



STATE OF WASHINGTON
DEPARTMENT OF COMMERCE

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November 15, 2019

Mr. Brad Hendrickson, Secretary of the Senate
Legislative Building 312
PO Box 40600
Olympia, WA 98504-0600

Mr. Bernard Dean, Chief Clerk of the House of Representatives
Legislative Building 338B
PO Box 40600
Olympia, WA 98504-0600

Re: The Sexual Assault Nurse Examiner Report

Dear Mr. Hendrickson and Mr. Dean:

The Sexual Assault Nurse Examiner report, written in response to Substitute House Bill 2101 2018 (Rep. McCabe), recommends best practices and training strategies that communities may use on a voluntary basis to increase access to sexual assault nurse examiners. It also recommends that the Legislature fund a statewide Sexual Assault Response Team technical assistant position and create a training program and scholarship fund. Nurses often attend trainings without compensation for their travel costs or their time and this fund would address that fact.

The report covers a period through December 2018 and does not include significant legislative accomplishments from the 2019 session. These include House Bill 1166, a bipartisan bill sponsored by Representative Orwall and Representative Mosbrucker, which will help preserve untested sexual assault kits for future testing and extend the work of the legislative task force on sexual assault forensic examinations. Another achievement was House Bill 1016, sponsored by Representative Caldier, which requires hospitals who do not perform sexual assault evidence kit collection to coordinate care with the local rape crisis center and assist the patient to find a facility with a trained provider. The policy advanced by House Bill 1016 aligns with, and implements, one of the key report recommendations.

Despite significant policy advances achieved this session we recognize that there is much work to do before we will achieve the goal of ensuring that all survivors of sexual assault have access to trained providers and a pathway to protecting their rights. We look forward to collaborating

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with policy leaders and stakeholders to advocate for the resources and programs to achieve that goal.

Sincerely,

A handwritten signature in blue ink that reads "Lisa J. Brown". The signature is written in a cursive style with a large, prominent "L" and "B".

Lisa Brown

Director



Department of Commerce

Sexual Assault Response

*Increasing Sexual Assault Nurse Examiner Availability
and Access Statewide
Pursuant to Chapter 88, Laws of 2018*

October 2019
Report to the Legislature
Lisa Brown, Director

Acknowledgements

Washington State Department of Commerce

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Executive Summary

Sexual Assault Nurse Examiners – Availability (Chapter 88, Laws 2018) required the Department of Commerce (Commerce) Office of Crime Victims Advocacy (OCVA) to:

“Develop best practices that local communities may use on a voluntary basis to create more access to sexual assault nurse examiners, including, but not limited to, partnerships to serve multiple facilities, mobile sexual nurse examiner teams, and multidisciplinary teams to serve sexual assault survivors in local communities. ... [It will] publish them on its web site. ...

“[It will] develop strategies to make sexual assault nurse examiner training available to nurses in all regions of the state without requiring the nurses to travel unreasonable distances or incur unreasonable expense ... the office of crime victims advocacy shall report the strategies to the governor and the appropriate committees of the legislature.”

In addition to the above required materials, this report includes a discussion of the principles, terminology and practices of sexual assault response in Washington to shed greater light on the topic and what can be done to improve it.

Recommended Best Practices

Commerce’s recommended best practices for providing examinations to adults, adolescents and pediatric patients who have experienced sexual assault can be found on the OCVA website¹ and in the report appendices. OCVA also developed best practices for creating, maintaining and sustaining sexual assault response teams (SARTs), multidisciplinary teams (MDTs) and partnerships to serve multiple facilities.

An important finding of this report is that no states employ “mobile” sexual assault nurse examiner (SANE) teams. This report, and a study conducted by the West Virginia Foundation for Rape Information and Services, found that no such model exists in practice and the idea is operationally impractical (see “[What Is a Mobile Team?](#)”).² Local communities looking to make SANEs more mobile can review the Commerce best practices for partnerships among multiple facilities.

¹ Washington State Department of Commerce, *Sexual Assault Response Best Practices*, <https://www.commerce.wa.gov/serving-communities/crime-victims-public-safety/office-of-crime-victims-advocacy/creating-access-to-sexual-assault-nurse-examiners-best-practices-for-local-communities/>

² West Virginia Foundation for Rape Information and Services, Mobile SANE Project Report, <http://fris.org/Resources/PDFs/Books/SANEMobile-Final.pdf>

Recommended Training Strategies

Commerce recommends a SANE training program and scholarship fund be created and that an established, experienced organization administer both. Investing in an existing program with expertise and extensive experience providing SANE trainings across Washington would standardize the methods medical staff use to perform sexual assault examinations.

Washington currently has a statewide program that offers specialized SANE trainings that align with the International Association of Forensic Nurses Education Guidelines and the Department of Justice's Office on Violence Against Women Act National Training Standards for Sexual Assault Medical Forensic Examiners Program.

Through this provider, SANE trainings are provided in both rural and urban areas across Washington. These trainings do not have a robust or reliable source of funding. They are paid for through federal grants and are free for attendees. However, trainings do not always occur in the municipality in which a nurse works. Consequently, nurses often incur travel-related costs to attend trainings. Medical staff surveyed for this report indicated their employing hospitals do not routinely compensate them for time spent traveling to and attending trainings.

The proposed scholarship and training fund would allow trainings to be provided more frequently, add a clinical skills lab training to Washington's statewide training program and offer scholarships to reimburse nurses for travel-related expenses.

Further Recommendations

Improving patient access to sexual assault nurse examiners is not only about training nurses. It is also about state and local community response to sexual assault as a whole. To improve sexual assault response across the state, Commerce recommends the Legislature take the steps outlined below.

Establish a State Sexual Assault Response Team (SART) Technical Assistant

Commerce recommends the Legislature fund a statewide SART technical assistant who would be associated with an established organization that has extensive experience and expertise in sexual assault response. This assistant would help local communities:

- Create, maintain and enhance SARTs
- Track the development of SARTs statewide
- Disseminate sexual assault response best practices and resources
- Report on sexual assault response across the state

Support Greater Coordination Between the Crime Victims Compensation Program (CVCP) and Hospitals

Commerce recommends increasing funding for CVCP so it can hire additional staff and conduct outreach and education about CVCP. Additional staff and funding would also help CVCP ensure victims never have to cover exam costs and that out-of-state jurisdictions cover exam costs when applicable.

Mandate That Every Hospital Have a Response

It is the position of Commerce that not every hospital in Washington needs to have a SANE program. However, every hospital should have a coordinated, victim-centered response plan.

Commerce recommends requiring every hospital to have a response plan that aligns with the best practices suggested in this report to ensure an advocate is promptly contacted no matter where a patient presents. If a hospital does not have SANEs on staff or on call, they should be prepared to refer and help transport a patient, with the assistance of an advocate, to the nearest hospital offering SANE-conducted medical forensic exams.

Explore Opportunities to Build New Partnerships

In addition to establishing a scholarship and training fund to expand access to the existing SANE program, Commerce would like to explore opportunities to allow a standardized statewide curriculum to be delivered by additional providers, through alternative modes of delivery. Establishing a standardized curriculum would require extensive stakeholder collaboration on several issues including SANE certification, ongoing training and experience requirements, education standards, exam guidelines, and the role of sexual assault advocates. This approach would require additional investment. Given the current constraints on SANE funding such an approach would be best justified if the state and alternate providers were able to leverage state and non-state funds to help cover the additional costs that would be incurred, in developing new training delivery models and building consensus around a standard statewide curriculum.

Introduction

In 2018, the Legislature charged Commerce’s Office of Crime Victims Advocacy (OCVA) with studying sexual assault nurse examiner practices, access and opportunities for improvement to best meet victim and forensic needs.

For the purposes of this report, sexual assault is defined as a violation of human rights and a person’s sovereignty over his, her or their body.³

The consequences of sexual assault are far-reaching. This section briefly discusses:

- National and state rates of occurrence
- Financial impacts of sexual assault
- The gap between best practices and actual responses to sexual assault
- What has and is being done to improve response in Washington
- Underlying principles that frame the report’s analysis and recommendations

Prevalence and Cost of Sexual Assault

Sexual assault is a violation of human rights and a person’s sovereignty over his, her or their body.⁴

In Washington:

- 45 percent of women and 22 percent of men experience sexual violence at some time in their lives⁵
- 18 percent of women and 8 percent of men experience attempted or completed vaginal, oral or anal penetration through the use of force or threats of physical harm⁶
- The National Intimate Partner and Sexual Violence survey has neither national nor state data for transgender or gender nonconforming people who have been victims of sexual assault.⁷

³ United Nations, “Universal Declaration of Human Rights,” Article 3, (1948), <http://www.un.org/en/universal-declaration-human-rights/>

⁴ Ibid.

⁵ Sexual violence includes rape, being made to penetrate someone else, sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences such as harassment and flashing.

⁶ Centers for Disease Control, “The National Intimate Partner and Sexual Violence Survey — 2010-2012 State Report,” (2017), <https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf>

⁷ Centers for Disease Control, “The National Intimate Partner and Sexual Violence Survey — Key Terms and FAQs (2017),” https://www.cdc.gov/violenceprevention/datasources/nisvs/FAQ.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fnisvs%2FFAQ.html

Sexual assault also has financial impacts. Nationally, the estimated lifetime cost of rape is \$122,461 per victim.⁸ This calculation is based on the total physical and mental health costs, productivity losses, criminal justice costs, and other costs (such as property loss or damage) that follow from rape. It does not include financial costs to family members or any monetized quantification of a victim's pain or suffering.⁹

Responding to a Sexual Assault

According to best practices developed for this report, a victim of sexual assault should be triaged as high priority as soon as he, she or they arrive at a hospital. The patient should be provided a private room to await a sexual assault advocate and trained sexual assault nurse examiner (SANE), both of whom hospital staff should contact immediately. The advocate and SANE should arrive within an hour. After discussing a patient's options and needs, the SANE should administer a forensic exam and ensure all medical concerns are addressed.

If an adult victim elects to report the incident to law enforcement, the SANE and advocate should work with law enforcement, prosecutors and crime lab staff to ensure proper procedures are followed to initiate prosecution proceedings. If the victim is younger than age 18, the crime must be reported to law enforcement, which should launch a criminal investigation in accordance with the county's sexual abuse protocol.¹⁰

Coordinated, multidisciplinary sexual assault responses, like the one described above, have been shown to offer victims prompt, compassionate and comprehensive medical care as well as better medical and legal outcomes, which could help mitigate the physical, financial and

⁸ Cora Peterson, DeGue S., Florence C., and Lokey C., "Lifetime Economic Burden of Rape Among U.S. Adults," *American Journal of Preventative Medicine*, Volume 52, no. 6, (2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5438753/>

⁹ Ibid.

¹⁰ See Appendix D.

psychological costs of an assault.¹¹ However, quality responses do not occur consistently in Washington or the U.S.¹²

¹¹ Ericksen et al, "Clients' Experiences with a Specialized Sexual Assault Service," *Journal of Emergency Nursing* Volume 28, no. 1 (2002), <https://www.sciencedirect.com/science/article/pii/S0099176702210430>

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https://www.researchgate.net/publication/7549172_The_Effectiveness_of_Sexual_Assault_Nurse_Examiner_SANE_Programs_A_Review_of_Psychological_Medical_Legal_and_Community_Outcomes

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<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.360.4500&rep=rep1&type=pdf>

Giannina Fehler-Cabral, Campbell R., and Patterson D., "Adult Sexual Assault Survivors' Experiences with Sexual Assault Nurse Examiners (SANEs)," *Journal of Interpersonal Violence*, Volume 26, no. 18, (2011),

<https://www.ncbi.nlm.nih.gov/pubmed/21602203>

Kirsten Bechtel, Ryan E., and Gallagher D., "Impact of Sexual Assault Nurse Examiners on the Evolution of Sexual Assault in a Pediatric Emergency Department," *Pediatric Emergency Care*, Volume 24, no. 7, (2008),

https://www.researchgate.net/publication/5274914_Impact_of_Sexual_Assault_Nurse_Examiners_on_the_Evaluation_of_Sexual_Assault_in_a_Pediatric_Emergency_Department

Rebecca Campbell, Patterson D., Bybee D., and Dworkin E., "Predicting Sexual Assault Prosecution Outcomes: The Role of Medical Forensic Evidence Collected by Sexual Assault Nurse Examiners," *Criminal Justice and Behavior*, Volume 36, no. 7, (2009),

https://www.researchgate.net/publication/247745026_Predicting_Sexual_Assault_Prosecution_Outcomes_The_Role_of_Medical_Forensic_Evidence_Collected_by_Sexual_Assault_Nurse_Examiners

Rebecca Campbell, Patterson D., and Fehler-Cabral G., "Using Ecological Theory to Evaluate the Effectiveness of an Indigenous Community Intervention: A Study of Sexual Assault Nurse Examiner (SANE) Programs," *American Journal of Community Psychology*, Volume 46, no. 4, (2010), <https://www.ncbi.nlm.nih.gov/pubmed/20853158>

Janice Du Mont and Parnis D., "Forensic Nursing in the Context of Sexual Assault: Comparing the Opinions and Practices of Nurse Examiners and Nurses," *Applied Nursing Research*, Volume 16, no. 3, (2003),

<https://www.sciencedirect.com/science/article/pii/S0897189703000442>

Rebecca Campbell, Bybee D., Kelley, K., and Patterson D., "The Impact of Sexual Assault Nurse Examiner (SANE) Program Services on Law Enforcement Investigational Practices," *Criminal Justice and Behavior*, Volume 39, no. 2, (2012),

https://www.researchgate.net/publication/241645193_The_Impact_of_Sexual_Assault_Nurse_Examiner_SANE_Program_Services_on_Law_Enforcement_Investigational_Practices

Rebecca Campbell, Patterson D., and Bybee D. "Prosecution of Adult Sexual Assault Cases: A Longitudinal Analysis of the Impact of a Sexual Assault Nurse Examiner Program," *Violence Against Women*, Volume 18, no. 2, (2012),

<https://www.ncbi.nlm.nih.gov/pubmed/22433229>

F. Derhammer, Lucente V., Reed JF III, and Young MJ, "Using a SANE Interdisciplinary Approach to Care of Sexual Assault Victims," *The Joint Commission Journal on Quality and Patient Safety*, Volume 26, no. 8, (2000), <https://www.ncbi.nlm.nih.gov/pubmed/10934639>

¹² U.S. Government Accountability Office, "Information on Training, Funding, and the Availability of Forensic Examiners," <https://www.gao.gov/assets/680/675879.pdf>

Washington Coalition of Sexual Assault Programs, "Medical Advocacy State Assessment Summary 2013," (2013), http://www.wcsap.org/sites/default/files/uploads/working_with_survivors/advocacy/Medical_Advocacy_State_Assessment_Summary_2013.pdf

As is the case nationally, victims of sexual assault in Washington often experience long waits in busy emergency rooms and examinations by staff who are either untrained or inadequately trained.¹³ Sometimes a victim might not receive an exam at all despite going to a hospital.

Reasons can include that the hospital:

- Does not provide forensic exams
- Does not have an established procedure for contacting an advocate
- Does not have a plan to help the patient reach the nearest SANE-staffed hospital

In contrast, if a patient receives an exam from a medical provider who lacks formal SANE training, the exam might be improperly administered, which could jeopardize medical and legal outcomes and retraumatize the patient.¹⁴

Sexual Assault Response: Legislative History

In recent years, the Legislature, state agencies, nonprofits, local communities and key stakeholders have taken important steps to improve sexual assault responses across the state.

Recent laws related to sexual assault response include:

- **Sexual Assault Nurse Examiners — Availability** (Chapter 88, Laws of 2018) directed Commerce to conduct this study.
- **Student Sexual Abuse Prevention Curriculum (Chapter 64, Laws of 2018)** established a curriculum for the prevention of sexual abuse of students.
- **Child Forensic Interviews — Privacy (Chapter 171, Laws of 2018)** exempted forensic interviews of child victims from public disclosure requirements.
- **Sexual Assault Nurse Examiners — Availability Study (Chapter 50, Laws of 2016)** commissioned the 2016 report produced by Commerce: “Sexual Assault Nurse Examiners – Study of Sexual Assault Nurse Examiner Availability, Adequacy, Costs, and Training.”¹⁵
- **Sexual Assault — Examination Kits (Chapter 247, Laws of 2015)** established the Washington State Sexual Assault Forensic Examination Best Practices Task Force (SAFE) and a process for prioritizing sexual assault kits for testing.
- **Sexual Assault Kits — Tracking and Donations for Testing (Chapter 173, Laws of 2015)** developed a sexual assault kit (SAK) tracking system, making Washington the first state in the U.S. to do so.
- **Protection Orders — Sexual Assault (Chapter 74, Laws of 2013)** established sexual assault protection orders.

¹³ Ibid.

¹⁴ Sievers et al, “Sexual Assault Evidence Collection”

Campbell and Wasco, “Understanding Rape and Sexual Assault: 20 Years of Progress and Future Directions”

Du Mont and Parnis, “Forensic Nursing in the Context of Sexual Assault”

Linda Hutson, “Development of Sexual Assault Nurse Examiner Programs,” *Nursing Clinics of North America*, Volume 37, no. 1, (2002), <https://www.sciencedirect.com/science/article/abs/pii/S0029646503000847>

¹⁵ Washington State Department of Commerce, “Sexual Assault Nurse Examiners”

- **Child Abuse Investigations (Chapter 389, Laws of 1999)** mandated counties have written protocols for handling criminal investigations involving the sexual abuse of a child.

The Office of Crime Victims Advocacy (OCVA) uses state and federal funds to support:

- 36 accredited Community Sexual Assault Programs (CSAPs) serving every county in the state
- 26 specialized and culturally specific programs to support advocacy and sexual assault prevention
- 21 Children’s Advocacy Centers (CACs)
- Seven SANE programs, which provide medical forensic examinations

OCVA proactively works with the:

- Harborview Center for Sexual Assault and Traumatic Stress to train SANEs
- Washington Coalition of Sexual Assault Programs (WCSAP) to offer training and technical assistance to advocates
- Washington State Department of Health (DOH) to provide rape prevention and education (RPE) funds to local programs
- Department of Corrections (DOC) to provide inmates with sexual assault services, including forensic exams and a sexual assault hotline
- Children’s Advocacy Centers of Washington (CACWA) on child neglect, abuse and sexual assault
- Crime Victims Compensation Program (CVCP) on sexual assault exam compensation and related issues

Other statewide sexual assault response-related efforts include, but are not limited to, the following:

- In 2017, the Attorney General’s Office started using U.S. Department of Justice (DOJ) funds to support sexual assault kit (SAK) testing and tracking.¹⁶
- In 2017, the Washington State Patrol started using DOJ funding to reduce the state’s SAK backlog.¹⁷

Additionally, members of Washington’s congressional delegation are also writing, sponsoring and supporting the Survivors’ Access to Supportive Care Act to:

- Strengthen the sexual assault examiner workforce by evaluating state needs
- Develop and test national standards of care for survivors of sexual assault
- Increase understanding of and access to sexual assault care nationwide

¹⁶ U.S. Department of Justice, Office of Justice Programs, “Department of Justice Awards Nearly \$37 Million to Support Sexual Assault Kit Testing, Tracking, and Investigation,” (2017), <https://ojp.gov/newsroom/pressreleases/2017/ojp-news-10052017a.pdf>

¹⁷ National Institute of Justice, *NIJ Award Detail—Washington State Patrol Forensic DNA Initiative*, <https://www.nij.gov/funding/awards/pages/award-detail.aspx?award=2017-DN-BX-0092>

- Expand access to sexual assault nurse services, particularly for rural and tribal communities and institutions of higher education
- Create a new resource center to provide technical assistance to states and hospitals in providing care to survivors¹⁸

Positioning Washington as a Leader in Sexual Assault Response

This report builds on the work being done to make Washington state a leader in sexual assault response. Four principles guide its analysis:

Sexual assault response is an issue of both public health and criminal justice: It is important that patients receive adequate treatment for their physical and mental injuries, victims receive justice and perpetrators are prosecuted for their crimes.¹⁹

Sexual assault response should be victim-centered: Patients need to be treated in a caring, compassionate and respectful manner. For instance, patients need clear explanations about their medical and legal options from sexual assault advocates who specialize in supporting victims in making informed decisions. For child victims, non-offending family members and caregivers should also be briefed. Such victim-centered care “minimizes trauma, encourages further utilization of community resources, facilitates the criminal investigation and increases the likelihood of holding offenders accountable and preventing further assaults.”²⁰

Communities that best respond to sexual assault have Sexual Assault Response Teams (SARTs) and Multidisciplinary Teams (MDTs): A SART is a specialized, coordinated community response team that provides high-quality, victim-centered responses for adult, adolescent and child victims of sexual assault as well as their communities. It includes, but is not limited to, local law enforcement, advocates, SANEs and prosecutors. Qualitative and quantitative research demonstrates that these teams are best able to provide compassionate,

¹⁸ U.S. Senate Committee on Health, “Education, Labor & Pensions, Survivors’ Access to Supportive Care Act (SASCA),” (2018), <https://www.help.senate.gov/imo/media/doc/SASCA%202018%20Fact%20Sheet%20final.pdf>

¹⁹ D. Patterson, Campbell R., and Townsend S., “Sexual Assault Nurse Examiner (SANE) Program Goals and Patient Care Patients,” *Journal of Nursing Scholarship*, Volume 38, no. 2, (2006), <https://sigmapubs.onlinelibrary.wiley.com/doi/full/10.1111/j.1547-5069.2006.00098.x>

²⁰ U.S. Department of Justice, “A National Protocol for Sexual Assault Medical Forensic Examinations—Adults/Adolescents,” <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>

comprehensive, victim-centered, trauma-informed medical and legal services.²¹ MDTs serve child victims only and have been demonstrated to provide similar results.²²

Every sexual assault response should be a quality response: Victims should not have to worry that the quality of medical or legal services they receive could vary across the state. By extension, victims should not have to worry about law enforcement officials questioning their stories, hospitals failing to contact advocates immediately, prosecutors not properly preparing nurses to give testimony or nurses inadequately performing examinations and possibly re-traumatizing patients because the nurses were either untrained or inadequately trained. When it comes to forensic exams and medical care in particular, all sexual assault patients should be triaged within an hour of arriving at a SANE-staffed hospital and all exams should be conducted by medical staff who have undergone formal SANE training.²³ Sexual assault victims who arrive at hospitals that do not have SANEs on staff or on-call should be transferred to SANE-staffed hospitals with the assistance of advocates.

²¹ National Sexual Violence Research Center, “Sexual Assault Response Team (SART) Functioning and Effectiveness—Findings from the National SART Project,”

https://www.nsvrc.org/sites/default/files/publication_researchbrief_sexual-assault-response-team-functioning-effectiveness.pdf

National Sexual Violence Research Center, *Sexual Assault Response Team Toolkit*,

<https://www.nsvrc.org/sarts/toolkit>

Megan Greeson and Campbell R., “Sexual Assault Response Teams (SARTs): An Empirical Review of Their Effectiveness and Challenges to Successful Implementation,” *Trauma Violence Abuse*, Volume 14, no. 2, (2013),

<https://www.ncbi.nlm.nih.gov/pubmed/23271431>

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<https://www.sciencedirect.com/science/article/abs/pii/S0029646503000847>

²² James Leslie Herbert and Bromfield L., “Evidence for the Efficacy of the Child Advocacy Center Model: A Systematic Review,” *Trauma, Violence, & Abuse*, Volume 17, no. 3 (2015),

<http://journals.sagepub.com/doi/abs/10.1177/1524838015585319>

JoAnna Elmquist, Shorey, R. C., Febres, J., Zapor, H., Klostermann, K., Schratte, A., and Stuart, G. L., “A Review of Children’s Advocacy Centers’ (CACs) Response to Cases of Child Maltreatment in the United States.” *Aggression and Violent Behavior*, Volume 25, Part A, (2015),

<https://www.sciencedirect.com/science/article/pii/S1359178915000877?via%3Dihub>

Poonam Tavakar and Hansen D. J., “Interventions for Families Victimized by Child Sexual Abuse: Clinical Issues and Approaches for Child Advocacy Center-Based Services,” *Aggression & Violent Behavior*, Volume 16, no. 3, (2011),

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National Children’s Advocacy Center, “Children’s Testimony-Issues and Concerns—A Bibliography,” (2014),

https://www.nawj.org/uploads/pdf/conferences/2014/CLE/childrens_testimony_issues_and_concerns_ncac.pdf

²³ When the patient arrives, they should be acknowledged by reception in line with the best practices in this report. A SANE and advocate should be notified immediately. Ideally, they should arrive at the facility within an hour. Weather, rugged terrain, exceptionally long distances across rural parts of the state and rush-hour traffic may make a one hour response time improbable, if not impossible, in some cases. Consideration of such factors must be taken into account when judging if a response time longer than one hour was adequate or not.

Methodology

Overview

This report draws heavily on the collection and empirical analysis of local, state and national quantitative and qualitative data. More than 30 interviews were conducted with diverse stakeholders from across Washington and beyond to ensure the most comprehensive analysis possible given the finite resources of this project.

These interviews included but were not limited to:

- Association of Washington Cities
- Children’s Advocacy Centers of Washington
- Cowlitz Indian Tribe
- Harborview Center for Sexual Assault and Traumatic Stress
- Harrison Hospital
- International Association of Forensic Nurses
- King County Sexual Assault Resource Center
- Lutheran Community Services
- Mary Bridge Children’s Hospital and Health Center
- Massachusetts SANE Program
- Minnesota Coalition Against Sexual Violence
- National Telenursing Center
- Nursing Care and Quality Assurance Commission
- Oregon Sexual Assault Task Force
- Partners with Families and Children
- Providence Intervention for Assault & Abuse
- Providence St. Peter Hospital
- Rebuilding Hope
- Rural Resources
- Washington Association of Prosecuting Attorneys
- Washington Association of Sheriffs and Police Chiefs
- Washington Coalition of Sexual Assault Programs
- Washington State Association of Counties
- Washington State Nurses Association
- Washington State Crime Victims Compensation Program
- Washington State Department of Health
- Washington State Hospital Association
- Washington State Labor & Industries
- Washington State Office of the Attorney General
- Washington State Telemedicine Collaborative
- Washington State Hospital Association

Interviewees received open-ended questions focused on:

- Decision making processes that led to their communities’ written and unwritten response protocols.
- Resources they might have to support responses.
- Degree of coordination and collaboration in their responses.
- Formal and informal practices that go into their responses.
- Barriers to better responses in their communities.
- What is needed to overcome barriers to better responses.
- Recommendations for best practices for local communities.
- Recommendations for state policymakers.

Washington State Hospital Association (WHSA) and Harborview Center for Sexual Assault and Traumatic Stress survey findings were used to identify the number of trained sexual assault nurses performing examinations in the state.²⁴ The Washington State Nurses Association (WSNA) surveyed its members to provide information about the SANE profession. Children’s Advocacy Centers of Washington (CACWA) conducted a survey of its members to inform this report’s discussion of Children’s Advocacy Centers (CACs). National literature reviews and the 2016 “Sexual Assault Nurse Examiners — Study of Sexual Assault Nurse Examiner Availability, Adequacy, Costs, and Training” (2016 SANE Report)²⁵ supplemented these interviews and surveys.

Limitations

Data Gaps

As discussed in the 2016 SANE Report, data on sexual assault and sexual assault response are scarce and not uniformly tracked across the state or nation.²⁶ It was beyond the scope of this study to collect new data on the rate of sexual assault or the degree to which adequate responses are in place in every community across the state.

²⁴ In addition to collecting data on the number of “SANE-trained staff” at hospitals, the WHSA survey captured information on “vendor” and “other-trained staff” across the state. Since no definition was provided for these terms, it was up to each hospital to define them. This poses a number of methodological problems at a granular level of analysis, as it cannot be said how each hospital determined who was or was not a “SANE-trained staff” or an “other-trained staff.” More broadly, it is clear that hospitals are making a distinction between “SANE-trained staff” and “other-trained staff.” WHSA’s survey results match this report’s qualitative findings, reinforcing their validity, assuming that “SANE-trained staff” can be loosely defined as professionally trained SANEs and “other-trained staff” refers to nurses who have not received formal SANE training but rather a short (probably one-hour) informal, ad-hoc tutorial of a sexual assault kit by a trained SANE at a particular hospital, something that has been widely documented to be a common, problematic, and potentially trauma-inflicting practice in communities reporting a large number of “other-trained staff.” While it is noted that there are a number of methodological issues that prevent some conclusions from being drawn from WHSA’s survey results, the trends drawn from it match the qualitative data collected in this report; hence, the inclusion of the survey’s findings.

²⁵ Washington State Department of Commerce, “Sexual Assault Nurse Examiners”

²⁶ Ibid.

U.S. Department of Justice, “A National Protocol for Sexual Assault Medical Forensic Examinations”

Nevertheless, it can be said with a high degree of confidence that the interviews and surveys conducted for this report provide an ample sampling of variations and outcomes of sexual assault responses from every region of the state. They also represent the best means of overcoming data gaps given the finite resources of this project.

Lack of Standardized Terminology for Sexual Assault Response

No standardized terminology for sexual assault response exists. Rather, a variety of terms are frequently used to describe the various aspects of sexual assault response. In many instances, terms are misleading or left undefined.

To address the absence of standardized terminology, report authors scrutinized terms carefully throughout the research process and created a standard terminology (see this report's "[Sexual Assault Response and Its Terminology](#)" section).

Sexual Assault Kits and Investigatory and Prosecutorial Aspects of a Response

Sexual assault kits (SAKs), the medical kits used to collect biological evidence during sexual assault forensic examinations, are a critical part of any sexual assault response. However, the issues related to the availability, tracking and storage of these kits is beyond the scope of this report and are, therefore, not discussed.²⁷ Similarly, the investigatory and prosecutorial aspects of a response, while important, are not the focus of this report and are, therefore, not discussed.

²⁷ Sexual-assault-forensic-evidence-kit specific work is currently being undertaken by the Washington State Attorney General's Office, the results of which will be important for ensuring that forensic examinations translate into positive legal outcomes for sexual assault victims.

Sexual Assault Response and Its Terminology

Sexual assault response is a relatively new concept that emerged in a fragmented, ad-hoc fashion over the past several decades. As a result, no standardized terminology exists.

This section introduces one to encourage clarity and understanding about sexual assault response. It concludes with a discussion of sexual assault response in Washington and the factors that influence it. The information contained in this section serves as the basis for this report's policy recommendations.

What Is Sexual Assault Response?

Sexual assault response refers to the short- and long-term medical and legal services that victims of sexual assault commonly need to receive justice and realize mentally and physically healthy lives as they define them. This includes but is not limited to:

- Information and referral services
- Emergency medical care
- Forensic evidence collection
- Sexual assault kit processing
- Legal accompaniment
- Long-term advocacy services that further support holistic healing and empowerment²⁸

SANE, P-SANE, IAFN-Certified SANE, and Other-Trained or Untrained Staff

A SANE is a medical staff member who has been formally trained to provide sexual assault forensic examinations and continues to demonstrate competency through continued training or practice.

A medical staff member trained to work with child victims is a pediatric SANE (P-SANE).²⁹

An IAFN-certified SANE is a nurse who has received an International Association of Forensic Nurses (IAFN) certification. IAFN training costs \$500 per person. Certification requires completing the IAFN certification exam, which costs between \$325 and \$575. Recertification costs between \$325 and \$575 per recertification.

An "other-trained" or untrained medical staff is a medical staff member who has not undergone formal sexual assault forensic examination training but is nevertheless tasked with performing medical forensic exams.

SANEs are crucial for ensuring sexual assault patients receive appropriate medical care and legal outcomes. Substantial quantitative and qualitative evidence show SANEs provide patients

²⁸ National Sexual Violence Resource Center, "Sexual Assault Demonstrative Initiative," (2017), <https://www.nsvrc.org/sites/default/files/2017-09/sadi-finalreportfinal508.pdf>

²⁹ Unless otherwise noted, when this report speaks of SANEs, it refers to P-SANEs as well.

with better medical-legal outcomes than untrained nurses.³⁰ SANEs have also been shown to provide more compassionate, victim-centered care and more accurate and complete forensic examinations than other medical staff, leading to increased prosecution rates of assailants.³¹

During the course of this study, no evidence was found that IAFN-certified SANEs provided better medical services than SANEs or that IAFN-certification translated into better legal outcomes.

³⁰ Ericksen et al, "Clients' Experiences"

Campbell et al, "The Effectiveness of Sexual Assault Nurse Examiner (SANE) Programs"

Campbell and Wasco, "Understanding Rape and Sexual Assault"

Du Mont and Parnis, "Forensic Nursing in the Context of Sexual Assault"

³¹ Rebecca Campbell, Greeson M., Fehler-Cabral G., "With Care and Compassion: Adolescent Sexual Assault Victims' Experiences in Sexual Assault Nurse Examiner Programs," *Journal in Forensic Nursing*, Volume 9, no. 2, (2013),

https://www.researchgate.net/publication/258043280_With_Care_and_Compassion_Adolescent_Sexual_Assault_Victims%27_Experiences_in_Sexual_Assault_Nurse_Examiner_Programs

Hutson, "Development of Sexual Assault Nurse Examiner Programs"

Gail Hornor, Thackeray J., Scribano P., Benzinger E., "Pediatric Sexual Assault Nurse Examiner Care: Trace Forensic Evidence, Ano-Genital Injury, and Judicial Outcomes," *Journal of Forensic Nurses*, Volume 8, no. 3 (2012),

<https://www.ncbi.nlm.nih.gov/pubmed/22925125>

Sievers et al, "Sexual Assault Evidence Collection"

Fanfik et al, "Testing the Efficacy of SANE/SART Programs: Do They Make A Difference in Sexual Assault Arrest & Prosecution Outcomes," *National Criminal Justice Reference Service*, (2006),

<https://www.ncjrs.gov/pdffiles1/nij/grants/214252.pdf>

Rebecca Campbell, Bybee D., Ford K., Patterson D., "Systems Change Analysis of SANE Programs: Identifying the Mediating Mechanisms of Criminal Justice System Impact," *National Criminal Justice Reference Service*, (2005),

<https://www.ncjrs.gov/pdffiles1/nij/grants/226498.pdf>

Campbell et al, "The Impact of Sexual Assault Nurse Examiner (SANE) Program Services"

Campbell et al, "Prosecution of Adult Sexual Assault Cases"

U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, "Increasing Sexual Assault Prosecution Rates," (2009), <https://www.ncjrs.gov/pdffiles1/nij/228384.pdf>

Campbell et al, "Sexual Assault Nurse Examiners' Experiences Providing Expert Witness Court Testimony," *Journal of Forensic Nursing*, Volume 3, no. 1, (2007), <https://www.ncbi.nlm.nih.gov/pubmed/17479561>

Campbell et al, "Predicting Sexual Assault Prosecution Outcomes"

Sexual Assault Response Team (SART)

A Sexual Assault Response Team (SART) is a professional, coordinated community response team that provides prompt, coordinated medical and legal services to victims of sexual assault. Their memberships often vary from one jurisdiction to another.³² However, nearly all include representatives from the groups described below.

Law Enforcement

If victims do not contact advocates or go to hospitals first, law enforcement might be their first point of contact. In such cases, law enforcement is responsible for treating victims in a dignified manner and getting them to the closest SANE-staffed hospitals. Law enforcement also secures evidence from crime scenes. Officers might continue to carry out investigative activities, such as interviewing suspects and witnesses, if the victims choose to go forward with a case against their assailants. Throughout this process, investigative information is reported to SART members.

Advocates

Advocates serve many roles on a SART. Primarily, they serve as the main point of contact for victims from the time the crimes are reported to law enforcement or hospital staff. Community-based advocates provide confidential services and support to victims of all ages for as long as they need assistance. This could take the forms of phone calls on 24-hour hotlines, hospital visits and long-term assistance. In all cases, advocates empower patients by providing them with the information they need to make informed decisions.³³

In Washington, 62 community-based sexual assault programs, local governments and tribes provide advocacy services and conduct primary prevention activities.³⁴ Their efforts are supported and strengthened by the presence of the Washington Coalition of Sexual Assault Programs (see [“What Nongovernmental, Statewide Institutions Support the Development and Maintenance of Sexual Assault Response\(s\) Across Washington?”](#)).

Sexual Assault Nurse Examiners (SANEs)

SANEs provide immediate medical care, conduct forensic examinations and serve as expert witnesses if cases go to court. Medical care can include responding to injuries, providing

³² Courtney Ahrens, Campbell R., Wasco S. and Aponte G., “Sexual Assault Nurse Examiner (SANE) Programs: Alternative Systems for Service Delivery for Sexual Assault Victims,” *Journal of Interpersonal Violence*, Volume 15, no. 9, (2000), https://www.researchgate.net/publication/238432363_Sexual_Assault_Nurse_Examiner_SANE_ProgramsAlternative_Systems_for_Service_Delivery_for_Sexual_Assault_Victims

National Sexual Violence Resource Center, “Report on the National Needs Assessment of Sexual Assault Response Teams,” (2012), https://www.nsvrc.org/sites/default/files/2012-03/Publications_NSVRC_Reports_Report-on-the-National-Needs-Assessment-of-SARTs.pdf

Campbell et al, “Organizational Characteristics of Sexual Assault Nurse Examiner Programs: Results from the National Survey Project,” *Journal of Forensic Nurses*, Volume 1, no. 2, (2005), <https://www.ncbi.nlm.nih.gov/pubmed/17089484>

³³ National Sexual Violence Center, “Sexual Assault Response Team (SART) Functioning and Effectiveness”

³⁴ Primary prevention refers to efforts to prevent rape from happening.

emergency contraceptives and offering measures to address any sexually transmitted infections.³⁵ A forensic examination requires the skilled use of a 68-piece sexual assault kit.

Collected evidence can be used to potentially identify and prosecute perpetrators of sexual assault.³⁶ If a case goes to court, the SANE is called to testify and is often cross-examined about the forensic examination process.³⁷ It is important to note that nearly all SANEs have primary responsibilities as registered or advanced practice nurses at their respective facilities.

Crime Lab Specialists

Crime lab specialists analyze SAKs and provide the results to law enforcement. Even though they are typically not part of the day-to-day operation of SARTs, crime lab specialists are crucial to their mission. Therefore, it is critical that points of contact are established between SARTs and crime lab specialists.

Prosecutors

Prosecutors prosecute cases when sufficient evidence exists to do so. They work closely with the rest of the team to ensure all evidence has been collected and each member is properly prepared to testify on behalf of the victim.

How Do SART Members Collaborate?

Collaboration and coordination among SART members typically take place at regularly scheduled meetings. These meetings enable members to exchange information, build relationships and solve problems related to their community's sexual assault responses and individual patient cases.

These meetings often improve contact, and thus relationships, among members, leading to better outcomes for patients and communities.³⁸ However, when roles and responsibilities are

³⁵ U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, "SANE Development and Operation Guide," https://www.ncjrs.gov/ovc_archives/reports/saneguide.pdf

³⁶ Ibid.

³⁷ Ibid.

³⁸ Christopher Mallios, Markowitz J., "Benefits of a Coordinated Community Response to Sexual Violence," *AEquitas*, (2011), <https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=266119>

U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, *SANE Program and Operation Guide*, <https://www.ovctac.gov/saneguide/>

Jennifer Cole and Logan T.K., "Negotiating the Challenges of Multidisciplinary Responses to Sexual Assault Victims: Sexual Assault Nurse Examiner and Victim Advocacy Programs," *Research in Nursing & Health*, Volume 31, no. 1, (2007), <https://www.ncbi.nlm.nih.gov/pubmed/18163392>

TK Logan, Cole J., and Capillo A., "Sexual Assault Nurse Examiner Program Characteristics, Barriers, and Lessons Learned," *Journal of Forensic Nursing*, Volume 3, no. 1, (2008), <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1939-3938.2007.tb00089.x>

not clear, tensions can emerge and frustrate progress.³⁹ Therefore, all members need to clearly understand their own and others' roles and responsibilities from the outset.⁴⁰

What Is a SANE Program, and How Does It Differ from a SART?

These two terms are often used interchangeably. However, they are different. A SANE program refers to a hospital's unit of SANEs. In contrast, a SART is a coordinated community response team that includes both SANEs and other local professionals (see "[Sexual Assault Response Team](#)"). A hospital may offer a SANE program but, if it is not connected to a communitywide response, it will most likely not provide the benefits that a coordinated, multidisciplinary SART might.

What Is a Multidisciplinary Team (MDT), and How Does It Differ from a SART?

MDTs and SARTs are both multidisciplinary teams and are often confused for one another. MDTs are specific to Children's Advocacy Centers (CACs) (see "[Children's Advocacy Centers](#)"). They focus on child sexual assault, physical abuse and neglect. Hence, their scope is narrower than a SART, in terms of their sole focus on children, but broader because they address physical abuse and neglect in addition to sexual assault.

All efforts should be made to avoid duplicating work between MDTs and SARTs. For instance, some communities adopt shared meetings, with the first half being for child-specific cases and the second for adult and adolescent cases. In some communities, SARTs and MDTs are incorporated as one unit that treats adults, adolescents and children.

What Does Access to Quality Sexual Assault Response Mean?

Access to quality response means the following:

- A patient should be triaged within an hour
- A formally trained SANE should conduct every sexual assault-related exam⁴¹
- When a patient arrives at a hospital, a SANE and advocate should be notified immediately. For a hospital with no SANE on staff or on-call, a patient should be swiftly notified and transferred to a SANE-staffed hospital with the assistance of an advocate
- An advocate should be available to assist the patient before, during and after an examination

What Is the Hub-and-Spoke Model of Sexual Assault Response?

There are two types of hub-and-spoke models:

1. Centralized dispatch model

³⁹ Greeson and Campbell, "Sexual Assault Response Teams"

Shana Maier, "Sexual Assault Nurse Examiners' Perceptions of Their Relationship with Doctors, Rape Victim Advocates, Police, and Prosecutors," *Journal of Interpersonal Violence*, Volume 27, no. 7, (2011), https://www.researchgate.net/publication/51895780_Sexual_Assault_Nurse_Examiners'_Perceptions_of_Their_Relationship_With_Doctors_Rape_Victim_Advocates_Police_and_Prosecutors

⁴⁰ National Sexual Violence Center, *Sexual Assault Response Team Toolkit*, <https://www.nsvrc.org/sarts/toolkit>

⁴¹ See footnote 18

2. Centralized transfer model

A centralized dispatch model of sexual assault response ([Figure 1](#)) describes when SANEs are housed at a central location — the hub — and then dispatched to partner hospitals — the spokes — to assist patients who arrive at those hospitals. This keeps all SANEs under one roof and enables partner hospitals to avoid administrative costs associated with keeping SANEs on staff. The hub often serves as the convening point for the local SART.

This model frees up resources for the hospitals that serve as spokes and also offers consistent, well-established responses and improved accessibility for SART members. It is important to note that the hub need not be a hospital; for instance, it could be an advocacy center.

The Harborview Center for Sexual Assault and Traumatic Stress typifies the centralized dispatch hub-and-spoke model. Harborview keeps two SANEs on-call at all times, and it dispatches SANEs to partner hospitals when victims arrive there. The expectation is that a patient should not have to wait more than an hour for a SANE. Built into the contracts between Harborview and its partners are provisions regarding the coordination of advocacy services, storage and processing of sexual assault kits, and other resources involved in ensuring a response to an assault.

Figure 1: Centralized Dispatch Model

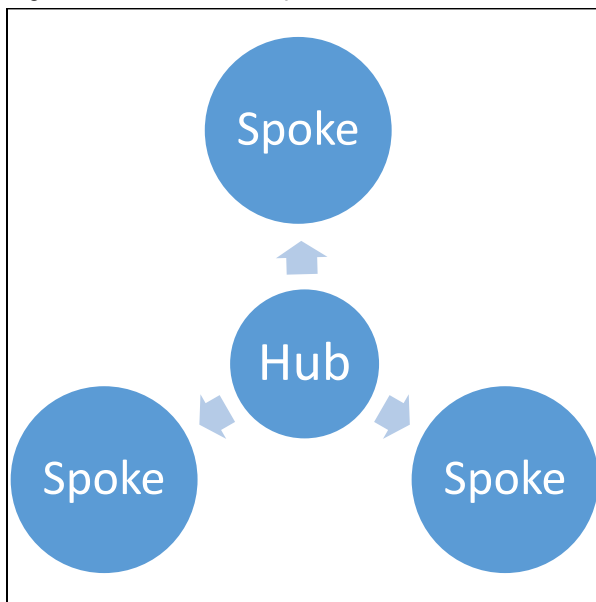
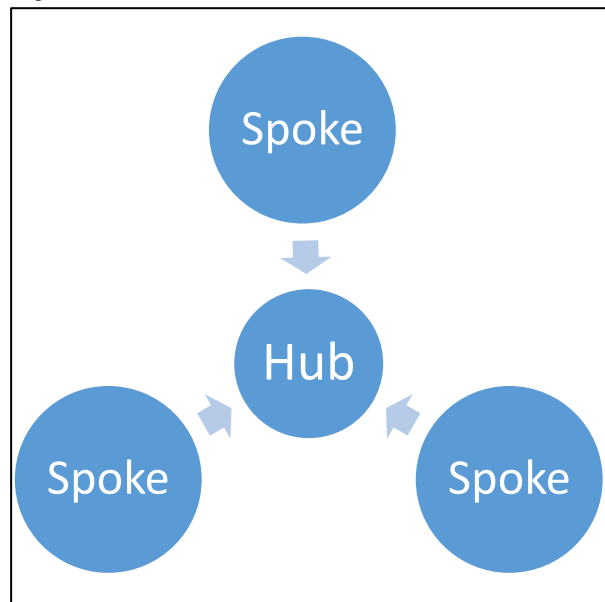


Figure 2: Centralized Transfer Model



The centralized transfer model refers to a hub-and-spoke system where patients who arrive at the spokes are transported to the hub to receive emergency medical care ([Figure 2](#)). Generally speaking, it offers the same systemic benefits of the centralized dispatch model except the patient goes to the SANE rather than vice versa. For the hospitals that serve as the spokes in this model, it has the additional benefit of not requiring them to store and make readily available exam supplies, since the exams will be taking place at the hub, not the spokes.

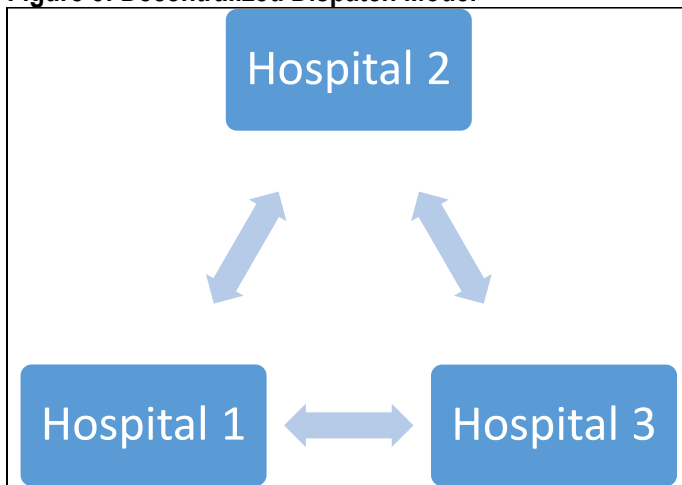
Providence St. Peter’s Sexual Assault Clinic and Child Maltreatment Center in Olympia serves as an example of the centralized transfer model. Providence St. Peter’s keeps SANEs on-call 24/7 and serves the residents of Thurston, Lewis, Mason, Grays Harbor and Pacific counties. SART meetings among local stakeholders are convened at the end of every week. St. Peter’s also dispatches nurses to Providence Centralia and Joint Base Lewis-McChord as needed for adult and adolescent exams.

What Is the Hubless, or Decentralized, Dispatch Model of Sexual Assault Response?

A hubless, or decentralized, dispatch model does not have a central location from which SANEs are dispatched ([Figure 3](#)). Rather, a collection of hospitals form partnerships to ensure 24/7 access to SANE services. When a patient arrives, a SANE is dispatched from whichever hospital has a SANE on-call at that time. This allows full access to SANE services without every hospital having to staff SANEs 24/7.

The challenge of this model is that it requires extensive coordination and collaboration among hospitals. Nevertheless, for some communities, particularly rural ones, this report concludes it might be the best model for ensuring 24/7 access. It might also enable SANEs at low-volume hospitals to maintain their skills and hours of practice.

Figure 3: Decentralized Dispatch Model



What Is a Mobile Team?

This report recommends replacing the term “mobile team” with “hubless dispatch model,” or “decentralized dispatch model.” The term “mobile team” evokes the image of SANEs traversing the state or regions. This report, and a study conducted by the West Virginia Foundation for Rape Information and Services (FRIS), found that no such model exists in practice.⁴²

⁴² West Virginia Foundation for Rape Information and Services, Mobile SANE Project Report, <http://fris.org/Resources/PDFs/Books/SANEMobile-Final.pdf>

FRIS rejected the concept for the following reasons:

- Mobile exam unit would be too large and difficult to maneuver
- Lack of security for patients and SANEs in remote areas
- Inability to receive medical backup
- Privacy and confidentiality concerns of patients
- Difficulty responding to multiple incidents in a timely fashion
- Other practical concerns, such as ensuring supplies are stocked and records maintained⁴³

FRIS goes on to describe what this report terms the decentralized dispatch model. This report recommends abandoning the term and concept of “mobile team” and replacing it with “decentralized dispatch model.”

What Primary Factors Influence Access?

This report found that access to medical and legal services for sexual assault victims are primarily the result of the availability of resources and coordination of a response. Indicators of high levels of access to short- and long-term medical and legal services for victims in a community include but are not limited to:

- Number of SANEs
- Presence of 24/7 SANE programs
- Whether an advocate is notified at the time the patient arrives
- Presence of SARTs
- Presence of SARTs or MDTs with P-SANEs
- Response times within one hour of a patient arriving at a hospital
- Number of sexual assault kits available at local hospitals
- Incorporation of underserved populations in a community’s response
- Formalized partnerships or transfer agreements among hospitals in a community
- Memorandums of understanding (MOUs) or agreements among hospitals and CACs
- Whether a community and, in particular, its hospitals have adopted and implemented protocols or guidelines in line with best practices of this report

The absence of the above indicators suggests that a community is lacking in either resources or coordination, both of which are key to providing quality sexual assault responses.

What Nongovernmental Statewide Institutions Support the Development and Maintenance of Sexual Assault Response(s) Across Washington?

The nongovernmental statewide institutions that support the development and maintenance of sexual assault response across the state include but are not limited to:

⁴³ Ibid.

Harborview Center for Sexual Assault and Traumatic Stress

One of the first rape crisis centers in the United States, Harborview has provided forensic medical care, advocacy and mental health services to victims of sexual assault since the late 1970s. It has also offered sexual assault trainings to medical providers across Washington state since 1989.

Washington Coalition of Sexual Assault Programs (WCSAP)

Founded in 1979, WCSAP has a long history of providing technical assistance, training and support to sexual assault programs in Washington. It remains the primary statewide institution committed to providing information to programs and individuals who support victims.⁴⁴

Children’s Advocacy Centers of Washington (CACWA)

CACWA is the Washington State Chapter of the National Children’s Alliance. As a member of the Alliance, CACWA provides training, technical assistance and information regarding funding sources for startups, training, operations and research about best practices to Washington’s Children’s Advocacy Centers (CACs).

Children’s Advocacy Centers (CACs)

CACs are child-focused, child-friendly facilities where children and non-offending family members can safely get help. Representatives from Child Protective Services, law enforcement, prosecution, mental health, advocacy and the medical community meet to discuss and make decisions about investigation, treatment and prosecution of child abuse cases.

Community Sexual Assault Programs (CSAPs)

Thirty-six Office of Crime Victims Advocacy-accredited CSAPs provide sexual assault advocacy services across the state. Their services include but are not limited to:

- Free, confidential 24/7 hotlines
- Information about sexual assault
- Crisis intervention and ongoing support
- Medical and legal advocacy
- Referrals to other community service providers
- Systems coordination
- Community awareness, outreach and prevention activities⁴⁵

Some CSAPs also offer specialized services such as support groups, therapy and medical social work.⁴⁶

What Is the Crime Victims Compensation Program (CVCP)?

Established in the 1973 Crime Victims Compensation Act and housed in the Washington State Department of Labor & Industries, CVCP uses federal and state funds to assist victims with the

⁴⁴ Washington Coalition of Sexual Assault Programs, *About Us*, <http://www.wcsap.org/about.htm>

⁴⁵ Ibid.

⁴⁶ Ibid.

many costs associated with violent crime, such as the costs of sexual assault examinations and pharmacy-related items billed at the time of the exam.⁴⁷

Who Pays for an Exam?

The 1994 federal Violence Against Women Act (VAWA) established that victims of sexual assault must not be charged for medical forensic exams. To comply with this act, all exams performed in Washington must be billed to CVCP. Hospitals and emergency medical providers are reimbursed for exams through CVCP.⁴⁸

CVCP also covers the following pharmacy-related items when billed in conjunction with the initial sexual assault examination, provided all conditions satisfy RCW 7.68.170:

- Postcoital contraception
- Prophylaxis, or measures, to address sexually transmitted diseases
- Hepatitis B immune globulin
- Tetanus toxoid vaccine
- 28-day course of HIV therapy medication

Timing of Evidence Collection

Forensic DNA evidence needs to be collected as soon as possible, because DNA evidence deteriorates with time.⁴⁹ The recommended time frame in which evidence can be collected varies depending on the type of assault (see [Table 1](#)). However, case-specific circumstances might support evidence collection beyond any standardized period.⁵⁰

Table 1: National Justice Institute Recommended Time Frames for Evidence Collection⁵¹

Type of Assault	Collection Time
Vaginal	Up to 120 hours (5 days)
Anal	Up to 72 hours (4 days)
Oral	Up to 24 hours (1 day)
Bite marks/saliva on skin	Up to 96 hours (4 days)
Unknown	Collect respective samples within the time frames listed above.

⁴⁷ Washington State Department of Labor and Industries, *About Crime Victims Compensation*, <https://www.lni.wa.gov/ClaimsIns/CrimeVictims/About/Default.asp>

⁴⁸ Exemptions to this rule involve sexual assaults of victims who were incarcerated in a city, county, or federal jail or in a facility operated by the Department of Social and Health Services or Department of Corrections at the time of the assault.

⁴⁹ U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, “National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach,” (2017), <https://www.ncjrs.gov/pdffiles1/nij/250384.pdf>

⁵⁰ Ibid.

⁵¹ Ibid.

History of Sexual Assault Response in Washington and Its Significance

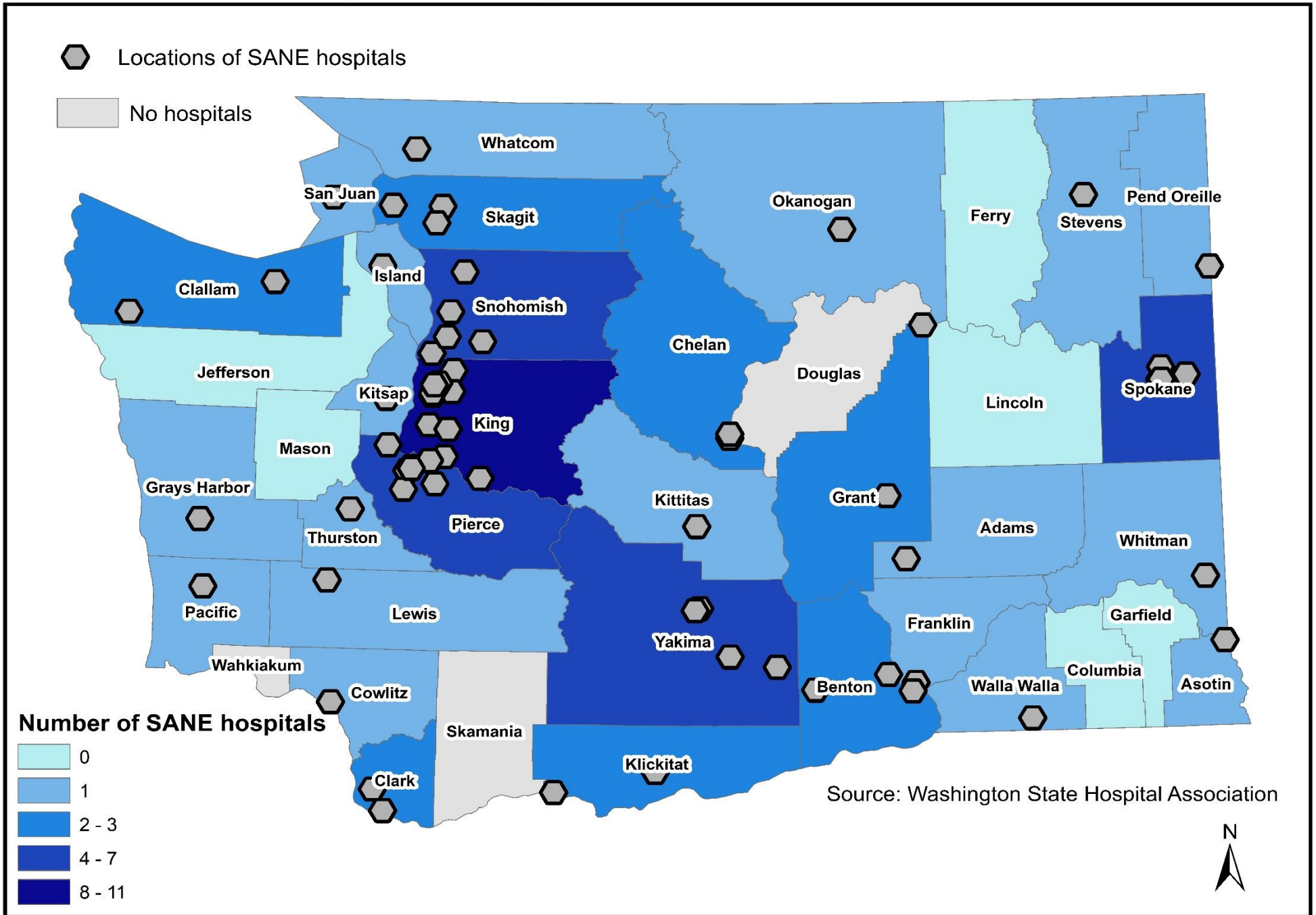
The development of sexual assault response in Washington is tied to both local efforts and the formation of statewide institutions. Communities with the leadership, resources, stakeholder buy-in and technical skill began developing organized, but not comprehensive, responses throughout the late 1970s and into the 1990s. By 1989, Harborview was providing SANE training across the state. Coupled with the efforts of the Washington Coalition of Sexual Assault Programs (WCSAP) and Children’s Advocacy Centers of Washington (CACWA) efforts, these institutions boosted the capacity of local jurisdictions to have coherent, coordinated responses to sexual assault through trainings, technical assistance and increased awareness about sexual assault response more generally.

By the 2000s, communities that had started their journeys toward full-fledged SANE programs consolidated their programs and began establishing SARTs and partnerships with local MDTs for pediatric services. Based on interviews with key stakeholders, the most successful SANE programs reached out to nearby communities, statewide institutions and out-of-state resources. This allowed them to better understand and align their own local practices with more effective ones while maintaining a subset of practices specifically tailored to their locality’s circumstances. Meanwhile, communities that lacked leadership, resources, know-how or stakeholder buy-in struggled to create quality responses, and many still lack them today. As described below, all programs struggled to one degree or another with a number of issues surrounding SANE availability and access (see [“Factors Influencing SANE Availability”](#) and [“Factors Influencing Access”](#)).

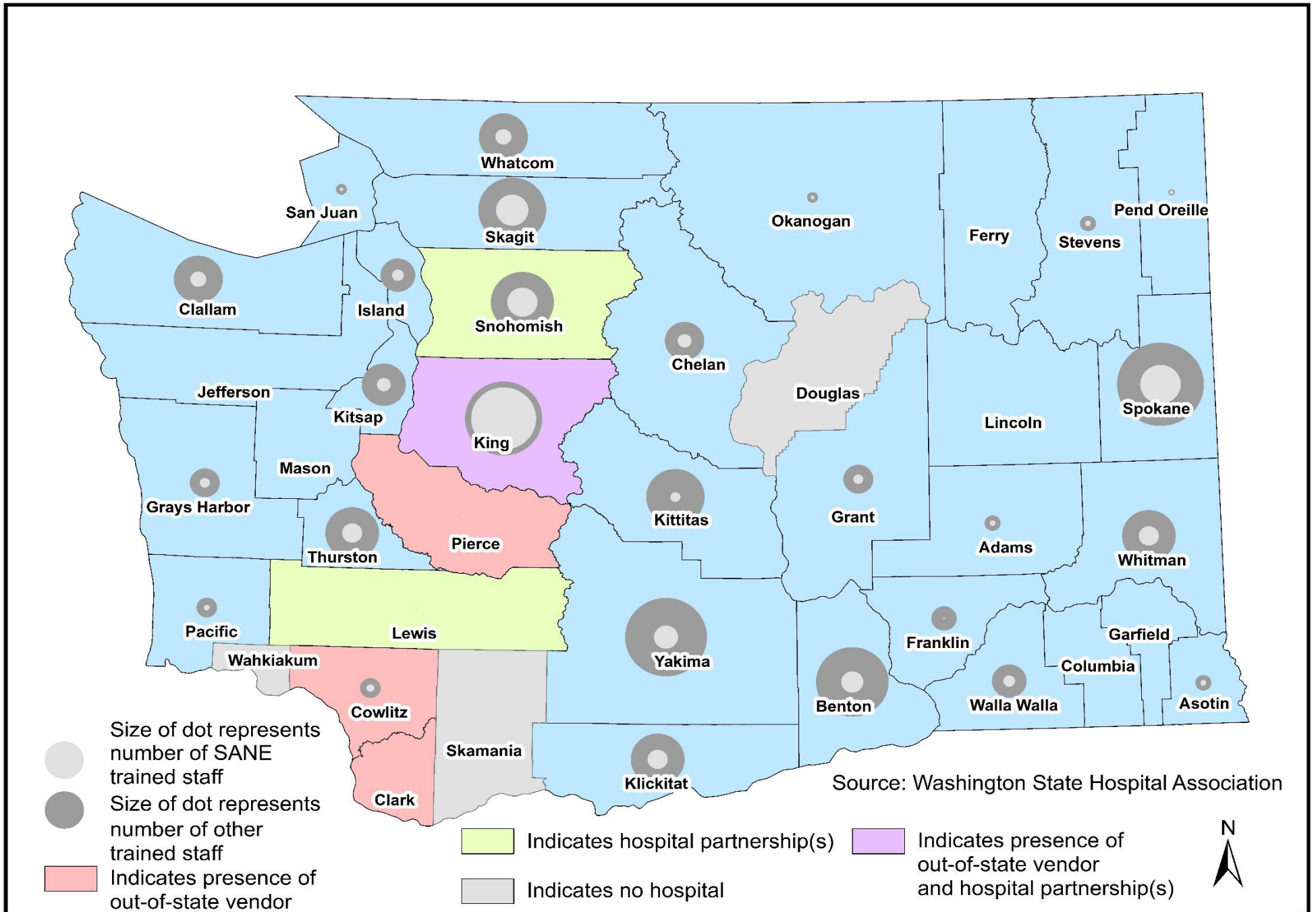
National accreditation standards serve, in part, to enhance the coordination of responses for pediatric victims. Despite having the standards guide their work, a fair amount of local variation exists among CACs due to varying community needs, number of local partnerships, degrees of accreditation and availability of P-SANEs across the state. A fair amount of local variation also exists among CSAPs, which follow state accreditation and service standards. One of these standards covers system coordination for adult and child victims.

In sum, Washington did not develop one standard, coherent response. Rather, its communities developed a patchwork of often partial, ad-hoc responses with many gaps, as shown in the following maps.

Hospitals Offering Medical Forensic Examinations



Health Care Providers Performing Sexual Assault Medical Forensic Examinations



SANE Accessibility

In Washington, 65 hospitals offer medical forensic examinations, 290 SANE-trained medical staff and 205 [other-trained medical staff](#). About 46 SANEs work in the Portland, Oregon, and Clark County region, and 31 SANEs work for an out-of-state contractor in the Pierce County and King County region.⁵² Of the 65 hospitals reporting to offer SANE services, eight have partnerships with other hospitals and 13 have established contracts with an out-of-state vendor. Out of Washington’s 39 counties, 30 report offering medical forensic exams. Of those, 19 each have only one hospital that has SANE-trained staff.⁵³

Excluding counties that rely on an out-of-state vendor or nurses from a hospital in another county, 15 counties each have fewer than 10 SANEs.⁵⁴ Four counties each have more than 10 other-trained nurses performing examinations.⁵⁵ In two counties, more than 75 percent of the medical staff designated to perform examinations have not undergone formal SANE training.⁵⁶ This data corresponds with the observations made by many practitioners of sexual assault response across the state, nearly all of whom noted the inadequate and inconsistent nature of sexual assault response in their communities.

Table 2: Sexual Assault Nurse Examiner Availability in Washington

Measure of SANE Availability	Number
Hospitals offering medical forensic exams	65
Trained SANE medical staff	290
Other-trained medical staff	205
Out-of-state vendor supplied SANEs in the Portland, Oregon, and Clark County region	46
Out-of-state vendor supplied SANEs in the Pierce County and King County region	31
Partnerships among hospitals	8
Hospitals that have a contract with an out-of-state vendor	13
Counties that have only one hospital with SANE-trained staff	19
Counties with fewer than 10 SANEs	15
Counties with more than 10 other-trained medical staff	4
Counties in which more than 75 percent of medical staff performing examinations are other-trained	2

⁵² These numbers include most, but not all, of the hospitals that provide sexual assault forensic evidence kit collection. The numbers do not reflect all trained nurses or other providers in the state. See footnote 19 for definitions and an explanation of the data.

⁵³ Adams, Asotin, Clark, Cowlitz, Franklin, Grays Harbor, Island, Kitsap, Kittitas, Lewis, Okanogan, Pacific, Pend Oreille, San Juan, Stevens, Thurston, Walla Walla, Whatcom, and Whitman

⁵⁴ Adams, Asotin, Chelan, Cowlitz, Franklin, Grant, Grays Harbor, Island, Kittitas, Okanogan, Pacific, Pend Oreille, San Juan, Thurston, and Walla Walla

⁵⁵ Benton, Kittitas, Spokane, and Yakima

⁵⁶ Spokane and Yakima

Primary Factors That Influence Access in Washington

As noted in the “[Sexual Assault Response and Its Terminology](#)” section (“[What Primary Factors Influence Access?](#)”), this report found that a lack of available resources and coordination within communities decreases access to short- and long-term medical and legal care for victims. The next two sections look at this issue in detail.

Factors Influencing SANE Availability

This report found four primary reasons for the lack of SANE availability across Washington.

1. Funding for SANE Training

In the past ten years, federal dollars have intermittently passed through OCVA to Harborview to provide statewide SANE training. However, these funds are not guaranteed, not regularly available and often not enough to address the lack of SANEs statewide. In other words, no steady stream of guaranteed funds maintain SANE trainings or meet demand for them.

Related, nurses have historically shouldered the financial burdens associated with attending trainings, such as travel-related costs and lost wages. In recent years, Harborview has attempted to defray these costs through scholarships. But not enough funds are available to offer scholarships to every nurse.

2. Lack of Strong, Financially Backed Stakeholder Support

A lack of stakeholder support was widely cited as a reason for the failure to adequately develop a pool of available SANEs. Medical staff reported that they often:

- Are not compensated for attending trainings in their local areas
- Are not appropriately compensated for their services
- Do not receive adequate time to decompress and debrief following an exam
- Do not have the ability to pursue further training to refine their skills and remain up-to-date on best practices

This lack of financially backed support discourages nurses from attending trainings and staying in the profession.

3. Low Retention Rates

Low retention rates are a problem in the SANE profession in Washington and the U.S.⁵⁷

The reasons for this include but are not limited to the following:

- Inadequate Compensation: Interviewees for this report frequently noted that SANE pay is inadequate. They also expressed that SANEs are often not compensated for being on-call, either in the form of a per-case premium or on-call pay equivalent to that of other on-call professionals.

⁵⁷ Variation in retention rates across states suggests that retention is primarily a product of policy, rather than inherent to the profession itself.

U.S. Government Accountability Office, “[Information on Training, Funding](#)”

- **Long Hours:** In communities where nurses are on-call, they often work 12-hour shifts. This provides for little emotional or physical relief when performing multiple exams over the course of a shift. If a SANE required a break following a particularly physically or emotionally trying exam, few hospitals (particularly those with SANE coordinators) reduced on-call shifts to eight hours or were willing to find someone else to fill the remainder of a shift.
- **Missed Opportunities for Continued Education:** SANE interviewees frequently cited a lack of opportunity to maintain and further their skills and build confidence as a reason why SANEs leave the profession. Harborview offers advanced SANE trainings, and IAFN holds yearly international conferences, both of which serve to further equip nurses as well as foster a greater sense of shared community. However, attendance is often dependent on employer support.
- **Burnout and Vicarious Trauma:** Performing a forensic exam is an emotionally trying task.⁵⁸ Shortening on-call times and granting post-exam debrief time and participation in sexual assault response-related trainings and conferences are ways of combating burnout and vicarious trauma.⁵⁹

4. Low Population Density and Terrain-Specific Challenges

Jurisdictions with low population density and rugged terrains encounter a number of challenges that often exacerbate the impacts of low retention rates. These jurisdictions typically have fewer health care providers and, thus, fewer SANE programs. Weather and terrain-related travel restrictions, such as heavy snowfall on treacherous mountain passes, can also limit the ability of victims from nearby communities to receive care. That in turn can lead some health care providers to discontinue SANE programs or not establish them in the first place.

Jurisdictions with low population density and rugged terrain often struggle with the deterioration of SANEs' skills because they experience fewer cases than hospitals located in more populous jurisdictions.⁶⁰ Hospitals located in these jurisdictions also often struggle to send nurses to trainings, given their smaller staff pools.⁶¹

Individual Explanations

A perceived lack of commitment from nurses has been cited as a reason for the lack of SANEs in Washington. According to this explanation, being a SANE is difficult and most nurses either do not want to be a SANE in the first place or find it is not for them after trying it.

⁵⁸ Shana Maier, "The Emotional Challenges Faced by Sexual Assault Nurse Examiners: ER Nursing Is Stressful on a Good Day Without Rape Victims," *Journal of Forensic Nursing*, Volume 7, no. 4, (2011), <https://www.researchgate.net/publication/51832316> The emotional challenges faced by Sexual Assault Nurse Examiners ER nursing is stressful on a good day without rape victims

⁵⁹ U.S. Government Accountability Office, "Information on Training, Funding" Stephanie Townsend and Campbell R. "Organizational Correlates of Secondary Traumatic Stress and Burnout Among Sexual Assault Nurse Examiners," *Journal of Forensic Nursing*, Volume 5, no. 2 (2009), <https://www.ncbi.nlm.nih.gov/pubmed/19538654>

⁶⁰ U.S. Government Accountability Office, "Information on Training, Funding"

⁶¹ Harborview has rural trainings designed specifically for this purpose.

While it can be true that some nurses might not want to be a SANE, and being one is mentally and emotionally trying, such explanations overlook context. Specifically, the following disincentives could be addressed:

- Lack of strong, financially-backed stakeholder support
- Inadequate compensation
- Long hours
- Lack of continuing educational opportunities
- Other contributing factors

Factors Influencing Access

Even if communities have SANEs available, emergency medical services and long-term medical and legal care are not guaranteed. The reasons for this include, but are not limited to, the following:

Multiple Providers in a Community, None of Whom Provide 24/7 Services

When it comes to providing medical and forensic services for sexual assault victims, a common problem is knowing where to send patients. This is especially problematic in communities where there are multiple providers, none of whom provide 24/7 services. When this is the case, patients might be sent from hospital to hospital until they get to one with a SANE on staff or on-call.

Absence of Partnerships Among Hospitals in Most Communities

A lack of partnerships or transfer agreements among hospitals represents a missed opportunity to improve access to emergency medical services in most communities, according to this report's findings. Through partnerships, communities can aggregate and share resources as well as further disseminate best practices to provide better services for victims. So far, hospital-to-hospital partnerships are largely absent.

Similarly, for pediatric care, MOUs should be used among hospitals that do not have P-SANEs and hospitals or CACs that do. Hospitals should also have specific protocols related to pediatric care, know the difference between treating adults/adolescents and children, and know where to send pediatric patients if no P-SANEs are on-call. In both surveys and interviews, respondents indicated they did not have P-SANEs on staff or did not know where to send patients.

Absence of SARTs and MDTs

Many communities in Washington do not have SARTs, and a few do not have MDTs. Those that do described a significant difference in their community responses. By bringing experts from disparate fields together to serve victims, each part of their responses improved significantly. To paraphrase one interviewee, SARTs and MDTs elicit internal feedback about their community responses, encourage constant learning, and promote adaptability and, consequently, sustainability of communitywide responses.

For SANEs, in particular, SARTs and MDTs can provide technical assistance in such areas as testifying in court and working with specific populations.⁶² National literature notes that even in communities that lack capacity or have low volume of patients, SARTs led to significant improvements in case coordination.⁶³ The same has been found for MDTs.⁶⁴

Little to No Diffusion of Local Best Practices

One argument for a patchwork approach to sexual assault response is that if a community were to develop a new, wholly successful best practice to sexual assault response, other communities could benefit from adopting it. However, according to the majority of SANEs and hospital administrators surveyed, best practices tend to remain localized. Dissemination issues could include communities not knowing of best practices or not adopting them, perhaps because of stakeholders who do not want to change the status quo. While solutions to the latter must be treated on a case-by-case basis, the former could be addressed by statewide personnel tracking, disseminating and promoting successful best practices across the state with CACs, CSAPs and other stakeholders.

Absence of Regularly Available Technical Assistance

Many stakeholders noted the absence of a state-level resource dedicated to the creation of comprehensive, high-quality, community-oriented SARTs. Whether stakeholders are struggling with other stakeholders or experiencing a lack of resources or knowhow, a technical assistant could help quarterback capacity-building efforts and ensure SARTs across the state are thoughtfully constructed to benefit patients.

Lack of Coordination Between Hospitals and CVCP

Interviews conducted with CVCP revealed that hospital billings for medical forensic exams are often wrongly coded, leading to lower reimbursement rates for exams. CVCP can request that bills be resubmitted with correct codes, but CVCP cannot correct codes to ensure the highest reimbursement rate possible for exams.

Lack of Incorporation of Tribes

Tribal members consulted reported not feeling included in community responses. While tribal members provide information packets with tribal contact information to hospitals, they noted not having working relationships with nearby communities' officials. They reported that they are not regularly included in community meetings and, when they are, "it feels that it is only so they [the local community] can check the box. There is no meaningful response to [the tribe's]

⁶² National Sexual Violence Center, "Sexual Assault Response Team"

Mallios and Markowitz, "Benefits of a Coordinated Community Response to Sexual Violence"

Greeson and Campbell, "Sexual Assault Response Teams (SARTs)"

⁶³ Ibid.

⁶⁴ Aaron Miller and Rubin D., "The Contribution of Children's Advocacy Centers to Felony Prosecutions of Child Sexual Abuse," *Child Abuse & Neglect*, Volume 33, no. 1, (2009),

<https://www.sciencedirect.com/science/article/abs/pii/S014521340800241X>

Herbert and Bromfield, "Evidence for the Efficacy of the Child Advocacy Center Model"

Elmqvist et al, "A Review of Children's Advocacy Centers' (CACs) Response to Cases of Child Maltreatment"

Tavakar and Hansen, "Interventions for Families Victimized by Child Sexual Abuse"

proposals or requests.”⁶⁵ Tribal members also noted a lack of understanding and respect regarding both cultural awareness of historical trauma and tribes as governments.

Out-of-Date Protocols

As mandated by state law, every county in Washington has child abuse investigation protocols that must be updated every two years. Interviews with pediatric care providers indicate these protocols might not always be updated or followed.

High Staff Turnover

The majority of subject matter experts consulted indicated that high staff turnover in all professions related to sexual assault response was associated with coordination failures and the continued need to inform stakeholders about what should be done when victims seek medical or legal assistance.

Washington State Comparatively

Washington is not the only state to struggle with a patchwork of responses to sexual assault. Alaska, which relies solely on local SARTs, struggles with the limitations of such a response. As concluded in the 2016 “Study of Sexual Assault Nurse Examiner Availability, Adequacy, Costs, and Training”:

“Alaska is the living representation of a community that recognizes a problem, implements a solution, has success, and loses ground, because community alone cannot build enduring solutions. The innovation and motivation of a community are simultaneously enough to begin a community-led response to sexual assault, but are not enough to sustain that response.”⁶⁶

Oregon has attempted to overcome such a patchwork by layering the Oregon Sexual Assault Taskforce, organized under that state Attorney General’s Office, on top of a loose affiliation of hospitals and organizations. Oregon has also established its own state certification process, whereby SANEs can receive basic certification that must be renewed every three years by a state advisory board. Reimbursements for exams are then weighted based on whether the exams were performed by certified SANEs or other medical staff members. However, according to representatives of Oregon’s Sexual Assault Forensic Task Force, many parts of the state still lack SANE-trained medical staff. This suggests that layering additional state apparatuses and certification requirements for nurses on top of a patchwork of responses does not necessarily secure access to emergency medical care and long-term medical and legal services for victims statewide.

One state that has overcome a decentralized patchwork of responses is Massachusetts. The Massachusetts SANE Program has a line item in the state budget of \$3.8 million. Of that

⁶⁵ Interview with tribal official.

⁶⁶ Washington State Department of Commerce, “Sexual Assault Nurse Examiners”

amount, \$1 million goes toward paying SANEs and the rest goes toward paying other program staff. Service delivery is conducted through regions whose regional coordinators (who are state employees) interact with a state-level administrative team of 22 members housed at the Massachusetts Department of Health. Coordinators ensure protocols are upheld, quality assurance is sustained and education is provided to nurses. In Massachusetts, to administer an exam, the exam provider must be certified as a SANE by the state. Recertification is required every year. The state currently has 30 hospitals in which SANE services are available 24/7. Two other hospitals are serviced through Massachusetts' National Telenursing Project.⁶⁷

Conclusion

The efficacy of sexual assault response in Washington has largely been determined by local leadership, resources, stakeholder buy-in and technical skills, coupled with support from statewide institutions. The latter tends to be underfunded and, consequently, underused. This has resulted in a patchwork of responses to sexual assault that hinders access to short- and long-term medical and legal care for victims in many communities across the state.

What is clear nationally, and from Washington's history, is that a patchwork approach does not ensure access statewide. Addressing many of the issues related to SANE availability and access involves strategically moving Washington sexual assault response policy toward a more robust, statewide approach that is not prescriptive about particular practices but instead aims to ensure all sexual assault victims receive quality responses.

⁶⁷ See Appendix H

Recommendations

Improving SANE accessibility involves addressing the availability and coordination of resources between state and local communities and among local stakeholders. This section offers recommendations to further these goals.

Establish a Training Program and Scholarship Fund

To make SANE training uniformly available to nurses in all regions of the state, Commerce recommends the establishment of a statewide training program and scholarship fund. An established organization with extensive experience and expertise should provide these trainings, such as the Harborview Center for Sexual Assault and Traumatic Stress. Harborview currently offers most of the highly specialized trainings discussed below. These align with the IAFN Education Guidelines and DOJ's National Training Standards for Sexual Assault Medical Forensic Examiners.

With a robust, reliable state-level training and scholarship fund, trainings could be more frequent and held in more locations. This fund could annually procure the following services:

40-Hour In-Person Core SANE Trainings

These trainings would teach nurses how to perform sexual assault exams, including how to recognize genital trauma; collect forensic evidence; and collaborate with advocates, law enforcement, prosecutors and mental health professionals. This initial training could be a hybrid, containing both in-person and online portions to provide more flexibility for hospitals and attendees. These trainings would be offered multiple times a year in various locations across the state. Local community experts would be invited to present.

Three-Day In-Person SANE Trainings

These trainings would be for nurses in low population density areas of the state where five-day trainings significantly impact hospital staffing. Detailed didactic instruction and practice sessions on exam and evidence collection would be provided as well as training on a variety of issues related to the care of adult and adolescent patients. This introductory training could also be a hybrid (online and in-person) training to provide more flexibility for hospitals and attendees. These trainings would be offered multiple times per year in low population density areas of the state. Local community experts would be invited to present.

Five-Day In-Person Pediatric SANE Trainings

These trainings would be designed for nurses who want to provide pediatric exams in their communities. The training would cover how to perform a pediatric exam as well as the role of SART members and MDTs in caring for pediatric victims and their families. These trainings would be offered multiple times a year in various locations across the state. Local community experts would be invited to present.

One-Day Refresher SANE Trainings

These trainings would be offered to maintain and enhance the skills of practicing SANEs. Refresher trainings would provide a review of basic skills and introduction to new skills. They would also provide opportunities to update nurses on clinical practices. They would be offered multiple times a year in various locations across the state.

One-Day Advanced SANE Trainings

These trainings would be offered to continue the education of practicing SANEs. They would cover topics related to sexual assault care that were not detailed in the initial trainings. They would also provide opportunities for peer review of cases, because local community experts would be encouraged to bring specific cases for discussion. These trainings would be offered multiple times a year in various locations across the state.

One-Day Northwest Child Maltreatment Peer Review Trainings

These trainings would provide regular formal practice and peer review for SANEs serving CACs. This training would offer providers an opportunity to maintain up-to-date, evidence-based practices. They would be offered multiple times a year in areas with CACs.

Clinical Skills Labs

These labs would offer SANEs and P-SANEs an opportunity to further practice hands-on sexual assault examinations with live simulations. Medical history documentation, speculum insertion, toluidine blue dye use, documentation of evidence and courtroom testimony would be practiced. These trainings would be offered multiple times a year in various locations across the state. Local community experts would be invited to present.

Web-Based Case Reviews

These reviews would provide opportunities for SANEs across the state of Washington to further develop their skills, particularly those related to patient interviews, documentation of evidence and follow-up planning. These services have been widely requested. Cases would be submitted by SANEs from all regions of the state. Case reviews would be offered monthly and be accessible via secure video conferencing.

Scholarships

Scholarships would assist nurses with costs associated with attending trainings, such as hotel, food and other travel-related expenses. Financial support for training participants could help recruit and retain qualified nurses.

Maintenance and Updates to Washington State Sexual Assault Forensic Exam Website

This fund would support continued maintenance and updates to the Washington State Sexual Assault Forensic Exam website.⁶⁸ WASAFE.org is a statewide resource for sexual assault services. It includes information about where adult, adolescent, and pediatric examinations are

⁶⁸ WASAFE (Washington State Sexual Assault Forensic Exam), *A Washington State Resource for Sexual Assault Forensic Medical Care*, <http://depts.washington.edu/hcsats/ch/index.html>

available, where advocacy and support resources are located, and where and when statewide training events will be held.

Per-Year Cost of Training and Scholarship Fund

The training and scholarship fund proposed below would cost \$375,000 and result in the training of 115 new SANEs and the retraining of 290 others.⁶⁹

Table 3: Proposed Training and Scholarship Fund Costs

Training Program Item	Annual Cost
Training Event (venue, refreshments, models, guest speakers)	\$100,000
Professional Staff (instructors, consultants, event planners)	\$200,000
Travel (mileage, airfare, hotel, meals, rental vehicles, parking)	\$25,000
Scholarships (estimated for 210 nurses)	\$30,000
Supplies (kits, equipment, training materials, website maintenance, education certificate)	\$20,000
Total	\$375,000

Alternative Strategies Considered

Establishing Additional Training Programs

Commerce considered the option of establishing regionalized training programs across Washington. It found that the establishment of such programs would duplicate costs; marginally impact SANE staffing; and further fragment the state’s approach to sexual assault response through the potential bifurcation of training standards, skill evaluations and medical guidelines. When it comes to any missing components in the state’s current statewide SANE training program, Commerce recommends investing in improvements to the state’s current statewide SANE training provider for the benefit of all victims in Washington.

Unnecessary, Duplicative Costs

Establishing regional SANE training programs would require significant startup, fixed and ongoing costs. The programs would need to rent spaces, procure training equipment, hire instructors, and establish registration systems and ways to publish upcoming trainings. They would need curriculum in line with the IAFN’s Education Guidelines and DOJ’s Violence Against Women Act National Training Standards for its SAFE Program.

Additionally, administrative operations would need to be funded continuously. Rather than allocating funds to establish new programs, using those funds to support an established, experienced provider of statewide SANE training would allow trainings to be provided more regularly and would ultimately cost less than establishing and operating multiple training programs across Washington.

⁶⁹ This estimate is based on current OCVA training and technical assistance grants. It does not include any overhead expenses, such as an organization’s facility or administrative costs.

Marginal Impact on SANE Staffing

As discussed above, one of the primary reasons some communities in the state struggle to train and retain SANEs and P-SANEs is that medical staff report not being compensated for their time to attend trainings when trainings are offered in their local communities. In other words, medical staff must often take their own personal leave time to attend trainings. This discourages attendance — even when the trainings occur within miles of staff members' medical facilities. Commerce recommends offering scholarships to offset lost wages and travel-related costs.

Bifurcation of Sexual Assault Examination Practices

Having two programs in the state training SANEs rather than one program risks bifurcating sexual assault examination practices, leading to different quality levels of sexual assault examinations performed by SANEs across the state. To avoid this, Commerce recommends a standardized training program through one provider of SANE trainings across the state.

Benefits of a Statewide Training Program, Relative to Regional or Localized Ones

Diverting statewide funds to particular localities to address training issues that affect every victim of sexual assault in Washington state would represent a missed opportunity to invest in improving SANE trainings for all nurses in Washington. Thus, Commerce recommends investing in a statewide training provider to the benefit of all residents rather than investing in localized or regionalized programs.

Online Trainings

Commerce considered whether state funding should be put toward online IAFN training for Washington state nurses. IAFN training costs \$500 per nurse. At \$294, Washington's current provider's average per-person cost is cheaper. IAFN's training does not provide information on state-specific protocols governing sexual assault response. IAFN trainings do not provide the hands-on practice in-the-classroom trainings do. They also require nurses to expend their own time and resources outside work to get training. For these reasons, Commerce does not recommend this approach.

A Statewide SANE Certification Program

A few nurses interviewed for this report indicated an individual desire to achieve IAFN certification to increase their professional status and also boost their confidence testifying in court. Other stakeholders have suggested the state establish its own certification program to accomplish the same things. However, Commerce found no empirical evidence to suggest that certification translates into better outcomes for patients. It did find certification to be costly. IAFN certification costs up to \$575. Recertification costs up to \$575 as well. Commerce did not determine the cost for setting up a statewide certification of its own. However, the costs are estimated to be significant since a new certification program would have to be created and staffed.

In light of the shortage of SANEs across the state and the known benefits of training them, Commerce recommends putting funds that could go toward investing in a certification program toward training more SANEs.

Further Recommendations

Establish a SART Technical Assistant

To assist local communities in creating and maintaining SARTs, a statewide technical assistant position should be funded by the state and contracted out by OCVA to an established organization with extensive experience and expertise. This assistant would help communities:

- Create, maintain and enhance SARTs
- Track the development of SARTs statewide
- Disseminate best practices and resources
- Provide reports on sexual assault response

A SART technical assistant should have extensive knowledge of the theory and practice of SARTs, the demonstrated ability to work with local stakeholders and a deep appreciation for the need to craft SARTs to local circumstances while ensuring quality responses across Washington.

To support the work of a SART technical assistant, adequate funding should also be included for:

- Contracted interpreting services
- Ongoing education, webinars and online courses (venue, refreshments, audio/visual technology, contracted design services and software)
- Travel (mileage, airfare, hotel, meals, rental vehicles, parking)
- Publications (design, print, translation, postage)

Promote Greater Coordination Between CVCP and Hospital Billing Departments

CVCP should be empowered through additional staff and funding to conduct outreach and education about CVCP and liaise between the hospital billing department and insurance (as well as sexual assault victims in cases where the victims were billed for forensic exams and should not have been). Additional funding and staff would also assist CVCP in coordinating with other states' compensation programs to ensure the jurisdictions where assaults occurred cover the costs of exams.

Mandate That Every Hospital Have a Response Plan

Every hospital in Washington state need not have a SANE program, but every hospital should have a coordinated, victim-centered response. Such a response should be in line with the best practices suggested in this report. Principally, no matter where patients arrive following sexual assaults, advocates should be contacted immediately. If hospitals do not have SANEs on staff or on-call, they should be prepared to help transport patients with the assistance of advocates to the nearest SANE-staffed hospitals in a timely fashion.

Local Communities Should Adopt, Tailor and Add to This Report's Suggested Best Practices

The best practices included in the appendices of this report follow from extensive research of sexual assault response best practices in Washington state and nationally. Commerce highly recommends that local communities adopt, tailor and add to these best practices to best serve victims in their communities.

Explore Opportunities to Build New Partnerships

In addition to the establishing a scholarship and training fund to expand access to the existing SANE program, Commerce would like to explore opportunities to allow a standardized statewide curriculum to be delivered by additional providers, through alternative modes of delivery. Establishing a standardized curriculum would require extensive stakeholder collaboration on several issues including SANE certification, ongoing training and experience requirements, education standards, exam guidelines, and the role of sexual assault advocates. This approach would require additional investment. Given the current constraints on SANE funding, such an approach would be best justified if the state and alternate providers were able to leverage additional state and non-state funds to help cover the additional costs that would be incurred, in developing new training delivery models and building consensus around a standard statewide curriculum.

Appendix A: Sexual Assault Response Best Practices for Adult and Adolescent Patients

To meet the intent of Chapter 88, Laws of 2018, this appendix proposes best practices local communities can use on a voluntary basis to create more access to sexual assault nurse examiners (SANEs) and quality sexual assault responses for adult and adolescent victims. These best practices are informed by statewide interviews, surveys and national literature reviews. Local communities are encouraged to adopt, tailor and add to them as they see fit. The following best practices are available on the OCVA webpage:⁷⁰

- Sexual assault patients need to be triaged as high priority for care and escorted to safe, private rooms upon arrival at emergency care facilities.
- Sexual assault advocates need to be contacted immediately upon patient arrival at emergency care facilities. Patients need to be told advocates are on the way, will comprehensively explain patient options, and that patients can consent or refuse to speak with advocates.
- Patients need to have access to medical care and forensic evidence collection and medically appropriate sexually transmitted disease prophylaxis, or measures, and emergency contraception from formally trained SANEs.
- Hospitals should have procedures in place for maintaining chain of custody of evidence, providing patient reporting options, and storing evidence and transferring it to law enforcement for testing.
- SANEs need to receive continuing education and evaluation and be up-to-date on changes to best practices in forensic evidence collection and trauma-informed care.
- If they request it, SANEs need to be given time following an exam to recompose before being sent to another task.
- SANEs need to be compensated with on-call pay as well as pay for each case. If on-call pay does not make sense in low population density communities, P-SANEs should be compensated at a premium for each case.
- Hospitals should assist their local communities by developing, sustaining and improving SANE programs and supporting community SARTs.
- Hospitals unable to support their own SANE programs should establish policies and procedures as well as partnerships with other facilities to ensure that when sexual assault patients arrive, SANEs are available to assist in timely manners or have patients transferred to SANE-staffed hospitals with the assistance of advocates. Patient should be triaged within an hour of arriving at SANE-staffed hospitals.
- Hospitals should establish partnerships with community health agencies or physician groups that receive trauma-informed care training and specialized training in the care of survivors of sexual assault. Patients should be referred to such locations for follow-up care.

⁷⁰ Washington State Department of Commerce, *Office of Crime Victims Advocacy*, www.commerce.wa.gov/ocva

- Preferably, SANE-staffed hospitals should have safe, private rooms designated for sexual assault patients. If not possible, hospitals should have accessible mobile carts — outfitted with the tools necessary for medical forensic exams — that can be easily moved among rooms for examinations.
- Stakeholders and community members should continue to seek ways to provide better responses for their local communities.
- Hospitals need to address the potential for vicarious trauma among SANEs by building proactive environments that provide team-based mechanisms that can be individually tailored to decrease the risk of vicarious trauma, such as established support networks with regular check-ins to debrief and discuss coping mechanisms.
- Hospitals and SANEs should not automatically call law enforcement for adult victim cases.
- Hospitals and SANEs should not require adult victims to report to law enforcement as a condition for receiving exams.
- Hospitals should not bill patients or their insurance for exams.

Appendix B: Sexual Assault Response Best Practices for Pediatric Patients

To meet the intent of Chapter 88, Laws of 2018, this appendix proposes best practices local communities can use on a voluntary basis to create more access to sexual assault nurse examiners (SANEs) and quality sexual assault responses for pediatric patients. Pediatric patients differ significantly from adult and adolescent patients, which creates a need for a tailored set of best practices. These best practices are informed by statewide interviews, surveys and national literature reviews. Local communities are encouraged to adopt, tailor and add to them as they see fit. The following best practices are available on the OCVA webpage:⁷¹

- Pediatric patients need to be triaged as high priority for care and escorted to safe, private rooms upon arrival at emergency care facilities.
- Patients and nonoffending parents or caregivers should be given access to advocates when patients arrive at emergency care facilities.
- Patients need to be seen by pediatric sexual assault nurse examiners (P-SANEs), preferably in child-friendly environments, such as Child Advocacy Centers (CACs).
- P-SANEs need to “screen and assess all acute and non-acute concerns or disclosures of sexual abuse, neglect, or suspected abuse, making proper jurisdictionally mandated reports, referrals, and transfers based on the need for time-sensitive exams or follow-up.”⁷²
- P-SANEs need to remain vigilant about nondisclosed child abuse when other children live in the same household as victims. Local authorities should be notified if any concerns about nondisclosed abuse arise.
- Hospitals and CACs should have procedures in place for maintaining chain of custody of evidence, storing evidence and transferring it to law enforcement for testing.
- P-SANEs need to receive continuing education and evaluation and be up-to-date on changes to best practices in forensic evidence collection and trauma-informed care.
- If they request it, P-SANEs need to be given time following an exam to recompose before being sent to another task.
- P-SANEs need to be compensated with on-call pay as well as pay for each case. If on-call pay does not make sense in low population density communities, P-SANEs should be compensated at a premium for each case.
- Hospitals should have policies regarding patient and staff safety when “the person accompanying the child victim is the suspected offender, is suspected to be in collusion with the offender, or is otherwise believed to be contributing to the abuse.”⁷³
- Law enforcement and hospitals should know where the nearest CACs are, and hospitals should have established transfer arrangements with their local CACs if it is P-SANE staffed.

⁷¹ Washington State Department of Commerce, *Office of Crime Victims Advocacy*, www.commerce.wa.gov/ocva

⁷² U.S. Department of Justice, Office on Violence Against Women, “A National Protocol for Sexual Abuse Medical Forensic Examinations - Pediatric,” (2016), <https://www.justice.gov/ovw/file/846856/download>

⁷³ Ibid.

- Hospitals and CACs unable to support their own P-SANE programs should establish partnerships with facilities that do maintain P-SANE programs to ensure that when sexual assault child patients arrive, they are seen by P-SANEs as soon as possible. If patients need to be transferred to hospitals or CACs, the action should be taken with the assistance of advocates and hospital staff.
- Before transferring patients to other facilities, hospital staff should confirm the availability of P-SANEs at the receiving hospitals if the receiving hospitals do not offer 24/7 P-SANE services.
- Stakeholders and communities should seek ways to continuously improve service in their communities.
- Local law enforcement and medical staff should regularly update and follow county sexual abuse protocol with pediatric patients.
- Sexual Assault Response Teams need to address the potential for vicarious trauma among members by building proactive environments that provide team-based mechanisms that can be individually tailored to decrease the risk of vicarious trauma, such as established support networks with regular check-ins to debrief and discuss coping mechanisms.

Appendix C: Best Practices for Creating, Maintaining and Sustaining a SART or MDT

To meet the intent of Chapter 88, Laws of 2018, which requires the Office of Crime Victims Advocacy (OCVA) to “develop best practices that local communities may use on a voluntary basis to create more access to sexual assault nurse examiners,” this appendix proposes best practices for sexual assault response teams (SARTs) and multidisciplinary teams (MDTs). These best practices are informed by statewide interviews, surveys and national literature reviews. Local communities are encouraged to adopt, tailor and add to them as they see fit. The following best practices are available on the OCVA webpage:⁷⁴

- Form a multi-stakeholder planning team of representatives, which could include local law enforcement, sexual assault survivor advocates, sexual assault nurse examiners, prosecutors, Child Protective Services, therapists, crime lab specialists, medical administrators, tribal officials, children’s advocacy center administrators and other concerned stakeholders, such as victims.
- Identify an executive leadership team, and coordinator to facilitate the development of the SART or MDT.
- Define the SART’s or MDT’s jurisdiction.
- Write a mission statement.
- Identify local barriers to access to emergency and long-term care for victims of sexual assault, and identify resources to help overcome them.
- Establish protocols that delineate cross-disciplinary roles and responsibilities for each member of the SART or MDT and how members function to promote the best response possible given local circumstances.
- Ensure all members are aware of and understand their responsibilities for compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) and state confidentiality, privilege and privacy laws.
- Establish regularly scheduled SART or MDT meetings to elicit feedback from members, review and track cases, and promote constant learning.
- Establish mechanisms for communicating with SART or MDT members and other key stakeholders outside SART or MDT meetings.
- Ensure underserved populations are meaningfully included and proactively listened to.
- Identify and establish mechanisms to increase professional and public awareness of and support for SART or MDT services.
- Work with local children’s advocacy centers, community sexual assault programs and other stakeholders to avoid duplication of work among SARTs, MDTs and others.
- Establish mechanisms to incorporate team member and patient feedback to evaluate and improve the SART or MDT process.

⁷⁴ Washington State Department of Commerce, *Office of Crime Victims Advocacy*, www.commerce.wa.gov/ocva

- Address the potential for vicarious trauma among members of SARTs by building a proactive environment that provides team-based mechanisms that can be individually tailored to decrease the risk of vicarious trauma, such as established support networks with regular check-ins to debrief and discuss coping mechanisms.

Appendix D: Best Practices for Partnerships Among Hospitals

To meet the intent of Chapter 88, Laws of 2018, Commerce developed best practices for partnerships among hospitals. These best practices are the hub-and-spoke and hubless partnership models of sexual assault response. These models are discussed on OCVA's website⁷⁵ and in the "[Sexual Assault Response and Terminology](#)" section of this report ("[What Is the Hub-and-Spoke Model of Sexual Assault Response?](#)" and "[What Is the Hubless, or Decentralized, Dispatch Model of Sexual Assault Response?](#)").

⁷⁵ Washington State Department of Commerce, "Creating Access to Sexual Assault Nurse Examiners: Best Practices for Local Communities," <https://www.commerce.wa.gov/serving-communities/crime-victims-public-safety/office-of-crime-victims-advocacy/creating-access-to-sexual-assault-nurse-examiners-best-practices-for-local-communities/>

Appendix E: Further Reading on Best Practices

American College of Emergency Physicians, “Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient,” (1999), <https://www.familyjusticecenter.org/wp-content/uploads/2017/11/American-College-of-Emergency-Physicians-Evaluation-and-Management-of-the-Sexually-Assaulted-or-Sexually-Abused-Patient-1999.pdf>

Emergency Nurses Association and the International Association of Forensic Nurses, “Care of Prepubescent Pediatric Sexual Abuse Patients in the Emergency Care Setting,” (2017), https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/joint-statements/careofpedsexualabusepatientser.pdf?sfvrsn=8d3e6e17_8

Emergency Nurses Association and the International Association of Forensic Nurses, “Adult and Adolescent Sexual Assault Patients in the Emergency Care Setting,” (2016), <https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/joint-statements/adultandadolescentsexualassaultpatientser.pdf?sfvrsn=234258f1>

National Sexual Violence Center, “Sexual Assault Response Team Toolkit,” <https://www.nsvrc.org/sarts/toolkit>

Office of the District Attorney of Cambria County, “Cambria County Sexual Assault Protocol and Anonymous Reporting of Sexual Assault Protocol,” (2012), <http://www.evawintl.org/library/DocumentLibraryHandler.ashx?id=75>

Oregon Sexual Assault Forensic Taskforce, “Sexual Assault Response Team: SART Handbook,” (2009), <http://50.116.64.16/~oregonv6/wp-content/uploads/2016/07/SART-Handbook-FINAL-July-09.pdf>

U.S. Department of Justice, “A National Protocol for Sexual Abuse Medical Forensic Examinations: Adults/Adolescents,” <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>

U.S. Department of Justice, “A National Protocol for Sexual Abuse Medical Forensic Examinations Pediatric,” (2016), <https://www.justice.gov/ovw/file/846856/download>

U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, “National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach,” (2017), <https://www.ncjrs.gov/pdffiles1/nij/250384.pdf>

U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, “SANE Program and Operation Guide,” <https://www.ovcttac.gov/saneguide/>

UW Medicine Harborview Medical Center, “Recommended Guidelines: Sexual Assault Emergency Medical Evaluation, Washington State, Adults and Adolescents,” (2017), <https://depts.washington.edu/hcsats/PDF/guidelines/Recommended%20Guidelines-2017-adult.pdf>

UW Medicine Harborview Medical Center, “Recommendation Guidelines: Sexual Assault Emergency Medical Evaluation, Washington State, Child 12 Years or Younger,” (2017), <https://depts.washington.edu/hcsats/PDF/guidelines/Recommended-Guidelines-2017-Children.pdf>

Appendix F: The Harrison Medical Center

The Harrison Medical Center in Bremerton (Harrison) epitomizes a 24/7 Sexual Assault Nurse Examiner (SANE) program that offers comprehensive adult, adolescent and pediatric SANE services. Before the establishment of Harrison's SANE program, patients were waiting up to five hours in emergency rooms to get seen, causing many patients not to stay for their exams.

Harrison established its SANE program in October 1997 and continues to proactively support it. Kitsap Sexual Assault Center provide advocates on-call to victims who arrive at Harrison. Forensic interviewers from the Prosecutor's Office interview all children, consistent with county protocol. The program established relationships with law enforcement within Kitsap and surrounding counties. Its members visited Seattle's and Tacoma's crime labs to establish personal connections with them. Telephone calls and in-person meetings with local stakeholders are used to promote the program, and law enforcement officers are intentionally reminded of the program every time they visit Harrison.

Harrison's program started with the premise that it would provide 24/7 services for adults, adolescents and children. The SANE team is composed of on-call SANEs, one part-time Clinic RN who is in charge of coordinating the program and an on-call clinical coordinator who provides quality oversight. Harrison also provided a room dedicated to medical forensic exams and office space for SANE staff. All the equipment a SANE RN needs is in the exam room, so SANEs never have to leave the patient alone. The room also provides privacy for patients and allows law enforcement and advocates to know exactly where they should go once they reach the hospital. The program works with law enforcement and advocates if patients need assistance getting to Harrison.

Harrison's SANEs complete five-page charts of patient medical histories. They then perform head-to-toe exams and genital and forensic exams if patients opt for them. Patients get to choose what they want throughout the entire process. They do not have to agree to anything and can decline any of the medical or forensic options. A complete exam takes a few hours.

To support its SANE RNs, Harrison pays staff both on-call wages and per-exam pay. The program actively uses Harborview Medical Center's trainings, particularly its advanced trainings. Harrison wants each of its nurses to have the most current information and training. Harrison values repetition and updates, both of which are available through Harborview's Advanced Trainings. Harrison also sends its SANEs to the International Association Forensic Nursing's (IAFN) international conference periodically.

Harrison's SANE program has its own budget. The program is supported through grants from OCVA and the Harrison Medical Center Foundation, which contributes funds to support education and equipment expenses. The SANE program also benefits from support from the local community through donations of clothes and money.

Appendix G: Profile of SANEs and Their Work in Children’s Advocacy Centers

By Alice Zillah, section manager, Research Services

Adapted from the 2016 report “Sexual Assault Nurse Examiners — Study of Sexual Assault Nurse Examiner Availability, Adequacy, Costs, and Training.”⁷⁶

Thurston County’s Providence St. Peter Hospital Sexual Assault Clinic (Clinic) helps children, teens and adults recover from sexual assault, using an approach that is victim-centered and trauma-informed. Today, law enforcement, Child Protective Services and medical providers know to refer individuals to the Clinic when they suspect sexual abuse. In addition, the Clinic’s Sexual Assault Nurse Examiners (SANEs) serve a five-county area as well as Madigan Army Medical Center, providing medical care and forensic evidence collection for adolescents and adults in an emergency setting.

The first step is usually a forensic interview conducted by law enforcement officers. Astro, a calm Labrador service dog, is available to accompany the patient during the interview. The interviews are video-recorded and shared with prosecutors if charges are litigated.

The next step is a noninvasive medical exam, done in a warmly decorated room. The medical provider explains exactly what will happen at each step of the way. A high-tech colposcope allows the provider to identify and photograph genital injuries not readily visible to the unaided eye. Many offenders do not inflict visible injuries. In other cases, injuries have healed since the offense occurred.

As part of the healing process, children, teens and adults are encouraged to take advantage of free, onsite therapy for them and family. Astro makes himself available for canine companionship during sessions and in the courtroom, if the case proceeds to trial.

Finally, if the investigation results in charges against the perpetrator, two Thurston County Special Victim Team prosecutors, who have offices at the Clinic, litigate the cases.

The well-coordinated services provided to patients are the result of a lot of work behind the scenes to ensure the process runs smoothly from the time patients walk through the door to the day they leave their last therapy sessions.

Key to the unified approach is a weekly multidisciplinary team (MDT) meeting involving everyone who will be staffing the cases. “Multidisciplinary meetings provide communication and expert care for the kids every step of the way,” said Clinic Director Dr. Joyce Gilbert. “Being able to communicate very openly with health and welfare, law enforcement, prosecutors is

⁷⁶ Washington State Department of Commerce, “Sexual Assault Nurse Examiners”

really what aids [the patients] and helps get the best outcome.” Confidential, community-based advocates are also integral to MDTs.

MDT meetings, held every Friday, allow all team members to both collaborate on individual cases and hash out policy issues. “It’s so amazing to have these meetings,” added Nancy Young, the nurse practitioner who oversees the Clinic’s SANE program. “We used to operate in a vacuum. Now we work together as a team.”

An MDT approach enables SANE staff to follow up on cases with the police and prosecutors directly, and together the group makes system modifications for better outcomes. For instance, they developed a form that is mailed with every sexual assault kit to the Washington State Patrol (WSP) Crime Lab. The WSP fills out the form and returns it, indicating that they received all the evidence and providing feedback about packaging and methodology.

The collaboration leads to more referrals, since law enforcement agencies in the region know exactly where to refer victims. “The answer is good education and community partnering,” Young said.

One challenge the MDT cannot surmount is a consistent funding stream. “Our SANE program is a money-loser for the hospital,” explained Young, referring to Providence St. Peter Hospital, which manages the program. Providence provides about \$700,000 per year in subsidized services to the Clinic. Additional costs are covered by a hodge-podge of sources, including the Crime Victims Compensation Program and grants from DSHS, Office of Crime Victims Advocacy and the Attorney General’s Office. The funding instability contributes to a high degree of turnover in SANE practitioners, which leads to the need for ongoing training for new SANE providers – an additional expense.

Individuals served by the Clinic and its SANE program are unaware of the search for funding sources going on behind the scenes. They experience a well-organized facility staffed by kind and caring individuals – and one amiable dog – who help make it possible to heal from the trauma of sexual abuse.

Appendix H: Tele-SANE

Telemedicine, or telehealth, has been nationally suggested as a way to increase access to SANE services. Telemedicine or telehealth is when “a health care practitioner uses HIPAA-compliant, interactive, real-time audio and video telecommunications, including web-based applications, to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located.”⁷⁷ The promise of “tele-SANE” care is that it would provide “around-the-clock medical assistance in sexual assault treatment services to providers who do not offer anything in this area.”⁷⁸

Its proponents tout it as a way to increase access to SANE services, unfettered by place or the skillset of the staff performing the examination. All a hospital would need is a good internet connection, they say. But this is not the case. A number of empirically based observations, questions and risks associated with tele-SANE call into question its utility as a viable victim-centered, trauma-informed practice for increasing access to SANE services:

- Significant start-up costs are associated with training hospital administrators and staff about how to use tele-SANE services and procuring telehealth technologies.
- Limited internet connection bandwidth can disrupt telehealth services or prevent them from being an option at all, particularly in low population density areas.
- Current tele-SANE projects have not included feedback from patients, despite concerns about patient privacy, confidentiality and informed consent.⁷⁹
- Potential risks exist related to how prosecutors evaluate evidence gathered in exams conducted by untrained medical staff under the supervision of a tele-SANE.⁸⁰

Because of the large investments in infrastructure required as well as the known and unknown risks for hospitals, medical staff and victims of sexual assault, this report does not recommend tele-SANE as a policy option for Washington at this time. Nevertheless, to better understand what is involved in undertaking a tele-SANE project, a brief description of Massachusetts’ tele-SANE project is provided below.

Massachusetts’ Telehealth Program

Massachusetts established a telehealth pilot for sexual assault medical and forensic examinations in 2013 with \$3.3 million in grant funding from the U.S. Department of Justice.⁸¹ The pilot is housed in its own office space at a central hospital, with 25 participating SANEs.

⁷⁷ Healthcare-Informatics, *Massachusetts Announces Telehealth Pilot for Sexual Assault Treatment*, <https://www.healthcare-informatics.com/print/news-item/massachusetts-announces-telehealth-pilot-sexual-assault-treatment>

⁷⁸ Ibid.

⁷⁹ Interviews with telehealth experts.

⁸⁰ Ibid.

⁸¹ Massachusetts Department of Public Health, “National Assault TeleNursing Project,” http://www.ncdsv.org/images/MDPH_NationalSATeleNursingProjectRequestingInformation_2-1-2013.pdf

Telehealth providers give in-person trainings of four to six hours to inform participating hospital administrators and SANEs on how to use telehealth services. The Massachusetts Department of Public Health (DPH) worked with the American Doctors Association to procure telemedicine technologies and provide them to the four facilities participating in the project. All six sites were inspected and selected because they met DPH expectations. Memorandums of understanding were established between DPH and the sites to provide tele-SANE services. As a part of this, DPH provided further training on cultural and diversity issues at sites where cultural guidance was deemed lacking.

After two years of operation, the Massachusetts tele-SANE project has seen the following outcomes:

- 224 patients served
- 135 exams conducted
- 90 percent of patients agreed to have their exams conducted with telehealth

Most SANEs reported positive experiences and a sense of feeling supported by telehealth providers. In the two cases that went to court, the defendants pleaded guilty. No opportunity has surfaced to see what would happen if a defense attorney were to cross-examine the service. Notably, problems did occur when:

- Certain sites updated their broadband networks
- Weather affected the video quality
- Bandwidth was not enough to support the service

No study has looked into how patients feel about the service.

Appendix I: Washington State Hospital Association Survey

Table 5: Results of Washington State Hospital Association Survey

Hospital/Provider	No. of SANE-Trained Staff	No. of <u>Other Trained Staff</u>	Comments
Astria Regional Medical Center	8	0	-
Astria Sunnyside Community Hospital		4	-
Astria Toppenish Community Hospital	3	2	-
Cascade Valley Hospital & Clinics	7	0	-
CHI Harrison Medical Center	10	0	-
CHI Highline Medical Center	Out-of-state vendor	0	-
CHI St. Anthony Hospital		0	-
CHI St. Clare Hospital		0	-
CHI St. Elizabeth Hospital		0	-
CHI St. Francis Hospital		0	-
CHI St. Joseph Medical Center		0	-
Confluence Health/Central Washington Hospital		4	0
Confluence Health/Wenatchee Valley Hospital	5	0	-
Coulee Medical Center	3	0	-
EvergreenHealth	18	0	-
EvergreenHealth Monroe	Contract with EvergreenHealth Kirkland	0	-
Forks Community Hospital	3	0	-
Grays Harbor Community Hospital	7	0	-
Island Hospital	5	0	-
Kadlec Medical Center	8	0	-
Kittitas Valley Hospital	6	10	-
Klickitat Valley Hospital	6	0	-
Legacy Salmon Creek Medical Center	Out-of-state vendor	0	-
Lourdes Medical Center		6	-
Mid-Valley Hospital	2	0	-
MultiCare Allenmore Hospital	Out-of-state vendor	0	-
MultiCare Auburn Medical Center		0	-

Hospital/Provider	No. of SANE-Trained Staff	No. of <u>Other Trained Staff</u>	Comments
MultiCare Deaconess Hospital	5	0	-
MultiCare Good Samaritan Hospital	Out-of-state vendor	0	-
MultiCare Mary Bridge Children's Hospital	Out-of-state vendor	0	-
MultiCare Tacoma General Hospital		0	-
MultiCare Valley Hospital	4	15	-
Newport Hospital & Health Services	1	0	-
Olympic Medical Center	8	0	-
Othello Community Hospital	3	0	-
Overlake Hospital Medical Center	8	0	-
PeaceHealth Island Medical Center	2	0	-
PeaceHealth Southwest Medical Center	Out-of-state vendor	0	-
PeaceHealth St. John Medical Center	5	0	-
PeaceHealth St. Joseph Medical Center	11	0	-
PeaceHealth United General Hospital	6	0	-
Prosser Memorial Health	5	14	-
Providence Centralia Hospital		0	The SANEs at Providence St. Peter Hospital travel to Providence Centralia as needed.
Providence Holy Family Hospital	15	35	-
Providence Mount Carmel Hospital	3	0	-
Providence Regional Medical Center Everett	14	0	-
Providence Sacred Heart Medical Center & Children's Hospital	4	50	-
Providence St. Mary Medical Center	8	0	-
Providence St. Peter Hospital	14	0	-
Pullman Regional Hospital	14	0	-
Samaritan Hospital	4	0	-

Hospital/Provider	No. of SANE-Trained Staff	No. of <u>Other Trained Staff</u>	Comments
Seattle Children's	Contract with UW Harborview	0	-
Skagit Valley Hospital	11	0	-
Skyline Hospital	8	0	-
Swedish First Hill	Contract with UW Harborview	0	-
Swedish Edmonds	Contract with Providence Intervention Center for Assault and Abuse	0	Providence Intervention Center for Assault and Abuse provides 24/7 SANE coverage to conduct sexual assault medical exams.
Swedish Mill Creek Emergency Department	Contract with Providence Intervention Center for Assault and Abuse	0	-
Trios Health	2	0	-
Tri-State Memorial Hospital	3	0	-
UW Harborview Medical Center	20	2	-
UW Medical Center	Contract with UW Harborview	0	-
UW Valley Medical Center	Contract with UW Harborview	0	-
Virginal Mason Memorial	6	65	-
Whidbey General Hospital	8	0	-
Willapa Harbor Hospital	3	2	-
Total	290	205	-

Source: Zosia Stanley, Washington State Hospital Association, (July 2018).⁸²

⁸² Important notes on Table 5:

- All references to “out-of-state vendor” refer to the same vendor. Cells are merged to show where facilities share the same contract.
- These numbers include most, but not all, of the hospitals that provide sexual assault forensic evidence kit collection. The numbers do not reflect all trained nurses or other providers in the state.
- These numbers are not comprehensive and do not include precise numbers for the private, out-of-state vendor that supplies SANE nurses to some hospitals in Clark, Pierce and King counties. The vendor has about 46 SANEs available in the Portland, Oregon, and Clark County region and about 31 SANEs available in the Pierce County and King County region.
- The number of SANE-trained nurses and other specially trained providers fluctuates regularly as staff move to other roles, leave the hospital or decide they no longer want to be SANEs.
- Most hospitals contact SANEs on an as-needed basis if one is not on shift when needed.
- Some hospitals have SANEs specially trained for pediatric patients (those younger than 12-14), but this information was not collected. Many hospitals refer out pediatric patients due to the highly specialized nature of the exam.

Appendix J: Sample Memorandum of Understanding

Harborview Medical Center
Center for Sexual Assault and Traumatic Stress
AGREEMENT FOR SERVICES

This Agreement (“Agreement”) is made and entered on the 1st day of _____ by and between _____ a Washington state non-profit corporation and Harborview Medical Center, operated by the University of Washington an institute of higher education (“HMC”). The purpose of this Agreement is to establish the delivery of services and payment between parties, and to define other contingencies on which the business relationship will rest.

- I. **Purpose of the Agreement** the parties wish to provide for the provision of **Sexual Assault Nurse Examiner (“SANE”)** services by a HMC staff-member working onsite at _____ and _____ sites.

- II. **Responsibilities of (Name of offsite hospital)**
 - A. Comply with essential aspects of the HMC and Harborview Center for Sexual Assault and Traumatic Stress (“HCSATS”) sexual assault protocols as provided by HMC in advance of the start date of this Agreement.
 - B. Create policies and procedures for sexual assault care and provide these policies to HCSATS.
 - C. Identify patients in _____ emergency department and on inpatient settings that may be victims of sexual assault age 13 and older.
 - D. Obtain consent from patient for forensic examination and evidence collection.
 - E. Notify the SANE provider on-call (via HMC ED social work XXX-XXXX). When a SANE provider is not on-call, _____ retains the responsibility for treating the patient or transferring the patient to HMC ED.
 - F. Provide the same parking conditions to SANE who arrives to do exam as provided to _____ staff who arrive for similar shift times.
 - G. Provide social work [or sexual assault advocate] services to include: medical and legal advocacy, and assessment and intervention when needed consistent with _____ policies for urgent safety, psychiatric and psychosocial need.
 - H. Provide medical screening exams, evaluation and treatment of medical, psychiatric and surgical conditions for all patients who are triaged for forensic sexual assault exam in accordance with _____ policies and procedures.
 - I. Provide physician or other independent provider (ARNP, PA-C) back up to SANE, including evaluation of other medical and surgical conditions, prescribing medications, and supervision of any medical care rendered by the SANE provider.
 - J. Maintain responsibility for patient care until arrival of SANE; after SANE arrival continue responsibility for patient care outside the scope of practice of SANE.

- K. Provide enclosed exam room in staffed area or other appropriate examination space for the identified patient(s).
- L. Provide chaperone for examination when requested by patient or SANE.
- M. Provide equipment specific to current standards for forensic examination techniques, including sexual assault evidence kits.
- N. Provide digital camera in accordance with HCSTS specifications.
- O. Provide digital media, storage and transfer of photos to law enforcement according to HCSATS specifications.
- P. Provide necessary clinical laboratory services in accordance with HCSTS procedures.
- Q. Provide necessary pharmacy services; on site provision of emergency contraception, post-exposure prophylaxis, and HIV post exposure medications when indicated.
- R. Provide structured medical forms for sexual assault examination (sample provided with HCSATS standards).
- S. Provide additional medical/nursing/ancillary support as directed by individual patient needs.
- T. Provide to SANE patient background medical information as needed for patient care.
- U. Provide paper scrubs or other substitute clothing for patient when patient's clothing is collected for forensic evidence.
- V. Maintain medical patient and forensic examination records.
- W. Maintain evidentiary chain of custody as needed for any related criminal investigation or prosecution.
- X. Request patient authorization to disclose copy of medical records and photographs of records for uses and disclosures that require patient authorization including 1.) Release of medical records and evidence to law enforcement, 2.) Release of medical records to HCSATS for quality assurance, and 3.) Release of records to HCSATS counseling for psychosocial outreach.
- Y. Release evidence to law enforcement where there is appropriate consent to release protected health information or otherwise permitted by law. Maintain records regarding release of forensic evidence.
- Z. Establish policy for secure maintenance of evidence for six months in the absence of law enforcement report establish policy for notifying patient of plan to discard evidence after six months if police report not made.
- AA. With patient consent, FAX report to HCSATS within 24 hours (attn. Patient Care Coordinator XXX-XXXX).
- BB. Provide means for medical and legal advocacy and psychosocial follow-up either through HCSATS (patient consent to release medical records required) or via _____ staff.
- CC. Develop discharge summary for patient, to be given to patient with summary of care and resources.
- DD. _____ is responsible for billing to Crime Victims Compensation.
- EE. Forward subpoenas directly to HCSATS SANE providers promptly – mail to HCSATS office Attn: Patient Care Coordinator.

III. Responsibilities of Harborview Medical Center

- A. Provide Sexual Assault Nurse Examiner coverage for a minimum of 96 hours per week. Care to be provided in the (offsite) emergency department, and inpatient floors on ___ and ___ campuses.
- B. Provide legal testimony services as required.
- C. Train SANE providers and establish and complete annual competencies. Ensure compliance with the requirements of Exhibit A.
- D. Inform ___ of current list of SANE providers.
- E. Provide ___ current copy of HMC and HCSATS sexual assault protocols.
- F. Follow HCSATS sexual assault examination procedures.
- G. Maintain effective communication with ___ emergency department or inpatient floor staff.
- H. Provide continuous quality assurance of services provided to ___ patients by SANE.
- I. Comply with HMC hospital guidelines, bylaws, protocols, and procedures and ___ policies and procedures for sexual assault care (Section II B.) when established.
- J. Complete CVC documentation sheets (SAFE billing forms) as needed for ___ to bill for services provided by SANE.
- K. Provide initial in-service training to ___ staff to include ED medical staff, Inpatient medical staff and social work on HCSATS protocols and procedures and updates as needed.
- L. HMC agrees that the SANE assigned to provide services under this Agreement shall meet the following criteria:
 - a. Maintain an unrestricted license to practice in the State of Washington as a Registered Nurse or Advanced Registered Nurse Practitioner or Physician Assistant.
 - b. Maintain eligibility to participate in federal health care programs and the Washington State Medicaid program.
- M. Maintain the following documentation for each SANE:
 - 1. SANE position description
 - 2. Documentation of current licensure and credentialing
 - 3. Documentation of specialized/SANE training
 - 4. Statement of safety and infection control education
 - 5. Statement of immunization status, Statement of Basic Life Support Certification
 - 6. Evidence of orientation to _____ Emergency Department
 - 7. Program specific competencies
- N. Make documentation in paragraph K, L and M available to ___ upon request.
- O. Provide
 - 1. Legal and medical advocacy services
 - 2. Psychosocial outreach
 - 3. Follow-up RN/social work visits at HCSATS as requested by patient

- IV. Payment** – ___ shall pay HMC at the rate of \$850.00 per patient case. HMC HCSATS will submit a billing statement to ___ every 45 days. Payment of all undisputed amounts shall be made by ___ to HMC within 30 days.
- A. If the SANE is called out and while in transit is notified that the patient has left, ___ Medical Center shall pay HMC 50% of the above rate
 - B. If the SANE is called out and arrives at ___ and finds patient has left, ___ shall pay HMC 75% of the above rate
 - C. If the SANE provides in-person services to the patient, with or without a complete exam, ___ shall compensate HMC 100% of the above rate.
- V. Relationship of Parties** – The parties intend that an independent contractor relationship will be created by this Agreement. Nothing in this Agreement is intended to create an employer/employee relationship between HMC and ___ or between ___ and any HMC employee that did not exist prior to the effective date of this agreement. ___ and its employees or agents performing under this Agreement are not employees or agents of ___. ___ will not hold itself out as or claim to be an officer or employee of HMC or of the State of Washington by reason hereof, nor will the ___ make any claim of right, privilege or benefit that would accrue to a state employee under law. No HMC employee shall be entitled to any right privilege or benefit that would accrue to a ___ employee under law.
- VI. OSHA/WISHA** – Each party agrees to comply with the requirements of the Federal Occupational Safety and Health Act of 1970 (OSHA), the Washington Industrial Safety and Health Act of 1973 (WISHA), and the standards and regulations issued thereunder. Each party (“indemnifying party”) further agrees to defend, indemnify and hold harmless the other party, its officers, directors, employees and agents (“indemnified party”) from all damages assessed against the indemnified party as a result of the indemnifying party’s failure to comply with the OSHA/WISHA and the regulations or standards issued thereunder.
- VII. INDUSTRIAL INSURANCE COVERAGE** – ___ and HMC shall provide industrial insurance coverage for their own respective employees, in accordance with Title 51 RCW.
- VIII. TAXES** – All payments accrued on account of payroll taxes, unemployment contributions, any other taxes, insurance or other expenses for the SANE shall be the responsibility of HMC.
- IX. ASSURANCES AND CORPORATE COMPLIANCE PLAN** – HMC and ___ agree that all activity pursuant to this Agreement will be in accordance with all the applicable current federal, state and local laws, rules, and regulations, and medical center compliance policies and additional accreditation requirements.
- X. Term** – The term of this Agreement is two years. This Agreement may be renewed upon mutual written agreement of the parties.

- XI. No Obligation to Refer** – This Agreement does not impose an obligation on any party to refer patients to any party, including those not a party to this Agreement for any services. No person shall receive any payment hereunder for referral of any patient or ordering of any test or procedure.
- XII. Debarment/Suspension** – Both parties hereby represent and warrant that neither they nor their principals (if applicable) are presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from participation in any federally funded health care program, including Medicare and Medicaid. Both parties hereby agree to immediately notify the other of any threatened, proposed, or actual debarment, suspension or exclusion from any federally funded health care program, including Medicare and Medicaid, that would affect this agreement. In the event that either party is debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in any federally funded health care program during the term of this Agreement, or if at any time after the effective date of this Agreement it is determined that either party is in breach of this Section, this Agreement shall, as of the effective date of such action or breach, automatically terminate.
- XIII. INSURANCE** – During the term of this Agreement, both parties agree to maintain the following insurance coverage: a) comprehensive general liability insurance with limits of at least \$2 million per occurrence and \$5 million aggregate; b) professional liability insurance with limits of at least \$2 million per occurrence and \$5 million aggregate; c) automobile liability insurance with limits of at least \$2 million per occurrence and \$5 million aggregate; and d) such other insurance as the other party requests. Each party will notify the other at least 30 days before canceling or making any material change to the above coverage or within 15 days after receiving notice of cancellation or renewal or any other material change in coverage from any of its insurers and will provide the other party with acceptable evidence of coverage upon request. HMC maintains liability coverage through the University of Washington, operator of HMC, pursuant to RCW 28B.20.250, .253, and .255, and such coverage shall be deemed to satisfy the provisions of this paragraph. _____ maintains self-insured programs in accordance with the requirements of Washington state and such coverage shall be deemed to satisfy the provisions of this paragraph.
- XIV. Assignment** – This Agreement may not be assigned or transferred by any party without the prior written consent of the other party. The terms of this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective heirs and successors in interest.
- XV. Entire Agreement.** This agreement and any exhibits represent the entire agreement, and no other representations or agreements, oral or otherwise, shall be of any force or effect.

XVI. Indemnification – ___ agrees to indemnify and hold harmless HMC, its directors, officers, employees and agents from and against any and all claims, actions, or liabilities which may be asserted against them by third parties in connection with the negligent performance of ___, its directors, officers, employees, or agents under this Agreement. HMC agrees to indemnify and hold harmless ___, its directors, officers, employees, and agents from and against any and all claims, actions, or liabilities which may be asserted against them by third parties in connection with the negligent performance of HMC, its directors, officers, employees, or agents under this Agreement.

XVII. AMENDMENTS – This Agreement may be amended by mutual agreement of the parties. Such amendments shall not be binding unless they are in writing and signed by personnel authorized to bind each of the parties. No alterations in any of the terms, conditions, delivery, price, quality, quantity or specifications shall be effective unless the alteration is expressly acknowledged and accepted in writing by HMC.

XVIII. Termination without Cause – HMC and ___ shall have the right to terminate the terms of this Agreement with 30 days written notice from one to the other.

XIV. Termination with Cause – Either party may terminate this Agreement immediately upon written notice of the following by either party: a) exclusion from participation in a federal health care program or from contracting with state or federal agencies; b) dissolution, insolvency, or cessation of business; or c) loss of professional liability coverage required by this Agreement. In addition, either party may terminate this Agreement for material breach of the provisions of this Agreement subject to the following opportunity for cure: The non-breaching party shall provide written notice of the breach to the breaching party and shall allow the breaching party not less than fifteen (15) days to cure. If, following the period for cure, the breach remains, the non-breaching party may immediately terminate on written notice to the breaching party.

XX. Notice. Written notice required under this Agreement shall be delivered personally or sent by U.S. registered or certified mail, postage prepaid and return receipt requested, and addressed to the following designated individuals at the following addresses:

Harborview Medical Center
Contact

Off site Hospital
Contact

XXI. Governing Law. This Agreement shall be governed in all respects by the laws of the state of Washington. Venue shall be in King County.

XXII. Severability. The provisions of this Agreement are severable and if any portion is held to be invalid, illegal, or unenforceable for any reason, the remaining provisions shall be effective and binding upon the parties.

Appendix K: Bibliography

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