House/Rape Crisis Center** Tallahassee, FL 32316 Hotline Phone: 850-681-2111
Georgia**	Georgia Network to End Sexual Assault (GNESA) Atlanta, GA 404-659-6482	**Sexual Assault Center of Northeast Georgia, Inc.** Athens, GA 30605 Hotline Phone: 706-353-1912 **Rape Crisis Center** Atlanta, GA 30335 Hotline Phone: 404-616-4861 **Rape Crisis and Sexual Assault Services** Augusta, GA 30901 Hotline Phone: 706-724-5200 **SAFE Inc.** Blairsville, GA 30514 Hotline Phone: 706-379-3000 **North Georgia Mountain Crisis Network** Blue Ridge, GA 30513 Hotline Phone: 706-632-8400 **Coastal Area Rape Crisis Center, Inc.** Brunswick, GA 31521 Hotline Phone: 912-230-6994 **Carroll Rape Crisis Center** Carrollton , GA 30117 Hotline Phone: 770-834-7273 **F.A.I.T.H.** Clayton, GA 30525 Hotline Phone: 706-782-1338 **Columbus Rape Crisis, Inc.** Columbus, GA 31902 Hotline Phone: 706-571-6010

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		DeKalb Rape Crisis Center Decatur, GA 30031 Hotline Phone: 404-377-1428 **Women in Need of God's Shelter, Inc.** Dublin, GA 31040 Hotline Phone: 478-272-8000 **Gwinnett Sexual Assault Center** Duluth, GA 30096 Hotline Phone: 770-476-7407 **Rape Response, Inc.** Gainesville, GA 30503 Hotline Phone: 770-503-7273 **Teem Plus of Griffin Rape Crisis Center** Griffin, GA 30224 Hotline Phone: 770-636-0088 **Southern Crescent Sexual Assault Center** Jonesboro, GA 30237 Hotline Phone: 770-477-2177 **Crisis Line of Middle Georgia** Macon, GA 31201 Hotline Phone: 478-745-9292 **YWCA of NW Georgia** Marietta, GA 30064 Hotline Phone: 770-427-3390 **The Sexual Assault Center of Northwest Georgia** Rome, GA 30162 Hotline Phone: 706-802-0580 **Rape Crisis Center of the Coastal Empure, Inc.** Savannah, GA 31412 Hotline Phone: 912-233-7273 **The Haven** Valdosta, GA 31603 Hotline Phone: 229-244-1765

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		HODAC's Victim Resource Center Warner Robins, GA 31093 Hotline Phone: 478-953-7234 **Satilla Rape Crisis Program** Waycross, GA 31501 Hotline Phone: 912-283-0987 **HODAC's Victim Resource Center** Warner Robins, GA 31093 Hotline Phone: 478-953-7234 **Satilla Rape Crisis Program** Waycross, GA 31501 Hotline Phone: 912-283-0987
Guam	Guam Healing Arts Crisis Center Tamuning, GU 671-647-5351	
Hawaii	Hawaii State Coalition for the Prevention of Sexual Assault Honolulu, HI 808-733-9038	**YWCA of Hawaii Island SAVE** Hilo, HI 96720 Hotline Phone: 808-935-0677 **Sex Abuse Treatment Center** Honolulu, HI 96813 Hotline Phone: 808-524-7273 **Child & Family Service** Kahului, HI 96732 Hotline Phone: 808-873-8624 **Kauai YWCA Sexual Assault Treatment** Lihue, HI 96766 Hotline Phone: 808-245-4144
Idaho	Idaho Coalition Against Sexual & Domestic Violence (ICASDV) Boise, ID 208-384-0419	**Bingham Crisis Center** Blackfoot, ID 83221 Hotline Phone: 208-681-8713 **YWCA Women's Crisis Center- Rape Crisis Alliance** Boise, ID 83702 Hotline Phone: 208-343-7025

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Boundary County Youth Crisis & DV Hotline Bonners Ferry, ID 83805 Hotline Phone: 208-267-5211 **Coeur d'Alene Women's Center** Coeur d'alene, ID 83814 Hotline Phone: 208-661-2522 **Family Safety Network** Driggs, ID 83422 Hotline Phone: 208-354-7233 **Advocates for Survivors of Domestic Violence** Hailey , ID 83333 Hotline Phone: 208-788-4191 **Rape Response & Crime Victim Center** Idaho Falls, ID 83402 Hotline Phone: 208-521-6018 **YWCA Lewiston/Clarkston Crisis Services** Lewiston, ID 83501 Hotline Phone: 800-669-3176 **Oneida Crisis Center** Malad, ID 83252 Hotline Phone: 208-766-3119 **Support for Women in Crisis** McCall, ID 83638 Hotline Phone: 208-382-7172 **Support for Women in Crisis** McCall, ID 83638 Hotline Phone: 208-382-6748 **New Valley Crisis Center** Nampa, ID 83653 Hotline Phone: 208-465-5011 **Family Services Alliance of Southeast Idaho** Pocatello, ID 83204 Hotline Phone: 208-251-4357

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Family Crisis Center Rexburg, ID 83440 Hotline Phone: 208-356-0065 **Lemhi County Crisis Intervention / Mahoney Family Safety Center** Salmon, ID 83467 Hotline Phone: 208-940-0600 **ROSE Advocates** Weiser, ID 83672 Hotline Phone: 208-414-0740
Illinois**	Illinois Coalition Against Sexual Assault (ICASA) Springfield, IL 217-753-4117	**Northwest Center Against Sexual Assault** Arlington Heights, IL 60005 Hotline Phone: 888-802-8890 **Mutual Ground, Inc.** Aurora, IL 60506 Hotline Phone: 630-897-8383 **YWCA Sexual Assault Program -- Stepping Stones** Bloomington, IL 61704 Hotline Phone: 309-827-4005 **Rape Crisis Services** Carbondale, IL 62901 Hotline Phone: 618-529-2324 **Rape Crisis Services** Champaign, IL 61820 Hotline Phone: 877-2-End-Rape **Sexual Assault Counseling and Information Service** Charleston, IL 61920 Hotline Phone: 217-348-5033 **YWCA Metro Chicago** Chicago, IL 60601 Hotline Phone: 888-293-2080 **YWCA -- South Suburban** Chicago Heights, IL 60411 Hotline Phone: 708-748-5672

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		YWCA Sexual Assault Crisis Services Danville, IL 61832 Hotline Phone: 217-443-5566 **Growing Strong Sexual Assault Center** Decatur, IL 62523 Hotline Phone: 217-428-0770 **Sexual Assault Abuse Services** DeKalb, IL 60115 Hotline Phone: 815-756-5228 **YWCA of the Sauk Valley** Dixon, IL 61021 Hotline Phone: 815-288-1011 **Sexual Assault Victim's Care Unit** Edgemont, IL 62203 Hotline Phone: 618-397-0975 **Community Crisis Center Inc.** Elgin, IL 60121 Hotline Phone: 847-697-2380 **Riverview Center Sexual Assault Intervention/Prevention Services** Galena, IL 61036 Hotline Phone: 888-707-8155 **YWCA of DuPage/West Surburban Area** Glen Ellyn, IL 60137 Hotline Phone: 630-971-3927 **Call for Help, Inc.** Granite City, IL 62040 Hotline Phone: 618-452-2763 **Lake County Council Against Sexual Assault** Gurnee, IL 60031 Hotline Phone: 847-872-7799 **Des Plaines Valley Community Center** Hickory Hills, IL 60457

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 708-482-9600 **Sexual Assault Service Center Guardian Angel Home** Joliet, IL 60435 Hotline Phone: 815-730-8984 **KC-CASA** Kankakee, IL 60901 Hotline Phone: 815-932-3322 **Western Illinois Regional Council Sexual Assault Program** Macomb , IL 61455 Hotline Phone: 309-837-5555 **Center for Prevention of Abuse** Peoria, IL 61612 Hotline Phone: 309-691-4111 **Freedom House** Princeton, IL 61356 Hotline Phone: 800-474-6031 **Quanada Sexual Assault Program** Quincy, IL 62301 Hotline Phone: 217-222-2873 **Counseling and Information for Sexual Assault/Abuse** Robinson, IL 62454 Hotline Phone: 618-544-9379 **Quad Cities Rape/Sexual Assault Counseling Program** Rock Island, IL 61201 Hotline Phone: 309-797-1777 **Rockford Sexual Assault Counseling, Inc.** Rockford, IL 61108 Hotline Phone: 815-636-9811 **Riverview Center** Savanna, IL 61074

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 815-273-7772 **Prairie Center Against Sexual Assault** Springfield, IL 62704 Hotline Phone: 217-753-8081 **YWCA of the Sauk Valley** Sterling, IL 61081 Hotline Phone: 815-626-7277 **ADV/SAS** Streator, IL 61364 Hotline Phone: 815-673-1555 **Sexual Assault and Family Emergencies** Vandalia, IL 62471 Hotline Phone: 618-283-1414
Indiana	Indiana Coalition Against Sexual Assault Indianapolis, IN 317-423-0233	**Alternatives, Inc. of Madison County** Anderson, IN 46015 Hotline Phone: 765-643-0200 **Middle Way House Rape Crisis Center** Bloomington, IN 47402 Hotline Phone: 812-336-0846 **Family Crisis Shelter of Montgomery County Inc.** Crawfordsville, IN 47933 Hotline Phone: 765-362-2030 **Albion Fellows Bacon Center** Evansville, IN 47731 Hotline Phone: 812-424-7273 **Rape Awareness Program of the Fort Wayne Women's Bureau, Inc.** Fort Wayne, IN 46805 Hotline Phone: 260-426-7273 **Crisis Center** Gary, IN 46403 Hotline Phone: 219-938-7509 **Crisis & Suicide Intervention** Indianapolis, IN 46205

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 317-251-7575 **Crisis Connection, Inc.** Jasper, IN 47547 Hotline Phone: 812-482-1555 **Lafayette Crisis Center** Lafayette, IN 47904 Hotline Phone: 765-742-0244 **Directions of Community Mental Health Center, Inc.** Lawrenceburg, IN 47025 Hotline Phone: 812-537-1302 **Hands of Hope** Marion, IN 46953 Hotline Phone: 765-664-0701 **A Better Way Crisis & Information Center** Muncie, IN 47308 Hotline Phone: 765-288-4357 **A Better Way Crisis & Information Center** Muncie, IN 47308 Hotline Phone: 765-747-9107 **Prevail, Inc.** Noblesville, IN 46060 Hotline Phone: 317-776-3472 **North Central Indiana Rural Crisis Center, Inc.** Rensselaer, IN 47978 Hotline Phone: 800-933-0374 **Hoosier Hills Pact DV Shelter** Salem, IN 47167 Hotline Phone: 812-883-1959 **Center for Women and Families** Sellersburg, IN 47172 Hotline Phone: 812-944-6743 **Sex Offense Services**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		South Bend, IN 46624 Hotline Phone: 574-289-4357 **The Caring Place, Inc.** Valparaiso, IN 46383 Hotline Phone: 219-464-2128
Iowa**	Iowa Coalition Against Sexual Assault (ICASA) Des Moines, IA 515-244-7424	**Crisis Intervention & Advocacy Center** Adel, IA 50003 Hotline Phone: 800-400-4884 **ACCESS** Ames, IA 50014 Hotline Phone: 515-292-5378 **Family Crisis Support Network** Atlantic, IA 50022 Hotline Phone: 712-243-5123 **Family Crisis Support Network** Atlantic, IA 50022 Hotline Phone: 712-243-6615 **Domestic Abuse Prevention Center** Carroll, IA 51401 Hotline Phone: 712-792-6722 **Catholic Charities DV/SA Program** Council Bluffs, IA 51503 Hotline Phone: 712-328-0266 **Rural Iowa Crisis Center** Creston, IA 50801 Hotline Phone: 641-782-6632 **Quad Cities Rape/Sexual Assault Counseling Program/Family Resources Inc.** Davenport, IA 52803 Hotline Phone: 563-326-9191 **Domestic & Sexual Abuse Resource Center** Decorah, IA 52101 Hotline Phone: 563-382-2989 **Riverview Center Sexual Assault Prevention &**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Intervention Services Dubuque, IA 52003 Hotline Phone: 563-557-0310 **Domestic/Sexual Assault Outreach Center** Ft. Dodge, IA 50501 Hotline Phone: 515-573-8000 **Seeds of Hope** Grundy Center, IA 50638 Hotline Phone: 319-824-5522 **Turning Point** Knoxville, IA 50138 Hotline Phone: 641-828-8419 **Crisis Intervention Services** Mason City, IA 50402 Hotline Phone: 641-424-9133 **Crisis Center & Women's Shelter** Ottumwa, IA 52501 Hotline Phone: 641-683-3122 **Family Crisis Center of Northwest Iowa** Sioux Center, IA 51250 Hotline Phone: 800-382-5603 **CSADV** Sioux City, IA 51102 Hotline Phone: 712-258-7233 **Cedar Valley Friends of the Family** Waverly , IA 50677 Hotline Phone: 319-352-0037
Kansas**	Kansas Coalition Against Sexual & Domestic Violence Topeka, KS 785-232-9784	**Crisis Center of Dodge City** Dodge City, KS 67801 Hotline Phone: 620-225-6510 **SOS, Inc.** Emporia, KS 66801 Hotline Phone: 620-342-1870

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Family Crisis Center Great Bend, KS 67530 Hotline Phone: 620-792-1885 **NW Kansas Family Shelter** Hays, KS 67601 Hotline Phone: 785-625-3055 **Sexual Assault And Domestic Violence Center of Reno County** Hutchinson, KS 67501 Hotline Phone: 620-663-2522 **Hope Unlimited** Iola, KS 66749 Hotline Phone: 620-365-7566 **Rape Victim's Survivor Service, Inc.** Lawrence, KS 66046 Hotline Phone: 785-841-2345 **Alliance Against Family Violence** Leavenworth, KS 66048 Hotline Phone: 913-682-9131 **Liberal Area Rape Crisis/DV Services, Inc.** Liberal, KS 67901 Hotline Phone: 620-624-8818 **The Crisis Center, Inc.** Manhattan, KS 66505 Hotline Phone: 785-539-2785 **SAFEHOME** Overland Park, KS 66204 Hotline Phone: 913-262-2868 **Crisis Resource Center of SE Kansas** Pittsburg, KS 66762 Hotline Phone: 800-794-9148 **DVACK** Salina, KS 67401 Hotline Phone: 785-827-5862

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Sexual Assault Center Topeka, KS 66601 Hotline Phone: 785-234-3300 **Wichita Area Sexual Assault Center** Wichita, KS 67202 Hotline Phone: 316-263-3002 **Safe Homes, Inc.** Winfield, KS 67156 Hotline Phone: 620-221-4357
Kentucky**	Kentucky Association of Sexual Assault Programs Frankfort, KY 502-226-2704	**Pathways Inc.** Ashland, KY 41101 Hotline Phone: 606-324-1141 **Hope Harbor** Bowling Green, KY 42101 Hotline Phone: 270-846-1100 **Cumberland River Rape Victim Services** Corbin, KY 40702 Hotline Phone: 606-523-9386 **Women's Crisis Center** Covington, KY 41011 Hotline Phone: 859-491-3335 **Advocacy & Support Center** Elizabethtown, KY 42701 Hotline Phone: 270-234-9236 **Kentucky River Community Care Rape Crisis Center** Hazard, KY 41701 Hotline Phone: 800-375-7273 **Bluegrass Rape Crisis Center** Lexington, KY 40588 Hotline Phone: 859-253-2511 **Center for Women & Families** Louisville, KY 40201 Hotline Phone: 502-581-7222

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		New Beginnings Sexual Assault Support Services Owensboro , KY 42303 Hotline Phone: 800-226-7273 **Rape Crisis Center** Paducah, KY 42002 Hotline Phone: 270-534-4422 **Mountain Comprehensive Care Center** Prestonsburg, KY 41653 Hotline Phone: 606-886-4408 **Regional Victim Services Program** Somerset, KY 42501 Hotline Phone: 606-451-9647 **Sanctuary, Inc. Crisis Intervention Center** Hopkinsville , KY 42241 Hotline Phone: 270-887-6200
Louisiana**	Louisiana Foundation Against Sexual Assault (LAFASA) Independence, LA 504-747-8815	**Family Counseling Agency Work Against Rape Program** Alexandria, LA 71301 Hotline Phone: 318-445-2022 **Tri-Parish Victim Assistance Rape Crisis** Amite, LA 70422 Hotline Phone: 985-748-6882 **Stop Rape Crisis Center** Baton Rouge, LA 70802 Hotline Phone: 225-383-7273 **Washington Parish Rape Crisis Center** Bogalusa, LA 70427 Hotline Phone: 985-732-4961 **The Haven** Houma, LA 70361 Hotline Phone: 985-872-0450 **Sexual Abuse Response Center** Lafayette, LA 70505 Hotline Phone: 337-233-7273

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Calcasien Women's Shelter Rape Crisis Outreach Program Lake Charles, LA 70602 Hotline Phone: 337-494-7273 **YWCA Rape Crisis Program** Monroe, LA 71202 Hotline Phone: 318-323-1543 **YWCA Rape Crisis Program** New Orleans, LA 70119 Hotline Phone: 504-483-8888 **St. Landry-Evangeline Sexual Assault Center** Opelousas, LA 70570 Hotline Phone: 337-585-4673 **Pine Hills Sexual Assault Center** Ruston, LA 71273 Hotline Phone: 318-255-7273 **YWCA Rape Crisis Center** Shreveport, LA 71101 Hotline Phone: 318-222-0556 **YWCA Rape Crisis Program** Slidell, LA 70458 Hotline Phone: 504-483-8888
Maine**	Maine Coalition Against Sexual Assault Augusta, ME 207-626-0034	**Sexual Assault Crisis Center** Auburn, ME 04212 Hotline Phone: 207-795-2211 **Sexual Assault Crisis & Support Center** Augusta, ME 04330 Hotline Phone: 800-871-7741 **Rape Response Services** Bangor , ME 04402 Hotline Phone: 207-989-5678 **Sexual Assault Support Services of Midcoast Maine** Brunswick, ME 04011 Hotline Phone: 800-822-5999

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Downeast Sexual Assault Services Ellsworth, ME 04605 Hotline Phone: 207-667-5304 **S.A.V.E.S.** Farmington, ME 04938 Hotline Phone: 207-778-0110 **R.E.A.C.H.** Norway, ME 04268 Hotline Phone: 207-743-3868 **Sexual Assault Response Services of Southern Maine** Portland, ME 04104 Hotline Phone: 800-313-9900 **Sexual Assault Helpline/ Emergency Services** Presque Isle, ME 04769 Hotline Phone: 207-762-4851 **Rape Crisis Assistance & Prevention** Waterville, ME 04901 Hotline Phone: 207-872-0601
Maryland	Maryland Coalition Against Sexual Assault Arnold, MD 410-974-4507	**Family Violence Unit** Baltimore City, MD 21224 Hotline Phone: 410-828-6390 **Family Violence Unit** Baltimore County, MD 21206 Hotline Phone: 410-828-6390 **Harford County Sexual Assault/Spouse Abuse Resource Center** Bel Air, MD 21014 Hotline Phone: 410-836-8430 **Prince George's County Sexual Assault Center** Cheverly, MD 20785 Hotline Phone: 301-618-3154 **The STTAR Center**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Columbia , MD 21046 Hotline Phone: 410-997-3292 **Family Crisis Resource Center** Cumberland, MD 21502 Hotline Phone: 301-759-9244 **For All Seasons, Inc.** Easton, MD 21601 Hotline Phone: 410-820-5600 **Cecil County DV Rape Crisis Program** Elkton, MD 21922 Hotline Phone: 410-996-0333 **Heartly House, Inc.** Frederick, MD 21705 Hotline Phone: 301-662-8800 **Anne Arundel County Sexual Assault Crisis Center** Glen Burnie, MD 21061 Hotline Phone: 410-222-7273 **CASA, Inc.** Hagerstown, MD 21740 Hotline Phone: 301-739-8975 **Walden/Sierra, Inc.** Leonardtown, MD 20650 Hotline Phone: 301-863-6661 **Dove Center** Oakland, MD 21550 Hotline Phone: 301-334-9000 **Calvert County Health Department Crisis Intervention Center** Prince Frederick, MD 20678 Hotline Phone: 410-535-1121 **Calvert County Health Department Crisis Intervention Center** Prince Frederick, MD 20678 Hotline Phone: 301-855-1075

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Victim Assistance & Sexual Assault Program Rockville, MD 20850 Hotline Phone: 240-777-4247 **Life Crisis Center** Salisbury, MD 21803 Hotline Phone: 410-749-4357 **Family Violence Unit** Towson, MD 21212 Hotline Phone: 410-828-6390 **Center for Abused Persons** Waldorf, MD 20601 Hotline Phone: 301-645-3336 **Rape Crisis Intervention Service** Westminster, MD 21157 Hotline Phone: 410-857-7322
Massachusetts	Jane Doe Inc. / MCASADV Boston, MA 617-248-0922	**Everywoman's Center** Amherst, MA 01003 Hotline Phone: 413-545-0800 **North Shore Rape Crisis Center** Beverly, MA 01915 Hotline Phone: 978-922-4491 **Voices Against Violence** Framingham, MA 01702 Hotline Phone: 800-593-1125 **New England Learning Center for Women in Transition** Greenfield, MA 01301 Hotline Phone: 413-772-6507 **Independence House/Cape Cod Rape Crisis Center** Hyannis, MA 02601 Hotline Phone: 508-771-6507 **Rape Crisis Services of Greater Lowell, Inc.** Lowell, MA 01852 Hotline Phone: 978-975-1776 **Valley Rape Crisis Program**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Milford, MA 01757 Hotline Phone: 508-478-1776 **A Safe Place** Nantucket, MA 02554 Hotline Phone: 508-228-2111 **New Bedford Women's Center, Inc. Sexual Assault Program** New Bedford, MA 02740 Hotline Phone: 508-999-2111 **Elizabeth Freeman Center** Pittsfield, MA 01201 Hotline Phone: 413-443-0089 **YWCA of Western Massachusetts Sexual Assault Program** Springfield, MA 01108 Hotline Phone: 413-733-7100 **Rape Crisis Center of Central Mass** Worcester, MA 01606 Hotline Phone: English: 800-870-5905; Spanish: 800 223-5001 **Boston Area Rape Crisis Center** Cambridge, MA 02139 Hotline Phone: 617-492-7273
Michigan	Michigan Coalition Against Domestic & Sexual Violence Okemos, MI 517-347-7000	**Catherine Cobb DV & SA Program** Adrian, MI 49221 Hotline Phone: 517-265-6776 **Sexual Assault Prevention & Awareness Center** Ann Arbor, MI 48104 Hotline Phone: 734-936-3333 **SAFE House Center** Ann Arbor, MI 48107 Hotline Phone: 734-995-5444 **Sexual Assault Services of Calhoun County** Battle Creek, MI 49015

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 269-381-4357 **Bay County Women's Center** Bay City, MI 48706 Hotline Phone: 989-686-4551 **Women's Information Service, Inc. (WISE)** Big Rapids, MI 49307 Hotline Phone: 231-796-6600 **Cadillac Area OASIS/Family Resource Center** Cadillac, MI 49601 Hotline Phone: 231-775-7233 **Branch County Shelterhouse** Coldwater, MI 49036 Hotline Phone: 517-278-7432 **Detroit Police Department Rape Counseling Center** Detroit, MI 48201 Hotline Phone: 313-833-1660 **Listening Ear Crisis Center** East Lansing, MI 48823 Hotline Phone: 517-337-1717 **Alliance Against Violence & Abuse** Escanaba, MI 49829 Hotline Phone: 906-789-1166 **YWCA Domestic Assault/Sexual Assault Services** Flint, MI 48502 Hotline Phone: 810-238-7233 **YWCA Sexual Assault Program** Grand Rapids, MI 49503 Hotline Phone: 616-776-7273 **River House Shelter** Grayling, MI 49738 Hotline Phone: 888-554-3169 **Center for Women in Transition** Holland, MI 49424

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 800-848-5991 **Dial Help Sexual Assault Crisis Center** Houghton, MI 49931 Hotline Phone: 906-482-4357 **Sexual Assault Recovery Assistance (SARA)** Howell , MI 48843 Hotline Phone: 517-548-4228 **Relief After Violent Encounter--Ionia/Montcalm** Ionia, MI 48846 Hotline Phone: 616-527-7170 **Caring House, Inc.** Iron Mountain , MI 49801 Hotline Phone: 906-774-1112 **Domestic Violence Escape, Inc.** Ironwood, MI 49938 Hotline Phone: 800-711-6744 **AWARE Inc.** Jackson , MI 49204 Hotline Phone: 517-783-2861 **YWCA Sexual Assault Program** Kalamazoo, MI 49007 Hotline Phone: 269-345-3036 **Baraga County Shelter Home** Lanse, MI 49946 Hotline Phone: 906-524-7078 **Region IV Community Services** Ludington, MI 49431 Hotline Phone: 800-950-5808 **Harbor House** Marquette, MI 49855 Hotline Phone: 906-226-6611 **Shelterhouse** Midland, MI 48641

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 989-835-6771 **Family Counseling & Shelter Services** Monroe, MI 48161 Hotline Phone: 734-243-6410 **Turning Point Inc.** Mt. Clemens, MI 48046 Hotline Phone: 586-463-6990 **Women's Aid Service, Inc.** Mt. Pleasant, MI 48804 Hotline Phone: 989-772-9168 **Every Woman's Place Crisis Center** Muskegon, MI 49441 Hotline Phone: 231-722-3333 **Women's Resource Center of Northern Michigan, Inc.** Petoskey, MI 49770 Hotline Phone: 231-347-0082 **First Step** Plymouth, MI 48148 Hotline Phone: 734-459-5900 **HAVEN** Pontiac, MI 48343 Hotline Phone: 248-334-1274 **Safe Horizons** Port Huron, MI 48061 Hotline Phone: 810-985-5538 **Sexual Assault Program of Child & Family Service of Saginaw** Saginaw, MI 48602 Hotline Phone: 989-790-9118 **Underground Railroad** Saginaw, MI 48605 Hotline Phone: 989-755-0411

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Eastern Upper Peninsula Domestic Violence Program Sault St. Marie, MI 49783 Hotline Phone: 906-635-0566 **Relief After Violent Encounter, Inc.** St. Johns, MI 48879 Hotline Phone: 989-224-7283 **Women's Resource Center - Grand Traverse Area** Traverse City, MI 49684 Hotline Phone: 231-941-1210 **Common Ground Victim Assistance** Bloomfield Hills, MI 48302 Hotline Phone: 248-456-0909
Minnesota**	Minnesota Coalition Against Sexual Assault Minneapolis, MN 612-313-2797	**Sexual Assault Services for Aitkin County** Aitkin, MN 56431 Hotline Phone: 218-828-4357 **Crime Victims' Resource Center** Austin, MN 55912 Hotline Phone: 507-437-6680 **Sexual Assault Program of Beltrami, Cass & Hubbard Counties** Bemidji, MN 56619 Hotline Phone: 218-444-9522 **Community Action Council, Inc. Sexual Assault Services - Dakota County** Burnsville, MN 55337 Hotline Phone: 651-405-1500 **Rape and Sexual Violence Center** Cottage Grove, MN 55016 Hotline Phone: 651-777-1117 **Lakes Crisis Center** Detroit Lakes, MN 56502 Hotline Phone: 218-847-7446 **Program for Aid to Victims of Sexual Assault, Inc.** Duluth, MN 55802

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 218-726-1931 **WomanSafe Center** Faribault, MN 55021 Hotline Phone: 800-607-2330 **Someplace Safe** Fergus Falls, MN 56538 Hotline Phone: 800-974-3359 **Itasca Alliance Against Sexual Assault** Grand Rapids, MN 55744 Hotline Phone: 218-326-5008 **Pathways of West Central MN, Inc.** Granite Falls , MN 56241 Hotline Phone: 320-564-4894 **WINDOW (Women in Need Depending on Other Women)** Hinckley, MN 55037 Hotline Phone: 320-384-7113 **Koochiching County Sexual Assault Program** International Falls, MN 56649 Hotline Phone: 218-283-9334 **Hands of Hope Resource Center** Little Falls, MN 56345 Hotline Phone: 320-632-4878 **Mahnomen County Victim Resource Program** Mahnomen, MN 56557 Hotline Phone: 218-766-4119 **CADA, Inc.** Mankato, MN 56002 Hotline Phone: 507-625-3966 **New Horizons Crisis Center** Marshall, MN 56258 Hotline Phone: 507-532-5764 **Rape and Sexual Abuse Center** Minneapolis, MN 55405

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 612-825-4357 **Sexual Violence Center** Minneapolis, MN 55412 Hotline Phone: 612-871-5111 **Sexual Violence Center** Minneapolis, MN 55412 Hotline Phone: 952-448-5425 **SAVES Resource Center** Olivia, MN 56277 Hotline Phone: 320-523-2096 **Women's Resource Center of Steele County** Owatonna, MN 55060 Hotline Phone: 507-451-1202 **Victim Services** Rochester, MN 55904 Hotline Phone: 507-289-0636 **Central Minnesota Sexual Assault Center** Saint Cloud, MN 56304 Hotline Phone: 320-251-4357 **Victim Services** St. James, MN 56081 Hotline Phone: 507-375-5770 **Sexual Offense Services of Ramsey County (SOS)** St. Paul, MN 55104 Hotline Phone: 651-643-3006 **Nicollet/Sibley Sexual Assault Services** St. Peter, MN 56073 Hotline Phone: 507-227-1425 **Violence Intervention Project** Thief River Falls, MN 56701 Hotline Phone: 218-681-5557 **North Shore Horizons** Two Harbors, MN 55616 Hotline Phone: 218-834-5924

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Sexual Violence and Abuse Crisis Center Willmar, MN 56201 Hotline Phone: 888-235-8001
Mississippi	Mississippi Coalition Against Sexual Assault Jackson, MS 888-987-9011	**Gulf Coast Women's Center** Biloxi, MS 39533 Hotline Phone: 228-435-1968 **Safe Haven, Inc.** Columbus, MS 39704 Hotline Phone: 662-327-2259 **Our House, Inc.** Greenville, MS 38702 Hotline Phone: 662-332-5683 **Sexual Assault Crisis Center, Inc.** Hattiesburg, MS 39406 Hotline Phone: 601-264-7777 **Catholic Charities Rape Crisis Center** Jackson , MS 39202 Hotline Phone: 601-982-7273 **Sexual Assault Crisis Services** Meridian, MS 39302 Hotline Phone: 601-482-2828 **Guardian Sexual Assault Center** Natchez, MS 39120 Hotline Phone: 601-442-0107 **Family Crisis Services of Northwest Mississippi** Oxford, MS 38655 Hotline Phone: 662-234-9929 **Safe, Inc.** Tupelo, MS 38802 Hotline Phone: 662-841-2273
Missouri**	Missouri Coalition Against Sexual Assault Jefferson City, MO	**New Way Shelter** Bonne Terre, MO 63628 Hotline Phone: 573-358-4461

STATE	STATE AGENCY[2]	LOCAL AGENCIES
	573-636-8776	**Women's Crisis Center** Branson, MO 65615 Hotline Phone: 417-561-5084 **Citizens Against Domestic Violence/Victim Outreach Center** Camdenton, MO 65020 Hotline Phone: 888-809-7233 **The Shelter** Columbia , MO 65205 Hotline Phone: 573-875-1370 **Coalition Against Rape & Domestic Violence** Fulton, MO 66251 Hotline Phone: 866-642-4422 **AVENUES** Hannibal, MO 63401 Hotline Phone: 573-221-4280 **Rape & Abuse Crisis Service** Jefferson City, MO 65102 Hotline Phone: 573-634-4911 **Lafayette House** Joplin, MO 64801 Hotline Phone: 417-782-1772 **Metropolitan Organization to Counter Sexual Assault** Kansas City, MO 64111 Hotline Phone: 816-531-0233 **Metropolitan Organization to Counter Sexual Assault** Kansas City, MO 64111 Hotline Phone: 913-642-0233 **Christian Associates of Table Rock Lake** Kimberling City, MO 65686-0398 Hotline Phone: 877-507-7233

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Victim Support Services Kirksville, MO 63501 Hotline Phone: 660-665-1617 **Safe Passage** Moberly, MO 65270 Hotline Phone: 800-616-3754 **SafeHaven -- Synergy Services** Parkville, MO 64152 Hotline Phone: 816-452-8535 **Haven House, Inc.** Poplar Bluff, MO 63901 Hotline Phone: 573-686-4873 **Phelps County Family Crisis Services, Inc.** Rolla, MO 65402 Hotline Phone: 573-364-0222 **CASA, Inc.** Sedalia, MO 65302 Hotline Phone: 660-827-5555 **House of Refuge** Sikeston, MO 63801 Hotline Phone: 877-633-3843 **The Victim Center** Springfield, MO 65806 Hotline Phone: 417-864-7233 **YWCA Rape Crisis/Sexual Assault Services** St Joseph, MO 64501 Hotline Phone: 816-232-1225 **Bridgeway Sexual Assault Center** St. Charles, MO 63302 Hotline Phone: 636-946-6894 **YWCA St. Louis Regional Sexual Assault Center** St. Louis, MO 63105 Hotline Phone: 314-531-7273 **Women's Support and Community Services**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		St. Louis, MO 63139 Business Phone: 314-646-7500 **Warren County Council Against Domestic Violence** Warrenton , MO 63383 Hotline Phone: 636-456-1186
Montana**	Montana Coalition Against Domestic Violence and Sexual Assault Helena, MT 406-443-7794	**Anaconda PCA Family Resource Center** Anaconda, MT 59711 Hotline Phone: 406-563-7972 **Sexual Assault Services -- YWCA** Billings, MT 59101 Hotline Phone: 406-259-8100 **The Sexual Assault Center Bozeman Help Center** Bozeman, MT 59715 Hotline Phone: 406-586-3333 **The Voice Center** Bozeman, MT 59717 Hotline Phone: 406-994-7069 **Safe Space** Butte, MT 59703 Hotline Phone: 406-782-8511 **Hi-Line's Help** Conrad, MT 59425 Hotline Phone: 406-759-5170 **Women's Resource Center** Dillon, MT 59725 Hotline Phone: 406-683-3621 **Women's Resource Center** Glasgow, MT 59230 Hotline Phone: 406-228-8400 **Dawson County Domestic Violence** Glendive, MT 59330 Hotline Phone: 406-989-1318 **Voices of Hope** Great Falls, MT 59403

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 406-453-4357 **Supporters of Abuse-Free Environments** Hamilton, MT 59840 Hotline Phone: 406-363-4600 **District 4 HRDC DV Program** Havre, MT 59501 Hotline Phone: 406-265-2222 **Friendship Center** Helena, MT 59601 Hotline Phone: 406-442-6800 **Violence Free Crisis Line** Kalispell, MT 59903 Hotline Phone: 406-752-7273 **Healing Hearts** Lame Deer, MT 59043 Hotline Phone: 406-477-6412 **SAVES, Inc.** Lewistown, MT 59457 Hotline Phone: 406-538-2281 **Lincoln Co. Women's Help Line** Libby, MT 59923 Hotline Phone: 406-756-2835 **Tri-County Network Against Domestic & Sexual Violence** Livingston, MT 59047 Hotline Phone: 406-222-8154 **CNADA** Miles City, MT 59301 Hotline Phone: 406-951-0475 **YWCA of Missoula** Missoula, MT 59802 Hotline Phone: 406-542-1944 **Family Crisis & Resource Center**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Polson, MT 59860 Hotline Phone: 406-883-3350 **Richland County Coalition Against Domestic Violence** Sidney, MT 59270 Hotline Phone: 406-433-7421 **Mineral County Helpline** Superior, MT 59872 Hotline Phone: 406-822-4202 **Sanders County Coalition for Families** Thompson Falls, MT 59873 Hotline Phone: 406-827-3218
Nebraska**	Nebraska Domestic Violence/Sexual Assault Coalition Lincoln, NE 402-476-6256	**Project Response** Auburn, NE 68305 Hotline Phone: 402-274-5092 **Family Service Domestic Abuse** Bellevue, NE 68005 Hotline Phone: 402-292-5888 **CEDARS Family Violence Services** Broken Bow, NE 68822 Hotline Phone: 308-872-5988 **Family Rescue Services** Chadron, NE 69337 Hotline Phone: 308-432-4113 **Center for Sexual Assault & Domestic Violence Survivors** Columbus, NE 68601 Hotline Phone: 402-564-2155 **Blue Valley Crisis Intervention** Fairbury, NE 68352 Hotline Phone: 402-474-3434 **Domestic Abuse/Sexual Assault Crisis Center** Fremont, NE 68026 Hotline Phone: 402-727-7777

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		DOVES Gering, NE 69341 Hotline Phone: 308-436-4357 **Crisis Center, Inc.** Grand Island, NE 68802 Hotline Phone: 308-381-0555 **Spouse Abuse/Sexual Assault Crisis Center** Hastings, NE 68901 Hotline Phone: 402-463-4677 **The S.A.F.E. Center** Kearney, NE 68847 Hotline Phone: 308-237-2599 **Dawson County Parent/Child Center** Lexington, NE 68850 Hotline Phone: 308-324-3040 **Rape/Spouse Abuse Crisis Center** Lincoln, NE 68510 Hotline Phone: 402-475-7273 **Domestic Abuse/Sexual Assault Services** McCook, NE 69001 Hotline Phone: 308-345-5534 **Bright Horizons** Norfolk, NE 68702 Hotline Phone: 402-379-3798 **Rape & Domestic Abuse Program** North Platte, NE 69103 Hotline Phone: 308-534-3495 **Sandhills Crisis Intervention Program** Ogallala, NE 69153 Hotline Phone: 308-284-6055 **Catholic Charities -- The Shelter** Omaha, NE 68104 Hotline Phone: 402-558-5700

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		YWCA Women Against Violence Omaha, NE 68131 Hotline Phone: 402-345-7273 **North Central Quad Counties DV/SA Services** Valentine, NE 69201 Hotline Phone: 402-376-2045 **Haven House Family Service Center** Wayne, NE 68787 Hotline Phone: 402-375-4633
Nevada	Nevada Coalition Against Sexual Violence Henderson, NV 702-940-2033	**SARA** Carson City, NV 89702 Hotline Phone: 775-883-7654 **Committee Against Domestic Violence** Elko, NV 89803 Hotline Phone: 775-738-9454 **Support, Inc. Family Crisis Center** Ely , NV 89301 Hotline Phone: 775-289-2270 **Support, Inc. Family Crisis Center** Ely , NV 89301 Hotline Phone: 775-962-5888 **Community Action Against Rape** Las Vegas, NV 89101 Hotline Phone: 702-366-1640 **Douglas County Family Support Council** Minden, NV 89423 Hotline Phone: 775-782-8692 **Crisis Call Center/Sexual Assault Support Services Coordinator** Reno , NV 89507 Hotline Phone: 775-784-8090
New Hampshire	New Hampshire Coalition Against Domestic & Sexual	**RESPONSE** Berlin, NH 03570

STATE	STATE AGENCY[2]	LOCAL AGENCIES
	Violence Concord, NH 603-224-8893	Hotline Phone: 800-277-5570 **Women's Supportive Services** Claremont, NH 03743 Hotline Phone: 603-543-0155 **Rape & Domestic Violence Crisis Center** Concord, NH 03302 Hotline Phone: 800-277-5570 **Starting Point** Conway, NH 03818 Hotline Phone: 603-527-7394 **SHARPP** Durham , NH 03824 Hotline Phone: 603- 862-3494 **Monadnock Center for Violence Prevention** Keene , NH 03431 Hotline Phone: 603-352-3782 **New Beginnings** Laconia, NH 03247 Hotline Phone: 800-277-5570 **Women's Information Service (WISE)** Lebanon, NH 03766 Hotline Phone: 603-448-5525 **The Support Center Against Domestic Violence and Sexual Assault** Littleton, NH 03561 Hotline Phone: 603-444-0544 **YWCA Crisis Service** Manchester, NH 03101 Hotline Phone: 603-668-2299 **Bridges** Nashua, NH 03061 Hotline Phone: 603-883-3044 **Voices Against Violence**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Plymouth , NH 03264 Hotline Phone: 603-536-1659 **Sexual Assault Support Services** Portsmouth, NH 03801 Hotline Phone: 888-747-7070
New Jersey**	New Jersey Coalition Against Sexual Assault Trenton, NJ 609-631-4450	**Domestic Abuse and Rape Crisis Center, Inc.** Belvedere, NJ 07823 Hotline Phone: 908-475-8408 **St. Francis Sexual Abuse and Assault Program** Brant Beach, NJ 08008 Hotline Phone: 732-370-4010 **Services Empowering Rape Victims** Camden, NJ 08103 Hotline Phone: 866-295-7378 **Coalition Against Rape and Abuse** Cape May Court House, NJ 08210 Hotline Phone: 609-522-6489 **East Orange General Hospital- Crisis Intervention Unit** East Orange, NJ 07019 Hotline Phone: 973-672-9685 **East Orange General Hospital- Crisis Intervention Unit** East Orange, NJ 07019 Hotline Phone: 973-672-9686 **Rape Crisis Intervention Center of Middlesex County** Edison, NJ 08837 Hotline Phone: 732-452-5900 **Women's Crisis Service** Flemington, NJ 08822 Hotline Phone: 908-788-4044 **Services Empowering Rape Victims** Glassboro, NJ 08028

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 866-295-7378 **YWCA of Bergen County Rape Crisis Center** Hackensack, NJ 07601 Hotline Phone: 201-487-2227 **180 Turning Lives Around** Hazlet, NJ 07730 Hotline Phone: 732-264-4111 **Jersey City Medical Center** Jersey City, NJ 07304 Hotline Phone: 201-433-6161 **Cumberland County Guidance Center- Sexual Assault Program** Millville, NJ 08332 Hotline Phone: 856-293-9753 **Essex County Rape Crisis Center** Montclair, NJ 07042 Hotline Phone: 973-746-0800 **CONTACT/Burlington County -- The Rape Crisis Program** Moorestown, NJ 08057 Hotline Phone: 856-234-8888 **Morris County Sexual Assault Center** Morristown, NJ 07960 Hotline Phone: 973-829-0587 **Safe and Sound Rape Crisis Center** Newark, NJ 07103 Hotline Phone: 973-972-1325 **Sexual Trauma Resource Center** Newton, NJ 07860 Hotline Phone: 973-875-1211 **Atlantic County Women's Center** Northfield, NJ 08225 Hotline Phone: 609-646-6767

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Passaic County Women's Center Paterson, NJ 07513 Hotline Phone: 973-881-1450 **Salem County Women's Services** Salem, NJ 08079 Hotline Phone: 856-935-6655 **Women's Health & Counseling Center** Somerville, NJ 08876 Hotline Phone: 908-526-7444 **Womanspace** Trenton, NJ 08618 Hotline Phone: 609-394-9000 **Union County Rape Crisis Center** Westfield, NJ 07090 Hotline Phone: 908-233-7273
New Mexico	New Mexico Coalition of Sexual Assault Programs Albuquerque, NM 505-883-8020	**Albuquerque Rape Crisis Center** Albuquerque, NM 87108 Hotline Phone: 505-266-7711 **Artesia Counseling Center** Artesia, NM 88210 Hotline Phone: 505-365-7606 **Daybreak Center, Inc.** Aztec, NM 87410 Hotline Phone: 505-947-3645 **La Buena Vida** Bernalillo, NM 87004 Hotline Phone: 505-269-7596 **Carlsbad Mental Health** Carlsbad , NM 88220 Hotline Phone: 505-885-8888 **Border Area Mental Health Center** Deming, NM 88030 Hotline Phone: 505-388-4412 **Crisis Center of Northern New Mexico**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Espanola, NM 87532 Hotline Phone: 505 -753-1656 **Guidance Center of Lea County** Hobbs, NM 88240 Hotline Phone: 505-393-6633 **La Pinon Sexual Assault Recovery Service of Southern New Mexico** Las Cruces, NM 88005 Hotline Phone: 505-526-3437 **Los Alamos Family Council** Los Alamos , NM 87544 Hotline Phone: 505-662-4422 **Counseling Associates, Inc.** Roswell , NM 88202 Hotline Phone: 505-623-1480 **The Counseling Center** Ruidoso Downs, NM 88346 Hotline Phone: 505-437-7404 **Santa Fe Rape Crisis Center** Santa Fe, NM 87502 Hotline Phone: 505-986-9111 **Community Against Violence** Taos, NM 87571 Hotline Phone: 505-758-9888
New York**	New York State Coalition Against Sexual Assault Albany, NY 518-482-4222 New York City Alliance Against Sexual Assault New York, NY 518-482-4222	**Albany County Rape Crisis Center** Albany, NY 12207 Hotline Phone: 518-447-7716 **Rape Crisis Service of Planned Parenthood of Orleans County** Albion, NY 14411 Hotline Phone: 800-527-1757 **Fulton Montgomery Rape Crisis Service of Planned Parenthood** Amsterdam , NY 12010

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 518-843-4367 **Rape Crisis Service of Planned Parenthood of Genesee County** Batavia, NY 14020 Hotline Phone: 800-527-1757 **Crime Victims Assistance Center, Inc.** Binghamton, NY 13904 Hotline Phone: 607-722-4256 **Safe Horizon** Brooklyn, NY 10007 Hotline Phone: 212-227-3000 **Advocate Program** Buffalo, NY 14214 Hotline Phone: 716-834-3131 **Citizens Against Violent Acts/ CAVA RCC** Canton, NY 13617 Hotline Phone: 315-386-3777 **Rape Crisis Sexual Assault Support Services** Cobleskill, NY 12043 Hotline Phone: 518-234-4949 **Rape Crisis Service of Planned Parenthood of Livingston County** Dansville, NY 14437 Hotline Phone: 800-527-1757 **Delaware Opportunities Inc., Safe Against Violence** Delhi, NY 13753 Hotline Phone: 607-746-6278 **Victims' Assistance Services** Elmsford, NY 10523 Hotline Phone: 800-726-4041 **Rape and Abuse Crisis Service of the Finger Lakes, Inc.** Geneva, NY 14456 Hotline Phone: 800-247-7273

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Rape Survivor Advocacy Program- The Mental Health Association of Orange County Goshen, NY 10924 Hotline Phone: 845-294-9355 **Victims Information Bureau of Suffolk County** Hauppauge, NY 11788 Hotline Phone: 631-360-3606 **Nassau County Coalition Against Domestic Violence** Hempstead, NY 11550 Hotline Phone: 516-222-2293 **Rape Crisis of the Southern Tier** Horseheads, NY 14845 Hotline Phone: 607-795-5713 **Sexual Trauma & Recovery Services** Hudson Falls, NY 12839 Hotline Phone: 866-677-8764 **Center for Crime Victims & Sexual Assault** Ithaca, NY 14850 Hotline Phone: 607-277-5000 **The Salvation Army Rape Crisis Program** Jamestown, NY 14702 Hotline Phone: 716-661-3897 **Ulster County CVAP** Kingston, NY 12401 Hotline Phone: 845-340-3442 **Putnam-North Westchester Women's Resource Center** Mahopac, NY 10541 Hotline Phone: 845-628-2166 **RISE -- Rape Intervention Services & Education** Monticello, NY 12701 Hotline Phone: 845-791-9595

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Lewis Co. Opportunities Domestic Violence & Rape Crisis Dept. New Bremen, NY 13367 Hotline Phone: 315-376-4357 **Rockland Family Shelter Sexual Trauma Services** New City, NY 10956 Hotline Phone: 845-634-3344 **Victim Resource Center of the Finger Lakes, Inc.** Newark, NY 14513 Hotline Phone: 315-294-5398 **Niagra County Rape Crisis Services** Niagra Falls, NY 14301 Hotline Phone: 716-285-3518 **Victims of Violence/Liberty Resources, Inc**. Oneida, NY 13421 Hotline Phone: 315-366-5000 **Violence Intervention Program** Oneonta, NY 13820 Hotline Phone: 607-432-4855 **SAF Rape Crisis Program** Oswego, NY 13126 Hotline Phone: 315-342-1600 **Family Services** Poughkeepsie, NY 12601 Hotline Phone: 845-452-7272 **Rape Crisis Service of Planned Parenthood of Monroe County** Rochester, NY 14605 Hotline Phone: 585-546-2777 **Rape Crisis Service of Planned Parenthood of Monroe County** Rochester, NY 14605 Hotline Phone: 585-343-1212 **Saratoga Rape Crisis Services**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Saratoga Springs, NY 12866 Hotline Phone: 518-587-2336 **Rape Crisis Service of Schenectady** Schenectady, NY 12305 Hotline Phone: 518-346-2266 **SAVAR** St. Auburn, NY 13021 Hotline Phone: 315-252-2112 **Rape Crisis Center of Syracuse** Syracuse, NY 13203 Hotline Phone: 315-422-7273 **Sexual Assault Care Center for Rensselaer County** Troy, NY 12180 Hotline Phone: 518-271-3257 **YWCA of the Mohawk Valley** Utica, NY 13502 Hotline Phone: 315-797-7740 **YWCA of the Mohawk Valley** Utica, NY 13502 Hotline Phone: 315-866-4120 **Community Action of Wyoming County** Warsaw, NY 14569 Hotline Phone: 585-237-2600 **Victims Assistance Center of Jefferson County, Inc.** Watertown, NY 13601 Hotline Phone: 315-782-1855
North Carolina**	North Carolina Coalition Against Sexual Assault Raleigh NC 888-737-CASA (2272)	**Union County Rape Crisis/Child Abuse Center** Monroe, NC 28112 Hotline Phone: 704-283-7770 **Options, Inc.** Morganton, NC 28680 Hotline Phone: 828-438-9444 Business Phone: 828-438-9444

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Reach, Inc. Murphy, NC 28906 Hotline Phone: 828-837-8064 **Community Coalition Against Family Violence** New Bern, NC 28563 Hotline Phone: 252-474-4343 **Interact** Raleigh, NC 27605 Hotline Phone: 919-828-3005 **Hannah's Place, Inc./Roanoke Valley Rape Crisis** Roanoke Rapids, NC 27870 Hotline Phone: 252-535-5946 **My Sister's House** Rocky Mount, NC 27804 Hotline Phone: 252-459-3094 **Haven in Lee County** Sanford, NC 27331 Hotline Phone: 919-774-8923 **Abuse Prevention Council of Cleveland County, Inc.** Shelby, NC 28151 Hotline Phone: 704-481-0043 **Harbor, Inc** Smithfield, NC 27577 Hotline Phone: 919-934-6161 **DANA** Sparta, NC 28675 Hotline Phone: 336-372-3262 **Mirchell County Safe Place** Spruce Pine, NC 28777 Hotline Phone: 828-385-1716 **Hope Harbor Home, Inc.** Supply, NC 28462

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 910-754-5856 **Reach of Jackson County** Sylva, NC 28779 Hotline Phone: 828-586-1911 **Crisis Council** Troy, NC 27371 Hotline Phone: 910-572-3747 **Anson County Domestic Violence & Sexual Assault Coalition** Wadesboro, NC 28170 Hotline Phone: 704-690-0362 **Sarah's Refuge, Inc.** Warsaw, NC 28393 Hotline Phone: 910-293-3206 **Options to Domestic Violence & Sexual Assault, Inc.** Washington, NC 27889 Hotline Phone: 877-723-8390 **REACH of Haywood County** Waynesville, NC 28786 Hotline Phone: 828-456-7898 **Help, Incorporated: Center Against Violence** Wentworth, NC 27375 Hotline Phone: 336-342-3331 **Families First, Inc.** Whiteville, NC 28472 Hotline Phone: 910-641-0444 **SAFE, Inc.** Wilkesboro, NC 28697 Hotline Phone: 336-667-7656 **Rape Crisis Center of Coastal Horizons Center, Inc.** Wilmington, NC 28412 Hotline Phone: 910-392-7460

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Family Services, Inc. Winston Salem, NC 27106 Hotline Phone: 336-722-5153
North Dakota**	North Dakota Council on Abused Women's Services/CASAND Bismarck, ND 701-255-6240	**Mercer County Women's Action & Resource Center** Beulah, ND 58523 Hotline Phone: 701-873-2274 **Mercer County Women's Action & Resource Center** Beulah, ND 58523 Hotline Phone: 701-748-2274 **Abused Adult Resource Center** Bismarck, ND 58502 Hotline Phone: 701-222-8370 **Safe Alternatives for Abused Families** Devils Lake, ND 58301 Hotline Phone: 701-662-5050 **Domestic Violence & Rape Crisis Center** Dickinson , ND 58602 Hotline Phone: 701-225-4506 **Kedish House** Ellendale, ND 58436 Hotline Phone: 701-349-5118 **Rape & Abuse Crisis Center of Fargo ND & Moorhead MN** Fargo, ND 58108 Hotline Phone: 701-293-7273 **Spirit Lake Victim Assistance Program** Fort Totten, ND 58335 Hotline Phone: 701-766-1816 **Spirit Lake Victim Assistance Program** Fort Totten, ND 58335 Hotline Phone: 701-351-5033 **Tri-County Crisis Intervention**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Grafton, ND 58237 Hotline Phone: 701-352-3059 **Community Violence Intervention Center** Grand Forks, ND 58201 Hotline Phone: 866-746-8900 **SAFE Shelter** Jamestown, ND 58402 Hotline Phone: 888-353-7233 **Abuse Resource Network** Lisbon, ND 58054 Hotline Phone: 701-683-5241 **Domestic Violence Crisis Center, Inc.** Minot, ND 58702 Hotline Phone: 701-857-2500 **Domestic Violence Program NW ND** Stanley, ND 58784 Hotline Phone: 701-628-3233 **Abused Persons Outreach Center, Inc.** Valley City, ND 58072 Hotline Phone: 701-845-0072 **Three Rivers Crisis Center** Wahpeton, ND 58075 Hotline Phone: 701-642-2115 **McLean Family Resource Center** Washburn, ND 58577 Hotline Phone: 701-462-8643 **Family Crisis Shelter** Williston, ND 58801 Hotline Phone: 701-572-9111
Ohio**	Ohio Coalition on Sexual Assault Columbus, OH 614-268-3322	**Rape Crisis Center of Medina and Summit Counties** Akron, OH 44303 Hotline Phone: 1-877-906-7273 **Rape Crisis Service of Ashland County**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Ashland, OH 44805 Hotline Phone: 419-289-8085 **Homesafe Rape Crisis Center** Ashtabula, OH 44004 Hotline Phone: 440-998-2100 **Careline Survivor Advocacy** Athens, OH 45701 Hotline Phone: 740-593-3344 **YWCA Sexual Assault Program** Batavia, OH 45103 Hotline Phone: 513-753-7281 **SAAFE Program** Bowling Green, OH 43402 Hotline Phone: 419-352-1545 **American Red Cross Rape Crisis Center** Canton, OH 44709 Hotline Phone: 330-452-1111 **Rape Crisis and Abuse Center** Cincinnati, OH 45202 Hotline Phone: 513-872-9259 **Cleveland Rape Crisis Center** Cleveland, OH 44113 Hotline Phone: 216-619-6192 **Sexual Assault Response Network of Central Ohio** Columbus, OH 43212 Hotline Phone: 614-267-7020 **Women And Family Services Inc.** Defiance , OH 43512 Hotline Phone: 419-592-3577 **HelpLine of Delaware and Morrow Counties, Inc.** Delaware, OH 43015 Hotline Phone: 740-369-3316 **HelpLine of Delaware and Morrow Counties, Inc.** Delaware, OH 43015

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 419-947-2520 **Open Arms Domestic Violence Shelter** Findlay, OH 45839 Hotline Phone: 419-422-4766 **Community Assault Prevention Services** Jackson , OH 45640 Hotline Phone: 740-286-6611 **Townhall II** Kent, OH 44240 Hotline Phone: 330-678-4357 **Abuse & Rape Crisis Shelter of Warren County** Lebanon, OH 45036 Hotline Phone: 513-695-2292 **Crime Victims Services** Lima, OH 45801 Hotline Phone: 419-222-8666 **Christina House** Lisbon, OH 44432 Hotline Phone: 330-420-0036 **Lorain County Rape Crisis Center WG Nord** Lorain, OH 44053 Hotline Phone: 440-233-5747 **Sexual Assault Intervention Network/EVE, Inc.** Marietta , OH 45750 Hotline Phone: 740-374-3111 **Medina County Rape Crisis Center** Medina, OH 44256 Hotline Phone: 888-334-4064 **New Directions** Mt. Vernon, OH 43050 Hotline Phone: 740-397-4357 **Compass, Inc.** New Philadelphia, OH 44663

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 330-339-1427 **Rape Crisis Program of Community Counseling & Crisis Center** Oxford, OH 45056 Hotline Phone: 513-523-4146 **Project Woman** Springfield, OH 45505 Hotline Phone: 937-325-3707 **Women's Tri-County Help Center, Inc.** St. Clairsville, OH 43950 Hotline Phone: 740-695-5441 **YWCA Rape Crisis Center** Toledo, OH 43624 Hotline Phone: 419-241-7273 **Rape Crisis Team of Trumbull County** Warren, OH 44482 Hotline Phone: 330-393-1565 **Lake County Victim Assistance Program** Willoughby, OH 44094 Hotline Phone: 440-953-5823 **Every Woman's House, Inc.** Wooster, OH 44691 Hotline Phone: 330-263-1020 **Rape Information and Counseling Program of Family Service Agency** Youngstown, OH 44502 Hotline Phone: 330-782-3936 **Crime Victim Services** Ottawa, OH 45875 Hotline Phone: 419-523-1111
Oklahoma**	Oklahoma Coalition Against Domestic Violence and Sexual Assault Oklahoma City, OK 405-848-1815	**Family Crisis Center** Ada, OK 74820 Hotline Phone: 580-436-3504 **ACMI House**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Altus , OK 73521 Hotline Phone: 580-482-3800 **Family Shelter of Southern Oklahoma for Victims of Domestic Violence, Inc.** Ardmore, OK 73402 Hotline Phone: 580-226-6424 **Family Crisis & Counseling Center** Bartlesville, OK 74006 Hotline Phone: 918-336-1188 **Women's Service & Family Resource Center** Chickasha, OK 73023 Hotline Phone: 405-222-1818 **Rogers County Community Services Center, Inc.** Claremore, OK 74018 Hotline Phone: 918-341-9400 **Women's Haven** Duncan, OK 73534 Hotline Phone: 580-252-4357 **Crisis Control Center** Durant, OK 74702 Hotline Phone: 580-924-3030 **YWCA Crisis Center** Enid, OK 73701 Hotline Phone: 580-234-7644 **SOS for Families** Idabel, OK 74745 Hotline Phone: 580-286-3369 **New Directions, Inc.** Lawton, OK 73502 Hotline Phone: 580-357-2500 **Community Crisis Center** Miami, OK 74354 Hotline Phone: 918-542-1001

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		WISH Muskogee, OK 74402 Hotline Phone: 918-682-7878 **Women's Resource Center** Norman, OK 73070 Hotline Phone: 405-701-5540 **YWCA Crisis Intervention Services** Oklahoma City, OK 73112 Hotline Phone: 405-943-7273 **Okmulgee Safehouse** Okmulgee, OK 74447 Hotline Phone: 918-756-2545 **Domestic Violence Program Of North Central Oklahoma** Ponca City, OK 74602 Hotline Phone: 580-762-2873 **Women's Crisis Center of LeFlore County** Poteau, OK 74953 Hotline Phone: 918-647-9800 **Family Resource Center** Seminole, OK 74868 Hotline Phone: 800-373-5608 **Project Safe** Shawnee, OK 74801 Hotline Phone: 405-273-9953 **Kibois Women's Shelter** Stigler, OK 74462 Hotline Phone: 918-967-3277 **Stillwater Domestic Violence Services** Stillwater, OK 74074 Hotline Phone: 405-624-3020 **Help in Crisis** Tahlequah, OK 74465 Hotline Phone: 918-456-4357

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Call Rape, Inc Tulsa, OK 74114 Hotline Phone: 918-744-7273 **Northwest Domestic Crisis Services, Inc.** Woodward, OK 73801 Hotline Phone: 580-256-8712
Oregon	Oregon Coalition Against Domestic and Sexual Violence Salem, OR 503-365-9644	**Clatsop County Women's Resource Center Safe Home Network** Astoria, OR 97103 Hotline Phone: 503-325-5735 **May Day, Inc. Safe Home Network** Baker City, OR 97814 Hotline Phone: 541-523-4134 **Central Oregon Battering & Rape Alliance** Bend, OR 97701 Hotline Phone: 541-389-7021 **HHOPE** Burn, OR 97720 Hotline Phone: 541-573-7176 **New Beginnings Intervention Center** Christmas Valley, OR 97641 Hotline Phone: 541-576-3051 **New Beginnings Intervention Center** Christmas Valley, OR 97641 Hotline Phone: 541-410-7036 **Center Against Rape & Domestic Violence** Corvallis, OR 97339 Hotline Phone: 541-754-0110 **Sable House** Dallas, OR 97338 Hotline Phone: 503-623-4033 **Sexual Assault Support Service** Eugene, OR 97401

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 541-343-7277 **Siuslaw Area Women's Center** Florence, OR 97439 Hotline Phone: 541-997-4444 **Women's Crisis Support Team** Grants Pass, OR 97526 Hotline Phone: 541-479-9349 **Helping Hands Against Violence, Inc.** Hood River, OR 97031 Hotline Phone: 541-386-6603 **Shelter From the Storm** La Grande, OR 97850 Hotline Phone: 541-963-9261 **Lake County Crisis Center** Lakeview, OR 97630 Hotline Phone: 541-947-2449 **Sexual Assault Victim Services** Medford, OR 97504 Hotline Phone: 541-779-4357 **Clackamas Women's Services** Milwaukie, OR 97269 Hotline Phone: 503-654-2288 **My Sister's Place** Newport, OR 97365 Hotline Phone: 800-841-8325 **Coos County Women's Crisis Service** North Bend, OR 97459 Hotline Phone: 800-793-5612 **Domestic Violence Eliminated (Project DOVE)** Ontario, OR 97914 Hotline Phone: 541-889-2000 **Domestic Violence Services** Pendleton, OR 97801

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 541-278-0241 **Sexual Assault Resource Center** Portland, OR 97225 Hotline Phone: 503-640-5311 **Portland Women's Crisis Line** Portland, OR 97242 Hotline Phone: 503-235-5333 **Battered Persons' Advocacy** Roseburg, OR 97470 Hotline Phone: 541-673-7867 **Tillamook County Women's Resource Center** Tillamook, OR 97141 Hotline Phone: 503-842-9486
Pennsylvania**	Pennsylvania Coalition Against Rape (PCAR) Enola, PA 717-728-9740	**Crime Victims' Council of the Lehigh Valley** Allentown, PA 18101 Hotline Phone: 610-437-6611 **Family Services of Blair County** Altoona, PA 16601 Hotline Phone: 814-944-3585 **Women's Center of Beaver County** Beaver, PA 15009 Hotline Phone: 724-775-0131 **Women's Center** Bloomsburg, PA 17815 Hotline Phone: 570-784-6631 **YWCA -- Victims' Resource Center** Bradford, PA 16701 Hotline Phone: 814-368-6325 **Sexual Assault/Rape Crisis Services of Cumberland County** Carlisle, PA 17013 Hotline Phone: 717-258-4324 **Women in Need, Inc.** Chambersburg, PA 17201

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 717-264-4444 **A Way Out** Coudersport, PA 16915 Hotline Phone: 814-274-0240 **Victim Outreach Intervention Center** Evans City, PA 16033 Hotline Phone: 724-776-5910 **Victims' Resource Center** Franklin, PA 16323 Hotline Phone: 814-432-5960 **Survivors, Inc.** Gettysburg, PA 17325 Hotline Phone: 717-334-9777 **Blackburn Center Against Domestic & Sexual Violence** Greensburg, PA 15601 Hotline Phone: 724-836-1122 **YWCA Rape Crisis Services** Harrisburg, PA 17103 Hotline Phone: 717-238-7273 **Victims Intervention Program** Honesdale, PA 18431 Hotline Phone: 570-253-4401 **Network of Victim Assistance** Jamison, PA 18929 Hotline Phone: 800-675-6900 **Victim Services, Inc.** Johnstown, PA 15905 Hotline Phone: 814-288-4961 **Helping All Victims in Need** Kittanning, PA 16201 Hotline Phone: 724-548-8888 **Sexual Assault Prevention and Counseling Center**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Lancaster, PA 17602 Hotline Phone: 717-392-7273 **Sullivan County Victim Services** Laporte, PA 18626 Hotline Phone: 570-946-4215 **Lebanon Rape Crisis Center** Lebanon, PA 17042 Hotline Phone: 717-272-5308 **Susquehanna Valley Women in Transition** Lewisburg, PA 17837 Hotline Phone: 570-523-6482 Business Phone: 570-523-1134 **The Abuse Network, Inc.** Lewistown, PA 17044 Hotline Phone: 717-242-2444 **Clinton County Women's Center** Lock Haven, PA 17745 Hotline Phone: 570-748-9509 **Women's Services, Inc.** Meadville, PA 16335 Hotline Phone: 814-333-9766 **AW/ARE, Inc.** Mercer, PA 16137 Hotline Phone: 724-981-1457 **Survivors' Resources, Inc.** Milford, PA 18337 Hotline Phone: 570-296-4357 **Women's Shelter/Rape Crisis Center of Lawrence County** New Castle, PA 16101 Hotline Phone: 724-652-9036 Special Services: Disabled, Elderly, Family, GLBT, **Victim Services Center of Montgomery County, Inc.** Norristown, PA 19401 Hotline Phone: 888-521-0983

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Women Organized Against Rape Philadelphia, PA 19107 Hotline Phone: 215-985-3333 **Pittsburgh Action Against Rape** Pittsburgh, PA 15203 Hotline Phone: 866-END-RAPE **Allegheny County Center for Victims of Violent Crime** Pittsburgh, PA 15219 Hotline Phone: 412-392-8582 **Berks Women in Crisis** Reading, PA 19601 Hotline Phone: 610-372-9540 **CAPSEA, Inc.** Ridgway, PA 15853 Hotline Phone: 814-772-1227 **Women's Resource Center** Scranton, PA 18501 Hotline Phone: 570-346-4671 **Women's Resources of Monroe County, Inc.** Stroudsburg, PA 18327 Hotline Phone: 570-421-4200 **The C.A.R.E. Center STTARS Program** Washington, PA 15301 Hotline Phone: 724-229-5007 **HAVEN of Tioga County** Wellsboro, PA 16901 Hotline Phone: 570-724-3554 **Crime Victims Center of Chester County, Inc.** West Chester, PA 19382 Hotline Phone: 610-692-7273 **Victims Resource Center** Wilkes-Barre, PA 18701

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 570-823-0765 **YWCA -- Wise Options** Williamsport, PA 17701 Hotline Phone: 570-323-8167 **Victim Assistance Center** York, PA 17405 Hotline Phone: 717-854-3131 **Crime Victim Center of Erie County, Inc.** Erie , PA 16501 Hotline Phone: 814-455-9414 **Centre County Women's Resource Center** State College, PA 16801 Hotline Phone: 814-234-5050
Rhode Island**	Sexual Assault & Trauma Resource Center of Rhode Island Providence, RI 401-421-4100	**Sexual Assault & Trauma Resource Center** Providence, RI 02903 Hotline Phone: 401-723-3057
South Carolina**	South Carolina Coalition Against Domestic Violence & Sexual Assault Columbia, SC 803-256-2900	**Aiken Coalition to Assist Abused Persons** Aiken, SC 29802 Hotline Phone: 803-649-0480 **Foothills Rape Crisis Center** Anderson, SC 29621 Hotline Phone: 864-231-7273 **Barnwell County Help Line** Barnwell, SC 29812 Hotline Phone: 803-259-3333 **Hope Cottage, Inc.** Beaufort, SC 29901 Hotline Phone: 843-524-2256 **Kershaw County Sexual Assault Center** Camden, SC 29020 Hotline Phone: 803-425-4357 **Sexual Trauma Services of the Midlands** Columbia, SC 29205

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 803-771-7273 **Pee Dee Coalition Against Domestic & Sexual Assault** Florence, SC 29503 Hotline Phone: 843-669-4600 **Greenville Rape Crisis & Child Abuse Center** Greenville, SC 29611 Hotline Phone: 864-467-3633 **Sexual Trauma & Counseling Center** Greenwood , SC 29648 Hotline Phone: 864-227-1623 **Palmetto Citizens Against Sexual Assault** Lancaster , SC 29720 Hotline Phone: 803-286-5232 **Grand Strand Community Against Rape** Myrtle Beach, SC 29578 Hotline Phone: 843-448-7273 **People Against Rape** North Charleston, SC 29406 Hotline Phone: 843-745-0144 **CASA/Family Services** Orangeburg, SC 29116 Hotline Phone: 803-531-6211 **Rape Crisis Council** Pickens, SC 29671 Hotline Phone: 864-898-5575 **Sexual Assault Resource Center** Rock Hill , SC 29731 Hotline Phone: 803-327-7558 **Safe Homes** Spartanburg, SC 29306 Hotline Phone: 864-583-9803 **YWCA of the Upper Lowlands** Sumter, SC 29150

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 803-773-4357
South Dakota	South Dakota Coalition Against Domestic Violence & Sexual Assault Pierre, SD 605-945-0869	**Safe Harbor** Aberdeen, SD 57401 Hotline Phone: 888-290-2935 **Northern Hills Crisis Outreach** Belle Fourche, SD 57717 Hotline Phone: 866-874-9512 **Brookings Domestic Abuse Shelter** Brookings, SD 57006 Hotline Phone: 605-692-7233 **WEAVE** Custer, SD 57730 Hotline Phone: 605-673-4357 **Sacred Heart Women's Shelter** Eagle Butte, SD 57625 Hotline Phone: 605-964-7233 **Wiconi Wawokiya, Inc.** Ft. Thompson, SD 57339 Hotline Phone: 800-723-3039 **CAVA (Communities Against Violence & Abuse, Inc.)** Lemmon, SD 57638 Hotline Phone: 605-244-7233 **Bridges Against Domestic Violence** Mobridge, SD 57601 Hotline Phone: 605-845-2110 **Cangleska Inc.** Pine Ridge, SD 57770 Hotline Phone: 605-867-5111 **Cangleska Inc.** Pine Ridge, SD 57770 Hotline Phone: 605-455-2311 **Working Against Violence, Inc.** Rapid City, SD 57701

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 605-341-2046 **Rape & Domestic Abuse Center** Sioux Falls, SD 57103 Hotline Phone: 605-339-0116 **Artemis House** Spearfish, SD 57783 Hotline Phone: 605-642-7825 **Crisis Intervention Services** Sturgis, SD 57785 Hotline Phone: 605-347-0050 **Vermillion Coalition Against Domestic Violence** Vermillion, SD 57069 Hotline Phone: 605-624-5311
Tennessee	Tennessee Coalition Against Domestic and Sexual Violence Nashville, TN 615-386-9406	**The Hope Center, Inc.** Athens, TN 37371 Hotline Phone: 423-745-5289 **Sexual Assault Crisis & Resource Center of the Partnership for Families, Children and Adults** Chattanooga, TN 37403 Hotline Phone: 423-755-2700 **Rape & Sexual Abuse Center** Clarksville, TN 37041 Hotline Phone: 615-256-8526 **Family Resource Agency** Cleveland, TN 37311 Hotline Phone: 423-476-3886 **Genesis House, Inc.** Cookeville, TN 38503 Hotline Phone: 800-707-5197 **Avalon Center: DV and Sexual Assault Program** Crossville, TN 38557 Hotline Phone: 931-484-4642 **Women's Resource & Rape Assistance Program**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Jackson, TN 38305 Hotline Phone: 731-668-0411 **Sexual Assault Response Center** Johnson City, TN 37601 Hotline Phone: 423-928-4710 **Sexual Assault Crisis Center** Knoxville, TN 37939 Hotline Phone: 865-522-7273 **Memphis Sexual Assault Resource Center** Memphis, TN 38112 Hotline Phone: 901-272-2020 **CEASE, Inc.** Morristown, TN 37815 Hotline Phone: 423-581-2220 **Rape Recovery and Prevention Center** Murfreesboro, TN 37129 Hotline Phone: 615-494-9262 **Domestic Violence Program, Inc.** Murfreesboro, TN 37133 Hotline Phone: 615-896-2012 **Rape & Sexual Abuse Center** Nashville, TN 37210 Hotline Phone: 615-256-8526
Texas	Texas Association Against Sexual Assault Austin, TX 512-474-7190	**Crime Victim Crisis Center** Abilene, TX 79604 Hotline Phone: 325-677-7895 **Family Crisis Center of Big Bend** Alpine, TX 79831 Hotline Phone: 432-837-2242 **Family Support Services** Amarillo, TX 79101 Hotline Phone: 806-374-5433

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Women's Center of Brazoria County, Inc. Angleton, TX 77516 Hotline Phone: 979-849-5166 **SafePlace** Austin, TX 78760 Hotline Phone: 512-267-7233 **Family Crisis Center** Bastrop, TX 78602 Hotline Phone: 512-303-7755 **Matagorda County Women's Crisis Center** Bay City , TX 77404 Hotline Phone: 979-245-9299 **New Horizons Family Center** Baytown, TX 77520 Hotline Phone: 281-422-2292 **Rape & Suicide Crisis of Southeast Texas** Beaumont , TX 77704 Hotline Phone: 409-835-3355 **Friends for Hope, Inc.** Big Lake, TX 76932 Hotline Phone: 325-884-9804 **Victim Services of Big Spring, Texas** Big Spring, TX 79721 Hotline Phone: 432-263-3312 **Fannin County Family Crisis Center** Bonham, TX 75418 Hotline Phone: 903-583-7000 **Hutchinson County Crisis Center, Inc.** Borger, TX 79007 Hotline Phone: 806-273-2313 **The Haven Family Shelter of McCulloch County** Brady, TX 76825 Hotline Phone: 325-597-7644

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Friendship of Women, Inc. Brownsville, TX 78523 Hotline Phone: 956-544-7412 **Brazos County Rape Crisis Center** Bryan, TX 77805 Hotline Phone: 979-731-1000 **Wintergarden Women's Shelter, Inc.** Carizzo Springs, TX 78834 Hotline Phone: 830-876-9441 **Johnson County Family Crisis Center** Cleburne, TX 76033 Hotline Phone: 817-641-2332 **Women's Shelter of the Corpus Christi Area** Corpus Christi, TX 78463 Hotline Phone: 361-881-8888 **Victim's Outreach** Dallas, TX 75205 Hotline Phone: 214-358-5693 **Dallas County Rape Crisis Center** Dallas, TX 75235 Hotline Phone: 214-590-0430 **Amistad Family Violence & Rape Crisis Center** Del Rio, TX 78841 Hotline Phone: 888-774-2744 **Denton County Friends of the Family** Denton, TX 76202 Hotline Phone: 940-382-7273 **Safe Place, Inc.** Dumas, TX 79029 Hotline Phone: 806-935-2828 **Eastland County Crisis Center, Inc.** Eastland, TX 76448 Hotline Phone: 254-629-3223

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		S.T.A.R.S. El Paso, TX 79902 Hotline Phone: 915-779-1800 **Rape Crisis Program** Fort Worth, TX 76110 Hotline Phone: 817-927-2737 **Cooke County Friends of the Family, Inc.** Gainesville, TX 76241 Hotline Phone: 940-665-2873 **Women's Resource and Crisis Center** Galveston, TX 77553 Hotline Phone: 409-765-7233 **Brighter Tomorrows, Inc.** Grand Prairie, TX 75053 Hotline Phone: 972-262-8383 **Rape Crisis Center of Northeast Texas** Greenville, TX 75404 Hotline Phone: 903-454-9999 **Family Crisis Center, Inc.** Harlingen, TX 78550 Hotline Phone: 956-423-9304 **Women & Children's Crisis Center** Hereford, TX 79045 Hotline Phone: 806-363-6727 **Houston Area Women's Center** Houston, TX 77019 Hotline Phone: 713-528-7273 **Family Time** Humble, TX 77347 Hotline Phone: 281-446-2615 **Walker County Family Violence Council** Huntsville, TX 77340 Hotline Phone: 936-291-3369

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Cherokee County Crisis Center of Anderson & Cherokee Counties Jacksonville, TX 75766 Hotline Phone: 903-586-9118 **Hill Country Crisis Council** Kerrville, TX 78029 Hotline Phone: 830-257-2400 **Families in Crisis, Inc./ Rape Crisis** Kileen, TX 76540 Hotline Phone: 254-634-8309 **Kilgore Community Crisis Center** Kilgore, TX 75662 Hotline Phone: 903-984-2377 **Hardin County Crime Victims' Assistance Center** Kountze, TX 77625 Hotline Phone: 409-246-4300 **Serving Children and Adolescents in Need, Inc.** Laredo, TX 78042 Hotline Phone: 956-724-3177 **Women's Center of East Texas** Longview, TX 75606 Hotline Phone: 903-295-7526 **Lubbock Rape Crisis Center, Inc.** Lubbock, TX 79457 Hotline Phone: 806-763-7273 **Family Crisis Center** Marble Falls, TX 78654 Hotline Phone: 830-693-5600 **Women Together/Mujeres Unidas** McAllen, TX 78501 Hotline Phone: 956-630-4881 **Midland Rape Crisis Center** Midland, TX 79702 Hotline Phone: 432-682-7273

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Shelter Agencies for Families in East Texas, Inc. Mt. Pleasant, TX 75455 Hotline Phone: 903-575-9999 **Women's Shelter of East Texas, Inc.** Nacogdoches, TX 75964 Hotline Phone: 936-569-1018 **Crisis Center of Comal & Guadalupe Counties** New Braunfels, TX 78131 Hotline Phone: 800-434-8013 **Center for Crisis Advocacy** Odessa, TX 79760 Hotline Phone: 432-339-2747 **Tralee Crisis Center** Pampa, TX 79065 Hotline Phone: 806-669-1788 **Family Haven Sexual Assault Services** Paris , TX 75461 Hotline Phone: 903-784-6842 **Bridge Over Troubled Waters** Pasadena, TX 77501 Hotline Phone: 713-473-2801 **Panhandle Crisis Center** Perryton, TX 79070 Hotline Phone: 806-435-5008 **Hale County Crisis Center** Plainview, TX 79073 Hotline Phone: 806-293-7273 **Turning Point** Plano, TX 75086 Hotline Phone: 972-985-0951 **Atascosa Family Crisis Center** Pleasanton, TX 78064 Hotline Phone: 830-569-2001

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		The Harbor Port Lavaca, TX 77982 Hotline Phone: 361-552-4357 **Fort Bend County Women's Center** Richmond, TX 77469 Hotline Phone: 281-342-4357 **Williamson County Crisis Center** Round Rock, TX 78664 Hotline Phone: 800-460-7233 **Concho Valley Rape Crisis Center, Inc.** San Angelo, TX 76903 Hotline Phone: 325-658-8888 **Rape Crisis Center** San Antonio, TX 78227 Hotline Phone: 210-349-7273 **Hays Caldwell Women's Center** San Marcos, TX 78667 Hotline Phone: 512-396-4357 **Cross Timbers Family Services** Stephenville, TX 76401 Hotline Phone: 254-965-4357 **Domestic Violence Prevention** Texarkana, TX 75504 Hotline Phone: 903-793-4357 **Montgomery County Women's Center** The Woodlands, TX 77387 Hotline Phone: 936-441-7273 **East Texas Crisis Center** Tyler, TX 75711 Hotline Phone: 903-595-5591 **Hope of South Texas** Victoria , TX 77901 Hotline Phone: 361-573-3600

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Advocacy Center for Crime Victims & Children Waco, TX 76701 Hotline Phone: 254-752-7233 **Freedom House** Weatherford, TX 76086 Hotline Phone: 817-596-8922 **Bay Area Turning Point** Webster, TX 77598 Hotline Phone: 281-286-2525 **First Step** Wichita Falls, TX 76310 Hotline Phone: 940-692-1993
Utah	Utah Coalition Against Sexual Assault Salt Lake City, UT 801-322-1500	**YWCA of Box Elder County** Brigham City, UT 84302 Hotline Phone: 435-723-5600 **Canyon Creek Women's Crisis Center** Cedar City, UT 84721 Hotline Phone: 435-867-6149 **Safe Harbor Crisis Center** Kaysville, UT 84037 Hotline Phone: 801-444-9161 **Community Abuse Prevention Services Agency** Logan, UT 84321 Hotline Phone: 435-753-2500 **Seekhaven Family Resource Center** Moab, UT 84532 Hotline Phone: 435-259-2229 **YCC Rape Recovery Center** Ogden, UT 84401 Hotline Phone: 801-392-7273 **Victim Assistance Program** Park City, UT 84098 Hotline Phone: 435-615-3850

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Center for Women & Children in Crisis, Inc. Provo, UT 84603 Hotline Phone: 801-377-5500 **New Horizons Crisis Center** Richfield, UT 84701 Hotline Phone: 435-896-9294 **Rape Recovery Center** Salt Lake City, UT 84105 Hotline Phone: 801-467-7273 **D.O.V.E Center** St. George, UT 84771 Hotline Phone: 435-628-0458 **Vernal Victim Advocacy Program** Vernal, UT 84078 Hotline Phone: 435-789-4222
Vermont**	Vermont Network Against Domestic Violence and Sexual Assault Montpelier, VT 802-223-1302	**Sexual Assault Crisis Team** Barre, VT 05641 Hotline Phone: 802-479-5577 **Project Against Violent Encounters** Bennington, VT 05201 Hotline Phone: 802-442-2111 **Women's Rape Crisis Center** Burlington, VT 05402 Hotline Phone: 802-863-1236 **AWARE** Hardwick, VT 05843 Hotline Phone: 802-472-6463 **WomenSafe** Middlebury , VT 05753 Hotline Phone: 802-388-4205 **Clarina Howard Nichols Center** Morrisville, VT 05661 Hotline Phone: 802-888-5256 **Safeline, Inc.**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Randolph, VT 05060 Hotline Phone: 800-NEW-SAFE **New Beginnings, Inc.** Springfield, VT 05156 Hotline Phone: 802-885-2050 **Voices Against Violence** St. Albans, VT 05478 Hotline Phone: 802-524-6575 **Umbrella** St. Johnsbury, VT 05819 Hotline Phone: 802-748-8645
Virginia	Virginians Aligned Against Sexual Assault Charlottesville, VA 804-979-9002	**Doves, Inc.** Danville, VA 24541 Hotline Phone: 888-403-6837 **Victim Assistance Network** Fairfax, VA 22306 Hotline Phone: 703-360-7273 **Piedmont Crisis Center** Farmville, VA 23901 Hotline Phone: 434-292-1076 **Rappahannock Council Against Sexual Assault** Fredericksburg, VA 22402 Hotline Phone: 540-371-1666 **Sexual Assault Crisis Center** Gloucester, VA 23061 Hotline Phone: 804-694-5890 **Response Peninsula** Hampton, VA 23666 Hotline Phone: 757-825-2591 **Citizens Against Sexual Assault (CASA)** Harrisonburg, VA 22801 Hotline Phone: 540-434-2272 **The James House** Hopewell, VA 23860 Hotline Phone: 804-458-2840

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		People Incorporated of Southwest Virginia Lebanon, VA 24266 Hotline Phone: 877-697-9444 **People Incorporated of Southwest Virginia** Lebanon, VA 24266 Hotline Phone: 276-935-6295 **LAWS Sexual Assault Services** Leesburg, VA 20176 Hotline Phone: 703-777-6552 **Project Horizon** Lexington, VA 24450 Hotline Phone: 540-463-2594 **Choices** Luray, VA 22835 Hotline Phone: 540-743-4414 **Sexual Assault Response Program** Lynchburg, VA 24503 Hotline Phone: 434-947-7273 **Citizens Against Family Violence, Inc.** Martinsville, VA 24114 Hotline Phone: 276-632-8701 **Response Sexual Assault Support Services of the YWCA** Norfolk, VA 23508 Hotline Phone: 757-622-4300 **FCSS, Inc.** Norton, VA 24273 Hotline Phone: 276-926-4816 **Women's Resource Center of the New River Valley** Radford, VA 24141 Hotline Phone: 540-639-1123 **YWCA of Richmond** Richmond, VA 23219 Hotline Phone: 804-643-0888

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		SARA Program Blue Ridge Behavioral Healthcare Roanoke, VA 24016 Hotline Phone: 540-981-9352 **New Directions** Staunton, VA 24402 Hotline Phone: 540-886-6800 **The Haven Shelter & Services, Inc.** Warsaw, VA 22572 Hotline Phone: 804-333-5321 **Avalon: A Center for Women and Children** Williamsburg, VA 23187 Hotline Phone: 757-258-5051 **The Shelter for Abused Women** Winchester, VA 22604 Hotline Phone: 540-667-6466 **SAVAS (Sexual Assault Victims' Advocacy Services)** Woodbridge, VA 22194 Hotline Phone: 703-368-4141 **Response** Woodstock, VA 22664 Hotline Phone: 540-459-5161 **SARA (Sexual Assault Response and Awareness)** Alexandria, VA 22314 Hotline Phone: 703-683-7273 **Violence Intervention Program** Arlington, VA 22201 Hotline Phone: 703-228-4848 **Hanover Safe Place** Ashland, VA 23005 Hotline Phone: 804-752-2702 **The Crisis Center** Bristol, VA 24201

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 276-628-7731 **Project Hope at Quin Rivers Agency** Charles City, VA 23030 Hotline Phone: 804-966-2520 **Sexual Assault Resource Agency** Charlottesville, VA 22906 Hotline Phone: 434-977-7273 **Safehome Systems, Inc.** Covington, VA 24426 Hotline Phone: 540-965-3237
Washington**	Washington Coalition of Sexual Assault Programs Olympia, WA 360-754-7583	**Beyond Survival** Aberdeen, WA 98520 Hotline Phone: 360-533-9752 **Domestic Violence and Sexual Assault Services of Whatcom County** Bellingham, WA 98225 Hotline Phone: 360-715-1563 **Human Response Network** Chehalis, WA 98532 Hotline Phone: 360-748-6601 **NEWA Rural Resources Development Assoc. Family Support Center** Colville, WA 99114 Hotline Phone: 509-684-6139 **Family Resource Center of Lincoln County** Davenport, WA 99122 Hotline Phone: 509-725-4357 **DVSA Services of the San Juan Islands** Eastsound, WA 98245 Hotline Phone: 360-376-1234 **ASPEN** Ellensburg, WA 98926 Hotline Phone: 509-925-9384 **Providence Sexual Assault Center**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Everett, WA 98206 Hotline Phone: 425-252-4800 **DVSA Services of the San Juan Islands** Friday Harbor, WA 98250 Hotline Phone: 360-378-2345 **Sexual Assault Response Center** Kennewick, WA 99336 Hotline Phone: 509-374-5391 **New Hope DV & SA Service** Moses Lake, WA 98837 Hotline Phone: 509-764-0215 **Safeplace Rape Relief & Women's Shelter Services** Olympia, WA 98501 Hotline Phone: 360-754-6300 **Domestic Violence/Sexual Assault Program** Port Townsend, WA 98368 Hotline Phone: 360-385-5291 **Alternative to Violence of the Palouse** Pullman, WA 99163 Hotline Phone: 509-332-4357 Business Phone: 509-332-0552 **King County Sexual Assault Resource Center** Renton, WA 98057 Hotline Phone: 888-99-VOICE **Mason County Council on Abuse & Neglect** Shelton, WA 98584 Hotline Phone: 360-490-9228 **Sexual Assault & Family Trauma and Response Center (SAFeT)** Spokane, WA 99201 Hotline Phone: 509-624-7273 **Sexual Assault Center of Pierce County** Tacoma, WA 98406 Hotline Phone: 253-474-7273

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		YWCA Clark Co. Sexual Assault Program Vancouver, WA 98663 Hotline Phone: 360-695-0501 **YWCA Domestic Violence/Sexual Assault Center** Walla Walla, WA 99362 Hotline Phone: 509-529-9922 **Phoenix Place** Wentachee, WA 98807 Hotline Phone: 509-663-7446 **Central WA Comprehensive Mental Health** Yakima, WA 98907 Hotline Phone: 509-452-9675
West Virginia**	West Virginia Foundation for Rape Information and Services Fairmont, WV 304-366-9500	**Women's Resource Center** Beckley, WV 25802 Hotline Phone: 304-255-2559 **Family Services of Kanawha Valley** Charleston, WV 25301 Hotline Phone: 304-340-3676 **Women's Aid in Crisis** Elkins, WV 26241 Hotline Phone: 304-636-8433 **HOPE, Inc.** Fairmont, WV 26554 Hotline Phone: 304-367-1100 **CONTACT Rape Crisis Center** Huntington, WV 25728 Hotline Phone: 304-399-1111 **Family Crisis Center** Keyser, WV 26726 Hotline Phone: 304-788-6061 **Family Refuge Center** Lewisburg, WV 24901 Hotline Phone: 304-645-6334

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Shenandoah Women's Center Martinsburg, WV 25401 Hotline Phone: 304-263-8292 **Rape and Domestic Violence Information Center** Morgantown, WV 26505 Hotline Phone: 304-292-5102 **Sexual Assault Help Center** Wheeling, WV 26003 Hotline Phone: 304-234-8519
Wisconsin**	Wisconsin Coalition Against Sexual Assault Madison, WI 608-257-1516	**AVAIL, Inc.** Antigo, WI 54409 Hotline Phone: 715-623-5767 **Sexual Assault Crisis Center** Appleton, WI 54914 Hotline Phone: 920-832-4646 **New Day Shelter** Ashland, WI 54806 Hotline Phone: 715-682-9565 **Hope House** Baraboo, WI 53913 Hotline Phone: 608-356-7500 **People Against a Violent Environment, Inc.** Beaver Dam, WI 53916 Hotline Phone: 920-887-3786 **Sexual Assault Recovery Program of Rock County** Beloit, WI 53511 Hotline Phone: 608-365-1119 **Family Support Center** Chippewa Falls, WI 54729 Hotline Phone: 715-723-1138 **Bolton Refuge House, Inc.** Eau Claire, WI 54702 Hotline Phone: 715-834-0628 **The Association for the Prevention of Family**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Violence Elkhorn, WI 53121 Hotline Phone: 262-723-4653 **ASTOP, Inc.** Fond Du Lac, WI 54935 Hotline Phone: 920-921-7657 **Sexual Assault Center of Door County** Green Bay, WI 54301 Hotline Phone: 920-746-8996 **Family Services Sexual Assault Center** Green Bay, WI 54305 Hotline Phone: 920-436-8899 **Sexual Assault Center of Oconto County** Green Bay, WI 54305 Hotline Phone: 920-846-2111 **Alternatives to Violence Program** Janesville, WI 53546 Hotline Phone: 608-752-2583 **Pathways of Courage** Kenosha, WI 53141 Hotline Phone: 262-657-9900 **Sexual Abuse Counseling & Support Program Gunderson Lutheran Medical Center** La Crosse, WI 54601 Hotline Phone: 608-775-5950 **Time-Out Family Shelter** Ladysmith, WI 54848 Hotline Phone: 715-532-6976 **Rape Crisis Center, Inc.** Madison, WI 53713 Hotline Phone: 608-251-7273 **Personal Development Center** Marshfield, WI 54449 Hotline Phone: 715-384-5555

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Stepping Stones, Inc. Medford, WI 54451 Hotline Phone: 715-748-5140 **Reach Counseling Services** Menasha, WI 54952 Hotline Phone: 920-722-8150 **The Bridge** Menomonie, WI 54751 Hotline Phone: 715-235-9074 **Haven, Inc.** Merrill, WI 54452 Hotline Phone: 715-536-1300 **Community Referral Agency** Milltown, WI 54858 Hotline Phone: 715-825-4404 **Milwaukee Women's Center** Milwaukee, WI 53202 Hotline Phone: 414-671-6140 **Sexual Assault Treatment Center** Milwaukee, WI 53233 Hotline Phone: 414-219-5555 **Family Advocates, Inc.** Platteville, WI 53818 Hotline Phone: 608-348-3838 **Sexual Assault Services of Lutheran Social Services** Racine, WI 53404 Hotline Phone: 262-637-7233 **Tri-County Council on DV& SA** Rhinelander, WI 54501 Hotline Phone: 715-362-6800 **Passages, Inc.** Richland Center, WI 53581 Hotline Phone: 608-647-3616

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Turningpoint River Falls, WI 54022 Hotline Phone: 715-425-6751 **Advocates of Ozaukee** Saukville, WI 53080 Hotline Phone: 262-375-4034 **Center Against Sexual and Domestic Abuse** Superior, WI 54880 Hotline Phone: 715-392-3136 **The Women's Center** Waukesha, WI 53186 Hotline Phone: 262-542-3828 **The Women's Community Inc.- Sexual Assault Victim Service** Wausau, WI 54403 Hotline Phone: 715-842-7323 **Friends of Abused Families, Inc.** West Bend, WI 53095 Hotline Phone: 262-334-7298
Wyoming**	Wyoming Coalition Against Violence & Sexual Assault Laramie, WY 307-755-5481	**Johnson County Family Crisis Center** Buffalo, WY 82834 Hotline Phone: 307-684-2233 **Women's Self Help Center** Casper, WY 82601 Hotline Phone: 307-235-2814 **Safe House/Sexual Assault Services** Cheyenne, WY 82003 Hotline Phone: 307-637-7233 **Crisis Intervention Services (CIS)** Cody , WY 82414 Hotline Phone: 307-527-7801 **Converse County Coalition Against Family Violence**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Douglas, WY 82633 Hotline Phone: 307-358-4800 **Sexual Assault & Family Violence Task Force** Evanston, WY 82930 Hotline Phone: 307-789-7315 **Gillette Abuse Refuge Foundation (GARF)** Gillette, WY 82717 Hotline Phone: 307-686-8070 **Community Safety Network** Jackson, WY 83001 Hotline Phone: 307-733-7233 **Safe Project** Laramie, WY 82070 Hotline Phone: 307-745-3556 **Help Mate** Lusk, WY 82225 Hotline Phone: 307-334-2608 **FOCUS Family Crisis Center** Newcastle, WY 82701 Hotline Phone: 307-746-3630 **Sublette County SAFV Task Force** Pinedale, WY 82941 Hotline Phone: 307-367-6305 **Fremont Alliance** Riverton, WY 82501 Hotline Phone: 307-856-4734 **YWCA Support & Safe House (SASH)** Rock Springs, WY 82902 Hotline Phone: 307-352-1030 **Advocacy & Resource Center** Sheridan, WY 82801 Hotline Phone: 307-672-3222 **Sacred Shield** St. Stephens, WY 82524

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 307-857-3877 **Hope Agency & Crisis Line** Thermopolis, WY 82443 Hotline Phone: 307-864-4673 **Goshen County Task Force on Family Violence & Sexual Assault** Torrington , WY 82240 Hotline Phone: 307-532-2118 **Project Safe** Wheatland, WY 82201 Hotline Phone: 307-322-4794 **Victims of Violence Center** Worland, WY 82401 Hotline Phone: 307-347-4991

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

OJJDP

J. Robert Flores, Administrator

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JUVENILE JUSTICE BULLETIN

Office of Justice Programs • Partnerships for Safer Communities • *www.ojp.usdoj.gov*

Assessing the Mental Health Status of Youth in Juvenile Justice Settings

Gail A. Wasserman, Susan J. Ko, and Larkin S. McReynolds

Youth in the juvenile justice system are at high risk for mental health problems that may have contributed to their criminal behavior and that are likely to interfere with rehabilitation (Loeber et al., 1998; Lynam, 1996). Emotional impairment due to an untreated mental disorder may contribute to an adverse reaction to confinement, which in turn may result in a poor adjustment during incarceration. Poor adjustment can have a negative impact on behavior, discipline, and on a youth's ability to participate in available program components designed to address mental health, emotional, physical, and academic needs. Together, all of these factors may increase the risk for recidivism.

In a review of 34 studies on mental health needs and services in the juvenile justice system, Otto and colleagues (1992) found that rates of mental disorders were substantially higher among youth involved in the justice system than among youth in the general population. They also found that rates of disorder were higher in studies that assessed youth in person than in those that assessed youth by chart review. These authors suggested that existing studies of the prevalence of mental disorders among youth in the juvenile justice system were limited by the use of instruments with inadequate psychometrics, the failure to consider comorbidity (i.e., co-occurring conditions), problems with identifying sample characteristics, and a lack of information regarding when the assessments were conducted. They note that previous studies often did not define the timeframe for symptoms. However, distinguishing between lifetime and current symptoms is important not only for determining the prevalence of disorders but also in planning for immediate service needs.

Although great advances have been made in reliable mental health assessment of children and adolescents (Jensen et al., 1995; Shaffer et al., 1996), assessment practices in juvenile justice settings remain highly variable and generally have not used evidence-based, scientifically sound instruments (Cocozza and Skowyra, 2000; LeBlanc, 1998; Nicol et al., 2000; Towberman, 1992; Wiebush et al., 1995). A common practice has been to rely on a youth's history of using mental health services as an indicator of whether the youth currently needs services. However, research suggests that the juvenile justice system cannot rely on other systems to provide information on the previous use of mental health services for all youth at entry. For example, Novins and colleagues (1999)

A Message From OJJDP

Serious mental health and substance use disorders can interfere with the rehabilitation of youth who come into contact with the juvenile justice system and increase their risk for recidivism. Too often, the needs of these youth have gone unrecognized and untreated because of inadequate screening and assessment.

One obstacle to assessing the mental health needs of youth in the juvenile justice system has been the dearth of reliable, easy-to-use assessment instruments. This Bulletin reports the results of a study of the Voice DISC–IV, a version of the Diagnostic Interview Schedule for Children (DISC) that is self-administered using a computer and headphones. The DISC is an extensively tested child and adolescent diagnostic interview that has been evaluated in clinical and community settings. The self-administered Voice DISC offers several advantages for use within the juvenile justice system—notably, minimal staff support requirements, immediate scoring that generates provisional *DSM–IV* diagnoses, and the assurance of privacy that can enhance the willingness of youth to disclose sensitive personal information.

Based on their findings and those of other researchers, the authors recommend best practices in assessing the mental health of juvenile offenders. This Bulletin provides guidance to juvenile justice professionals seeking to establish guidelines for mental health assessment in juvenile justice facilities.

found that only 34 percent of a sample of juvenile detainees with a documented anxiety, affective (mood), or disruptive behavior disorder had previously received services for those disorders. Similarly, the Policy Design Team (1994) found that approximately 50 percent of the juvenile detainees in Virginia showed mental health problems of moderate severity or higher and that 8.5 percent showed "severe" problems, but that only 15 percent of the detainees who exhibited mental health problems were receiving mental health services while in custody. A study of youth in South Carolina found that despite higher rates of disorder, incarcerated youth were significantly less likely to have received outpatient mental health services previously than were youth enrolled in a community mental health service (Pumariega et al., 1999). Other research suggests that minority youth and youth of low socioeconomic status are less likely to have a history of using mental health services (Pumariega et al., 1998).[1]

This Bulletin reports the results of a study that used a computerized, self-administered version of the Diagnostic Interview Schedule for Children (DISC) to screen for psychiatric disorders in youth newly admitted to juvenile assessment centers in Illinois and New Jersey. The study assessed rates of psychiatric disorders and tested the feasibility of using this assessment instrument among youth in the juvenile justice system.[2] Recommendations are also offered for "best practices" for mental health assessment in juvenile justice settings based on a comparison of the rates of psychiatric disorder identified in this study with those found in other studies in which earlier versions of the DISC were used in juvenile justice settings.

Diagnostic Interview Schedule for Children

The Diagnostic Interview Schedule for Children (DISC) is an extensively tested child and adolescent diagnostic interview that has been evaluated in both clinical and community samples (Shaffer et al., 1996). A family of highly structured psychiatric interviews designed to assess more than 25 different mental disorders in children and adolescents, the DISC incorporates the diagnostic criteria of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition *(DSM–IV)* and third edition revised *(DSM–III–R)*, and of the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems,* 10th revision *(ICD–10)*. The DISC–IV provides a detailed assessment of impairment based on responses to six sets of questions about the effect of symptoms on the youth's relationships with his or her caretakers, family, or peers and at school.[3]

The psychometrics of the DISC have been evaluated extensively in a variety of settings. Five studies of psychiatric disorders in youth in various juvenile justice settings have reported rates based on systematic assessment using the DISC (Atkins, Pumariega, and Rogers, 1999; Duclos et al., 1998; Garland et al., 2001; Randall et al., 1999; and Teplin et al., 2002). Except for the study by Garland and colleagues, all of these investigations were based on earlier, now superseded, versions of the DISC, and none used the recently developed Voice DISC, which is self-administered using a computer and headphones. Several aspects of the Voice DISC make it well suited for use within the juvenile justice system:

- Minimal staff support requirements.
- Immediate scoring, with a printout of provisional *DSM–IV* diagnoses and symptom counts available for followup by a clinician.
- Increased likelihood of disclosure, especially for suicidality and substance use. (The enhanced privacy of the self-administered format contributes to the willingness of youth to disclose sensitive personal information.)

Preliminary data show that the reliability of the Voice DISC is comparable to that of other versions of the DISC (Lucas, 2003).

In contrast to many other assessment instruments, the Voice DISC provides provisional diagnoses for the youth assessed. Because diagnosis drives mental health treatment, having information about a youth's diagnosis is critical. Most evidence-based treatment services have been designed for specific disorders and have been shown to be effective only when they are provided to youth who have those disorders. The Voice DISC generates provisional diagnoses of disorders present in the past month, which makes it especially useful within juvenile justice settings, where prompt identification of youth who need immediate treatment is important.

Study Method

The executive director of the Council of Juvenile Correctional Administrators (CJCA) helped to solicit collaboration from juvenile facilities by announcing the study at the Council's 1998 annual conference. The directors of the Illinois Department of Corrections, Juvenile Division, and the New Jersey Juvenile Justice Commission provided access to the St. Charles Reception Center in Illinois and the New Jersey Training School for Boys. The study provided training, technical assistance, assessment materials, and funding for reimbursement of staff time. Local staff agreed to collect assessments for 100 randomly selected male youth in Illinois and 200 in New Jersey.

Altogether, 320 youth were asked to participate; of these, all but 5 agreed. Twelve assessments were not included for technical and logistical reasons. Seven parents withdrew their child's data. Data were available, then, for 296 youth (94 in Illinois and 202 in New Jersey), reflecting a response rate of more than 92 percent for youth approached in both sites.[4]

For all youth who agreed to participate, the data collector briefly demonstrated the operation of the computer program and made sure the youth was comfortable proceeding independently after the first module, which gathers demographic data. The data collectors remained available at a distance (to ensure privacy) throughout the assessment.

Background information (age, race/ethnicity, school grade, admission date, number of prior offenses, and current offense) was abstracted from reception center files in each location. Because a youth could have more than one current offense, up to four current offenses were provided from justice records for each youth.

Results

The average participant in the study was 17 years old and in the 9th grade (i.e., 2 years behind the expected grade), and more than half (53.7 percent) of the youth were African American (tables 1 and 2). Eighty-eight percent of the youth were assessed within 4 weeks of their admission to the facility, with 40 percent being assessed within 2 weeks of admission. Most of the youth had previous contact with the juvenile justice system; 28 percent had committed one or more substance-related offenses.

Table 1: Demographic and Offense Characteristics of the Study Sample

Characteristic	Mean	SD
Age (years)	17.04	1.39
Current school grade	9.63	1.39
Number of prior convictions	4.7	4.4
Number of days since admission	18.7	12.6

Table 2: Race/Ethnicity of the Study Sample

Race/Ethnicity	Number	Percent
African American	159	53.7
White	81	27.4
Hispanic	49	16.6
Other	7	2.4

Note: Percents do not sum to 100 because of rounding.

The assessment inquired about 20 psychiatric disorders and took an average of 60 minutes to complete. As would be expected, the youth in whom more disorders were diagnosed needed more time to complete the assessment. Unsolicited, five youth commented that they felt safer disclosing information to the computer than to a person.

Table 3 presents the number of youth who met the criteria for each disorder in the preceding month. Because suicidality is of great concern for management in residential programs, information on reported suicidal ideation and attempts is presented in table 4.

Table 3 shows high current rates for many disorders in the sample as a whole. Beyond the expectably high numbers of youth meeting criteria for substance use or conduct disorders, the rates of current mood and anxiety disorders were also high (9.1 percent and 18.9 percent, respectively). In addition, 9.1 percent of the youth reported suicidal ideation in the past month and 2.7 percent reported having attempted to commit suicide during the past month.

To examine the degree to which a Voice DISC–IV diagnosis of a substance use disorder corresponded to a record of substance use offenses, three groups within the sample were examined: youth who met criteria for a substance use disorder only ($n = 68$), those who met criteria for a disorder other than substance use ($n = 53$), and those with no evidence of a disorder ($n = 97$).[5] Sixty-five of these 218 youth were incarcerated for a substance use offense: 28 who had only a substance use disorder, 10 who had a disorder other than substance use, and 27 who had no diagnosed disorder. Of these 65 youth, those with a substance use disorder were significantly more likely to have been incarcerated for a substance-related offense than the youth in either of the other two groups (see the figure on page 4).

Table 3: Prevalence of Psychiatric Disorders Within the Past Month

Disorder	Number of Youth ($N = 296$)	Percent*
None	**97**	**32.8**
Any anxiety disorder†	**56**	**18.9**
Anxiety disorder only	**17**	**5.7**
Agoraphobia	13	4.4
Generalized anxiety	6	2.0
Obsessive-compulsive	13	4.5
Panic	13	4.5
Posttraumatic stress	13	4.5
Social phobia	7	2.4
Specific phobia	25	8.5
Any mood disorder	**27**	**9.1**
Mood disorder only	**1**	**0.3**
Manic episode	6	2.1
Hypomanic episode	2	0.7
Major depressive	21	7.2
Dysthymic‡	2	0.7
Any disruptive disorder	**94**	**31.8**
Disruptive disorder only	**21**	**7.1**
ADHD	6	2.3
Conduct§	89	31.7
Oppositional defiant	8	2.8
Any substance use disorder	**146**	**49.3**
Substance use disorder only	**68**	**23.0**
Alcohol dependence	38	12.9
Alcohol abuse	47	17.0
Marijuana dependence	72	25.7
Marijuana abuse	42	15.0
Other substance dependence	36	12.8
Other substance abuse	11	3.9

Note: Diagnoses are based on *DSM–IV* criteria only.

* The prevalence for some diagnoses is based on a slightly reduced number because some youth did not complete the entire DISC interview (e.g., because they were transferred).
† Separation anxiety disorder either not assessed or not included.
‡ Current DISC and *DSM–IV* criteria necessitate that youth with major depressive disorder do not also receive a diagnosis of dysthymia.
§ Past 6 months.

Discussion

Prevalence of Psychiatric Disorder in Justice System Youth

Arriving at a *DSM* diagnosis requires consideration of the extent of a youth's impairment (i.e., deficits in functioning) across a number of different domains. Because the DISC uses the logic of the *DSM–IV,* it also provides an impairment score. For several reasons, the findings presented in this Bulletin are based on diagnostic criteria only and do not consider the level of impairment.[6]

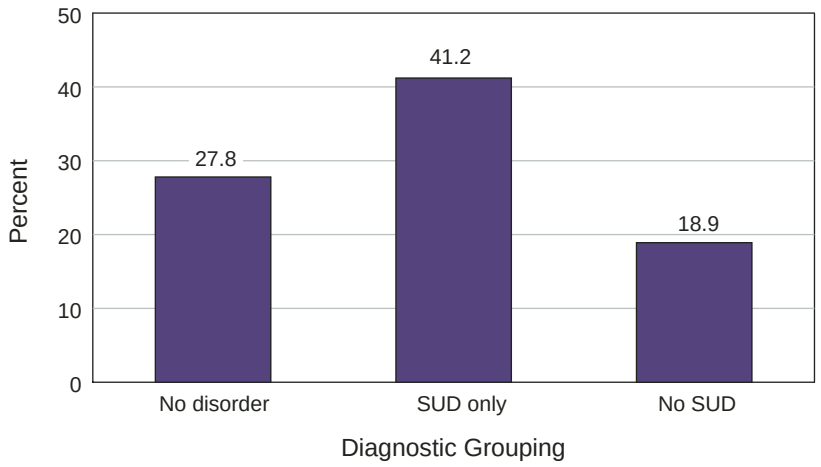
Table 4: Prevalence of Suicide Ideation or Attempt

Suicide Ideation or Attempt	Number of Youth (*N*=296)	Percent*
Ideation (past month)	27	9.1
Attempt		
Past month	8	2.7
Lifetime	35	11.8

Note: Diagnoses are based on *DSM–IV* criteria only.

* The prevalence for some diagnoses is based on a slightly reduced number because some youth did not complete the entire DISC interview (e.g., because they were transferred).

Percent of Youth Incarcerated for a Substance Use Offense Relative to Disorder Status as Diagnosed by the Voice DISC–IV



Note: SUD, substance use disorder.

Although its assessment of disorder criteria is straightforward, the self-administered nature of the Voice DISC relies on a youth's awareness of the social and personal consequences of his or her disorder to determine impairment. Because the social judgment of youth found guilty of delinquent or criminal behavior may be particularly poor, the Voice DISC may substantially underreport the level of impairment in these youth. A clinician considering impairment for the purpose of making a diagnosis should rely on multiple informants and various pieces of information to determine the level of impairment.

Comparison With Other Studies

As shown in table 5, the rates of disorder found in the present study are somewhat lower than those reported by previous studies that used the DISC in juvenile justice populations. However, the earlier studies used earlier versions of the DISC. Consideration of four basic differences in instrumentation and sample characteristics between the present study and the previous investigations puts the differences in the results into context:

- Participants in the present study responded to questions about the month preceding the interview, a period considerably shorter than the 6-month reporting timeframe of most of the earlier studies. In some cases, the rates of disorder found in the present study were correspondingly somewhat lower than those found in the studies that used a longer timeframe (Atkins, Pumariega, and Rogers, 1999; Duclos et al., 1998; Randall et al., 1999; Garland et al., 2001; Teplin et al., 2002).
- The present study evaluated youth who recently had been sent to secure placement (likely after they had spent weeks in juvenile detention). The youth assessed by Teplin and colleagues (2002) were being held in detention—that is, they recently had been in the community, where they had the opportunity to offend. Garland and colleagues (2001) assessed "wards of the court" without regard to whether they were in the community or in custody. By intent, secure placement limits misbehavior. The more structured and controlled the setting, the less opportunity youth have to engage in the behaviors characteristic of conduct and substance use disorders. Therefore, rates for those disorders might be expected to be lower for the youth in the present study than for the youth evaluated in the earlier studies.
- The present study relied exclusively on self-report, whereas Garland and colleagues (2001) pooled diagnostic information received from parents as well as youth, a procedure that results in increased prevalence rates (Bird, Gould, and Staghezza-Jaramillo, 1992). Parental informants are more likely than youth to report symptoms of disruptive behavior disorders such as attention deficit/hyperactivity disorder (ADHD) and conduct disorder (Jensen et al., 1999), and this may account for the variability in the reported rates of disorder across the studies.
- Because many youth entering secure care will recently have been removed from their homes, their endorsement of separation anxiety symptoms may not reflect enduring disorder. Therefore, in contrast to the earlier studies, the present investigation did not inquire about separation anxiety disorder. This decision may have caused the rates for overall anxiety disorders observed in the present study to be somewhat lower than those in the earlier studies.

The rate of suicide attempts in the past month (2.7 percent) reported by youth in the present study is comparable to the rate of suicide attempts by youth in the past month that was reported by facilities in the Conditions of Confinement study (2.5 percent) (Parent et al., 1994), lending further support to the validity of the Voice DISC assessment.

Although the prevalence of conduct disorder in the study sample was high (31.7 percent), the prevalence rates for other

Table 5: Comparison of Rates of Mental Health Disorders Found in the Present Study With Those Found in Earlier Studies Using the DISC

DISC Format and Study	Question Timeframe	Number of Youth Evaluated	Rate of Disorder (percent)			
			Disruptive	Substance	Mood	Anxiety
Administered by interviewer						
Duclos et al. (1998)*	Past 6 months	150	21	38†	10	7
Atkins, Pumariega, and Rogers (1999)	Past 6 months	75	43	20	24	33
Randall et al. (1999)‡	Past 6 months	118	45	NA	14	36
Garland et al. (2001)*	Past 6 months	478	48§	NA	7	9
Teplin et al. (2002)	Past 6 months	1,826	42	50	19	22
Self-report (Voice DISC)						
Present study	Past month	296	32	49	9	19

Note: NA, not assessed.

* Study used impairment criteria in the determination of diagnostic status. That is, in addition to meeting diagnostic criteria, youth had to endorse a response to one of three impairment questions at the end of individual disorder modules to receive a diagnosis.
† Assessed on the Composite International Diagnostic Interview (Robins et al., 1988).
‡ Aggregate data provided by the authors.
§ Includes responses of both youth and parental informants.

disruptive behavior disorders—ADHD (2.3 percent) and oppositional defiant disorder (2.8 percent)—were lower than might be anticipated. In clinical samples, as many as 75–90 percent of children with conduct disorder have also been found to have ADHD (Abikoff and Klein, 1992). Other studies have reported a link between the impulsivity of ADHD and delinquency (Mannuzza et al., 1993; Masse and Tremblay, 1997; McGee, Williams, and Feehan, 1992; Tremblay et al., 1994).

The rates of self-reported ADHD in other studies of juvenile justice populations that used the DISC are similarly low—between 1 and 7 percent (Atkins, Pumariega, and Rogers, 1999; Randall et al., 1999; Teplin et al., 2002). In the study done by Garland and colleagues (2001), who combined information from parental and youth reports, almost 13 percent of the youth received a diagnosis of ADHD, but this rate is still lower than expected. However, the rates of mood and anxiety disorders are high in the present study (9.1 percent and 18.9 percent, respectively) and across all five of the other DISC studies in juvenile justice populations (10–35 percent). Zoccolillo (1992) noted a high rate of comorbidity between mood and anxiety disorders and conduct problems in community samples of youth. Further, studies that used the DISC–2.3 to assess clinic-referred children found associations between anxiety symptoms ("trait anxiety") and both conduct problems and aggression (Frick et al., 1999) and between mania and conduct disorder (Biederman et al., 1999).

Although a determination of juvenile delinquency is not synonymous with a diagnosis of a disruptive disorder, the results of the present study and the existing research indicate systematic underreporting of ADHD symptoms by youth in the justice system. This suggests that self-reported information should be supplemented by reports from another informant (e.g., a parent or teacher), especially as parents' reports are more consistent with other indicators of conduct disorder, such as school suspension and police contacts, than youth's reports (Loeber et al., 1991).[7]

Recommendations for Juvenile Justice Mental Health Assessment

The findings of the present study shed light on the prevalence of mental health disorders among youth in the juvenile justice system. Consideration of the ways in which case identification is affected by the assessment method used suggests the following best practices for clinical assessment in different justice settings:[8]

- **Mental health assessments should be based on multiple methods of evaluation and on the input of multiple informants.** A structured interview is one important component of a mental health assessment. Other important components include direct observation, a mental status examination, chart review, an interview with parent(s) or caregiver(s), and obtaining a family psychiatric and psychosocial history.
- **Assessments should be based on reliable and valid instruments.** Use of a common assessment "language" eliminates uncertainty about the criteria used to determine diagnoses and enables comparison across studies and facilities.
- **Assessments should include parental input.** Parental input is valuable in diagnosing certain disorders, particularly ADHD. Incorporating parental reports into mental health assessments of youth in the justice system is complicated by several factors, including parents' unavailability or reluctance to incriminate their children. The accuracy of parental reports may also be limited due to parent-child separation. However, when parental and youth reports of ADHD symptoms are combined, increased rates of this disorder are detected (Garland et al., 2001).
- **Assessments should focus on recent symptoms in order to determine current treatment needs.** Depending on the purpose of the assessment and the setting in which it takes place, the timeframe for diagnostic status might vary from the past year to the past month. Assessments should be driven by

practical decisions that take into consideration needs at various stages of justice system processing. For example, assessments might aim to accurately identify at least two groups of youth: (1) those whose mental health needs should be met quickly, such as youth who recently have attempted suicide or who currently suffer from a panic disorder or substance dependence, and (2) those who need close supervision and regular reassessment, such as youth with less severe disorders (e.g., depression or posttraumatic stress disorder) that may worsen under the stress of confinement.

- **Some youth should be reassessed periodically.** Youth should be reassessed regularly when they are held in custody over an extended period of time, as symptom profiles may shift. Mood disorders and anxiety disorders, in particular, may wax and wane over time.

Conclusions

The study reported in this Bulletin represents the first investigation of the Voice DISC–IV in juvenile justice settings. The results demonstrate that use of a systematic instrument for assessing psychiatric disorders is feasible in juvenile justice settings. The assessment was well tolerated by youth and their parents and by the agency/institution staff who were involved in administration procedures. Two findings provide initial support for the validity of the Voice DISC–IV assessment:

- Youth who met the Voice DISC–IV criteria for substance use diagnoses had been incarcerated for substance offenses.
- The rate of suicide attempts in the past month reported by youth in this study is comparable to the rate of suicide attempts by youth in the past month reported by facilities in the Conditions of Confinement study.

Thus, this initial feasibility study demonstrates that a comprehensive, scientifically sound diagnostic instrument can be a valuable part of mental health assessment for youth in the juvenile justice system.

For Further Information

More information on the authors' research using the Voice DISC–IV and on other assessment-related research is available online at www.promotementalhealth.org, the Web site of the Center for the Promotion of Mental Health in Juvenile Justice.

Endnotes

1. The rate of mental health services received by youth in the juvenile justice system prior to detention has not been compared with the rate of previous mental health services for youth in a similar population (as opposed to the general youth population).

2. For a more comprehensive earlier report, see Wasserman et al., 2002.

3. In addition to the self-report version of the DISC for youth, a parent-report version is available. Some juvenile justice facilities may find this useful when assessing a youth's mental health.

4. The data reported here include data for four youth who inadvertently were not included in an earlier report of this research by Wasserman and colleagues (2002). Inclusion of the additional data does not alter the findings.

5. Youth who had a substance use disorder plus some other disorder ($n = 78$) were not included in these analyses.

6. See Wasserman et al., 2002, for further discussion of this issue and for rates that take impairment into account.

7. Although more research is needed, it is likely that youth also underreport ADHD symptoms in other arenas, such as the child welfare system and the educational system. Unidentified behavior disorders can contribute to a youth's coming into contact with the juvenile justice system.

8. For an expanded discussion of these recommendations, see Wasserman et al. (2003).

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Gail A. Wasserman, Ph.D., is Director of the Center for the Promotion of Mental Health in Juvenile Justice, Division of Child Psychiatry, Columbia University, New York State Psychiatric Institute, New York, NY. Larkin S. McReynolds, M.P.H., is Senior Data Analyst at the Center. Susan J. Ko, Ph.D., Clinical Director at the Center at the time of this study, is currently Director of the Service Systems Core at the National Center for Child Traumatic Stress, University of California, Los Angeles.

SEPTEMBER 2004

A National Protocol for Sexual Assault Medical Forensic Examinations

Adults/Adolescents

PRESIDENT'S DNA INITIATIVE

A National Protocol for Sexual Assault Medical Forensic Examinations

Adults/Adolescents

U.S. Department of Justice
Office on Violence Against Women

September 2004

NCJ 206554

Acknowledgments

Many individuals contributed their skills and expertise to the development of this protocol. Special appreciation goes to Kristin Littel, who served as the primary writer and researcher for the protocol. We would also like to thank the Office for Victims of Crime for initiating this project and for providing feedback and guidance throughout the drafting process. We are grateful to all of the women and men who gave their time and energy to attend the focus groups, participate in the conference calls, and review numerous drafts of the protocol; their efforts greatly enhanced the final product.

Foreword

Sexual violence continues to plague our Nation and destroy lives. All members of society are vulnerable to this crime, regardless of race, age, gender, or social standing. When sexual assault does occur, victims deserve competent and compassionate care. This first *National Protocol for Sexual Assault Medical Forensic Examinations* provides detailed guidelines for criminal justice and health care practitioners in responding to the immediate needs of sexual assault victims. We know that effective collection of evidence is of paramount importance to successfully prosecuting sex offenders. Just as critical is performing sexual assault forensic exams in a sensitive, dignified, and victim-centered manner. For individuals who experience this horrendous crime, having a positive experience with the criminal justice and health care systems can contribute greatly to their overall healing.

As we have learned in the 10 years since the implementation of the 1994 Violence Against Women Act, coordinated community efforts are the best way to stop violence against women and hold offenders accountable for their crimes. That is why this protocol was designed as a guide for criminal justice and health care practitioners who respond to victims of sexual assault. Combining cutting edge response techniques with collaboration among service providers will greatly enhance our ability to treat and support victims as well as identify and punish the sex offenders. We hope that this protocol lays the foundation for these efforts.

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Goals of the National Protocol for Sexual Assault Medical Forensic Examinations

Consider what it might be like to be a victim of sexual assault who has come to a health care facility for a medical forensic examination. Sexual assault is a crime of violence against a person's body and will. Sex offenders use physical and/or psychological aggression to victimize, in the process often threatening a victim's sense of privacy, safety, and well-being. Sexual assault can result in physical trauma and significant mental anguish and suffering for victims. Victims may be reluctant, however, to report the assault to law enforcement and to seek medical attention for a variety of reasons. For example, victims may blame themselves for the sexual assault and feel embarrassed. They may fear their assailants or worry about whether they will be believed. A victim may also lack easy access to services. Those who have access to services may perceive the medical forensic examination as yet another violation because of its extensive and intrusive nature in the immediate aftermath of the assault. Rather than seek assistance, a sexual assault victim may simply want to go somewhere safe, clean up, and try to forget the assault ever happened.[1] It is our hope that this protocol will help jurisdictions to respond to sexual assault victims in the most competent, compassionate, and understanding manner possible.

This protocol was developed with the input of national, local, and tribal experts throughout the country, including law enforcement representatives, prosecutors, advocates, medical personnel, forensic scientists, and others. We hope that this protocol will be useful in helping jurisdictions develop a response that is sensitive to victims of sexual assault and that promotes offender accountability. Specifically, the protocol has the following goals:

- Supplement but not supercede the many excellent protocols that have been developed by States, tribes, and local jurisdictions, as well as those created at the national level. We hope that this protocol will be a useful tool for jurisdictions wishing to develop new protocols or revise their existing ones. **It is intended as a guideline for suggested practices rather than a list of requirements.** In many places, the protocol refers to "jurisdictional policies" because there may be multiple valid ways to handle a particular issue and which one is best should be determined by the jurisdiction after consideration of local laws, policies, practices, and needs.

- Provide guidance to jurisdictions on responding to adult and adolescent victims. Adolescents are distinguished in the protocol from prepubertal children who require a pediatric exam. **Pediatric exams are not addressed in this document. This protocol generally focuses on the examination of females who have experienced the onset of menarche and males who have reached puberty.** Legally, jurisdictions vary in the age at which they consider individuals to be minors, laws on child sexual abuse, mandatory reporting policies for sexual abuse and assault of minors, instances when minors can consent to treatment and evidence collection without parental/guardian involvement, and the scope of confidentiality that minors are afforded. **If the adolescent victim is a minor under the jurisdictional laws, the laws of the jurisdiction governing issues such as consent to the exam, mandatory reporting, and confidentiality should be followed.**

- Support the use of coordinated community responses to sexual violence. Although this document is directed primarily toward medical personnel and facilities, it also provides guidance to other key responders such as advocates and law enforcement representatives. This type of coordinated community response is supported by the Violence Against Women Act and subsequent legislation. Such a response can help afford victims access to comprehensive immediate care, minimize trauma victims may experience, and encourage them to utilize community resources. It can also facilitate the criminal investigation and prosecution, increasing the likelihood of holding offenders accountable and preventing further sexual assaults.

- Address the needs of victims while promoting the criminal justice system response. Stabilizing, treating, and engaging victims as essential partners in the criminal investigation are central aspects

[1] Paragraph adapted in part from the *Ohio Protocol for Sexual Assault Forensic and Medical Examination*, 2002, p. 2.

of the protocol. Thus, this protocol includes information about concepts such as "blind reporting," which may give victims needed time to decide if and when they are ready to engage in the criminal justice process. A blind report may also provide law enforcement agencies with potentially useful information about sex crime patterns in their jurisdictions. The objective is to promote better and more victim-centered evidence collection, in order to provide better assistance in court proceedings and hold more offenders accountable.

- Promote high-quality, sensitive, and supportive exams for all victims, regardless of jurisdiction and geographical location of service provision. The protocol offers recommendations to help standardize the quality of care for sexual assault victims throughout the country. It also promotes timely evidence collection which is accurately and methodically gathered, so that high-quality evidence is available in court.

This protocol discusses the roles of the following responders: health care providers, advocates, law enforcement representatives, forensic scientists, and prosecutors. Clearly, each of these professions has a role in responding to victims, investigating the crime, and/or holding offenders accountable. But rather than dictate who is responsible for every procedure within the exam process, the protocol is designed to help communities consider what each procedure involves and any related issues. With this information, each community can make decisions for its jurisdiction about the specific tasks of each responder during the exam process and the coordination needed among responders. The following is a general description of what each responder may assist with:

- **Advocates** may be involved in initial victim contact (via 24-hour hotline or face-to-face meetings); offer victims advocacy, support, crisis intervention, information, and referrals before, during, and after the exam process; and help ensure that victims have transportation to and from the exam site. They often provide followup services designed to aid victims in addressing related legal and nonlegal needs.

- **Law enforcement representatives** (e.g., 911 dispatchers, patrol officers, officers who process crime scene evidence, and investigators) respond to initial complaints, work to enhance victims' safety, arrange for victims' transportation to and from the exam site as needed, interview victims, coordinate collection and delivery of evidence to designated labs or law enforcement facilities, and investigate cases.

- **Health care providers** assess patients for acute medical needs and provide stabilization, treatment, and/or consultation. Ideally, sexual assault forensic examiners perform the medical forensic exam, gather information for the medical forensic history, and collect and document forensic evidence from patients. They offer information, treatment, and referrals for sexually transmitted infections (STIs) and other nonacute medical concerns; assess pregnancy risk and discuss treatment options with the patient, including reproductive health services; and testify in court if needed. They typically coordinate with advocates to ensure patients are offered crisis intervention, support, and advocacy during and after the exam process and encourage use of other victim services. They may follow up with patients for medical and forensic purposes. Other health care personnel that may be involved include, but are not limited to, emergency medical technicians, staff at hospital emergency departments, gynecologists, surgeons, private physicians, and/or local, tribal, campus, or military health services personnel.

- **Forensic scientists** analyze forensic evidence and provide results of the analysis to investigators and/or prosecutors.

- **Prosecutors** determine if there is sufficient evidence for prosecution and, if so, prosecute the case. They should be available to consult with first responders as needed. A few jurisdictions involve prosecutors more actively, paging them after initial contact and having them respond to the exam site so that they can become familiar with the case and help guide the investigation.

This document is intended only to improve the criminal justice system's response to victims of sexual assault and the sexual assault forensic examination process and does not create a right or benefit, substantive or procedural, of any party.

Recommendations at a Glance: A National Protocol for Sexual Assault Medical Forensic Examinations

The National Protocol for Sexual Assault Medical Forensic Examinations offers guidance to jurisdictions in creating and implementing their own protocols, as well as recommending specific procedures related to the exam process. *Recommendations at a Glance* highlights key points discussed in the protocol, but it is not designed to be a stand-alone checklist on exam procedures or responsibilities of each involved responder. The protocol should be read to understand and respond to the complex issues presented during the exam process. See the protocol introduction for an explanation of select terms used in this chapter and the protocol.

Goal of the Protocol

A timely, well-done medical forensic examination can potentially validate and address sexual assault patients'[2] concerns, minimize the trauma they may experience, and promote their healing. At the same time, it can increase the likelihood that evidence collected will aid in criminal case investigation, resulting in perpetrators being held accountable and further sexual violence prevented.

The examination and the related responsibilities of health care personnel are the focus of this protocol. Recognizing that multidisciplinary coordination is vital to the success of the exam, the protocol also discusses the responses of other professionals, as they relate to the exam process.

A. Overarching Issues

1. Coordinated approach: A coordinated, multidisciplinary approach to conducting the exam provides victims[3] with access to comprehensive immediate care, helps minimize trauma they may experience, and encourages their use of community resources. Such a response can also enhance public safety by facilitating investigation and prosecution, which increases the likelihood that offenders will be held accountable for their actions. Raising public awareness about the existence and benefits of a coordinated response to sexual assault may lead more victims to disclose the assault and seek help. (SEE PAGES 23–26)

Recommendations for jurisdictions to facilitate a coordinated approach to the exam process:

- Understand the dual purposes of the exam process to address patients' needs and justice system needs. Addressing patients' needs may include evaluating and treating injuries; conducting prompt exams; providing support, crisis intervention, and advocacy; providing prophylaxis against sexually transmitted infections (STIs) and referrals; assessing reproductive health issues; and providing followup contact/care. Addressing justice system needs may include obtaining a history of the assault; documenting exam findings; properly collecting, handling, and preserving evidence; and (postexam) interpreting/analyzing findings, presenting findings, and providing factual and expert opinions.
- Identify key responders and their roles.
- Develop quality assurance measures to ensure effective immediate response.

2. Victim-centered care: Victim-centered care is paramount to the success of the exam process. Response to victims should be timely, appropriate, sensitive, and respectful. (SEE PAGES 27–37)

[2] Sexual assault patients are also referred to as victims, depending on which responders are primarily being discussed. The term "patients" is generally used by health care professionals.
[3] The term "victim" is not used in a strictly criminal justice context. The use of "victim" simply acknowledges that persons who disclose that they have been sexually assaulted should have access to certain services.

Recommendations for health care providers and other responders to facilitate victim-centered care:

- Give sexual assault patients priority as emergency cases and respond in a timely manner. Provide them with as much privacy as possible, while ensuring that they are supported.
- Recognize that the medical forensic exam is an interactive process that must be adapted to the needs and circumstances of each patient.
- Be aware of issues commonly faced by victims from specific populations. For example, certain characteristics (e.g., culture, religion, language skills/mode of communication, disabilities, gender, and age) may influence a victim's behavior in the aftermath of an assault, including the exam process.
- Understand the importance of victim services within the exam process. Victim service providers/advocates typically offer victims support, crisis intervention, information and referrals, and advocacy to ensure that victims' interests are represented, their wishes respected, and their rights upheld. Providers/advocates also may offer support for family members and friends who are present. In addition, they can promote sensitive, appropriate, and coordinated interventions.
- Involve victim service providers/advocates in the exam process as soon after a victim discloses an assault as possible. Victims have the right to accept or decline victim services.
- Accommodate patients' requests to have relatives, friends, or other support persons (e.g., a religious/spiritual counselor) present during the exam, unless the presence of that person could be considered harmful. (See *C.4. The Medical Forensic History* for confidentiality considerations regarding the presence of these individuals during history taking.)
- Accommodate victims' request for responders of a specific gender as much as possible.
- Prior to starting the exam and before each procedure, describe what is entailed and its purpose to patients. Be sure that communication/language needs are met and information is conveyed in a manner that patients will understand. After providing this information, seek patients' permission to proceed and respect their right to decline any part of the exam. However, follow exam facility and jurisdictional policy regarding minors and adults who are incompetent to give consent. (For a more detailed discussion on seeking informed consent of patients, including consent by victims from specific populations, see *A.3. Informed Consent*.)
- Assess and respect patients' priorities.
- Integrate exam procedures where possible (e.g., blood samples needed for medical and evidentiary purposes should be drawn at the same time).
- Address patients' safety concerns during the exam. Sexual assault patients have legitimate reasons to fear further assaults from their attackers. Local law enforcement may be able to assist facilities in addressing patients' safety needs.
- Provide information that is easy for patients to understand and that can be reviewed at their convenience. (Also see *C.10. Discharge and Followup*.)
- After the exam is finished, provide patients with the opportunity to wash, change clothes (providing clean replacement clothing if necessary), get food or drinks, and make needed phone calls.

3. Informed consent: Patients should understand the full nature of their consent to each exam procedure. By presenting them with relevant information, they are in a position to make an informed decision about whether to accept or decline a procedure. However, they should be aware of the impact of declining a particular procedure, as it may negatively affect the quality of care, the usefulness of evidence collection, and, ultimately, any criminal investigation and/or prosecution. They should understand that declining a particular procedure might also be used to discredit them in court. If a procedure is declined, reasons why should be documented if the patient provides such information. (SEE PAGES 39–41)

Recommendations for health care providers and other responders to request patients' consent during the exam process:

- Seek informed consent as appropriate throughout the exam process for medical evaluation and treatment and the forensic exam and evidence collection. Coordinate efforts to obtain consent among responders.

- Be aware of statutes and policies governing consent in cases of minor patients, vulnerable adult patients, and patients who are unconscious, intoxicated, or under the influence of drugs. In all cases, however, the exam should never be done against the will of the patient.

4. Confidentiality: Involved responders must be aware of the scope and limitations of confidentiality related to information gathered during the exam process. Confidentiality is intricately linked to the scope of patients' consent. Members of a Sexual Assault Response Team (SART) or other collaborating responders should inform victims of the scope of confidentiality with each responder and be cautious not to exceed the limits of victim consent to share information in each case. (SEE PAGES 43–44)

Recommendations that jurisdictions may take to maintain confidentiality of patients:

- Make sure that jurisdictional policies address confidentiality related to the medical forensic exam (e.g., of forensic documentation, photographs, and colposcopic video images).
- Increase responders' and patients' understanding of confidentiality issues (e.g., scope of confidentiality advocates can provide; scope of confidentiality of information shared with examiners, law enforcement, prosecutors, and other responders with whom patient has contact; and what happens to information once it enters the criminal justice system).
- Consider the impact of Federal privacy laws regarding health information on victims of sexual assault.
- Strive to resolve intrajurisdictional conflicts.

5. Reporting to law enforcement: Reporting provides the criminal justice system with the opportunity to offer immediate protection to victims, collect evidence from all crime scenes, investigate cases, prosecute if there is sufficient evidence, and hold offenders accountable for crimes committed. Given the danger that sex offenders pose to the community, reporting can serve as a first step in efforts to stop them from reoffending. Equally important, reporting gives the justice system the chance to help victims address their needs, identify patterns of sexual violence in the jurisdiction, and educate the public about such patterns. It is recommended that service providers encourage victims to report due in part to the recognition that delayed reporting is detrimental to the prosecution and to holding offenders accountable. Victims need to know that even if they are not ready to report at the time of the exam, the best way to preserve their option to report later is to have the exam performed.

Reporting requirements in sexual assault cases vary from one jurisdiction to another. Every effort should be made to facilitate treatment and evidence collection (if the patient agrees), regardless of whether the decision to report has been made at the time of the exam. Victims who are undecided about reporting who receive respectful and appropriate care and advocacy at the time of their exam are more likely to assist law enforcement and prosecution. (SEE PAGES 45–48)

Recommendations for jurisdictions and responders to facilitate victim-centered reporting practices:

- Where permitted by law, patients, not health care workers, should make the decision to report a sexual assault to law enforcement. Patients should be provided with information about possible benefits and consequences of reporting so that they can make an informed decision.
- It is not recommended to require reporting as a condition of performing or paying for the exam. Even if patients are undecided about reporting, they should be encouraged to provide a medical forensic history, undergo the forensic exam, and have evidence collected and stored.
- Jurisdictions may want to consider alternatives to standard reporting procedures. For example, an anonymous or blind reporting system may be useful in cases in which victims do not want to report immediately or are undecided about reporting.
- Jurisdictions should consider a variety of approaches that promote a victim-centered reporting process.

6. Payment for the examination under VAWA: Under the Violence Against Women Act (VAWA),[4] a State, Territory, or the District of Columbia is entitled to funds under the STOP Violence Against Women Formula Grant Program only if it, or another governmental entity, incurs the full out-of-pocket cost of medical forensic exams for victims of sexual assault. The VAWA provisions indicate the exam should minimally include "an examination of physical trauma; determination of penetration/force; a victim interview; and collection and evaluation of evidence."[5] "Full out-of-pocket costs" means any expense that may be charged to a victim in connection with the exam for the purpose of gathering evidence of a sexual assault.[6] (SEE PAGES 49–50)

Recommendations for jurisdictions to facilitate payment for the sexual assault medical forensic exam:

- Understand the scope of the VAWA provisions related to exam payment.
- Ensure that victims are notified of exam facility and jurisdictional policies regarding payment for medical care and the medical forensic exam, as well as if and how reporting decisions will impact payment. Relevant government entities are strongly encouraged to pay for medical forensic exams regardless of whether victims pursue prosecution.

B. Operational Issues

1. Sexual assault forensic examiners: These are the health care professionals who conduct the examination. It is critical that all examiners, regardless of their discipline, are committed to providing compassionate and quality care for patients disclosing sexual assault, collecting evidence competently, and testifying in court as needed. (SEE PAGES 53–55)

Recommendations for jurisdictions to build the capacity of examiners performing these exams:

- Encourage the development of specific examiner knowledge, skills, and attitudes.
- Encourage advanced education and supervised clinical practice of examiners, as well as certification for nurses who are examiners.

2. Facilities: Health care facilities have an obligation to provide services to sexual assault patients. Designated exam facilities or sites served by specially educated and clinically prepared examiners increase the likelihood of a state-of-the-art exam, enhance coordination, encourage quality control, and increase quality of care for patients. (SEE PAGES 57–59)

Recommendations for jurisdictions to build capacity of health care facilities to respond to sexual assault cases:

- Recognize the obligation of health care facilities to serve sexual assault patients.
- Ensure that exams are conducted at sites served by specially educated and clinically prepared examiners. A designated facility may employ or have ready access to examiners to conduct the exam. Some jurisdictions have examiner programs that serve one or multiple exam sites within a specific area.
- Explore what is best for the community regarding locations for exam sites. It is critical to consider how accessible facilities are to patients disclosing sexual assault, as well as the facility's capacity to properly conduct these exams and treat related injuries.
- Recognize that exam facilities and examiners may benefit from networking with examiners in other facilities or areas for support with peer review of medical forensic reports, quality assurance, and information sharing (e.g., on training opportunities, practices, and referrals for patients).
- Consider developing basic jurisdictional requirements for exam sites.

[4] 42 U.S.C. § 3796gg-4.
[5] 28 C.F.R. § 90.2(b) (1). The analysis of evidence gathered during the examination, along with examiner documentation of findings, may help in determining whether penetration occurred or force was used. However, examiners are not responsible for drawing conclusions about how injuries were caused or whether the assault occurred or not (although they can note consistency between patients' statements and injuries they identify).
[6] 28 C.F.R. § 90.14(a).

- Promote public awareness about where exams are conducted. Use specially educated and clinically prepared forensic examiners to conduct the exam, ensuring dissemination of relevant information to appropriate agencies and community members. Encourage first responders to work together to assist victims in using these sites.
- If a transfer from one health care facility to a designated site is necessary, use an established protocol that minimizes time delays and loss of evidence while addressing a patient's needs. However, avoid transferring these patients whenever possible.

3. Equipment and supplies: Certain equipment and supplies are essential to the exam process (although they may not be used in every case). These include a copy of the most current exam protocol used by the jurisdiction, standard exam room equipment and supplies, comfort supplies for patients, sexual assault evidence collection kits, an evidence drying device/method, a camera, testing and treatment supplies, an alternate light source, an anoscope, and written materials for patients. A microscope and/or toluidine blue dye may be required, depending on jurisdictional policy. A colposcope or other magnifying instrument is strongly suggested. Some jurisdictions are also beginning to use advanced technology (telemedicine), which allows examiners offsite consultation with medical experts by using computers, software programs, and the Internet. (SEE PAGES 61–63)

Recommendations for jurisdictions and responders to ensure that proper equipment and supplies are available for examinations:

- Consider what equipment and supplies are essential.
- Address cost barriers to obtaining equipment and supplies.

4. Sexual assault evidence collection kit (for evidence from victims): Most jurisdictions have developed their own sexual assault evidence collection kits or purchased premade kits through commercial vendors. Kits often vary from one jurisdiction to another. Despite variations, however, it is critical that every kit meets or exceeds minimum guidelines for contents: broadly including a kit container, instruction sheet and/or checklist, forms, and materials for collecting and preserving all evidence required by the applicable crime laboratory. Evidence that may be collected includes, but is not limited to, clothing, foreign materials on the body, hair (including head and pubic hair samples and combings), oral and anogenital swabs and smears, body swabs, and a blood or saliva sample for DNA analysis and comparison. The instruction sheet and/or checklist should guide examiners on maintaining the chain of custody for evidence collected. (SEE PAGES 65–66)

Recommendations for jurisdictions and responders when developing/customizing kits:

- Use standardized kits (across a local jurisdiction, region, State, Territory, or tribal land) that meet or exceed minimum guidelines for contents, as described above.
- Make kits readily available at any facility that conducts sexual assault medical forensic exams.
- Periodically review the kit's efficiency and usefulness and make changes as needed.

5. Timing considerations for collecting evidence: Although many jurisdictions currently use 72 hours after the assault as the standard cutoff time for collecting evidence, evidence collection beyond that point is conceivable. Because of this, some jurisdictions have extended the standard cutoff time (e.g., to 5 days or 1 week). Advancing DNA technologies continue to extend time limits because of the stability of DNA and sensitivity of testing. These technologies are even enabling forensic scientists to analyze evidence that was previously unusable when it was collected years ago. Thus, it is critical that in every case where patients are willing, examiners obtain the medical forensic history, examine patients, and document findings. Not only can the information gained from the history and exam help health care providers address patients' medical needs, but it can guide examiners in determining whether there is evidence to collect and, if so, what to collect. (SEE PAGES 67–68)

Recommendations for health care providers and other responders to maximize evidence collection:

- Whether or not evidence is collected, examiners should obtain the medical forensic history as appropriate, examine patients, and document findings (with patients' consent). Patients' demeanor and statements related to the assault should also be documented.
- Promptly examine patients to minimize loss of evidence and to identify medical needs and concerns.
- Decide whether to collect evidence and what to collect on a case-by-case basis, remembering that outside time limits for obtaining evidence vary.
- In any case, where the need for evidence collection is in question, encourage dialogue about the potential benefits or limitations of collection. Avoid basing decisions about whether to collect evidence on a patient's characteristics or circumstances (e.g., the patient has used illegal drugs).
- Responders should seek education and resources that aid them in making well-informed decisions about evidence collection.

6. Evidence integrity: Properly collecting, preserving, and maintaining the chain of custody of evidence is critical to its subsequent use in criminal justice proceedings. (SEE PAGES 69–70)

Recommendations for health care providers and other responders to maintain evidence integrity:

- Follow jurisdictional policies for drying, packaging, labeling, and sealing the evidence.
- Follow jurisdictional policies for documenting exam findings, the medical forensic history, and the patient's demeanor/statements, and packaging, labeling, and sealing such documentation.
- Follow jurisdictional policies for consistent evidence management and distribution. A duly authorized agent should transfer evidence from the exam site to the appropriate crime lab or other designated storage site (e.g., a law enforcement property facility).
- Make sure storage procedures maximize evidence preservation. Ensure that storage areas are kept secure and at the proper temperature for the evidence. Also, make sure jurisdictional policies are in place to address the secure storage of evidence in cases in which patients are undecided about reporting.
- Maintain the chain of custody of evidence. All those involved in handling, documenting, transferring, and storing evidence should be educated regarding the specifics of their roles in properly preserving evidence and maintaining the chain of custody.

C. The Examination Process

1. Initial contact: Some sexual assault patients may initially present at a designated exam facility, but most who receive immediate medical care initially contact a law enforcement or advocacy agency for help. If 911 is called, law enforcement or emergency medical services (EMS) may be the first to provide assistance to victims. Communities need to have procedures in place to promptly respond to disclosures/reports of sexual assault in a standardized and victim-centered manner. (SEE PAGES 73–75)

Recommendations for jurisdictions and responders to facilitate initial contact with victims:

- Build consensus among involved agencies regarding procedures for a coordinated initial response when a recent sexual assault is disclosed or reported, and educate responders on procedures. Encourage victims to interact with advocates as soon after disclosure as possible.
- Recognize essential elements of initial response. In particular, encourage victims to seek medical care and have evidence collected. In the case of life-threatening or serious injuries, obtain emergency medical assistance according to jurisdictional policy. Any life-threatening wounds should be treated and victims' immediate safety needs should be addressed before evidence is collected.
- If victims decide to seek medical care and/or have evidence collected, follow jurisdictional policies for preserving evidence, collecting a urine sample if needed, and transporting victims to the exam site.

2. Triage and intake: Once patients arrive at the exam site, health care personnel must evaluate, stabilize, and treat for life-threatening and serious injuries according to facility policy. Standardized procedures for response in these cases should be followed, while respecting patients and maximizing evidence preservation. (SEE PAGES 77–78)

Recommendations for health care providers to facilitate triage and intake that addresses patients' needs:

- Consider sexual assault patients a priority. Use private locations in the exam facility for the primary patient consultation and initial law enforcement interviews, offer a waiting area for family members and friends, and provide childcare if possible.
- Respond to acute injury, trauma care, and safety needs of patients before collecting evidence. Patients should not wash, change clothes, urinate, defecate, smoke, drink, or eat until initially evaluated by examiners, unless necessary for treating acute medical needs.
- Alert examiners to the need for their services at the exam site.
- Contact victim advocates so they can offer services to the patient, if not already done.
- Assess and respond to safety concerns, such as threats to the patient or staff, upon arrival of patients at the exam site.
- Assess patients' needs for immediate medical or mental health intervention. Seek informed consent from patients before providing treatment, according to facility policy.

3. Documentation by health care personnel: Examiners document exam findings, the medical forensic history, and evidence collected in the medical forensic report. Examiners and/or other involved clinicians separately document medical care in the patient's medical record. (SEE PAGES 79–80)

Recommendations for health care providers to complete needed documentation:

- Ensure completion of all appropriate documentation. The forensic details of the exam are documented in the medical forensic report, according to jurisdictional policy. The only medical issues documented in this report are acute findings that potentially relate to the assault or preexisting medical factors that could influence interpretation of findings. Separate medical documentation by examiners and other involved clinicians follows a standard approach—address acute complaints, gather pertinent historical data, describe findings, and document treatment and followup care.
- Ensure the accuracy and objectivity of medical forensic reports by seeking education on proper report writing.

4. The medical forensic history: Examiners ask the patient questions to obtain this history. This information guides them in examining the patient and collecting evidence. (SEE PAGES 81–84)

Recommendations for health care providers to facilitate gathering information from patients:

- Examiners should coordinate with other responders, primarily law enforcement representatives, to facilitate information gathering that is respectful to patients and minimizes repetition of questions.
- Keep in mind that advocates may support and advocate for patients when the medical forensic history is taken (if desired by patients), but they may not actively participate in the process. Patients should be informed that the presence of family members, friends, and others offering personal support during this time may influence or be perceived as influencing their statements. If patients choose to have others present despite this knowledge, these individuals should not actively participate in the process.
- Consider and address patients' needs prior to information gathering, including identifying the level of their communication skill and modalities and then tailoring information gathering accordingly.
- Obtain the medical forensic history in a private, quiet setting.
- Gather information for the history according to jurisdictional policy. Include the date and time of the assault, pertinent patient medical history (e.g., menstruation history), recent consensual sexual activity of the patient, the patient's activities since the assault (e.g., took a shower), the patient's assault-related

history (e.g., loss of consciousness), suspect information, if known (e.g., number and gender of assailants), nature of the physical assault, and description of the sexual assault.

5. Photography: Photographic evidence of injury on the patient's body can supplement the medical forensic history and document physical findings. (SEE PAGES 85–87)

Recommendations for health care providers and other responders to photograph evidence:

- Come to a consensus about the extent of forensic photography necessary. Some jurisdictions routinely take photographs of both detected injuries on patients and normal (apparently uninjured) anatomy, while others limit photography to detected injuries.
- Consider who will take photographs and what equipment will be used. Photographers should be familiar with equipment operation as well as educated in forensic photography and in ways to maintain the patient's privacy and dignity while taking photographs. Consult with jurisdictional criminal justice agencies and examiners regarding the type of equipment that should be used.
- Obtain informed consent from patients before taking photographs. Patients should understand the purpose of the photographs, what will be photographed and any related procedures, the potential uses of photographs during investigation and prosecution, and the possible need for followup photographs.
- Consider the patient's comfort and need for modesty.
- Identify who will be present when photographs are taken.
- Take initial and followup photographs as appropriate, according to jurisdictional policy.

6. Exam and evidence collection procedures: Examiners examine patients and collect evidence according to jurisdictional policy. Findings from the exam and collected evidence often help reconstruct the events in question in a scientific and objective manner. (SEE PAGES 89–99)

Recommendations for health care providers to conduct the exam and facilitate evidence collection:

- Strive to collect as much evidence from patients as possible, considering the scope of informed consent, the medical forensic history, the examination, and evidence collection kit instructions.
- Be aware of evidence that may be pertinent to the issue of whether the patient consented to sexual contact with the suspect. Understand how biological evidence is tested.
- Prevent exposure (of both patients and staff) to infectious materials and contamination of evidence.
- Understand the implication of the presence or lack of semen (in cases involving male suspects).
- Seek informed consent from patients for each portion of the exam and evidence collection.
- Modify the exam and evidence collection to address the specific needs and concerns of patients.
- Conduct the general physical and anogenital examination, guided by the scope of informed consent and the medical forensic history. Document findings on body diagram forms. With the patient's consent, use an alternate light source, colposcope, and anoscope, as appropriate and if available, to increase the likelihood of detecting evidence.
- Collect evidence to submit to the crime lab for analysis, according to jurisdictional policy.
- Collect blood and/or urine for toxicology screening, if applicable.
- Keep medical specimens separate from forensic specimens collected during the exam.

7. Drug-facilitated sexual assault: Responders must consider the possibility that drugs may have been used to facilitate an assault. They must know how to screen for suspected drug-facilitated sexual assault, obtain informed consent of patients for testing, and collect toxicology samples when needed. (SEE PAGES 101–104)

Recommendations for jurisdictions and responders to facilitate response in suspected drug-facilitated sexual assault:

- Educate examiners, 911 dispatchers, law enforcement representatives, prosecutors, judges, and advocates on related issues. Develop jurisdictional policies to clarify first responders' roles in cases involving suspected drug-facilitated assault.
- Be clear about the circumstances in which toxicology testing may be indicated (for optimal care or when there is a suspicion of drug-facilitated sexual assault). Routine toxicology testing in all sexual assault cases is not recommended.
- Informed consent of patients should be sought to collect toxicology samples. Patients should be aware of the purposes and scope of testing that will be done, potential benefits and consequences of testing, any followup treatment necessary, how they can obtain results, who will pay for the testing, and if they have any opportunity to revoke consent to testing.
- With patients' permission, immediately collect a urine specimen if it is suspected that ingestion of drugs used to facilitate sexual assault occurred within 96 hours prior to the exam. The first available urine should be collected—law enforcement and emergency medical services should be trained and prepared to collect a urine sample if patients must urinate prior to arrival at the health care facility for the exam. Advocates and other professionals who may have contact with patients prior to their arrival at the exam site should also be educated to provide those who suspect drug-facilitated assault with information on how to collect a sample if the patient cannot wait to urinate until getting to the site.
- Also, collect a blood sample if it is suspected that the ingestion of drugs used to facilitate sexual assault occurred within 24 hours of the exam. If a blood alcohol determination is needed, collect blood within 24 hours of ingestion of alcohol, according to jurisdictional policy.
- Jurisdictional policies should be in place and followed for packaging, storing, and transferring samples.

8. Sexually transmitted infection (STI) evaluation and care: Because contracting an STI from an assailant is of significant concern to patients, it should be addressed during the exam. (SEE PAGES 105–109)

Recommendations for health care providers to facilitate STI evaluation and care:

- Offer patients information about the risks of STIs (including HIV), the symptoms and what to do if symptoms occur, testing and treatment options, followup care, and referrals. Referrals should include free and low-cost testing, counseling, and treatment available in various sections of the community. For HIV testing, confidential and anonymous testing is recommended.
- Consider testing patients for STIs during the initial exam on a case-by-case basis. If testing is done, follow the guidelines of the Centers for Disease Control and Prevention (CDC).
- Encourage patients to accept prophylaxis against STIs during the initial exam. (Note, however, that treatment may not be appropriate for some individuals—for example, if they have a condition that may be adversely affected by taking prophylaxis.) The CDC suggests a regimen to protect against chlamydia, gonorrhea, trichomonas, and bacterial vaginosis (BV), as well as the hepatitis B virus. If accepted, provide care that meets or exceeds CDC guidelines. If declined, it is medically prudent to obtain cultures and arrange for a followup exam and testing. Seek informed consent from patients for treatment, according to facility policy.
- Encourage and facilitate followup STI examinations, testing, immunizations, and treatment as directed.
- Offer postexposure prophylaxis for HIV to patients at high risk for exposure, particularly when it is known that suspects have HIV/AIDS. Meet or exceed CDC recommendations. Discuss risks and benefits of the prophylaxis with patients prior to their decisions to accept or decline treatment. Careful monitoring and followup by a health care provider or agency experienced in HIV issues is required.

9. Pregnancy risk evaluation and care: Female patients may fear becoming pregnant as a result of an assault. Health care providers must address this issue according to facility and jurisdictional policy. (SEE PAGE 111)

Recommendations for health care providers to facilitate pregnancy evaluation and care:

- Discuss the probability of pregnancy with patients.
- Administer a baseline pregnancy test for all patients with reproductive capability.
- Discuss treatment options with patients, including reproductive health services.

10. Discharge and followup: Health care personnel have specific tasks to accomplish before discharging patients, as do advocates and law enforcement representatives (if involved). Responders should coordinate discharge and followup activities as much as possible to reduce repetition and avoid overwhelming patients. (SEE PAGES 113–115)

Recommendations to facilitate discharge and followup:

- It is important to ensure that patients are fully informed about postexam care. Information may include referrals to other professionals to make sure that patients' medical and/or mental health needs related to the assault have been addressed, discharge instructions, followup appointments with the examiner or other health care providers, and contact procedures for medical followup. In addition to medical followup, followup may be indicated to document developing or healing injuries and complete resolution of healing.
- Advocates and law enforcement representatives, if involved, should coordinate with examiners to discuss other issues with patients, including planning for their safety and well-being, physical comfort needs, information needs, the investigative process, advocacy and counseling options, and law enforcement and advocacy followup contact procedures.

11. Examiner court appearances**:** Health care providers conducting the exam should expect to be called on to testify in court as fact and/or expert witnesses. (SEE PAGES 117–119)

Recommendations for jurisdictions to maximize the usefulness of examiner testimony in court:

- Encourage broad education for examiners on testifying in court.
- Promote prompt notification of examiners if there is a need for them to testify in court.
- Encourage pretrial preparation of examiners.
- Encourage examiners to seek feedback on testimony to improve effectiveness of future court appearances.

Introduction

Sexual assault is a prevalent crime in our society that has a devastating and long-term impact on individuals from all walks of life. Although an assault can be traumatizing in and of itself, it can result in a range of problems for the victim, such as mental anguish, physical injuries, and sexually transmitted infections (STIs).[7] It is essential that communities offer assistance to victims in the immediate aftermath of an assault. Communities must also work to hold offenders accountable for their actions and stop them from committing further sexual violence. Elements of response typically include the following:

- Provision of medical care for victims as needed;
- Collection of evidence from victims, which may aid investigation and prosecution;
- Investigation of reports of sexual assault, which may lead to charges against suspects and prosecution;
- Support, crisis counseling, information and referrals for victims, as well as advocacy to ensure that victims receive appropriate assistance; and
- Support and information for victims' families and friends.

This document focuses on elements of immediate response that are the responsibility of health care providers—medical care for sexual assault patients and collection of evidence from them. It seeks to assist health care personnel in validating and addressing patients' health concerns, minimizing the trauma patients may experience, promoting healing, and maximizing the collection and preservation of evidence from patients for potential use in the legal system. (A sexual assault medical forensic examination as described in this document addresses both evidence collection from patients and medical care for serious injuries).

This protocol also addresses the role of advocates, law enforcement representatives, prosecutors, forensic scientists, and other responders in the medical forensic exam process. For various reasons, many sexual assault victims choose not to seek medical care or have evidence collected. However, coordination among professionals involved in immediate response may be instrumental in reversing this trend. It is often found that victims will seek assistance when responders work together to ensure that victims are informed of their options for assistance, encouraged to address their needs, and aided in obtaining the help they want. In addition, multidisciplinary coordination may enhance medical care provided to victims as well as evidence collection and preservation efforts.[8]

Background

This national protocol was developed by the Office on Violence Against Women under the direction of the Attorney General pursuant to the Violence Against Women Act of 2000.[9] In developing the protocol, OVW reviewed existing protocols on sexual assault forensic examinations and consulted with national, State, local, and tribal experts on sexual assault. Experts were consulted from rape crisis centers; State and tribal sexual assault and domestic violence coalitions and programs; and programs for criminal justice, forensic nursing, forensic science, emergency room medicine, law, social services, and sex crimes in underserved communities.[10]

Starting in the summer of 2001, the Department of Justice (DOJ) began gathering information on resources, issues, and gaps related to sexual assault medical forensic exams. The first task was to identify and obtain relevant materials and data. Existing national and jurisdictional protocols on the exam and immediate

[7] STI are also commonly known as sexually transmitted diseases (STDs).
[8] For example, when first responders explain to victims how to preserve evidence on their bodies and clothing prior to arrival at the exam site, they may increase the likelihood that the evidence will be collected rather than contaminated or destroyed.
[9] The statutory requirement to develop this protocol can be found in Section 1405 of the Violence Against Women Act of 2000, Public Law 106-386. The statutory requirement also mandates the development of a national recommended standard for training for health care professionals performing these examinations, as well as related training for all health care students. These training standards will be created at a later date and, due to this fact, this protocol does not provide extensive training information.
[10] Such consultation was required under Section 1405 of the Violence Against Women Act of 2000, Public Law 106-386.

multidisciplinary responses to sexual assault were sought,[11] as well as documents that analyzed jurisdictional response. Input was solicited on issues, gaps, and promising practices from numerous organizations, associations, and individuals representing disciplines involved in the response to sexual assault. In addition, numerous persons were contacted who could offer perspectives on particular issues related to the exam process. State sexual assault coalitions and/or State government agencies that oversee violence against women programs were also contacted to gain information on their activities concerning protocol development and training. In some States, data was obtained through discussions with sexual assault forensic examiners and coordinators of examiner programs or sexual assault response teams.

A series of forums was held in the summer and fall of 2002, calling upon practitioners and policymakers involved in victim advocacy, health care, forensic science, and criminal justice fields to assist in developing a national protocol. After a draft protocol for adult and adolescent victims was developed in early 2003, it was distributed to a wide array of individuals and organizations for their review and feedback.[12] Comments were first solicited from the individuals who were invited to the forums. Then input was sought from sexual assault survivors, as well as tribal sexual assault and domestic violence coalitions and local advocacy programs. Members of the National Advisory Committee on Violence Against Women also reviewed the draft and provided input. After several revisions of the document, feedback was solicited during the summer of 2003 from many national and State organizations and some local agencies that deal with sexual assault issues or serve diverse populations, as well as other individuals representing relevant disciplines. Comments received were incorporated into the document where appropriate. The finalized protocol will be reviewed periodically and revised as needed.[13]

Many of the provisions of this protocol are based on recommendations made by the consulted experts. Some of the recommendations are based on empirical research. Although research has been and continues to be done in many areas related to the medical forensic exam and was considered to the extent those involved in protocol development were aware, much more research needs to be done to provide support and validity to the exam process.

The national protocol recommends, rather than mandates, methods for conducting the medical forensic exam.[14] It serves as an informational guide to communities as they develop or revise their own protocols.[15] In no way does it invalidate previously established jurisdictional protocols, policies, or practices.

About This Document

Organization. Protocol recommendations are organized into several broad sections: A) overarching issues, B) operational issues, and C) the examination process. Each section builds on information presented in previous sections and comprises tasks to be addressed, issues to be considered, and related recommendations. Although an effort has been made to avoid repetition of information throughout the document, there are instances where data is repeated for clarity or emphasis. The appendixes discuss the topics of protocol customization by jurisdictions and creation of sexual assault response teams.

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[11] Protocols reviewed varied in scope, focus, targeted audiences, and level of detail. Most addressed to some extent exam and evidence collection procedures, drug-facilitated assault, evidence integrity, and evaluation and care for STIs, HIV, and pregnancy. Some also addressed roles of involved responders, multidisciplinary coordination, reporting, crime lab testing, court testimony, issues related to victims' needs, working with specific populations of victims, payment for the exam, and crime victims' compensation.

[12] The scope of this protocol is limited to the sexual assault medical forensic exam of adult and adolescent victims. A separate protocol should be developed on child exams. Not only is child sexual victimization a complex topic in and of itself, but response to child victims can be considerably different from response to adult and adolescent victims.

[13] Future revisions will attempt to incorporate new research, advances in science and technology, and promising practices. Rather than depending solely on revisions to the national protocol for updated information, responders involved in the exam process are urged to stay informed of cutting-edge research, advances, and practices, and promote change to their jurisdictional protocols to reflect the most effective responses possible.

[14] The protocol has no regulatory purpose and is not intended to nor does it provide legal advice. (Statement adapted from the *Hawaii State Sexual Assault Protocol for Forensic and Medical Examinations*, Introduction, 1999.)

[15] Those involved in the development of this protocol strove to create a document that addressed the many issues facing communities across the Nation related to the exam process. However, there may be instances where the document falls short of adequately addressing specific needs or challenges facing a jurisdiction or a specific population of victims. See appendix A on customizing protocols for ways that jurisdictions can address these limitations when they are developing/revising their own protocols.

Protocol foundation. This protocol is based on a belief that it is possible, with a victim's consent, to simultaneously address the two primary purposes of sexual assault forensic examinations: the immediate health needs of a victim and the future needs of the justice system.

Key principles underlying response to sexual assault victims as discussed in this document include:

- Recognition of victim safety and well-being as paramount goals of response;
- Recognition that victims know far more about themselves and their needs than responders;
- Respect for victims' right to make their own choices;
- Recognition that providing victims with information about their options during the exam process, expected consequences of choosing one option over another, and available resources can help them make more informed decisions;
- Recognition that all victims, regardless of differences in backgrounds and circumstances, have the right to receive a high-quality medical forensic exam and to be treated with respect and compassion;
- Respect for victims' right to confidentiality; and
- Recognition of the importance of victims' feedback to improving the exam process.

Another important principle is recognition that the vast majority of sexual assaults are committed by assailants known to victims. Historically, sexual assault committed by nonstrangers was not taken seriously and interventions were less than adequate. It is imperative that all involved responders acknowledge that sexual assaults committed by persons known to victims are as grave a crime as those committed by strangers. Responders should be aware that victims' reactions to an assault are affected by a multitude of factors: one of them being the prior relationship between the victim and the offender. They should also understand that many variables may affect the relevance of certain types of evidence to a particular case, including whether an assault was committed by a stranger, a known offender who claims no sexual contact with the victim, or a known offender who claims the victim consented to the contact.[16]

Use of Terms

Many terms are explained throughout the protocol to clarify the context in which they are used.[17] However, it may be helpful to discuss briefly the following terms in advance (in alphabetical order):

Adolescent: Adolescents are distinguished in the protocol from prepubertal children who require a pediatric exam. This document focuses on the examination of females who have experienced the onset of menarche and males who have reached puberty. However, it is important to recognize that age also plays a role in whether a person is treated as a child or adolescent. For example, some adolescent girls may not start menstruating until their later teen years. While the physical developmental level of these patients must be taken into account when performing the exam, they should otherwise be treated as adolescents rather than children. Legally, jurisdictions vary in the age at which they consider individuals to be minors, laws on child sexual abuse, mandatory reporting policies for sexual abuse and assault of minors, instances in which minors can consent to treatment and evidence collection without parental/guardian involvement, and the scope of confidentiality that minors are afforded. Involved responders should be well versed in their jurisdictional laws and policies regarding the above issues, screening procedures for determining whether a pediatric exam is needed (particularly in the case of younger adolescents), and local protocols for response to prepubertal victims. Exam sites are to follow the jurisdictional laws regarding parental/guardian consent.

Communitywide sexual assault coordinating councils: These multidisciplinary groups typically work to facilitate a communitywide response to sexual assault that is appropriate, coordinated, and comprehensive. They tend not to be involved in direct response, but rather endeavor to improve overall services, interventions, and prevention efforts. Communitywide coordinating council is a broad term for such a group,

[16] For example, evidence that identifies a suspect in a stranger case, such as DNA evidence, is critical to the continuing investigation. In cases in which the victim knows the suspect, evidence that identifies suspects is important if suspects claim they had no sexual contact with victims. In cases in which suspects claim that victims consented to the sexual contact, evidence identifying suspects is less crucial and evidence and documentation related to whether force or coercion was used against victims is often more important.

[17] Keep in mind that these definitions may vary from those used generally or in exam protocols developed by States, Territories, tribes, and local communities.

but possibilities are endless for what a jurisdiction may call such a group. This group may be a subcommittee of an entity that more generally promotes coordinated response to violence in the community.

Coordinated community response: This term refers to immediate and longer term community response to sexual assault that is coordinated among involved responders. The idea is that while each responder provides services and/or interventions according to agency-specific policies, they also work with responders from other agencies and disciplines to ensure that they coordinate responses. The desired result is a collective response to victims and offenders that is appropriate, streamlined, and as comprehensive as possible. Coordinated community response to sexual assault is a concept that developed out of a need to reduce the historically fragmented approach to these cases and the negative impact of fragmentation on victim well-being, offender accountability, and prevention of future assault.

Culture: This term refers to a body of learned beliefs, traditions, and guides for behaving and interpreting behavior that may be shared among members of a particular group. Aspects of a culture include its values, beliefs, customs, communication styles, behaviors, practices, and institutions.[18] In this document, a cultural group refers not only to an ethnic, racial, or religious group, but also to other groups with distinct cultures such as senior citizens, deaf and hard-of-hearing communities, populations with differing sexual orientations, the homeless, military personnel and their dependents, adolescents, prison inmates, and victims of sex trafficking. Individuals often belong to multiple cultural groups.

An immediate response to victims should sensitively and appropriately address their related cultural needs and concerns. It is important that responders acknowledge that victims from certain cultures in a community may be underserved, unserved, or misserved by the systems responsible for response and should work to improve response to these populations.

Disability: For the purpose of this document, this term includes physical, sensory, or mental disabilities, or a combination of disabilities. Physical disabilities may result from injury (e.g., spinal cord injury and amputation), chronic disease (e.g., multiple sclerosis and rheumatoid arthritis), or congenital impairments (e.g., developmental conditions such as cerebral palsy and muscular dystrophy). Sensory disabilities include hearing or visual impairments. Mental disabilities include developmental conditions (e.g., mental retardation), cognitive impairment (e.g., traumatic brain injury), or mental illness.[19] Note that developmental disabilities have an onset prior to age 22. While there are general issues to consider when working with victims with disabilities, unique issues will arise according to the specific type of disability. The protocol takes these needs into consideration to an extent; however, it is beyond the scope to provide a comprehensive discussion of all victim issues related to specific types of disabilities.

Domestic violence: This term broadly refers to any abusive and coercive behavior used to control an intimate partner (a spouse, boyfriend/girlfriend, or former spouse or boyfriend/girlfriend) and/or a family member.[20] Some examples of tactics employed by abusers to control victims are use of coercion, threats, and intimidation; emotional, physical, and sexual abuse; economic manipulation; use of privilege; use of children and pets; isolation of victims; minimization and denial of violence; and blaming victims for violence.[21] An episode of domestic violence often includes multiple actions, and the violence typically escalates over time. In this protocol, it is important to be aware that sexual assault can be a significant part of domestic violence. Response to sexual assault occurring within a domestic violence context requires understanding of the overlapping dynamics of sexual assault and domestic violence, the complex needs of victims, the potential dangerousness of offenders, the resources available for victims, and adherence to jurisdictional policies on response to domestic violence.

Examiner: The term refers to the health care provider conducting the sexual assault medical forensic examination. The examiner is also referred to in this document as the "sexual assault forensic examiner," "sexual assault examiner," and "forensic examiner." Many communities refer to their sexual assault

[18] The first two sentences in this paragraph are drawn from A. Blue, *The Provision of Culturally Competent Health Care*, from the Web site of the Medical University of South Carolina College of Medicine (www.musc.edu/deansclerkship/recultur.html).
[19] This definition was drawn from M. Nosek and C. Howland, *Abuse and Women with Disabilities*, 1998, p. 1.
[20] Drawn from M.A. Dutton, "The Dynamics of Domestic Violence: Understanding the Response from Battered Women," *Florida Bar Journal* 68(9), January 24, 1994.
[21] Drawn from the Power and Control Wheel developed by the Domestic Violence Intervention Project of Minnesota.

examiners by more specific acronyms based upon the discipline of practitioners and/or specialized education and clinical experiences.

First responder: A first responder is a professional who initially responds to a disclosure of a sexual assault (there is often more than one first responder). These professionals typically must follow agency-specific policies for responding to victims. Those who traditionally have been responsible for immediate response to adult and adolescent sexual assaults include victim advocates, 911 dispatchers, law enforcement representatives, and health care providers. A wide range of other responders also may be involved, such as emergency medical technicians, public safety officials, protective service workers, prosecutors and victim/witness staff, private physicians, staff from local health care facilities, mental health providers, social service workers, corrections and probation staff, religious and spiritual counselors/advisors, school personnel, employers, certified interpreters, and providers from organizations that address needs of specific populations (e.g., persons with disabilities, racial and cultural groups, senior citizens, the poor and homeless, runaways and adolescents in foster care, and domestic violence victims). Families and friends of victims also can play an important role in the initial response, because victims may first disclose the assault to them, ask for their help in seeking professional assistance, and want their ongoing support. However, they are not considered first responders in this document, because they are not responding to these disclosures in an official capacity.

Forensic scientist: The forensic scientist is responsible for analyzing evidence in sexual assault cases. This evidence typically includes DNA and other biological evidence, toxicology samples, latent prints, and trace evidence. Some forensic scientists specialize in the analysis of specific types of evidence. In this protocol, forensic scientists working in jurisdictional crime laboratories are often referred to as “crime lab/laboratory personnel” and “crime lab/laboratory scientists.” Forensic scientists analyzing drug and alcohol samples are also referred to as “toxicologists.”

Health care facility: Emergency health care facilities, such as those in hospitals, traditionally have been the setting for provision of medical forensic services to sexual assault patients. However, nonemergency health care programs, such as hospital-based or community-based examiner programs, community clinics, mobile health clinics, local health departments, military hospitals or clinics, and college and university health centers, may also offer full or partial sexual assault medical forensic services. Sexual assault forensic examiners also may conduct exams at additional health care and non-health care sites. The facility conducting the exam may be referred to in this protocol as the “exam site,” in recognition of the fact that not all sites performing the exam are health care facilities. Clinical staff providing care at exam sites are broadly referred to in this document as “health care providers,” ”health care staff,” “health care personnel,” and “health care clinicians.”

Jurisdiction: This term is used in two ways in the protocol. One is to broadly describe a community that has power to govern or legislate for itself. For example, a jurisdiction may be a local area, a State, a Territory, or tribal land. A jurisdiction may also be referred to in the protocol as a “community.” The term also describes the authority to interpret and apply laws and is used in this context mainly when identifying who has “jurisdiction” over a particular case.

Law enforcement representative: Different types of law enforcement agencies exist at the local, State, Territory, tribal, and Federal levels (e.g., county or tribal sheriff and/or police, State police, sworn police on college campuses, the FBI, criminal investigators from the Bureau of Indian Affairs (BIA), and military police). Any of these agencies could potentially be involved in responding to sexual assault cases. Also, in areas without a local law enforcement agency, public safety officials may assist in immediate response to sexual assault victims. Some agencies may have staff with specialized education and experience in sexual assault investigations. In this protocol, personnel from law enforcement agencies are referred to as “law enforcement officers” or “law enforcement representatives,” unless more specificity is required.

Prosecutor: Different types of prosecution offices exist at the local, tribal, State, Territory, and Federal level (e.g., tribal prosecutor’s office, county prosecutor’s office, district attorney’s office, State attorney’s office, United States Attorney’s office, and military judicial branches). Any of these offices could be involved in responding to sexual assault cases. In addition, some offices may have personnel with specialized education

and experience in sexual assault prosecutions. In this protocol, attorneys from prosecution offices will be referred to as "prosecutors" unless more specificity is required.

Sexual assault: Generally speaking, sexual assault is the sexual contact of one person with another without appropriate legal consent. This definition includes, but is not limited to, a wide range of behavior classified by State, Territory, Federal, and tribal law as rape, sexual assault, sexual misconduct, and sexual battery. Refer to applicable statutes for precise definitions in a specific jurisdiction.[22]

Sexual assault medical forensic examination: The sexual assault medical forensic exam is an examination of a sexual assault patient by a health care provider, ideally one who has specialized education and clinical experience in the collection of forensic evidence and treatment of these patients. The forensic component includes gathering information from the patient for the medical forensic history, an examination, documentation of biological and physical findings, collection of evidence from the patient, and followup as needed to document additional evidence. The medical component includes coordinating treatment of injuries, providing care for STIs, assessing pregnancy risk and discussing treatment options, including reproductive health services, and providing instructions and referrals for followup medical care. This exam is referred to as the "forensic medical examination" under the Violence Against Women Act (VAWA).

Sexual assault response team (SART): A SART is a multidisciplinary team that provides specialized immediate response to victims of recent sexual assault. The team typically includes health care personnel, law enforcement representatives, victim advocates, prosecutors (usually available on-call to consult with first responders, although some may be more actively involved at this stage), and forensic lab personnel (typically available to consult with examiners, law enforcement, or prosecutors, but not actively involved at this stage). However, SART components vary by community.

Suspected sex offender: A suspected sex offender is an individual suspected of committing a sexual assault. In this document, the suspected sex offender is typically referred to as a "suspect." When litigation is discussed, the suspected sex offender may be referred to as a "defendant." When talking more broadly about sex offenders, they may be referred to as "sex offenders," "assailants," or "perpetrators."

Victim: A sexual assault victim is someone who has been sexually assaulted. In this document, a victim can be a female or male; either adult or adolescent. There may be instances where individuals, such as unconscious persons or persons with cognitive disabilities, do not actually disclose that they have been assaulted, but others suspect that this may be this case and may be lawfully able to seek help for them. The term "survivor" is used in this document when referring to victims who are involved in long-term healing or have healed from sexual assault. It is important to note that because this document addresses a multidisciplinary response, the term "victim" is not used in a strictly criminal justice context. The use of "victim" simply acknowledges that persons who disclose they have been sexually assaulted should have access to certain services and interventions designed to help them be safe, recover, and seek justice. The term "patient" is also used when discussing the role of medical providers.

Victim service provider/advocate: A victim service provider/sexual assault victim advocate (also referred to as "victim advocate" and "advocate") may offer victims and their significant others a range of services during the exam process. These services may include support, crisis intervention, information and referrals, and advocacy to ensure that victims' interests are represented, their wishes respected, and their rights upheld. In addition, advocates and other victim service providers may provide followup services, such as support groups, counseling, accompaniment to related appointments, and legal advocacy to help meet the needs of victims, their families, and friends.

A number of agencies may offer some or all of the services described above, including community-based sexual assault victim advocacy programs,[23] criminal justice system victim-witness offices, patient advocate programs at health care facilities, campus or military victim service programs, tribal social services, adult

[22] Drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, Overview, p. 7.

[23] In some areas, the community-based sexual assault victim advocacy program is a component of an umbrella organization serving additional populations (e.g., a dual sexual assault/domestic violence advocacy agency, a center for women, or a mental health agency). In others, the community-based sexual assault victim advocacy program is a stand-alone organization.

protective services, and others. Where they exist, community-based sexual assault victim advocacy programs are typically best positioned to provide these specific services. Community-based advocacy programs may use paid and/or volunteer advocates to provide services 24 hours a day, every day of the year. It is important to know that information victims share with government-based service providers usually becomes part of the criminal justice record, while community-based advocates typically can provide some level of confidential communication for victims. In addition, community-based advocates commonly receive education specific to the medical forensic exam process and sexual assault issues in general.

Victim-centered: A “victim-centered” approach as used in this protocol recognizes that sexual assault victims are central participants in the medical forensic exam process, and they deserve timely, compassionate, respectful, and appropriate care. Victims have the right to be well informed in order to make their own decisions about participation in all components of the exam process. Responders need to do all that is possible to explain possible options, the consequences of choosing one option over another, and available resources.

Vulnerable adults: This term is used in this document to refer to adult individuals with impaired and/or reduced mental capacity who have difficulty or cannot comprehend events that occurred or will occur (e.g., the assault itself or initial response by professionals), questions they will be asked during the exam, or the exam process itself. Exam sites should have internal policies based on jurisdictional statutes governing consent for treatment for and evidence collection from such patients.

A. Overarching Issues

This section presents issues that impact all or most of the sexual assault medical forensic exam process. The following chapters are included:

1. Coordinated Team Approach
2. Victim-Centered Care
3. Informed Consent
4. Confidentiality
5. Reporting to Law Enforcement
6. Payment for the Examination Under VAWA

1. Coordinated Team Approach

Recommendations at a glance for jurisdictions to facilitate a coordinated team approach:

- Understand the dual purposes of the exam to address patient and justice system needs.
- Identify key responders and their roles.
- Develop quality assurance measures to ensure effective immediate response.

Communities should ensure that victims, regardless of their backgrounds or circumstances, have access to medical, legal, and advocacy services. Use of a coordinated, multidisciplinary approach in conducting the medical forensic examination can afford victims access to comprehensive immediate care, help minimize trauma they may be experiencing, and encourage the use of community resources. Such a response can also enhance public safety by facilitating investigation and prosecution, thereby increasing the likelihood that offenders will be held accountable for their behavior and further sexual assaults will be prevented. Raising public awareness about the existence and benefits of a coordinated response to sexual assault may lead more victims to disclose the assault and seek the help they need.[24]

Understand the dual purpose of the exam process.[25] One purpose is to address the needs of individuals disclosing sexual assault. This is accomplished (with their permission) by:

- Evaluating and treating injuries;
- Conducting prompt examinations;
- Providing support, crisis intervention, and advocacy;
- Providing prophylaxis against STIs;
- Assessing female patients for pregnancy risk and discussing treatment options, including reproductive health services; and
- Providing followup care for medical and emotional needs.

The other purpose is to address justice system needs. This is accomplished by:

- Obtaining a history of the assault;
- Documenting exam findings;
- Properly collecting, handling, and preserving evidence; and
- Interpreting and analyzing findings (postexam); and
- Subsequently, presenting findings and providing factual and expert opinion related to the exam and evidence collection.

Coordination among involved disciplines is strongly recommended to simultaneously address the needs of both victims and the justice system. Ensuring that victims' needs are met often can increase their level of comfort and involvement with the legal system.

Identify key responders and their roles. Two types of teams are recommended to facilitate a coordinated community response to sexual assault. Some form of a sexual assault response team (SART) is useful to coordinate immediate interventions and services, including victim support, medical care, evidence collection and documentation, and the initial criminal investigation. A communitywide coordinating group (often called a "council") can help promote efforts to improve comprehensive response to sexual violence, including prevention education and outreach,[26] training and technical assistance, improvement of victim services,

[24] This paragraph is drawn partially from American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 7.
[25] Adapted from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 20.
[26] Although victim advocacy programs and coordinating councils often lead local prevention efforts, SARTs play a role in prevention by helping victims plan for their safety and well-being and connecting them with resources that may reduce the likelihood of their future revictimization (e.g., emergency shelters and longer term housing programs, protective orders, programs offering free cell phones that

protocol development, public policy advocacy, dissemination of materials, and evaluation of the effectiveness of these efforts.[27] A communitywide coordinating council may also oversee activities of a SART. Military bases, school campuses, and tribes may develop coordinating councils or SARTs of their own to allow for a more specialized response tailored to the needs of their populations. Coordinating councils may also exist to encourage consistent responses across a State, Territory, or region.

SART membership. A SART is composed of professionals involved in immediate response to disclosures of sexual assault. A core SART commonly includes health care providers, law enforcement representatives, and victim advocates. Prosecutors and forensic scientists also are often involved, but more as consultants than first responders. Broad roles for SART members include (listed in alphabetical order):[28]

- **Advocates** may be involved in initial victim contact (via 24-hour hotline or face-to-face meetings), offer victims advocacy, support, crisis intervention, information, and referrals before, during, and after the exam process, and help ensure that victims have transportation to and from the exam site. They often provide followup services designed to aid victims in addressing related legal and nonlegal needs.
- **Forensic scientists** analyze forensic evidence and provide results of the analysis to investigators and/or prosecutors.
- **Health care providers** assess patients for acute medical needs and provide stabilization, treatment, and/or consultation. Ideally, sexual assault forensic examiners perform the medical forensic exam, gather information for the medical forensic history, and collect and document forensic evidence from patients. They offer information, treatment, and referrals for STIs and other nonacute medical concerns, assess pregnancy risk and discuss treatment options with the patient, including reproductive health services, and testify in court if needed. They typically coordinate with advocates to ensure that patients are offered crisis intervention, support, and advocacy during and after the exam process and encourage use of other victim services. They may follow up with patients for medical and forensic purposes. Other health care personnel that may be involved include, but are not limited to, emergency medical technicians, staff at hospital emergency departments, gynecologists, surgeons, private physicians, and/or local, tribal, campus, or military health services personnel.
- **Law enforcement representatives** (e.g., 911 dispatchers, patrol officers, officers who process crime scene evidence, and investigators) respond to initial complaints, work to enhance victims' safety, arrange for victims' transportation to and from the exam site as needed, interview victims, coordinate collection and delivery of evidence to designated labs or law enforcement property facilities, and investigate cases.
- **Prosecutors** determine if there is sufficient evidence for prosecution and, if so, prosecute the case. They should be available to consult with first responders as needed. A few jurisdictions more actively involve prosecutors, paging them after initial contact and having them respond to the exam site so that they can become familiar with the case and help guide the investigation.[29] Prosecutors may want to consider whether participation in a SART would be beneficial.[30]

Each responder should be able to explain to victims the roles of other team members. Depending on the case and jurisdictional policies, other professionals or agencies may also be involved in immediate interventions and service provision. They need information about the SART and its procedures to guide their responses and facilitate coordination of activities with the SART. SART members also need information about those professionals and agencies, their roles in response, and how to contact and interact with them.

Team efforts are enhanced when SART members reflect the communities being served. At the least, SART members should strive to understand the needs and concerns of specific populations living in the area

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automatically dial 911 when activated, or businesses that can help change locks and install alarm systems). Initial evidence collection and investigative efforts can play a pivotal role in holding offenders accountable and preventing them from reoffending.

[27] American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 19.

[28] Bulleted section partially adapted from Pennsylvania's *SART Guidelines*, 2002, created by the Pennsylvania Coalition Against Rape.

[29] In addition to seeking prosecution of offenders, victims who attend institutions of higher education may have the option of filing disciplinary charges. When that happens, members of the judiciary board review the case to decide if the institutional code of conduct has been violated and, if so, to determine sanctions. Tribes may also have their own codes related to sexual assault and/or processes through which victims can seek remedies, beyond what is available through State or Federal prosecution.

[30] For additional information or resources on the prosecution of sexual violence, contact the Violence Against Women Program at the American Prosecutors Research Institute at www.ndaa-apri.org or 703-549-4253.

served. SARTs should reach out to agencies that serve these populations so that team members can promptly access their services if needed.

See *Appendix B* for more information on the creation of SARTs.

Membership of a coordinating council. A coordinating council typically comprises a wide array of professionals and citizens who develop the community's response to sexual assault. Organizations with an interest in or a responsibility for sexual assault victims should be considered for membership.[31] For example, members might include[32] victim advocates; survivors of sexual assault and their families and friends; health care workers; public health and safety officials; law enforcement personnel; prosecutors; victim/witness staff; judicial personnel;[33] corrections and probation staff; sex offender treatment providers; forensic lab personnel; staff from mental health agencies; personnel serving persons with disabilities; substance abuse treatment staff, staff from residential living settings such as nursing homes, assisted living programs, and group homes; educators from all levels; legislators and government policymakers; health care facility administrators; religious and spiritual leaders; and the media and business community. Representation from all levels of government that potentially have jurisdiction over these cases in the area served should be involved. Equally important are members who can address the needs of diverse populations in the community (e.g., racial and cultural groups, senior citizens, persons with disabilities, the poor and homeless, runaways and adolescents in foster care, domestic violence victims, college students, military personnel and dependents, and populations with differing sexual orientations). Agencies that provide certified interpreters in sexual assault cases should also be invited to participate.

Attempting to involve all agencies and individuals listed above is an enormous task and could prove to be a barrier to council formation and initial council efforts. Therefore, communities should make their own decisions about which stakeholders are critical to initial efforts and form a core membership, and then identify which agencies and individuals would be useful to have at the table at some point but are not essential to getting started.[34]

Develop quality assurance measures to ensure effective coordinated response during the exam process. Involved agencies should have mechanisms to ensure that the quality of discipline-specific response and coordinated response is optimal. Some tools to ensure consistent high-quality response by involved professionals include training, ongoing education, supervision, periodic performance evaluations, and peer reviews (e.g., medical forensic reports). Also useful in facilitating improvements to immediate response are feedback from victims and involved professionals and collection and analysis of data from the exam process (as discussed below).

Obtain feedback on victim impact, the exam process, and criminal justice outcomes. All involved responders can benefit from victims' feedback about whether they felt response to the crime was adequate and if anything could have been done to improve response or better address their needs. It can be useful to talk with victims about their experiences during the exam process and explore how the process might be changed to better minimize trauma. Victim feedback can be obtained in several ways: by requesting completion of an evaluation form (not immediately after the exam), conducting a followup phone survey, and inviting participation in focus group discussions. Ask victims prior to medical discharge if they will allow such subsequent contacts and the best method of contacting them. Advocates can help design a victim feedback system that is sensitive, does not harm victims, and has mechanisms to quickly link victims with appropriate victim services if needed. Families and friends of victims may also be able to provide useful feedback.

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[31] American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 19.

[32] List adapted from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 19.

[33] Judges' conduct in and out of the courtroom is governed by a code of judicial conduct that requires that they do nothing that would give the appearance of partiality. Depending on local interpretation of the code, the participation of judicial personnel on a council should not negate their ability to be impartial in court. In the unlikely instances that the council is involved with individual cases, judges can excuse themselves from those activities.

[34] The protocol does not further explore issues related to more comprehensive coordinated response to sexual assault. However, one useful resource for communities interested in the development of a multidisciplinary response is the National Center for Victims of Crime's *Looking Back, Moving Forward: A Guidebook for Communities Responding to Sexual Assault*.

Obtaining feedback from and facilitating dialogue among first responders on the exam process and criminal justice outcomes is also critical. Some of this information could be routinely solicited and discussed at SART meetings and jurisdictional sexual assault coordinating council meetings (to assess what works and what needs improvement). Also, periodic evaluation of the exam process by examiners, medical supervisors/examiner program directors, advocates, law enforcement representatives, and prosecutors can help ensure that victims' needs are addressed, problems are resolved, cutting-edge practices and technologies are utilized as much as possible, and training needs are identified. In terms of getting feedback on how the exam process impacts criminal justice outcomes, examiners can benefit from access to crime lab reports on evidence collected and feedback from crime lab personnel about improving their evidence collection techniques. Prosecutors can provide examiners and law enforcement representatives with information about the usefulness of evidence collected in case prosecution. Advocates can encourage discussion on how the exam process can affect victims' interest in and willingness to be involved in the criminal justice system. Law enforcement representatives and other first responders can discuss with examiners and crime lab personnel optimal methods to preserve evidence from victims prior to their arrival at the exam site. These are but a few examples of how first responders could use feedback on criminal justice outcomes to improve the exam process.

Consider collecting and analyzing data from the exam process to better understand the nature of assaults in the community and evaluate effectiveness of responses. (Information that identifies victims should not be included in collected data. Attention must be given to protecting victims' identity in communities where residents tend to know one another or word of a crime travels quickly). Over time, such data may help to:[35]

- Track the participation of involved responders, agencies, and facilities;
- Evaluate the strengths and weaknesses of agency and coordinated responses;
- Assess the effectiveness of response in different types of cases (e.g., stranger assaults versus nonstranger assaults);
- Improve the quality of the examination;
- Evaluate the impact of the collected evidence on criminal justice outcomes; and
- Track and evaluate victim service outcomes.

A national SANE–SART database has been developed to allow data collection from nurse examiner programs around the country. All victim information provided is anonymous. See www.sane-sart.com for more details.

Some jurisdictions have developed centralized databases to collect and analyze information across disciplines. However, such a venture requires significant resources, coordination, and thought regarding how to maintain victims' confidentiality. Coordination can be particularly challenging in communities where cross-jurisdictional issues arise frequently (e.g., in tribal lands). A centralized database may be more easily accomplished if it is built into multidisciplinary coordination planning. For example, involved agencies can together determine how to utilize existing resources, seek new funding, maintain victims' privacy, and systematically obtain data.

[35] Bulleted section partially adapted from the *County of San Diego Sexual Assault Response Team Systems Review Committee Report: Five-Year Review,* 2000, San Diego County, California.

2. Victim-Centered Care

Recommendations at a glance for health care providers and other responders to facilitate victim-centered care during the exam process:

- Give sexual assault patients priority as emergency cases.
- Provide the necessary means to ensure patient privacy.
- Adapt the exam process as needed to address the unique needs and circumstances of each patient.
- Be aware of issues commonly faced by victims from specific populations.
- Understand the importance of victim services within the exam process. Involve victim service providers/advocates in the exam process (including the actual exam) to offer support, crisis intervention, and advocacy to victims, their families, and friends.
- Respect patients' requests to have a relative, friend, or other personal support person present during the exam, unless considered harmful by responders.
- Accommodate victims' requests for responders of a specific gender as much as possible.
- Prior to starting the exam and conducting each procedure, describe what is entailed and its purpose to patients. After providing this information, seek patients' permission to proceed and respect their right to decline any part of the exam. However, follow exam facility and jurisdictional policy regarding minors and adults who are incompetent to give consent.
- Assess and respect patients' priorities.
- Integrate exam procedures where possible.
- Address patients' safety concerns during the exam. Sexual assault patients have legitimate reasons to fear further assaults from their attackers. Local law enforcement may be able to assist facilities in addressing patients' safety needs.
- Provide information that is easy for patients to understand and that can be reviewed at their convenience.
- After the exam is finished, provide patients with the opportunity to wash, brush their teeth, change clothes, get food or drink, and make needed phone calls. Assist them in arranging transportation home or to another location if needed.

It is critical to respond to individuals disclosing sexual assault in a timely, appropriate, sensitive, and respectful way.[36] Every action taken by responders during the exam process should be useful in facilitating patients' care and healing and/or the investigation (if the case was reported).

Give patients priority as emergency cases. Recognize that every minute patients spend waiting to be examined may cause loss of evidence and undue trauma. Individuals disclosing a recent sexual assault should be quickly transported to the exam site, promptly evaluated, treated for serious injuries, and undergo a medical forensic exam. (For more discussion on this topic, see *C.2. Triage and Intake*.)

Provide the necessary means to ensure patients' privacy. Exercise discretion to avoid the embarrassment for individuals of being identified in a public setting as a sexual assault victim. Some health care facilities use code plans to avoid inappropriate references by staff to sexual assault cases. Also, do not leave sexual assault patients in the main waiting area at the exam site. Instead, give them as much privacy as possible (e.g., a private treatment room and waiting area) and be cognizant of their sense of safety (e.g., do not examine suspects in same location at the same time). Make sure that the first responding health care providers attend to patients' initial medical needs and arrange for an on-call advocate to offer onsite support, crisis intervention, and advocacy. It may be useful to give patients the option of speaking with an advocate via a 24-hour crisis hotline (if one exists) until an on-call advocate arrives. Health care providers should provide patients with access to a phone to contact family members and friends as desired, and should

[36] The chapter was partially built on information from the *North Carolina Protocol for Assisting Sexual Assault Victims*, 2000.

promptly contact law enforcement, if not already involved, if patients want to report the assault (or according to jurisdictional policy).

Health care providers should explain to patients the scope of confidentiality during the exam process and during communication with advocates. (For information on this topic, see *A.4. Confidentiality*.)

Recognize that the medical forensic exam is an interactive process that must be adapted to the needs and circumstances of each patient. Patients' experiences during the crime and the exam process, as well as their postassault needs, may be affected by multiple factors, such as:

- Age;
- Gender and/or gender identity;
- Physical health history and current status;
- Mental health history and current status;
- Disability;
- Language needs and communication modalities;
- Ethnic and cultural beliefs and practices;
- Religious and spiritual beliefs and practices;
- Economic status, including homelessness;
- Immigration and refugee status;
- Sexual orientation;
- Military status;
- History of previous victimization;
- Past experience with the criminal justice system;
- Whether the assault involved drugs and/or alcohol;
- Prior relationship with the suspect, if any;
- Whether they were assaulted by an assailant who was in an authority position over them;
- Whether the assault was part of a broader continuum of violence and/or oppression (e.g., intimate partner and family violence, gang violence, hate crimes, war crimes, and trafficking);
- Where the assault occurred;
- Whether they sustained physical injuries from the assault and the severity of the injuries;
- Whether they were engaged in illegal activities at the time of the assault (e.g., voluntary use of illegal drugs or underage drinking) or have outstanding criminal charges;
- Whether they were involved in activities prior to the assault that traditionally generate victim blaming or self-blaming (e.g., drinking alcohol prior to the assault or agreeing to go to the assailant's home);
- Whether birth control was used during the assault (e.g., victims may already have been on a form of birth control or the assailant may have used a condom);
- Capacity to cope with trauma and the level of support available from families and friends;
- The importance they place on the needs of their extended families in the aftermath of the assault;
- Whether they have dependents who require care during the exam, were traumatized by the assault, or who may be affected by decisions patients make during the exam process;
- Community/cultural attitudes about sexual assault, its victims, and offenders; and
- Frequency of sexual assault and other violence in the community and historical responsiveness of the local justice system, health care systems, and community service agencies.

Clearly, the level of trauma experienced by patients can also influence their initial reactions to an assault and to postassault needs. While some may suffer physical injuries, contract an STI, or become pregnant as a result of an assault, many others do not. The experience of psychological trauma will be unique to each patient and may be more difficult to recognize than physical trauma. People have their own method of coping with sudden stress. When severely traumatized, they can appear to be calm, indifferent, submissive, jocular, angry, emotionally distraught, or even uncooperative or hostile towards those who are trying to help.[37]

[37] Paragraph adapted from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, pp. 1–4.

In addition, patients' fears and concerns can affect their initial reactions to the assault, their postassault needs, and decisions before, during, and after the exam process. For example, female patients may be worried about getting pregnant. If they are already pregnant or have just given birth, they may be concerned about how the assault will affect their children. Patients may be concerned about being infected with HIV or another STI. They may not want anyone to know about the assault, or may be afraid that family members and friends will reject or blame them. They may fear bringing shame to their families or be concerned that family members will seek revenge against the assailant. They may fear perceived consequences of reporting to law enforcement. They may be concerned how their cultural background could affect the way they are treated by responders. They may wonder if the assailant will harm or harass them or their loved ones if they tell anyone about the assault. They may worry about losing their home, children, job, and other sources of income as a result of disclosure, particularly if an intimate partner assaulted them.[38] They may be concerned about costs related to the exam and subsequent care of injuries.[39]

It is important to avoid making assumptions about patients, offenders, and the assault itself. Forms used during the exam process and discussions with patients should be framed in a way that does not assume they are of a specific background. Always ask questions and actively look and listen to understand patients' circumstances and tailor the exam process to address their needs and concerns. Whatever the response, it should be respectful to patients and adhere to jurisdictional policies.

Recognize that patients control the extent of personal information they share. While it is useful for responders to get a full picture of patients' circumstances, it is up to patients to decide whether and to what extent to share personal information. During the exam process, responders may ask patients to divulge some data, such as age or whether they think the assault was drug-facilitated. Some information, such as language needs, may be obvious. There is no reason for responders to question patients about certain data, such as sexual orientation and gender identity, religious or spiritual beliefs, or previous victimization.

Be aware of issues commonly faced by patients from specific populations. It is important to realize that for some patients, certain personal characteristics (e.g., culture, language skills/mode of communication, disability, gender, and age) may strongly influence their experiences in the immediate aftermath of a sexual assault and during the exam process. Education for responders on issues facing a specific population may serve to enhance care, services, and interventions provided during the exam process. Responders should identify different populations that exist in their jurisdiction and determine what information they should have to help them serve patients from these populations. Building understanding of the perspectives of a specific population may help increase the likelihood that the actions and demeanor of responders will mitigate victim trauma. However, do not assume that patients will hold certain beliefs or have certain needs and concerns merely because they belong to a specific population. And, as pointed out earlier, recognize that patients' experiences are affected by a plethora of other personal and external factors.

Develop policies and plans. Involved agencies and SARTs should develop policies and plans to meet the needs of specific patient populations (e.g., to obtain certified interpreters for Deaf and hard-of-hearing patients). When creating these plans, consider what barriers exist for patients from different populations to receiving a high-quality exam and what can be done to remove these barriers. Also, consider what equipment and supplies might be needed to assist persons from specific populations (e.g., a hydraulic lift exam table may be useful with victims who have a physical disability). Relevant responders need to have access to and know how to use such equipment or supplies.

Partner with those who serve specific populations. Involved responders should seek expertise from and collaborate with organizations and leaders that serve specific populations. Not only may they be willing to provide information and training on working with victims from the population they serve, but they also may be a resource before, during, and after the exam process. If responders may be involved in the immediate response to victims, they should be trained on the dynamics of sexual victimization and procedures for getting help for victims and work with the multidisciplinary response team to clarify their roles and procedures for response.

[38] Minors may fear being removed from their homes if suspects live with them. Persons living in residential settings, such as group homes or nursing facilities, may fear being removed from their homes if they report an assault that occurred in that setting.
[39] Paragraph partially adapted from the *Ohio Protocol for Sexual Assault Forensic and Medical Examination*, 2002, p. 2.

Explore the needs of specific populations. To gain a basic understanding of potential issues and concerns facing different groups of sexual assault victims, this section explores several specific populations.[40] Clearly, this exploration is not inclusive of all populations of victims, but a more comprehensive discussion on this topic is beyond the scope of this document.

—Victims from various cultural groups and those with limited English proficiency

- Understand that culture can influence beliefs about sexual assault, its victims, and offenders. It can affect health care beliefs and practices related to the assault and medical treatment outcomes. It can also influence beliefs and practices related to emotional healing from an assault. In addition, it can impact beliefs and practices regarding justice in the aftermath of a sexual assault, the response of the criminal justice system, and the willingness of victims to be involved in the system.[41]
- Understand that some victims may be apprehensive about interacting with responders from ethnic and racial backgrounds different from their own. They may fear or distrust responders or assume they will be met with insensitive comments or unfair treatment. They may benefit from responders of the same background or at least who understand their culture.
- Be aware that cultural beliefs may preclude a member of the opposite sex from being present when victims disrobe. Also, it may be uncomfortable for victims from some cultures to speak about the assault with members of the opposite sex.
- Understand that victims may not report or discuss the assault because the stigma associated with it is so overwhelmingly negative. In some cultures, for example, the loss of virginity prior to marriage is devastating and may render victims unacceptable for an honorable marriage. Even discussing an assault or sexual terms may be linked with intense embarrassment and shame in some cultures.
- Recognize that some cultures (e.g., Indian tribes) may have their own laws and regulations to address sexual assault, in addition to or in place of applicable jurisdictional laws. Responders should be familiar with procedures for coordinating services and interventions for victims from these communities.
- Be aware that beliefs about women, men, sexuality, sexual orientation, race, ethnicity, and religion may vary greatly among victims of different cultural backgrounds. Also, understand that what helps one victim deal with a traumatic situation like sexual assault may not be the same for another victim.
- Help victims obtain culturally specific assistance and/or provide referrals where they exist.[42]
- Be patient and understanding toward victims' language skills and barriers, which may worsen with crisis.
- Make every attempt to provide interpretation services and translated materials for victims who do not speak English. Use certified interpreters when possible and not victims' families or friends.[43] Take the victim's country of origin, acculturation level, and dialect into account when responding or arranging interpretation.[44] Remember to speak directly to victims when interpreters are used.
- Train interpreters about issues related to sexual assault, confidentiality, and cultural concerns whenever they are needed to facilitate communication in these cases.

—Victims with disabilities

- Understand that victims with disabilities may have physical, sensory, or mental disabilities, or a combination of disabilities. (For a more detailed explanation, see "Use of Terms" in the *Introduction*.)

[40] This section was adapted partially from Connecticut's *Technical Guidelines for Health Care Response to Victims of Sexual Assault*, 1998, pp. 12–14, and from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, pp. 1–4.
[41] Bullet drawn from A. Blue, *The Provision of Culturally Competent Health Care,* from the Web site of the Medical University of South Carolina College of Medicine (http://www.musc.edu/fm_ruralclerkship/culture.html).
[42] For example, to raise their level of hope and comfort during the exam, some patients may benefit from talking about culturally specific models of healing (where they exist) and their application to recovery from sexual assault. To facilitate such a discussion, they may wish to speak with a religious or spiritual healer from their culture.
[43] Consult with jurisdictional statutes and policies regarding the use of community-based advocates as interpreters—such a dual role may jeopardize their confidentiality with victims.
[44] For example, a Cuban interpreter may encounter language and trust obstacles when trying to communicate with a victim from rural Mexico. (L. Zarate, Suggestions for Upgrading the Cultural Competency Skills of SARTs, Arte Sana Web site, www.Arte-sana.com, 2003.)

Make every effort to recognize issues that arise for victims with disabilities (both in general and in relation to their specific disability) and provide reasonable accommodations when working with them.

- Be aware that the risk of criminal victimization (including sexual assault) for people with disabilities appears to be much higher than for people without disabilities. People with disabilities are often victimized repeatedly by the same offender.[45] Caretakers, family members, or friends may be responsible for the sexual assault.
- Respect victims' wishes to have or not have caretakers, family members, or friends present during the exam. Although these individuals may be accustomed to speaking on behalf of persons with disabilities, it is critical that they not influence the statements of victims during the exam process. If aid is required (e.g., from a language interpreter or mental health professional), ideally those providing assistance should not be associated with victims.
- Follow exam facility and jurisdictional policy for assessing vulnerable adults' ability to consent to the exam and evidence collection and involving protective services. Again, note guardians could be offenders. (For a more detailed discussion on seeking informed consent of patients, including consent by victims from specific populations, see *A.3. Informed Consent*.)
- Speak directly to victims with disabilities, even when interpreters, intermediaries, or guardians are present.
- Assess a victim's level of ability and need for assistance during the exam process. Explain exam procedures to victims and ask what help they require, if any (e.g., people with physical disabilities may need help to get on and off the exam table or to assume positions necessary for the exam). Do not assume they will need special aid. Also, ask for permission before proceeding to help them (or touch them, handle a mobility or communication device, or touch a service animal[46]).
- Note that not all individuals who are Deaf or hard-of-hearing understand sign language or can read lips. Not all blind persons can read Braille. Communication equipment that may be beneficial to victims with sensory disabilities include TTY machines, word boards, speech synthesizers, anatomically correct dolls, materials in alternative formats, and access to interpreter services. Responders should familiarize themselves with the basics of communicating with an individual using such devices.[47] Be aware that victims with sensory disabilities may prefer communicating through an intermediary who is familiar with their patterns of speech.
- Recognize that individuals may have some degree of cognitive disability: mental retardation, mental illness, developmental disabilities, traumatic brain injury, neurodegenerative conditions such as Alzheimer's disease, or stroke. Note that not all developmental disabilities affect cognitive ability (e.g., cerebral palsy may result in physical rather than mental impairment). Be aware that victims with cognitive disabilities may be easily distracted and have difficulty focusing. To reduce distractions, conduct the exam in an area that is void of bright lights and loud noises. Speak to victims in a clear and calm voice and ask very specific and concrete questions. Be exact when explaining what will happen during the exam process and why. It may also be helpful if examiners and others present in the exam room refrain from wearing uniforms with ornamental designs and jewelry.
- Keep in mind that victims with disabilities may be reluctant to report the crime or consent to the exam for fear of losing their independence. For example, they may have to enter a long-term care facility if their caretakers assaulted them or may need extended hospitalization to treat and allow injuries to heal.
- Recognize that it may be the first time victims with disabilities have an internal exam. The procedure should be explained in detail in language they can understand.[48] They may have limited knowledge of reproductive health issues and not be able to describe what happened to them. They may not know how they feel about the incident or even identify that a crime was committed against them.
- Some victims with disabilities may want to talk about their perceptions of the role their disability might have played in making them vulnerable to an assault. Listen to their concerns and what the experience

[45] The above two sentences are drawn from the Office for Victims of Crime, *First Response to Victims of Crime Who Have a Disability*, 2002, p. 1.
[46] Examples of service animals include guide dogs and hearing-assistance dogs, and therapy dogs.
[47] Note that individuals may have their own assistive devices, but words needed to communicate may have to be programmed.
[48] Drawn from A. Conrad, *SANE/SAFE Organizing Manual*, 1998, p. 7, developed for the New York State Coalition Against Sexual Assault.

was like for them.[49] Assure them that it was not their fault they were sexually assaulted. If needed, encourage discussion in a counseling/advocacy setting on this issue as well as on what might help them feel safer in the future,.

- Recognize that the exam may take longer to perform with victims with disabilities. Avoid rushing through the exam—such action not only may distress victims, it can lead to missed evidence and information.

—Male victims[50]

- Help male victims understand that male sexual assault is not uncommon and that the assault was not their fault. Many male victims focus on the sexual aspect of the assault and overlook other elements such as coercion, power differences, and emotional abuse. Broadening their understanding of sexual assault may help reduce their self-blame.
- Because some male victims may fear public disclosure of the assault and the stigma associated with male sexual victimization, emphasis may need to be placed on the scope of confidentiality of patient information during the exam process.
- Offer male victims assistance in considering how friends and family members will react to the fact that they were sexually assaulted (e.g., by a male offender or a female offender).
- Male victims may be less likely than females to seek and receive support from family members and friends, as well as from advocacy and counseling services. Their ability to seek support may vary according to the level of stigmatization they feel, the circumstances of the assault, the sensitivity of care they initially receive, and the appropriateness of referrals provided.
- Encourage advocacy programs and the mental health community to build their capacity to serve male sexual assault victims and increase their accessibility to this population. Requests by male victims to have an advocate of a particular gender should be respected and honored if possible.[51]

—Adolescent victims[52]

- Adolescents may be brought to the exam site by their parents or guardians. The presence of parents or guardians creates an additional challenge for those involved in the exam process because they are often traumatized by their child's victimization.
- Understand that parents or guardians may blame victims for the assault if the victim disobeyed them or engaged in behaviors perceived as increasing risk for victimization.
- Health care providers must assess the physical development of adolescent victims and take their age into consideration when determining appropriate methods of examination and evidence collection.[53] Involved professionals should be well versed in jurisdictional policies related to response to minor victims.
- Be aware of jurisdictional laws governing minors' ability to consent to forensic exams and medical treatment. Follow exam facility and jurisdictional policy in obtaining appropriate consent. (For a more detailed discussion on seeking informed consent of patients, including consent by victims from specific populations, see *A.3. Informed Consent*.)
- Recognize that the sexual assault medical forensic exam may be the first time an adolescent female victim has an internal exam. There may be a need to go into detail when explaining what to expect.[54]
- Adolescence is often a time of experimentation. Reassure these victims that regardless of their behavior (e.g., using alcohol and drugs, engaging in illegal activities, or hitchhiking), no one has the right to sexually assault them, and they are not to blame for the assault.

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[49] Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, pp. 82–85.
[50] Drawn partially from L. Ledray, *SANE Development* and *Operation Guide*, 1998, p. 79.
[51] A national resource for male patients is Male Survivor: The National Organization Against Male Sexual Victimization. Contact information: PMB 103, 5505 Connecticut Avenue, NW, Washington, DC 20015–2601, 800–738–4181, www.malesurvivor.org.
[52] Adapted partially from the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2002, p. 11.
[53] For example, the size of the speculum used with adolescent female victims and exam positions of victims may vary.
[54] Drawn from A. Conrad, *SANE/SAFE Organizing Manual*, 1998, p. 7, developed for the New York State Coalition Against Sexual Assault.

- Ideally, attending health care providers should gather information from adolescents without parents or guardians in the room, subject to victims' consent. The concern is that parents or guardians may influence or be perceived as influencing victims' statements.
- Inform victims, particularly those who do not involve parents or guardians in the exam process, of facility billing practices (e.g., that their parents may get a bill or statement of services provided).[55]

—Older victims

- Keep in mind that the emotional impact of the assault may not be felt by older victims until after the exam when they are alone and become aware of their physical vulnerability, reduced resilience, and mortality.[56] Fear, anger, and depression can be especially severe in older victims who are isolated, have little support, and live on a meager income. [57]
- Be aware that caretakers may sexually assault their older dependents. Offenders may bring victims to the exam site, and jurisdictional and facility policies should be in place to provide guidance on how staff should screen for and handle situations that are threatening to patients or facility personnel.
- Note that older victims are generally more physically fragile than younger victims and thus may be at risk for tissue or skeletal damage and exacerbation of existing illnesses and vulnerabilities.[58]
- Hearing impairment and other physical conditions attendant to advancing age, coupled with the initial reaction to the assault, may render older victims unable to make their needs known, which could result in prolonged or inappropriate treatment.[59] Do not mistake this confusion and distress for senility.
- Health care personnel should follow facility policy for assessing a vulnerable adult's ability to consent to the exam and evidence collection, as well as involving adult protective services.
- Some older victims may want to talk about their perceptions of the role their age and physical condition might have played in making them vulnerable to an assault. Listen to their concerns and what the experience was like for them.[60] Assure them that it was not their fault they were sexually assaulted. If needed, encourage further discussion on this issue in a counseling/advocacy setting.
- Older victims may be reluctant to report the crime or seek treatment because they fear the loss of independence. Although sometimes relatives wish to place older victims in an assisted living situation after an assault occurs, such an action is not always necessary or useful to a victim's recovery. When a change in living environment is truly needed, assist victims and their relatives in making plans that maximize independence yet enhance safety.[61]
- Encourage use of followup medical, legal, and nonlegal assistance. Older victims may be reluctant to seek these services or proceed with prosecution. For example, they may rely on family members for transportation and may not want to burden them by asking to be taken to postexam followup appointments.

Recognize the importance of victim services within the exam process. In many jurisdictions, sexual assault victim advocacy programs and other victim service programs offer a range of services before, during, and after the exam process (see below for a description of typical services). Ideally, advocates should begin interacting with victims prior to the exam, as soon after disclosure of the assault as possible. Victims who come to exam sites in the immediate aftermath of an assault are typically coping with trauma, anticipating the exam, and considering the implications of reporting. Most responders that victims come in contact with are focused on objective tasks. Law enforcement officials gather information and collect crime scene evidence to

[55] Drawn from L. Ledray, *SANE Development* and *Operation Guide*, 1998, p. 98.
[56] Drawn from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, p. 3.
[57] Ibid.
[58] Older women are at an increased risk for vaginal tears and injury when they have been vaginally assaulted. Decreased hormonal levels following menopause result in a reduction in vaginal lubrication and cause the vaginal wall to become thinner and more friable. Because of these physiological changes, a Pedersen speculum, which is longer and thinner than the Graves speculum, should be used during the pelvic exam for evidence collection. Special care should also be taken to assess for intravaginal injury. In some older women, examiners will need to simply insert the swabs and avoid the trauma of inserting a speculum. If there are external tears in the introitus, internal injuries must also be considered. The recovery process for older victims also tends to be longer than for younger victims. (Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 86–87.)
[59] Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 87.
[60] Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 82–85.
[61] Ibid.

facilitate the investigation. Health care personnel assess medical needs, offer treatment, and collect evidence from victims. Victims must make many related decisions that may seem overwhelming. Advocates[62] can offer a tangible and personal connection to a long-term source of support and advocacy. Community-based advocates, in particular, have the sole purpose of supporting victims' needs and wishes. Typically, these advocates are able to talk with victims with some degree of confidentiality, depending on jurisdictional statutes, while statements victims make to examiners become part of the medical forensic report.[63] When community-based advocates support victims, examiners can more easily maintain an objective stance.[64]

Be aware of the extent of services. Services offered by advocates during the exam process may include:[65]

- Accompanying the victims through each component (advocates may accompany victims from the initial contact and the actual exam through to discharge and followup appointments);
- Assisting in coordination of victim transportation to and from the exam site;
- Providing victims with crisis intervention[66] and support to help cope with the trauma of the assault[67] and begin the healing process;
- Actively listening to victims to assist in sorting through and identifying their feelings;
- Letting victims know their reactions to the assault are normal and dispelling misconceptions regarding sexual assault;
- Advocating for victims' self-articulated needs to be identified and their choices to be respected, as well as advocating for appropriate and coordinated response by all involved professionals;
- Supporting victims in voicing their concerns to relevant responders;
- Responding in a sensitive and appropriate manner to victims from different backgrounds and circumstances and advocating for the elimination of barriers to communication;
- Serving as an information resource for victims (e.g., to answer questions, explain the importance of prompt law enforcement involvement if the decision is made to report, explain the value of medical and evidence collection procedures, explain legal aspects of the exam, help them understand their options in regard to treatment for STIs, HIV, and pregnancy, and provide referrals);
- Providing replacement clothing when clothing is retained for evidence, as well as toiletries;
- Aiding victims in identifying individuals who could support them as they heal (e.g., family members, friends, counselors, employers, religious or spiritual counselors/advisors, and/or teachers);
- Helping victims' families and friends cope with their reactions to the assault, providing information, and increasing their understanding of the type of support victims may need from them; and
- Assisting victims in planning for their safety and well-being.

Postexam, advocates can continue to advocate for victims' rights and wishes, offer victims ongoing support, counseling,[68] information, and referrals for community services, assist with applications for victim compensation programs, and encourage victims to obtain followup testing and treatment and take medications as directed. They can also accompany victims to followup appointments, including those for related medical care and criminal and civil justice related interviews and proceedings. They can work closely

[62] To prepare them to competently provide sexual assault victim services, community-based advocates are typically trained according to the policies of the sexual assault advocacy agency where they are employed/volunteer and receive supervision related to their interactions with victims. In addition, many jurisdictions have specific requirements that community-based advocates must meet in order to fit within jurisdictional confidentiality or privilege laws. Advocates should meet these requirements. System-based advocates may be required to have specific credentials based on system and jurisdictional policies and laws.
[63] K. Littel, *SANE Programs: Improving the Community Response to Sexual Assault Victims*, 2001, p. 6.
[64] Ibid.
[65] This bulleted section was drawn partially from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, p. 7, and the 1989 *Volunteer Manual* of Virginians Aligned Against Sexual Assault (VAASA).
[66] Crisis intervention counseling is short term in nature, aimed at returning individuals to their precrisis state through the development of adaptive coping responses. Broadly, it entails establishing a relationship with the individual in crisis, gathering information about what is occurring, clarifying the problem, helping the individual identify options and resources and decide what needs to happen next, and clarifying actions that will be taken. (Adapted from the 1991 Women Helping Women *Volunteer Training Manual*, Cincinnati, Ohio.) Note: Crisis intervention is not intended to address longer term counseling and advocacy needs.
[67] See A. Burgess and L. Holmstrom, Rape Trauma Syndrome, *American Journal of Psychiatry*, 131, for a summary of the psychological, somatic, and behavioral impact of sexual assault on victims.
[68] Many advocacy agencies offer ongoing peer counseling to victims. Some also provide professional mental health counseling, but many refer victims to community or private agencies.

with involved responders to ensure that postexam services and interventions are coordinated in a complementary manner and are appropriately based on victims' needs and wishes.

Contact the victim service/advocacy program immediately. Utilize a system in which exam facility personnel, upon initial contact with a sexual assault patient, call the victim service/advocacy program and ask for an advocate to be sent to the exam site (unless an advocate has already been called).[69] Prior to introducing the advocate to a patient, exam facility personnel should explain briefly to the patient the victim services offered and ask whether the victim wishes speak with the onsite advocate. Note that some jurisdictions require that patients be asked whether they want to talk with an advocate before the advocate is contacted.[70] Ideally, a patient should be assisted by the same advocate during the entire exam process.[71]

Accommodate patients' requests to have a relative, friend, or other personal support person (e.g., religious and spiritual counselor/advisor) present during the exam.[72] An exception would be if responders consider the request to be potentially harmful to the patient or the exam process.[73] Patients' requests not to have certain individuals present in the room should also be respected (e.g., adolescents may not want their parents present). Examiners should get explicit consent from patients to go forward with the exam with another person present. When others are present, appropriately drape patients and position additional persons. (It is also important to inform patients of confidentiality considerations regarding the presence of support persons during the medical forensic history. For a discussion of this topic, see *C.4. The Medical Forensic History*.)

Strive to limit the number of persons (beyond the patient, examiner, advocate, personal support person, and any necessary interpreters) in the exam room during the exam. The primary reason is to protect patients' privacy, but also because exam rooms often cannot accommodate more than a few individuals. Law enforcement representatives should not be present during the exam. When additional health care personnel are needed for consultation (e.g., a surgeon), patients' permission should be sought prior to their admittance. In cases in which examiners are supervising an examiner-in-training/licensed health care student, patients' consent should be obtained prior to the student's admittance to examine patients or observe the exam. It is inappropriate to ask patients to allow a group or nonlicensed medical students to view the exam.

Accommodate patients' requests for responders of a specific gender throughout the exam as much as possible. For a variety of reasons, some patients may prefer to work with a male or female law enforcement official, advocate, and/or examiner.

Prior to starting the exam and conducting each procedure, explain to patients what is entailed and its purpose. In addition, it is important to explain the exam process and the purpose of the exam more generally (*e.g.*, how the evidence may be used by the criminal justice system). Be sure that communication needs of patients are met and that information is conveyed in a manner they will understand. A clear explanation is particularly important for individuals who may not previously have had a pelvic exam or medical care, or who have difficulty understanding what has happened and why they are being asked to undergo a medical forensic exam. Remember that some exam procedures may be uncomfortable and painful to patients, considering the nature of the trauma they have experienced. By taking the time to explain procedures and their options, patients may be able to better relax, feel more in control of what's occurring, and make decisions that meet their needs. After providing the needed information, seek patients' permission

[69] Use community-based sexual assault victim advocates where possible. If not available, victim service providers based in the exam facility, criminal justice system, social services, or other agencies may be able to provide some advocacy services if educated to provide those services. Patients should be aware that government-based service providers typically cannot offer confidential communication.
[70] In very small communities, patients may know some or all advocates. Some patients may feel comfortable being supported by an advocate known to them while others may not. Patients concerned about anonymity should be provided with as many options as possible. For example, ask if they would like to speak with an on-call advocate on the phone prior to making their decision about whether they want an advocate present during the exam. Another option may be for the local advocacy program to partner with an advocacy program in a neighboring jurisdiction, so they can provide one another with backup to handle situations such as this one.
[71] Continuity of advocates can be challenging when response by other professionals is delayed, the exam process is lengthy, or travel to the exam site is considerable. Volunteers may or may not be able to continue providing services after the end of their on-call shift.
[72] Paragraph partially drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 15.
[73] For example, in cases involving adolescents or vulnerable adults, caretakers should not be allowed in the exam room if they are suspected of committing the assault or of being otherwise abusive to the patient.

to proceed with exam procedures. (For a more detailed discussion on seeking informed consent of patients, see *A.3. Informed Consent*.)

Respect patients' decisions. Although medical care and evidence collection may be encouraged during the exam process, responders should provide patients with information about all of their options and assess and respect their priorities.

Integrate medical and forensic exam procedures where possible. Medical care and evidence collection procedures should be integrated to maximize efficiency and minimize trauma to patients. For example, draw blood needed for medical and evidentiary purposes at the same time. Also, coordinate information gathering by health care and legal personnel to minimize the need for patients to repeat their statements. (For more information on coordination in information gathering, see *C.4. The Medical Forensic History*.)

Address patients' safety during the exam process. When patients arrive at the exam site, health care providers should assess related safety concerns. For example, a caretaker, partner, or family member who is suspected of committing the assault may have accompanied the patient to the facility. Follow facility policy on response to this and other types of threatening situations. Also, exam sites should have plans in place to protect patients from exposure to potentially infectious materials during the examination. (See *B.1. Sexual Assault Forensic Examiners*.) Prior to discharge, assist victims in planning for their safety and well-being. Planning should take into account needs that may arise in different types of cases. For example, patients who know the assailants may not be concerned only about their ongoing safety but also about the safety of their families and friends. Local law enforcement may be able to assist facilities in addressing patients' safety needs. (See *C.10. Discharge and Followup.)*

Offer patients information that they can review at their convenience.[74] Information should be tailored to patients' communication skill level/modality and language. Developing material in alternative formats may be useful, such as information that is taped, in Braille, in large print, in various languages, or uses pictures and simple language.[75] A victim booklet or packet that includes information about the following topics may be helpful:

- The crime itself (e.g., facts about sexual assault and related criminal statutes);
- Normal reactions to sexual assault (stressing that it is never the victim's fault), and signs and symptoms of traumatic response;
- Victims' rights;
- Victim support and advocacy services;
- Mental health counseling options and referrals;
- Resources for the victim's significant others;
- The examination—what happened and how evidence/findings will be used;
- Medical discharge and followup instructions;
- Planning for their safety and well-being;
- Examination payment and reimbursement information;
- Steps and options in the criminal justice process;
- Civil remedies that may be available to sexual assault victims; and
- Procedures for patients to access their medical record or applicable law enforcement reports.

[74] Many local sexual assault advocacy programs and state coalitions of sexual assault programs offer publications that speak to victims' concerns in the aftermath of an assault. However, any involved agency, SART, or coordinating council could develop such literature.
[75] For example, one sexual assault advocacy program offers a booklet "for those who read best with few words" designed for people with developmental disabilities who have been sexually assaulted. For more information on this publication, contact the Los Angeles Commission on Assaults Against Women by phone (213–955–9090) or e-mail info@lacaaw.org.

Address physical comfort needs of patients prior to the investigative interview and discharge. For example, provide them with the opportunity to wash in privacy (offering shower facilities if at all possible[76]), brush their teeth, change clothes (clean and ideally new replacement clothing should be available), get food and/or a beverage, and make needed phone calls. They may also require assistance in coordinating transportation from the exam site to their home or another location.

[76] It would be useful for the exam room to have an attached bathroom with a shower.

3. Informed Consent

Recommendations at a glance for health care providers and other responders for requesting patients' consent throughout the exam process:

- Seek the informed consent of patients as appropriate.
- Be aware of statutes and policies governing consent in cases of minor patients, vulnerable adult patients, and patients who are unconscious or intoxicated.

Seek informed consent of patients as appropriate throughout the exam process. There are two essential but separate consent processes—one for medical evaluation and treatment and another for the forensic exam and evidence collection. Patients should understand the full nature of their consent to each procedure, whether it be medical or forensic (e.g., what the procedure entails, possible side effects, and potential impact). The only way to put patients in the position of being able to make informed decisions about whether to allow a procedure is by presenting them with all relevant information. Patients can decline any part or all of the examination. However, the informed consent process includes making patients aware of the impact of declining a procedure, as it may negatively affect the quality of care and the usefulness of evidence collection. It may also have a negative impact on a criminal investigation and/or prosecution both because evidence not collected may have been useful and because defense attorneys may use the fact that the victim declined a procedure to claim that the victim is hiding something that would have been revealed by that procedure. They should understand that declining a procedure might also be used by opposing counsel to discredit the victim at trial.

Health care providers and other responders must refrain from any judgment or coercive practice in seeking patients' consent. It is contrary to ethical and professional practices to influence their decisions.

Seek both verbal and written consent as required by policy. In addition to verbally providing information and seeking consent throughout the exam process, written consent of patients may be needed in order to carry out specific procedures. It is important that jurisdictions, agencies, and exam facilities make it very clear to responders when written consent is necessary, how it should be sought, and provide appropriate checklists and forms to facilitate obtaining written consent in a consistent manner.

Methods to inform patients verbally and seek their consent vary significantly across jurisdictions and individuals requesting consent. For example, some examiners ask patients to voice their consent to each exam procedure while others explain from the start that they need patients to tell them if they want to stop at any time. While respecting the individual communication styles of responders, the process of obtaining consent can be enhanced when they are educated on how to seek verbal consent logistically in a way that is consistent across patients and helps facilitate the exam process as specified by the jurisdiction and facility.

Verbal and written information given to patients to facilitate the consent process should be complete, clear, and concise. This information, along with consent forms, should be tailored to the communication skill level/modality and language of patients. Responders should be aware of verbal and nonverbal cues from patients and adjust their methods of seeking consent to meet patients' needs. Encourage patients to ask questions and to inform relevant responders if they need a break or information repeated or do not want a particular part of the exam process done. Make sure all signatures and dates needed are obtained on written consent forms and document consent or reasons for declining to consent as appropriate (either on the medical record or forensic report forms).

Seek consent for medical evaluation and treatment. Follow facility policy for seeking patients' consent for medical evaluation and treatment. Any written medical consent forms developed for the purpose of the exam may need to be reviewed and approved by facility administration. Documentation on consent for medical evaluation and treatment becomes part of the medical record, not the forensic report. Informed consent of patients for medical evaluation and treatment typically is needed for the following:

- General medical care;
- Pregnancy testing and care;
- Testing and prophylaxis for STIs;
- HIV prophylaxis;
- Permission to recontact the patient for medical purposes; and
- Release of medical information.

Seek consent for the forensic exam and evidence collection. Follow jurisdictional procedure for obtaining informed consent for the exam and evidence collection. Informed consent of patients typically is needed for:

- Notification to law enforcement or other authority (depends upon reporting requirements);
- Photographs, including colposcopic images;
- The examination itself and evidence collection;
- Toxicology screening;
- Release of information and evidence to law enforcement;
- Permission to recontact patients for reasons related to their criminal sexual assault case; and
- Patient notification in case of DNA match or additional victims.

Responders should coordinate efforts to seek patients' consent. On a jurisdictional level, SARTs (or involved responders, if a SART does not exist) can identify all procedures where consent is needed during the exam process. They can make sure appropriate written consent forms are developed as well as procedures for requesting verbal and written consent. They should determine which responder has the knowledge needed to provide patients with information about each procedure and consider from whom patients might feel the most comfortable receiving this information. For example, while each responder may provide discipline-specific information to patients, advocates may provide a broad overview of all components of the exam process. Checklists that clarify discipline-specific roles in obtaining consent may be useful.

Make sure policies exist to guide seeking informed consent from specific populations. In order to provide informed consent, patients should be able to weigh the risks and benefits of different treatment and evidence collection options. It is always important for examiners to assess patients' ability and legal capacity to provide informed consent.[77] Providers should be aware of jurisdictional laws governing the ability of specific populations to provide consent.

In addition, facilities should have internal policies based on applicable jurisdictional statutes governing consent for treatment of vulnerable adult patients. The medical provider will generally need to assess whether the patient has the cognitive capacity to give consent for the examination, and, if not, the provider should follow these internal policies and jurisdictional statutes. Policies should include procedures to determine whether or not patients are their own guardians; if there is a guardian, to determine the extent of the guardianship; to obtain consent from a guardian if needed; and what to do if the guardian is not available or is suspected of abuse or neglect. Exam facilities should also have policies in place to address consent for treatment in cases in which patients are unconscious, intoxicated, or under the influence of drugs, and are therefore temporarily incompetent to give consent.

In cases of adolescent patients, jurisdictional statutes governing consent and access to the exam should be followed. For instance, a State statute may allow minors to receive care for STIs and pregnancy, but not a medical forensic examination without parental or guardian consent. Exceptions to parental consent requirements also exist when the parent or guardian is the suspected offender or where the parent or guardian can't be found and the collection of evidence needs to be done quickly. In such cases, the law generally specifies who may give consent in lieu of the parent or guardian, such as a police officer, representative from the jurisdiction's children's services department, or judge.[78]

[77] L. Ledray, *SANE Development and Operation Guide*, 1998, p. 82.
[78] L. Ledray, *SANE Development and Operation Guide*, 1998, p. 97.

It should be clarified whether policies and statutes regarding consent for medical evaluation and treatment for the above populations encompass consent for the forensic component of the exam. If not, additional guidance from the jurisdiction is needed to develop the appropriate policies. Also, jurisdictional statutes regarding mandatory reporting to law enforcement or protective services in cases of vulnerable adult and minor sexual assault victims must be observed.

In all cases, the medical forensic examination should never be done against the will of patients. Responders should not touch patients or otherwise perform exam procedures without their permission.

4. Confidentiality

Recommendations at a glance for jurisdictions to maintain confidentiality:

- Be sure jurisdictional policies address confidentiality issues related to the exam process.
- Increase the understanding of responders and patients in relevant confidentiality issues.
- Consider the impact of the Federal privacy laws regarding health information on victims of sexual assault.
- Strive to resolve intrajurisdictional conflicts.

Be sure that jurisdictional policies address the scope and limitations of confidentiality as it relates to the examination process and with whom information can be legally and ethically shared. The confidentiality of records (as well as forensic evidence and photographic and video images) is intricately linked to the scope of patients' consent. Members of a SART or other collaborating responders should inform victims of the scope of confidentiality with each responder and be cautious not to exceed the limits of victim consent.

Promote understanding of confidentiality issues. Responders involved in the exam process need education on the basics of maintaining the confidentiality of their patients (e.g., knowing what information is confidential and with whom confidential data can be shared, and being aware of their surroundings and who may be listening when discussing cases). They also should build their understanding of the scope and limitations of confidentiality of each agency and responder involved.

In addition, responders should be aware of the laws in their jurisdiction pertaining to privileged communications.[79] More than half of the States have laws in place providing some level of privilege to the communications of sexual assault/rape crisis and domestic violence counselors. A few States' laws apply to victim counselors in general. In most States, counselors must complete a certain number of training hours to qualify for the privilege. However, privileges vary from State to State. Jurisdictions should be careful in their local response to protect the privileges. This can be done by limiting who speaks with the victim at each stage of the process, who will be present, and who will be the recordkeeper or notetaker.

Involved responders should be able to explain the following to patients:

- Community-based advocates usually can provide patients with some level of confidentiality (depending upon applicable jurisdictional statutes). It is important to convey to patients the scope and limits of confidentiality of this communication.
- Patients' medical records are confidential—exam facilities typically have policies in place to protect these records. It is important that patients understand the scope and limits of confidentiality of these records.
- If the assault is reported to law enforcement, health care providers provide to the criminal justice system information collected during the examination that is related to forensic evidence.
- When jurisdictions allow health care providers to collect evidence and forensic information from patients without a law enforcement report, the evidence collection kit is typically held in a secure setting for a period of time as determined by jurisdictional policy. Patients' identity should not be revealed to law enforcement. Patients usually need to make an official report by the end of the designated period of time or the evidence and information will be destroyed.
- Information that patients share with law enforcement representatives, prosecutors, justice system based advocates, and adult/child protective services becomes part of the criminal justice record. This record is typically available to investigators and prosecutors handling the patient's case. It also may be

[79] Traditionally, many types of communication have been protected from disclosure in court. These include communication between husband and wife, physician and patient, attorney and client, clergy and parishioner, and psychotherapist and patient. Confidential communication generated in the course of a counseling relationship has more recently been afforded some statutory protection. In general, victim-counselor privilege laws enable counselors (such as community-based victim advocates) to maintain confidentiality of information revealed to them. In addition to preventing counselors from testifying in court, many privilege laws extend protection to their written records. (Drawn from *Privacy of Victims' Counseling Communications*, Office for Victims of Crime, Legal Series, Bulletin #8 (November 2002), pp. 1–2.)

discovered[80] by the defense (although prosecutors may request the court to shield certain information from the defense, such as history of prior pregnancies, abortions, and STIs).[81]

- Each case potentially involves responders from different agencies that may have their own confidentiality policies (e.g., school counselors and mental health providers).
- Both prosecutors and defense attorneys can call witnesses to testify in court; and
- Court documents and proceedings are generally matters of public record, with the exception of certain excluded materials (e.g., some States' statutes prohibit victim contact information from appearing on public court documents).
- Patients may at some point wish to view or obtain applicable medical records and/or law enforcement reports. They should have access to such documentation, and exam site and jurisdictional procedures for accessing this data should be conveyed to patients.

Consider the impact of Federal privacy laws regarding health information on victims of sexual assault. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations (found at 45 CFR Parts 160 and 164), established national standards for the protection of certain individually identifiable health information created or held by health care providers, health insurance companies, and health clearinghouses. The impact of these privacy laws on the provision of services to victims of sexual assault is unclear, because interpretation of the laws depends on individual situations and the law of the particular State. Responders are encouraged to contact their State coalition for further discussion about the impact of the HIPAA regulations on their participation in the exam process.[82]

Strive to resolve intrajurisdictional conflicts. For example, maintaining confidentiality is often difficult in isolated or small communities where people know one another or word of a crime travels quickly (e.g., school campuses and tribal, military, religious, or immigrant communities). Special precautions must be taken in these situations to preserve confidentiality. Every effort should be made to avoid conflicts of interest (e.g., the investigator is the cousin of the suspect or the health care provider, advocate, or interpreter is an acquaintance of the patient). Give patients as many options as possible to avoid these dilemmas (e.g., allow them to work with a different investigator or be examined at another site or by another examiner, if possible).

[80] Discovery in a criminal case is the turning over of any evidence or information that the prosecutor is obligated by jurisdictional statute or case law to turn over to the defense. (Drawn from electronic communications with Norm Gahn, Assistant District Attorney, Office of the District Attorney for Milwaukee County, Wisconsin, during the fall of 2003.)

[81] Depending on jurisdictional law, law enforcement reports and reports of other governmental agencies may be subject to open public records laws or Freedom of Information Act laws. In such instances, jurisdictional policy would govern when such information could be released to the general public upon request. (Drawn from electronic communications with Robert Laurino, Deputy Chief Assistant Prosecutor, Essex County Prosecutor's Office, New Jersey, during the fall of 2003.)

[82] A list of State sexual assault coalitions is available at http://www.ojp.usdoj.gov/vawo/saresources.htm.

5. Reporting to Law Enforcement

Recommendations at a glance for jurisdictions and responders to facilitate victim-sensitive reporting practices:

- Where permitted by law, patients, not health care workers, should make the decision to report a sexual assault to law enforcement. Patients should be provided with information about the possible benefits and consequences of reporting so that they can make an informed decision.
- It is not recommended to require reporting as a condition of performing or paying for the exam. Even if patients are undecided about reporting, they should be encouraged to provide a medical forensic history, undergo the forensic exam, and have evidence collected and stored.
- Jurisdictions should consider an anonymous or blind reporting system for cases in which victims do not want to report immediately or are undecided about reporting.
- Communities should consider a variety of approaches to promote a victim-centered reporting process.

Many sexual assault victims who come to health care facilities or other exam sites for the medical forensic exam choose to report the assault to law enforcement. Reporting provides the criminal justice system with the opportunity to offer immediate protection to the victim, collect evidence from all crime scenes, investigate the case, prosecute it if there is sufficient evidence, and hold the offender accountable for crimes committed. Given the danger that sex offenders pose to the community, reporting can serve as a first step in efforts to stop them from reoffending. Equally important, reporting gives the justice system the chance to encourage victims to seek assistance to address their needs, identify patterns of sexual violence in the jurisdiction, and educate the public about such patterns. It is recommended that service providers encourage victims to report due in part to the recognition that delayed reporting is extremely detrimental to the prosecution and holding offenders accountable. Victims need to know that even if they are not ready to report at the time of the exam, the best way to preserve their option to report later is to have the exam performed.

Some victims, however, are unable to make a decision about whether they want to report or be involved in the criminal justice system in the immediate aftermath of an assault. Pressuring these victims to report may discourage their future involvement. Yet, they can benefit from support and advocacy, treatment, and information that focus on their well-being. Recognizing that evidence on their bodies is lost as time passes and that they may report at a later date, victims can also be encouraged to have the medical forensic exam conducted. Victims who are recipients of compassionate and appropriate care at the time of the exam are more likely to cooperate with law enforcement and prosecution in the future.

Where permitted by law, patients, not health care workers, should make the decision to report a sexual assault to law enforcement. Health care workers in some jurisdictions are bound by law to report some or all forms of sexual assault, regardless of patients' wishes.[83] In the remaining jurisdictions, no report should be made without the consent of patients. (Exceptions typically include cases involving vulnerable adults and minors victimized by caretakers or other authority figures). All involved health care providers should be aware of the reporting requirements in the jurisdiction in which they work.

In jurisdictions in which mandatory reporting by health care personnel is required, patients should be informed of the legal obligations of health care personnel, what triggers a mandatory report, that a report is being made, and the contents of the report. Patients should understand that even if health care personnel make a mandatory report, they are not obligated to talk with law enforcement officials or make a formal complaint themselves.[84]

[83] Some jurisdictions call for mandated reporting for some or all violent crimes, requiring health care workers to notify law enforcement in cases involving a gunshot or knife wound, strangulation/choking, or other serious bodily injury. They vary, however, in whether they require acts of sexual violence without serious physical injuries to be reported.

[84] Some victims may fear perceived consequences of reporting (e.g., retaliation by offenders; rejection by family members and friends; being discriminated against if they are males.) Victims may have these and other fears because they are from populations with differing sexual orientations or from racially or otherwise oppressed groups; inmates; or are being deported or refused citizenship (in the case of recent immigrants and refugees). Some recent immigrants or refugees may fear law enforcement because of past experiences of oppression by authorities in their countries of origin. In addition, many victims are not willing to deal with the humiliation, loss of privacy, and negativity they perceive would accompany reporting, an investigation, and prosecution. If an intimate partner or a family member

Jurisdictions are encouraged to pay for forensic exams regardless of the level of cooperation of victims with law enforcement and the criminal justice process. Jurisdictions should conduct the exam and pay for exam costs without requiring patients' involvement in the criminal justice system. Documentation and evidence collected could be invaluable to the investigation and prosecution if patients should report at a later date, which often occurs. Patients should also have the right to receive medical care for assault-related injuries and concerns, regardless of their decision to report and/or have evidence collected.

Patients should be informed of the policies of the jurisdiction regarding whether the exam can be performed and paid for by a government entity if they elect not to report or are undecided about reporting. Also, they should be aware of jurisdictional and exam site policies on payment for medical care, if a report is made, no report is made, or no decision has yet been made on reporting.

Inform patients about reporting consequences. Prior to making a decision about reporting, patients need information about issues related to reporting. For example, they should be informed of the following:

- The contents and process of reporting;
- Procedures dealing with reporting in the jurisdictional protocol for immediate response to sexual assault;
- Whether health care personnel are bound by law to report the assault;
- The fact that the report will most likely trigger an investigation and possible prosecution;
- The medical and forensic purposes of the exam and how evidence gathered could be used during investigation and prosecution;
- Types of evidence (beyond that found on patients) that may be gathered during an investigation;[85]
- The fact that delays in reporting, especially extended ones, can result in loss of evidence and may negatively affect the ability of the criminal justice system to investigate and prosecute a case;[86]
- Practices regarding prosecution of sexual assault victims for unrelated criminal charges;
- Potential outcomes of criminal justice system interventions, such as possible sentences should assailants be convicted and the possibility of restitution for victims;
- The right to accept or decline exam procedures and the possible consequences of declining;
- The right to copies of any communication or report issued to law enforcement and procedures for accessing such data;
- Policies related to payment for the exam, evidence collection, and medical care, whether or not a report is made; and
- Policies on collecting/holding evidence in cases where patients are undecided about reporting, and, if evidence can be collected with no report, the amount of time they have to make a reporting decision.

Consider alternatives to standard reporting procedures.[87] Communities may want to consider alternatives to reporting, such as anonymous or blind reporting, in cases in which victims do not want to immediately report or are undecided about reporting (but are willing to report anonymously).[88] Government

committed the assault, victims may also be concerned about the consequences of prosecution on their families (e.g., loss of income, employment, profession, attorney fees, and childcare costs) and being blamed for "tearing the families apart." Incest victims may be deterred from reporting because offender registries might indirectly identify them.

[85] For example, other evidence may be found at the locations of the seductions/lures, locations of actual assaults, locations victims went to immediately after the assaults, and the suspects' bodies.

[86] Prompt reporting can facilitate a thorough investigation. Collecting evidence from patients is but one piece of investigative information gathering. Other investigative activities may include, but are not limited to, identifying and collecting evidence from all crime scenes; identifying, apprehending, and interviewing suspects; interviewing witnesses (both eyewitnesses and persons to whom victims initially disclose); obtaining search warrants as needed (e.g., to search for drugs that might have been used to facilitate an assault or for evidence used during an assault such as clothing, ropes, or condoms). Investigative activities depend on the specifics of each case.

[87] The first two paragraphs in this section are drawn from S. Garcia and M. Henderson, *Blind Reporting of Sexual Violence,* FBI Law Enforcement Bulletin, June 1999, pp. 12–16.

[88] For example, the Chapel Hill, North Carolina, Police Department's blind reporting system for sexual assault enables victims to disclose as much or as little information as they want. A detective records the information but does not initiate an investigation unless victims decide to file a formal complaint. The blind reporting system has been credited with contributing to a steady increase in sexual assault reporting. The number of male victims who reported during that time also rose. (K. Littel, M. Malefyt, and A. Walker, *Assessing the Justice System Response to Violence Against Women: A Tool for Law Enforcement, Prosecution, and the Courts to Use in Developing Effective Response,* 1998, pp. 18–9.*)*

entities that mandate reporting for sexual assaults, in particular, may want to explore the option of third-party anonymous reporting for mandated reports.[89] Although the practice of anonymous reporting is not widespread, it appears promising in that it allows victims and/or third-party reporters to share critical information about the assault with law enforcement without sacrificing confidentiality and filing a complaint. It also enables investigators to gain information about sex crimes that would otherwise go unreported.

To develop an anonymous/blind reporting system, law enforcement agencies can:

- Establish and uphold a policy of victim confidentiality;
- Allow victims to disclose as little or as much information as they wish;
- Accept the information whenever victims might offer it—a delay in disclosure is not an indicator of the validity of the statement;
- Develop procedures and forms to facilitate anonymous information from third parties (e.g., examiners);
- Clarify options with victims for future contact—where, how, and under what circumstances they may be contacted by the law enforcement agency; and
- Maintain these reports in separate files from official complaints to avoid inappropriate use.

Victims making anonymous or blind reports and going through the medical forensic exam should be informed about jurisdictional policies regarding storage of evidence and exam payment. (In some communities, it is a challenge to find adequate space to hold evidence in cases where a report has not been made. For more information on this topic, see *B.6. Evidence Integrity.)* If victims have evidence collected, they also should have the option of being notified if DNA evidence from their case is linked to an offender already in the national DNA database or identifies other victims of the same offender.[90] Informed consent from victims for notification should be sought during the initial report, as well as appropriate times and methods to recontact them.[91]

Promote a victim-centered reporting process. Some approaches for communities to consider:

- Encourage victims to consent to the medical forensic history, an examination, and documentation regardless of whether an evidence collection kit is used.
- Explore the myriad reasons why victims are reluctant to report and how the actions or attitudes of agencies may help perpetuate these fears. Help agencies consider how to reduce reluctance and fears.
- Evaluate local trends regarding reporting and victims' involvement in the criminal justice system. Based on feedback, develop and implement a plan to improve multidisciplinary response to sexual assault.
- Increase victim-sensitivity education for first responders (e.g., educate law enforcement investigators on interviewing versus interrogating skills, educate health care personnel to be compassionate and not blame patients for the assault, and educate prosecutors to be victim-centered in their approaches).
- Encourage criminal justice statistical reports that accurately reflect the frequency and severity of sexual assaults reported in a jurisdiction.
- Initiate community education, outreach, and services targeting groups that may be reluctant to seek assistance after an assault.
- Offer viable options for reimbursement of exam costs for which victims are responsible.[92]

[89] For example, all health care providers in Massachusetts who attend to, treat, or examine a sexual assault patient are required to submit a third-party anonymous report (with no identifying information) to law enforcement in the community where the assault occurred as well as to the State police. This report is required even if patients report the assault. (Commonwealth of Massachusetts *SANE Protocol*, 2002, pp. 8–9.)

[90] The Combined DNA Index System (CODIS) is an electronic database of DNA profiles obtained from evidence samples from unsolved crimes and from known individuals convicted of particular crimes. Contributions to this database are made through State crime laboratories. The FBI maintains the data.

[91] All those involved in immediate response, including victims, need to understand the nature of DNA evidence and how CODIS can be used to match offenders with DNA in the database. They also need to know the status of CODIS in their jurisdiction (CODIS is not yet up and running in some States, and States have varying laws regarding which crimes qualify for inclusion in the database).

[92] It would be ideal if victims did not have to cover any costs for the exam and related medical care. However, jurisdictions and exam facilities vary in the costs that victims are required to cover. Often, but not always, victims are responsible for the costs of treatment for injuries and possible pregnancy, STIs, and HIV infection. Some exam facilities are flexible—they may allow victims to pay as they are financially able or may be willing to waive some or all charges. In some jurisdictions, if victims decide not to report but want the exam performed, they are held responsible for the cost of the exam.

- Encourage the development of a coordinating council and/or SART to facilitate a more coordinated, victim-centered, comprehensive community response to sexual violence.
- Support the formation of specialized examiner programs, investigative and prosecution units, and sexual assault victim advocacy programs to handle these cases. Specialization can potentially increase the knowledge base and commitment of involved responders, increase adherence to jurisdictional protocols for immediate response to sexual assault, encourage a victim-centered response, and positively advertise services offered.
- Develop jurisdictionwide public information initiatives on mandatory reporting—mandatory reporters need to know applicable statutes regarding reporting sexual assault cases that involve older vulnerable adults, persons with disabilities, and minors. A toll-free hotline number exclusively dedicated to abuse reports may also help simplify reporting and ensure a written report of each case and referrals to appropriate agencies. Such a hotline could be operated at a State, tribal, regional, or local level. To encourage both reporting and followthrough, protective agencies that investigate these cases should work collaboratively with local law enforcement agencies to ensure that each case is dealt with in the best possible manner and that further harm does not occur.[93]
- In institutional settings such as prisons, jails, immigrant detention centers, nursing homes and assisted living programs, inpatient treatment centers, and group homes, ensure that victims can report assaults to outside agencies and are offered protection from retaliation for reporting.
- In each case, strive to create an environment in which victims are encouraged to report and are supported throughout the criminal justice process and beyond. Even in those cases that do not develop beyond an initial report to the police, victims should feel that they are respected.[94]
- After steps have been taken to identify and remove barriers to reporting sexual assaults, educate the public about the potential benefits of reporting, how to go about reporting, what happens once a report is filed, and jurisdictional legal advocacy services available (if any) for sexual assault victims. Build upon already existing public awareness efforts of local advocacy programs.

[93] Bullet drawn from A. Vachss, *Redefining Rape Response: When the Victim is Elderly or Has a Disability*, 2001, pp. 6–8, and 10.
[94] Bullet adapted from the New Jersey Office of the Attorney General's *Standards for Providing Services to Survivors of Sexual Assault*, 1998, pp. 6 and 18.

6. Payment for the Examination Under VAWA

Recommendations at a glance for jurisdictions to facilitate payment for the sexual assault medical forensic exam:

- Understand the scope of the VAWA provisions related to exam payment.
- Victims should be notified of exam facility and jurisdictional policies regarding payment for medical care and the medical forensic exam, as well as if and how their reporting decisions will affect payment. Relevant government entities are strongly encouraged to pay for medical forensic exams without requiring sexual assault victims to report to law enforcement.

Understand the VAWA provisions related to exam payment. Under the Violence Against Women Act (VAWA), grantees of the STOP Violence Against Women Formula Grant Program must meet certain requirements concerning payment for the forensic medical exam in order to receive funds. The STOP Program is a formula grant program which provides funds to all States, Territories, and the District of Columbia.[95]

Each of these entities certifies each year that it is in compliance with the requirements of VAWA. Specifically, the State, Territory, or the District of Columbia must certify that it or another governmental entity "incurs the full out-of-pocket cost of forensic medical exams" for victims of sexual assault. If one part of a State or Territory, such as a county or city, is forcing victims to incur these costs, then the State or Territory will not be able to certify and will be ineligible for the grant funds.[96]

Definitions under VAWA. For the purpose of the VAWA requirement, the term "forensic medical examination" means “an examination provided to a sexual assault victim by medical personnel trained to gather evidence of a sexual assault in a manner suitable for use in a court of law.”[97] According to regulations of the STOP Program, the exam should include, at a minimum, “i) examination of physical trauma; ii) determination of penetration or force;[98] iii) patient interview; and iv) collection and evaluation of evidence.”[99] The inclusion of additional procedures (e.g., testing for STIs) to obtain evidence may be determined by the State, Indian tribal government, or unit of local government in accordance with its current laws, policies, and practices.[100]

By regulation, "full out-of-pocket cost” means “any expense that may be charged to a victim in connection with a medical forensic examination for the purpose of gathering evidence of a sexual assault.”[101] Examples of such expenses may include the full cost of the exam or a fee established by the facility conducting the exam. Often, medical services that are not related to evidence gathering will not be covered by this requirement.

It is important that victims are advised of jurisdictional policies regarding payment for the medical forensic examination. Victims must be aware of exam facility and jurisdictional policies regarding payment for other medical care related to the sexual assault. Typically, all costs related to the exam and to medical care are not paid for by government entities even if a report is made. Thus, involved responders are encouraged to

[95] Its purpose is to assist these jurisdictions in developing and strengthening law enforcement and prosecution strategies to combat violence against women, as well as in developing and strengthening victim services in cases involving violence against women.
[96] Under 42 U.S.C. § 10607, for Federal cases, the Federal investigating agency that investigates the sexual assault shall pay for the cost of a forensic exam "which an investigating officer determines was necessary or useful for evidentiary purposes."
[97] 28 C.F.R. § 90.2(b). Note that the term “medical forensic examination” is used throughout the protocol, rather than “forensic medical examination” as used in the VAWA requirements.
[98] The analysis of evidence gathered during the exam, along with examiner documentation of findings, may help determine whether penetration occurred or force was used. Examiners, however, are not responsible for drawing conclusions about how injuries were caused or whether an assault occurred or not, although they can note consistency between patients’ statements and injuries they identify.
[99] 28 C.F.R. § 90.2(b) (1).
[100] 28 C.F.R. § 90.2(b) (2).
[101] 28 C.F.R. § 90.14(a).

assist victims in identifying and accessing jurisdictional resources to cover the costs of the exam.[102] For example, responders can help them apply for crime victims' compensation (if available) or arrange a payment plan with the exam facility.[103] When victims are billed by the exam facility for costs that are their responsibility, procedures to protect their privacy should be incorporated into the billing process. Personnel in facility billing departments should be educated regarding coding and billing practices in these cases, as determined by facility and/or jurisdictional policy.

Reporting to law enforcement. States, Territories, the District of Columbia, and tribes are strongly encouraged to pay for sexual assault medical forensic exams without requiring victims to report the assault to law enforcement. Some victims are unable to make a decision about whether they want to report to law enforcement in the immediate aftermath of the assault. Recognizing that evidence is lost as time progresses, victims should be encouraged to have the evidence collected right away, and then have time to decide about reporting the crime.

See www.ojp.usdoj.gov/vawo/faqforensic.htm for more information on the STOP Formula Grant Program medical forensic exam payment requirement.

[102] Victims in Federal cases should first apply to the State or Territory crime victims' compensation program for reimbursement of costs that are their responsibility. If they are unable to obtain reimbursement via this channel, they should work with victim-witness specialists in the Federal agency investigating or prosecuting the case to identify other possible sources of funding or reimbursement.
[103] Exam facilities are sometimes willing to waive some related medical care costs that are not covered by government entities.

B. Operational Issues

This section discusses components essential to conducting the sexual assault forensic examination: the health care providers conducting the exam, the facilities where exams are performed, the equipment and supplies needed during the exam, and the sexual assault evidence collection kit. It also discusses timing considerations in collecting evidence and evidence integrity during and after the exam.

The following chapters are included:

1. Sexual Assault Forensic Examiners
2. Facilities
3. Equipment and Supplies
4. Sexual Assault Evidence Collection Kit
5. Timing Considerations for Collecting Evidence
6. Evidence Integrity

1. Sexual Assault Forensic Examiners

Recommendations at a glance for jurisdictions to build capacity of examiners to conduct these exams:

- Encourage the development of specific examiner knowledge, skills, and attitudes.
- Encourage the advanced education and supervised clinical practice of examiners, as well as certification for nurses who are examiners.

It is critical that health care providers conducting the sexual assault medical forensic exam are committed to providing compassionate and quality health care, collecting evidence in a thorough and appropriate manner, and testifying in court if needed. Their commitment should be grounded both in an understanding that sexual assault is a serious crime that can have profound, negative effects on those victimized and in recognition of the role of advanced education and clinical experience in building competency to perform the exam.

A growing trend across the United States is the use of sexual assault nurse examiners (SANEs) to conduct the exam. SANEs are registered nurses who receive specialized education and fulfill clinical requirements to perform these exams. Some nurses have been certified as SANEs–Adult and Adolescent (SANE–A) through the International Association of Forensic Nurses (IAFN).[104] Others are specially educated and fulfill clinical requirements as forensic nurse examiners (FNEs), enabling them to collect forensic evidence for a variety of crimes. The terms "sexual assault forensic examiner" (SAFE) and "sexual assault examiner" (SAE) are often used more broadly to denote a health care provider (e.g., a physician, physician assistant, nurse, or nurse practitioner) who has been specially educated and completed clinical requirements to perform this exam.

All communities should strive to ensure that victims of a recent sexual assault have access to specially educated and clinically prepared examiners to perform the medical forensic exam. As much as possible, examiners should be permanent rather than on temporary assignment in a jurisdiction. It can be challenging for examiners who are temporary (e.g., at an Indian Health Service facility) to understand needs of victims from the community or to be familiar with jurisdictional policies and procedures. If they move to another job assignment, arranging for them to testify in court can be complicated.[105]

Encourage the development of specific knowledge, skills, and attitudes. Conducting a sexual assault medical forensic examination is a complex and time-consuming procedure. It is useful for examiners to have specific knowledge and skills that can guide them as they perform these exams.[106] For example, it is beneficial for them to know about the following:

- The dynamics and impact of sexual victimization;
- Jurisdictional laws related to sexual offenses;
- Coordinated multidisciplinary response, roles of each responding agency, and procedures for communicating with each agency during immediate response;
- The importance of examiner neutrality and objectivity during the examination;
- The broad spectrum of potential evidence and physical findings in these cases;
- The importance of the medical forensic history and other documentation;

[104] Eligibility criteria for IAFN SANE Adult/Adolescent certification includes: registered license as an R.N. in the United States or its Territories, or a license as a first-level general nurse in the jurisdiction of current practice; a minimum of 2 years of practice as an R.N. in the United States or as a first-level general nurse in the country of licensure; successful completion of an adult/adolescent SANE education program that includes either (a) a minimum of 40 continuing education contact hours of classroom instruction, or (b) 3 semester hours (or the equivalent) of academic credit in an accredited school of nursing, and sufficient supervised clinical practice until determined competent in SANE practice. An appropriate clinical authority, as outlined in the adult section of the IAFN *SANE Education Guidelines* (1998) must validate current SANE competency. (Drawn from the *IAFN SANE Certification Brochure*, available at www.iafn.org.)

[105] Most hospitals or medical clinics that physicians or advanced practice nurses are employed by or affiliated with require them to apply for facility privileges. Those requesting privileges usually must agree to provide forwarding addresses when they leave. Also, medical licenses can be tracked to the State or Territory where the health care provider is working.

[106] The next two bulleted sections are adapted from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, pp. 25–26, produced by the California Governor's Office of Criminal Justice Planning. Also see L. Ledray's *SANE Development and Operation Guide*, pp. 54–55, for information on SANE training components.

- Proper evidence collection and preservation procedures;
- Preexisting needs and circumstances of patients that may affect how the exam is conducted;
- Treatment options and procedures for common concerns such as pregnancy, STIs, and HIV infection;
- Equipment, supplies, and medication typically used during the exam;
- Precautions to prevent exposure to potentially infectious materials;[107]
- Indications for followup health care and documentation of injuries;
- Applicable laws and protocols regarding performance of medical forensic exams and standardized forms used to document findings;
- Patients' needs for support, crisis intervention, advocacy, information, and referrals during the exam process, local resources for addressing these needs, and procedures for accessing resources;
- The importance of establishing vehicles to ensure the quality of the exam and related documentation;
- Examiner court testimony (what it involves and how examiners can prepare for it); and
- Applicable research findings, technological advances, and promising practices.

It is useful for examiners to be able to:

- Preserve their neutrality and objectivity in each case;
- Assess patients' clinical condition (physical and psychological assessment[108]) and provide appropriate treatment and medical referrals (e.g., to a surgeon);
- Adapt exam procedures to address patients' needs and circumstances as much as possible;
- Take measures during the exam process to reduce the likelihood of patients' retraumatization;
- Take precautions according to facility policy to prevent exposure to potentially infectious materials;
- Contact advocates upon initial contact with patients (where available) so they can offer patients support, crisis intervention, advocacy, information, and community referrals before, during, and after the exam;[109]
- Gather information sensitively from patients for a medical forensic history and use the history as a guide when performing an exam;
- Explain to patients what items need to be collected for evidence and for what purposes;
- If patients want to report, promptly involve law enforcement representatives and work with them to maximize the collection of evidence from patients and from crime scenes;
- Identify and describe pertinent genital and anorectal anatomical structures and external landmarks;
- Identify and document injuries and interpret physical findings;
- Use enhancement techniques for detection and documentation of findings;
- Collect and preserve evidence for analysis by the crime laboratory;
- Collect and preserve toxicology samples in suspected drug-facilitated sexual assault cases;
- Maintain and document the chain of custody for evidence;
- Maintain the integrity of the evidence to ensure that optimal lab results are obtained;
- Evaluate the possibility of STIs and HIV infection and provide prophylactics and/or treatment;

[107] See the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) for its Bloodborne Pathogens Standard (CFR 1910.1030). It may be accessed at www.osha.gov or by calling 800–321–0SHA. According to this standard, bloodborne pathogens are pathogenic microorganisms that are present in human blood and can cause disease in humans. Among other things, the standard requires employers who have employees at risk for occupational exposure to bloodborne pathogens and other potentially infectious materials to develop plans to eliminate or minimize employee exposure. It also advises universal precautions that should be observed to prevent contact with blood or other potentially infectious materials (this approach treats all human blood and certain human body fluids as if they are known to be infectious). In addition, the standard requires employers to ensure that all employees at risk participate in a training program to inform them of risks, related facility policies, and necessary precautions. Employers must also establish and maintain a record for each employee with occupational exposure.

[108] Examiners typically assess patients' psychological functioning to determine whether there is a risk for suicide and whether patients are oriented to person, place, and time. They may request a mental health evaluation for patients, if necessary.

[109] It is helpful if jurisdictions clarify the specific roles of advocates and examiners during the exam process. In the absence of advocates or other victim service providers, examiners may be responsible for providing crisis intervention and support to patients. In situations where examiners are both collectors of evidence and crisis counselors, it is important to understand whether these dual roles affect their ability to testify in an unbiased manner.

- Assess pregnancy risk and discuss treatment options with the patient, including reproductive health services;
- Ensure that patients' immediate medical needs and concerns are addressed and appropriate medical referrals are provided prior to discharge;
- Recognize evidence-based conclusions and limitations in the analysis of findings;
- Complete standard forms for documenting the medical forensic results of the exam;
- Discuss evidentiary findings with investigators, prosecutors, and defense attorneys as requested (according to jurisdictional policy); and
- Testify in court if needed.

Encourage a minimum standard for advanced education and supervised clinical practice for health care personnel conducting the exam, as well as certification for nurse examiners. Such a standard must speak to specific education and supervision needs of involved disciplines. For example, nonphysician examiners may require medical supervision and backup, in addition to completing necessary training and clinical requirements. Certification through the IAFN is currently available only to nurses trained as SANEs. When designing classroom education for examiners, make sure the examiners understand the importance of a multidisciplinary response during the exam process. Consider involving trainers from health care, advocacy, law enforcement, prosecution, judiciary, and crime laboratories.

Standardized curricula on sexual assault exams in medical school, nursing and nurse practitioner programs, and physician assistant programs are recommended. Consideration must be given to how to systematically secure, supervise, and retain examiners in/for poor, rural, or remote areas, institutional settings,[110] military bases, college campuses, tribal lands, migrant farm worker communities, and other areas needing increased victim outreach. Examiners need to know how to respond in a respectful manner to various populations within their community (e.g., local tribal victim service providers may be able to provide training on cultural beliefs and practices that might be relevant in sexual assault cases).

In addition, other health care providers who come into contact with patients who disclose a recent assault need information on procedures for obtaining immediate patient assistance and caring for patients prior to their arrival at the exam site.

[110] Examples of institutional settings include prisons, jails, immigration detention centers, juvenile detention centers, nursing homes, assisted living and rehabilitation programs, and inpatient treatment centers.

2. Facilities

Recommendations at a glance for jurisdictions to build the capacity of health care facilities to respond to sexual assault cases:

- Recognize the obligation of health care facilities to serve sexual assault patients.
- Ensure that exams are conducted at sites served by examiners with advanced education and clinical experience.
- Communities should explore what is best for them regarding locations of exam sites.
- Communities may wish to consider developing basic requirements for designated exam sites.
- Promote public awareness about designated exam sites, ensuring information is disseminated to appropriate agencies and community members. Encourage first responders to work together to assist victims in using these sites.
- If a transfer from one health care facility to a designated exam site is necessary, use a protocol that minimizes time delays and loss of evidence and addresses patients' needs. However, avoid transferring these patients where possible.

Recognize the obligation of health care facilities to serve sexual assault patients.[111] It is essential that all sexual assault patients who present to health care facilities be thoroughly evaluated. Treating injuries alone is not sufficient in these cases. Staff who examine these patients must be educated and clinically prepared to collect evidence and document findings while maintaining the chain of custody. They should be able to coordinate crisis intervention and support for patients, as well as provide STI evaluation and care, pregnancy assessment, and discuss treatment options, including reproductive health services. They must be aware of and follow jurisdictional reporting policies, and be able to provide court testimony if necessary.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)[112] requires emergency and ambulatory care facilities to have established policies for identifying and assessing possible victims of rape and other sexual molestation. It also requires staff to be trained on these policies. As part of the assessment process, JCAHO requires these facilities to define their responsibilities related to the collection and preservation of evidentiary materials.[113] Sexual assault examiner programs are helping many health care facilities to carry out these requirements. Facilities should also familiarize themselves with the Federal Emergency Medical Treatment and Active Labor Act (EMTALA), which has provisions pertaining to the ability of hospitals to turn away patients with emergency medical conditions.[114]

Conduct exams at sites served by specially educated and clinically prepared examiners. Some jurisdictions designate specific facilities as exam locations because they employ or have ready access to specially educated and clinically prepared examiners, as well as the necessary space, equipment, supplies, and policies to facilitate the exam process. Jurisdictions may rely on examiner programs to serve multiple exam sites within a specific area.[115] Communities can benefit from designated exam facilities and examiner programs that use specially educated and clinically prepared examiners to conduct the exam because they:

- Increase the likelihood of a state-of-the-art examination;
- Enhance a coordinated team approach;

[111] This and the next paragraph were drawn from L. Ledray, *Evidence Collection and Care of the Sexual Assault Survivor: The SANE-SART Response*, 2001, p. 1.
[112] JCAHO standards for accreditation address a health care organization's level of performance in specific areas—not just what the organization is capable of doing, but what it actually does. The standards set forth maximum achievable performance expectations for activities that affect the quality of care. These standards are developed in consultation with health care experts, providers, measurement experts, purchasers, and consumers, and usually are updated every 2 years. (Drawn from www.ljcaho.org/pms/index.htm. See www.jcaho.org for more information on JCAHO.)
[113] Information on these requirements was drawn from www.sasafefamily.com.
[114] 42 U.S.C. § 1395dd. See http://www.emtala.com for more information about EMTALA.
[115] A mobile examiner program may be based in a health care facility—in addition to providing services at that facility, it also may contract with other exam sites to provide services as requested. Such a program may also be independent, with administrative offices only, and solely contract with exam sites to provide examiner services.

- Encourage quality control (e.g., through use of competent and dedicated examiners, established procedures for evidence collection, and standards for medical care); and
- Increase the quality of care for patients and attention to their needs.

Explore possibilities for optimal site locations. SARTs (or involved agencies) should determine where exams should be conducted. Some factors to consider when identifying sites include safety and security for patients and staff, physical and psychological comfort for patients, capacity to accommodate victims with disabilities,[116] availability of examiners with advanced education and clinical experience, access to a pharmacy for medication, access to medical support services for care of injuries, access to lab services, and access to the supplies and equipment needed to complete an exam.[117] Decisions about site location should reflect the needs of victims (e.g., for accessible care close to their home and local referrals), what is most efficient for the multidisciplinary response team, and the need to maintain the neutrality and objectivity of examiners. Designated facilities may be in hospitals, health clinics, mobile health units, or other alternative sites, including family justice centers.[118, 119] The majority of medical forensic exams are conducted in hospital emergency departments. This location typically offers some level of security, is open 24 hours a day, and provides access to a wide array of medical and support services. Clinical staff often have the experience and expertise to perform the exam and collaborate with appropriate disciplines. Some jurisdictions have or are developing specialized hospital or community-based examiner programs.[120]

SARTs may need to decide whether a local, regional, or State/Territorial system of designated facilities best serves community needs. Some issues that might impact this decision include community demographics and geography; the need for and availability of specialized services; availability of local health care facilities; local capacity to secure competent examiners and necessary space, equipment, and supplies; willingness of involved disciplines to coordinate with a local facility or examiner program; distance to/from regional or State/Territorial facilities; and service capacity of regional or State/Territorial facilities. Communities are encouraged to first consider using local designated exam sites. However, some may ultimately opt for regional- or State/Territorial-level facilities. For example, a small State or sparsely populated region may establish one or more designated facilities to serve all of its localities.

Exam facilities and examiners that serve at the local level may benefit from networking with examiners in other facilities or areas for support for peer review of medical forensic reports, quality assurance, and information sharing (e.g., on training opportunities, practices, and referrals for patients).

Communities may wish to consider basic requirements for designated exam sites, such as:[121]

- The site will be within a reasonable distance from any point in the area it serves ("reasonable" is locally defined);
- The site will promptly alert the SART, if one exists, when sexual assault patients arrive;
- Urgent or emergent physical injuries will be treated immediately;
- Responding examiners will be competent in their knowledge and skills;
- The site will arrange for certified interpretation as needed in patients' preferred languages and/or obtain devices that facilitate communication for individuals with communication disabilities.

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[116] Title II and Title III of the Americans with Disabilities Act explains requirements for facilities in accommodating persons with disabilities (which may vary depending on the type of facility). Title II prohibits discrimination against persons with disabilities in all programs, activities, and services of public entities. Title III requires places of public accommodation to make reasonable modification in their policies, practices, and procedures in order to accommodate individuals with disabilities. See www.usdoj.gov/crt/ada for related information and resources.

[117] Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 35–36.

[118] Particularly on tribal land that is devoid of or a significant distance from a hospital, Indian Health Service (IHS) facilities should consider securing and maintaining examiners and necessary space, equipment, and supplies to conduct these exams. Ideally, all IHS facilities should have examiners and a minimum standard for examiner training.

[119] For more information on the President's Family Justice Center Initiative, see http://www.ojp.usdoj.gov/vawo.

[120] The pros and cons of developing hospital versus community-based examiner programs are discussed in more detail in L. Ledray's *SANE Development and Operation Guide,* 1998, p. 35–9; L. Ledray's Sexual Assault: Clinical Issues, SANE Program Pros and Cons, *Journal of Emergency Nursing,* 23(2), p. 183; and in K. Littel's *SANE Programs: Improving the Community Response to Sexual Assault Victims*, pp. 10–1.

[121] Adapted from Pennsylvania's *SART Guidelines*, 2002, p. 21.

- Patients will be provided with a comprehensive medical forensic exam and resources to address their immediate emotional and psychological needs;
- The site will provide a private, secure, and quiet waiting area for patients and for personal support persons accompanying them;
- The site will provide a private and secure setting for the investigative interview;
- The site will provide a private exam room and other measures to assure patients' privacy;
- The site will have a bathroom (preferably with shower facilities) available for patients' use following completion of the exam;
- The site or examiner program that serves the site will have/provide proper equipment and supplies to facilitate a comprehensive exam ("proper equipment and supplies" are locally defined);
- The site or examiner program that serves the site will have a mechanism to ensure evidence collection kits are up to date;
- Patients will be offered medications for possible exposure to sexually transmitted infections;
- Patients will be offered information about how exams are paid for in their jurisdiction and reimbursement sources (if they exist) for related expenses that are their responsibility; and
- Site billing departments will adhere to proper coding and billing practices for sexual assault cases, as determined by the facility and informed by jurisdictional policy.

If designated facilities or sites served by examiner programs are selected, their success depends on getting information about them to victims and agencies that provide immediate response or refer victims for treatment and evidence collection. At a minimum, the list of designated exam sites should be provided to all local hospitals, law enforcement agencies, emergency medical services, sexual assault victim advocacy programs, and protective services. Promoting community public awareness about these sites is also important given that victims may first disclose an assault to family members, friends, teachers, faith-based leaders, employers, coworkers, and others. In addition, success will depend on interagency cooperation in explaining facility options to victims and transporting them to designated exam sites (with their permission). Law enforcement representatives and advocates may need guidance on how to recommend an exam location to victims without mandating that they go to a specific site.

If transferring the patient from one health care facility to a designated site is necessary, use an established protocol that minimizes time delays and loss of evidence while addressing patients' needs.[122] Avoid transferring sexual assault patients where possible. Every transfer can destroy evidence and cause patients further stress. However, if a sexually assaulted individual arrives at a health care facility that, for some reason, is not able to provide a medical forensic exam, interagency transfer procedures must be in place to transfer that individual to the nearest designated exam site. Evidence should be preserved when examining, treating, or transferring patients. If there are acute medical or psychological injuries that must be treated immediately, treatment should be provided at the initial receiving facility. It may be helpful to offer patients support and advocacy from advocates at both the receiving facility and exam site. A copy of all records, including any X-rays taken, should be transported with patients to the exam facility. (However, it may not be necessary to send all medical records if patients' medical needs are met before they are transferred to a nonmedical exam site for evidence collection.) All health care facilities receiving Federal funds, including Medicare and Medicaid payments, are required to screen patients medically before transferring them to another health care facility.[123]

Patients have a right to decline a transfer. They should be aware, however, of the impact of refusing transfer, as it may negatively affect the quality of care, the usefulness of evidence collection (if it is collected at all), and, ultimately, any criminal investigation and/or prosecution. They should understand that declining a transfer might also be used to discredit them in court.

[122] This section was drawn from the *North Dakota Sexual Assault Evidence Collection Protocol*, 2001, p. 12, and the *Texas Evidence Collection Protocol*, 1998, p. 14.
[123] Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd.

3. Equipment and Supplies

Recommendations at a glance for jurisdictions and responders to ensure proper equipment and supplies are available for exams:

- Consider what equipment and supplies are necessary to conduct a medical forensic exam.
- Address cost barriers to obtaining necessary equipment and supplies.

Examiners should know how to use all equipment and supplies (including medications) properly during the exam. It is important that examiners and other responders involved in sexual assault cases stay abreast of the latest research on the use of equipment and supplies used in caring for sexual assault patients and/or collecting evidence from them.

Plan to have the following equipment and supplies readily available for the exam, according to jurisdictional policies: [124]

- A copy of the most current exam protocol used by the jurisdiction.
- Standard exam room equipment and supplies for a physical assessment and evidentiary pelvic exam. The needs of patients with physical disabilities should be taken into account.[125]
- Comfort supplies for patients, even if minimal. Suggested items: clean and ideally new replacement clothing, toiletries, food and drink, and a phone or at least easy access to a phone in as private a location as possible. It is also important during the exam process to help patients obtain items they request related to their spiritual healing.[126] It may be useful for facilities to have items on hand that are commonly requested in that jurisdiction (e.g., things that are used for local tribal traditional healing practices) and policies for their use in the facility.[127]
- Sexual assault evidence collection kits and related supplies. (See *B.4. Sexual Assault Evidence Collection Kit* for information on minimal kit contents.) Related supplies might include tweezers, tape, nail clippers and scrapers, scissors, dental floss, collection paper, saline solution or distilled water, extra swabs, slides, containers, envelopes, paper bags, and pens/pencils.
- A method or device to dry evidence. Drying evidence is critical to preventing the growth of mold and bacteria that can destroy an evidentiary sample. With any drying method or device used, ensure minimal contamination of evidence, and maintain the chain of custody. The kit's design can also aid in the drying process (e.g., by providing clear instructions and supplies to allow drying to occur).
- A camera and related supplies (using the most up-to-date technology possible) for forensic photography during initial and followup examinations. Related supplies might include film, batteries, a flash, and an inch scale or ruler for size reference. (Also see *C.5. Photography*.)
- Testing and treatment supplies needed to evaluate and care for patients medically (follow exam facility policies). Also, testing supplies may be needed for forensic purposes that are not included in the evidence collection kit. For example, supplies for toxicology testing are often not in the kit.
- An alternate light source (using the most up-to-date technology possible) can aid in examining patients' bodies, hair, and clothing. It is used to scan for evidence, such as dried or moist secretions, fluorescent

[124] All the equipment and supplies discussed will not be needed in every exam. What is appropriate in each case will depend on the circumstances of the assault and medical and forensic attention called for, patients' needs, and patients' consent to utilize equipment and supplies. Jurisdictional and/or facility policies will also influence what equipment and supplies are used.

[125] For example, it would be ideal to have an exam table with a hydraulic lift for persons with mobility impairments. If this exam table is not available, health care personnel must be aware of how to assist patients with physical disabilities onto standard exam tables. If it is determined that a patient can only be examined on an exam table with a hydraulic lift, procedures should be in place to get the patient to a site with such a table with as little loss of evidence as possible.

[126] Along with these items, patients may want the opportunity to speak with a trusted religious or spiritual leader, such as a medicine man/woman, a rabbi, a priest, or a pastor, before, during, or after the exam.

[127] Involved responders/facilities should be aware of local traditional healing practices and support American Indian and Alaska Native patients if they wish to use such practices at some point before, during, or after the exam. Keep in mind that each tribe has its own traditional practices to promote healing, but not all Native people follow traditional spiritual paths. Rather, spiritual values and belief systems among Native people are as widely diverse as they are among the general population.

fibers not visible in ambient light, and subtle injury.[128] While the exam can be done without a light source, it is a relatively inexpensive piece of equipment that is commonly used during exams.[129] (Also see *C.6. Exam and Evidence Collection Procedures*.)

- An anoscope may be used in cases involving anal/rectal trauma.[130] This instrument can help in visualizing an anal injury, obtaining reliable rectal swabs (if there is a concern about contamination), and identifying and collecting trace evidence. Many health care facilities have anoscopes available. (Also see *C.6. Exam and Evidence Collection Procedures*.)
- Written materials for patients. (For details on this topic, see *A.2. Victim-Centered Care*.)

In addition:

- A colposcope with photographic capability is strongly suggested. Although injuries can be detected visually by examiners without the colposcope, the colposcope is an important asset in the identification of microscopic trauma. Photographic equipment, both still and video, can be attached for forensic documentation. (Also see *C.6. Exam and Evidence Collection Procedures*.)
- A microscope. In some jurisdictions, examiners are required to wet mount and immediately examine vaginal/cervical secretions for motile and nonmotile sperm.[131] In these cases, an optically staining microscope is used to highlight cellular material and facilitate the search for sperm.[132] (Also see *C.6. Exam and Evidence Collection Procedures*.)
- Toluidine blue dye. In some jurisdictions, the dye is used to assist in identifying recent genital and perianal injuries. (Also see *C.6. Exam and Evidence Collection Procedures*.)

(See *C. The Examination Process* for more discussion on use of equipment and supplies during the exam.)

Note that some jurisdictions, particularly those in rural and remote areas, are beginning to utilize advanced technology (equipment and methods) such as real-time video consultation, store and forward video consultation, and interactive video consultation to support examiners conducting exams. Using this type of technology, examiners can eliminate the barriers of geography and consult with offsite medical "experts." (This use of such technology in medicine is sometimes called telemedicine.) Equipment needed to facilitate use of telemedicine may include, but is not limited to, computers, software programs, and the Internet.[133]

Consider ways to overcome cost barriers. Obtaining equipment and supplies that can increase the quality and quantity of evidence collected can have a significant impact on case outcomes. However, the costs of equipment and training on equipment use can be prohibitive for some jurisdictions and examiner programs. Some ideas to address cost barriers:

- Seek used or donated equipment or alternative, less-expensive equipment where it exists;
- Apply for grant or foundation funding for equipment where eligible;[134]

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[128] Drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 37.

[129] A Wood's Lamp is perhaps the most commonly used type of light source in sexual assault exams. Examiners should be aware of what the light sources they use will detect and their limitations. For example, many examiners find the Wood's Lamp useful in helping to detect secretions, stains, and fibers on patients. However, one research study questioned its utility as a screening device for the detection of semen. (K. Santucci, D. Nelson, K. McQuillen, S. Duffy, and J. Linakis, "Wood's Lamp Utility in the Identification of Semen," *Pediatrics,* 104(6), 1999.) Continued research is needed (and being conducted) on the utility of this and other light sources in evidence collection. Ongoing refinement of these instruments is encouraged.

[130] The examiner must use discretion in determining whether a case warrants the use of the anoscope for medical and/or forensic purposes, as well as obtain patients' informed consent for anoscopy. The discomfort this invasive procedure may cause the patient should be weighed against its potential medical or forensic uses.

[131] Wet-mount evaluation of vaginal secretions for infection (e.g., yeast infection and STIs) may be conducted if medically or forensically indicated, whether or not wet-mount evaluation for sperm is done. Hospital lab personnel rather than examiners usually analyze these samples rather than examiners.

[132] The most commonly used optically staining instrument by hospital labs is the phase contrast microscope. In jurisdictions that require examiners do wet-mount evaluations for sperm, an optically staining microscope should be readily available to them at all times. Ideally, due to chain-of-custody issues and the fact that the slide will dry in 5 to 10 minutes, examiners should not have to leave the exam room to evaluate the slide.

[133] Keep in mind that telemedicine in sexual assault cases is in its infancy—further research and debate is needed to address concerns related to logistics of use, patients' consent, confidentiality, and impact; legal implications; affordability; and accessibility.

[134] Funding under the STOP Violence Against Women Formula Grant Program and the STOP Violence Against Indian Women Discretionary Grant Program may be used to cover costs of some equipment. For more information, see www.ojp.usdoj.gov/vawo.

- Ask for help from community groups in raising funds for one-time equipment or ongoing supply costs;
- Consider sharing costs and equipment with other departments in an exam facility or among other near-by local health care facilities;
- Consider the benefits of a mobile examiner program where costs of equipment, examiner education and clinical preparation, and on-call costs may be shared by multiple exam sites; and
- Since the information gathered in the exam is used to investigate and prosecute the offense, ask for assistance from local law enforcement and prosecutor's offices in obtaining equipment and supplies used specifically for forensic evidence collection.

4. Sexual Assault Evidence Collection Kit

Recommendations at a glance for jurisdictions and responders when developing/customizing kits:

- Use kits that meet or exceed minimum guidelines for contents.
- Work to standardize kits within a jurisdiction. Make them readily available for use at any facility that conducts sexual assault medical forensic exams.
- Those involved in kit development and distribution should periodically review the kit's efficiency and usefulness and make changes as needed.

Use kits that meet or exceed minimum guidelines for contents. Many jurisdictions have developed their own sexual assault evidence collection kits (for evidence from victims) or have purchased premade kits through commercial vendors. Kits may vary from one another in types of samples collected, collection techniques, materials used for collection, and terms used to describe categories of evidence. Despite variations, however, it is critical that every kit meets or exceeds the recommended minimum guidelines for contents.[135]

- A kit container. It is suggested that this container have a label with blanks for identifying information and documenting the chain of custody. Most items gathered during evidence collection are placed into the container, after being dried, packaged, labeled, and sealed according to jurisdictional policy. Bags are typically provided for more bulky items that will not fit in the container (e.g., clothing). Some jurisdictions provide large paper bags to hold the container and additional evidence bags.
- An instruction sheet or checklist that guides examiners in collecting evidence and maintaining the chain of custody.
- Forms that facilitate evidence collection and analysis, including patients' authorization for collection and release of evidence and information to the law enforcement agency; the medical forensic history; and anatomical diagrams.
- Materials for collecting and preserving the following evidence, according to jurisdictional policy:[136]
    - Patients' clothing and underwear and foreign material dislodged from clothing;
    - Foreign materials on patients' bodies, including blood, dried secretions, fibers, loose hairs, vegetation, soil/debris, fingernail scrapings and/or cuttings, matted hair cuttings, material dislodged from mouth using dental floss,[137] and swabs of suspected semen, saliva, and/or areas highlighted by alternate light sources;[138]
    - Hair evidence (including head and pubic hair samples and combings);[139]
    - Vaginal/cervical swabs and smears;
    - Penile swabs and smears;
    - Anal/perianal swabs and smears;

[135] The following resources were helpful in developing this list: the *Sexual Assault Evidence Collection Kit, VEC100*, by Sirchie Finger Print Laboratories, the *Texas Customized Sexual Assault Evidence Collect Kit* by Tri-Tech, Inc., the Commonwealth of Virginia's *Physical Evidence Recovery Kit*, the State of California's *Medical Forensic Report: Adult/Adolescent Sexual Assault Examination, Less than 72 Hours (OCJP 923)),* the *Ohio Department of Health's Sexual Assault/Abuse Evidence Collection Kit* (as found in their protocol), *Detailed Instructions*; *Connecticut's Sexual Assault Evidence Collection Kit* (as found in their protocol), and the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, pp. 101–107.

[136] Some samples that historically have been collected are no longer recommended in many jurisdictions, unless the medical forensic history and physical exam indicate otherwise (e.g., a vaginal wash).

[137] Although in some instances flossing could help dislodge evidence that may be between the patient's teeth, flossing for evidence is not routinely done across jurisdictions. Any related safety risks to patients (e.g., potential increased risk of HIV exposure if there is semen in the mouth and flossing causes gums to bleed) should be considered before flossing for evidence.

[138] It is acknowledged that approaches to categorizing evidence vary. For example, one kit may collect external genital swabs when gathering foreign materials, while in another kit, collection of genital swabs may be a separate category of evidence.

[139] Some jurisdictions collect pubic and head hair combings, others collect only pubic combings. Some also collect pubic and/or head hair reference samples. Materials should be included in the kit to collect and preserve hair evidence required by jurisdictional policy.

- Oral swabs and smears;
- Body swabs;[140] and
- Known blood, saliva sample, or buccal swab for DNA analysis and comparison.

(See *C.6. Exam and Evidence Collection Procedures* for specifics about evidence collection techniques.)

Extra copies of forms should be available to examiners for cases when the kit is not used, but documentation of the medical forensic history and the exam is done. All forms included in the kit should be designed to facilitate optimal forensic evidence collection, analysis, and examiner testimony.

Separate from the kit, materials and forms for collecting toxicology samples should be available to examiners (and to responding law enforcement officers and emergency medical technicians, according to jurisdictional policy).

Work to standardize sexual assault evidence collection kits within a jurisdiction and preferably across a State or Territory, or for Federal cases.[141] A designated agency in the jurisdiction should be responsible for oversight of kit development and distribution.[142] It should:

- Ensure that any facility that conducts sexual assault medical forensic exams is involved in kit development and supplied with kits;[143]
- Work with relevant agencies (e.g., crime labs, law enforcement agencies, exam facilities and examiner programs, advocacy programs, and prosecutors' offices) to keep abreast of related changes in technology, scientific advances, and cutting-edge practice;
- Review periodically (e.g., every 2 to 3 years) kit efficiency and usefulness;
- Make adjustments to the kit as necessary; and
- Establish mechanisms to ensure that kits at exam facilities are kept up to date (e.g., if a new evidence collection procedure is added, facilities need to know what additional supplies should be readily available).

(See *B.6. Evidence Integrity* for handling and storage of kits.)

[140] Some jurisdictions use the medical forensic history, the examination, and patients' consent to determine whether and where to collect swabs, while others collect swabs from all orifices and from the surface of the body (with patients' consent). In particular, some do not collect anal swabs unless indicated.

[141] It may be useful to consider developing a standardized kit across all communities, States, and Territories, and for Federal cases. Further analysis is needed to assess the benefits and disadvantages of such a kit and the feasibility of development and implementation. Some challenges could include building consensus across communities regarding best practices and obtaining buy-in from involved agencies.

[142] It is important to consider costs to the State/Territory/Tribe/Federal agencies and local community, and ability of local communities to cover costs. In some States, one State agency (e.g., the crime laboratory) assumes the costs. In others, the costs are passed onto local criminal justice agencies.

[143] As a backup to having kits readily available at exam sites or with examiner programs, jurisdictions may also want to discuss the feasibility of storing a few kits at local law enforcement agencies or in law enforcement patrol cars. Before storing kits in patrol cars, however, make sure that the temperatures the kit will be exposed to will not affect kit contents.

5. Timing Considerations for Collecting Evidence

Recommendations at a glance for health care providers and other responders to maximize evidence collection:

- Whether or not evidence is collected for the sexual assault evidence collection kit, examiners should obtain the medical forensic history, examine patients, and document findings (with patients' consent). Patients' demeanor and statements related to the assault should also be documented.
- Examine patients promptly to minimize loss of evidence and identify medical needs and concerns.
- Make decisions about whether to collect evidence and what to collect on a case-by-case basis, guided by knowledge that outside time limits for obtaining evidence vary.
- Responders should seek education and resources to aid them in making well-informed decisions about evidence collection.

Recognize the importance of gathering information for the medical forensic history, examining patients, and documenting exam findings, separate from collecting evidence. Examiners should obtain the medical forensic history as appropriate, examine patients, and document findings when patients are willing, whether or not evidence is gathered for the sexual assault evidence collection kit. The history and documentation of exam findings can help in determining if and where there may be evidence to collect and in addressing patients' medical needs. In addition, they can be invaluable in and of themselves to an investigation and prosecution if a report is made. It is also important to document patients' demeanor during the exam process (e.g., crying, shaking, or showing signs of upset) and their statements made related to the assault because if the case is reported, this information could be admitted as evidence at trial.

Examine patients promptly to minimize the loss of evidence. Evidence can be lost from the body and clothing through a number of mechanisms. For example, degradation of some seminal fluid components can occur within body orifices, semen can drain from the vagina or wash from the mouth, sperm can lose motility, bodily fluids can get washed away, and dried secretions and foreign materials can fall from the body and clothing.[144] Prompt examination also helps to quickly identify patients' medical needs and concerns.

Recognize that evidence may be available beyond 72 hours after the assault. In recent history, 72 hours after a sexual assault has been considered a guideline to use as an outside limit for obtaining evidence for the evidence collection kit. Research and evidence analyses indicate that some evidence may be available beyond this time period. For instance, sperm might be found inside the cervix after 72 hours and urine may reveal traces of certain drugs up to 96 hours after ingestion. Some examples of situations where evidence may be found even after considerable periods of time include when patients complain of pain or bleeding, have visible injuries, or have not washed themselves since the assault, or where there is a history of significant trauma from the assault. Some jurisdictions have extended their standard cutoff time beyond 72 hours (e.g., to 5 days or 1 week).

Due to the stability of DNA and sensitivity of tests, advancing DNA technologies also continue to extend time limits. These technologies are even enabling forensic scientists to analyze stored evidence from crimes that occurred years before.[145] Such breakthroughs demonstrate the importance of collecting all possible evidence.

Make decisions about whether to collect evidence on a case-by-case basis, guided by the knowledge that outside time limits for obtaining evidence vary due to factors such as the location of the evidence or type of sample collected. Examiners and law enforcement representatives, in particular, should be aware of the standard cutoff time for evidence collection in their jurisdictions, which is typically indicated in instructions in evidence collection kits. But it is important to remember that evidence collection beyond the cutoff point is conceivable and may be warranted in particular cases. In any case where the utility

[144] Paragraph drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 29.

[145] When the evidence was initially collected after the assault, it was not of adequate quality to allow crime lab analysis using existing technologies.

of evidence collection is in question, encourage dialogue between law enforcement representatives (if involved), examiners, and forensic scientists regarding potential benefits or limitations.

Involved responders should avoid basing decisions about whether to collect evidence on how they think patients' characteristics or circumstances will affect the investigation and prosecution. For example, the fact that an adolescent may have lied to her parents about where she was going the night of the assault should in no way influence the decision of the examiner and/or the law enforcement representative to collect evidence.

Responders should seek education and resources to aid them in making well-informed decisions about evidence collection. Examiners and law enforcement representatives require training and resources to allow them to make informed decisions about whether to collect evidence and what to collect in each case. They also need local policies and kit instructions that encourage them to make informed decisions in each case, rather than applying a limiting general standard to all.[146] First responders also need instructions on collecting a urine sample if there is any suspicion of drug-facilitated sexual assault and victims cannot wait to urinate until their arrival at the exam site.

[146] For many communities, moving away from the 72-hour cutoff time represents a major shift in policy. Training and policies should discourage decisionmaking about evidence collection that is based on extraneous factors, such as reluctance of a criminal justice agency to pay for sexual assault evidence collection in general.

6. Evidence Integrity

Recommendations at a glance for health care providers and other responders to maintain evidence integrity:

- Follow jurisdictional policies for drying, packaging, labeling, and sealing evidence.
- Follow jurisdictional policies for consistent evidence management and distribution. A duly authorized agent should transfer evidence from the exam site to an appropriate crime laboratory or other designated storage site.
- Develop storage procedures that maximize evidence preservation. Ensure that storage areas are secure and the proper temperature for evidence.
- Make sure that jurisdictional policies are in place to address storage of evidence in cases where patients are undecided about reporting.
- Maintain the chain of custody for the evidence. Educate all those involved in handling, documenting, transferring, and storing evidence regarding the specifics of properly preserving evidence and maintaining the chain of custody.

Follow jurisdictional policies for drying,[147] packaging, labeling, and sealing the evidence. Involved responders should be educated regarding these policies. It is critical to air-dry wet evidence at room temperature in a clean, sterile environment and quick manner that prevents contamination.[148] A drying box or other device may be used to facilitate the drying process. Jurisdictions should have policies for handling evidence that cannot be dried thoroughly at the exam site (e.g., wet clothing, tampons, sanitary napkins, tissues, diaphragms, and condoms), as well as for liquid evidence such as urine and drawn blood samples. When packaging dry evidence, use paper containers rather than plastic, because plastic containers retain moisture and promote degradation of biological evidence. Following proper drying and packaging procedures is vital to prevent the growth of mold and bacteria that can destroy an evidentiary sample.

Keep in mind that evidentiary materials include exam documentation. Follow jurisdictional policies for documenting exam findings and the medical forensic history, and packaging, labeling, and sealing such documentation. Properly recording and preserving this information is critical for its admissibility during a trial.

Make sure transfer policies maximize evidence preservation. Minimize transit time between collection of evidence and storage of kits. To avoid potential degradation of evidence, it is important to transport kits containing liquid samples and other wet evidence in a timely fashion. Only a law enforcement official or duly authorized agent should transfer evidence from the exam site to the appropriate crime laboratory or other designated storage site (e.g., a law enforcement property facility). Jurisdictional procedures for evidence management and distribution must be in place and followed. Those involved in evidence management and distribution should be educated on the specifics of these procedures and their responsibilities.

Make sure storage policies maximize evidence preservation. Secure storage sites should be designated and storage requirements should be consistent across a jurisdiction. Storage requirements depend on what types of specimens are being collected and on jurisdictional policy. For example, kits without drawn blood or other wet evidence generally do not need to be refrigerated. Follow jurisdictional policy for refrigeration of drawn blood samples and other wet evidence. Dried blood samples on blood collection cards do not require refrigerated storage.[149] Urine should be refrigerated or frozen when stored. Those involved in storing evidence should be educated regarding storage requirements.

Make sure jurisdictional policies are in place to address evidence storage in cases where patients are undecided about reporting. Finding adequate storage space for these kits is a challenge for many facilities and agencies (e.g., community-based or hospital examiner programs may lack the capacity for secure long-term storage of kits at their facilities). Local responders, particularly examiners, law enforcement

[147] Dry evidence unless indicated otherwise (e.g., freezing).
[148] With the ever-increasing sensitivity of DNA analysis, there is a greater chance that accidental contamination and dilution by foreign DNA can be detected. Every precaution should be taken to reduce outside contamination and dilution of evidence.
[149] The National Institute of Standards and Technology is conducting a 10-year project on DNA storage. Thus far, it confirms that refrigeration of dried DNA is generally unnecessary.

representatives, and crime lab staff, should discuss and address these and related challenges and develop procedures that allow for the secure storage of these kits without revealing patients' identity. Storing the evidence as long as necessary is the ideal (e.g., until the patient decides whether to report or until the jurisdiction's statute of limitations for retaining evidence expires). However, due to lack of storage space, kits in some jurisdictions are stored for a limited period of time (e.g., 30, 60, or 90 days) and then destroyed if no report is made. If such a policy is implemented, it is important that patients are informed regarding the amount of time they have to decide to report and procedures for reporting. It is also critical that the period of time given to patients to decide allows them the chance to consider their decision thoroughly; 24 to 48 hours is not sufficient to make such a decision.

Document the handling, transfer, and storage of evidence. Examiners must maintain control of evidence during the exam, while evidence is being dried, and until it is in the kit container and sealed (and then follow jurisdictional procedures for storing evidence securely or handing it over to a duly authorized agent for transfer to a storage site). Documentation should continue with each transfer of the evidence to law enforcement, the crime laboratory, and others involved in the investigative process.[150] Patients, advocates, family members, and other support persons should not handle the evidence. Documentation of the chain-of-custody information is vital to ensuring that there has been no loss or alteration of evidence prior to trial. Educate all those involved in handling, transferring, and storing evidence regarding the specifics of maintaining the chain of custody.

[150] Adapted from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 34.

C. The Examination Process

This section focuses on the various medical and forensic components of the exam process, starting with the initial contact with victims to the court testimony by examiners on exam findings.

The following chapters are included:

1. Initial Contact
2. Triage and Intake
3. Documentation by Health Care Personnel
4. The Medical Forensic History
5. Photography
6. Exam and Evidence Collection Procedures
7. Drug-Facilitated Sexual Assault
8. STI Evaluation and Care
9. Pregnancy Risk Evaluation and Care
10. Discharge and Followup
11. Examiner Court Appearances

1. Initial Contact

Recommendations at a glance for jurisdictions and responders to facilitate initial contact with victims:

- Build consensus among involved agencies regarding procedures for coordinated initial response when a recent sexual assault is disclosed or reported. Educate responders to follow procedures.
- Recognize essential elements of initial response.

Build consensus among involved agencies regarding procedures for initial coordinated response when a recent sexual assault is disclosed or reported. First responders from these agencies (e.g., 911 dispatchers, law enforcement representatives, emergency medical services (EMS) technicians, hospital emergency department staff, sexual assault examiners, and advocates) need to be educated about and follow these procedures. Responders also need discipline-specific procedures (e.g., EMS procedures should stress preserving evidence when caring for acute injuries and treating victims with sensitivity).

In addition, other community professionals to whom victims may disclose need to know procedures for activating the SART or obtaining immediate assistance for victims if a SART does not exist. (For information on this topic, see *A.1. Coordinated Team Approach and Appendix B. Creation of SARTs*.) Also, recognize that some institutions and residential living programs have internal procedures for handling sexual assault disclosures. SART members should work with these entities to ensure that their procedures address the needs of victims and are coordinated with jurisdictional multidisciplinary response.

Recognize essential activities of initial response. Some victims may initially present at a health care facility. But most victims who receive immediate medical care for sexual assault initially contact 911, law enforcement, or an advocacy agency for help.

Law enforcement, 911, and EMS response. Elements during initial law enforcement, 911, or EMS contact include:

- Assess victims' needs for immediate care for potentially life-threatening or serious injuries. Administer necessary first aid and request/obtain emergency medical assistance according to jurisdictional policy.
- Address safety needs of victims and others at the scene (e.g., offenders may be present), calling for assistance/backup if needed.
- Assess quickly the age, abilities, communication modality, and health condition of victims and tailor response as appropriate (e.g., a certified interpreter or protective service worker may be needed).
- Respond to requests for victim assistance as quickly as possible.[151] Understand that victims need immediate assistance for many reasons: they may not be safe, may be physically injured, and/or are experiencing trauma. Be aware that time delays in response can cause loss of evidence and increased trauma.
- If injuries do not appear serious, emphasize to victims the need for medical evaluation and address related heath concerns. Also, explain the purpose of the exam and what happens during the exam process, keeping in mind that the amount of information that victims want at this time varies.

[151] In some areas, law enforcement representatives may not respond promptly because they must travel considerable distances and through rough terrain to get to victims' locations. Some law enforcement agencies may not have enough representatives to respond to each case in a timely manner (e.g., a rural sheriff's office may only have one officer). In communities with such problems, it is important that agencies and professionals involved in these cases advocate for increasing the capacity of law enforcement agencies to respond promptly. They also can work jointly to ensure that there is at least one responder/agency from which victims can consistently receive initial help (e.g., EMS or the advocacy program). That professional/agency should be trained in initial response and able to access emergency medical assistance if needed and coordinate transportation to the exam facility. Information about which agency/responder to call for help must be publicized in the community.

- Inform victims about exam facility options (if options exist) and seek their consent to transport them to the facility of their choice (if they had options) for treatment and/or evidence collection.[152]
- Encourage victims' interaction with advocates as soon as possible after disclosure of the assault, even if victims choose not to receive medical care and/or have the medical forensic exam. In a few jurisdictions, advocates may be dispatched directly to the scene to provide victim support and advocacy, if appropriate. Follow local procedures for activating an advocate.
- Ask victims if they would like family members or friends to be contacted.
- Take measures to preserve crime scene evidence, including evidence on victims. Document victims' demeanor and statements related to the assault, according to jurisdictional policy.
- Explain to victims their reporting options. Keep in mind that the amount of information desired will vary per individual.
- Responding law enforcement officials should seek basic information from victims about the assault in order to apprehend suspects and facilitate crime scene preservation in a timely manner.

If victims agree to seek emergency care and/or have evidence collected:

- Explain to victims how to preserve bodily evidence until it can be collected (e.g., do not wash, change clothes, urinate, defecate, smoke, drink, eat, brush hair or teeth, or rinse mouth).
- Explain to victims that clothing most likely will be taken as evidence. They may wish to bring or have someone bring a clean change of clothes to the exam facility. If applicable, let victims know that replacement clothing will be available at the exam site. If they changed clothes since the assault, clothing worn during and immediately after the assault will be needed. Follow law enforcement procedures for retrieving clothing or other items from a crime scene so that evidence is not inadvertently destroyed or contaminated.
- In suspected cases of drug-facilitated assault, victims' first available urine sample should be sought if they cannot wait to urinate until arrival at the exam site. (For information on procedures, see *C.7. Drug-Facilitated Sexual Assault*.) Victims might have been drugged without their knowledge. If they or their families, friends, or responders suspect drug-facilitated assault, a urine sample should be sought.
- Transport or arrange transportation for victims to the exam site. Victims with disabilities may have equipment (e.g., wheelchairs and other assistive devices) and/or service animals that also need to be transported.[153] Keep in mind that victims may consider such equipment as extensions of themselves and equipment should be treated with care.
- Follow jurisdictional policy on alerting exam facilities about the pending arrival of patients.
- Do not take suspects to the same exam facility as victims at the same time, if possible.

Advocate response. If victims have initial contact with advocates, this contact typically occurs through a phone hotline call or a face-to-face meeting. Advocates should follow agency-specific and jurisdictional policy for first response. For example, advocates should assess victims' safety and need for medical assistance and call 911 in cases of serious injuries or when there is an imminent threat to someone. Advocates should encourage victims to seek care for other injuries and offer support, information about their options (e.g., health care, advocacy and counseling, evidence collection, exam site options, and reporting to law enforcement), and referrals. They can explain to victims how to preserve bodily evidence for evidence collection and the importance of prompt toxicology testing if drug-facilitated assault is suspected. In general, advocates can help victims identify and consider how to address their needs and concerns, as well as

[152] Inform victims of the approximate amount of time it will take to travel to the facility and how long they will be at the exam site. This information can help them prepare for what to expect and make needed arrangements (e.g., childcare, getting time off from work or school, or informing family members). In some areas, it may take considerable time to get to the exam site (e.g., a number of hours). Involved agencies in these areas may want to consider the feasibility of having a specially trained examiner located in their community.
[153] Victims with disabilities may need assistive devices and service animals while at the exam site. Also, evidence might be found on them.

identify individuals who might support them in dealing with the aftermath of the assault. They can activate the SART (if one exists) with victims' permission. Alternately, advocates can offer to help victims arrange transportation to the exam site, obtain nonemergency medical care, and obtain assistance from law enforcement. They can also accompany them through medical forensic procedures.

Regardless of which agencies are first responders, responders should always be sensitive to the victim's needs and level of trauma. Even if victims have taken actions that destroy evidence, such as showering, responders should react in a sensitive and caring manner.

2. Triage and Intake

Recommendations at a glance for health care providers to facilitate a triage and intake process that addresses patients' needs:

- Consider sexual assault patients a priority. Use a private location within the exam facility for primary patient consultations and as a waiting area for family members and friends and law enforcement interviews.
- Respond to acute injury, trauma care, and safety needs of patients before collecting evidence. Patients should not wash, change clothes, urinate, defecate, smoke, drink, or eat until initially evaluated by forensic examiners, unless necessary for treating acute medical needs. Alert examiners of the need for their services at the exam site.
- Contact victim advocates so they can offer services to patients, if not already done.
- Assess and respond to safety concerns upon arrival of patients at the exam site, such as threats to patients or staff.
- Assess patients' needs for immediate medical or mental health intervention. Seek informed consent of patients before providing treatment, according to facility policy.

Consider sexual assault patients a priority, regardless of whether physical injuries are evident.[154] (For a discussion of this topic, see *A.2. Victim-Centered Care*.)

Utilize a private location within the exam facility for patient intakes, as well as for a waiting area for patients' family members and friends and law enforcement interviews. (Also see *A.2. Victim-Centered Care*.)

Respond to acute injury, trauma care, and safety needs before collecting evidence. In addition to promoting physical health, sensitive and timely medical care can help reduce the likelihood of acute psychological trauma and its aftereffects, support patients' existing and emerging coping skills, and set the tone for patients' resumption of normal functioning.

Acute medical needs take precedence over forensic needs. Patients should be instructed to not wash, change clothes, urinate, defecate, smoke, drink, or eat until initially evaluated by examiners, unless necessary for treating acute medical injuries. If drug-facilitated sexual assault is suspected, and patients need to urinate prior to the arrival of examiners, ensure that the urine sample is collected properly while maintaining the chain of custody.

As soon as possible after the initial medical evaluation, management, and stabilization of acute problems and before treating nonacute injuries, the medical forensic exam can be conducted (with patients' permission). In circumstances in which patients are seriously injured, examiners must be prepared to work alongside other health care providers who are stabilizing and treating them. In such cases, examiners may need to perform exams in settings such as a health care facility's emergency department, an operating room, a recovery room, or an intensive care unit.

Alert examiners of the need for their services. The SART, if one exists, can work with exam facilities to identify acceptable timeframes to conduct a medical forensic exam after a patient's arrival and medical evaluation, management, and stabilization. If examiners are not based at the site or need to be dispatched,

[154] Historically, sexual assault patients who came to a health care facility (namely hospital emergency departments) for medical care and forensic evidence collection had to wait a long time to be examined. Often, they were not considered priority cases because they lacked visible physical injuries or their physical injuries were less serious than others coming into the facility. The psychological trauma they were experiencing often was not taken into account, nor was the fact that evidence can be destroyed or contaminated if collection is delayed. Many communities are addressing this problem by establishing examiner programs. At busy health care facilities that make life or death decisions about prioritizing patients, these programs can help ensure that sexual assault patients are offered and receive a medical forensic examination promptly after being evaluated and treated for any serious or life-threatening injuries.

the facility should contact them immediately after identifying a sexual assault patient.[155] Examiners are often required to arrive at the exam site within a certain period of time (e.g., 30 minutes) after being dispatched.

Contact an advocate, if not already done. (For a discussion of this topic, see *A.2. Victim-Centered Care*.)

Assess safety needs upon arrival of the patient at the exam site. The facility should have procedures to assess safety concerns at the exam site, such as a threat to patients or staff, and to respond to such threats or dangerous situations. (For a discussion of this topic, see *A.2. Victim-Centered Care.)*

Assess patients' needs for immediate medical or mental health intervention prior to the medical forensic exam, following facility policy. Seek informed consent of patients before providing treatment. (For more information on this topic, see *A.3. Informed Consent*.) Also, inform them that they have a right to receive medical care regardless of whether the assault is reported to law enforcement, and if and how their reporting decision will affect payment for medical care and exam. (For more information on this topic, see *A.5. Reporting to Law Enforcement.)*

[155] It is possible that examiners could also be dispatched by first responders at the crime scene or by health care staff after being alerted that a sexual assault patient will be arriving at their facility. Although activating examiners as early as possible seems like it would benefit these patients, such a procedure can potentially cause confusion. For example, after activating an examiner to go to a particular exam facility, there may be significant delays in getting the patient to the site or changes en route to the facility patients. Sexually assaulted individuals may also change their minds about care or evidence collection.

3. Documentation by Health Care Personnel

Recommendations at a glance for health care providers to complete needed documentation:

- Ensure completion of all appropriate documentation.
- Ensure the accuracy and objectivity of medical forensic reports by seeking education on proper report writing.

Ensure completion of all appropriate documentation. Examiners are responsible for documenting forensic details of the exam in the medical forensic report, according to jurisdictional policy. This report usually includes patient consent forms related to evidence, the medical forensic history, and documentation of exam findings.[156] (The medical forensic history and documentation of exam findings are discussed in more depth in later chapters in this section.) The only medical issues documented in this report are findings that potentially relate to the assault or preexisting medical factors that could influence interpretation of findings. If the case is reported, the criminal justice system will use the medical forensic report, along with collected evidence, photographs and video images, and victim/witness statements, as a basis for investigation and possible prosecution. If examiners are required to testify in court, they will use the report to recall the incident.

Separate medical documentation by examiners and other clinicians follows a standard approach of addressing acute complaints, gathering pertinent historical data, describing findings, and documenting treatment and followup care. Forensic examination records should be maintained separately from other records to avoid inadvertent disclosure of unrelated information and to preserve confidentiality. The medical record is stored at the exam site. The exam site should have clear policies about who is allowed access to these records.[157]

The medical record is not part of the evidence collection kit and it should not be submitted to the crime lab. Much of the record is not relevant to case prosecution, and releasing it infringes upon patients' privacy rights and could be used against patients. Although all or part of the medical record may be subpoenaed, if patients do not consent to its release, it is ultimately up to the court to decide whether such information is pertinent to the case and should be released.

Educate examiners on proper documentation. It is vital that the exam documentation be thorough, precise, and accurate. It is essential that examiners receive education on the importance of proper documentation and on report writing that fits their role and is unbiased.

Involved law enforcement representatives and advocates should understand the importance of examiner documentation and be able to convey that importance to patients.

Ensure the accuracy and objectivity of medical forensic reports. It is suggested that examiners within an exam site, jurisdiction, or region, devise an appropriate review process tailored to their needs. Consider having a clinical director or supervisor at the exam site systematically review documentation related to the exam. (In some jurisdictions, review of nonphysician examiner's documentation by a medical director/supervisor is required.) These reviews can serve to increase the overall effectiveness of the examiner program by ensuring that reports are filled out according to policy, assessing staff training needs,

[156] Documentation on exam findings should include patients' demeanor and statements related to the assault not already recorded on the medical forensic history. Such documentation can be admitted as evidence at trial in most States. Local prosecutors can provide more detailed information on this type of documentation.

[157] Mechanisms to restrict access to records related to the exam are particularly important in small communities where health care facility employees may be acquaintances, friends, and family members of patients or suspects.

considering adjustments needed to paperwork, troubleshooting for potential problems, and identifying trends in presenting issues of patients. All identifying patient information should be removed when a document is copied for a review. The clinical director or supervisor can also be involved in broader multidisciplinary quality assurance efforts related to the exam process.

4. The Medical Forensic History

Recommendations at a glance for health care providers to facilitate gathering information from patients:

- Examiners should coordinate with other responders, such as law enforcement representatives and advocates, to facilitate information gathering that is respectful to patients and minimizes repetition of questions.
- Advocates should be allowed to support and advocate for patients during the medical forensic history.
- Consider patients' needs prior to gathering information for the history.
- Obtain information for the medical forensic history in a private and quiet setting.
- Ask patients routine questions for the history, including date/time of the assault, pertinent medical history, recent consensual sexual activity, activities since the assault, assault-related victim history, suspect information (if known), nature of the physical assault, and description of the sexual assault.

Coordinate medical forensic history taking and investigative interviewing. Examiners typically ask patients to provide a medical forensic history after initial medical care for acute problems and before the examination and evidence collection. This history, obtained by asking patients detailed forensic and medical questions related to the assault, is intended to guide the exam, evidence collection, and crime lab analysis of findings. Law enforcement representatives also collect information from patients to help in the apprehension of suspects and in case investigation.[158] Prosecutors familiar with the legal requirements of the criminal statutes may also need certain specific information.

Gathering information from patients often takes place soon after they have experienced the assault. Not only can discussing the assault cause patients to feel re-violated, but their emotional and physical condition may make communication difficult. They may also be uncomfortable discussing personal matters with involved responders. Those seeking information about the assault should work collaboratively to create an information-gathering process that is as respectful to patients as possible and minimizes repetition of questions.[159]

Promote a streamlined, victim-centered information-gathering process. Jurisdictions employ several methods, including the following:

- Communication and coordination among responding officers, examiners, investigators, and prosecutors as they go about their separate information-gathering processes.
- Examiners, investigators, and prosecutors together ask patients basic questions. One asks questions while the others listen. They then speak to patients separately to gather remaining information required.
- The medical forensic history and investigative interviews are conducted simultaneously to the extent feasible. The SART should determine the information-gathering process, reflecting the best use of resources and needs and consent of patients. The team may agree that a particular person or agency will be the main questioner, resulting in one end document.[160]

Whatever the method selected, jurisdictions should carefully plan how they will coordinate the logistics of medical forensic history taking and investigative interviewing.

[158] The Web site of the Violence Against Women Online Resources offers several resources on law enforcement investigation of sexual assault crimes. See www.vaw.umn.edu/library/sexassault.
[159] Some repetition of questions is likely to occur during the exam process.
[160] Caution should be exercised if combining medical forensic history taking with investigative interviewing. At the time of such information gathering, patients may not want to speak with law enforcement or be ready to go into the extensive details needed for investigative purposes. Patients may withhold information from law enforcement representatives or not want to talk with them about certain issues (e.g., their menstrual cycle or types of penetration). They might feel more comfortable talking to examiners in private about these topics. There is also a concern about questioners asking questions outside of their realm of responsibility.

Advocates should be able to provide support and advocacy during the history, if desired by patients. The presence of an advocate may help patients feel more comfortable answering questions. Advocates may also assist patients in voicing their concerns about questions being asked and clarifying their needs during this time. Advocates should not answer questions asked of patients or otherwise influence their statements.

Presence of family members, friends, and other personal support persons. Prior to taking the history, patients should be informed that the presence of personal support persons (other than advocates) may influence or be perceived as influencing their statements.[161] These individuals could be subpoenaed as witnesses in their case.[162] If, after receiving this information, patients choose to have personal support persons present during the history, these individuals should be advised not to actively participate in the process. For example, they should not answer questions for patients, comment on patients' answers, interrupt patients, or make facial expressions in response to patients' answers.[163]

Consider patients' needs prior to and during information gathering. Pressing issues (e.g., for treatment of serious injuries, crisis intervention and support, and childcare during the exam process) should be addressed before commencing with information gathering. Be mindful of patients' capacity to answer questions during a lengthy information-gathering process, and take breaks as needed.

The facility should have procedures in place and examiners should be educated to accommodate patients' communication skill level and preferred mode of communicating. This is particularly important for patients with communication-related disabilities and non-English speaking patients. If interpreters are necessary, they should be present prior to questioning and there should be space for them in the exam room and rooms where information is gathered. Patients with communication disabilities may wish to use wordboards, speech synthesizers, or other assistive communication devices to help them communicate. The use of cards with pictures (e.g., of medical procedures and human anatomy) may facilitate communications with patients with some types of cognitive disabilities or limited vocabularies.[164]

It is important that examiners are aware of and responsive to verbal and nonverbal cues from patients. For example, patients may react negatively as they recall experiences during the assault or are reminded of previous violence committed upon them. (It is important to document this information.) What they may need most at this point is a break, the understanding of examiners, and opportunities to talk about what they are experiencing. Advocates can be particularly helpful to patients who are dealing with these emotions.

Use a private and quiet setting for information gathering. Ideally, there should be no interruptions and no time constraints for questioners or for use of the room where the information is being gathered. Although some facilities may lack space, an effort should be made to secure a private and quiet setting for this purpose. In many jurisdictions, history taking takes place in the exam room prior to the exam.

[161] Ideally, these individuals should not be present when giving patients this information or when patients make the decision whether they want the support person present.
[162] They should also be informed that the presence of these individuals during the medical forensic history could potentially reduce the degree of confidentiality advocates can offer patients (e.g., they may be called on to provide testimony regarding the interactions between patients and family members or friends present during this time).
[163] Requests to have family, friends, and other personal support persons present during the medical forensic history should be allowed unless it is considered potentially harmful to the exam process by the SART/involved responders. For example, in cases involving adolescents, parents or guardians should not be allowed in the exam room if they are suspected of committing the assault or of being abusive to patients.
[164] Paragraph partially drawn from N. Baladerian, *Skills for Interviewing Adult Abuse Victims Who Have Developmental Disabilities*, p. 1.

Obtain the medical forensic history. The specific questions asked of patients by examiners for the medical forensic history vary from one jurisdiction to the next, as do forms used to record the history.[165] However, the following information should be sought routinely from patients:[166]

1. Date and time of the sexual assault(s): It is essential to know the period of time that has elapsed between the assault and the collection of evidence. Evidence collection may be directed by the time interval since the assault. Interpretation of both the physical exam and evidence analysis may be influenced by the time interval between the assault and the exam.
2. Pertinent patient medical history: The interpretation of physical findings may be affected by medical data related to menstruation, recent anal-genital injuries, surgeries, or diagnostic procedures, blood-clotting history, and other pertinent medical conditions or treatment.
3. Recent consensual sexual activity: The sensitivity of DNA analysis makes it important to gather information about recent consensual intercourse, whether it was anal, vaginal, and/or oral, and whether a condom was used. A trace amount of semen or other bodily fluid may be identified that is not associated with the crime. Once identified, it may need to be associated with a consensual partner, and then used for elimination purposes to aid in interpreting evidence.[167]
4. Postassault activities of patients: The quality of evidence is affected both by actions taken by patients and the passage of time. It is critical to know what, if any, activities were performed prior to the examination (e.g., have patients urinated, defecated, wiped genitals or the body, douched, removed/inserted a tampon/sanitary pad/diaphragm, used oral rinse/gargled, washed, brushed teeth, ate or drank, smoked, used drugs, or changed clothing?).
5. Assault-related patient history: Information such as whether there was memory loss, lapse of consciousness, vomiting, nongenital injury, pain and/or bleeding, and anal-genital injury, pain, and/or bleeding can direct evidence collection and medical care. Collecting toxicology samples is recommended if there was either loss of memory or lapse of consciousness, according to jurisdictional policy.
6. Suspect information (if known): Forensic scientists seek evidence on cross-transfer of evidence among patients, suspects, and crime scenes. The gender and number of suspects may offer guidance to types and amounts of foreign materials that might be found on patients' bodies and clothing. Suspect information gathered during this history should be limited to that which will guide the exam and forensic evidence collection. Detailed questions about suspects are asked during the investigative interview.
7. Nature of the physical assault(s): Information about the physical surroundings of the assault(s) (e.g., indoors, outdoors, car, alley, room, rug, dirt, mud, or grass) and methods employed by suspects is crucial to the detection, collection, and analysis of physical evidence. Methods may include, but are not limited to, use of weapons (threatened and/or injuries inflicted), physical blows, grabbing, holding, pinching, biting, using physical restraints, strangulation, burns (thermal and/or chemical), threat(s) of harm, and involuntary ingestion of alcohol/drugs. Knowing whether suspects may have been injured during the assault may be useful when recovering evidence from patients (e.g., blood) or from suspects (e.g., bruising, fingernail marks, or bite marks).

[165] In some jurisdictions, examiners ask for investigative details during history taking. In others, examiners only ask for information related to treatment and collecting/interpreting physical and lab findings. One concern is that investigative details reported by examiners that differ from the law enforcement report may be used against patients. (Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 77.) Another concern is that asking investigative questions is outside the examiner's role.

[166] Drawn from California's *Medical Forensic Report: Adult/Adolescent Sexual Assault Examination, Less Than 72 Hours* (OCJP 923), the *Tulsa Sexual Assault Report Form*, and the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2002, pp. 40–42.

[167] Patients should be aware that there might be a need at a later time to obtain an elimination sample from consensual partners. Jurisdictions may have policies in place for seeking such samples within a certain timeframe following the exam.

8. Description of the sexual assault(s): An accurate but brief description is crucial to detecting, collecting, and analyzing physical evidence. The description should include any:[168]

    - Penetration of genitalia (e.g., vulva, hymen, and/or vagina of female patient), however slight;[169]
    - Penetration of the anal opening, however slight;
    - Oral contact with genitals (of patients by suspects or of suspects by patients);
    - Other contact with genitals (of patients by suspects or of suspects by patients);
    - Oral contact with the anus (of patients by suspects or of suspects by patients);
    - Nongenital act(s) (e.g., licking, kissing, suction injury, and biting);
    - Other act(s) including use of objects;
    - If known, whether ejaculation occurred and location(s) of ejaculation (e.g., mouth, vagina, genitals, anus/rectum, body surface, on clothing, on bedding, or other); and
    - Use of contraception or lubricants.[170]

These questions require specific and sometimes detailed answers. Some may be difficult for patients to answer. Examiners should explain that these questions are asked during every sexual assault medical forensic exam. They should also explain why each question is being asked.

[168] Specific questions asked will depend on case facts (e.g., the gender of the patient and the gender of the suspect).
[169] Questions related to whether there was penetration should include what was used for penetration (e.g., penis, finger, or other object).
[170] Certain contraceptive preparations can interfere with accurate interpretation of preliminary chemical tests frequently used in the analysis of potential seminal stains. In addition, contraceptive foams, creams, or sponges can destroy sperm. Lubricants of any kind are trace evidence and may be compared with potential sources left at the crime scene or recovered from bodies of suspects. Knowing whether or not a condom was used also may be useful in explaining the absence of semen.

5. Photography

Recommendations at a glance for health care providers and other responders to photograph evidence on patients:

- Come to consensus regarding the extent of forensic photography necessary in sexual assault cases.
- Consider who will take photographs and what equipment will be used.
- Consider patients' comfort and need for modesty and privacy.
- Explain forensic photography procedures to patients.
- Take initial and followup photographs as appropriate, according to jurisdictional policy.

Consider the extent of forensic photography necessary. Taking photographs of patients' anatomy that was involved in the assault should be routine in sexual assault cases. Such photographs can supplement the medical forensic history and physical findings.[171] As to the extent of photographs necessary, communities appear to take two different approaches. Some routinely take photographs, with patients' permission, of both detected injuries and normal (apparently uninjured) anatomy involved in the assault. These jurisdictions encourage examiners to collect and document all evidence and leave the determination about the value of the evidence to litigants.[172] Other communities limit photographs to detected injuries.

Involved prosecutors, law enforcement officials, examiners, and advocates should further discuss the extent of photography they view as critical, examine any related case law, consider their concerns on this issue and how to be sensitive to victims, and, ultimately, determine what strategy is right for their community.

Consider the photographers and equipment. Examiners or law enforcement representatives typically take these photographs, according to jurisdictional policy. In many jurisdictions, examiners are responsible for forensic photography during the exam because patients are often more comfortable and less traumatized when they take photographs. If patients have not decided to report, they may not want law enforcement involved.[173]

Photographers should be familiar with equipment operation and be educated on forensic photography in sexual assault cases. Consult with local criminal justice agencies regarding the types of equipment that should be used (e.g., prosecutors can assess which types of equipment produce results acceptable by the court). In general, any good-quality camera may be used as long as it can be focused for undistorted, closeup photographs and provides an accurate color rendition.[174] If digital photography is used, the reliability of photographic images must be considered because of technological advances in computer alteration. Also consult with local examiners, because they are often knowledgeable regarding photographic and video equipment used in these cases and their effectiveness in capturing images during the exam.

Consider patient comfort and privacy. Minimize patients' discomfort while they are being photographed and respect their need for modesty and privacy. Drape them appropriately while taking photographs.[175]

Also, consider how to best provide support to patients during this time. Patients may want an advocate and/or a personal support person to be present. Take measures to avoid allegations of impropriety when photographing patients. For instance, if for some reason a male photographer is photographing a female patient, another woman should be present at this time.

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[171] The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 56.
[172] However, photographs should not be used to interpret subtle and/or nonspecific findings (e.g., erythema or redness) that are not noted on exam documentation. Review of photographs cannot reliably diagnose injuries not seen by examiners.
[173] Avoid requiring that patients go to another site (e.g., the law enforcement agency) to have initial photographs taken.
[174] The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 56.
[175] Drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 56, and the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 113.

Explain forensic photography procedures to patients. Taking photographs of patients in the aftermath of an assault can be retraumatizing. To help reduce the chances of retraumatization, help patients understand the purpose of photography in forensic evidence collection, the extent to which photographs will be taken and procedures that will be used, potential uses of photographs during investigation and prosecution (especially anogenital images if taken), and the possible need to obtain additional photographs following the exam. (Also see *A.3. Informed Consent*.)

Take initial and followup photographs as appropriate, according to jurisdictional policy.[176] Strive to control every element in the photograph to produce a clear, powerful statement. Photographs should be taken prior to evidence collection.

Patient identification. Link patients' identity and the date to the photographs, according to jurisdictional policy.[177] For example, print the patient's name, date of exam, and the photographer's name/initials on a plain sheet of paper. Photograph this sheet at the beginning and end of the roll of film for identification. Some jurisdictions also photograph the face of patients for identification purposes. Some cameras offer the option of imprinting the date and/or time on the negative, and some have the ability to enter a case number so the face or name of a patient is not on the film.

Mechanisms should be in place (e.g., at law enforcement agencies and exam facilities) to protect patients' privacy and confidentiality related to the photographs.

Clear and accurate photographs. Use the shutter speed and lens aperture to control exposure (automated cameras and flash units can give incorrect exposures). Use adequate lighting whether the source is natural, flood, or flash. Use of flashes and lighting in the exam room can change the color of evidence; a filter may help adjust lighting so that the photograph is truer to color (noting in records any alternations to the environment to enhance photographs). Include a color bar in the photograph to ensure accurate color reproduction.

Strive for undistorted photographs with good perspective (whenever possible, use a normal focal length lens, keep the camera level, and photograph the subject at eye level). Maintain sharp focus (keep the camera steady, focus carefully, use maximum depth of field, and look at the frame of the scene).

A good-quality macros lens with a ring strobe flash offers the best quality and most flexibility for forensic photography involving sexual assault.

Scale. Use an inch scale or ruler for size reference in photographs. In addition to those photographs that identify patients and anatomical locations being photographed, take at least two photographs of each area—one with and one without scale. Taking two photographs in this manner demonstrates that the scale was not concealing anything important. Photograph evidence in place before moving it or collecting it. Do not alter or move evidence when photographing, and make every effort to minimize distraction in photographs while maintaining the focus of areas being photographed.

Orientation of shots. Take at least two shots at three orientations:

1. Take full-body images (anterior, posterior, and lateral) with the patient's face visible and clearly identifiable. Position patients approximately two feet from the corner of the room, using walls to reflect and diffuse flash illumination. When photographing the backs of patients, turn their faces toward the camera so that they can be recognized.
2. Take medium-range photographs of each separate injury, including cuts, bruises, swelling, lacerations, and abrasions. Work from one side to the other and then top to bottom, or design a workable method. Be consistent. Take "regional" shots to show injuries in the context and orientation of a body region; these photographs should include easily identifiable anatomical landmarks.
3. Take closeup images of particular injuries, using the scale. When photographing a wound, show its relationship to another part of the body. Take at least three photographs involving a wound area. Shield

[176] This section is drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient,* 1999, pp. 113–115.
[177] The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 56.

uninvolved breast or genital areas when possible; highly graphic photos may be deemed inadmissible in court and make the case less credible. All injuries should be recorded with a closeup attachment. Try to capture subtleties in texture and color. Document pattern injuries caused by an object. Do not use an external light source around an injured eye as it can cause retinal damage.

Photographing skin. Closeup photographs of hands and fingernails may show traces of blood, skin, or hair. Be sure to look for damage to nails or missing nails. Photograph marks of restraint or bondage around wrists, ankles, or neck; they may be compared later with the object in question that made the marks. Photograph transfer evidence present on the body or clothing, such as dirt, gravel, or vegetation.

Bite mark evidence. Photograph bite marks, according to jurisdictional policy.

Accountability. All photographs should be clearly labeled and the chain of custody maintained. Follow jurisdictional policy for development of film, transfer, duplication or additional prints, and storage of photographs. Do not include photographs in the evidence collection kit sent to the crime lab.

Followup photographs. Photography should be repeated as new or different evidence on patients' bodies is found following the exam (e.g., bruising may appear days later). Create procedures that examiners, law enforcement investigators, and patients follow to ensure this evidence is documented. In addition to documenting emerging or evolving injuries, followup photographs provide documentation of healing or resolving injuries and clarify findings of stable, normal variants in anatomy that could be confused with acute injuries.

6. Exam and Evidence Collection Procedures

Recommendations at a glance for health care providers to facilitate the exam and evidence collection:

- Recognize the forensic purpose of the exam to document physical findings and facilitate the collection of evidence from patients.
- Strive to collect as much evidence from patients as possible, guided by the scope of informed consent, the medical forensic history, examination findings, and evidence collection kit instructions.
- Be aware of evidence that may be pertinent to the issue of whether the patient consented to the sexual contact with the suspect.
- Understand how biological evidence is tested.
- Prevent exposure to infectious materials and contamination of evidence.
- Understand the implications of the presence or absence of seminal evidence.
- Modify the exam and evidence collection to address the specific needs and concerns of patients.
- Explain exam and evidence collection procedures to patients.
- Conduct the general physical and anogenital exam and document findings on body diagram forms.
- Collect evidence to submit to the crime lab for analysis, according to jurisdictional policy.
- Collect blood and/or urine for toxicology screening if applicable.
- Keep medical specimens separate from forensic specimens collected during the exam.

Recognize the forensic purpose of the exam. During the exam, examiners methodically document physical findings and facilitate the collection of evidence from patients' bodies and clothing. The findings in the exam and collected evidence often provide information to help reconstruct the details about the events in question in an objective and scientific manner.[178] Of course, health care needs and concerns of patients may be presented in the course of the exam that should be addressed prior to discharge. However, patients must understand that the exam does not provide routine medical care. For example, a pap smear will not be done during the female pelvic exam.[179] (This chapter focuses on forensic components of the exam. Other chapters in the protocol discuss more fully medical and other related needs and concerns of patients.)

Collect as much evidence from patients as possible, guided by the scope of informed consent, the medical forensic history, exam findings, and instructions in the evidence collection kit. Evidence collected during the exam mainly includes biological and trace evidence. To reconstruct the events in question, evidence collected is used in two potential ways in sexual assault cases:

- Transfer or associative evidence can provide information about contact between patients and suspects, patients and crime scenes, and suspects and crime scenes. The type of evidence recovered and its location can provide details about the nature of the contact.
- Identification evidence can give scientific data about the source of a specific piece of evidence.

Be aware of evidence that may be pertinent to the issue of whether the patient consented to the sexual contact with the suspect. In the majority of sexual assaults, patients know the suspects. For example, according to the National Crime Victimization Survey, in 2002, 66.1 percent of rapes/sexual assaults involved offenders who were nonstrangers.[180] Most nonstranger suspects and many stranger suspects (if confronted by the criminal justice system) will claim that the patient consented to the sexual contact.[181] Consent claims typically stem from a lack of evidence and documentation concerning force and

[178] Note that while exam findings and evidence collected from patients are important in reconstructing the events in question, during a criminal investigation, law enforcement officials look for additional evidence that will create a more complete picture of the event.
[179] Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 63.
[180] U.S. Department of Justice, Bureau of Justice Statistics, *Criminal Victimization in the United States—Statistical Tables*, http://www.ojp.usdoj.gov/bjs/abstract/cvusst.htm.
[181] J. Archambault and D.K. Faugno, Overcoming a Consent Defense to Sexual Assault, *Journal of Emergency Nursing,* 27:204–208, April 2001.

coercion. Thus, evidence and documentation of physical findings related to whether force or coercion was used against patients (e.g., findings that reveal injuries, drugs taken involuntarily, or signs of a struggle) are important in these types of cases. However, the absence of physical trauma does not mean that coercion/force was not used or prove that patients consented to sexual contact.[182] Also, some physical findings that suggest force are not necessarily indicative of a sexual assault. It is important to remember that if an investigation takes place, law enforcement officials will look for additional crime scene evidence that may help to overcome a claim of consent.

Understand how biological evidence is tested.[183] Semen, blood, vaginal secretions, saliva, vaginal epithelial cells, and other biological evidence may be identified and genetically typed by a crime lab. The information derived from the analysis can often help determine whether sexual contact occurred, provide information regarding the circumstances of the incident, and be compared to reference samples collected from patients and suspects. A primary method used by crime labs for testing biological evidence is DNA (deoxyribonucleic acid) analysis.[184] The most common form of DNA analysis used in crime labs for identification is called polymerase chain reaction (PCR). PCR allows the analysis of evidence samples of limited quality and quantity by making millions of copies of very small amounts of DNA. Using an advanced form of PCR testing called "short tandem repeats" (STR), the laboratory is able to generate a DNA profile, which can be compared to DNA from a suspect or a crime scene.[185]

Distinguish patients' DNA from suspects' DNA. Blood, buccal (inner cheek) swabbings, or saliva should be collected from patients for DNA analysis to distinguish their DNA from that of suspects.[186] (Procedures for collecting these samples are provided later in this chapter.) If the case is reported, patients' biological samples and DNA profiles should be used only for investigation of the sexual assault, and their DNA profiles should not be inputted into CODIS.[187] Neither biological samples nor DNA profiles should be provided to law enforcement or prosecution for another case in which patients may be suspects, inadvertently given to health insurance carriers, or used for research purposes without patients' consent.[188] Criminal justice agency policies should be in place and followed for the secure storage of biological samples and appropriate disposal of these samples and DNA profiles.

Reduce exposure to infectious materials and risk of contamination of evidence. Examiners should take precautions during the exam to prevent exposure (to both patients and health care staff) to bloodborne pathogens and other potentially infectious materials. For example, it is important to follow facility policies on washing hands, handling contaminated needles and other contaminated sharps, wearing protective equipment, and minimizing splashing, spraying, and spattering of these materials. (For more information on this topic, see *B.1. Sexual Assault Forensic Examiners*.)

With the ever-increasing sensitivity of DNA analysis, there is a greater chance that accidental contamination can be detected. Forensic evidence, which is usually small in volume, can be contaminated and diluted by foreign DNA. Every precaution should be taken by all first responders to reduce outside contamination and dilution of evidence. For example, examiners should wear nonlubricated gloves[189] and change them

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[182] L. Ledray, *SANE Development and Operation Guide*, 1998, p. 68.

[183] Section drawn from *Understanding DNA Evidence: A Guide for Victim Service Providers* by the National Commission on the Future of DNA Evidence*;* the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2002, pp. 31–32; and the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 40.

[184] DNA determines each person's individual characteristics. An individual's DNA is unique except in identical twins. DNA in the cell nucleus is genetic material inherited from biological parents. (Drawn from Arkansas' *Sexual Assault: A Hospital/Community Protocol for Forensic and Medical Examination,* 2001.)

[185] There is a concern that if DNA evidence is found, prosecutors may not utilize other evidence, especially when labs have limited resources. But because persons known to victims commit the vast majority of sexual assaults, DNA findings must be used in conjunction with other forensic evidence recovered, particularly when issues of consent arise. Law enforcement investigators and prosecutors should receive training on maximizing the use of all forensic evidence collected.

[186] L. Ledray, *SANE Development and Operation Guide*, 1998, p. 65.

[187] In the fall of 2003, legislation was introduced to implement the President's DNA Initiative provisions that would bar the inclusion of elimination samples in CODIS. These samples include those obtained from sexual assault victims, as well as individuals with whom they had recent consensual sex prior to the exam.

[188] An exception is that a forensic lab may input frequency information related to the DNA profiles in its statistical database. Victims' identity remains anonymous.

[189] Drawn from Connecticut's Video Training Program, Part 1, *The Examination: Sexual Assault Evidence Collection*, 1998.

throughout the exam/evidence collection whenever cross-contamination could occur.[190] Examiners and other responders should seek guidance from their crime labs on procedures to follow to prevent contamination.

Understand the importance of semen evidence.[191] The relevance of semen evidence in cases involving male suspects covers the spectrum, depending upon case facts. Semen is composed of cellular and liquid components known as spermatozoa (sperm) and seminal fluid. Semen evidence can be useful because it is positive identification that ejaculation occurred,[192] and it can be used to positively identify suspects. However, it is critical to note that failure to recover semen is not an indication that a sexual assault did not occur. There are a number of reasons why semen might not be recovered in these cases: Assailants may have used condoms, ejaculated somewhere other than in an orifice or on patients' clothes or bodies, or not ejaculated at all. Semen may have been depleted by frequent ejaculation prior to the sample in question.[193] Chronic alcohol or drug abuse, chemotherapy, cancer, infection (e.g., mumps or tuberculosis), or congenital abnormalities also may suppress semen production. Other factors may contribute to the absence of detectable amounts of semen evidence. For example, significant time delays between the assault and collection of evidence may cause loss of semen evidence, semen may be washed away prior to the exam or improperly collected, and an object other than a penis may have been used for penetration.

Modify the exam and evidence collection to address patients' needs and concerns. (For information on this topic, see *A.2. Victim-Centered Care*. Accommodating mobility impairments is discussed in footnotes for this chapter. For details on accommodating communication skills and modalities and responding to verbal and nonverbal cues, see *C.4. The Medical Forensic History*.) In addition, examiners should be aware that patients' beliefs might affect whether and how certain evidence is collected. For example, patients from certain cultures or religious backgrounds may view hair as sacred and decline collection of hair evidence.

Explain exam and evidence collection procedures to patients. Whatever the methods used for seeking informed consent from patients for the exam and evidence collection, the full nature of procedures and options should be explained. Examiners may provide some basic information prior to starting the exam and additional information as the exam proceeds. For example, if the colposcope is used, examiners can explain to patients, at some point prior to its use, what the colposcope is, how it will be used, for what purpose, and how long the procedure will take. Encourage patients to ask questions and to inform examiners if they need a break or do not want a particular part of the exam or evidence collection done. (For more information on obtaining informed consent of patients, see *A.3. Informed Consent*.)

Conduct the exam.[194] In addition to instructions included in the evidence collection kit, the exam should be guided by the scope of informed consent and the medical forensic history.

In the course of the exam, examiners may question patients about trauma related to the assault. These questions should be specific enough to yield clinically relevant information. For example, simply asking if patients are injured or hurt anywhere is not focused enough—they may not know where they are injured until examined and/or asked questions such as if they hurt in specific body locations.

General physical examination. Obtain patients' vital signs, note the date and time of the exam, physical appearance, general demeanor, behavior, and orientation, and condition of clothing on arrival. Record all physical findings (which include observable or palpable tissue injuries; physiologic changes; and foreign materials such as grass, sand, stains, dried or moist secretions, or positive fluorescence) on body diagram forms. Use an alternate light source to assist in identifying findings.[195] Be observant for redness, abrasions,

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[190] Follow crime lab policy on whether to include used gloves in the evidence kit.

[191] Drawn from the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2002, pp. 31–32, and New Hampshire's *Sexual Assault: A Hospital Protocol for Forensic and Medical Examination*, 1998, pp. 26–27.

[192] In the absence of sperm, certain seminal fluid components may be used to identify semen.

[193] If assailants who had a vasectomy ejaculated, their seminal fluid would not contain sperm.

[194] This section on performing the exam is primarily drawn from the American College of Emergency Physicians' (ACEP) *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, pp. 103–107. Much of the ACEP exam procedures were based on the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*.

[195] Use an alternate light source in a darkened room to examine patients' entire bodies. Take care to protect their eyes when using ultraviolet light. Specifically examine the head, face, hair, lips, perioral region, and nares; chest and breasts; external genitalia, perineal area, inner thighs, and pubic hair; buttocks, skin, and anal folds; and any other area indicated by the medical forensic history. Dried semen stains have a characteristic shiny appearance and tend to flake off the skin. Semen may exhibit an off-white fluorescence under ultraviolet light. Fluorescent areas may appear as smears, streaks, or splash marks. Moist or freshly dried semen may not fluoresce.

bruises, swelling, lacerations, fractures, bites, burns, and other forms of physical trauma. Note areas of tenderness and induration. On dark-skinned individuals, it may be difficult to identify these areas and they may need to be sought out specifically.

Anogenital examination.[196] During the female genital exam,[197] examine the external genitalia and perineal area for injury, foreign materials, and other findings in the following areas: abdomen, thighs, perineum, labia majora, labia minora, clitorial hood and surrounding area, perurethral tissue/urethral meatus, hymen,[198] fossa navicularis, and posterior fourchette. The use of a colposcope during the external genital exam enhances viewing microscopic trauma and may provide photographic documentation.[199]

Then examine the vagina and cervix for injury, foreign materials, and foreign bodies. Use a colposcope or other magnifying device if available. In some jurisdictions, toluidine blue dye may be used to detect trauma, either with or without the use of a colposcope.[200] Examine the buttocks, perianal skin, and anal folds for injury, foreign materials, and other findings. If rectal injury is suspected, an anoscope can be used as a tool to identify and evaluate trauma (it may also be used to help obtain anal swabs and trace evidence).

For male patients, examine the external and perineal area for injury, foreign materials, and other findings, including from the abdomen, buttocks, thighs, foreskin, urethral meatus, shaft, scrotum, perineum, glans, and testes. Document whether patients are circumcised.

Documentation of findings. Record findings from the general physical and anogenital exam on appropriate body diagram forms. Detailed descriptions of findings should be provided as required. During the exam, collect evidence as specified in the evidence collection kit and photograph anatomy involved in the assault according to jurisdictional policy. Follow jurisdictional policy regarding documentation, photography, and collection of bite mark evidence.[201]

Collect swabs from suspicious areas. Note that the appearance of fluorescent areas does not confirm the presence of semen, as other substances such as urine or body lotions may also fluoresce and semen may not always fluoresce. Independent confirmation of findings by the crime lab is necessary. In addition, rope marks, bite marks, recent contusions, and other subtle injuries may be more visible with the aid of an alternate light source. (Drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims,* 2001, pp. 37–38.)

[196] If patients are mobility impaired, review their history at this stage. In patients with spinal cord injury (SCI), the level of injury and any history of autonomic dysreflexia will have to be noted and given special attention. Other considerations in these patients are histories of muscle spasm and triggers for both muscle spasm and autonomic dysreflexia. Examiners should be sure to ask about things such as whether these patients have ever had a speculum exam, what this experience was like, what the most comfortable position would be for the anogenital exam, and any history of autonomic dysreflexia with a speculum exam. (Commonwealth of Massachusetts's *SANE Protocol*, 2002, p. 36.)

[197] Some patients may not have previously had a gynecological exam and need a detailed explanation and support during this part of the exam. (Drawn from L. Zarate, 2003, Suggestions for Upgrading the Cultural Competency Skills of SARTs, Arte Sana Web site, 2003.)

[198] The Tanner Scale of Secondary Sexual Development is a sexual maturity rating scale that defines a child's stage of puberty. (American Professional Society on the Abuse of Children, *Glossary of Terms and the Interpretation of Findings for Child Sexual Abuse Evidentiary Examinations*, p. 7.) These developmental stages are relevant to the interpretation of physical findings in child and adolescent cases. There is a relationship between Tanner Stages and hymenal development. Physical findings must be evaluated in the context of hymenal development for the interpretation of findings. (The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 61.)

[199] Colposcopes have magnifying lenses ranging from 4x to 30x power and can have 35-mm camera or video camera attachments. Colposcopes have a green filter that enhances the visualization of scars, unusual vascular patterns, and genital warts. Examiners can use the colposcope to obtain magnified images of the oral pharynx, genital, and rectal areas. Minor skin and/or mucosal trauma such as abrasions, lacerations, petechiae, focal edema, hymenal tears, and anal fissures are more easily seen with magnification, and photographs can be taken for documentation. Attached video cameras can also record images. (Drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims,* 2001, p. 58).

[200] The use of toluidine blue dye is controversial in some jurisdictions (e.g., it may be perceived by the court as changing the appearance of the tissue) and not universally used. When employed, toluidine blue dye (1-percent aqueous solution) should be applied by cotton swab before any internal or digital speculum examination (including the colposcopic exam). Although DNA evidence will be preserved, care should be taken to avoid letting dye enter the vaginal vault. Vaginal application should occur after the anal application is completed (if indicated) to avoid any cross-contamination. Excess dye may be blotted away with 1-percent acetic acid solution or lubricating jelly. Toluidine blue dye cannot separate consensual from nonconsensual lesions. Patients should be advised that small traces of the dye might shed in their clothing over the 2 days following the exam. (Information on use of this dye is drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Abused Patient*, 1999, p. 117.)

[201] In addition to documenting, swabbing, and photographing bite marks, an odontologist may need to make casts. Without a cast, teeth cannot be matched to suspects. The American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Abused Patient,* 1999, pp. 111–112, offers guidelines for bite mark documentation.

Collect evidence to submit to the crime lab for analysis, according to jurisdictional policy.[202] The following evidence from patients, along with completed documentation forms, typically is submitted to the crime lab designated by the jurisdiction.[203] Jurisdictions may require collection of additional or different specimens. Instructions on evidence collection are usually contained in the evidence collection kit. If any requested evidence is not collected, examiners should note reasons on documentation forms.

Collect clothing evidence. Clothing frequently contains important evidence in sexual assault cases. It provides a surface upon which traces of foreign materials, such as semen, saliva, blood, hairs, fibers, and debris from the crime scene, may be found. While foreign matter can be washed off or worn off the body, the same substances often can be found intact on clothing for a considerable length of time following an assault. Damaged or torn clothing may be significant, as damage may be evidence of force (do not cut through any existing holes, rips, or stains on clothing). Evidence on patients' clothing can be compared with evidence collected from suspects and crime scenes. Common items collected from patients include underwear, hosiery, blouses, shirts, and pants. Coats and shoes are collected less frequently.[204]

Procedures for collecting clothing, underwear, and foreign material dislodged while undressing:

- Place a clean hospital sheet on the floor as a barrier. Then place the collection paper on the barrier sheet. Be careful to prevent evidence transfer. Document all findings. Ask patients to disrobe (assisting them as requested and then draping them appropriately).[205] When disrobing, have patients remove shoes and then undress over the collection paper to catch any foreign material that is dislodged.[206] If someone assists, she/he should wear gloves.
- Collect clothing pertinent to the assault. First determine if patients are wearing the same clothes worn during or immediately following the assault. If so, the clothing should be examined for any apparent foreign material, stains, or damage. When the determination has been made that items may contain possible evidence, those items should be collected. If it is determined that patients are not wearing the same clothing, examiners should inquire as to the location of the original clothing. If original clothing has not been brought to the exam site, information on clothing location should be provided to law enforcement (if involved) so that clothing can be retrieved before any potential evidence is destroyed.[207] In addition to collecting underwear worn at the time of or immediately after the assault, collect underwear patients are wearing at the time of the exam (if relevant to the case).
- Be sensitive about how much clothing to take as evidence. For example, take patients' coats or shoes only if it is determined that there may be evidence on them. The exam site can coordinate with advocacy programs to ensure that replacement clothing is available for patients in a range of sizes. This clothing is critical in some instances (e.g., a patient may own only the clothing that is being collected).
- If female patients are menstruating, collect tampons and sanitary napkins. Air-dry them as much as possible and then place them in a separate paper collection bag.
- Follow jurisdictional policy for handling and transporting wet evidence that cannot be dried thoroughly at the exam site (e.g., wet clothing, tampons, and sanitary napkins). Ensure that it is packaged in leak-

[202] Much of this section was drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Abused Patient*, 1999, pp. 103–107.

[203] In some cases, it may be appropriate to submit evidence to the FBI Laboratory. It accepts cases from any duly authorized law enforcement agency. However, if the case is not a FBI case and the jurisdiction has capability to analyze DNA, then the DNA Unit of the FBI Lab will generally not accept the case. Cases that occur on Indian reservations may be submitted directly to the FBI Lab from local or tribal law enforcement agencies, the BIA, or the FBI and will be worked on by the Indian County Evidence Task Force. Should a jurisdictional lab not have a hair examiner but have the capability to analyze DNA, items requiring only DNA analysis should not be submitted. Items such as clothing that will be examined for both DNA and trace evidence should be submitted to the FBI Lab first. These items will be returned after processing for trace evidence and can then be sent along with DNA-only evidence to the jurisdictional lab. Do not submit items to the FBI Lab for trace evidence analysis after they have been previously examined by another lab. For more information or help submitting a case to the FBI Lab, contact your local FBI office or see the *Handbook of Forensic Services* at www.fbi.gov/programs/lab/handbook/intro.htm.

[204] Paragraph drawn from the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2002, p. 32.

[205] If patients are concerned about disrobing in front of advocates and/or personal support persons, they can turn around, hold up a sheet to shield patients, or leave the room while patients disrobe.

[206] For patients with mobility impairments, put the foreign material collection sheet on the exam table and leave in place until the exam is completed. If patients prefer to disrobe in their wheelchairs, sheets can be tucked in around the wheelchair to catch debris. Avoid putting chairs on paper, as debris from wheels may contaminate evidence. (Commonwealth of Massachusetts *SANE Protocol*, 2002, p. 33.)

[207] Paragraph drawn from the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2002, p. 33. In the course of the exam process, additional crime scene items that could be potential evidence may be identified and should be collected and preserved.

proof containers and separated from other evidence when being transported. It is critical to alert involved law enforcement representatives and crime lab personnel about the presence of wet evidence and the need for its immediate analysis or further drying.[208]

- After drying items according to jurisdictional policy, place each piece of clothing and collection paper in a separate paper bag, label, seal, and initial seal. If additional bags are needed, use new grocery-style paper bags only. The barrier sheet is not submitted as evidence.
- Tape/seal bags closed; label, seal,[209] and initial the seal.

Collect debris.[210]

- Collect obvious debris on patients' bodies (e.g., dirt, leaves, fibers, and hair) on a collection sheet—package, label, seal, and initial seal.
- Fingernail evidence: ask patients whether or not they scratched the suspects' face, body, or clothing. If so, or if fibers of other materials are observed under patients' fingernails, collect fingernail clippings, scrapings, and/or swabbings, according to jurisdictional policy.[211] If fingernail scrapings are collected, package fingernail scrapings and tools used to obtain the sample, label, seal, and initial seal. Cut broken fingernails at the remaining jagged edge for later comparison. Collect a fake nail as a known sample if one is missing. Package, label, seal, and initial the seals.
- If requested, assist patients in putting on exam gowns after clothing and debris are collected.

Collect foreign materials and swabs from the surface of the body. Carefully inspect the body, including head, hair, and scalp, for dried or moist secretions and stains (e.g., blood, seminal fluid, sweat, and saliva) and other foreign material. Use an alternate light source to assist in identifying evidence. Obtain swabs from any suspicious area that may be a dry secretion or stain, any moist secretion, any area that fluoresces with longwave ultraviolet light, and any area for which patients relate a history or suspicion of bodily fluid transfer (e.g., licking, kissing, biting, splashed semen, or suction injury). Also collect swabs from potentially high-yield areas (e.g., neck, breasts, or external genitalia) if the history is absent or incomplete.

- Flake off dried secretions and/or swab dried secretions with a swab moistened with one drop of water. Swab moist secretions with a dry swab. Separate swabs should be used for every sample area collected. Follow jurisdictional policies regarding the number of swabs required to collect each specimen.
- Swab bite marks.
- Optional—smear swabs onto microscope slides, according to jurisdictional policy.
- Cut matted head, facial, or pubic hairs bearing crusted material (or flake off material if possible) and place in an envelope.
- According to jurisdictional policy, air-dry all specimens, package swabs and slides separately, label, seal, and initial seals. Note that coding of evidence must allow the crime lab to know which swab was used to prepare which slide.
- If teeth are flossed prior to oral swab collection, package used floss, label, seal, and initial the seal.

Collect hair combings. Follow jurisdictional policy for collecting hair combings. The purpose of this procedure is to collect hair shed by suspects that may have been transferred to patients' hair. Hair combings may also reveal other foreign materials. Some jurisdictions collect head hair combings only if indicated. Whether or not head combings are collected, it is important to examine head, facial, and pubic hair for secretions, foreign materials, and/or debris and collect as appropriate (see above for collection of debris and foreign materials). Pubic hair combings are typically collected if the assault involved the genital area of patients.

[208] Drawn from Connecticut's Video Training Program, Part 1*, The Examination: Sexual Assault Evidence Collection*, 1998.
[209] Do not use saliva to seal envelopes; rather, try using moistened gauze pads or paper towels. (Drawn from Connecticut's Video Training Program, Part 1, *The Examination: Sexual Assault Evidence Collection*, 1998.)
[210] Debris-containing evidence may be found on equipment, such as wheelchairs, scooters, canes, wheelchair pads, assistive communication devices, catheters, and service animals, used by some patients with physical impairments. Swab equipment and/or animals for evidence, if appropriate, according to jurisdictional policy. Always ask patients for permission to do so.
[211] Some jurisdictions routinely collect fingernail samples and photograph fingernail damage that may have been related to the assault.

Head hair combings[212]

- Use the comb and collection paper provided for this procedure.
- Place the unfolded paper under patients' heads. Comb head hair towards paper (patients may comb).
- Fold comb with debris/hair into paper. Package paper, label, seal, and initial the seal.

Pubic hair combings

- Use the comb and collection paper provided for this procedure.
- Place the unfolded paper under patients' buttocks and comb hair toward paper (patients may comb).
- Fold comb with debris/hair into paper. Package paper, label, seal, and initial the seal.

Collect hair reference samples as needed.[213] Follow jurisdictional policy for collection of hair reference samples.[214] Many jurisdictions do not collect pubic hair reference samples routinely and some do not collect head hair reference samples routinely during the exam. In other jurisdictions, both samples are collected routinely unless otherwise indicated or declined by patients.[215] Whatever the jurisdictional policy, patients should always be informed about the purpose of collection, procedures used to collect samples, discomfort that may be involved, and how these samples may be used during the investigation and prosecution. If hair reference samples are not collected at the initial exam, it is important to inform patients that there might be a need to collect these samples for crime lab analysis at a later date. They should be aware that hair evidence collected at a later date may not be as conclusive as if it is collected at the time of the initial exam (e.g., due to the fact that hair characteristics can change over time).

When these samples are collected, the indications, timing, and techniques vary. Jurisdictional policies should be in place and followed. Give patients the option of collecting samples themselves.

Collect oral and anogenital swabs and smears. Patients' consent, the medical forensic history, and exam findings should guide collection of oral and anogenital specimens. In general, specimens should be collected only from orifices and areas surrounding the orifices that patients report to be involved in the assault.[216] Keep in mind that some patients may be vague about the type(s) of sexual contact that occurred. Examiners can help clarify which orifices were involved by asking appropriate questions. If there is uncertainty about involved orifices (e.g., because patients have little memory of the assault, were unconscious or incoherent, or do not understand what occurred), collection from oral, vaginal, and anal orifices (with patients' permission) may be appropriate. In some jurisdictions, policy calls for collection from all three orifices. Again, patients' consent is needed to collect these samples. Things to note when collecting these swabs and smears:

- Caution patients who use a bathroom prior to the exam that evidence may be present in pubic, genital, and anal areas and urge them not to wash or wipe away secretions until after evidence collection.
- When taking a swab, examiners should take care not to contaminate the collection with secretions or materials from other areas, such as vaginal to rectal or penile to rectal.
- Follow jurisdictional policy for collecting swabs (and the number of swabs used to collect a sample), smearing swabs on slides, and drying and packaging swabs and slides. Also, follow jurisdictional policy

[212] For patients whose mobility is limited, examiners may have to hold the paper or have an assistant hold patients' heads over the paper during combing. Check with patients to find out what is acceptable. (Commonwealth of Massachusetts *SANE Protocol*, 2002, p. 34.)
[213] See footnote under hair combing regarding patients with limited mobility.
[214] Crime labs use reference samples to determine whether or not evidence specimens collected are foreign to patients. There is a lack of consensus across jurisdictions about whether to collect these samples routinely during the initial exam. Head and pubic hair reference samples from patients can provide a source of comparative information for forensic scientists, but these samples are not needed in many cases and can be retrieved from patients at a later date if necessary. If the samples are not taken at the time of the exam, however, patients may be reluctant to return later for collection. Also, hair characteristics may change over time. For patients, gathering these samples can be a painful and embarrassing procedure that follows the trauma of the assault. But, given the choice of having samples taken at the initial exam or at a later date, many opt to get it over with during the exam. From a prosecutorial perspective, hair pulled or cut from patients is rarely used to prosecute a case. With the advent of DNA technology, the court's use of these reference samples declined. Yet, particularly in cases where DNA evidence is not available, hair reference samples could be useful evidence. SARTs (or involved responders) should ensure that their decisions about collecting hair reference samples reflect current best forensic practices, advances in technology, and the need for sensitivity to patients.
[215] Note that a patient may believe hair is sacred and thus may be reluctant or decline to have hair evidence collected.
[216] It is important to note, however, that there is a lack of consistency across jurisdictions as to whether specimen collection from all orifices is routine or conducted on a case-by-case basis, based on the assault history and exam findings.

for timeframes in which samples should be collected (e.g., oral and penile samples are only collected within 24 hours of the assault in one jurisdiction) unless otherwise indicated.

- Do not stain or chemically fix swabs or smears.
- When preparing slides, note that coding of evidence material must allow the crime lab to know which swab was used to prepare which slide.
- Document any foreign substance or material introduced by health care providers (e.g., lubricating jelly on a speculum or betadine prior to introduction of a catheter).

Oral sample[217]

- Place swabs together to collect specimen from oral cavity between gums and cheeks and under tongue. Remove dentures and swab with same swabs.
- Optional—smear swabs onto two microscopic slides.
- Air-dry swabs and slides.
- Package slides and swabs, place in envelope, label, seal, and initial the seal.

External genital sample[218]

- Swab external genital dry-skin areas with swabs (blind swabbing by protocol or history), at least one dry and one moistened with a drop of sterile, distilled, or deionized water, according to jurisdictional policy.
- Optional—smear swabs on two microscope slides.
- Air-dry swabs and slides.
- Package slides and swabs, place in envelope, label, seal, and initial the seal.

Vaginal/cervical sample

- Use swabs together to collect a sample from vaginal pool. It is prudent to collect swabs from both the vagina and cervix, regardless of time between assault and exam.
- Optional—smear swabs onto microscope slides.
- Air dry swabs and slides.
- Package slides and swabs, place in envelope, label (specifically indicating sampling site), seal, and initial the seal.

Wet-mount evaluation.[219] Some jurisdictions require examiners to conduct wet-mount examinations of vaginal/cervical secretions for motile and nonmotile sperm in cases in which a male suspect may have ejaculated in a patient's vagina.[220] Because sperm motility decreases quickly with time and removal from the vagina/cervix,[221] wet-mount evaluation during the exam can provide the only opportunity to see sperm motility.[222] The presence of motile sperm may help narrow the timeframe that the crime could have occurred. In other jurisdictions, however, the crime lab is responsible for all analysis of evidence[223] and examiners do

[217] One jurisdiction also collects a lip/lip area swab and smear and an oral rinse if there was oral contact.

[218] Note that cleansing the area for catheterization and/or applying Lidocaine may dilute or contaminate the evidence. Therefore, when Lidocaine is applied to the perineal and anal areas to minimize the risk of autonomic dysreflexia, it should be done only after swabbing the external genitalia for evidence. If catheterization is required either for evidence collection or to empty the bladder for speculum examination, it should be done only after swabbing the external genitalia. (Commonwealth of Massachusetts *SANE Protocol*, 2002, p. 38.)

[219] Note for clarity that this and the next paragraph discuss wet-mount evaluation for sperm. However, wet-mount evaluation of vaginal secretions for infection (e.g., yeast infection and STIs) may also be done during the exam if medically or forensically indicated. Hospital lab personnel usually analyze these samples.

[220] If and when wet-mount evaluation for sperm is done, examiners should exercise discretion conducting this procedure in the presence of patients and be sensitive in explaining the implications of positive and negative wet mounts to patients (if they want to know). Examiners should remind law enforcement investigators that a lack of sperm does not mean an assault did not occur and that the crime lab will later examine prepared slides using stains and other techniques not available to examiners. Thus, if sperm is present, the lab's rate of identification will probably be higher than it was for examiners. Providing this information might help deter misinterpretation of results.

[221] In most cases, sperm becomes nonmotile in the vagina within 10 to 12 hours after ejaculation. (Drawn from W. Green, M. Kaufhold, and E. Schulman, *Sexual Assault Evidentiary Exam Training for Health Care Providers*, Participant Manual, 2001, p. 39 of Module 7.) Both motile and nonmotile sperm may be found in the cervix for longer periods of time after the assault than in the vagina. Sperm may not be found after an assault for many reasons (see section in this chapter on the importance of semen evidence).

[222] Drawn from W. Green, M. Kaufhold, and E. Schulman, *Sexual Assault Evidentiary Exam Training for Health Care Providers*, Participant Manual, 2001, p. 39 of Module 7.

[223] A possible exception may be toxicology analysis.

not do the wet-mount evaluation for sperm.[224] Follow jurisdictional policy on whether wet-mount evaluation for sperm is needed and methods of evaluation. If it is required, examiners should be educated on use of the microscope, identification of sperm, and reporting their findings.

- Prepare a wet-mount slide according to jurisdictional policy. Smear one swab collected from the vaginal pool on a slide.[225] Typically, the slide is prepared by placing one drop of normal saline onto the slide. Roll the swab into the drop and place a cover slip on the slide.
- View for presence of sperm under a microscope at 400x or by using a phase contrast or other optically staining microscope (within 10 minutes of preparing slide).[226]
- Air-dry this swab and slide (not removing the cover slip).
- Package swab and slide, place in envelope, label as "wet mount" (specifically indicating sampling site), seal, and initial the seal.

Immediately following collection of vaginal/cervical samples and any necessary wet-mount evaluation, the pelvic examination should be performed and any necessary medical cultures taken.

Penile sample

- Slightly moisten swabs with distilled water and thoroughly swab the external surface of the penile shaft and glans. Swab all outer areas of the penis and scrotum where contact is suspected.
- Gently roll the swabs over one of the microscope slides, according to jurisdictional policy.
- Air-dry swabs and slides.
- Package slides and swabs, place in envelope, label, seal, and initial the seals.

Immediately following this procedure, any necessary medical cultures should be taken.

Perineal area sample[227]

- If there was vaginal/anal contact, there may be leakage of semen in the perineal area. Use an alternate light source on the anal area and flake off or swab areas of dried secretions.
- Optional—smear swabs on microscopic slides, according to jurisdictional policy.
- Flaked dried secretions should be placed into the provided container. Air-dry swabs and slides and package them separately. Place in envelope, label, seal, and initial the seal.
- Avoid contaminating anal/rectal samples by cleansing the perianal area after external secretions and foreign materials have been collected.

Anal/rectal sample[228]

- Collect swabs from the anal cavity.[229] Avoid contact with external skin surfaces.

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[224] While crime labs can reliably identify the presence of sperm on permanent stained slides, they cannot identify motile sperm due to time delays. Information about the presence or absence of sperm and motile sperm obtained at the time of the exam can impact the investigation and patients' decisionmaking. One concern related to examiners doing wet-mount evaluations for sperm is that their findings may be different than those of crime labs (e.g., the examiner may not detect sperm, while the crime lab does).

[225] Alternate methods for obtaining materials for wet mounts: a sample may be collected from a vaginal aspirate or fluid from the lower bill of speculum after withdrawing it from vagina, or sperm are occasionally found on microscopic urinalysis. (W. Green, M. Kaufhold, and E. Schulman, *Sexual Assault Evidentiary Exam Training for Health Care Providers*, Participant Manual, 2001, p. 38 of Module 7.)

[226] Examiners rather than hospital lab personnel should view these slides. Otherwise, delays between preparation of slides in the exam room and analysis in the hospital lab could cause a negative result (e.g., sperm present, but not motile). Also, those involved in the chain of custody of this evidence should be kept to a minimum.

[227] See the next footnote for patients with spinal cord injury and/or history of autonomic dysreflexia.

[228] Note that for patients with spinal cord injury and/or history of autonomic dysreflexia, collection of anal/rectal samples is performed only with the highest level of awareness of risks and with observance of precautionary steps. Possible triggers for autonomic dysreflexia are anxiety, pelvic exam (a cold speculum or the pressure of manipulating a speculum or manipulation of the cervix and pressure on the uterus), rectal exam or swabbing, impacted bowel, urinary retention, a kinked catheter, a bladder infection, and deep skin lesion. Some symptoms are highly elevated blood pressure, nasal congestion, sudden onset of headache, flushing, sweating, shortness of breath, and muscle spasm. Precautions against a possible attack requires an empty bladder or leg bag for the exam; application of lidocaine gel to perineum and/or anal area before exam; examination performed in a semi-supine position; slow insertion and minimal manipulation of a warm speculum; constant monitoring of blood pressure and "checking in" with patients; having rapid acting anti-hypertensive medication on hand; and making health care staff aware of risks and on alert. Treatment for autonomic dysreflexia includes stopping the exam, bringing patients to sitting or semi-supine position, and involving emergency medical staff immediately who can administer a fast-acting anti-hypertensive medication. (Commonwealth of Massachusetts *SANE Protocol*, 2002, p. 40.)

[229] If needed, an anoscope can be used to identify anal injuries and obtain anal swabs after perianal cleansing. These swabs should be obtained by direct visualization from the rectal mucosa visible above the tip of the anoscope. If patients are unable to tolerate a water-

- Optional—smear swabs on microscopic slides, according to jurisdictional policy.
- Air-dry swabs and slides.
- Package swabs and slides, place in envelope, label, seal, and initial the seal.

At this time, any additional examinations or tests involving the anus should be conducted.

Known blood or saliva sample or buccal swab for DNA analysis and comparison. Many samples collected during the exam contain a mixture of secretions. To interpret genetic typing results obtained from these swabs, it is essential to know the genetic profile of patients. Patients' DNA reference samples are used for this purpose. Follow jurisdictional policy regarding the type of samples accepted by the crime lab. Collection of a buccal swab or saliva sample is encouraged unless it is medically or forensically necessary to take blood. If a blood sample is collected, the most noninvasive method of collection should be used.

Buccal swabs: Decide on a case-by-case basis whether it is appropriate to collect a buccal (inner cheek) swab reference sample for DNA typing rather than a blood sample. For example, a blood sample may not be needed or patients might not allow blood to be drawn. A saliva sample is an alternative to the buccal swab. (Note that buccal swabs and saliva samples are not suitable for blood typing and serology.) If oral copulation is asserted or suspected, a buccal swab or saliva sample for patients' DNA reference may be contaminated. In those cases, blood is usually the better reference sample.

- Buccal swab: Have patients rinse their mouths with tap water and then expose the inner cheek area. Swab this area with gentle pressure. Air-dry the swab, package, place in envelope, label, seal, and initial the seal.
- Saliva sample: Have patients saturate with saliva the inner circle of a folded piece of absorbent paper (e.g., filter paper).[230] Allow the paper to air-dry according to jurisdictional policy. Without touching the inner circle, package the paper, place in envelope, label, seal, and initial the seal. (Patients should not eat, drink, or smoke for at least 15 minutes prior to the saliva sample collection.)

Dry blood
- If drawn blood is not being collected for medical or toxicological purposes, consider dry blood collection because it is a less invasive method of blood collection.[231]
- Using a betadine swab, wipe the tip of the left or right ring finger.
- Using a sterile lancet, prick the finger.
- While holding the finger over one of four circles on the blood collection card, milk the finger, allowing two drops of blood to fall in a circle. Repeat procedure for the remaining circles as required by jurisdictional policy (it may not be necessary to fill all four circles).
- Allow blood to air-dry according to jurisdictional policy. Fill out the patient's name on the first line. Package according to jurisdictional policy, then place in envelope, label, seal, and initial the seal.

Drawn Blood
- In order to minimize patients' discomfort, collect drawn blood needed for the reference sample at the same time blood is collected for medical or toxicological purposes.
- Blood for the reference sample may be collected in lavender-top and/or yellow-top blood drawing tubes. These colored tubes contain preservatives suitable for forensic blood typing. The color to use is typically specified by the designated crime lab.[232] If tubes are included in the evidence collection kit, check expiration dates and replace if expired.[233] Mix according to jurisdictional policy.
- Write the patient's name, date and time of collection, and the collector's initial on the tube. Package according to jurisdictional policy, then place in envelope, label, seal, and initial the seal.

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moistened anoscope or anal speculum, lightly coat the instrument with lidocaine jelly or use manual traction and obtain samples from the anal canal. If a lubricant (other than water or saline) or lidocaine jelly is used, document its use and the reason for it. (The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 48.)

[230] For patients with compromised manual dexterity, examiners may hold the paper. (Commonwealth of Massachusetts *SANE Protocol Draft*, p. 31.)

[231] Several State protocols indicate dry blood collection is an acceptable method to obtain known DNA samples.

[232] The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 52.

[233] Drawn from Connecticut's Video Training Program, Part 1, *The Examination: Sexual Assault Evidence Collection*, 1998.

Collect other evidence. Other evidence may be collected beyond what is needed for the sexual assault evidence collection kit.

Toxicology samples. Make the decision about whether to collect toxicology samples for forensic purposes, what to collect, and collection methods according to jurisdictional policy. Do not put toxicology samples in the sexual assault evidence collection kit, unless otherwise indicated. Identify which forensic labs the jurisdiction has selected to analyze these samples, choose a lab, and follow transfer policies. (See *C.7. Drug-Facilitated Sexual Assault* for more information on collecting toxicology samples.)

Keep medical specimens separate from forensic specimens obtained during the exam. Specimens collected for medical purposes should be kept and processed at the medical facility, and specimens collected for forensic analysis should be transferred to the crime laboratory or other specified laboratories for analysis (with patients' consent). It is not necessary to maintain the chain of custody on medical specimens—instead, follow exam facility policy for documenting medical care and storing medical records.

7. Drug-Facilitated Sexual Assault

Recommendations at a glance for jurisdictions and responders to facilitate response in suspected drug-facilitated sexual assault:

- Educate examiners, 911 dispatchers, law enforcement representatives, prosecutors, judges, and advocates on issues related to drug-facilitated sexual assault. Develop policies to clarify first responders' roles in cases involving suspected drug-facilitated assault.
- Be clear about the circumstances in which toxicology testing may be indicated. Routine testing is not recommended.
- Informed consent of patients to collect toxicology samples should be sought. Prior to giving consent, patients should be aware of the purposes and scope of testing, potential benefits and consequences, any followup treatment necessary, how they can obtain results, who will pay for testing, and if they have any opportunity to revoke consent to testing.
- With patients' permission, immediately collect a urine specimen if patients may have been given drugs used for facilitating sexual assault within 96 hours prior to the exam. Also, collect a blood sample if these drugs may have been ingested within 24 hours of the exam. If a blood-alcohol level needs to be determined, collect a blood sample within 24 hours of alcohol ingestion, following jurisdictional policy.
- Make sure jurisdictional procedures are in place and followed for packaging, storing, and transferring these samples.

Promote training and develop jurisdictional policies. It is essential that examiners and other relevant health care personnel, 911 dispatchers, law enforcement representatives, emergency medical technicians, prosecutors, judges, and advocates receive training and information on drug-facilitated sexual assault. They need to be educated on the use of drugs and alcohol to facilitate sexual assault, screening for drug-facilitated assault, and how to handle situations in which a drug-facilitated sexual assault is suspected. Both agency-specific and multidisciplinary policies should be developed to guide immediate response to a suspected drug-facilitated sexual assault.[234]

First responders must recognize that although Rohypnol and gamma hydroxy butyrate (GHB) are widely publicized as the "drugs of choice" in drug-facilitated sexual assault, assailants may use numerous other drugs (including alcohol) to facilitate sexual assault.[235] They must understand the urgency of collecting toxicology samples, if it is medically necessary, or if a drug-facilitated sexual assault is suspected, as well as the importance of obtaining informed consent from patients prior to sample collection. They should also be aware that collection of toxicology samples is typically separate from the sexual assault forensic evidence collection kit, and procedures for toxicology analysis may be different from that of other evidence analysis.

Ideally, the first available urine sample should be collected in suspected drug-facilitated sexual assault cases. Law enforcement agencies and emergency medical services should develop procedures and staff training for collection in cases where patients must urinate before arriving at the exam site. Advocates and other professionals who may have contact with patients prior to their arrival at the exam site should also be educated to provide those who suspect that drugs were used to facilitate the assault with information on how to collect a sample if they cannot wait to urinate until they get to the site.

Plan response to voluntary use of drugs and/or alcohol by patients. It may be revealed during the exam process or through toxicological analysis that patients voluntarily used drugs and/or alcohol just prior to the assault.[236] Voluntary drug and/or alcohol use by patients during this period should not diminish the perceived seriousness of the assault. Law enforcement officers and prosecutors should guard against disqualifying

[234] These policies should clarify that patients should not be responsible for costs related to toxicology testing. Testing done as part of forensic evidence collection is typically paid for by the involved government entity.
[235] For more information about use of Rohypnol and GHB in drug-facilitated cases, see American Prosecutors Research Institute, Violence Against Women Program, *The Prosecution of Rohypnol and GHB Related Sexual Assaults*, 1999.
[236] Health care personnel involved in sexual assault cases should adhere to facility policy regarding 1) asking patients about alcohol and drug use in the course of intake and treatment and 2) testing for alcohol and/or drugs if deemed medically necessary.

cases in which patients voluntarily used illegal drugs or illegally used alcohol. Patients should understand that information related to voluntary alcohol or drug use may be used against them in court, but also that in some instances it might be helpful in prosecuting a case (see the following section on explaining procedures). Also, before pursuing charges related to illegal drug or alcohol use by patients, prosecutors should give great weight to the impact that the threat of such charges may have on patients' willingness to report the sexual assault and be involved in subsequent criminal justice proceedings.

It is important to document patient voluntary use of drugs and alcohol between the time of the assault and the exam. Some patients may self-medicate to cope with postassault trauma and require immediate medical treatment. In addition, ingestion of drugs and/or alcohol during this period may affect the quality of evidence and impede patients' ability to make informed decisions about treatment and evidence collection.

Be clear about the circumstances in which toxicology testing may be indicated.[237] Routine toxicology testing is not recommended. However, in any of the following situations, the collection of a urine and/or blood sample may be indicated:[238]

- If a patient's medical condition appears to warrant toxicology screening for optimal care (e.g., the patient presents with drowsiness, fatigue, light-headedness, dizziness, decreased blood pressure, memory loss, impaired motor skills, or severe intoxication);
- If a patient or accompanying persons (e.g., family member, friend, or law enforcement representative) states the patient was or may have been drugged; and/or
- If a patient suspects drug involvement because of a lack of recollection of event(s).[239]

Patients should be questioned about involuntary drug/alcohol use only if determined to be medically necessary or if there is a suspicion the assault was drug-facilitated.

Toxicology testing procedures should be explained to patients. Seek informed consent from patients to collect toxicology samples. Patients should understand the following before agreeing to toxicology testing:[240]

- The purposes of toxicology testing and the scope of confidentiality of results;[241]
- The ability to detect and identify drugs and alcohol depends on collection of urine and/or blood within a limited time period following ingestion;
- There is no guarantee that testing will reveal that drugs were used to facilitate the assault;
- Testing may or may not be limited to drugs commonly used to facilitate sexual assault[242] and may reveal other drugs or alcohol that patients may have ingested voluntarily;
- Whether any followup treatment is necessary if testing reveals the presence of drugs used to facilitate sexual assault;[243]
- Test results showing voluntary use of drugs and/or alcohol may be discoverable by the defense and used to attempt to discredit patients or to question their ability to accurately perceive the events in

[237] There is some controversy related to if and when to collect toxicology samples and test patients for drug and/or alcohol use. Some jurisdictions only collect these samples if drug-facilitated sexual assault is suspected or if a medical need arises. They seek to minimize patients' discomfort and avoid collecting unnecessary items. Other jurisdictions collect toxicology samples from every patient (with permission) and analyze these samples as case facts and jurisdictional policy dictate. In addition to cases of suspected drug-facilitated assault, some jurisdictions may request a toxicology sample if there is indication that patients voluntarily used drugs and/or alcohol prior to the assault. One rationale for such a policy is that prosecutors will want all information on drug and alcohol use to prepare for the case. When developing jurisdictional policy about when and if to collect toxicology samples, involved professionals should consider the perspective of patients and the criminal justice system and make thoughtful, victim-centered decisions.

[238] Bullets drawn from Connecticut's *Interim Sexual Assault Toxicology Screen Protocol*, 2002.

[239] Often, drugs used to facilitate sexual assault are mixed with alcohol and other beverages to further incapacitate patients, usually without their knowledge. Once patients recover from the effects of drugs and/or alcohol, anterograde amnesia may make it difficult to recall events. Consequently, patients may not be aware of the assault or even of how they were drugged. (Drawn from Connecticut's *Interim Sexual Assault Toxicology Screen Protocol*, 2002.)

[240] List adapted partially from Connecticut's *Interim Sexual Assault Toxicology Screen Protocol*, 2002.

[241] If the patient authorizes the release of toxicology testing results to law enforcement and/or prosecution, this information will most likely be discoverable by the defense. If toxicology testing is done for purely clinical purposes and results are documented only in the patient's medical records, the results are typically more difficult, but not impossible, to discover.

[242] In some jurisdictions, examiners may be able to request testing for specific drugs used to facilitate sexual assault. In others, tests for specific drugs are not done, rather, toxicology samples are screened for all ingested drugs and alcohol.

[243] For example, patients with health conditions that may be affected by drug or alcohol intake may need information on possible impact of involuntary drug/alcohol ingestion and what to do to identify, treat, or avoid potential problems.

question (however, these results could also help substantiate that voluntary drug and/or alcohol use sufficiently impaired patients' consent and prevented legal consent);[244]
- Whether there is a local prosecution practice of charging sexual assault victims for illegal voluntary drug and/or alcohol use revealed through toxicology screening;
- Failure or refusal to undergo testing when indicated by circumstances as described above may negatively impact the investigation and/or prosecution;[245]
- When and how they can obtain information on the results from toxicology testing;
- Who will pay for toxicology testing; and
- Whether patients have the opportunity to revoke their consent to toxicology testing.[246]

Care should be taken when providing the above information to patients. In particular, they may need to hear repeatedly from examiners that voluntary use of drugs and/or alcohol, if any, does not reduce the seriousness of the assault. Under no circumstances should the medical forensic exam and treatment be conditioned upon patient consent to toxicology testing.

Toxicology samples should be collected as soon as possible after a suspected drug-facilitated case is identified and informed consent is obtained, even if patients are undecided about reporting to law enforcement. The length of time that drugs used for drug-facilitated assault remain in urine or blood depends on a number of variables (e.g., the type and amount of drug ingested, patients' body size and rate of metabolism, whether patients had a full stomach, and whether they previously urinated).[247] Urine allows for a longer window of detection of drugs commonly used in these cases than does blood.[248] The sooner a urine specimen is obtained after the assault, the greater the chances of detecting drugs that are quickly eliminated from the body.[249]

Immediately collect a urine sample when appropriate. If patients may have ingested a drug used for facilitating sexual assault within 96 hours prior to the exam, a urine specimen of at least 30 milliliters but preferably 100 milliliters (about 3 ounces) should be collected[250] in a clean plastic or glass container (follow jurisdictional policy). The urine sample does not have to be a clean catch (e.g., blood in the urine will not compromise test results). If patients cannot wait to urinate until their arrival at the exam facility, first responders should ask them to provide a sample and bring it to the facility, documenting the chain of custody. It is suggested that law enforcement officers and emergency medical technicians keep toxicology screening kits readily available, according to agency policy.

Ideally, patients should not urinate until after evidence is collected. However, the number of times that patients urinated prior to collection of the sample should be documented.

Collect a blood sample when appropriate. If ingestion of drugs used to facilitate sexual assault may have occurred within 24 hours prior to the exam, a blood sample of at least 20 milliliters should be collected in a gray-top tube (contains preservatives sodium fluoride and potassium oxalate[251]) according to jurisdictional policy. A blood sample taken within this time period may pinpoint the time when drugs were ingested.[252] If a blood sample is collected for toxicology screening, it should be accompanied by a urine sample. If blood alcohol determination is needed, collect blood within 24 hours of alcohol ingestion, according to jurisdictional policy. (If blood has already been taken due to suspected drug ingestion, that sample can be used to determine blood-alcohol level. An additional sample usually is not needed.)

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[244] The prosecutor can work to minimize the possibility that information about voluntary alcohol and/or drug use will be used against patients, particularly if patients are truthful from the start about their preassault drug/alcohol use and consent to testing.
[245] For example, if there is a suspicion the assault was drug-facilitated and there was no toxicology testing, investigators and prosecutors may lack critical evidence, making it difficult to prosecute the case. Prosecutors might choose not to go forward with such a case. Refusal to get tested may also be used by the defense to discredit the patient and question the validity of the charges.
[246] In one jurisdiction, sexual assault victims have 48 hours after giving samples to finalize or revoke their consent to testing.
[247] American Prosecutors Research Institute, Violence Against Women Program, 1999, *The Prosecution of Rohypnol and GHB Related Sexual Assaults*, Chapter 2, p. 1.
[248] M. LeBeau, Toxicological Investigations of Drug-Facilitated Sexual Assaults*, Forensic Science Communications*, 1999, p. 3.
[249] Ibid.
[250] Ibid.
[251] Ibid.
[252] American Prosecutors Research Institute, Violence Against Women Program, 1999, *The Prosecution of Rohypnol and GHB Related Sexual Assaults*, Chapter 2, p. 2.

Occasionally, patients of drug-facilitated sexual assault vomit. The analysis of the vomit may also be useful to an investigation.[253] Collect and preserve according to jurisdictional policy.

Package samples as appropriate. Package each toxicology sample according to the policy of the lab doing the analysis, place in envelope, label, seal, and initial the seal.

Identify toxicology laboratories. Exam facility laboratories should not analyze toxicology samples in suspected drug-facilitated sexual assault cases. Instead, involved criminal justice agencies should identify forensic laboratories that can analyze these toxicology samples (they should have the capacity to detect drugs in very small qualities).[254] Information about these labs (e.g., contact information, evidence collection and packaging procedures, and transfer procedures) should be provided to law enforcement representatives investigating these cases, exam facilities, and examiner programs.

If toxicology tests are needed purely for the medical evaluation of patients, the exam facility lab typically performs these tests. Lab results are recorded in patients' medical records, according to facility policy. If toxicology samples are needed for both clinical and forensic purposes, one sample can be collected for immediate evaluation by the exam facility lab and another for analysis by the identified forensic lab. Take samples at the same time to avoid more discomfort to patients than is necessary.

Preserve evidence and maintain the chain of custody. Involved health care personnel should be aware of the toxicology lab's requirements on collection, packaging, labeling, storage, handling, transportation, and delivery of specimens.[255] Policies should be in place for storage of these samples when patients are undecided about reporting. As with any forensic evidence, the chain of custody must be maintained.

Refer to the current *Forensic Toxicology Laboratory Guidelines* by the Society of Forensic Toxicologists, Inc., and the American Academy of Forensic Sciences for detailed guidance on proper collection, labeling, handling, submission, and analysis of toxicology samples.[256]

[253] M. LeBeau, Toxicological Investigations of Drug-Facilitated Sexual Assaults*, Forensic Science Communications*, 1999, p. 3.
[254] American Prosecutors Research Institute, Violence Against Women Program, 1999, Video supplement, *The Prosecution of Rohypnol and GHB Related Sexual Assaults*.
[255] Refrigerate toxicology samples according to jurisdictional policy. In general, drawn blood should be refrigerated when it is stored. Urine should be refrigerated or frozen when stored.
[256] These guidelines are available at www.soft-tox.org

8. STI Evaluation and Care

Recommendations at a glance for health care providers to facilitate evaluation and treatment of STIs:

- Offer patients information about the risks of STIs (including HIV), symptoms, what to do if symptoms occur, testing and treatment options, followup care, and referrals.
- Consider the need for testing patients for STIs during the initial exam on a case-by-case basis. If testing is done, follow the guidelines of the Centers for Disease Control and Prevention (CDC).
- Encourage patients to accept prophylaxis against STIs at the time of the initial exam. If accepted, provide care that meets or exceeds CDC guidelines. If declined, it is medically prudent to obtain cultures and arrange for a followup examination and testing.
- Obtain informed consent of patients for treatment, according to exam facility policy.
- Encourage followup STI examinations, testing, immunizations, and treatment as directed.
- Offer postexposure prophylaxis for HIV to patients at high risk for exposure, particularly when it is known that suspects have HIV/AIDS. Meet or exceed guidelines recommended by the CDC. Discuss risks and benefits of the prophylaxis with patients prior to their decision to accept/decline treatment. Careful monitoring and followup by a health care provider or agency experienced in HIV issues is required.

Contracting a sexually transmitted infection (STI), also commonly known as a sexually transmitted disease or STD, from assailants is typically a significant concern of sexual assault patients. Because of this concern, it should be addressed as part of the medical forensic exam. Mechanisms should be in place in any setting where these patients are examined for STIs to ensure continuity of care (including timely review of test results) and monitor compliance with and adverse reactions to any therapeutic or prophylactic regimens.[257]

Offer patients information. Include information about the risks of STIs, symptoms and the need for immediate examination if symptoms occur, testing and treatment options (and the need for abstinence from sexual intercourse until treatment is completed), followup care, and referrals as needed.[258] Referrals should include free and low-cost testing, counseling, and treatment offered in various sections of the community. Patients should be aware of the scope of confidentiality related to information in their medical records related to STIs.[259] The level of detail needed when providing this information verbally varies (e.g., some patients may be aware of risks and want treatment, while others may not be as knowledgeable of risks or their options).

The need for testing for STIs should be considered on a case-by-case basis by examiners and patients. Testing at the time of the initial exam does not typically have forensic value if patients are sexually active and an STI could have been acquired prior to the assault. Also, despite rape shield laws, there may be a concern that positive test results could be used against patients (e.g., to suggest sexual promiscuity). There may, however, be situations in which testing has legal purposes, as in cases where the threat of transmission or actual transmission of an STI was an element of the crime. Or, for nonsexually active patients, a baseline negative test followed by an STI could be used as evidence, if the suspect also had an STI.

Among sexually active patients, the identification of STIs after an assault is usually more important for psychological and medical management than for forensic purposes.[260] Trichomoniasis, bacterial vaginosis (BV), gonorrhea, and chlamydial infection are the most frequently diagnosed infections among sexually

[257] Sexually Transmitted Diseases Treatment Guidelines, *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, May 10, 2002, 51(RR-6), p. 69. Available at www.cdc.gov/std/treatment/default.htm (CDC general phone: 800–311–3435). Much of the information in this chapter was drawn from these guidelines. Note that the guidelines are updated periodically. In addition to the guidelines, the CDC Web site at www.cdc.gov offers information on related research, news, and Internet links.
[258] Drawn partially from Sexually Transmitted Diseases Treatment Guidelines, 2002, p. 70.
[259] Laws in all States limit the evidentiary use of a patient's prior sexual history, including evidence of previously acquired STIs, as part of an effort to undermine the credibility of a patient's testimony. Evidentiary privilege against revealing any aspect of the exam or treatment is enforced in most States. In unanticipated, exceptional situations, however, STI diagnoses may later be accessed. (Sexually Transmitted Diseases Treatment Guidelines, 2002, p. 69.)
[260] This paragraph is drawn from Sexually Transmitted Diseases Treatment Guidelines, 2002, p. 69.

assaulted women.[261] Their presence does not necessarily indicate acquisition during the assault, since these infections are prevalent among sexually active women. The medical forensic exam presents an opportunity to identify preexisting STIs, regardless of when they were acquired, and for examiners to make recommendations for specific treatment. Testing for STIs at the time of the exam also gives examiners and patients the option of deferring treatment until it is needed.

Seek the informed consent of patients for testing, if indicated, following CDC guidelines. (For more information on this topic, see *A.3. Informed Consent*.)

Encourage patients to accept prophylaxis against STIs if indicated.[262] If prophylaxis is accepted at the time of the exam, testing is usually not indicated medically. Routine preventive therapy after a sexual assault is often recommended because followup with these patients can be difficult.[263] It also may reduce the need for more expensive/extensive treatment if an STI is discovered at a later time. Meet or exceed current CDC guidelines for STI preventive therapy for your geographic area.[264] (The CDC suggests a regimen to protect against chlamydia, gonorrhea, trichomonas, and BV, as well as the hepatitis B virus.) If prophylaxis is declined at the time of the initial exam, it is medically prudent to obtain cultures and arrange for a followup examination and testing (it is recommended that all patients are reexamined—see the section on followup activities). Document patients' decisions and rationales for declining prophylaxis in their medical records.[265]

For nonsexually active patients, taking a prophylaxis could prevent development of STIs that could be used as evidence if the suspect had an STI. Keep in mind that patients' medical needs take priority over collection of forensic evidence. However, patients should be aware of this consequence of taking the prophylaxis against STIs and be able to make their own decisions about treatment.

If patients' clinical presentation suggests a preexisting ascending STI, such as fever, abdominal or pelvic pain, and/or vaginal discharge, they should be evaluated and treated for the ascending infection. This treatment may differ from suggested STI prophylaxis.[266]

Hepatitis B virus (HBV) and postexposure prophylaxis. See CDC recommendations related to HBV diagnosis, treatment, prevention, postexposure immunizations, prevaccination antibody screening, postexposure prophylaxis, and special considerations.[267] Patients who have completed a full hepatitis B vaccination regimen prior to the assault are protected from HBV infection and do not need further doses. (See the CDC recommended regimen for adolescents and adults.) For those who were not fully vaccinated prior to the assault, the vaccine should be completed as scheduled. Patients unvaccinated prior to the assault or unsure of whether they have been vaccinated should receive active postexposure prophylaxis (e.g., hepatitis B vaccine alone) upon the initial clinical evaluation. Followup doses should be given 1 to 2 and 4 to 6 months after the first dose. Unless suspects are known to have acute hepatitis B, HBIG (hepatitis B immune globulin) is not required. (When HBIG is needed, use CDC recommended doses.)

Examiners must stress to patients receiving the HBV vaccine the importance of following up for administration of doses as scheduled for full protection. Advocates should also be educated about the possibility of patients receiving prophylaxis against HBV and encourage those who start the vaccine regimen to follow up for required additional doses.

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[261] Chlamydial and gonococcal infections in women are of particular concern due to the possibility of ascending infection. In addition, postassault testing can detect hepatitis B virus (HBV) and human immunodeficiency virus (HIV) infection (Sexually Transmitted Diseases Treatment Guidelines, 2002, p. 69).

[262] Keep in mind that prophylaxis against STIs may not be appropriate for some individuals (e.g., because of a disability or other medication they may be taking). Before recommending prophylaxis, it may be helpful to talk with these patients' primary healthcare providers (with patients' permission).

[263] Sexually Transmitted Diseases Treatment Guidelines, 2002, p. 70.

[264] Antibiotic prophylaxes are updated periodically and are usually tailored to specific regions (because, for example, one part of the country may be resistant to a certain antibiotic).

[265] Nonphysician examiners providing STI prophylaxis typically must operate within the boundaries of a protocol and have access to medical supervision, consultation, and review.

[266] Paragraph from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 92.

[267] Sexually Transmitted Diseases Treatment Guidelines, 2002, p. 64. This section was drawn from this document.

Obtain informed consent from patients for treatment. (For information on this topic, see *A.3. Informed Consent*.) Patients should be aware of the benefits and toxicity associated with recommended regimens.

Encourage followup STI exams, testing, immunizations, counseling, and treatment as directed.[268] Although patients may be reluctant to go for followup exams for STIs, such exams are essential because they provide an opportunity to detect new infections acquired during or after the assault, complete hepatitis B immunization, if indicated, and complete counseling and treatment for other STIs. Examinations for STIs for all patients should be repeated according to exam facility policy—the CDC recommends a followup appointment within 1 to 2 weeks of the assault. If patients tested negative at the time of the medical forensic exam and chose not to receive prophylaxis, followup testing should be conducted.[269] The CDC recommends that in this case the followup exam be done within a week to ensure that positive test results are discussed promptly with patients and treatment is offered. The CDC recommends followup testing for patients who received treatment only if they report having symptoms consistent with an STI. (However, patients who were treated should be informed of the option of followup testing to confirm the presence or lack of infection.) The CDC recommends that testing for syphilis and HIV infection should be repeated 6, 12, and 24 weeks after the assault if initial test results were negative and if these infections are likely to be present in assailants (see the upcoming section on evaluating risk for exposure to HIV).

It is important that followup communication with patients (particularly by examiners and advocates) include a reminder to go to followup exams and receive STI-related testing, immunizations, and treatment as directed. Advocates and health care personnel may be able to assist patients in making followup appointments, obtaining transportation to and from appointments, and determining how to pay for expenses involved with followup testing and care. Some jurisdictions may cover followup treatment as part of initial care through funds such as crime victims' compensation. In such instances, patients may be more apt to seek followup treatment. Advocates may also be able to accompany patients to these followup appointments.

Address concerns about HIV infection. Although the risk of human immunodeficiency virus (HIV) infection[270] from a sexual assault appears to be low,[271] it is typically of grave concern for sexual assault patients.

Provide information and referrals.[272] Examiners should talk with patients about their concerns regarding the possibility of contracting HIV.[273] As with other STIs, offer patients information about HIV risks, symptoms and the need for immediate examination if symptoms occur, testing and treatment options, and the need for abstinence from sexual intercourse until any treatment received is completed. Include local referrals for testing/counseling and comprehensive HIV services in the community and region. This information can help patients make decisions about testing and treatment based on facts rather than fear.[274]

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[268] This paragraph is drawn from Sexually Transmitted Diseases Treatment Guidelines, 2002, p. 70.

[269] Infectious agents acquired through the assault may not have produced sufficient concentrations of organisms to result in positive test results at the medical forensic exam. (Sexually Transmitted Diseases Treatment Guidelines, 2002, p. 70.)

[270] HIV refers to any of a group of retroviruses that infect and destroy helper T-cells of the immune system. AIDS (acquired immunodeficiency syndrome) can be triggered by infection with HIV. (Drawn from Arkansas' *Sexual Assault: A Hospital/Community Protocol for Forensic and Medical Examination*, 2001, p. B2.)

[271] Although HIV-antibody seroconversion has been reported among individuals whose only known risk factor was sexual assault or sexual abuse, the risk for acquiring HIV infection through a single episode of sexual assault is likely low. The overall probability of HIV transmission during a single act of intercourse from a suspect known to be HIV-infected depends on many factors. In specific circumstances, the probability of transmission could be high. These factors may include the type of sexual intercourse (oral, vaginal, or anal), presence of oral, vaginal, or anal trauma (including bleeding), site of exposure to ejaculate, viral load in ejaculate, and presence of a STI or genital lesions in assailants or patients. (Sexually Transmitted Diseases Treatment Guidelines, 2002, p. 70.)

[272] A useful referral is the CDC's National HIV/AIDS Information Hotline at 800–342–AIDS. For Spanish speakers, call 800–344–SIDA. For Deaf and hearing-impaired persons, call the TTY/TDD Hotline at 800–AIDS–TTY. Also see the Revised Guidelines for HIV Counseling, Testing, and Referral, *Morbidity and Mortality Weekly Report*, CDC, November 9, 2001, 50(RR-19). This document is available through aidsinfo.nih.gov/guidelines/ or by calling the CDC's HIV/AIDS Information Hotline (see below footnote).

[273] Some States statutes provide for mandatory HIV testing of suspected sex offenders upon arrest and/or conviction. Patients should be advised of the availability of such testing.

[274] L. Ledray, *SANE Development and Operations Guide*, 1998, p. 74.

Discuss testing options. Baseline HIV testing is not typically an exam component. However, if the assault is considered a high risk for HIV exposure, patients should establish their baseline HIV status within 72 hours after the assault and then be tested periodically as directed by health care personnel. However, even if the assault is not considered a high risk for HIV exposure, some patients may still wish to be tested.

HIV testing should be done in settings where counseling can be offered to explain results and implications. When providing testing referrals, let patients know whether testing services are free, anonymous, and/or confidential.[275] Confidential and anonymous testing is recommended.

Assess the need to offer HIV postexposure prophylaxis.[276] In certain circumstances, the likelihood of HIV transmission may be reduced by postexposure therapy for HIV with antiretroviral agents. Postexposure therapy with zidovudine has been associated with a reduced risk for HIV infection and has become the standard of care for health workers who have percutaneous (e.g., needle stick) exposure to HIV, but whether these findings can be extrapolated to other exposure situations, including sexual assault, is unknown.

The use of antiretroviral agents after possible exposure through sexual assault must balance potential benefits of treatment with its possible adverse side effects.[277] Health care personnel must evaluate patients' risk of exposure to HIV and consider whether to offer treatment based on their perceived risk. Examiners unfamiliar with known risks associated with exposure or side effects of postexposure therapeutic agents should consult with a specialist in HIV treatment. Numerous factors may influence the decision to offer treatment, such as the time since the exposure occurred; the probability that the assailant is infected with HIV; the likelihood that transmission could occur from the assault; and the prevalence of HIV in the geographic area or institutional setting (e.g., a prison) the assault occurred.[278]

Offer postexposure prophylaxis for HIV to patients at high risk for exposure, particularly when it is known that suspects have HIV/AIDS. If offered, the following information should be discussed with patients:[279]

- The unknown efficacy of postexposure prophylaxis for HIV in cases of sexual assault;
- The known side effects and toxicity of antiretroviral medications;
- The need for frequent dosing of medication and the followup care necessary;
- The importance of compliance with the recommended therapy;
- The necessity for immediate initiation of treatment for maximum effectiveness; and
- The estimated costs of the medication and monitoring.[280]

When given following a sexual assault, postexposure prophylaxis is the same as for occupational exposure to HIV. Refer to CDC recommendations for postexposure antiretroviral therapy[281] and consult with an HIV specialist where possible. Careful monitoring and followup by a health care provider or agency experienced

[275] Drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Abused Patient*, 1999, p. 126.
[276] The following two paragraphs were drawn from Sexually Transmitted Diseases Treatment Guidelines, p. 70, L. Ledray, *SANE Development and Operations Guide*, 1998, p. 74, and the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, pp. 93-4.
[277] A table listing primary side effects associated with specific antiretroviral agents is provided in the CDC's Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis, *Morbidity and Mortality Weekly Report* 2001, 50 (RR-11), p. 13. Some examples of known shorter term adverse symptoms of antiretroviral medications include nausea, vomiting, diarrhea, and other gastrointestinal effects. Protease inhibitors may cause lipid abnormalities, diabetes mellitus, and hyperglycemia and lead to diabetic ketoacidosis in previously diagnosed diabetics. Combination therapy has lead to some serious side effects, including hepatitis, nephrolithiasis, and pancytopenia. (The American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 125.)
[278] Paragraph drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Abused Patient*, 1999, p. 125.
[279] Bullets drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 93.
[280] Patients may be able to obtain reimbursement for some or all related costs through State crime victims' compensation programs. (L. Ledray, *SANE Development and Operation Guide*, 1998, p. 74.)
[281] See aidsinfo.nih.gov/guidelines/ for the CDC's Guidelines for the following documents: *Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents* (July 14, 2003); the Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis, *Morbidity and Mortality Weekly Report* 2001, 50(RR-11), and Management of Possible Sexual, Injecting-Drug-Use, or Other Nonoccupational Exposure to HIV, Including Considerations Related to Antiretroviral Therapy, Public Health Statement, *Morbidity and Mortality Weekly Report* 1998; 47(RR-17).

in HIV issues is required. Patients should be alerted to symptoms of primary HIV infection (e.g., fever, fatigue, sore throat, lymphadenopathy, and rash) and seek care if these symptoms arise.

Seek informed consent of patients to administer treatment. The decision to begin or withhold treatment should be made by patients and health care personnel after patients have been adequately informed of the risks and benefits of treatment options. (For information on this topic, see *A.3. Informed Consent*.)

9. Pregnancy Risk Evaluation and Care

Recommendations at a glance for health care providers to evaluate and treat pregnancy:

- Discuss the probability of pregnancy with female patients.
- Administer a pregnancy test for all patients with reproductive capability.
- Discuss treatment options with patients, including reproductive health services.

Patients of different ages, social, cultural, and religious/spiritual backgrounds may have varying feelings regarding acceptable treatment options. Examiners and other involved health care personnel must be careful not to influence patients' choices of treatment.

Discuss the probability of pregnancy with female patients. The risk of pregnancy from sexual assault is estimated to be 2 to 5 percent. However, pregnancy resulting from sexual assault often is a cause of great concern and significant additional trauma to the victim, so victims' fears should be taken seriously.[282]

Conduct a pregnancy test for all patients with reproductive capability (with their consent).[283] An exception is if a patient clearly is pregnant. If a patient is pregnant, the pregnancy may affect what medications can be administered or prescribed in the course of or after the exam.

Discuss treatment options with patients.[284] In cases of sexual assault, pregnancy is often an overwhelming and genuine fear. Therefore, discuss treatment options with patients, including reproductive health services.

[282] L. Ledray, *SANE Development and Operation Guide*, 1998, p. 75.
[283] Preexisting pregnancy may raise patient privacy issues. If the case is prosecuted, the prosecutor should work to address concerns such as this one.
[284] The National Sexual Violence Resource Center (877–739–3895 or 717–909–0710) offers more detailed information about sexual assault and pregnancy on their Web site at www.nsvrc.org.

10. Discharge and Followup

Recommendations at a glance for responders to facilitate discharge planning and followup with patients:

- It is important to ensure that patients are fully informed about postexam care. Information may include referrals to other professionals to make sure that patients' medical and/or mental health needs related to the assault have been addressed, discharge instructions, followup appointments with the examiner and other health care providers as needed, and medical followup contact procedures. In addition to medical followup, followup may be indicated to document developing or healing injuries and complete resolution of healing.
- Advocates and law enforcement representatives (if involved) should coordinate with examiners to discuss a range of other issues with patients prior to discharge, including planning for safety and well-being, physical comfort needs, information needs, the investigative process, advocacy and counseling options, and law enforcement and advocacy followup contact procedures.

Health care personnel have important tasks to accomplish prior to discharging patients, as do advocates and law enforcement representatives (if involved). These responders should coordinate their activities as much as possible to reduce repetition and avoid further overwhelming patients.

Address issues related to medical discharge and followup care. Health care personnel (preferably examiners) should address the following issues with patients prior to discharge:

Make sure patients' medical and mental health needs related to the assault have been addressed. Discuss with patients whether they have any other medical and/or mental health concerns related to the assault. If injuries or trauma have not been treated yet, examiners should refer patients to exam facility clinicians (e.g., hospital emergency department staff) for care or provide the appropriate community referrals prior to discharge.

Provide patients with oral and written medical discharge instructions. Include a summary of the exam (e.g., evidence collected, tests conducted, medication prescribed or provided, information provided, and treatment received), medication doses to be taken, followup appointments needed or scheduled, and referrals. The discharge form could also include contact information and hours of operation for local advocacy programs.

Arrange followup appointments for patients. Followup may be indicated to document developing or healing injuries and complete resolution of healing. (A jurisdictional policy describing the indications and procedures for followup for documentation purposes should be in place.) Appointments may also be needed to address ongoing medical concerns. If appointments are not scheduled, at least indicate to patients which appointments are needed and if sites are different than the initial exam. Make it clear that patients do not have to disclose the assault to receive followup medical care. Followup appointments may include:[285]

- For patients with evidence of acute trauma: A short-term followup appointment to reexamine and document the development of visible findings and photograph areas of injury; and an exam 2 to 4 weeks later to document resolution of findings or healing of injuries.
- For all patients: Repeat exams for STIs according to facility policy (see *C.8. STI Evaluation and Care*).
- Primary health care providers or other nonacute care providers can provide longer term care as needed (e.g., for HIV testing, STI testing, and administering doses of Hepatitis B vaccine).

Discuss followup medical contact procedures. Discuss with patients whether they would like health care providers to provide a followup call and, if so, the best method and time for this contact (maintaining patients' privacy and safety). The main purposes of such a call are to check on medical status and remind patients about the necessity of followup testing and care. An optimal time for a first medical followup contact is 24 to

[285] Bullets drawn partially from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 98.

48 hours following discharge. Personnel following up with patients should be familiar with the case, confidentiality issues, and potential medical needs.[286]

Advocates, law enforcement representatives, and other involved responders can coordinate with health care providers to discuss a range of other issues with patients prior to discharge. Involved responders should come to agreement about who is responsible for each step below and where coordination is necessary. For example, while advocates usually explain advocacy services and law enforcement representatives explain the investigative process, each responder may have a role in helping patients plan for their safety and well-being. If health care personnel are the only responders involved, however, they may need to provide patients with much of the information below.

After the exam is finished, address patients' physical comfort needs. (For a discussion of this topic, see *A.2. Victim-Centered Care*.)

Help patients plan for their safety and well-being. Jurisdictional and exam site policies should be in place to facilitate this process. Assist patients in developing a postexam plan that addresses their physical safety and emotional well-being. Screen for domestic and dating violence and others forms of abuse. Assist patients in considering things such as:

- Where are they going after being discharged? With whom? Will these individuals provide them with adequate support? Is there anyone else they would like to contact? (Provide information about available community resources for obtaining support and help in making the contact if needed.)
- Will their living arrangements expose them to the threat of continued violence or harassment? Is there a need for emergency shelter or alternative housing options? (Provide options and help obtain if needed.)
- Are they eligible for protection orders? (Provide information and help obtain if desired.)
- Is there a need for enhanced security measures? (Discuss options and help obtain if desired.)
- If they feel unsafe, what will they do to get help? (Discuss options and help them develop a plan.)

Planning must take into account the needs and concerns of specific populations. For example, if patients with physical disabilities require shelter, the shelter must be accessible and staff able to meet their needs for personal assistance with activities of daily living.[287] If patients living in institutional settings have been assaulted by another resident, a staff person, or person who has easy access to residents, the institution should offer alternative living arrangements and reduce the likelihood that patients have to come into contact with the assailant again. It should also ensure them access to services designed to promote their recovery.

Explain followup contact procedures of all responders involved. Coordinate followup contact of involved agencies as much as possible, keeping the number of responders contacting patients to a minimum. Explain if contact procedures are different for non-English-speaking patients or specific communities or institutions (e.g., schools, military bases, prisons, or residential programs may have their own procedures). Consider offering patients prepaid phone cards they can use to call a contact person with concerns or questions.

Explain advocacy and counseling services. Sexual assault advocacy programs typically offer a host of services for victims and their significant others, in addition to those provided during the exam process. (For more information on services, see *A.2.Victim-Centered Care*.) Advocates can describe and offer patients, their family members, and friends these services, as well as explain options for counseling in the jurisdiction and offer referrals. Some advocacy programs provide professional mental health counseling, but many refer patients to community or private agencies. Before being discharged, advocates should ask patients if they can follow up with them. If they agree, they can determine optimal methods and times for the contacts. During followup contacts, advocates can help patients reassess their safety; offer support and crisis counseling; answer their questions and provide additional referrals and information; and help coordinate other advocacy services and counseling based upon identified needs.

[286] When appropriate, advocates may assist health care personnel in encouraging patients to seek the followup medical care they need. They also may encourage patients to discuss with health care providers their concerns about initial and followup medical care.
[287] Drawn from M. Nosek and C. Howland, *Abuse and Women with Disabilities,* 1998, p. 3.

Explain the investigative process. If law enforcement is involved, inform patients that investigators will request an interview with them, if not already done, explain the criminal justice process and victims' rights, reassess their safety and provide assistance as warranted, and then recontact them as needed as their case progresses.[288] Patients should receive contact information of involved law enforcement representatives and agencies and a case report number. They should feel free to call their investigator with any new relevant information, if new signs of injuries appear, about suspects' compliance with protection orders or bond conditions, if suspects try to contact them, or with other related questions or concerns. They should be aware that they will be contacted by the prosecution office if their case goes forward. (Patients should be aware that it is their decision whether to report their case and talk with law enforcement officials and prosecutors.)

If evidence has been gathered and law enforcement is involved, the law enforcement representative can discuss with patients the possibility of a match being found through DNA analysis or of other victims of the same assailant being identified. Ask patients if they want to be contacted by law enforcement in these situations and, if so, determine the best contact method.

Provide information. Offer patients clear and concise information, both orally and in writing.[289] Information should be tailored to patients' communication skill level/modality and language. (For more information on the types of information that patients might find useful, see *A.2. Victim-Centered Care*.)

[288] Some patients may want information, either during the exam process or after, about the amount of time it takes to process cases in the criminal justice system. It can be helpful for them to know the range of time it typically takes in that jurisdiction for evidence to be analyzed and for cases to be forwarded to prosecution or tried in court. This information may help them prepare for their justice system involvement. At the same time, they must understand that every case is different and typical time estimates from the past may not apply.
[289] Many local sexual assault advocacy programs and state coalitions of sexual assault programs offer publications that speak to victims' concerns in the aftermath of an assault. However, any involved agency, SART, or coordinating council could develop such literature.

11. Examiner Court Appearances

Recommendations at a glance for jurisdictions to maximize the usefulness of examiner testimony:

- Encourage broad education for examiners on testifying in court.
- Promote prompt notification of examiners if there is a need for them to testify in court.
- Encourage pretrial preparation of examiners.
- Encourage examiners to seek feedback on their testimony to improve effectiveness of future court appearances.

It should be expected that examiners will be called on to testify in court as either fact and/or expert witnesses,[290] even though in some cases, a plea bargain may be agreed upon, or the prosecuting attorney may decide not to try the case. Examiners should always conduct and document each examination knowing that legal testimony may ultimately be required.

Encourage broad education for examiners on testifying in court:[291]

- Provide them with information about courtroom proceeding basics (e.g., criminal justice process and terms, who typically is present,[292] and prosecution and defense strategies).
- Educate them about different types of testimony (including what can and cannot be said during testimony). This information should assist examiners in explaining to patients during the exam their potential role as a witness should the case be prosecuted.
- Help them understand that testifying in court can be a difficult experience. In almost every case that makes it to trial, cross-examination of examiners after their initial testimony will occur. Cross-examining attorneys may be intimidating and hostile towards them. It is critical that examiners are prepared to effectively handle such situations and have a support system in place to help them prepare for and deal with related stress they may experience.
- Provide them with pretrial preparation (see the section below on this topic).

Involve trainers from health care, prosecution, and the judiciary in trainings on court testimony. Also, include defense attorneys who can educate examiners on defense perspectives. In addition to attending trainings, examiners should stay abreast of cutting-edge practices and related case law (e.g., rulings that impact the scope of issues they can testify on in court).[293]

Promote prompt notification of examiners if there is a need for them to testify in court. Examiners should be informed well in advance of a trial if they are being called as witnesses. It may be helpful for attorneys calling them (both prosecutors and defense attorneys) to first develop relationships with

[290] An expert witness is person who has training, education, and experience on a particular subject and who is formally found to be qualified as an expert by a judge. Expert witnesses may give opinions in court on matters in which their expertise is relevant. Nonexpert witnesses normally cannot give opinions in response to questions in court, but can only testify to the facts (what has been observed, collected, or heard). (Drawn from San Diego County's *SART Standards of Practice*, 2001, p. 40.)

[291] This section is partially adapted from the International Association of Forensic Nurses, *SANE Education Guidelines*, 1999. One useful resource for SANEs and attorneys who utilize SANEs for testimony is L. Ledray and L. Barry, Sexual Assault Clinical Issues: SANE Expert and Factual Testimony, *Journal of Emergency Nursing*, 24(3), June 1998, pp. 284–287.

[292] The following may be present in the courtroom: the judge, prosecutor, defense attorney, jury, bailiff, clerk, court reporter, law enforcement investigator, victim, defendant, and victim advocate.

[293] This section focuses on preparing examiners for court testimony. Beyond preparing examiners, it is critical to encourage training for attorneys who try these cases on how to properly interpret and use the medical forensic examination. In addition, they need an accurate understanding about the education and clinical preparation, roles, and responsibilities of the forensic examiner. Like examiners, they can benefit from participating in mock trials and need ongoing education to stay abreast of the latest best practices and related case law. Prosecutors should be aware of and share related case law and protocol guides with judges as references to qualify examiners as expert witnesses. They can also share questions they plan to ask to establish credentials of these witnesses. Additionally, prosecutors must understand how to educate the jury about evidence that will be presented (e.g., a lack of physical injury does not equal lack of sexual assault). Similarly, it is important to encourage judicial education on issues related to examiner testimony. Judges may not understand all that occurs during the exam process or the full extent of examiner expertise. *Understanding Sexual Violence: Prosecuting Adult Rape and Sexual Assault Cases, Video Library I: Presenting Medical Evidence in an Adult Rape Trial*, 2002, is a useful resource for prosecutors and judges (for more information, see www.legalmomentum.org/njep/medicalevidence.shtml). The National Judicial Education Program (NJEP) offers this resource. It also offers a judicial curriculum on sexual assault trials.

coordinators of examiner programs, if they exist, or staff that oversee examiners at the exam site. In some facilities, they may need to reach out to risk management departments, which oversee all potential areas of liability for the facility. The first time an attorney contacts the witness should not be through a subpoena. Unexpected subpoenas can cause examiners a great deal of anxiety.[294]

Attorneys should regard examiners they call as witnesses with respect for the knowledge and expertise examiners offer to the court. They also should work to minimize the amount of time examiners wait to testify, allowing them to return to their work as quickly as possible. Judges also should be aware of the need to give examiners priority in the scheduling of testimony.

Encourage pretrial preparation of examiners.[295] When preparing to testify, the following suggestions may be useful to examiners:

- Although the criminal justice record includes the medical forensic report, photographs, and the results of evidence analysis, medical records are confidential in most jurisdictions. Before examiners or other involved health care providers can talk with an attorney about information in patients' medical records, those records must be successfully subpoenaed. Health care facilities and/or independent examiner programs typically have procedures in place for handling subpoenas.[296]
- It is critical that examiners meet in advance with the attorney(s) calling them as witnesses, in order to prepare for testimony in individual cases. Not only should they review and discuss the initial examination of the patient, but also any subsequent contacts between the patient and the examiner.
- Prior to testifying, examiners should review records of the exam and keep a log of materials reviewed.
- Expert witnesses should be prepared to educate the court, particularly jurors. They should consider terminology and descriptions that will most clearly advise lay persons in the courtroom.
- Examiners should keep in mind that anything they write about the case is potentially discoverable.
- Examiners should be prepared to prove qualifications and ready to discuss educational background, clinical experience, and prior experience as expert witnesses. They may also need to explain qualifications if they are testifying to facts in a case. They should keep a portfolio that lists education, experience, and previous appearances as a witness.[297]
- Examiners should understand that they may not testify as to whether or not patients consented to sexual contact; that is for the jury to decide. However, some jurisdictions allow expert testimony that speaks to the consistency between patients' statements and injuries rather than attempting to draw conclusions about how injuries were caused or whether a sexual assault occurred.[298]

During testimony, it may be helpful to examiners to do the following:

- Dress appropriately.
- Be sincere, polite, and appear in control. Being nervous is normal, even for examiners who have testified previously. Make eye contact with those doing the questioning as well as with the jury.
- Listen to the questions carefully. Allow time to compose answers before speaking. Be concise and correct in responses. Avoid terms such as "I believe" or "I think."
- Avoid medical jargon to the extent possible. If it is needed, define its usage.
- Answer only questions that are asked. Ask the questioning attorney for clarification or to restate the question if needed.
- If the answer to a question is not known, say so. There is no reason for examiners to explain why they do not know the answer. They can ask to refer to records if their memories need refreshing.

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[294] This paragraph was drawn from the video reference guide for *Understanding Sexual Violence: Prosecuting Adult Rape and Sexual Assault Cases, Video Library I: Presenting Medical Evidence in an Adult Rape Trial*, 2002, pp. 17–18.
[295] Section partially adapted from Arkansas's *Sexual Assault: A Hospital/Community Protocol for Forensic and Medical Examination*, 2001, p. L1–3.
[296] This bullet was drawn from the video reference guide for *Understanding Sexual Violence: Prosecuting Adult Rape and Sexual Assault Cases, Video Library I: Presenting Medical Evidence in an Adult Rape Trial*, 2002, pp. 17–18.
[297] See L. Ledray and L. Barry, Sexual Assault Clinical Issues: SANE Expert and Factual Testimony, *Journal of Emergency Nursing*, 24(3), June 1998, pp. 284–287, for more discussion on qualifying as an expert witness.
[298] This bullet was drawn from the video reference guide for *Understanding Sexual Violence: Prosecuting Adult Rape and Sexual Assault Cases, Video Library I: Presenting Medical Evidence in an Adult Rape Trial*, 2002, pp. 19–20.

- Let the attorney guide the questioning. Do not give more information than is needed for the question. Do not elaborate unless the attorney or judge asks for more information.
- If it is realized that an error or omission occurred in testimony, acknowledge it politely.

Although it is most likely that examiners will be called by the prosecution, they may also be called by the defense. In either case, examiners are expected to give objective testimony. In addition to the previous tips, examiners should consider the following:

- Seek guidance from the prosecutor regarding appropriate interaction with the defense attorney prior to testimony.
- When disagreeing with the questioning attorney, do so without argument or interruption.
- Be aware of the phrasing of questions by the cross-examining attorney that may be designed to place doubt on examiner testimony. For instance, if a compound question is asked, the answer to one part may be “yes” and to the other part may be “no.” Be sure to divide answers as appropriate.
- If the questions of the cross-examining attorney include incorrect interpretation of previous examiner testimony or documentation, the erroneous information should be corrected.
- Be careful to provide consistent answers, especially if cross-examining attorneys ask the same question several times, using different wording.

Encourage examiners to seek feedback on their courtroom testimony to improve the effectiveness of future court appearances. For example, after the legal proceedings are over, examiners can meet with prosecutors to get feedback on and evaluate their testimony. Examiners might also want to watch other experts testify in these cases when possible.

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Appendix A. Developing Customized Protocols: Considerations for Jurisdictions

Jurisdictions starting from scratch in developing their own exam protocols are encouraged to consider the recommendations in this national protocol in their entirety and tailor them to fit local needs, challenges, statutes, and policies. Jurisdictions that have existing protocols can consider whether any of the protocol recommendations or the tasks below could serve to improve their immediate response to sexual assault or address gaps in services or interventions.

Form a protocol planning team. At the least, this team should include those responders involved in the exam process, including health care personnel, exam facility administrators, law enforcement representatives, victim advocates, prosecutors, and forensic laboratory personnel. Organizations serving specific populations in the community should also be involved at some level to make sure the protocol speaks to the needs of victims of diverse backgrounds. Team participants should have authority to make policy decisions on behalf of their agencies. Bringing together such a team can be challenging, particularly in jurisdictions with multiple sexual assault victim advocacy programs, exam facilities, law enforcement agencies, prosecution offices, and court systems (or where several levels of government may be involved in investigation and prosecution of sexual assault cases). Although representation from all involved disciplines and agencies is encouraged, at some point the team assembled will have to move ahead with planning efforts. Try to keep those absent informed of team activities and offer them opportunities to provide feedback on protocol development and revision.

Assess needs.[299] Before initiating policy changes, it is important that the planning team assess the jurisdiction's current response to sexual assault, with a focus on the exam process. Some activities that may help:

- Compare statistics on sexual assault within the community as captured by represented agencies;
- Identify community demographics, including the various populations that make up the area;
- Review existing feedback from victims about their experiences and satisfaction with immediate response;
- Seek input from professionals involved in the exam process on current gaps, problems, and challenges;
- Evaluate the adequacy of policies pertaining to each aspect of immediate response;
- Review systemic breakdowns that have occurred in immediate response;
- Evaluate the capacity of each discipline to support a coordinated immediate response;
- Evaluate the effectiveness of response to victims from diverse backgrounds or in certain types of cases;
- Evaluate the adequacy of related trainings and resource materials; and
- Identify related jurisdictional statutes and evaluate their adequacy in supporting effective response.

Devise an action plan. The protocol planning team can take what it learns through needs assessments and translate it into an action plan for improving the exam process and creating a protocol. The plan should clearly identify what needs to happen, who is responsible for coordinating or carrying out each action, possible resources,[300] desired outcomes, and how the effectiveness of the action will be evaluated. The plan can be revisited periodically to assess progress and evaluate outcomes.

[299] Section drawn from K. Littel, M. Malefyt, and A. Walker, *Promising Practices: Improving the Criminal Justice System's Response to Violence Against Women*, 1998, p. 240 and 246, and American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 21.

[300] Funding under the STOP Violence Against Women Formula Grant Program and the STOP Violence Against Indian Women Discretionary Grant Program may be used to cover costs related to protocol development and implementation. For more information, see www.ojp.usdoj.gov/vawo.

Create a protocol. To promote an effective protocol development process, consider the following:[301]

- Who should lead efforts to create and implement the protocol?
- What process will be used to facilitate decisionmaking on protocol development or revision?
- What process will be used for facilitating adoption of the protocol by individual agencies or communities?
- How will protocol compliance be monitored and what mechanisms will be put into place to solve problems as they arise?

The planning team should review the national protocol to determine what it wants to cover in its customized protocol and the appropriateness of national recommendations for the jurisdiction. It must consider what jurisdictional statutes and policies need to be discussed and how to address community-specific needs and challenges. Once a draft has been developed, it should be made available to relevant professionals, agencies, survivor groups, and organizations serving specific populations across the jurisdiction. Their feedback should be solicited and then incorporated into the draft to the extent possible. Once a final protocol is created, the team should consider pilot testing and revising it based on feedback from the tests. Then the protocol should be implemented, as per recommendations of team members and others from whom input has been sought.

Distribute the protocol. The planning team should determine the most efficient method to get the protocol to all professionals in the jurisdiction who are involved in the immediate response to sexual assault. The planning team needs an up-to-date contact list of these professionals, and it should agree upon a specific distribution plan (e.g., mailing or handing out hard copies and/or providing access to the protocol via the Internet). If the Internet is used to distribute the document, make sure that professionals who do not have Internet access get a hard copy.

Build the capacity of agencies to implement the protocol.[302] A protocol's effectiveness depends on individual agencies having adequate resources (e.g., funding, personnel, multilanguage capacity, equipment, supervision, training, professional development opportunities, and community partnerships) to carry out their responsibilities and coordinate efforts with other involved responders. Agencies can assist one another in building individual and collective capacity to respond to sexual assault and participate in coordinated interventions. For example, together they can seek opportunities for technical assistance, training, and grants and share costs, personnel, equipment, expertise, and information. Also, each jurisdiction most likely will encounter a variety of barriers and difficulties in protocol implementation. Overcoming such problems requires a willingness on the part of involved agencies to individually and collaboratively understand the unique needs of victims in their community and to think "outside the box" to identify solutions.

To help with implementation, consider asking responding agencies to supplement the protocol with interagency agreements or memorandums of understanding. Using the protocol as a basis, these agreements can outline roles and articulate how responders should work together to coordinate response. These documents should be jointly developed, agreed upon, and signed by agency policymakers. They can be revised and signed on a periodic basis to ensure all professionals involved in the response are aware of protocol changes and to reaffirm their commitment to carrying out agreements.

Promote training. Agency-specific and multidisciplinary trainings are crucial components of protocol implementation. Involved responders must be informed of any changes in how they carry out agency-specific responsibilities during the exam process and understand why these changes are needed. If they are being asked to coordinate their efforts formally with other agencies, they must understand their role in coordination, the benefits of a collaborative response, the challenges such an effort involves, and ways to overcome challenges.

[301] Bulleted section drawn from K. Littel, M. Malefyt, and A. Walker, *Promising Practices: Improving the Criminal Justice System's Response to Violence Against Women*, 1998, p. 242.
[302] Section drawn from K. Littel, M. Malefyt, and A. Walker, *Promising Practices: Improving the Criminal Justice System's Response to Violence Against Women*, 1998, p. 241.

Set up an evaluation system. The planning team should take the time to consider how to best compile data related to the exam process (while maintaining victims' anonymity) and how to use it to evaluate effectiveness of response and make improvements to the protocol as needed.

Revise the protocol periodically. Revisions may be based on feedback from responders and victims, evaluation recommendations, changes in laws, identification of new crime trends and prevention efforts, technology, research, and identification of new promising practices. The planning team should keep track of protocol areas needing improvement and meet periodically to discuss pertinent issues such as language to be used, how to resolve controversies, and, ultimately, to make needed changes.

Appendix B. Creation of Sexual Assault Response Teams

Create a SART to facilitate coordination among involved disciplines.[303] After identifying members and defining roles, members can plan how to operate their team to best serve community needs.

Determine how the SART is activated. Activation procedures should take into account that victims enter the "system" at different points (e.g., through a call to 911 or a 24-hour advocacy hotline, arrival at a health care facility, or disclosure to a community professional). The SART must determine how to publicize its services to community professionals who may have frequent contact with individuals disclosing sexual assaults. These professionals might include, but are not limited to, private physicians, health clinic staff, mental health and social service program staff, personnel serving persons with disabilities, substance abuse treatment program staff, school personnel, personnel from faith-based communities, corrections and probation staff, and staff from residential living programs and emergency shelters. It also should publicize its services more broadly to the public, explain the dynamics of sexual assault, and encourage victims to seek help.

Plan SART response to varying circumstances facing victims. The team should consider and plan for modifications to the exam process to address specific needs and concerns of victims. For example, in order to respond to non-English-speaking victims, team members must be able to speak their language or promptly arrange for certified interpretation. For victims thought to have cognitive disabilities, team members must know who to contact for assistance and ensure they receive the same access to services that other victims would obtain. Some victims may request advocates and other responders of a specific gender or from specific cultures. Procedures should be in place to ensure response to minors follows jurisdictional statutes. SARTs should be prepared to deal with multijurisdictional coordination issues that may arise when assaults occur on military sites or to soldiers in the field, school campuses, tribal lands, prisons, and residential programs. Involving relevant agencies as soon as possible according to agreed-upon procedures may help quickly determine who has jurisdiction over a case and how to best assist each victim.

Meet regularly. Outside of an immediate response, the SART should meet regularly[304] for two distinct purposes. The first is to review immediate response in individual cases in order to improve overall team performance. These reviews allow team members the opportunity to give each other feedback on effectiveness of response during the exam process, problems needing resolution, and areas needing improvement. Cases are typically reviewed anonymously,[305] without using victims' names or other identifying information.[306] During these discussions, it is important that the team respect the confidentiality of information in patients' medical records and shared with community-based advocates. Secondly, the SART can utilize meetings of members to maintain and enhance the quality of the SART. This task involves addressing system issues, such as creating and revising policies and procedures in response to local changes in governmental or community-based agencies, scientific or technological advances, and feedback from victims. It also involves sharing general information related to the SART and facilitating the continuing education of the team.

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[303] A more indepth discussion of SART development and maintenance than is provided is beyond the scope of this document. However, resources do exist on this topic. For example, numerous jurisdictions have published guidebooks on organizing a SART and/or protocols for SART response. Some sexual assault coalitions offer information, technical assistance, and training for communities interested in starting SARTs. Since 2001, a national SART training conference has been held biannually (see www.sane-sart.com for information).

[304] "Regularly" is locally defined. Some teams meet monthly, while others meet every 6 weeks or quarterly. Teams might meet on a regular basis for case review and get together less frequently to discuss more systemic issues.

[305] In California, there is a law to protect discussions of individual cases during SART meetings. These discussions are technically characterized as medical quality-assurance activities.

[306] Case reviews usually include only those SART members typically involved in immediate response. But, even if all or most SART members were involved in a particular case and were aware of victims' identity, there is still no reason to reveal victims' identity during SART case reviews. SARTs may choose not to take notes about cases reviewed to ensure that the case-related information is not shared with anyone outside of the meeting. In situations where victims' identity might be easily deduced during a case review by members not involved in response (e.g., if there had only been one case handled during the time period being reviewed), comments should be kept as broad as possible and avoid case specifics. In communities where residents tend to know each other and news about crime travels quickly, it may be challenging to not inadvertently reveal victims' identify during SART case reviews. SARTs in these jurisdictions should consider how to best approach case reviews in a way that reduces the likelihood of revealing victims' identify.

Although it might be difficult to involve all relevant responders in SART meetings (e.g., crime labs may be a considerable distance from the community and lack resources to respond to local inquiries), consider options such as teleconferencing to include their perspectives.

Encourage education for SART members on coordinated response during the exam process. For example:

- Discipline-specific training that advances responder skills and emphasizes a team approach is crucial.
- Multidisciplinary training sessions can describe the SART process, stress the need for a prompt exam, explain the roles and challenges of each discipline, emphasize a victim-centered approach, and make clear where coordination among disciplines is needed and how it should occur. They can describe multidisciplinary policies, interagency agreements, standardized forms, and other related materials.
- Multidisciplinary training can also build members' understanding of needs, values/beliefs, and practices of specific populations in their community. They can raise awareness of how different populations respond to disclosures of sexual assault and work to build the capacity of involved professionals to be sensitive to the needs of victims from those populations.
- Cross-training sessions are useful to allow responders from one discipline to educate those from another discipline about the specifics of how they intervene in these cases and answer questions that may arise. For example, law enforcement investigators can educate examiners and advocates about what is involved in a thorough investigation, stressing that the forensic exam of the victim is but one part of the investigation. In jurisdictions that border Indian Country, Federal prosecutors can educate other responders regarding Federal Indian law and how it applies to sexual assault cases.
- Multidisciplinary trainings and cross-trainings can provide a forum for staff from different agencies to get to know and respect one another, build common goals, and increase their comfort in working together. Collaboration among agencies and individuals can provide responders with a broader network of support as they do this work. These trainings can also stress the difficulty of working on sexual assault cases and the secondary trauma that responders can experience. They can facilitate discussion among responders about self-care and preventing or coping with secondary trauma, so they in turn can provide optimal interventions and assistance to victims.
- There are more informal educational opportunities and tools that can foster coordination among SART members. For example, all key responders, especially those newly involved in sexual assault cases, may find it useful to tour sites and offices involved in SART response. Such tours and discussions with site/office staff can help build knowledge of what response by each discipline entails and the logistics of that response. Sharing related educational materials and literature is an easy way to continuously expand the base of common knowledge among SART members. Tools such as flow charts and discipline-specific checklists that help SART members understand the continuum of response and appropriately coordinate their interventions may also be useful.

Trainers. In addition to involving representatives from health care, advocacy, law enforcement, prosecution, the judiciary, and crime and toxicology laboratories as SART trainers, include defense attorneys to educate participants on defense tactics. Utilize local agencies and leaders that serve specific populations to educate the SART on the needs of residents and services they offer relevant to victims of sexual assault.

Outreach to rural, remote, and poor communities. It may be difficult for rural, remote, and poor communities to offer training for SART members, due to lack of resources and/or expertise. States, Territories, and tribes may want to consider forming specialized teams that can offer multidisciplinary training consistent with cutting-edge practices across all of their jurisdictions. These teams can work with local responders to ensure that the training sessions they offer address unique community needs and challenges.

Organization	Ethical Codes and Guidelines	Website
American Academy of Physician Assistants	**Code of Ethics** **Confidentiality-**Physician assistants should maintain confidentiality. By maintaining confidentiality, PAs respect patient privacy and help to prevent discrimination based on medical conditions. If patients are confident that their privacy is protected, they are more likely to seek medical care and more likely to discuss their problems candidly. In cases of adolescent patients, family support is important but should be balanced with the patient's need for confidentiality and the PA's obligation to respect their emerging autonomy. Adolescents may not be of age to make independent decisions about their health, but providers should respect that they soon will be. To the extent they can, PAs should allow these emerging adults to participate as fully as possible in decisions about their care. It is important that PAs be familiar with and understand the laws and regulations in their jurisdictions that relate to the confidentiality rights of adolescent patients. (See the section on ***Informed Consent***.) Any communication about a patient conducted in a manner that violates confidentiality is unethical. Because written, electronic, and verbal information may be intercepted or overheard, the PA should always be aware of anyone who might be monitoring communication about a patient. PAs should choose methods of storage and transmission of patient information that minimize the likelihood of data becoming	http://www.aapa.org/

Organization	Ethical Codes and Guidelines	Website
AAPA Cont'	available to unauthorized persons or organizations. Computerized record keeping and electronic data transmission present unique challenges that can make the maintenance of patient confidentiality difficult. Pas should advocate for policies and procedures that secure the confidentiality of patient information.	
American Counseling Association	**Code of Ethics** **B.1.c. Respect for Confidentiality:** Counselors do not share confidential information without client consent or without sound legal or ethical justification. **B.1.d. Explanation of Limitations:** At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify foreseeable situations in which confidentiality must be breeched. **B.2.a. Danger and Legal Requirements:** Confidentiality does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of	http://www.counseling.org/

Organization	Ethical Codes and Guidelines	Website
ACA Cont'	an exception. Additional considerations apply when addressing end-of-life issues.	
American Medical Association	**Code of Medical Ethics** **E 5.505 Confidentiality**-The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law. The obligation to safeguard patient confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities. Also,	http://www.ama-assn.org/

Organization	Ethical Codes and Guidelines	Website
AMA Cont'	communicable diseases and gun shot and knife wounds should be reported as required by applicable statutes or ordinances.	
American Mental Health Counselors Association	**Code of Ethics** **Principle 1- Welfare of the Consumer: J. Informed Consent** Mental health counselors are responsible for making their services readily accessible to clients in a manner that facilitates the clients' abilities to make an informed choice when selecting a provider. This responsibility includes a clear description of what the client can expect in the way of tests, reports, billing, therapeutic regime and schedules, and the use of the mental health counselor's statement of professional disclosure. In the event that a client is a minor or possesses disabilities that would prohibit informed consent, the mental health counselor acts in the client's best interest. **Principle 2- Clients' Rights** The following apply to all consumers of mental health services, including both in- and out-patients and all state, county, local, and private care mental health facilities, as well as clients of mental health practitioners in private practice.	http://www.amhca.org/

Organization	Ethical Codes and Guidelines	Website
AMHCA Cont'	The client has the right: A) To be treated with dignity, consideration and respect at all times; B) To expect quality service provided by concerned, trained, professional and competent staff; C) To expect complete confidentiality within the limits of the law, and to be informed about the legal exceptions to confidentiality; and to expect that no information will be released without the client's knowledge and written consent; D) To a clear working contract in which business items, such as time of sessions, payment plans/fees, absences, access, emergency procedures, and third-party reimbursement procedures are discussed; E) To a clear statement of the purposes, goals, techniques, rules of procedure and limitations, as well as the potential dangers of the services to be performed, and all other information related to or likely to affect the ongoing mental health counseling relationship; F) To appropriate information regarding the mental health counselor's education, training, skills, license and practice	

Organization	Ethical Codes and Guidelines	Website
AMHCA Cont'	limitations and to request and receive referrals to other clinicians when appropriate; G) To full, knowledgeable, and responsible participation in the ongoing treatment plan to the maximum extent feasible; H) To obtain information about their case record and to have this information explained clearly and directly; I) To request information and/or consultation regarding the conduct and progress of their therapy; J) To refuse any recommended services and to be advised of the consequences of this action; K) To a safe environment free of emotional, physical and sexual abuse; L) To a client grievance procedure, including requests for consultation and/or mediation; and to file a complaint with the mental health counselor's supervisor, and/or the appropriate credentialing body; and	

Organization	Ethical Codes and Guidelines	Website
AMHCA Cont'	M) To a clearly defined ending process, and to discontinue therapy at any time. **Principle 3- Confidentiality** Mental health counselors have a primary obligation to safeguard information about individuals obtained in the course of practice, teaching, or research. Personal information is communicated to others only with the person's written consent or in those circumstances where there is clear and imminent danger to the client, to others or to society. Disclosure of counseling information is restricted to what is necessary, relevant and verifiable. A) At the outset of any counseling relationship, mental health counselors make their clients aware of their rights in regard to the confidential nature of the counseling relationship. They fully disclose the limits of, or exceptions to, confidentiality, and/or the existence of privileged communication, if any. B) All materials in the official record shall be shared with the client, who shall have the right to decide what information may be shared with anyone beyond the immediate provider of service and be informed of the implications of the materials to be shared. C) Confidentiality belongs to the clients. They may direct the mental	

Organization	Ethical Codes and Guidelines	Website
AMHCA Cont'	health counselor, in writing, to release information to others. The release of information without the consent of the client may only take place under the most extreme circumstances. The protection of life, as in the case of suicidal or homicidal clients, exceeds the requirements of confidentiality. The protection of a child, an elderly person, or a person not competent to care for themselves from physical or sexual abuse or neglect requires that a report be made to a legally constituted authority. The mental health counselor complies with all state and federal statutes concerning mandated reporting of suicidality, homicidality, child abuse, incompetent person abuse and elder abuse. The protection of the public or another individual from a contagious condition known to be fatal also requires action that may include reporting the willful infection of another with the condition. The mental health counselor (or staff member) does not release information by request unless accompanied by a specific release of information or a valid court order. Mental health counselors will comply with the order of a court to release information but they will inform the client of the receipt of such an order. A subpoena is insufficient to release information. In such a case, the counselor must inform his client of the situation and, if the client refuses release, coordinate between the client's attorney and the requesting	

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AMHCA Cont'	attorney so as to protect client confidentiality and one's own legal welfare. In the case of all of the above exceptions to confidentiality, the mental health counselor will release only such information as is necessary to accomplish the action required by the exception. D) The anonymity of clients served in public and other agencies is preserved, if at all possible, by withholding names and personal identifying data. If external conditions require reporting such information, the client shall be so informed. E) Information received in confidence by one agency or person shall not be forwarded to another person or agency without the client's written permission. F) Service providers have the responsibility to ensure the accuracy and to indicate the validity of data shared with their parties. G) Case reports presented in classes, professional meetings, or publications shall be so disguised that no identification is possible unless the client or responsible authority has read the report and	

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AMHCA Cont'	agreed in writing to its presentation or publication. H) Counseling reports and records are maintained under conditions of security, and provisions are made for their destruction when they have outlived their usefulness. Mental health counselors ensure that all persons in his or her employ, volunteers, and community aides maintain privacy and confidentiality. I) Mental health counselors who ask that an individual reveal personal information in the course of interviewing, testing or evaluation, or who allow such information to be divulged, do so only after making certain that the person or authorized representative is fully aware of the purposes of the interview, testing or evaluation, and of the ways in which the information will be used. J) Sessions with clients may be taped or otherwise recorded only with their written permission or the written permission of a responsible guardian. Even with a guardian's written consent, one should not record a session against the expressed wishes of a client. Such tapes shall be destroyed when they have outlived their usefulness. K) Where a child or adolescent is the primary client, or the client is	

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AMHCA Cont'	not competent to give consent, the interests of the minor or the incompetent client shall be paramount. Where appropriate, a parent(s) or guardian(s) may be included in the counseling process. The mental health counselor must still take measures to safeguard the client's confidentiality. L) In work with families, the rights of each family member should be safeguarded. The provider of service also has the responsibility to discuss the contents of the record with the parent and/or child, as appropriate, and to keep separate those parts, which should remain the property of each family member. M) In work with groups, the rights of each group member should be safeguarded. The provider of service also has the responsibility to discuss the need for each member to respect the confidentiality of each other member of the group. He must also remind the group of the limits on and risk to confidentiality inherent in the group process. N) When using a computer to store confidential information, mental health counselors take measures to control access to such information. When such information has outlived its usefulness, it should be deleted from the system.	

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American Nurses' Association	**Code of Ethics** **3.2 Confidentiality**-Associated with the right to privacy, the nurse has a duty to maintain confidentiality of all patient information. The patient's well-being could be jeopardized and the fundamental trust between patient and nurse destroyed by unnecessary access to data or by the inappropriate disclosure of identifiable patient information. The rights, well-being, and safety of the individual patient should be the primary factors in arriving at any professional judgment concerning the disposition of confidential information received from or about the patient, whether oral, written or electronic. The standard of nursing practice and the nurse's responsibility to provide quality care require that relevant data be shared with those members of the health care team who have a need to know. Only information pertinent to a patient's treatment and welfare is disclosed, and only to those directly involved with the patient's care. Duties of confidentiality, however, are not absolute and may need to be modified in order to protect the patient, other innocent parties and in circumstances of mandatory disclosure for public health reasons. Information used for peer-review, third-party payments, and other quality improvements or risk management mechanisms may be disclosed under defined policies, mandates, or protocols. These	http://www.nursingworld.org/

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ANA Cont'	written guidelines must assure that the rights, well-being, and safety of the patient are protected. In general, only that information directly relevant to a task or specific responsibility should be disclosed. When using electronic communications, special effort should be made to maintain data security.	
American Philosophical Practitioners Association	**Code of Ethics** **Part I: Fundamental Canons i.** Philosophical practitioners will, above all, endeavor to do no harm. **Part I: Fundamental Canons iv.** Philosophical practitioners will respect the dignity and autonomy of their clients, and will respect their confidentiality and protect their anonymity to the extent required by law. **Part II: Standards of Ethical Practice xii.** At all junctures in the process of providing philosophical services, the philosophical practitioner should seek to maintain the freely given and informed consent of the client. **Part II: Standards of Ethical Practice xiv.** The philosophical practitioner should safeguard a client's right to privacy by treating as	http://www.appa.edu/

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APPA Cont'	confidential all information obtained from the client, except where disclosure is required by law or is justified in order to prevent imminent, substantial harm to the client or to others. In all such exceptional cases, disclosure may be made provided that it is made to the appropriate party or authority and no more information than necessary is disclosed. The philosophical practitioner should inform the client of the pertinent limits to confidentiality upon initiating services. **Part II: Standards of Ethical Practice xv.** The philosophical practitioner who confidentially receives information establishing that his or her client has a contagious, fatal disease is justified in disclosing (necessary) information to an identifiable third party who, by his or her relation to the client, is at high risk of contracting the disease. The philosophical practitioner should, however, first confirm that neither the client nor any other party has already disclosed the information nor intends to make the disclosure in the immediate future. Prior to disclosing the information, the practitioner should inform the client of his or her intention to disclose. In proceeding with disclosure, the practitioner should act mindfully of the welfare, integrity, dignity, and autonomy of both client and third party.	

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APPA Cont'	**Part II: Standards of Ethical Practice xvi.** The philosophical practitioner should secure and treat as confidential all records and written documents obtained or produced in the course of providing services. Such documents, or the content thereof, may not be shared with other professionals without the freely given and informed consent of the client. **Part II: Standards of Ethical Practice xxiii.** Consistent with the Standards of Ethical Practice, the philosophical practitioner should comply with existing local, state or provincial, and federal laws relevant to the private practice of philosophy and should work for change of existing laws where such laws prevent or obstruct its ethical practice.	
American Public Health Association	**Code of Ethics** 12 Ethical Principles with the 10 Essential Public Health Services: **(9)** enhance physical and social environments **(10)** protect confidentiality	www.apha.org
American Society for Philosophy, Counseling and Psychotherapy	**Standards of Ethical Practice** **Code of Ethics 14.** The philosophical practitioner should safeguard a client's right to privacy by treating as confidential all information obtained from the client, except where disclosure is required by law	http://www.aspcp.org/

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ASPCA Cont'	or is justified in order to prevent imminent, substantial harm to the client or to others. In all such exceptional cases, disclosure may be made provided that it is made to the appropriate party or authority and no more information than necessary is disclosed. The philosophical practitioner should inform the client of the pertinent limits to confidentiality upon initiating services. **Code of Ethics 15.** The philosophical practitioner who confidentially receives information establishing that his or her client has a contagious, fatal disease is justified in disclosing (necessary) information to an identifiable third party who, by his or her relation to the client, is at high risk of contracting the disease. The philosophical practitioner should, however, first confirm that neither the client nor any other party has already disclosed the information nor intends to make the disclosure in the immediate future. Prior to disclosing the information, the practitioner should inform the client of his or her intention to disclose. In proceeding with disclosure, the practitioner should act mindfully of the welfare, integrity, dignity, and autonomy of both client and third party. **Code of Ethics 16.** The philosophical practitioner should secure and treat as confidential all records and written documents obtained or produced in the course of providing services. Such documents, or the	

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ASPCA Cont'	content thereof, may not be shared with other professionals without the freely given and informed consent of the client. **Code of Ethics 22.** Philosophical practitioners should keep informed about current statutes, legal precedents, social issues, etc. that are relevant to their practice and which might affect the quality of services they render. Similarly, those practicing as consultants in a specialized field, such as medical ethics, should keep informed of changes in health law and policies that may affect the quality of their services. **Code of Ethics 23.** Consistent with the Standards of Ethical Practice, the philosophical practitioner should comply with existing local, state or provincial, and federal laws relevant to the private practice of philosophy and should work for change of existing laws where such laws prevent or obstruct its ethical practice.	
Association for Addiction Professionals	**Code of Ethics** **Principle 2: Client Welfare** I understand that the ability to do good is based on an underlying concern for the well being of others. I shall act for the good of others and exercise respect, sensitivity, and insight. I understand that my primary professional responsibility and	http://naadac.org/

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AAP Cont'	loyalty is to the welfare of my clients, and I shall work for the client irrespective of who actually pays his/her fees. • I shall do everything possible to safeguard the privacy and confidentiality of client information except where the client has given specific, written, informed, and limited consent or when the client poses a risk to himself or others. • I shall provide the client his/her rights regarding confidentiality, in writing, as part of informing the client of any areas likely to affect the client's confidentiality. • I understand and support all that will assist clients to a better quality of life, greater freedom, and true independence. • I shall not do for others what they can readily do for themselves but rather, facilitate and support the doing. Likewise, I shall not insist on doing what I perceive as good without reference to what the client perceives as good and necessary. • I understand that suffering is unique to a specific individual and not of some generalized or abstract suffering, such as might be found in the understanding of the disorder. I also understand that the action taken to relieve suffering must be uniquely suited to the suffering individual and not simply some universal prescription. • I shall provide services without regard to the compensation provided by the client or by a third party and shall render equally appropriate services to individuals whether they are paying a reduced fee or a full fee. **Principle 5: Compliance with Law** I understand that laws and regulations exist for the good ordering of society and for the restraint	

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AAP Cont'	of harm and evil, and I am aware of those laws and regulations that are relevant both personally and professionally and follow them, while reserving the right to commit civil disobedience. • I understand that the determination that a law or regulation is unjust is not a matter of preference or opinion but a matter of rational investigation, deliberation, and dispute. • I willingly accept that there may be a penalty for justified civil disobedience, and I must weigh the personal harm of that penalty against the good done by civil protest. **Principle 8: Preventing Harm** I understand that every decision and action has ethical implication leading either to benefit or harm, and I shall carefully consider whether any of my decisions or actions has the potential to produce harm of a physical, psychological, financial, legal, or spiritual nature before implementing them. • I shall refrain from using any methods that could be considered coercive such as threats, negative labeling, and attempts to provoke shame or humiliation. • I shall make no requests of clients that are not necessary as part of the agreed treatment plan. • I shall terminate a counseling or consulting relationship when it is reasonably clear that the client is not benefiting from the relationship. • I understand an obligation to protect individuals, institutions, and the profession from harm that might be done by others. Consequently, I am	

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	aware that the conduct of another individual is an actual or likely source of harm to clients, colleagues, institutions, or the profession, and that I have an ethical obligation to report such conduct to competent authorities.	
National Association of Social Workers	**Code of Ethics** **Social Workers' Ethical Responsibilities to Clients** **1.01 Commitment to Clients:** Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.) **1.03 Informed Consent** (a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable	http://www.socialworkers.org/

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NASW Cont'	alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions. (b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible. (c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent. (d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse	

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NASW Cont'	service. (e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services. (f) Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party. **1.07 Privacy and Confidentiality** (a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply. (b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client. (c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for	

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NASW Cont'	compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed. (d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent. (e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the	

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NASW Cont'	course of the relationship. (f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements. (g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling. (h) Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure. (i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such	

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NASW Cont'	as hallways, waiting rooms, elevators, and restaurants. (j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection. (k) Social workers should protect the confidentiality of clients when responding to requests from members of the media. (l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access. (m) Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines,	

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NASW Cont'	telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible. (n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure. (o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death. (p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information. (q) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure. (r) Social workers should protect the confidentiality of deceased	

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National Commission on Correctional Healthcare	**Standards and Guidelines for Delivering Services** **Correctional Mental Health Care** **M-G-09 Procedure in the Event of a Sexual Assault** The medical and psychological trauma of a sexual assault are minimized as much as possible by prompt and appropriate health intervention. **Compliance Indicator 2d:** A report is made to the correctional authorities to effect a separation of the victim from his or her assailant in their housing assignments. **M-H-02 Confidentiality of Health Records and Information** The confidentiality of a patience written or electronic health record, as well as verbally conveyed health information, is maintained. **Compliance Indicator 3:** Access to health records and health information is controlled by the health authority.	http://www.ncchc.org/

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NCCH Cont'	**Correctional Health (Medical) Care:** **P-G-09 Procedure in the Event of Sexual Assault** The medical and psychological trauma of a sexual assault are minimized as much as possible by prompt and appropriate health intervention. **Compliance Indicator 2d:** A report is made to the correctional authorities to effect a separation of the victim from his or her assailant in their housing assignments. **P-H-02 Confidentiality of Health Records and Information** The confidentiality of a patience written or electronic health record, as well as verbally conveyed health information, is maintained. **Compliance Indicator 3:** Access to health records and health information is controlled by the health authority.	