

DNP Portfolio Executive Summary
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The OHSU Doctor of Nursing Practice (DNP) program has provided me with an opportunity to expand my role as an advanced practice nurse in the areas of clinical leadership, evidenced based practice, and public policy. This has been accomplished through a broad range of course work ranging from information technology to applied economics and finance, and from clinical inquiry to health policy. In addition, residency experiences with both the Department of Human Services and the Attorney General's Sexual Assault Task Force have provided exposure to both the legislative process and population focused health care.

While my clinical experience is in college health and internal medicine, my focus throughout the DNP program has been in the area of sexual assault. As reflected in my DNP portfolio, I have addressed issues of sexual violence related to alcohol, health disparities, human trafficking, ethics, health outcomes, and forensic evidence collection. Additionally within my residency, I have utilized my experience as a Sexual Assault Nurse Examiner to improve statewide guidelines and evidenced-based practice pertaining to acute sexual assault care and forensic evidence collection.

As a component of my residency, I had the unique opportunity to participate in the Legislative and Public Policy Committee of the Attorney General's Sexual Assault Task Force. Utilizing my clinical and leadership experience in medical forensic, I was able to provide input on proposed sexual violence legislation to then Attorney General Hardy Meyers and members of the committee. In addition, I was involved in policy and legislative issues related to sexual assault and mandatory reporting, alcohol and incapacitation, HIV post-exposure prophylaxis, forensic evidence collection, and caring for diverse populations. Much of the outcome of this work has subsequently been distributed to medical clinics and emergency rooms throughout Oregon.

My clinical inquiry project, *Evaluating Campus-based Sexual Assault Nurse Examiner Effectiveness*, highlights an aspect of my work as an advanced practice nurse. As a DNP student I was able to complete a program evaluation of this project which measured the quality of clinical services provided to individuals post sexual assault. The results demonstrate important findings regarding the capacity of a non-emergency room facility to offer sexual assault services and supports the use of SANEs for the provision of sexual assault care. This project exemplifies an opportunity for nurses to work in an expanded role. The success of this project demonstrates my clinical skills and leadership capacity in a complex effort to improve the delivery of care which required working with multiple disciplines. I believe I now have the capacity to initiate similar quality improvement projects in other clinical areas.

Over the course of this DNP program I have acquired the skills necessary to impact the clinical response to acute sexual assault in the state of Oregon through improvements in policies, medical response, and legislation. My residency experience has allowed me to work with a number of individuals across multiple disciplines who can remain future resources and collaborators on issues of sexual assault in our communities. I believe my accomplishments at the state level will provide me career opportunities to become involved in sexual violence issues at the national level, to engage in further research opportunities, and to pursue work as both a teacher and clinician. As a DNP graduate, I have acquired the initiative and independence necessary to improve the care of the patients I see on a daily basis, while also promoting improvements in the delivery of clinical care among a full range of populations. It is with much anticipation that I hope, just as the DNP program signals a change to the face of nursing, that as a DNP graduate I can prove to be a role model for innovative excellence in clinical care.

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Clinical Inquiry Proposal

Evaluating Campus-based Sexual Assault Nurse Examiner Effectiveness

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Evaluating Campus-based Sexual Assault Nurse Examiner Effectiveness

Clinical Problem

Rape is a public health concern of significant magnitude in the United States and affects nearly 1 million American women annually (Resnick et al., 2000). United States Department of Justice (2006) data reveal that forcible rape accounts for approximately 6.5% of all violent crimes. The Federal Bureau of Investigation asserted that sexual assault is the least reported of all violent crimes (U.S. Department of Justice). A National Women's Study concluded that only one of five victims reported a sexual assault to law enforcement (Resnick et al.).

While victims of sexual assault have traditionally received post assault care in emergency room settings, research has shown that survivors do not receive the services they require (Campbell et al., 2006). In this setting, victims are often cared for by health care providers untrained in post-assault care and who have been found to provide improper documentation of the sexual assault details and exam, neglect emotional needs, and participate in victim blaming (Taylor, 2002).

Historically at Oregon colleges and on most campuses nationwide, students presenting acutely following sexual assault to campus-based health centers receive fragmented and inconsistent medical care without the option of forensic evidence collection. In general, clinicians lack the knowledge to best care for sexual assault victims and more specifically, lack the specialized training necessary to collect forensic evidence that would preserve future reporting options (Patterson, Campbell & Townsend, 2006).

Sexual Assault Nurse Examiner (SANE) programs were formed in the 1970s to address the need for comprehensive sexual assault care (Campbell et al., 2005). SANEs are specially trained in forensic evidence collection, trauma response, and expert testimony (Patterson et al., 2006). The

SANE's role includes providing impartial documentation of the assault, medical and injury care, proper evidence preservation, and appropriate referrals (Ferguson, 2006; Taylor, 2002). The goals of these programs are to minimize trauma, expand use of community resources, and facilitate the investigation and prosecution of offenders (J. Cole & Logan, 2008). Taylor identifies SANEs as critical to facilitating a positive experience for a sexual assault survivor and contributing to a more rapid and adaptive resolution to the assault.

According to Ferguson (2006), advanced practice nurses are ideally suited to care for survivors of sexual assault in community-based settings given their advanced education in anatomy and physiology, physical assessment, and mental health evaluation. The purpose of this practice improvement project is to examine SANE services provided by nurse practitioners in a campus-based health center on an Oregon campus. The clinical inquiry project will examine archival data through medical records and SANE log review to describe the percentage change in documentation of medical and forensic evidentiary services provided to survivors of sexual assault following implementation of a Sexual Assault Nurse Examiner program.

The student leading this inquiry project guided the efforts to create this campus SANE program. As the first SANE program of its kind in Oregon and one of only a few nationwide, there is significant interest in the results of such a clinical inquiry project. It is important to examine the outcome of this program, as similar programs are being implemented on other campuses. Finally, there is strong support from the Oregon Attorney General's Sexual Assault Task Force for the advancement of knowledge in the area of SANE practice in this state.

Conceptual Framework

According to Wasco (2003), empowerment can help mediate the effects of sexual violence and is a useful construct in examining comprehensive care for a sexual assault victim. Finfgeld

(2004) provides a framework (see Figure 1) that is particularly well suited to illustrating sexual victimization and the interconnection between survivor, community response, and outcomes.

Sadan (1997/2004) describes empowerment as a transition from a situation of powerlessness to a position of relative control over one's life, destiny, and environment. Critical to sexual assault is the additional tenet that this process can include either an actual or *perceived* ability to control aspects of one's life (Sadan). Furthermore, although empowerment cannot be imparted to individuals, there are means by which people can empower themselves (Wallerstein, 2006). Enhancement and utilization of internal resources that promote healthy responses to coping post assault are critical aspects of empowerment.

There are several assumed and defining attributes to empowerment theory that are pertinent to sexual assault (Finfgeld, 2004; Napier, 2006; Sadan, 1997/2004):

1. Empowerment resides in an individual. It is not a product of heredity and the potential for empowerment exists in every person.
2. Empowerment is a process that encourages internal resource utilization to strive for power sharing and participatory decision making.
3. Empowerment does not ascribe blame for powerlessness.
4. Empowerment is a dynamic process that aims to increase personal and political power of individuals or groups to improve the lives of the similarly oppressed.

Finfgeld (2004) proposes four levels of empowerment: participating, choosing, supporting, and negotiating. In sexual assault, the first level may simply be the victim's willingness to present to a clinic for post-assault care. It reflects a demonstration of courage in confronting their victimization. At the second level, survivors are asserting themselves through shared decision making and choosing options (often regarding law enforcement reporting). This level implies a

level of trust by the victim and commitment to care by the SANE to avoid revictimization. The third level requires engagement by the survivor in issues beyond his/her personal needs and may include efforts toward social activism. The lines between the organization and the oppressed may begin to blur, given the obligations of the SANE to both the survivor and community. The fourth level involves a shift in perception by the oppressed leading to a sense of justice by the victim and others. It is not always possible to achieve this aspect of empowerment. In sexual assault, it may occur at a later stage of the medical-legal process when a satisfactory outcome is achieved, which may or may not include perpetrator conviction.

The outcomes of empowerment are not always easy to define, and because it is a dynamic process, there are no absolute outcomes (Sadan, 1997/2004). Yet, the theory retains the capacity to successfully describe individuals or groups under changing circumstances. In some situations empowerment may be simply an intermediary step toward health outcomes (Wallerstein, 2006). Sometimes empowerment is merely an individual or collective effort to improve one's life and environment and it is the process that can be as important as the outcome (Sadan; Wallerstein). Empowerment encompasses a principle of self determination that should allow a victim to choose post assault care options linked to meaningful outcomes in their lives. With this in mind, empowerment theory would support the victim who chooses not to proceed with reporting an assault to law enforcement.

The concepts of empowerment theory are generalizable to sexual assault, as they are grounded in issues affecting vulnerable populations. With regard to sexual victimization, empowerment theory allows for a greater understanding of the integral connection between sexual assault and the larger ecological framework of the society in which it occurs. Empowerment theory acknowledges the relationship between individuals and the social and political context of

their lives. That is, the private and public, or the personal and the political, are intimately connected in society (Sadan).

Review of the Literature

The literature review outlines national sexual violence statistics among adult women with a specific discussion of campus data. Included is a review of current knowledge regarding post assault medical care and forensic evidence collection, with an emphasis on examination of SANE services. Strengths and gaps within the current literature are discussed.

In a National Violence Against Women survey, only 36% of victims over the age of 18 received medical care following their assault (Tjaden & Thoennes, 1998). Resnick et al. (2000) found that reporting victims were nine times more likely to receive medical care than non-reporters. Over 4 million adult women in the United States have been sexually assaulted without having ever received medical care to address rape related outcomes (Resnick et al.). Many others received care too late to benefit from pregnancy or infection prevention treatment (Patterson et al., 2006; Campbell et al., 2005).

According to the U.S. Department of Justice (2006), rape is the most common violent crime on campuses in this country. College women are vulnerable given the increase in dating and sexual relationships during this time period (Nasta et al., 2005). In an Institute of Higher Education survey, it was found that more than 25% of college-aged women reported experiences that met the legal definitions of either rape or attempted rape (Karjane, Fisher, & Cullen, 2005). Women in sororities are at even higher risk for sexual victimization than other college women (Anderson, & Danis, 2007).

Statistics from the U.S. Department of Justice indicate 2.8% of college females are victims of either an attempted or completed sexual assault in any given academic year (Fisher, Cullen, &

Turner, 2000). When factored for multi-rape victims, it translates into nearly 35.3 incidents per 1,000 students (Fisher et al.). This in turn equates to approximately 350 assaults per year on an average size campus of 10,000 (Fisher et al.). Less than 5% of these rapes will be reported to law enforcement (T. Cole, 2006).

In a study of emergency room visits for assault approximately 143,647 sexual assaults were seen in the nation's emergency rooms between 2001 and 2002 (Saltzman et al., 2007). Rape victims seen in emergency rooms have received a lower standard of care as compared to other emergency room patients (Patterson et al., 2006; Taylor, 2002). Victims of sexual assault suffer long emergency room waits; go up to 12 hours without food, drink, or toileting; and have their injuries considered less serious than other trauma victims (Taylor). Campbell et al. (2005) reported that contact with the medical system often resulted in feelings of guilt, disappointment, distrust, and a reluctance to seek further help. The experiences of victims in emergency room settings or with law enforcement often make it less likely a sexual assault victim will seek medical care or report the crime.

Forensic evidence collection is essential to efforts to pursue further investigation and prosecution. Due to complex social issues surrounding sexual assault, many offenses are never reported (Scott, & Beaman, 2004). Victims are reluctant to report an assault for fear of criminal justice system mistreatment and perpetrator retaliation (Clay-Warner, & Burt, 2005). Legal reforms have attempted to remove barriers to victim reporting through changes in evidentiary requirements, establishment of rape shield statutes, and the redefining of definitions of rape (Clay-Warner, & Burt; Flowe, Ebbesen, & Putcha-Bhagavatula, 2007).

Law enforcement involvement in forensic evidence collection can be a deterrent to victim consent. While Johnston (2005) reported favorable results of SANE services in one program, 72%

of the victims regretted having reported to law enforcement. Findings of a National Women's Study support SANE programs that allow for the collection of forensic evidence without the need for the victim to immediately report the assault to law enforcement (Resnick et al., 2000).

In the immediate post assault period 50% of victims have evidence of physical trauma, nearly 30% will contract a sexually transmitted infection, and up to 5% become pregnant (Resnick et al., 2000). Over the years, sexual assault victims have been found to have 2.5 times higher utilization of medical services than non-victims for such things as chronic illnesses and self-destructive behavior (Resnick et al.).

The National Institute of Justice's report, *Sexual Assault on Campuses: What Colleges and Universities Are Doing About It* (Karjane et al., 2005) lists the provision of SANE services as one of the most promising practices of the report. The Attorney General's Sexual Assault Task Force *Guidelines for Comprehensive Sexual Assault Response and Prevention on Campus* (2006a) recommends medical providers treating victims of rape obtain sexual assault specific training and that forensic evidence be collected by certified SANEs.

A 2003 study funded by the National Institute of Justice evaluated the efficacy of SANE care on medical care, victim services, law enforcement and prosecution (Crandall, & Helitzer, 2003). The results support SANE programs as having a positive impact on the quality of medical services, including provision of emergency contraception and sexually transmitted infection prevention. In addition, a superior quality of forensic evidence was collected, enhancing law enforcements work and increasing the conviction rate and length of sentencing (Crandall, & Helitzer; Plichta, Clements, & Houseman, 2007; Stermac, Dunlap, & Bainbridge, 2005). Another study of 515 forensic evidence kits found that SANEs were more accurate and complete in the

performance of evidence collection as compared to either non-SANEs or physicians (Sievers, Murphy, & Miller, 2003).

Campbell et al. (2005) noted that SANE programs in existence less than five years were more likely to have been created to provide better medical care as compared to older programs that were initiated as a result of physician resistance to testifying. Another study found that attending to a victim's emotional needs, supporting empowerment of survivors, and changing community reactions to rape survivors were the most important values to many SANE programs (Patterson et al., 2006).

Presently, research examining the actual clinical practices of SANE programs is limited (Campbell et al., 2005; Patterson et al., 2006; Sievers, Murphy, & Miller, 2003; Stermac et al., 2005). In addition, there has been insufficient research on the function of programs providing sexual assault services over time (Campbell, 2005). Research is needed to examine emerging SANE programs to evaluate current service provision as compared to the goals of the initial programs (Patterson et al.). Historically, many sexual assault victims on campuses choose not to report an assault. Resnick et al. (2000) stresses the importance of gathering data on non-reporting victims to better understand the full spectrum of assault victims. Campbell et al. (2005) emphasizes the need to examine innovative programs that address sexual assault care, including campus-based SANE programs.

According to Stermac et al. (2005), although SANE programs are slowly developing and their clinical usefulness has been reported, there remains a lack of empirical research in this field. Even as the scope of practice for SANEs has become better defined, research on actual evidence-based SANE practices is missing (Stermac et al.). Ledray (2005) stresses the need for a scientific examination of the impact of SANE programs. Since its inception in 2005, the *Journal of Forensic*

Nursing has published no articles on SANE services in campus-based healthcare settings. A review of the *Journal of American College Health* from 2003-2008 reveals an absence of articles on SANE programs at the university level.

Other Evidence

In 2007, the Oregon legislature passed HB2154 which created a major change in practice with regard to sexual assault care. This legislation allows victims of sexual assault to consent to the collection of a rape kit regardless of whether the victim reports the assault to law enforcement (Attorney General's Sexual Assault Task Force [AG's SATF], 2007). HB2154 will ensure that the collection of a forensic evidence kit is done in a manner that protects the victim's identity (Oregon State Legislature, 2007).

The bill further outlines the conditions under which the Department of Justice will reimburse medical providers for sexual assault examinations and thus, eliminate charges to the victim for these services (Oregon Department of Justice, 2003). This bill was designed to promote the preservation of valuable forensic evidence through the immediate collection of a rape kit (AG's SATF, 2007). Should a victim later decide to report the assault, law enforcement and prosecutors would then have access to evidence that could potentially contribute to a successful investigation and prosecution (AG's SATF). Eliminating law enforcement authorization of the SAFE kit under this law provides survivors the option of having evidence collected while giving them time to come forward in the aftermath of a sexual assault (AG's SATF).

Summary

The literature suggests that SANE services are a superior means of providing post-assault care to victims of sexual assault. University settings are home to a group of individuals at high risk of sexual assault. Providing limited services by untrained health care professionals or deferring

responsibility for care of rape victims to local emergency rooms does not reflect best practices in the provision of medical care for the students attending these institutions. Survivors of sexual assault deserve to be offered a comprehensive range of post-assault services on campus.

Implementing SANE services in a non-emergency room setting offers the potential to expand the provision of comprehensive, compassionate post-assault care while still preserving all options for a victim of sexual assault who may desire forensic evidence collection.

Ultimately, SANE services aim to influence the empowerment process in sexual assault and the social structure in which this powerlessness exists. It starts with a SANE program philosophy that acknowledges a process that may begin with a perpetrator's advanced planning, use of coercion or force and search for a vulnerable victim. It includes understanding a victim's survival strategies, decisions to disclose, seek help, and attempt to cope (Wasco, 2003). It encompasses an awareness of societal responses that may include both victim blaming and relieving the perpetrator of responsibility.

As efforts are made to document the value of evidence-based practices for SANE programs in general, there is an even greater need for research on the effectiveness of campus-based SANE programs. With only 15% of sexual assaults reported to law enforcement, the public, and more specifically universities, must question the safety of their communities and researchers must identify programs that can impact this pattern of violence. This clinical inquiry project is an opportunity to fill a gap in the available research on the effectiveness of SANE services in college-based clinic settings. As this gap in research is filled, university health centers will have further evidence to support the establishment of SANE programs to better meet the needs of the students they serve.

Methods

Clinical Inquiry Question

What is the percentage change in documentation of medical and forensic evidentiary services provided to survivors of sexual assault following implementation of a Sexual Assault Nurse Examiner program?

Clinical Inquiry Design

The clinical inquiry project will use a retrospective design consisting of chart review to measure the change in medical and forensic evidentiary services provided to survivors of sexual assault following implementation of a Sexual Assault Nurse Examiner (SANE) program.

Quantitative, archival data from medical records and University Health Center SANE logs of sexual assault visits during the academic years of 2004-2008 will be reviewed.

Given the study population is victims of sexual assault a traditional Pre/Post design is not possible. Two years of data will be collected from a nonequivalent control group of patients seen prior to the intervention. Two additional years of data will be collected from the intervention group for a total of four years. The medical records under study will be all of the accessible archival records of acute sexual assault cases treated at the clinic during the study period and meeting the sample population inclusion criteria. No direct patient contact will occur. Given the intervention has already taken place random assignment is not feasible. The design was selected in order to provide a summative program evaluation of outcome measures.

Design Diagram: Y_1

$X \quad Y_2$

Setting

The setting is the University of Oregon, University Health Center. It is a campus-based health center at a public university serving approximately 20,000 students. The clinic is staffed by nurse practitioners and physicians who provide acute and chronic ambulatory medical care, including urgent care to students during their enrollment at the university. Prior to the implementation of a SANE program, usual care for sexual assault victims at this clinic consisted of the provision of post sexual assault services by one of approximately 12 nurse practitioners or physicians without sexual assault specific training. Sexual assault visits during this time period were scheduled under the existing appointment scheduling system utilized for all other types of patient care visits. At the time, a triage guideline or standard of care protocol for sexual assault care was not available to staff.

The implementation of a SANE program evolved at a time when both funding and local training were available from the Attorney General's Sexual Assault Task Force. In addition, nurse practitioners on staff were interested in taking on this expanded role and administrators were universally supportive of this practice change. The clinic staff, Student Health Advisory Committee (SHAC), Department of Public Safety, and Office of Student Life philosophically supported the concept of providing expanded sexual assault services on campus. There was further support from the police department, the District Attorney's office, and the local advocacy organization.

Sample

The sample population is all accessible medical records of instances of sexual assault presenting to the UHC during the academic years from 2004 to 2008. Given the small number of

sexual assault cases seen at the clinic, the sampling method includes all accessible sexual assault visits meeting the inclusion criteria during the designated time period.

Inclusion criteria:

1. Enrolled University of Oregon student eligible for services at the UHC.
2. University Health Center patient.
3. Initial visit that is coded for sexual assault.
4. Medical care post sexual assault provided by either a clinic nurse practitioner or physician.
5. Patient presented during the academic year (September to June) between the years of 2004-2008.
6. Ages 17-40. Age 17 is included in the event that a student of that age had presented for sexual assault care.

Exclusion criteria:

1. Follow up sexual assault patient care visits.
2. Sexual assault cases in which part of the care was received at another facility (i.e. Emergency room).
3. Identified sexual assault victim that declined services.
4. Cases of sexual assault presenting during summer term when limited staff and medical services are available.

Intervention

The intervention was the implementation of a Sexual Assault Nurse Examiner program at the University Health Center. After 2006, all sexual assault victims presenting to the health center for post assault care were triaged by a nurse following a Sexual Assault Triage Guideline.

Appropriate patients were scheduled with a SANE on an urgent basis. Patients received care based on the Attorney General's Sexual Assault Task Force document, the "State of Oregon Medical Guideline for Sexual Assault Evaluation: Adolescent (≥ 15 year)/Adult" (AG's SATF, 2006b).

Prior to this intervention, students that presented acutely for sexual assault follow-up received fragmented and inconsistent medical care without the option of forensic evidence collection. The use of SANEs who are specially trained to care for the acute sexual assault victim has been well documented as improving the medical care and quality of forensic evidence collection (Campbell et al., 2005; Sievers, Murphy, & Miller, 2003; Taylor, 2002). The intervention was initiated with the aim to improve the provision of post assault care that addresses both the physical and emotional needs of the survivor. Additionally, the implementation of SANE services provided the opportunity for forensic evidence collection which was previously unavailable. The goal of adding forensic services at the clinic was to avoid the need to refer patients to the emergency room, to provide a less traumatic environment for post-assault care, to provide care to students who otherwise would decline emergency room care, and to preserve all future reporting options for the victim.

Measures

Variable	Measure	Level of Measurement
Age	1 = 15-19 years of age 2 = 20-24 years of age 3 = 25-29 years of age 4 = 30-34 years of age 5 = 35-39 years of age 6 = 40-44 years of age	Ordinal

Location of Assault	1= Residence Hall 2 = Sorority 3 = Fraternity 4 = Other 5 = Unknown	Nominal
Assailant Relationship to assaulted person	1 = Spouse 2 = Partner 3 = Ex-Partner 4 = Faculty/Teaching Assistant 5 = Colleague or coworker 6 = Stranger 7 = Acquaintance 8 = Unknown	Nominal
Assailant Relationship to University	1 = Student 2 = Non-student 3 = Unknown	Nominal
Law Enforcement Reporting Status	1= Reporting 2 = Non-reporting 3 = Undecided 4= Unknown	Nominal
Sexual Assault Exam Components	Sexual Assault Medical Exam Quality Indicator Inventory (Appendix B) 1 = Yes 2 = No	Nominal

Age will be the only demographic information collected. Race and ethnicity will not be available from the medical records that are to be reviewed. Additional variables regarding the location of the assault, assailant relationship to the sexual assault victim and the university, as well as reporting status will be collected as it may be of benefit to the university.

The practice improvement outcome data will come from the Sexual Assault Medical Exam Quality Indicator Inventory (Appendix B) which is derived from prior comprehensive SANE program audit tools (Campbell et al., 2006; Johnston, 2005; Ledray, 1999). The 11 items measure services reflecting high quality, post sexual assault care. The appropriateness of each item on the

inventory is further supported by state and national guidelines for best practices for the care of adolescent and adult victims of sexual assault (AG's SATF, 2006b; U.S. Department of Justice, 2004). Content validity is present as the items for evaluation are known standards of high quality care.

The data will come from record review of each initial sexual assault visit that meets the inclusion criteria during the period of study. Record review is an acceptable data-collection strategy (Mateo & Kirchhoff, 1999). It is acknowledged that the reliability of medical record review is limited by the completeness of the clinician's documentation of the sexual assault visit. Given the potential for sexual assault exam documentation to be requested for law enforcement or prosecution purposes, there is significant value in examining appropriate documentation of services. As part of the SANE program, a standardized Sexual Assault Exam documentation form was implemented and should increase the reliability of the data collection. This method of measurement is feasible given a data set of sexual assault records for retrospective analysis is known to exist and no new data needs to be collected.

Data Collection Procedure

A list of patient visits to the University Health Center coded for sexual assault between the academic years of 2004-2008 will be obtained by the Medical Records Supervisor. The UHC Sexual Assault Nurse Examiner log will be reviewed as a cross check for sexual assault cases. The appropriate office visit from the medical records of these cases will be de-identified and reviewed by the investigator for valid inclusion criteria. Charts meeting valid inclusion criteria will be reviewed using a data collection form that includes the chosen variables described under "Measures."

The non-identifiable data obtained from chart review will be stored in electronic files and will be accessible only to the investigator. The electronic files will contain information from the data collection forms that has been transferred and stored into SPSS on the DNP student's personal computer which is password protected and will be maintained securely. If necessary, the student's computer will be transported securely from the agency to the student's home and to OHSU where the student may meet with DNP faculty and statisticians.

The aggregate data will be stored electronically for a minimum of seven years. Paper copies of the data collection forms will be in the sole custody of the investigator. Following data analysis the forms will be shredded and destroyed. The results, including aggregated non-identifiable data, will be used for the investigator's Clinical Inquiry Project, in presentations, and possibly in professional or peer-reviewed publications.

Chart review will be conducted solely by the investigator, who has extensive training and experience as a certified Sexual Assault Nurse Examiner. The data collection forms will contain no personally identifiable information and the final data analysis results will be presented in an aggregate table. All medical records will be reviewed on site with no portion leaving the UHC. This data collection method was chosen as a feasible means of collecting the retrospective data of interest while ensuring protection of the subjects.

Quality assurance will include pre-testing the data collection tool for ease of use and ability to accurately measure the variables under study. Ongoing quality assurance will be done by rechecking the data collection from every 10th medical record that is reviewed.

Analytical Methods

The research question, "What is the change in medical and forensic evidentiary services provided to survivors of sexual assault following implementation of a Sexual Assault Nurse

Examiner program?” will be answered using a series of Chi-square tests. The tests will compare the proportion of patients receiving medical and forensic evidentiary services in the nonequivalent control group and the intervention group following SANE implementation. All the variables on the Sexual Assault Medical Exam Quality Indicator Inventory can be analyzed using the Chi-square test. An alpha level of $p < 0.05$ will be used in data analysis. Given this SANE program has already been implemented, a positive change in the analytical results would provide evidence to support its feasibility.

The Clinical Inquiry Project budget reflects financial considerations for the initial start up expenditures and program implementation expenses that would be needed by the clinic’s administration to evaluate the viability of a SANE program. Administration is chosen as a key stakeholder given the importance of their support for such a project. The project has the potential to be cost neutral with the addition of a new source of reimbursement for the UHC from the Department of Justice’s Sexual Assault Victim Emergency (SAVE) Fund once a certified SANE is on staff at the clinic (US Department of Justice, 2003). The Sexual Assault Victim Emergency (SAVE) Fund was created to provide payment for a comprehensive medical assessment for victims of sexual assault. If the victim reports the crime, the SAVE Fund also reimburses providers for collecting forensic evidence.

The SANE program should not require a reallocation of funds beyond the initial start up costs for equipment and training. Future expenses are minimal beyond these modest start-up costs and should be covered through reimbursement for services. Overall revenue projections should improve given costs related to sexual assault services were previously written off by the clinic under the usual care model.

Protection of Human Subjects/Ethics

Study design measures have been put in place to ensure protection of human subjects. The investigator agrees to maintain confidentiality throughout all phases of the study. There will be no interaction between the investigator and the patients. Confidentiality for subjects during data collection will be maintained through the recording of study data in a non-identifiable form. The investigator will comply with all mandatory confidentiality requirements outlined by the federal Family Educational Rights and Privacy Act (FERPA).

Plan for Dissemination to Key Stakeholders

Study data can be shared with the University of Oregon, University Health Center administration, clinic staff, and Student Health Advisory Committee through a presentation and written summary at the conclusion of the Clinical Inquiry Project. An additional presentation could be arranged with the campus Alliance for Sexual Assault Prevention (ASAP) committee, a group with broad campus and community representation that includes housing, public safety, athletics, Greek life, faith organizations near campus, and the Office of Student Life. Further dissemination of data could be presented to the Attorney General's Sexual Assault Task Force and the sub-committees of the Campus Response Committee, of which the University of Oregon is a member.

Study timeline for project

IRB Started	IRB Review	OHSU IRB Submission	UO IRB Submission	Data Collection begins	Data Collection Complete	Complete Clinical Inquiry Project
10/1/08	Week of 10/13/08	Week of 10/20/08	Week of 11/15/08	12/01/08	2/1/09	5/18/08

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Appendix A

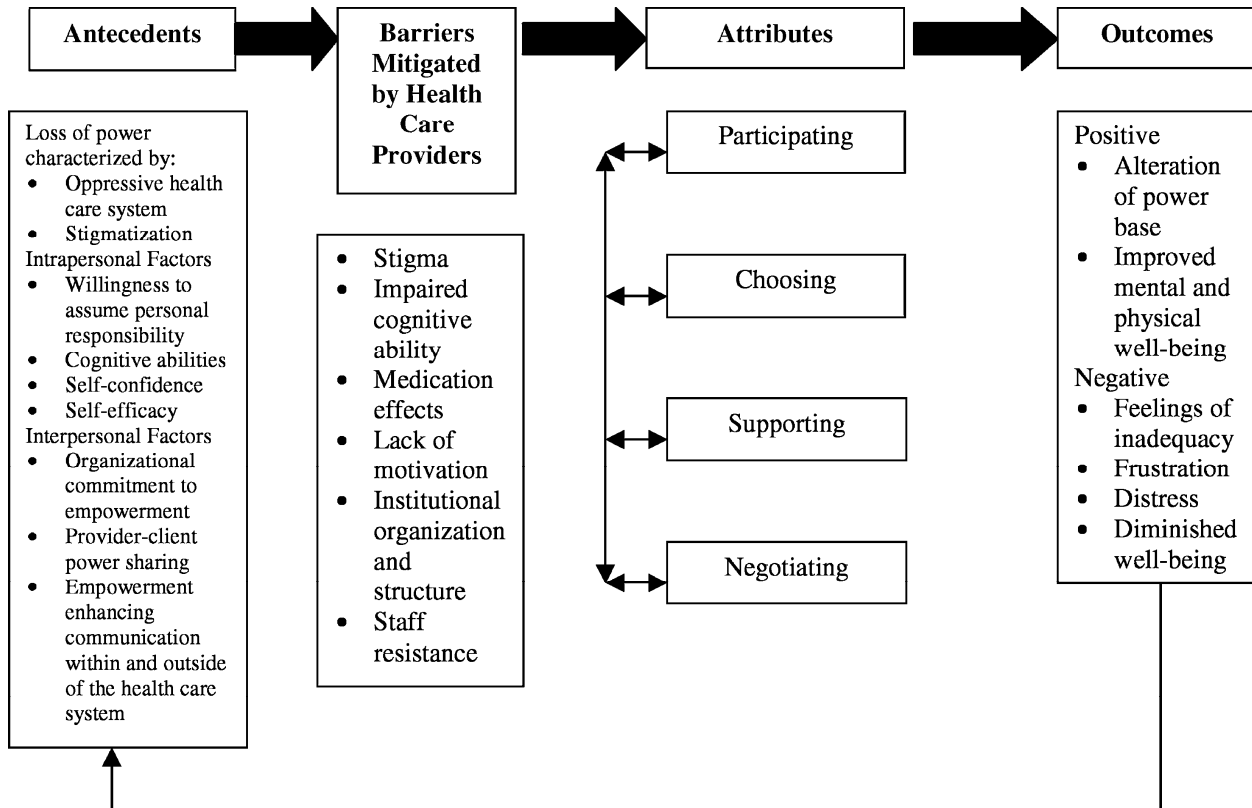


Figure 1. Empowerment Model for Individuals: interconnection between survivor, community response and outcomes in sexual victimization.

Note. From “Empowerment of Individuals With Enduring Mental Health Problems: Results from concept analyses and qualitative investigations,” by Deborah L. Finfgeld, 2004, *Advances in Nursing Science*, 27(1), p, 49. Copyright 2004 by Lippincott Williams & Wilkins, Inc.

Appendix B
Sexual Assault Medical Exam Quality Indicator Tool

Subject ID _____

Variable	Yes	No	Comments
Documented assessment for mandatory reporting			
Documented a description of the assault			
Documented alcohol/drug use by the patient at the time of the assault			
Complete physical exam performed			
Pregnancy prophylaxis given			
Sexually Transmitted Infection (STI) Prophylaxis provided			
Hepatitis B prophylaxis provided or documented prior immunization			
HIV risk assessment documented			
Advocacy contacted at time of post assault presentation			
Reporting patients: Oregon State Police (OSP) Sexual Assault Forensic Evidence (SAFE) kit collected and stored			
Non-reporting patients: Oregon State Police (OSP) Sexual Assault Forensic Evidence (SAFE) kit collected and stored			

Running Head: CLINICAL INQUIRY PROJECT REPORT

Clinical Inquiry Project Report

Evaluating Campus-based Sexual Assault Nurse Examiner Effectiveness

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Oregon Health & Sciences University, School of Nursing

May 11, 2009

Sample

The study population for the Clinical Inquiry Project came from a campus-based health center at a public university serving approximately 20,000 students. This university grants undergraduate and graduate degrees and primarily has a resident population living in on-campus dormitories, Greek housing, and nearby apartments. The campus is located in an urban setting that attracts most students from in-state, but also recruits nationwide and internationally. The clinic is staffed by nurse practitioners and physicians who provide acute and chronic ambulatory medical care, including urgent care to students.

A total of 63 records were reviewed to obtain the study sample of 46 charts. Cases of sexual assault were identified by searching for the ICD-9 codes E960.1 RAPE and V71.5 OBSERVATION FOLLOWING ALLEGED RAPE. They were cross checked with the encounter code 99214, which the clinic uses internally for SANE exams. The inclusion criteria were specific for records of acute sexual assaults seen at the clinic during the academic years of 2002-2008 for an initial post assault visit. Three years of data were reviewed from a non-equivalent control group and an additional three years of data were reviewed from the intervention group. The intervention was the implementation of nurse practitioners as Sexual Assault Nurse Examiners for the provision of post assault services.

The period under study spanned several changes made to the reporting options for victims of sexual violence presenting to the clinic. The pre-SANE group consisted of post-assault care provided by MDs and NPs without the option of forensic evidence collection. The post-SANE group included the provision of sexual assault services following a national protocol for evidence based care, including the option of forensic evidence collection if desired. Additionally,

during the final two years of study, changes in legislation allowed for forensic evidence collection without an initial report to law enforcement.

Findings

All 46 cases of sexual assault in the study were female victims ranging from 17 to 26 years of age. The majority of victims were either 18 or 19 years of age (28.3% and 23.9% respectively) (see Table 1). Only one victim was a minor. The pre-SANE group included 17 cases of sexual assault compared to 29 post-SANE cases, the majority ($n = 14$) presented during the 2005-2006 academic year. The provision of post-assault medical services was distributed between NPs (52.9%) and MDs (47.1%) prior to the intervention. After implementation of a SANE program, nurse practitioners trained as Sexual Assault Nurse Examiners provided 96.9% of the care compared to 3.4% provided by physicians.

Of the 38 records with information available regarding the location of the sexual assault, the majority occurred off campus (78.9%) compared to residence halls (13.2%) and fraternities (7.9%) (see Figure 1). Acquaintance rape (80%) was reported most often, followed by stranger (13.3%), colleague or coworker (4.4%) and ex-partner (2.2%). Information on the assailants' relationship with the university was rarely available, but when identified, was most often a non-student (62.5%, $n = 10$) compared to a student (37.5%, $n = 6$).

Documentation of a complete physical exam, $X^2 = 15.81$, $p < .001$, sexually transmitted infection (STI) prophylaxis, $X^2 = 8.87$, $p = .003$, and Hepatitis B prophylaxis or prior immunization, $X^2 = 18.74$, $p < .001$ all demonstrated clinical significance (see Table 2 and Figures 2, 3, and 4). While the frequency of documentation of an HIV risk assessment, $X^2 = 3.49$, $p = .062$, was not statistically significant, it is worth noting that 100% ($n = 7$) of sexual assault victims seen in the last year of the study (2007-2008) were evaluated for HIV risk (see

Figure 4 and Table 3). A description of the assault was present 100% of the time in both the pre and post-SANE groups (see Tables 2 and 3).

Of the records with information available on alcohol use by the victim, 88.1% (N = 37 of 42 cases) of the sexual assaults involved the consumption of alcohol. The documentation of alcohol and/or drug use at the time of the assault showed no statistical difference before or after implementation of SANEs, $p = .619$, estimated using Fischer's Exact Test (see Table 2). When alcohol and drugs were separated out and further analyzed, only 2 of 17 (11.8%) of the pre-SANE charts indicated that the patient had been specifically asked about drug use compared to 24 of 29 (82.8%) of the post-SANE documentation, a finding that was statistically significant ($X^2 = 23.3$, $p < .001$). There were no admissions of drug use by the victim in any records.

The percentage of victims receiving emergency contraception (ECP) decreased from 58.8% to 34.5% after the implementation of SANEs (see Table 2). At the same time, the number of victims who had already taken ECP on their own rose 20.7% (see Figure 5). Nearly equal percentages of victims (17.8% v. 20.7%) either declined ECP or had reliable contraception. In 17.4% of all cases, the victim arrived too late to receive ECP and 6.5% did not have a pregnancy risk necessitating ECP.

The frequency of the clinician contacting an advocate at the time of the exam increased from 5.9% to 72.4% after the introduction of SANEs and was statistically significant, $X^2 = 19.01$, $p < .001$ (see Table 2). Mandatory reporting assessments to identify victims under the age of 18, or who are disabled, mentally ill, or injured from a weapon were not documented on any of the pre-SANE group (n = 17) while 58.6% of the post-SANE group had evidence in the medical record of this being performed, (Fisher's Exact Test, $p < .001$) (see Table 2). During the final year of the study, 100% of victims (N = 7) in the post-SANE group received a mandatory

reporting evaluation (see Tables 7 and 9). The sole 17 year old victim received an appropriate mandatory report.

Following the implementation of SANEs, 8 of 29 (27.6%) of victims wished to report the assault to law enforcement (see Table 4). Three of these patients chose to collect a non-reporting Sexual Assault Forensic Evidence (SAFE) kit following legislation that allowed the collection of forensic evidence without an initial report to law enforcement. One individual reported her assault to law enforcement, but did not choose to have forensic evidence collected.

Macro and or Micro Financial Considerations

The National Institute of Justice identifies rape as the most costly crime in this nation and the consequences of sexual violence are ultimately paid for by society as a whole (Miller, Cohen, & Wiersema, 2006). In fact, the long term financial impact of sexual assault far exceeds the expenses of the acute care medical response (Agency for Healthcare Research and Quality, 2003; Miller, et al.). Health insurers are more likely to pay for costs related to a multitude of chronic health conditions rather than the acute assault expenses (Miller et al.). Employers pay in the form of health insurance premiums, sick time, and lost productivity. Lastly, the federal government, and thus the taxpayers, incur significant costs through the provision of emergency services, Medicare and Medicaid premiums, crime victims' services, and lost tax revenue (Miller et al.). When one in five college women in this country will experience an attempted or completed rape prior to graduation, institutions of higher learning are clearly integrally connected to the financial impact of sexual violence at the macro level (Karjane, Fisher, & Cullen, 2005).

At the micro level, providing SANE services requires a minimal financial investment on the part of a campus clinic, especially given the importance of the services provided. This SANE program was initiated with a small and manageable investment in training and equipment. Even

fewer financial resources are necessary to maintain the program. Additionally, with a SANE on staff the clinic became eligible for statewide reimbursement for services provided to the victim through the Department of Justice's Sexual Assault Victims' Emergency (SAVE) Fund. This type of external source of reimbursement has the potential to help a program become cost neutral. Finally, the greatest financial burden is the analysis of forensic evidence and the criminal investigations, both of which are assumed by organizations outside of the university and result in no additional cost to the institution.

Situational Analysis

This Clinical Inquiry Project benefited from the identification early on of a unique program that was well suited for an evaluation three years after implementation of a SANE program. Having intimate involvement in the health center's SANE program and a strong background in the subject matter allowed the DNP student investigator relatively easy identification of a concise clinical question and specific variables worthy of study. Lastly, having developed prior contacts in the field of forensic nursing proved useful to accessing a national expert to review the study's Quality Indicator Tool.

The extent of the Investigational Review Board (IRB) process was not fully appreciated at the onset of this project. It was a particular challenge to navigate and coordinate the expectations of IRBs at two universities. As a first time effort, it was difficult to anticipate the steps necessary to move the process along. The assistance received from the medical records department at the clinic was an enormous help in obtaining the necessary records for study in an expeditious manner.

Overall, the project was a success in that the program evaluation was completed and resulted in comprehensive and useful data regarding the use of SANEs in college health. It

became apparent during the process that it is critical for the investigator to be familiar with the IRB process so as to anticipate multiple institutional requirements. Additionally, time invested early in the planning process of a study is rewarded later when the analysis is performed. Given the subjects of this project were victims of sexual assault, it was critical as a DNP student to demonstrate competence, leadership, and integrity so as to achieve cooperation with the university to access sensitive medical records data.

Outcomes

This evaluation project demonstrated improvement in the quality of post assault services provided to victims of sexual assault in a campus-based health center when provided by a SANE. Additionally, there was an increase in the number of students accessing care following a rape. For the first time at this clinic, the option for both reporting and non-reporting forensic evidence collection was offered. None of these changes could have occurred without the implementation of trained Sexual Assault Nurse Examiners.

Context

The development of a SANE program in an outpatient clinic was a unique project from its inception. At the time there was not a similar one of its kind in the state and very few nationwide. Its success stemmed largely from a combination of administrative support, availability of SANE training locally, and motivated clinical staff. A series of challenges arose from the sheer enormity of the project which necessitated working with multiple agencies both on and off campus.

The expected outcomes were consistent with the literature supporting the effectiveness of SANEs. What was not well understood prior to this study was whether these services could be performed equally well in an outpatient university-based clinic. To date the most seminal

literature on campus sexual assault focuses on quantifying student's recollection of experiences with sexual victimization, campus policies, or prevention activities (Fisher et al., 2000; Karjane et al., 2005). No studies were identified specifically addressing the medical response to sexual assault on campus.

Interpretation

Demographic characteristics of the sexual assault victims were similar in the pre- and post-SANE groups. The young age and female gender of the victims is consistent with the literature on sexual assault (Humphrey & White, 2007; Loh, Gidycz, Lobo, & Luthra, 2005). These finding suggests that the youngest undergraduates are vulnerable targets for rape. Additionally, acquaintance rape was the most frequent type of assault, a finding also supported in the literature (Fisher et al., 2000; Karjane et al., 2005; Tjaden & Thoennes, 2000).

An unexpected finding of the study was that the majority of assaults occurred off campus. This information might be of interest to those responsible for reporting compliance with the Cleary Act, a federal requirement that mandates the reporting of violent crimes on campuses. The results of this study suggest that the current reporting practice of including in the Cleary Report only those sexual assaults occurring on campus may provide a misleading assessment of campus safety. Furthermore, the finding in this study that rapes in fraternities occurred less often than other settings, both on and off campus, is contrary to traditional beliefs about campus rape. These results should be examined further in a larger study across multiple university settings.

Documentation of alcohol use improved with the use of SANEs and following changes to the SANE exam documentation forms. Drug use screening appeared to also improve with changes in the documentation forms, but the lack of any acknowledged drug use could be a result of underreporting by victims. It would likely be beneficial to clearly separate out questions

regarding alcohol and drug use at the time of assault. Positive responses may ultimately prove useful to prosecution as efforts are underway to pass legislation that defines incapacitation related to alcohol and consent.

The results of this study demonstrate that the implementation of SANEs for post assault services results in more comprehensive care when compared to non-trained clinicians. SANE training and the use of medical guidelines specific to sexual assault resulted in higher numbers of patients receiving a complete physical exam, STI prophylaxis, Hepatitis B prophylaxis or screening for prior immunization, and HIV risk assessment. These results are consistent with the literature that demonstrates SANEs provide more comprehensive post assault care compared to non-SANEs (Campbell et al., 2006; Crandall & Heltizer, 2003). Services improved further over the three years SANEs provided care, with the best care noted in the final year of study. Despite a continuous influx of novice SANE staff, these results were most likely related to improvements in the exam documentation forms to provide prompts to the nurses regarding critical medical services.

The administration of pregnancy prophylaxis did decline between the pre and post SANE groups, but this also could be explained by the concomitant increase in victims arriving having already taken emergency contraception. The significance of this change in ECP use may be related to increased access to emergency contraception after the FDA adopted changes allowing this medication to be available over-the-counter without a prescription. Since ECP is more effective the earlier it is taken, this trend would support efforts to improve access to ECP and benefit from examining further in a larger study. No victim was denied appropriate access to ECP.

In a clinic setting that rarely deals with issues of mandatory reporting, it is not surprising that there was no mechanism to determine if this type of assessment was happening with sexual assault victims prior to the use of SANEs. While screening for mandatory reporting improved after the implementation of SANEs, it was not until the third year of the program that this reached 100%. This was again likely related to specific changes in the documentation forms that prompted mandatory screening to be completed.

The use of SANEs resulted in a dramatic increase in advocates being contacted as soon as the patient arrived. Once a victim has an opportunity to meet an advocate they are much more likely to utilize their services. This finding demonstrated a significant improvement in services from the pre-SANE group.

Following the implementation of SANEs, the number of students seeking post-assault care increased. It reached its highest level during the first year of the program when there was considerable media attention about the program and educational outreach efforts on campus and in the community. The subsequent drop in cases suggests the need to have ongoing campus-wide outreach efforts regarding SANE services.

Despite the option of forensic evidence collection, the majority of victims continued to choose not to report the assault to law enforcement, similar to national statistics on rape (Campbell et al., 2005, Resnick et al., 2000). However, findings here suggest that legislation that allows non-reporting evidence collection can increase the collection of SAFE kits from victims. The number of cases requiring more complicated forensic evidence collection services did not increase to unmanageable proportions in an outpatient setting.

Limitations

Given the unique population under study, a challenging limitation to this study was the inability to have the same group evaluated pre and post SANE. The relatively small sample size resulted in low frequency results for some variables which may limit the ability to evaluate the results statistically. Additional records were obtained for review to maintain similar size study groups pre and post SANE implementation. Collection of data by an investigator that also did some of the exams under review has the potential for bias. Bias was less likely given the study used categorical variables and was quantitative, not qualitative.

Conclusions

A Sexual Assault Nurse Examiner program in a campus-based clinic using advanced practice nurses improves the provision of post-assault medical care and advocacy services. In addition, the program successfully accommodated the option of forensic evidence collection for victims who wished to do so. The use of evidenced-based medical forensic guidelines and documentation forms increased the likelihood of appropriate and comprehensive services being provided to victims. Specific data related to the circumstances and outcomes of sexual violence on campuses can inform students, parents, campus officials, and the community at large.

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Doctor of Nursing Practice Candidate, OHSU School of Nursing

Executive Summary

The clinical inquiry project, *Evaluating Campus-based Sexual Assault Nurse Examiner Effectiveness*, used a retrospective design consisting of chart review to measure the change in medical and forensic evidentiary services provided to survivors of sexual assault at a campus-based health center following the implementation of a Sexual Assault Nurse Examiner (SANE) program.

In this study all of the victims of sexual assault were young females and the assailants were most often non-students known to the victim. The majority of these women were ages 18 and 19, which suggests it is the youngest undergraduates on campus that are the most vulnerable targets of rape. Equally important are findings that demonstrate higher rates of sexual assault off campus compared to either residence halls or fraternities. Such a finding suggests a possible gap in the Cleary Act reporting requirements that focus on reporting rapes occurring on campus or at campus operated facilities and may be providing a misleading assessment of campus safety. Results showing lower rates of sexual assault in fraternities compared to other settings warrants consideration of further study among a larger population.

The sexual assault cases reviewed identified alcohol use by victims prior to the rape in the majority of situations. This finding is of concern in that it suggests that assailants' are likely targeting an additional vulnerability in their victims. Such results could be important to legislative efforts aimed at further defining issues of incapacitation related to alcohol and consent. By contrast, no victims acknowledged drug use and this finding may reflect an underreporting by victims.

The most significant findings were improvements in the provision of a complete physical exam, sexually transmitted infection prophylaxis, Hepatitis B prophylaxis or screening for prior immunization, and advocacy referral. While not statistically significant, by the last year of the study and after changes in the documentation forms, 100% of victims received an HIV exposure risk assessment.

The study also found an increase in use of pregnancy prophylaxis prior to presenting for post-assault care and may be related to federal laws allowing for over-the-counter access to emergency contraception. Further study of this phenomenon would be beneficial. In all the cases of rape reviewed, no victim was denied appropriate access to emergency contraception.

The clinical inquiry project findings support the use of SANEs in campus health centers as an alternative to the emergency room for acute sexual assault care. Such settings are capable of offering a full range of post-assault options, including forensic evidence collection, to victims of sexual assault on a university campus. Lastly, the addition of trained SANEs as members of the clinical staff allowed access to reimbursement for services through the Department of Justice.

The DNP student was solely responsible for the design and implementation of this clinical inquiry project. The project benefited from the DNP's experience in developing this SANE program from its initial inception to its implementation. The student's strong background in sexual assault and involvement in statewide efforts to implement evidence based practice based on national guidelines for SANE care was critical to the success of this study.

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Sexual victimization: Incidence, knowledge and resource use among a population of college women. *Journal of Pediatric Adolescent Gynecology*, 18, 91-96.

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Evaluating Campus-based Sexual Assault Nurse Examiner Effectiveness

Cindy Smith MSN, RN, ANP

OHSU Doctor of Nursing Practice Candidate
May, 2009

Goals Upon Entering DNP Program

- Scholarly Practice
- Evidence Based Practice
- Leadership
- Teaching



Population Focus

Campus Sexual Violence

- ❖ 1 in 5*
- ❖ < 5% reported*
- ❖ Rape is the most common violent crime on campus
- ❖ NIJ: sexual assault the most costly crime in this nation**

* Karjane, Fisher, & Cullen, 2005

** Miller, Cohen, & Wiersema, 2006



Setting



- Public University
- Urban location
- 20,000 students
- Campus-based clinic
- NP/MD staffed

Clinical Inquiry Project Question

What are the changes in medical and forensic evidentiary services provided to survivors of sexual assault following the implementation of a Sexual Assault Nurse Examiner program?

Literature

- Fisher, B. S., Cullen, F. T. & Turner, M. G. (2000) *The sexual victimization of college women*. National Institute of Justice
- Karjane, H. M., Fisher, B. S., & Cullen, F. T. (2005) *Sexual assault on campus: What colleges and universities are doing about it*. U.S. Department of Justice

Inclusion Criteria

- Academic years of 2002-2008
- Records coded:
 - E960.1 RAPE
 - V71.5 OBSERVATION FOLLOWING ALLEGED RAPE
- Initial post assault visit
- NP or MD care

Data Collection

- Retrospective program evaluation
- Data collection tool based on:
 - ❖ The National Protocol for Sexual Assault Medical Forensic Exams (DOJ)
 - ❖ The State of Oregon Medical Guideline for Acute Sexual Assault (Older Adolescent >15 year and Adult) (AG's SATF)

Demographics

Age	Frequency	Percent
17	1	2.2%
18	13	28.9%
19	11	24.4%
20	5	11.1%
21	7	15.6%
22	2	4.4%
23	3	6.7%
24	1	2.2%
25	1	2.2%
26	1	2.2%

Missing = 1



Assailant Information

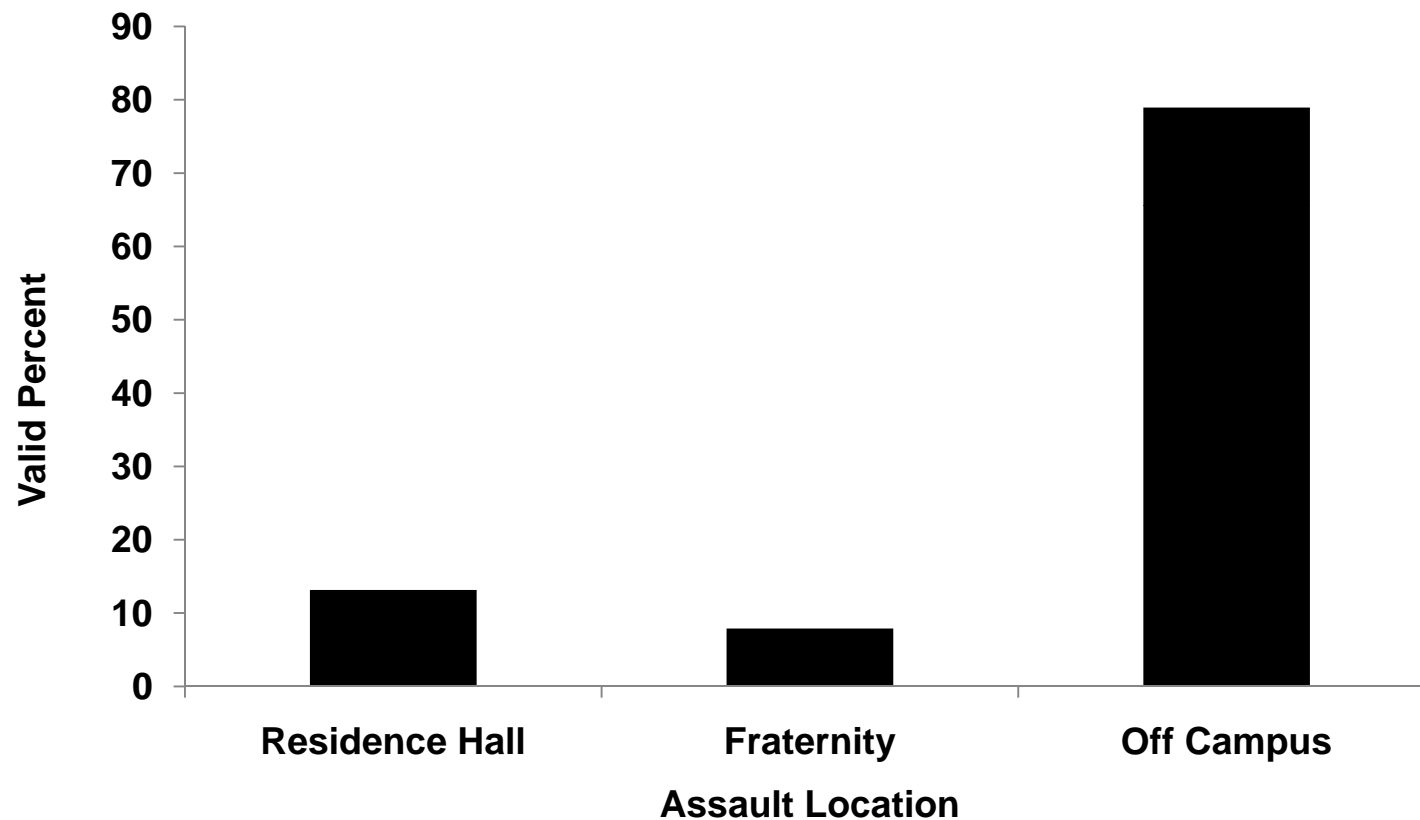
Assailants' relationship with the victim

- ❖ N = 46
- ❖ Acquaintance 80.0%
- ❖ Stranger 13.3%
- ❖ Colleague/coworker 4.4%
- ❖ Ex-partner 2.2%

Assailants' relationship with the university

- ❖ N = 16
- ❖ Non-student 62.5%
- ❖ Student 37.5%

Frequency by Location of Sexual Assault:



Cleary Act Reporting



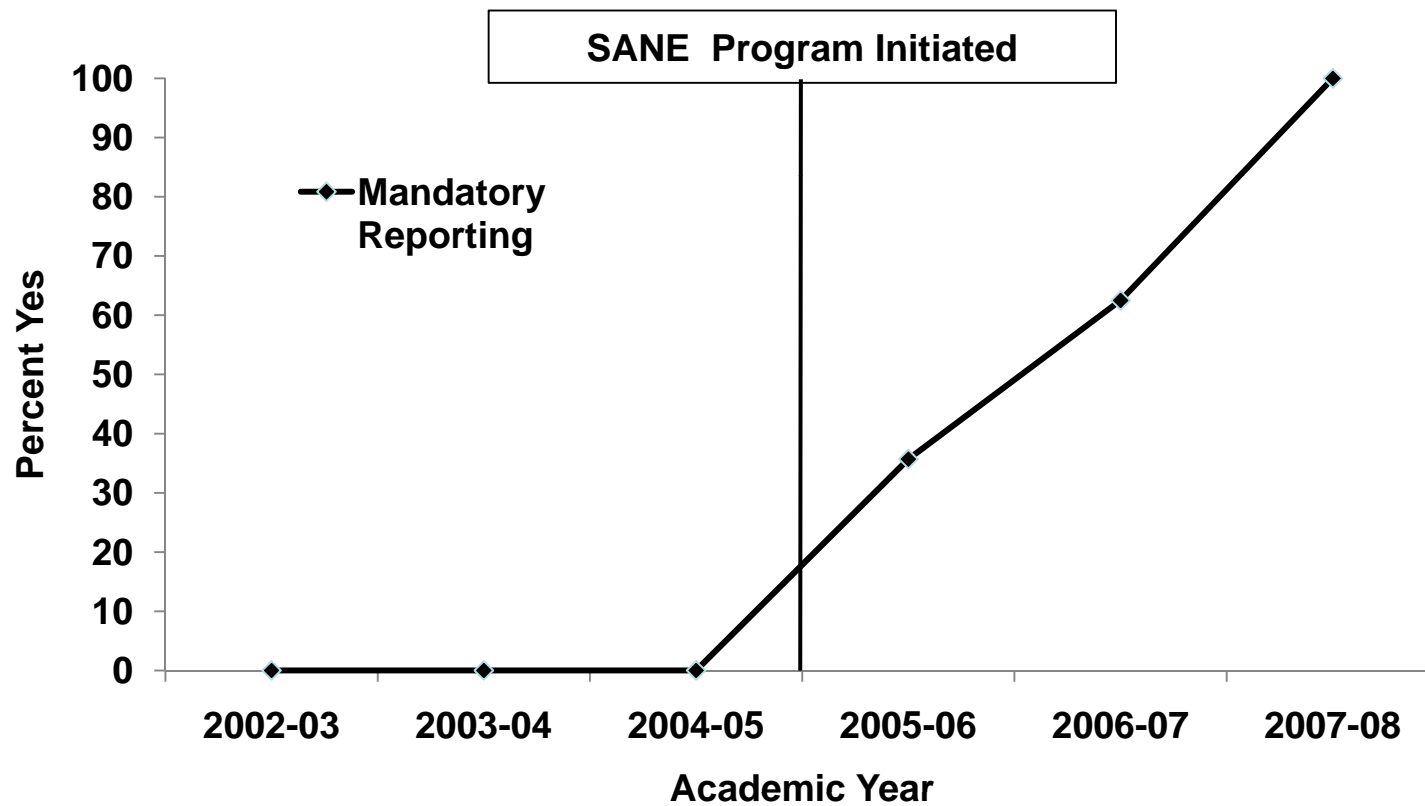
1990 Crime Awareness and
Campus Security Act

Post secondary institutions
participating in Title IV
financial aid programs

Disclose campus crime
statistics and safety
policies

Screening for Mandatory Reporting

N = 46



$\chi^2 = 15.81, p < .001$

Screening for Etoh/Drugs

N = 46

Etoh and/or Drugs

- ❖ Pre-SANE: 88.2%
- ❖ Post-SANE: 93.1%
- ❖ $p = .572$



Drugs

- ❖ Pre-SANE: 11.8%
- ❖ Post-SANE: 82.8%
- ❖ $X^2 = 23.3, p < .001$

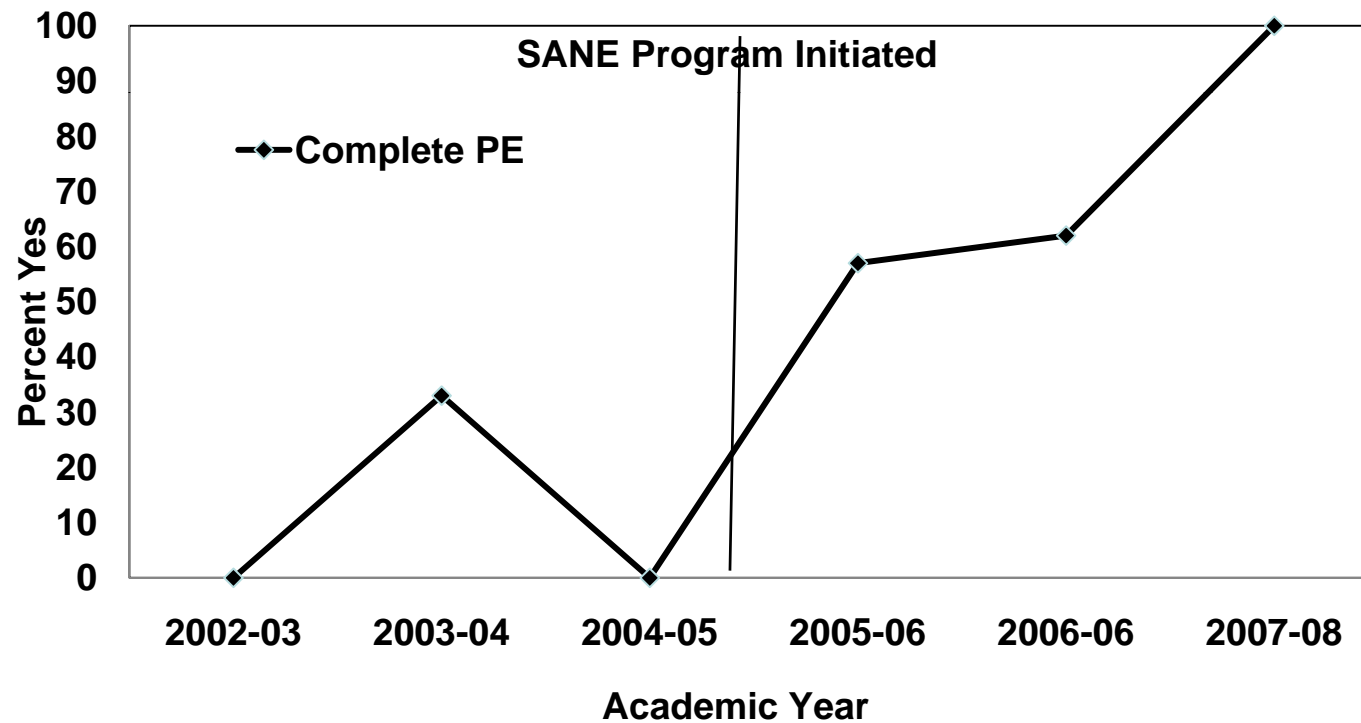


Alcohol and Drug Use by Victim

- ❖ 88.1 % (37 of 42 cases) consumed alcohol at the time of the assault
- ❖ 0% acknowledged drug use

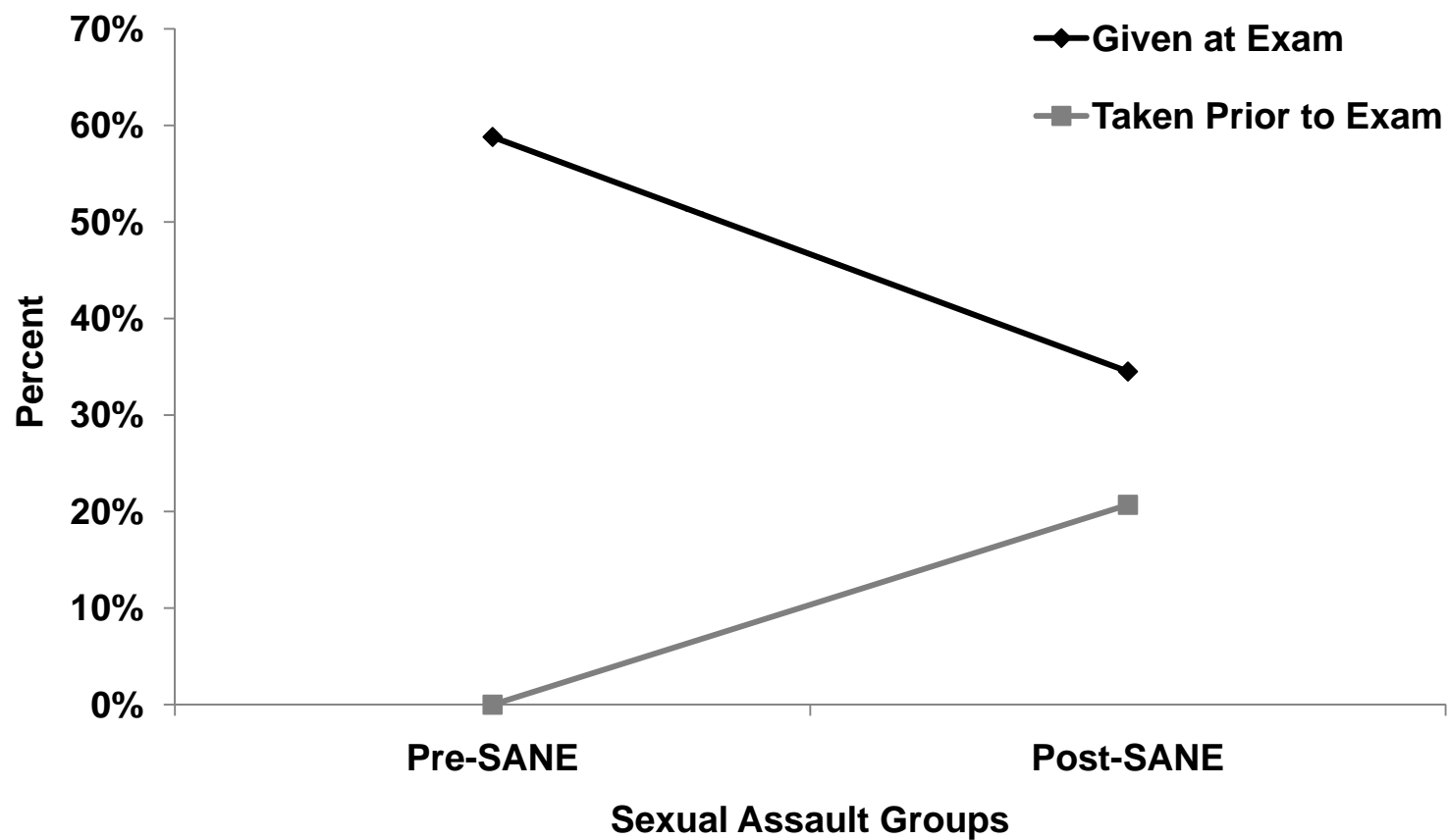
Complete Physical Exam

N = 46



$X^2 = 15.81, p < .001$

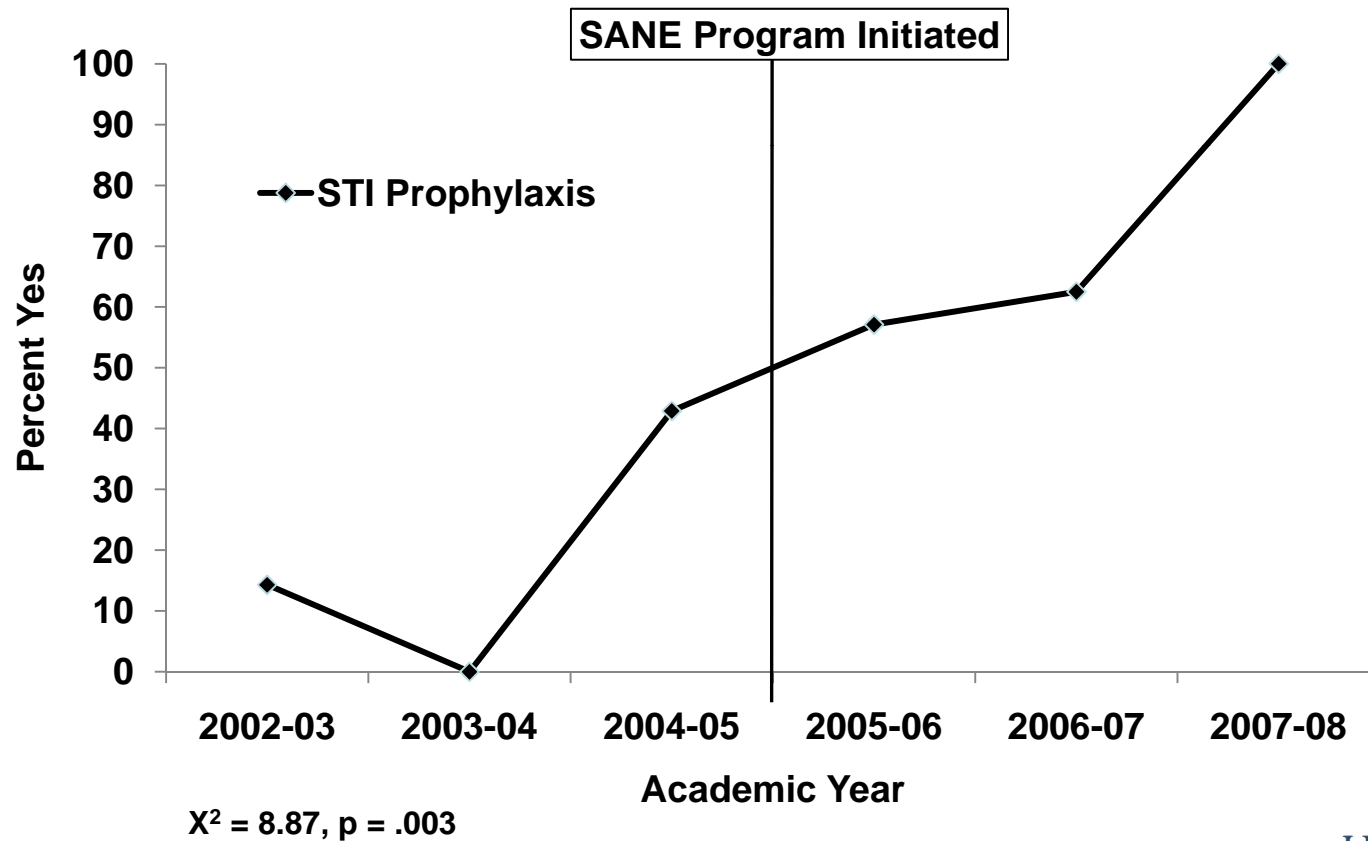
Pregnancy Prophylaxis



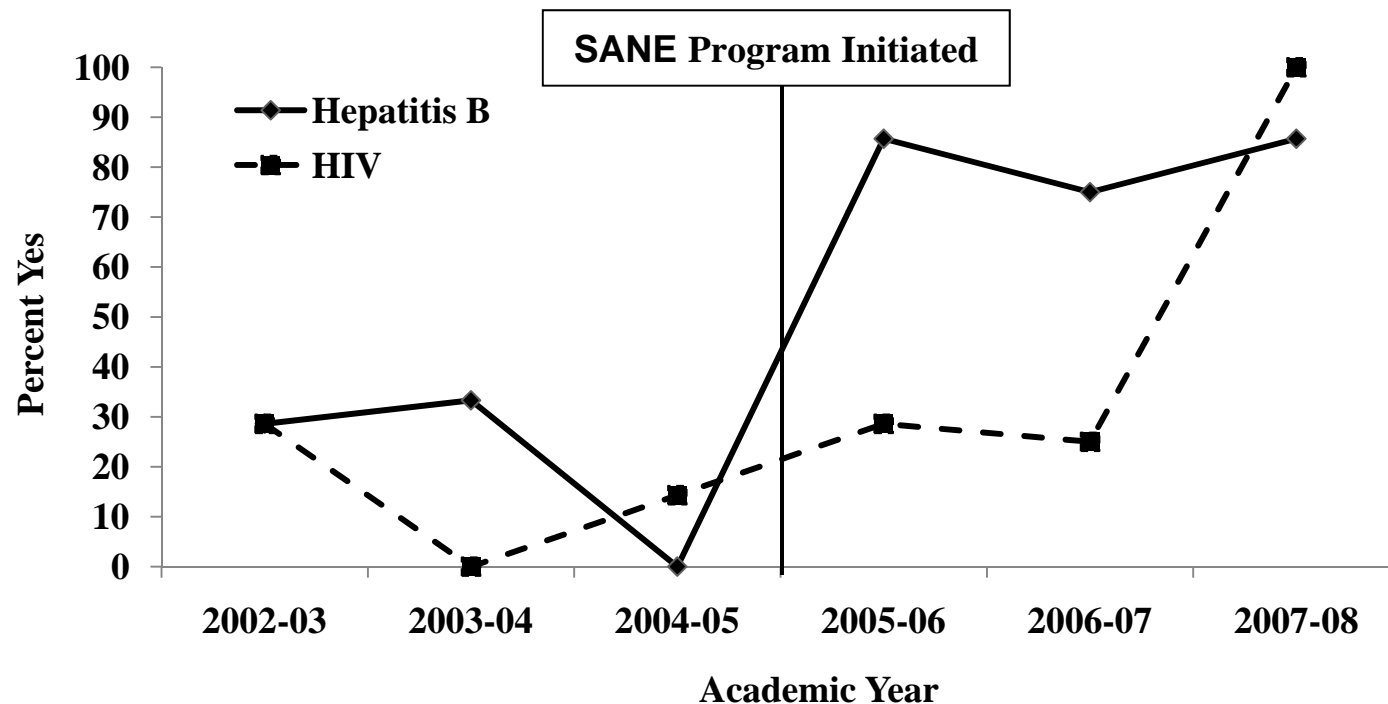
p = .108

Sexually Transmitted Infection Prophylaxis

N = 46



Hepatitis B Prophylaxis or Prior Immunization HIV Post-Exposure Prophylaxis Risk Assessment N = 46

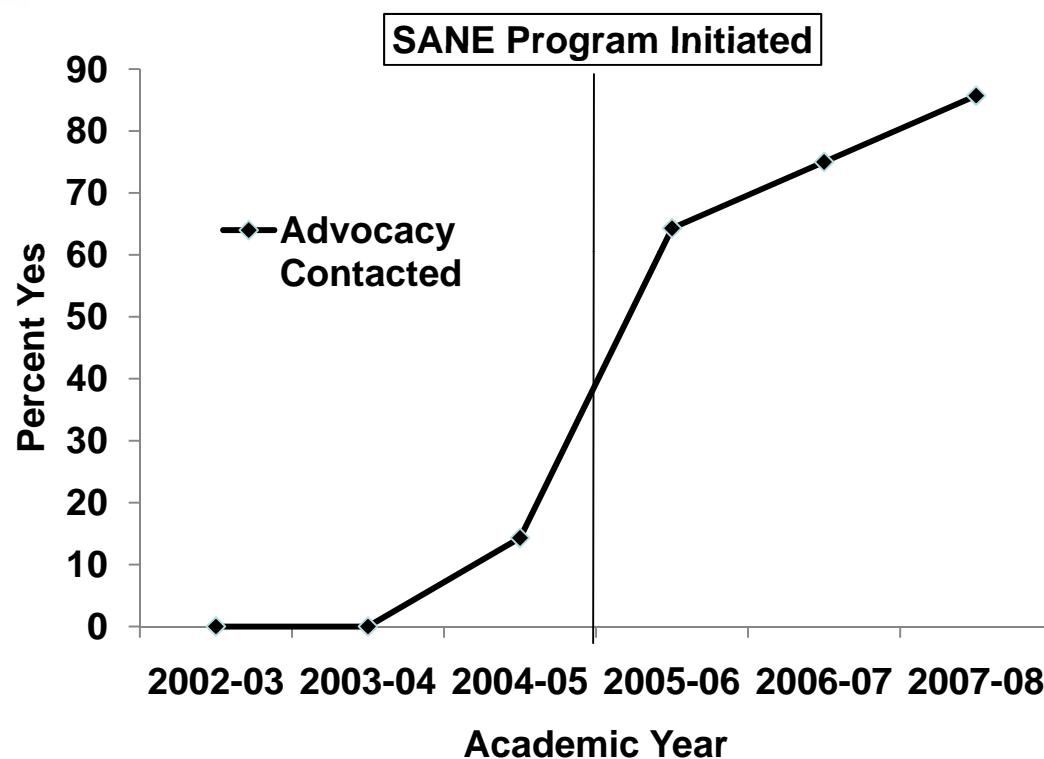


Hepatitis B: $X^2 = 18.74$, $p < .001$

HIV: $X^2 = 3.49$, $p = .062$

Advocacy Contacted

N = 46



$\chi^2 = 19.01, p < .001$

Frequency of Exams by Year

Pre-SANE	Total Patients	Reporting SAFE kit	Non-reporting SAFE kit
• 2002-2003	7		
• 2003-2004	3		
• 2004-2005	7		
Post-SANE			
• 2005-2006	14	1	
• 2006-2007	8	1	
• 2007-2008*	7	2**	3

* Non-reporting legislation implemented in 2007-2008

** One additional patient reported, but declined SAFE kit

Outcomes

- Implementation of SANEs for post assault services resulted in more comprehensive care when compared to non-trained clinicians
- Use of Evidence-based Medical Guidelines resulted in statistically significant findings in the documentation of:
 - ❖ Complete Physical Exam
 - ❖ Sexually Transmitted Infection Prophylaxis
 - ❖ Hepatitis B Prophylaxis or Prior Immunization
 - ❖ Mandatory Reporting
- Implementation of a SANE program resulted in a statistically significant increase in the use of advocates

Outcomes

- Implementation of a SANE program resulted in an increase in the number of students accessing care following a rape
- Legislation allowing non-reporting evidence collection appeared to increase the collection of SAFE kits from victims
- The option of reporting and non-reporting forensic evidence collection can be accomplished in a non-emergency room setting
- Off campus rape frequency needs further study
- Implications of health policy related to emergency contraception needs further study

Limitations

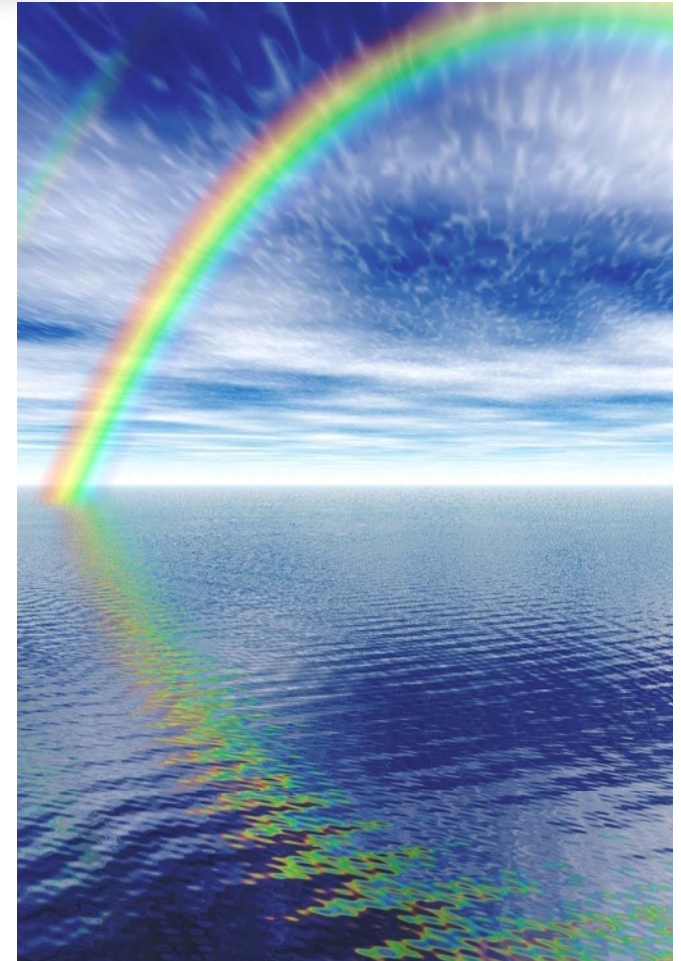
- Inability to have the same group evaluated pre and post SANE
- Relatively small sample size
- Collection of data by an investigator that also did some of the exams under review has the potential for bias

Accomplishments Related to DNP Competencies

- Provided Input on Health Policy
- Developed an Evidenced-based SANE Program
- Created a New Practice Model
- Changed SANE Practice Statewide:
 - ❖ Contributed to improvements in OR SANE Medical Guidelines
 - ❖ Encouraged a Public Health Approach to Post-sexual Assault Care
 - ❖ Initiated SANE Quality Improvement and Outcome Measurement Statewide

Reflection

- Individual to Population
- Local to State to National
- Beyond a Grassroots Approach
- Research





Questions?

Appendix A

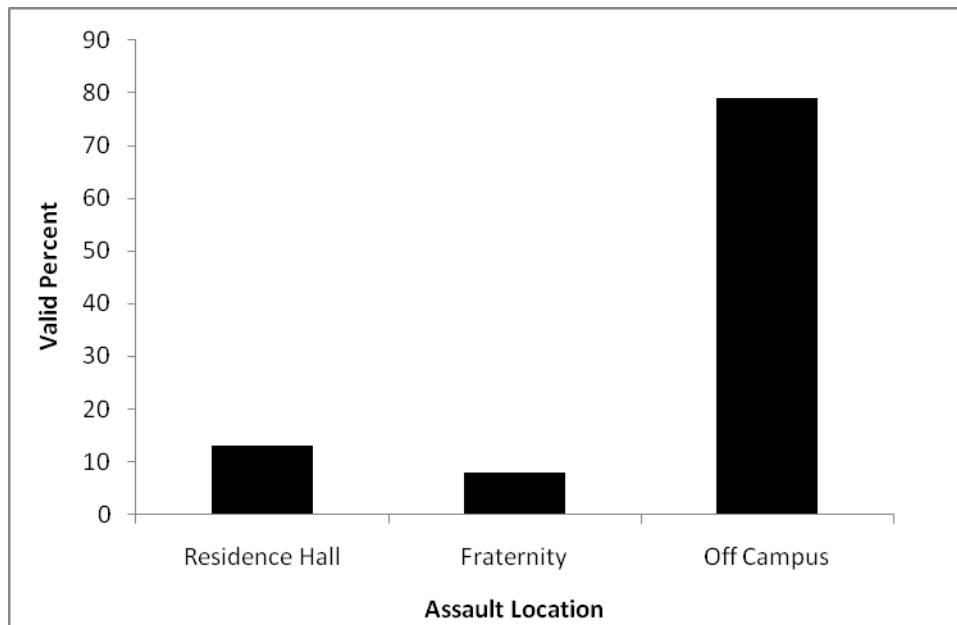
Table 1

Demographic characteristics of the study population

		Frequency	Percent
Gender (N = 46)	Female	46	100.0%
	Male	0	0.0%
		Frequency	Valid Percent
Age (N = 45)	17	1	2.2%
	18	13	28.9%
	19	11	24.4%
	20	5	11.1%
	21	7	15.6%
	22	2	4.4%
	23	3	6.7%
	24	1	2.2%
	25	1	2.2%
	26	1	2.2%

Appendix B

Figure 1. Frequency by Location of Sexual Assault, 2002-2008 (N = 38)



Appendix C

Table 2

Percentage Comparison of Documented Post-assault Services Pre and Post Sexual Assault

*Nurse Examiner**

Variable	Pre-SANE	Post-SANE	χ^2	Fischer's Exact Test	df	p value
Mandatory reporting	0.0 (0)	58.6 (17)	15.81		1	< .001
Description of the assault	100.0 (17)	100.0 (29)	**		**	**
Alcohol/Drug Screening	88.2 (15)	93.1 (27)	0.32	0.619	1	.572
Complete Physical Exam	17.3 (3)	69.0 (20)	11.29		1	< .001
Pregnancy Prophylaxis	58.8 (10)	34.5 (10)	0.002	2.548	1	.108
STI Prophylaxis	23.5 (4)	69.0 (20)	8.87		1	.003
Hepatitis B	17.6 (3)	82.8 (24)	18.74		1	< .001
HIV Risk Assessment	17.6 (3)	44.8 (13)	3.49		1	.062
Advocacy Contacted	5.9 (1)	72.4(29)	19.01		1	.001

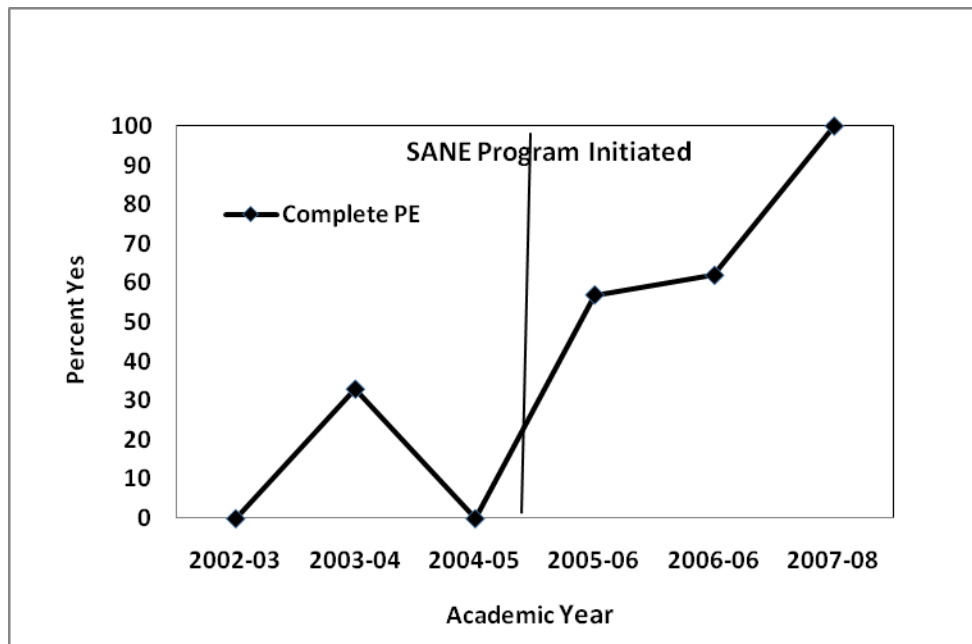
Values are percentage and (number)

* An alpha level of .05 was used for all statistical tests

** No statistics are computed because Description of the Assault is a constant

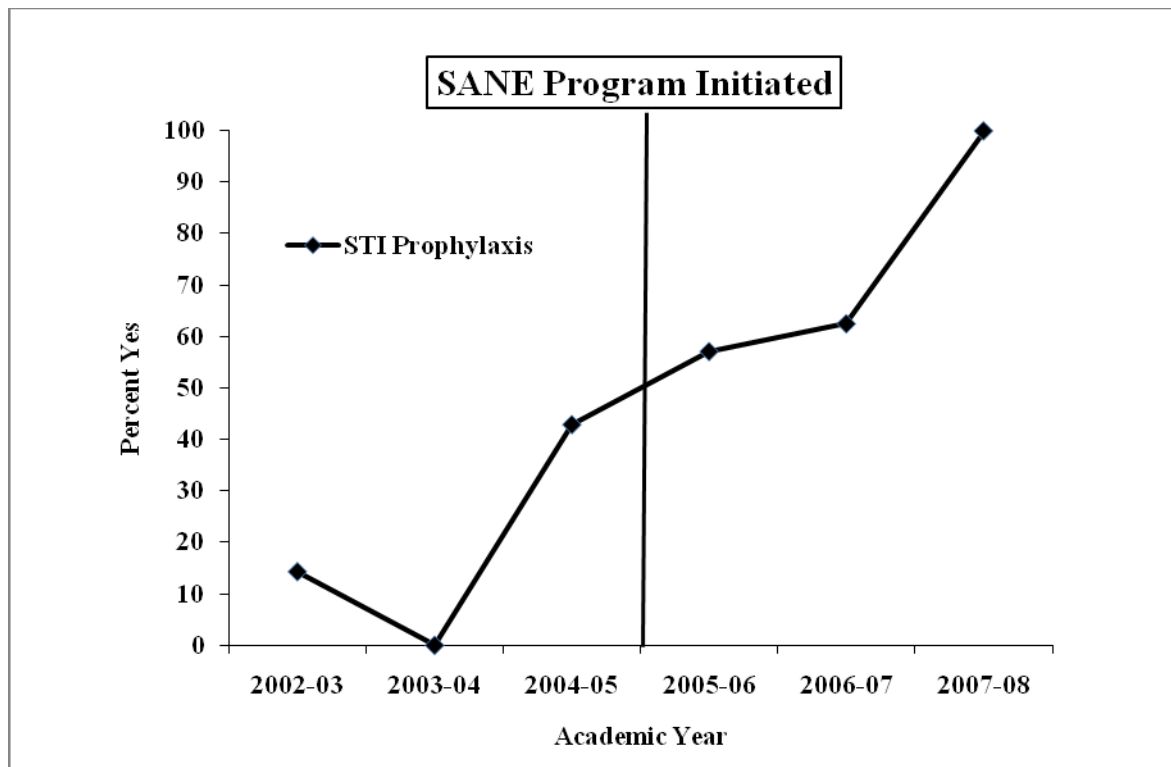
Appendix D

Figure 2. Percentage Change in Documentation of a Complete Physical Exam



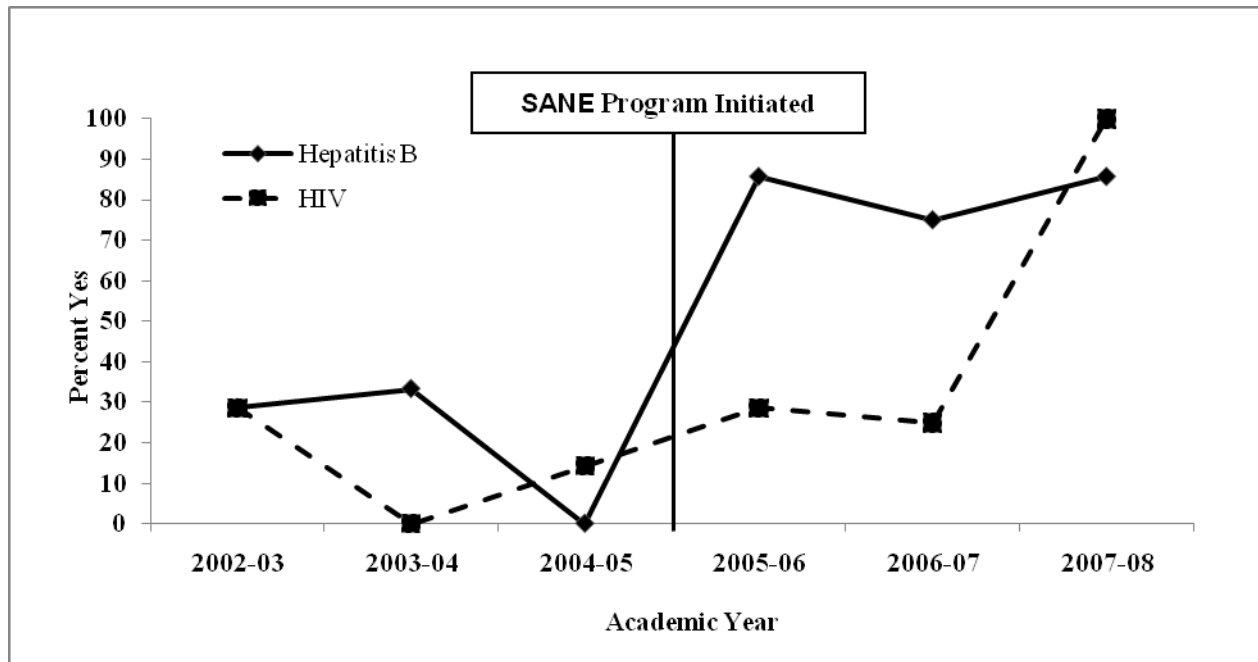
Appendix E

Figure 3. Percentage Change in Documentation of Sexually Transmitted Infection Prophylaxis



Appendix F

Figure 4. Percentage Change in Documentation of Hepatitis B Prophylaxis or Prior Immunization and HIV Post-Exposure Prophylaxis Risk Assessment



Appendix G

Table 3

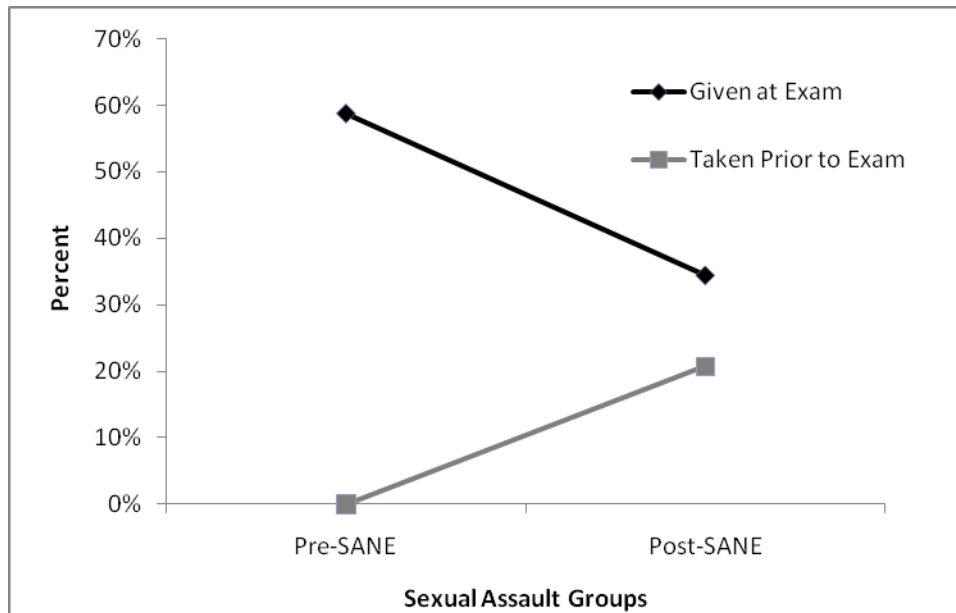
Percentage Comparison of Documented Medical Services by Academic Year

	2002-02	2003-04	2004-05	2005-06	2006-07	2007-08
Mandatory Reporting	0.0 (0)	0.0 (0)	0.0 (0)	35.7 (5)	62.5 (5)	100.0 (7)
Description of the Assault	100.0 (7)	100.0 (3)	100.0 (7)	100.0 (14)	100.0 (8)	100.0 (7)
Alcohol/Drug Screening	85.7 (6)	100.0 (3)	85.7 (6)	92.9 (13)	87.5 (7)	100.0 (7)
Complete Physical Exam	0.0 (0)	33.0 (1)	0.0 (0)	57.1 (8)	62.5 (5)	100.0 (7)
Pregnancy Prophylaxis	42.9 (3)	33.0 (1)	85.7 (6)	21.4 (3)	50.0 (4)	42.9 (3)
STI Prophylaxis	14.3 (1)	0.0 (0)	42.9 (3)	57.1 (8)	62.5 (5)	100.0 (7)
Hepatitis B Prophylaxis	28.6 (2)	33.0 (1)	0.0 (0)	85.7 (12)	75.0 (6)	85.7 (6)
HIV Risk Assessment	28.6 (2)	0.0 (0)	14.3 (1)	28.6 (4)	25.0 (2)	100.0 (7)
Advocacy Contacted	0.0 (0)	0.0 (0)	14.3 (1)	64.3 (9)	75.0 (6)	85.7 (6)

Values are percentage and (number)

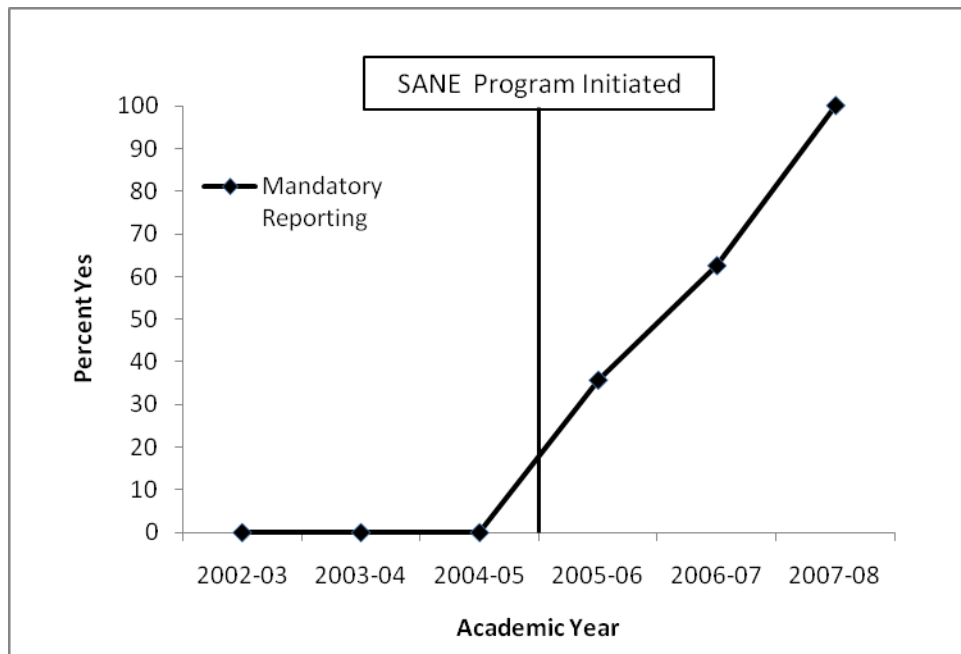
Appendix H

Figure 5. Frequency of Use of Emergency Contraception Given at the Time of the Sexual Assault Exam compared to Emergency Contraception Taken Prior to the Exam



Appendix I

Figure 6. Percentage Change in Documentation of a Mandatory Reporting Assessment



Appendix J

Table 4

Reporting and Non-reporting Sexual Assault Forensic Evidence (SAFE) Kit Collection by Year

Academic Year	Total no. of patients	Reporting SAFE kit	Non-reporting SAFE kit
Pre-SANE			
2002-2003	7		
2003-2004	3		
2004-2005	7		
Post-SANE			
2005-2006	14 [*]	1	
2006-2007	8	1	
2007-2008 ^{**}	7	2 ^{***}	3

* Highest levels of media attention and outreach regarding SANE services

** Non-reporting legislation implemented in 2007-2008

*** One additional patient reported, but declined SAFE kit

Running Head: EVIDENCE PRESERVATION IN SEXUAL ASSAULT

Evidence Preservation in Sexual Assault:

A Health Policy Analysis

Cynthia J. Smith

Oregon Health & Sciences University School of Nursing

Define the Context

Crime statistics suggest Americans live in a violent nation. According to the Federal Bureau of Investigation, an estimated 1,417,745 violent crimes occurred nationwide in 2006, an increase of 1.9% from the previous year (US Department of Justice [US DOJ], 2006). This translates into a rate of violent crime of 473.5 offenses per 100,000 (US DOJ). Regionally, the highest percentage of the violent crimes occurred in the South (43.2%), followed by the West (22.9%), Midwest (19.6%), and Northeast (15.1%), respectively (US DOJ).

United States Department of Justice (2006) data reveals that forcible rape accounts for approximately 6.5% of all violent crimes. Nationally, 1 in every 6 women and 1 in every 33 men have been the victim of a completed or attempted rape in their lifetime (Tjanden & Thoennes, 2000). Annually, almost 132,000 women report that they have been victims of rape or attempted rape, and nearly half of them are acquainted with their attackers (National Organization for Women, 2008). It's estimated that only 16% to 25% of assault victims report the crime (Resnick, 2000). According to the National Organization for Women, women who are young, unmarried, low-income or African American are disproportionately more likely to be victims of sexual assault.

Sexual violence has significant costs to both the victim and society. A National Institute of Health report on the cost and consequences of sexual assault suggests that a victim's suffering and lost quality of life should be analyzed when considering issues of public policy in this area (Miller, Cohen, & Wiersema, 1996). By quantifying more fully the realities of victimization, the effect of a crime such as sexual assault can be better characterized and prevention more appropriately addressed. More specifically, the report suggests that ignoring the nonmonetary effects of crime can result in a misallocation of resources (Miller, et al.).

The average tangible cost of a rape is estimated to be \$5,100, the majority of which is medical and mental health expenses (Miller et al., 1996). On the other hand, the expenditure of incarceration of a rape offender is approximately \$15,000 to \$20,000 per year (Miller et al.). Miller et al., further explains that if an additional year of incarceration of an offender were to help prevent one rape, this crime reduction would appear to pose a significant cost to society for that prison cell. However, when issues such as pain, suffering, and quality of life are considered, the cost of a single sexual assault is estimated to increase to \$87,000 (Miller, et al.; Agency for Healthcare Research and Quality [AHRQ], 2003).

Furthermore, given the long-term consequences to a victim of sexual assault compared to other crimes, the overall cost of rape is estimated to be \$127 billion (AHRQ, 2003). While this figure includes some of the previously mentioned expenditures such as medical care, police response, and lost quality of life, it does not include the costs of investigation, prosecution, or offender incarceration (Miller et al., 1996). According to the National Institute of Justice, this makes rape the most costly crime in this nation (Miller, et al., 1996).

A recent study of emergency room visits for assault estimates that approximately 143,647 sexual assaults were seen in the nation's emergency rooms between 2001 and 2002 (Saltzman, et al., 2007). Historically, rape victims have received a lower standard of care in emergency rooms as compared to other emergency room patients (Taylor, 2002). Sexual assault victims in emergency rooms suffer long waits; go up to 12 hours without food, drink, or toileting; and have their injuries considered less serious than other trauma victims (Taylor). The experiences of victims in emergency room settings or with law enforcement often make it less likely a sexual assault victim will seek medical care or report the crime. In sexual assault, timely follow up is particularly crucial so that important, time-sensitive forensic evidence is not lost (Attorney General's Sexual Assault Task Force [AG's SATF], 2007).

Historically in Oregon, if a victim of sexual assault desired to have forensic evidence collected at the time of presentation to a medical facility, a law enforcement officer had to be contacted by the Sexual Assault Nurse Examiner (SANE) to authorize the collection of an Oregon State Police (OSP) Sexual Assault Forensic Evidence (SAFE) kit (Oregon Department of Justice [OR DOJ], 2003). At that time, the law enforcement officer would obtain a report of the assault and the evidence would be retrieved and entered into storage. This practice often resulted in victims declining to collect evidence because, in the initial hours after an assault, they were not prepared to decide immediately if they wish to report the assault to law enforcement (AG's SATF, 2007). Contrary to best practices, many institutions, upon learning the victim did not want to report to law enforcement, declined to perform a complete medical exam (H. Huhtanen, personal communication, February 11, 2008). A complete medical exam is the standard of care and should be offered regardless of a victim's decision to report the assault.

Federal legislation addressing the needs of victims of domestic violence, dating violence, sexual assault and stalking dates back to 1994. At that time, Congress passed a landmark piece of legislation known as the Violence Against Women Act (VAWA) (National Task Force to End Violence Against Women, 2005). Since its inception, VAWA programs have made great strides in promoting a community coordinated response to sexual violence, improving criminal prosecution efforts, expanding training, and responding to sexual assault with a more victim-centered approach (National Task Force to End Violence Against Women).

Reauthorization of VAWA has been successfully passed by Congress in 2000 and 2005 (US DOJ, 2008). In 2007, VAWA added two additional requirements to address specific needs of the sexual assault victim with regards to forensic evidence collection (AG's SATF, 2007). First, the state must incur the full costs of the forensic medical exam for a victim of sexual assault. Secondly, by January 5, 2009, states will no longer be allowed to require victims of

sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to receive a forensic evidence exam. All states receiving Federal VAWA dollars must comply with this ruling or risk losing their funding (AG's SATF). In Oregon, VAWA dollars are an important source of funding for local, county and statewide sexual assault response programs (AG's SATF).

Several years ago, in response to VAWA requirements and identified problems with forensic evidence collection in the state of Oregon, the Attorney General's Sexual Assault Task Force began to consider a legislative effort to address these concerns. Legislation was initiated in an attempt to create more consistent and higher quality medical follow-up for sexual assault; allow the victim additional time to determine if they wanted to report the assault; and decrease the likelihood of losing critical forensic evidence post assault (AG's SATF, 2007).

In preparation for the 2007 legislative session, the Legislative and Public Policy Committee of the Attorney General's Sexual Assault Task Force began work on an evidence preservation bill to eliminate the requirement for law enforcement authorization prior to the collection of a SAFE kit (AG's SATF, 2007). This legislation would allow victims of sexual assault to consent to the collection of a rape kit regardless of whether the victim reports the assault to law enforcement. According to the Attorney General's Sexual Assault Task Force, it would ensure that the collection of the evidence kit is done in a manner that protects the victim's identity (Oregon State Legislature, 2007). Lastly, the bill would further outline the conditions under which the Department of Justice would reimburse medical providers for sexual assault examinations and thus, eliminate charges to the victim for these services (OR DOJ, 2003). Specifically, the bill was designed to promote the preservation of valuable forensic evidence through the immediate collection of a rape kit (AG's SATF). Should a victim later decide to report, law enforcement and prosecutors would then have access to evidence that could

potentially contribute to a successful investigation and prosecution (AG's SATF). Eliminating law enforcement authorization of the SAFE kit under this law would provide victims the option of having evidence collected while giving them time to come forward in the aftermath of a sexual assault (AG's SATF).

Under this proposed legislation, upon presentation to a medical facility a victim of sexual assault would be offered a complete medical assessment which includes a medical exam, sexually transmitted infection prophylaxis, and emergency contraception (Oregon State Legislature, 2007). If presentation occurs within 84 hours post assault, the option of a SAFE Kit collection for forensic evidence preservation would also be offered (OR DOJ, 2004). Once collected, the rape kit would be retrieved by law enforcement within two hours of collection (AG's SATF, 2007). If the rape kit was collected without an initial report to law enforcement, the evidence would be turned over to law enforcement and stored in a manner that protects the identity of the victim (Oregon State Legislature). If a victim chooses not to report to law enforcement upon initial presentation, a case number would be created with which the victim could later be linked to the kit if necessary (AG's SATF, 2007).

State the problem

In Oregon, sexual assault victims often decline to consent to the collection of a Sexual Assault Forensic Evidence (SAFE) kit as it requires first reporting to law enforcement for authorization. This results in the loss of critical, time-sensitive evidence needed by law enforcement and prosecution.

Search for evidence

Rape is a public health concern of significant magnitude in the United States and affects nearly 1 million American women annually (Resnick et al, 2000). In Oregon, one in every six adult women has been a victim of rape at some point in her lifetime (Kilpatrick & Ruggiero,

2003). Based on the 2000 Oregon census, that translates into approximately 230,000 sexual assaults and is considered a conservative estimate (Kilpatrick & Ruggiero).

There are several groups that are at particularly high risk for sexual assault. More than half of all rapes in this country occur to young women between the ages of 12 and 25 (Nasta et al., 2005). In fact, this age group experiences up to a threefold increase in sexual assault rates compared to older women (Nasta et al.). College women are vulnerable given the increase in dating and sexual relationships during this time period (Nasta, et al). In an Institute of Higher Education survey of a broad range of two and four year public and private colleges, it was found that more than 25% of college-aged women reported experiences that met the legal definitions of either rape or attempted rape (Karjane, Fisher, & Cullen, 2005).

The lifetime risk of sexual abuse for a disabled female is estimated to be between 51% and 79% (AHRQ, 2003). Additionally, only 3% of sexual abuse cases in the developmentally disabled population are ever reported to law enforcement (Wisconsin Coalition Against Sexual Assault [WCASA], 2003). Substance abuse, survival strategies, lack of safe housing, and mental illness are some of the many risk factors for sexual assault in women who are homeless (Goodman, 2006). In fact, in women who are both severely mentally ill and homeless, the likelihood of violent victimization is so high as to be considered normative (WCASA). Lastly, sexual abuse of the elderly is believed to be very prevalent, but few reliable studies regarding its frequency exist (AHRQ). In a rare study, Burgess (2006) reviewed 284 cases of suspected sexual abuse and the results showed that the majority of victims were female, suffered from dementia, and were known to their perpetrator.

Often forgotten is the estimated that 1 in 3 Native American women in this country who will be sexually assaulted in their lifetime (The National Task Force to End Sexual and Domestic Against Women, 2005). In at least 86% of the reported cases of rape in this population, survivors

report that the perpetrators were non-Native men (Lobe, 2007). Underfunding of tribal nations, compared to non-native communities has resulted in limited access to timely forensic evidence collection for victims, inadequately trained law enforcement responders, and limited prosecutorial efforts (Amnesty International, 2007).

Following a sexual assault, the victim deserves high quality, victim-centered care. It is in this immediate post assault period that 50% of victims will have evidence of physical trauma, nearly 30% will contract a sexually transmitted infection, and up to 5% become pregnant (Resnick et al, 2000). Sexual Assault Nurse Examiners (SANE) are specially trained to care for the acute sexual assault victim. The SANEs role includes providing impartial documentation of the assault, medical and injury care, proper evidence preservation, and appropriate referrals (Taylor, 2002).

A 2003 study funded by the National Institute of Justice evaluated the efficacy of SANE care on medical care, victim services, law enforcement and prosecution (Crandall & Helitzer, 2003). The results support SANE programs as having a positive impact on the quality of medical services, including provision of emergency contraception and sexually transmitted infection prevention. In addition, a superior quality of forensic evidence was collected, enhancing law enforcements work and increasing the conviction rate and length of sentencing (Crandall & Helitzer). Another study of 515 forensic evidence kits found that SANEs were more accurate and complete in the performance of evidence collection as compared to either non-SANEs or physicians (Sievers, 2003).

Forensic evidence collection is essential to any efforts to pursue further investigation and prosecution. Unfortunately, due to complex social issues surrounding sexual assault, many offenses are never reported (Scott & Beaman, 2004). The Federal Bureau of Investigation asserts that sexual assault is the least reported of all violent crimes (AG's SATF, 2006). It is estimated

that only 16% to 25% of victims ever report the assault to law enforcement (Resnick et al, 2000). In Oregon, a recent study contends that only 27% of victims of intimate partner sexual assault reported to law enforcement (Oregon Department of Human Services, 2004).

Law enforcement involvement in forensic evidence collection can be a deterrent to victim consent. Over the years, legal reforms have attempted to remove barriers to victim reporting through changes in evidentiary requirements, establishment of rape shield statutes, and the redefining of definitions of rape (Clay-Warner & Burt, 2005). Prior to these changes, victims were reluctant to report an assault for fear of criminal justice system mistreatment and perpetrator retaliation (Clay-Warner & Burt).

Policy Options

Within Oregon's legal system differing policy options are available to address the needs of sexual assault victims. An interview was conducted with Heather Huhtanen, Program Director for the Attorney General's Sexual Assault Task Force to discuss the alternative strategies considered in improving the collection of forensic evidence and medical care provided to victims of sexual assault in this state. According to Huhtanen (personal communication, February 11, 2008), a potential policy change could occur through three possible avenues: changes to the Oregon Revised Statutes (ORS), Oregon Administrative Rules (OAR), or Oregon Constitution.

As background, the option chosen by the Attorney General's Sexual Assault Task Force to address the preservation of forensic evidence was to pursue modification of the Oregon Revised Statute (H. Huhtanen, personal communication, February 11, 2008). Oregon Revised Statutes are the codified laws of the State of Oregon. By definition, codified denotes a means of arranging laws systematically (Oregon State Legislature, 2008). That is, once a law is codified it becomes incorporated into that section of the ORS that it either "modifies, amends or

accompanies” (Oregon State Legislature). To pursue this option, legislative intervention would be required and occur during one of the biennial sessions of the Oregon state legislature.

A second option would be to consider a change through an Oregon Administrative Rule. An Administrative Rule is an agency directive that implements a policy or describes the practice obligations of that agency (Oregon State Legislature, 2008). This option requires appointment of an advisory committee, as well as public input on the proposed rule or modification (Oregon State Archives, 2008). Public input occurs through the publication of potential changes in the *Oregon Bulletin* or notification of individuals on the agency’s rulemaking list (Oregon State Archives). The *Oregon Bulletin*, in addition to serving other functions, is a monthly publication that provides notice of intended rule actions (Oregon Secretary of State, 2008). Lastly, a hearing to review the changes may be scheduled or requested. It is the office of the Attorney General that has the capacity to interpret Administrative Rules and give legal advice regarding these Administrative Rules (Oregon State Archives).

The third option, changes to the Oregon Constitution, is an amendment process that would bring a proposal to the voters of the state. Either branch of the legislative assembly may propose a constitutional change (Oregon Blue Book, 2007). Constitutional changes reach the voters by first going through an initiative petition or by a simple majority vote by the legislature (Oregon Blue Book). To reach the ballot there must be signatures obtained from 8% of the number of voters that participated in the last gubernatorial election (Oregon Blue Book).

Another set of options for addressing this issue that was not discussed by Huhtanen would be to consider legislation modeled after that which has been implemented by other states in the nation. These laws can be broken down into four distinct areas (Scalzo, 2006). Each set of laws specifically addresses sexual assault in a competent, adult rape victim separately from the

universal mandatory reporting laws for vulnerable populations such as children, the elderly, or the disabled (Scalzo).

The first option would be a law specifically requiring the reporting by medical personnel to law enforcement any victim treated for sexual assault. Presently, California is the only state with such a mandatory reporting law (Scalzo, 2006). The forensic exam is paid for by the local law enforcement agency requesting the collection and no costs can be passed on to the victim when the exam is conducted for prosecutorial purposes (National Center for the Prosecution of Violence Against Women [NCPVAW], 2005). Kentucky, Colorado, and Rhode Island have a more limited policy that requires reporting of rape only if it is associated with domestic violence (AHRQ, 2003). Finally, Massachusetts mandates medical personnel to report any rape victim treated, but without any accompanied identifying information (Scalzo). Discussions with both victims and medical providers have produced a number of concerns with mandatory reporting legislation. This includes risk of exposing victims to retaliation, the lack of informed consent, and removal of patient autonomy in the process (AHRQ).

A second approach would be to model legislation after those states that require the reporting of injuries that may indirectly include rape (Scalzo, 2006). These laws are broader in scope and mandate the reporting of all non-accidental or intentional injuries (Scalzo). There are additional states that also require the reporting of injuries caused by criminal misconduct, of which rape is included (NCPVAW, 2005). There are more states in the later group, but some states mandate reporting under both of these conditions (Scalzo).

Third are those statutes that may indirectly affect rape victims. That is, those laws requiring certain types of injuries be reported (Scalzo, 2006). In the event a rape victim presents with one of these injuries, law enforcement would be required to be contacted. Examples of these injuries include harm from either a deadly weapon or burn (Scalzo).

Finally, there are some states that require sexual assault victims to report to law enforcement before a victim may receive a forensic exam without costs incurred by the victim (Scalzo, 2006). In addition, there are states with additional requirements necessitating victim cooperation with law enforcement or time limits under which the services will be provided (NCPVAW, 2005).

Outcomes and Evaluative Criteria

Each of the proposed options has significantly different potential outcomes. The legislative option of changing policy through the Oregon Administrative Rules would open the discussion of forensic evidence collection to the public and to state agencies for input and contains a certain amount of inherent risk (H. Huhtanen, personal communication, September 11, 2008). While the Sexual Assault Task Force has been universally supported by both Attorney General Hardy Meyers and its Legislative sub-committee, according to Huhtanen, the potential response from the law enforcement community was less clearly understood. Certainly, any attempt to legally change law enforcement's practice or the criminal code would make this legislative issue much more high profile. Huhtanen (personal communication, February 11, 2008) adds that, while improvements in the care of sexual assault victims were a goal of the policy, it was never an option to try and mandate a medical response from health care providers. According to the Attorney General's Sexual Assault Task Force (2007), it was expected that a revision in the method of forensic evidence collection would result in an annual addition of 219 SAFE kits being collected throughout 36 counties in Oregon. This policy change should not be an undue burden to any one law enforcement agency or medical facility.

An amendment to the Oregon State Constitution is an option to be considered in rare circumstances. While Constitutions were initially designed to allow for some alteration, the intent of the citizens is to have a stable document. Any change would have required an initial

proposal from either house of the Oregon Legislative Assembly, which must then be passed by at least a two-thirds majority vote (Oregon Blue Book, 2007). The proposed change, if passed, would then be put to the voters for an additional majority vote (Oregon Blue Book).

Consequently, Constitutional Amendments are much less accessible, more time consuming, and more expensive than other options. Forensic evidence collection was not the type of issue that belongs in a Constitutional Amendment, nor one the voters would be expected to understand.

The option of mandatory reporting would likely meet the needs of the law enforcement community, but lacks a victim-centered approach. It could increase perpetrator accountability and offer a means of tracking sexual assault statistics. The burden of paying for the forensic exam would be placed on the local law enforcement agency and patients would not be billed for the exam if it was performed for possible prosecution purposes (NCPVAW, 2006). This requirement might put undue pressure on a victim to cooperate with law enforcement to avoid the costs associated with their care. Likewise, mandatory reporting may also discourage victims from reporting and limit their ability to seek medical care (Rodriquez et al., 1998). It raises concerns about patient safety, especially given that most sexual assault victims know their perpetrator and is contrary to the strongly held beliefs of patient privacy and confidentiality (AHRQ, 2003). According to Sullivan and Hagan (2005), mandatory reporting laws have been put into place with little input from sexual assault survivors. In a study of 61 survivors of domestic or sexual violence, 60 individuals did not support mandatory reporting (Rodriquez et al.). For these victims the consequences of reporting outweighed the benefits, and personal safety was their biggest concern. Additional concerns voiced were fear of mental health histories becoming public record and media attention to their case (Rodriquez et al.).

Laws pertaining to the reporting of only those rapes associated with injury would result in incomplete reporting. Given most victims of rape experience no physical injury, the value of

such a reporting method is of questionable benefit. It would likely provide confusion as to whether reporting is required if the only injury to the victim is the rape itself (Scalzo, 2006). Additionally, associating the lack of visible injury to reporting perpetuates misinformation about sexual assault, questions the legitimacy of some sexual assault reports, and misses understanding the significant mental health consequences of rape.

Other laws regarding the reporting of assaults associated with firearms, stab wounds, and burns results in an even smaller subset of sexual assaults being reported (Scalzo, 2006). Furthermore, the reporting of rape in the presence of suspicious wounds is vague and likely confusing for healthcare providers. Under the Violence Against Women and Department of Justice Reauthorization Act of 2005, the medical portion on an exam cannot be denied, even when the forensic portion is not being completed (US DOJ, 2005). This policy is likely to further confuse medical personnel and result in many patients receiving neither the medical nor the forensic exam (Scalzo, 2006).

Lastly, some states have requirements of reporting a sexual assault to law enforcement before the cost of a forensic exam will be covered (NCPVAW, 2005). Prior to June, 2007, this included Oregon. In addition, some states have requirements for cooperation with law enforcement or limits as to the number of hours post-assault that a forensic exam can be performed without cost to the victim (NCPVAW). The Violence Against Women Act (VAWA) calls into question these reporting requirements (Scalzo, 2006). Specifically, VAWA indicates that nothing in the policy should be interpreted as permitting an agency from requiring victim cooperation with the criminal justice system in order to receive a forensic exam, reimbursement of expenses, or both (US DOJ, 2005). The effectiveness of such mandatory reporting laws as a viable option in sexual assault would require additional efforts and investments be made to enhance the training of medical personnel and law enforcement, to improve the criminal justice

system's ability to hold perpetrators accountable, and to improve support services for victims (Sullivan & Hagen, 2005).

The chosen policy option was to use the Oregon Revised Statutes process. While the Attorney General's Sexual Assault Task Force and Department of Justice both understood that the desired changes would require a legislative fix, according to Huhtanen (personal communication, February 11, 2008), this particular approach was thought to be able to change both law enforcement and medical provider behavior. In 2003, the AG's SATF had already successfully passed SB 752 which created the Sexual Assault Victims Emergency (SAVE) Medical Response Fund to pay the cost of forensic exams for victims of rape (A.G.'s SATF, 2007). It was believed that attaching this current legislation as a revision would be the simplest tactic to accomplish their goal. By aligning itself with prior legislation that created the SAVE Fund, agencies would have expanded access to financial reimbursement for the cost of evidence collection (AG's SATF). The proposed policy, while significantly changing the way in which forensic evidence is collected, would still permit the SAFE kits to remain the property of law enforcement (H. Huhtanen, personal communication, February 11, 2008).

While medical care for sexual assault victims could not be legislated, a statutory change was thought to offer an incentive for medical facilities to follow the recommendations for none other than liability purposes (H. Huhtanen, personal communication, February 11, 2008). An additional benefit of this legislation was also desired. According to Huhtanen (communication, February 11, 2008), by increasing the number of victims receiving evidence collection, it was hoped that additional victims would then receive more complete medical exams and improved care, regardless of whether they eventually reported their assault to law enforcement. Ultimately, this solution was felt to provide the best opportunity to preserve all options for the sexual assault victim.

Weigh the options

The legislative options to revise the manner in which forensic evidence is collected include changes through the Oregon Revised Statutes, Oregon Administrative rules, and state Constitutional Amendment process (H. Huhtanen, personal communication, February 11, 2008). The Oregon Revised Statute option utilizes an existing statute to introduce the proposed health policy initiative (AG's SATF, 2007). Attaching itself to previous legislation associated with reimbursement for sexual assault exams has the potential to encourage compliance (Huhtanen). Healthcare facilities are likely to be motivated to continue to receive financial reimbursement for services rendered and thus cooperate with all aspects of the legislation. This avenue also makes no potentially controversial legal changes to the practice of law enforcement. By encouraging more complete forensic exams with the addition of evidence collection, it moves the medical response towards a more victim-centered approach without creating mandates (Huhtanen).

Legislative change through the Oregon Administrative Rules presents a great deal more uncertainty. To pursue a health policy change under these circumstances would require input from the public and other state agencies (Oregon State Archives, 2008). Such an avenue might allow unsupportive stakeholders to significantly influence the process (H. Huhtanen, personal communication, February 11, 2008). Creating a legal change to the practice of law enforcement would likely have been a contentious undertaking. Emphasizing the collection of evidence, without ties to the financial reimbursement process, may have been less likely to impact the medical response to sexual assault.

The Constitutional Amendment process would have been an unnecessarily cumbersome and time consuming process for the desired health policy change. It would have required input from Oregon voters, a group that, for the most part, had very little stake in the outcome of this piece of legislation. The risk of a legislative failure would likely have increased through a piece

of health policy presented to an uninformed group for passage. In addition, such an avenue would have been an expensive process for the taxpayers of Oregon.

All four versions of the mandatory reporting legislation from other states have limitations (Scalzo, 2006). California's universal mandatory reporting laws are not in the spirit of this health policy change which emphasizes a victim-centered approach to sexual assault response. It perpetuates the notion that a victim of a sexual assault is capable of engaging in the criminal process while in the initial traumatic hours post assault (H. Huhtanen, personal communication, February 11, 2008). Rather than preserve options, it mandates them.

The other three mandatory reporting alternatives address specific events related to a sexual assault, such as the use of weapons (Scalzo, 2006). These approaches, while appropriately addressing certain criminal behaviors, are likely the exceptional circumstance in sexual assault. Other laws that require mandatory reporting in the presence of physical injury also involve a minority of victims and overlook the trauma experienced by most other victims of sexual assault. There are those mandatory reporting laws that require cooperation with law enforcement for the sexual assault services to be paid for, thus creating an obligation on the part of a victim to engage in a process they might not otherwise chose to participate in (Scalzo). Lastly, mandatory reporting has the potential of creating victim safety issues, challenges patient-provider confidentiality and disregards patient autonomy (AHRQ, 2003).

Policy Solution

The option to utilize the Oregon Revised Statutes to change the conditions under which forensic evidence is collected from sexual assault victims offers a sound solution to this health policy effort. Designing this policy as a revision to a previously successful piece of legislation is a subtle means of changing practice without introducing a new piece of legislation through a more complicated process (H. Huhtanen, personal communication, February 11, 2008). The

language of the bill takes an approach to changes in practice by both Sexual Assault Nurse Examiners and law enforcement without being controversial.

Implementation of this policy option is cost effective. The policy change will link the practice of evidence preservation to eligibility for reimbursement through the Sexual Assault Victims' Emergency (SAVE) Medical Response Fund (Oregon State Archives, 2007). Since the SAVE Fund is comprised of money acquired through private donations and criminal fines there will be no additional expense to the state (OR DOJ, 2004). This particular approach, while not mandating a medical response, does compel participation in more comprehensive post sexual assault care from the health care providers (AG's SATF, 2007).

Utilizing the Attorney General's Sexual Assault Task Force as a sponsor of the bill creates an association to an organization well respected among health care providers, advocates, law enforcement, and prosecution. The increase in Sexual Assault Forensic Evidence (SAFE) kits collected statewide under this policy change should not be a burden to any one law enforcement agency or medical facility (AG's SATF, 2007). Lastly, the passage of this bill will ensure that Oregon is in compliance with the federal Violence Against Women Act requirements so that it may continue to receive grant monies to fund domestic violence, sexual assault, and stalking programs statewide (AG's SATF, 2007).

This policy option is also known as HB 2154, the Evidence Preservation Bill (Oregon State Legislature, 2007). During the 2007 Oregon state legislative session, it was first introduced to the House Committee on Human Services and Women's Wellness (Oregon State Archives, 2007). Subsequently, it was reviewed by the Senate Committee on Health Policy and Public Affairs (Oregon State Archives, 2007). It passed both committees unanimously and went on to receive bipartisan support and was unanimously passed by both the House and Senate of the

Oregon State Legislative Assembly (AG's SATF, 2007). On June 1, 2007 Governor Ted Kulongoski signed HB 2154 into law.

House Bill 2154, while important to the work of both law enforcement and prosecution, also resulted in an equally important victim-centered approach to sexual assault care in Oregon. It compels organizations involved in sexual assault to make significant changes to the manner in which forensic evidence is collected. This legislation ensures that victims are treated equally regardless of their desire to report to law enforcement. It acknowledges the trauma of an assault while providing a means of preserving a full range of options for a victim. Most importantly, in the aftermath of a sexual assault, HB 2154 acknowledges that it is unrealistic to expect a victim of sexual assault to be prepared to make a decision regarding a potentially long-term involvement with the legal system. The Attorney General's Sexual Assault Task Force has demonstrated significant leadership in addressing this issue and in the process, produced a model piece of health policy for the rest of the nation to emulate.

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Running Head: ALCOHOL

N790 Clinical Residency

Case Report: Alcohol and Sexual Assault on College Campuses

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Selected Health Issue

According to Mohler-Kuo, Dowdall, Koss, and Wechsler (2004) alcohol-related sexual assault is a widespread problem among college campuses in this country. In fact, alcohol is known to be the most prevalent rape drug (Cole, 2006). The National Institute of Justice (NIJ) reports that alcohol intoxication in a college setting is a significant risk factor for sexual assault (Fischer et al., 2000). In addition, Mohler-Kuo et al. found that higher levels of intoxication by the victim and offender are associated with greater severity of sexual violence.

Studies have demonstrated that 50-72% of sexual assault victims on a campus have consumed alcohol, with almost 75% of perpetrators having engaged in heavy alcohol intake (Cole, 2006; Mohler-Kuo et al., 2004). Students enrolled in college drink more heavily than their non-college peers (McCabe et al., 2005). A nationwide survey of college students revealed an annual average of 72 drinking days, 44 heavy drinking days, and 21 episodes of intoxication (Goldstein, Barnett, Pedlow, & Murphy, 2007). Forty percent of college students engage in periods of heavy drinking and a school's episodic drinking level was found to be the strongest risk factor with regard to rape while intoxicated (Mohler-Kuo et al.).

Fraternities and sororities have the highest alcohol consumption rates on campus (McCabe et al., 2005). Students with Greek affiliation have a binge drinking rate of 65% and it increases to 80% if the member lives in a fraternity or sorority house (McCabe et al.). Fraternity membership resulted in a threefold increase in high drinking rates compared to other male campus members (McCabe et al.).

Alcohol-related sexual assault occurs more often among students who are casually acquainted or have met at a bar or party (Mohler-Kuo et al., 2004). Up to 90% of college sexual assault victims will know their assailant (Karjane et al., 2005). Women report significantly

higher rates of unwanted sexual contact than men and the risk of sexual victimization peaks between the ages 16 and 24 (Banyard et al., 2007; Nasta et al., 2005). White students experience alcohol-related sexual assault more often than other ethnic groups (Mohler-Kuo et al.)

Most rapes occur in the evening at parties or in residence halls (Cole, 2006). Timing is influenced by circumstances that result in periods of low academic demand and heavy alcohol use such as weekends, holidays and spring break (Grekin, Sher, & Krull, 2007). Women in university settings are at higher risk of sexual assault than non-college females (Anderson & Danis, 2007; Mohler-Kuo et al.). Freshman year presents the highest risk for rape and first year sexual assault increases risk for subsequent sexual victimization in college (Humphrey & White, 2000).

Case Study

Sarah was just 18 years old, a freshman, and in her first month of college when she was sexually assaulted by an acquaintance. She and her friends attended a fraternity party, had several alcoholic drinks, and were on their way to a second party when the assault occurred. A highly intoxicated member of the fraternity followed the women to the second party. Sarah had fallen behind the rest of the group when she was approached by a man she had just met at the party. She was not initially concerned as she recognized him, but it soon became apparent that he was trying to have nonconsensual physical contact as they walked down the dark street. He forced himself upon her, breaking her belt, and placing his hand down her pants with vaginal penetration. Sarah was eventually able to break away and catch up with her friends whom she told of the incident.

The following day Sarah presented at the university health center for post assault care. She was accompanied by a friend and came with a bag containing the clothing she had worn the

night before. She had not previously been sexually active. Sarah was reluctant to report the assault to the police for fear of her parents finding out about both the incident as well as her own under-aged drinking. Sarah was seen by a Sexual Assault Nurse Examiner (SANE) specially trained in sexual assault care. The nurse explained to Sarah her options, documented a thorough history, performed an exam, and collected the broken belt as evidence. On exam she had bruises, and pain in the genital area.

Throughout her clinic visit, Sarah remained ambivalent regarding her desire to report the assault to law enforcement or to campus personnel. Nevertheless, with the patient's consent the SANE contacted law enforcement and she did meet with a police officer to explore her options. In addition, as the alleged assailant was a university student, Sarah had the option of reporting the assault under the campus conduct code and was referred to the campus authorities.

Sarah's case is not an atypical story on a college campus in this country. It was chosen for this case study as it demonstrates the challenges and complexity of post assault care given the medical, legal, and social issues that must be addressed by the advanced practice nurse. The use of alcohol by either the victim or assailant is a common feature of sexual assault in this population and presents important challenges and areas for prevention, education, and policy that will be specifically addressed here.

Analysis

Sarah's case study is reflective of the statistics known about college sexual assaults. She was a freshman, Caucasian, briefly acquainted with her assailant, and had been drinking on the night of her assault. Her assailant was also reflective of the typical college campus perpetrator. He was a student, fraternity member, and engaged in heavy alcohol use the night of the assault. In addition, the assault occurred in the evening, near campus, and during Greek life activities.

For a number of years, the university health center on this campus had seen many sexual assaults, most of which involved alcohol. The extent of clinic services for students had been primarily to address issues of pregnancy prophylaxis and sexually transmitted infection prevention. There were no consistent sexual assault response protocols or practice guidelines in place and students desiring to report an assault had to be referred to the local emergency room for forensic evidence collection.

In an effort to provide comprehensive services, including forensic evidence collection, a Sexual Assault Nurse Examiner (SANE) program was developed. This required a well coordinated effort among a multi-disciplinary team of campus and local community members. It grew out of effort from advanced practice nurses to establish best practice care with regard to sexual assault response on campus.

Sarah was the first student the health center had seen under the recently created SANE program. For the first time, a standardized documentation form was used, a team response approach initiated, and evidence collected. This approach required that the SANE impart to the victim a sense of safety and control over the process while gathering information and making clinical decisions. Care had to be taken to provide the victim with all her options without influencing her decisions. Legal requirements necessitated careful compliance with requirements for patient consent, confidentiality, and chain of custody regarding documentation and evidence collection.

There were many critical steps to this process, all requiring either decision making on the part of the patient or expert judgment on the part of the advanced practice nurse. For the patient, each decision has significant consequences with regard to how the assault might later be handled. This placed substantial responsibility on the SANE to carefully outline all options to the patient.

For the SANE, each nursing action could seriously affect the judicial process for the victim, influence the patient's sense of control over the process, and impact the healing process for this individual. Criteria for decision making throughout this case was based on best practice guidelines with an emphasis on victim-centered care.

Nothing more seemed to come of Sarah's case following her initial visit. It was about six months later when her parents learned of the assault and insisted their daughter follow up further with the university. The SANE was contacted by a university lawyer in charge of administering the student conduct code. The SANE was interviewed and her documentation of the events was reviewed. Both students were interviewed. A decision was made that the alcohol use by the two students would not be used against either one of them. In the end, despite the months that had passed since the assault, the young women's story of the events completely matched the documentation noted months prior by the SANE. The fraternity student was found responsible for the assault and, at the victim's request, the only punitive action taking was his participation in sexual violence education with fraternity members.

Interventions

Historically, when alcohol is involved in sexual assault the general public, including juries, frequently view the circumstances through a different lens and victim blaming often results. On many campuses because of the heavy use of alcohol, many sexual assault victims are met with an indifferent response from law enforcement, an unsupportive reaction from prosecution, and subsequent low conviction rates (Centers for Disease Control and Prevention, 2004). In addition, victims often tend to view themselves as responsible for the assault despite logic that would suggest that a natural consequence of alcohol intoxication should not be rape. The SANE and other members of a Sexual Assault Response Team (SART) are critical to

challenging these biases in their respective fields. As advanced practice nurses, DNPs can work to take a leadership role in modeling care that avoids victim blaming in sexual assault response. In addition, DNPs can participate in organizations at the campus, state, and national level to educate other members of the SART and community with regard to issues of alcohol and sexual assault.

Heavy drinking associated with sexual assault on campuses is further influenced by the environment in which alcohol sales are made readily available. Close proximity of liquor stores to campus, low priced alcohol advertising, and bar drink specials have all been associated with increased rates of heavy alcohol consumption (Toomey, Lenk, & Wagenaar, 2006). In Oregon, efforts are being made by the Attorney General's Sexual Assault Task Force to work collaboratively with the Oregon Liquor Control Commission to educate alcohol servers about alcohol and sexual assault, particularly drug facilitated sexual assault. This is an example of a feasible, proactive measure that DNPs can be involved in through collaborative efforts and providing expertise from working with sexual assault victims.

When 25% of women in college are estimated to be sexually assaulted there are implications of social responsibility for the protection of the campus and community. In public health terms, both binge drinking and sexual assault are epidemic on U.S. campuses. Students are placed in a high risk environment made worse by the unwillingness of campuses to accurately report sexual assault rates or to take bold measures to address alcohol consumption. DNPs in these settings can be instrumental in more accurately documenting through research the prevalence of sexual assault on these campuses. They can address public health issues with regard to alcohol, educate others with respect to the role alcohol plays as a risk factor for sexual assault, and promote understanding that alcohol intoxication affects issues of consent.

Physical surroundings can influence alcohol consumption and subsequent sexual assault risk. Alcohol free dormitories, fraternities, and sororities have been shown to decrease the risk of alcohol-associated sexual victimization (Toomey et al., 2006). Low density of alcohol establishments near campuses, dry campuses, and restrictions of alcohol sales at campus events has also been positively associated with a decrease in alcohol consumption and subsequent problems (Toomey et al.). The legal implications of alcohol consumption and sexual assault are influenced by university conduct codes, alcohol policies, and federal reporting laws regarding campus violence. Data from the Harvard School of Public Health College Alcohol Study found that state-level alcohol control policies were protective against binge drinking among college students and impact subsequent risk for sexual victimization (Nelson, Naimi, Brewer, & Wechsler, 2005). DNPs have the capacity to influence campus and community health policy to advocate for evidenced-based risk reduction policies with regard to alcohol.

Evaluation

Sarah's case study is reflective of a more positive outcome that can result from the implementation of best practice nursing care. Without a comprehensive Sexual Assault Nurse Examiner program it is unlikely that Sarah's case could have had the same outcome. Timely documentation of the details of the sexual assault proved useful months later when Sarah's circumstances regarding reporting changed. More specifically, the university had never previously had a third party's documentation of a sexual assault to use as part of an evaluation of a conduct code violation. Equally important and quite unusual was Sarah's ability to maintain control over the final decision to impart an educational rather than more punitive consequence to the student found responsible for the assault.

The SANE program also allowed Sarah to receive post assault care in a setting much different from the typical emergency room environment. For the first time through the health center, a sexual assault victim was able to explore all her options for reporting without the need to refer the patient to the local emergency room. For Sarah the pressure to make an immediate report to law enforcement was removed. Lastly and most importantly, it would be hoped that this victim-centered approach to care best served to support the victim's healing process.

This SANE program has the potential to serve as a model for other campuses that provide sexual assault services. It provides support for the leadership role a DNP might pursue in advancing and expanding beyond the traditional models the best practices for providing post assault care. Additionally, with regard to sexual assault, DNPs can explore research opportunities, publish relevant articles on this topic, and advocate for evidence-based prevention activities at the campus and community level.

Reflection

Developing, sustaining, and expanding services and programs that address alcohol and sexual assault issues requires expert clinical and leadership skills. As a DNP I would like to pursue national certification as a Sexual Assault Nurse Examiner, which I believe would advance my knowledge base and add credibility as clinician. It would be important to gain a better understanding of campus policies regarding regulation of Greek life activities, campus conduct code policies, and community alcohol enforcement issues. It would be important to become better acquainted with community and state policies regarding access to alcohol, advertising, and underage drinking on campuses in this state. As a DNP there is the potential to explore and engage in prevention activities, educational opportunities, and policy changes to make campus communities safer.

I believe starting the SANE program demonstrated I have the leadership skills to pursue innovative, evidenced based program implementation. My clinical inquiry project will be beneficial in measuring the value of this program. Publication of the results would likely begin to measure outcomes related to SANE programs and expose other campus members to the viability of such programs in outpatient settings. As a DNP it would be helpful to gain additional expertise in grant writing and research to pursue further investigation into such issues as the extent of drug facilitated sexual assault on campuses, the role of primary prevention measures for both men and women, and the expansion of SANE programs.

Lastly, as a DNP I can continue to utilize my involvement in the Attorney General's Sexual Assault Task Force to address at the state level the unique concerns of higher education institutions with regard to alcohol and sexual assault. I can utilize my interest in policy to bring my clinical experience in college health to the public health arena to address alcohol and sexual violence issues. Finally, there is a role for the DNP to educate key campus and community members on the issues of alcohol and sexual assault and advocate for evidence-based prevention activities on campuses.

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Running Head: COST OF SEXUAL VIOLENCE

N790 Clinical Residency

Case Report: Sexual Assault Nurse Examiner Programs and the Cost of Sexual Violence

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Many studies have demonstrated the high quality of care provided to victims of sexual assault by specially trained Sexual Assault Nurse Examiners (SANEs) (Campbell et al., 2006; Sievers, 2003; Taylor, 2002). At the same time, most assault victims are traditionally cared for in emergency rooms, despite research that suggests that this setting does not always meet the patient's needs (Campbell et al.). In order to consider expanding post assault services to alternative health care settings utilizing SANEs, it is necessary to first consider the financial viability of this option. These costs must then be further weighed against the financial impact of rape on the victim and society.

Case Description

SG is a 20 year female who was raped by an acquaintance while at a fraternity party. The assault occurred upstairs at the fraternity after a night of drinking. The alleged assailant was verbally and physically aggressive, using force to restrain SG and frightening her. Following the assault, SG wandered downstairs wearing men's clothing. Others at the party seemed concerned and one individual retrieved SG's dress, though no one intervened in any other manner.

SG arrived at the clinic 15 hours post assault. She brought in the clothes she was wearing at the time of the assault though her underpants were still at the fraternity. She described a brief loss of consciousness and soreness in the vaginal area. On exam SG had multiple external genital injuries, a retained tampon, and a bruised cervix. She had bruises on her head, neck and breast. SG consented to forensic evidence collection and reported the assault to law enforcement.

Justification for case selection

This case was selected because it was the first forensic evidence collection performed at the clinic after the establishment of a Sexual Assault Nurse Examiner program. Such an exam would not have been possible without the clinic administration committing the financial and

personnel resources to allow for the establishment of a SANE program. This case provides an opportunity to examine the financial issues and resource allocation concerns associated with providing forensic services in an outpatient setting.

Literature

Sexual violence has significant costs to both the victim and society. A National Institute of Health report on the cost and consequences of sexual assault suggests that a victim's suffering and lost quality of life should be analyzed when considering issues of public policy in this area (Miller, Cohen, & Wiersema, 1996). By quantifying more fully the realities of victimization, the effect of a crime such as sexual assault can be better characterized and prevention more appropriately addressed. More specifically, the report suggests that ignoring the nonmonetary effects of crime can result in a misallocation of resources (Miller, et al.).

The cost of sexual violence is paid for by individuals, organizations, and society as a whole. In Oregon, victims often incur expenses despite legislation providing for the coverage of acute post-assault care (Attorney General's Sexual Assault Task Force, 2003). Health insurers are more likely to pay for costs related to a multitude of chronic health conditions rather than the acute assault expenses (Miller et al., 2006). Employers pay in the form of health insurance premiums, sick time, and lost productivity. Lastly, the federal government, and thus the taxpayers, incur significant costs through the provision of emergency services, Medicare and Medicaid premiums, crime victims' services, and lost tax revenue (Miller et al.).

The average tangible cost of a rape is estimated to be \$5,100, the majority of which is medical and mental health expenses (Miller et al., 1996). However, when issues such as pain, suffering, and quality of life are considered, the cost of a single sexual assault is estimated to increase to \$87,000 (Agency for Healthcare Research and Quality [AHRQ], 2003; Miller, et al.).

In addition, the psychological effects of sexual victimization may have costs related to lifestyle changes such as relocation, switching jobs, changing daily routines, and simply enjoying life less (Miller et al.).

Nearly 20% of female rape victims and 10% of male victims will lose time from work secondary to their victimization (Tjaden & Thoennes, 2006). The cost to an employer from an assault is estimated to be \$2200 in lost productivity (Miller et al., 1996). If only those individuals with injuries from their assault are considered, the work force loss rises to an average of \$15,400 (Miller et al.).

On the other hand, the expenditure of incarceration of a rape offender is approximately \$15,000 to \$20,000 per year (Miller et al., 2006). Miller et al., further explains that if an additional year of incarceration of an offender were to help prevent one rape, this crime reduction would appear to initially pose a significant cost to society for incarceration. It is not until the adjusted total cost and consequences of a rape are considered that, in fact, a financial benefit to prosecution of sex offenders becomes apparent.

Furthermore, given the long-term consequences to a victim of sexual assault compared to other crimes, the overall cost of rape is estimated to be \$127 billion (AHRQ, 2003). While this figure includes some of the previously mentioned expenditures such as medical care, police response, and lost quality of life, it does not include the costs of investigation, prosecution, or offender incarceration (Miller et al., 1996). According to the National Institute of Justice, this makes rape the most costly crime in this nation (Miller, et al.).

Intervention

As soon as the triage nurse determined that SG was at the clinic to be evaluated following a sexual assault a previously established protocol was initiated. The SANE was contacted and

her current schedule of patients was cleared by rescheduling patients or moving them to other practitioners. SG was promptly checked into an exam room.

A Sexual Assault Forensic Evidence (SAFE) kit, along with clothing worn the night of the assault, was collected from SG. Each item of evidence was appropriately packaged and sealed prior to releasing to law enforcement. Photographs of all non-genital injuries were obtained. An advocate met with SG and stayed while a police officer interviewed her and took a full report of the incident. SG received medications, care of her injuries, and referrals to the counseling center, student life and academic affairs.

A SAFE kit collection for SG would not have been possible without first investing in staff training and equipment. Initially a budget was developed that reflected the start up expenditures and program implementation expenses that would be expected to be requested by the clinic's administration to evaluate the viability of implementing a SANE program. The SANE training was initiated at a time when the AG's SATF had federal funds available to cover the costs of training nurses in forensic procedures. Equipment needs were minimal and primarily consisted of a camera, evidence dryer, storage locker, and supply cart. Other needs such as a procedure room, clinic supplies, support staff, and general overhead was already available as part of the general clinic operation.

Analysis

Utilizing the clinic administration's perspective in developing the budget was important to the success of this SANE program. Such an approach allowed for the implementation of this unique program with support by administration to create a change in practice, a shift in the allocation of resources, and authorization of appropriate staff training.

Support from students on campus for the development of a SANE program was also critical. This derived from an understanding that students desired access to sexual assault services in a non-emergency room setting and at the clinic supported by their student fees. More specifically, the Student Health Advisory Committee (SHAC) that reports to the clinic director recommended these services be added to those already provided at the clinic. SHAC's support early on was valuable to developing SANE services as there was the potential for this committee to fund this service even if a cost-analysis was not financially favorable. Lastly, SHAC's support influenced the administration in their decision to fund such a project and ultimately impacted its sustainability.

The addition of certified SANEs on staff allowed for access to previously inaccessible reimbursement for sexual assault medical services through the Department of Justice's Sexual Assault Victims' Emergency (SAVE) Fund. For the first time, the costs of the medical exam, emergency contraception, and sexually transmitted infection prophylaxis medications were reimbursed. In the past, these expenses were not charged to the patient and written off by the clinic. In an effort to increase the number of exams performed by trained nurses, the Department of Justice paid an extra \$75 per exam for each sexual assault exam performed by a SANE-money the clinic would now collect.

Other funding perspectives that were pertinent to SG's case include that of law enforcement and the District Attorney's office. The ability to investigate and prosecute a case depends on a sexual assault victim obtaining timely forensic evidence collection. Having a clinic in the community begin to collect SAFE kits had the potential to increase their case load which could ultimately impact budgets and affect allocation of resources. This would primarily affect victims receiving forensic evidence collection, with less financial impact from victims who

chose not to report an assault to law enforcement. In the end, both law enforcement and prosecution were very supportive of this SANE program.

Lastly, there are the societal costs of sexual violence to examine. In SG's case, it relates to the value of potentially identifying and prosecuting an alleged assailant. This necessitates services that allow sexual assault victims to receive evidence collection that might lead to a perpetrator conviction and impacts community safety. This also influences the university's need to provide a safe environment for students so as to maximize their education experience. Finally, there is benefit gained from appropriate care and support services that ultimately help keep someone like SG in school and potentially leading a more productive life.

The alternative to the establishment of this SANE program would have been to continue a usual care model which consisted of the provision of post sexual assault services by untrained clinicians, using physicians and nurse practitioners as available, without a standard of care guideline, and scheduled under the established clinic scheduling system for routine patient care visits. Under usual care, a victim of sexual assault such as SG would be cared for the same as any other patient visit with no additional resources available.

In the end, this SANE program was developed with minimal investment in training and equipment. Given the research that suggests there are significant costs to the victim and society as a result of sexual violence it appears to be money well spent. In SG's case, it allowed her to receive care at the university's health center from a specially trained advanced practice nurse, without limiting her options for follow-up.

Self Reflection

This SANE program would not have happened without one individual assuming a leadership role. While it took several years from the time of the initial training to the first SANE

exam, that was primarily a consequence of not having a similar program to model this program after and the strict attention to detail taken in establishing this program.

The process of introducing a program including the SANE examiner and standardized protocol was a tremendous growth experience for this advanced practice nurse. Much was learned about working with other disciplines such as law enforcement and prosecution. These interactions reinforced the important role nurses can take in leading a change in practice. My later involvement in the AG's SATF inadvertently grew out of my efforts to better understand the role of the forensic nurse by getting involved in this organization. My participation in the Task Force has proved to be a tremendous opportunity to be involved in an organization devoted to prevention, forensics, criminal justice, and health policy with regard to sexual violence.

After completing the DNP program, I plan to continue working to influence other organizations to develop SANE programs, whether in the emergency room or in other unique settings where victims of sexual violence access services. Such efforts will require continued involvement in issues of funding, training, and legislation. In addition, there are many opportunities to contribute to the field of forensic nursing through research in this relatively new field. My residency has provided an opportunity to expand my health policy skills and develop important relationships with organizations and people positioned to act as change agents on behalf of victims of sexual violence.

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Running head: ETHICS CASE STUDY

Ethics Case Study

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Ethics Case Study

Case and Dilemma

Mary* is a 20 year old college student who presents to her university's health center at the encouragement of friends for evaluation following a sexual assault. The previous evening Mary had been out drinking at a friend's house. She consumed approximately 8-10 shots of alcohol over a period of two hours. After midnight, she left the friend's house to walk home alone. While walking home, she was startled by a stranger, pushed to the ground, and raped. She attempted to wrestle away and to shout for help, but was unable to do so. Following the assault, she returned home alone and did not report the incident to law enforcement.

Early the next morning, too upset to call the health center for an appointment herself, Mary had a friend call requesting advice regarding follow-up. The friend was advised that Mary would be given an immediate appointment with a Sexual Assault Nurse Examiner (SANE) and to come to the clinic as soon as possible. Per clinic protocol, the triage nurse asked the patient not to bathe or shower, not to eat or drink, and to bring the clothing she had worn at the time of the assault with her.

Mary was seen by the SANE as soon as she arrived at the clinic. Her arrival 12 hours post-assault was well within the 84 hour time frame which allows for the collection of forensic evidence. Mary arrived having followed the triage nurse's instructions to best preserve any possible physical evidence. According to state law at the time, a Sexual Assault Forensic Evidence (SAFE) kit could only be collected with the consent of law enforcement, which would require the SANE to notify the local police department. After completing an initial history, Mary

*patient's identifying information has been changed to protect confidentiality

received a physical exam, emergency contraception, and sexually transmitted infection prophylaxis. Multiple referrals to support services on campus and in the community were provided, and she was scheduled for a follow-up visit in several days.

Within a few days of Mary's initial visit, a local newspaper ran a small article about a different student who reported an attempted rape to law enforcement in the same vicinity that Mary described her assault as taking place.

What is the Sexual Assault Nurse Examiner's obligation to share confidential patient information regarding a sexual assault when the victim declines to report to law enforcement and there is a potential serial rapist at large in the community?

Review of Topics

Medical Indications

Upon presentation, Mary appeared alert, oriented, and competent to make her own medical decisions. She carried a bag of clothing worn the night before, appeared disheveled, and had visible upper extremity abrasions. Though she was cooperative, her affect was flat and she exhibited very little eye contact, talking no more than to simply answer the SANE's questions. Mary was initially screened for mandatory reporting which includes any victim that is mentally ill or disabled, less than 18 years of age, elderly, or assaulted with the use of a weapon (Attorney General's Sexual Assault Task Force Medical Forensic Committee, 2006). Mary met none of the screening criteria.

A detailed history of the event revealed that Mary was vaginally penetrated without the use of a condom and that physical force was used. She did not think the assailant ejaculated inside her and she was uncertain of any injuries to the assailant. Mary was noted on physical exam to have a sore posterior neck, a large abrasion on her shoulder, with smaller abrasions on

her hand and legs. She had no life threatening injuries. Mary was found to have no visible genital injuries.

At a post-assault visit, a pregnancy and HIV test were negative, though a pap smear returned abnormal. Over the subsequent weeks, Mary no-showed for several follow-up appointments at the clinic. Eventually, she visited an outside gynecologist for abnormal pap smear follow-up. At last contact, she had no colposcopy follow-up and had declined repeat HIV testing, crisis center, or counseling follow-up.

Patient Preferences

Beginning with the call to the triage nurse, it was believed that Mary desired to be seen at the student health center for medical care and forensic evidence collection. Mary had already chosen not to go to the emergency room for follow-up care the night of the assault. Upon arrival, Mary was informed of the medical exam and forensic procedure details. She was informed of her right to speak with an advocate, and with her consent, one was called.

Though Mary did not have to report to law enforcement to access state funds to pay for the cost of her care, at the time of Mary's visit, state law stipulated that she must consent to reporting to law enforcement in order for a SAFE kit to be obtained for evidence collection. Upon learning this, Mary indicated she no longer wanted to have forensic evidence collected. She stated that she did not feel capable of sharing the details of the assault with a law enforcement officer and felt her inability to recall a description of the assailant would be limiting to an investigation. Mary acknowledged understanding that time-sensitive evidence would be lost if she chose not have a SAFE kit collected at that time. Though she declined the forensic evidence collection, she agreed to a full medical exam.

Mary returned several days later for follow-up and the SANE showed her the newspaper article about the reported attempted sexual assault of another university student. Mary indicated that she would not like to see what happened to her happen to anyone else and would now be willing to speak with law enforcement. At Mary's request, law enforcement was contacted by the SANE.

Throughout her contact with the health center, Mary repeatedly acknowledged that she had chosen not to tell either her family members or private gynecologist about the rape. Her decision not to follow-up with campus and community support services further suggested that Mary would like to have as few people as possible know about her assault.

Quality of Life

Mary's quality of life had the potential to be affected in both the short and long term. Clearly, upon presentation she was traumatized. Her affect suggested potential for depression and post traumatic stress disorder. Given the violent nature of the assault and her demeanor at follow-up visits, Mary appeared to be in a fragile state. Any decision to involve law enforcement would have had serious consequences with regard to the victim's confidentiality, and it was very clear from her behavior that she wanted the details of this assault kept private. Once in the legal system, the potential for much more information to become available to multiple parties was possible. In Mary's situation, this could have been especially difficult for her to handle.

Mary's relationship with her parents was not known. However, any breach in confidentiality that reached her parents could have been very distressing to Mary. Her choice to not inform her parents could have been an attempt to protect her from any potential blame for the rape, given the circumstances of under-age drinking and alcohol intoxication, or any possibility of removal from the university over fears for her safety living away from home. It was unknown

if this decision to not inform her parents deprived her of a potential support system and affected her quality of life. Though it is known that Mary had told some of her friends about the assault, she had not accessed any professional services for counseling. This decision likely played a significant role in her ability to process these events.

Contextual Features

Though the SANE tried to provide a victim-centered approach to care, it was likely the knowledge of the second report of an alleged rape unduly influenced the SANE's desire to see this crime reported. It was probable that the SANE suspected that the most likely outcome of sharing this information with the victim would be to have her consider talking with law enforcement, which in fact is exactly what happened. The SANE's role in terms of any legal obligation to report to law enforcement was not fully understood as these events unfolded.

Once the SANE learned of the second rape she attempted to access advice from clinic administration within the confines of confidentiality. The clinic medical director was approached and, having no past experience with such cases, offered no concrete advice. The director acknowledged the concern about a potential risk to the community and agreed with the SANE that contacting the university's legal counsel was an appropriate next step. Without any individually identifying information revealed about the assault, the general counsel was contacted, but had no immediate legal advice to offer.

It was later learned that law enforcement waited several days to interview Mary after they received Mary's contact information from the SANE. When the SANE later spoke with the police department to follow-up further on this information, she was informed that the other reported sexual assault was thought to be false and therefore, likely unrelated to the patient who was seen at the health center. Further details of the other assault were unknown. Mary's

discussion with law enforcement eventually took place, but the specifics were not known. It was known that after many months, no records of the victim's visit to the health center were requested by law enforcement or the District Attorney's office.

Case Analysis and Recommendations

Mary sought care at a university health center so her medical records fall under the guidance of the federal Family Educational Rights and Privacy Act (FERPA), rather than the Health Insurance and Portability and Accountability Act (HIPAA). Since Mary was over 18 years of age, FERPA would require written permission from her, not her parents, to release any information from her educational record, which included her medical record (U.S. Department of Education, 2007). According to the U.S. Department of Education, FERPA allows for the disclosure of records without consent in such cases as a judicial order or subpoena, health and safety emergency, or in conjunction with the juvenile justice system. A concern regarding a potential serial rapist in the community did not appear to qualify as a rationale for a breach in confidentiality under FERPA. Clearly this federal legislation, intended to monitor access to student's academic records, seems to not work well in complex situations involving higher education records at campus-based healthcare facilities.

If Mary had initially reported the assault to law enforcement the burden of determining the significance of a second assault in the community would have fallen on law enforcement and eliminated any dilemma for the nurse regarding a breach in confidentiality. Given the many complicated scenarios that could occur in any sexual assault case, it might then be easy to conclude that it is in the best interest of the patient and the nurse to encourage all sexual assault victims to report to law enforcement at the time of presentation. This assumption, while convenient, does not meet the expectations of the nurse's professional responsibilities to the

patient. Trustworthiness and respect for patient autonomy necessitate that all the options for care be truthfully outlined to the patient (Kipnis, 2006). This is the fundamental foundation of informed consent. Forensic evidence collection can not only be very invasive, but also involves the collection of DNA material which is the most personal of patient data. A victim-centered approach to sexual assault care requires the patient be in control of the decision making process with regard to both evidence collection and law enforcement reporting as long as there are no legal requirements for mandatory reporting.

Sharing information with the clinic medical director was well within the realms of nursing practice, as it is an expectation that nurse practitioners will appropriately consult with their physician colleagues. The more difficult decision with respect to confidentiality was for the nurse to contact the university's legal counsel. In a landmark California Supreme Court ruling, *Tarasoff v. Regents of the University of California*, 551 P.2d 334, 131 Cal. Rptr. 14 (1976), the court ruled that with regard to confidentiality, "the protective privilege ends where the public peril begins" (Gostin, 2002, p. 11). In support of this statement Jonsen, Siegler and Winslade (2006) advise, since not all jurisdictions accept the Tarasoff rule, it would be prudent to seek an ethics consultation or legal advice in similar uncertain situations. Unlike the Tarasoff case, this case had no single, identifiable third party at risk of injury which would have required consideration of direct notification of law enforcement.

Despite the serious nature of the circumstances surrounding this assault and the desire to prevent further public harm, a breach in confidentiality was not the only potential course of action available. The eventual resolution over the concerns regarding law enforcement notification came about through a course of action that might be summarized as the *deliberative* model of a provider-patient relationship (Balint, 2006). Balint explains that a deliberative

approach to interacting with a patient assumes a respectful, collaborative, patient-provider relationship exists that analyses the information at hand and results in a joint decision. In this situation, the patient's initial decision not to report was respected and as new information became available it was shared with the victim. Eventually, this resulted in a patient-driven decision to disclose to law enforcement. The critical limitation to this approach was the loss of forensic evidence that occurred with delayed reporting, but new state legislation, in part bolstered by this very case, now allows for the collection of evidence without notifying law enforcement.

Ethical Essay

Ethical dilemmas in confidentiality can arise when there is a conflict between respecting a patient's confidentiality and the need to disclose patient information (Beech, 2007). In such a case, the principles of absolute versus limited confidentiality are at odds with each other. For the clinician, the desire to protect the patient must be weighed against the need to protect the public from peril (Abbo & Volandes, 2006).

In *A Defense of Unqualified Confidentiality*, Kipnis (2006) maintains that unqualified confidentiality is the only effective means of protecting third parties in a healthcare setting. Kipnis asserts that a duty by clinicians to warn third parties does not necessarily afford added protection to those at-risk. More specifically, he contends a no-exceptions confidentiality rule has a higher likelihood of getting patients to be forthcoming about health information. This argument is based on the premise that the potential for a breach in confidentiality by a medical provider informing a third party risks deterring future patients from disclosure. Underlining this argument is an interpretation of the priority rule to "do no harm," that implies that patient autonomy trumps all other values (McGregor, 2006).

The opposing and more conventional wisdom regarding ethics in medical confidentiality suggests that confidentiality is “a stringent, but not unlimited, ethical obligation” (Jonsen et al., 2006, p. 172). Jonsen et al. outline two justifications for the exception to confidentiality: safety concerns for a specific person and concern for the welfare of the public. This was best illustrated in the previously mentioned legal case of *Tarasoff v. Regents of the University of California*, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) in which a duty to protect an endangered third party outweighs a protective privilege to patient confidentiality when the potential for serious public harm is at risk (Gostin, 2002).

Issues of confidentiality in healthcare are complex, yet both the American Medical Association and the American Nurses’ Association provide for exceptions in their respective Codes of Ethics (American Medical Association House of Delegates, 2006; Cochran, 1999). A nurse’s duty to patient confidentiality must be carefully weighed against any greater obligation, in rare circumstances, to disclose information to third parties.

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Running Head: FORENSIC NURSING

N790 Clinical Residency

Case Report: Forensic Nursing

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Forensic Nursing

Forensic nursing is the “application of nursing science to public or legal proceedings” (International Association of Forensic Nursing [IAFN], 2006). It is a unique specialty of the registered nurse that merges the RNs broad education in the bio-psycho-social aspects of health care with an advanced understanding of forensics. Forensic nursing, most often associated with issues of interpersonal violence, also encompasses care in the areas of public health, trauma, and death investigation (IAFN).

For many years, forensic science relied on biological markers such as ABO blood type and fingerprints for investigative purposes (Roper & Tatum, 2008). It wasn't until the 1980's that testing for variations in deoxyribonucleic acid (DNA) among individuals became a viable forensic technique (Roper & Tatum). In 1987, with the help of DNA evidence, the first conviction for sexual assault occurred (Ledray, 2001). Four years later, a Minnesota crime lab became the first to use DNA evidence to identify a previously unknown perpetrator of sexual assault which resulted in a conviction (Ledray).

Due to the power and potential consequence in the legal arena with the collection and evaluation of DNA materials, it is imperative that nurses have a grasp on this area of science. According to Roper & Tatum (2008), too often the “principles, practices, and applications of identity testing (p.156)” are often poorly understood by healthcare professionals. For the nurse providing acute sexual assault care this understanding is even more critical. Most importantly, the Sexual Assault Nurse Examiner (SANE) must show advanced competency in the collection of microscopic evidence for DNA analysis. Every SANE exam requires very unique evidence collection and documentation that is specific to the circumstances of that case. This results in the

need for the SANE to obtain a detailed and objective history to guide the very specific aspects of DNA collection.

Case Description

KC is a 23 year old waitress who presented 14 hours post assault for forensic evidence collection. On the night of KC's assault, she had met with friends and walked together to an acquaintance's home. All of them had been drinking alcohol. At some point during the evening KC was led outside by a young man. She repeatedly said no to his advances and tried to go back in the house. At one point, she struggled to get his arms off her and scratched him. He used physical force to restrain her, remove her clothing and assault her. She was later found partially undressed and lying in the grass. Her friends carried her to a friend's apartment, took care of her overnight, and brought her into the clinic for medical attention the next day.

While the patient had multiple bruises and scratches she had no life threatening injuries. She did describe some loss of consciousness; however, the circumstances of its cause were unclear. Since the assault, she had not changed clothing, showered or brushed her teeth, though she had voided several times and eaten some food. Before her arrival she had taken emergency contraception on her own. At the time of her presentation, she expressed ambivalence about reporting the assault to law enforcement.

Justification for case selection

The chosen clinical case exemplifies the critical role the SANE exam plays in any future legal investigation and the challenge of maintaining a victim-centered approach to care. There are very few nursing roles that so thoroughly span the medical-legal system. Competent forensic evidence collection can only occur in a setting of a highly trained and experienced nurse working

in a collaborative fashion. The level of expertise is often even more daunting given that traditional nursing programs do not generally train nurses in forensic principles.

This particular case demonstrates the need for the SANE to address each case as a unique set of evidentiary circumstances. The role of the forensic exam is to collect evidence that could confirm recent sexual contact; to document signs of force or coercion; to help identify the suspect; and to corroborate the survivor's story (Ledray, 2001). A one size fits all approach to forensic evidence collection will not work and risks missing the collection of critical, time-sensitive evidence. While there are many important aspects to a SANE exam, this paper will focus on the specific expertise required for appropriate DNA and trace evidence collection.

Literature

DNA is a basic building block for an individual's genetic make-up. It does not vary from cell to cell, nor is it altered over a person's lifetime (US DOJ, 2001). DNA is found in skin tissue, sweat, bone, the root and shaft of hair, mucus, urine, semen, and vaginal or rectal cells (US DOJ, 2006). During a sexual assault, biological evidence such as hair, skin tissue, semen, blood, or saliva can be left on the victim's body or at the crime scene (DOJ, 2001). In addition, hair, fiber, dirt or grass from clothing, carpet, bedding, or other materials can be transferred to the victim's body during an assault (DOJ). For obvious reasons, healthcare personnel are the only persons in a position to obtain evidence from inside or on a victim's body.

DNA properly collected from the victim, or in some cases the suspect, can be compared with already known samples to establish the presence of a suspect at the scene of a crime (US DOJ, 2001). In the case of no known suspect, the passage of the federal DNA Identification Act of 1994 provides an opportunity for investigators to establish a DNA profile of the crime scene by entering information into the Federal Bureau of Investigation's (FBI) Combined DNA Index

System (CODIS). This piece of legislation has allowed agencies to match DNA profiles with other profiles entered into other local, state, and national databases (US DOJ; FBI, 2005).

Equally important as the DNA samples used to identify subjects, is the collection of DNA samples to exclude an individual or differentiate DNA material from that of the victim. When investigating a sexual assault, it is often necessary to obtain an elimination sample, such as blood or saliva so as to account for the all of the DNA found on the victim or at the scene of a crime (US DOJ, 2001).

Proper identification, collection, transportation, and storage of DNA evidence are extremely critical to a forensic case. DNA evidence that is properly handled can be preserved and stored for years (US DOJ, 2001). Unfortunately, if DNA evidence is not initially identified, it may not be collected, and thus lost forever. Furthermore, if DNA evidence is not properly collected, it may become contaminated or degraded and be lost to use for investigational purposes (US DOJ).

The most common form of DNA analysis is called polymerase chain reaction (PCR), a technique that is greatly responsible for the advancement of DNA technology in forensics (US DOJ, 2001). This technique has allowed for the amplification of very minute amounts of DNA so that evidence can be further examined for a “DNA fingerprint” (US DOJ). In a laboratory in just a matter of hours, the PCR technique can yield up to 3 billion copies from a small fragment of DNA evidence (Roper & Tatum, 2008).

Collection of forensic evidence necessitates strict compliance with clinical protocols to avoid contamination and maintain sample integrity (Roper & Tatum, 2008). The appropriate guidelines for sexual assault exams have been outlined in the US DOJ’s President DNA Initiative, *A National Protocol for Sexual Assault Medical Forensic Examinations* created by the

Office on Violence Against Women (Roper & Tatum). The potential for evidence collected to be used in legal proceedings necessitates that collection procedures be carefully followed so as to ensure evidence will be admissible in court (Roper & Tatum).

Intervention

At the clinic, KC was seen by a SANE. An advocate was contacted from the local rape crisis center and arrived within 20 minutes. KC's options for follow-up were thoroughly explained to her and it was the patient's wish to collect forensic evidence, but defer law enforcement reporting until she had further opportunity to consider her options.

KC signed the consent for a forensic examination and evidence collection, including a separate consent allowing photographs of her injuries to be taken. KC did not meet any mandatory reporting requirements. A pertinent medical history was obtained followed by a more detailed account of the assault. This was documented in a comprehensive narrative followed by a more specific series of questions to elicit information on specific acts that occurred as a part of the assault.

KC received a lengthy forensic evidence exam. This entailed initially undressing on a large paper sheet and having individual items of clothing worn on the night of the assault packaged. During the undressing process fragments of material that looked like dirt and grass had fallen on it the paper sheet so it was carefully folded and packaged as evidence. Next, samples of hair, urine, blood, and oral, vaginal, and cervical swabs were obtained. Additional evidence swabs were taken from her neck and breasts based on her report of alleged assailant kissing her in these locations. Scrapings from under her nails were taken, though she declined to have any nail clippings taken.

Photographs of bruises and scratches on her legs, back and arms were obtained.

Following a careful protocol, these pictures were downloaded off the camera onto a computer disc and removed from either the computer or camera. While the patient declined to consent to genital photographs, detailed diagrams of external genital injuries, including several breaks in the skin and erythematous areas were obtained.

Given KC's report of loss of consciousness, she received a thorough screening for possible strangulation and a urine specimen was obtained for potential drug facilitated sexual assault evaluation. In addition, an HIV risk assessment was completed and, while some of her injuries and assault circumstances increased her risk for exposure, she declined HIV post-exposure prophylaxis. She did receive sexually transmitted prophylaxis for Chlamydia, Gonorrhea, and Bacterial Vaginosis/Trichomoniasis with three different antibiotics. Emergency contraception was not given as the patient had already taken this on her own prior to arriving at the clinic. Both Tetanus and Hepatitis B immunizations were administered. The patient received referrals for counseling, crisis intervention, and medical care follow-up. Lastly, she was given an identification number to link her SAFE kit and evidence collection to her name should she decide to pursue reporting the assault to law enforcement.

After the patient left the clinic, the SANE was left to dry and package all evidence collected. The SAFE kit and each item of clothing collected was sealed with evidence tape and appropriately labeled with a specific case identification number. Because the patient had chosen to collect evidence for storage purposes only, care was taken to keep her name off the outside of all packaging. Additional documents for the forensic laboratory was completed and submitted with the SAFE kit.

The local police department was contacted to pick up the SAFE kit, photographs, and clothing. This required the patient signing a consent, which had previously been obtained, for the release of information. An additional law enforcement property log was completed to document chain of custody with the transfer of evidence to the police department for storage purposes. A final document was completed to submit to the Department of Justice for reimbursement for the cost of the medical and forensic exam to avoid any charges to the patient for her care. Finally, all charting for the medical record was completed.

Analysis

The primary role of the SANE in such a clinical case is to meet the medical and psycho-social needs of the patient. At the same time, there are several legal obligations to be considered based on the patient's personal desires regarding the collection of a SAFE kit. KC's options for follow-up were thoroughly explained to her and it was the patient's wish to collect forensic evidence, but defer law enforcement reporting until she had further opportunity to consider her options. Since KC's assault occurred in October, 2007 she was eligible for SAFE kit collection under the recently passed HB2154, which for the first time in Oregon, allowed non-reporting evidence collection.

The SANE has a tremendous responsibility to ensure an appropriate and thorough exam. For this reason, careful attention was given to being certain there was no contamination of evidence. This can be a challenge as typically up to four swabs are taken from each evidence collection site and each must be carefully separated and properly labeled during the drying process. Any errors during the drying process, which can take up to one hour, can result in the degradation and loss of potential evidence.

Appropriate evidence collection could not occur without a strong knowledge base regarding the details of the evidentiary exam. In KC's case, it was important to use the assault history to guide evidence collection such as nail scrapings and additional swabs from the breast and neck. Equally important was to understanding why each specimen was necessary to collect. For example, there was the collection of hair samples and oral swabs that could be utilized as controls to exclude KC's DNA if necessary.

All of the evidence collection for KC occurred without ever having it leave the sight of the SANE so as to be able to maintain chain of custody. This was done while still trying to meet the emotional and physical needs of the patient, accommodate the advocate's need to interview the victim, and properly complete evidence preparation and documentation.

Evaluation

The expansion of the role of the SANE speaks to the power of nursing in advanced practice roles. It is impressive that while physicians are called to testify about injuries that they treated, in thousands of sexual assault cases there has not been one case where the testimony of the SANE alone was not sufficient (Ledray, 2001). In fact, in the many situations, the SANE's documentation is so complete as to have the suspect plead guilty before there is ever a trial (Ledray).

In this particular case, the needs of the patient were met through a collaborative relationship with the SANE which allowed the victim to guide the post assault services she received. She was fortunate to receive care from a clinic which offered a broad range of post-assault care based on a national protocol for evidence based best practices. While objective in its approach to evidence collection, the victim nevertheless received compassionate care in a victim-centered environment. Because the patient chose to have evidence collected for storage purposes

only, the final legal outcome remains uncertain. It is possible she later contacted law enforcement to report the assault, but it is just as probable she did not. Either way, the care provided on the day she presented to the clinic was intended to meet her immediate medical needs, assist with her emotional support, and offer her all options within the legal system.

Self Reflection

One of the challenges for a nurse in this advanced practice role is to document the assault complete enough to be able to review and explain the records, often months or years later, should there be the need to testify. In the court room, the SANE will be considered the expert witness regarding the medical and forensic evidence collection that was obtained. This requires a sound understanding of the evidence-based knowledge available in this field so as to respond to the challenges of the defense as to the details of the documentation by the SANE. This necessitates the ability to respond objectively to both what is currently known in the field of forensic nursing and its limitations. The advanced practice nurse has the education, credentials, and experience to be a very credible witness in this situation.

As a DNP I see my role as expanding beyond the realms of the SANE exam. Starting a SANE program in a non-emergency room setting demonstrates an ability to look beyond the traditional ways of caring for patients. It reflects an understanding of the many ways victims of sexual violence access healthcare services.

I see my future as a DNP combined with my past work as a SANE full of opportunities on a larger scale in the world of forensic nursing. There is a need in this relatively young subspecialty of nursing to measure outcomes of the care that SANEs provide. Not only to evaluate the effectiveness of the evidence collection process, but to examine the impact our nursing care has on the patient. As a DNP, I would like to work with others to implement care

strategies that are evidenced based, to identify ways to sustain nurses in this difficult work, to engage men in a dialogue regarding sexual violence, and to identify promising prevention strategies.

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Running Head: HEALTH CONSEQUENCES

N790 Clinical Residency

Case Report: Health Consequences of Sexual Violence

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03-31-09

Studies have shown that there are significant differences in the health of victims and non-victims of sexual violence. More specifically, sexual assault adversely affects the physical and psychological well being of the victim, both in the short and long term (Campbell et al., 2006; Tjaden & Thoennes). Victims of sexual violence have been found to access healthcare services at a much higher rate than non-victims and thus are much more likely to have contact with advanced practices nurses in a variety of settings (Campbell).

Case Description

NT is a 19 year old freshman college student who presents nine hours post sexual assault. The previous evening she had been at a party. At approximately 1:00am she left the party and walked home alone. While walking down an alley she was startled by a stranger and pushed to the ground. The assailant used his weight to hold her down while assaulting her. She attempted to get away and to make some noise, but was not seen or heard by anyone else. Her clothing was torn and she received several abrasions and other injuries. Following the assault, NT was left in the alley and after several minutes went toward a nearby lit street, flagged down a car and asked for a ride home. Once home she informed her roommate of the assault, but chose not to contact police or inform her family. Her roommate accompanied NT to the health center the following day.

NT's past medical history is significant for a history of rare migraines. She had not had a pap smear in two years. She had tried oral contraceptives for birth control in the past, but had quit them one month previously secondary to concerns about weight gain. Her last consensual sexual intercourse was one month earlier with a new partner using condoms.

Justification for case selection

This case was chosen as it describes both acute and chronic health consequences post assault in a victim who is otherwise very healthy. This particular case also exemplifies many similar scenarios of sexual violence for young women such as alcohol consumption, resistance to reporting, injury, and ongoing mental health concerns. Lastly, this case offers enough follow-up visits to be able to examine health outcomes beyond the initial visit.

Literature

Women are nearly twice as likely as men to suffer an injury following a rape (Tjaden & Thoennes, 2006). Physical injuries detected during a forensic exam influence multiple decision making points in the criminal justice process (Baker & Sommers, 2008). Both minor and major injuries may impact a victim's decision to report, law enforcement's investigation, the district attorney's willingness to prosecute, and a judge or jury's punishment (Baker & Sommers). It is the responsibility of the forensic nurse to thoroughly and objectively address the patient's injuries and thus potentially affect both health and criminal justice outcomes.

In an acute sexual assault, victims may experience physical injuries ranging from scratches and bruises, to broken bones, dislocated joints, and broken teeth (Tjaden & Thoennes). In one study (Tjaden & Thoennes), 36.2% of women received some form of medical treatment for their injuries and a third of victims received some type of counseling. In addition, Tjaden & Thoennes found that 19.4% of female rape victims and 9.7% of male victims lost time from work secondary to their victimization.

Research has identified a number of other long term health effects of sexual assault from cardiovascular to neurological, and musculoskeletal to gastrointestinal (Campbell, et al. 2006). Nevertheless, gynecological complaints remain the most frequently reported physical ailments in

both the acute and non-acute aftermath of a sexual assault (Campbell, 2006). Up to 50% of all rape victims experience genital trauma following an assault (Groer et al., 2006). Other common gynecological concerns include chronic pelvic pain, dysmenorrhea, menstrual disorders, and painful intercourse (Campbell; Weitlaf, Finney, Rusek, et al., 2008). Some of these physical complaints, such as pelvic pain, may be challenging as they are often associated with a normal physical exam. Furthermore, the CDC (2009) reports that sexual assaults result in as many as 32,000 pregnancies annually in this country.

Overall, rape victims suffer Post-Traumatic Stress Disorder (PTSD) at six times the rate of non-victims (Rape, Abuse, & Incest National Network, 2008). In a study of 148 women seeking a protective order because of intimate partner physical abuse, sexual assault was significantly more highly correlated with PTSD than physical abuse alone. Similarly, Suris et al. (2004) found that sexual violence perpetrated against women in the military resulted in higher rates of PTSD compared to other women in the service who experienced sexual assault as a child.

Additional mental health consequences of sexual assault include depression, anxiety and sleep disorders (CDC, 2008; Groer et al., 2006). According to the World Health Organization, the psychological effects of sexual violence often persist long after the physical injuries (Medicins Sans Frontieres [MSF], 2009). Feelings of guilt, lack of control, and concerns over safety can add to the psychological stress (MSF). Of particular concern is that all of these issues place victims at higher risk for an attempted or completed suicide (CDC, 2009).

Recent exploratory studies have examined the role of stress hormones and the immune response in sexual assault (Groer, 2006). It has been established that in acute trauma, including sexual assault, inflammatory mediators function rapidly and are important to healing. Persistent

and excessive trauma is also known to result in tissue damage. Groer observed that a number of inflammatory markers were found to be elevated in victims reporting sexual assault. It is speculated that these elevated inflammatory markers can remain persistently elevated in the traumatized assault victim and contribute to the multitude of chronic health conditions observed in rape victims (Groer).

Intervention

At the time of presentation, NT was very quiet, but cooperative. Prior to an exam she met with an advocate. After their discussion, the patient became faint without loss of consciousness. She lay down for a few moments, drank juice, and felt well enough to continue with the forensic interview. She went on to describe pain on her hand, upper back, and knee. On exam she was noted to have a sore neck, with multiple abrasions on her extremities and back. The back of her head was tender to touch with a small tender swollen area noted. There was a cut on her elbow with gravel present in the wound.

On pelvic exam the patient had a tear at the posterior fourchette. The inner labia minora had small bruises present bilaterally. The vaginal exam was uncomfortable for the patient and revealed a small tear to the left vaginal wall without injuries to the cervix. A pregnancy test was negative.

At her initial visit, NT received care of her injuries, including tetanus and Hepatitis B immunizations. She was given pregnancy prophylaxis in the form of Plan B and received several medications for sexually transmitted infection prevention. All of these measures were consistent with evidenced based practice necessary to avoid some of the most frequent health consequences of an acute sexual assault.

NT returned to the clinic two weeks post assault for an overdue annual exam and follow up. Upon exam her physical injuries had healed. NT acknowledged problems with insomnia and she had experienced two migraine headaches since she was last seen. She had been attending class, but admitted problems with concentration and motivation. She had not yet followed up with the counseling center as previously advised. After some discussion, she was willing to meet with a counselor following her annual exam visit. A phone call was placed to the counseling center, a walk-in appointment was found, and the patient was accompanied up to the counselor's office for an appointment that morning.

Over the course of the next several months, NT was seen for several more visits unrelated to her assault. At her fourth visit she was noted to still be having difficulty coping with the assault. Her grades were suffering and she continued to sleep poorly, though she was no longer experiencing migraines. She was eventually started on an anti-depressant and remained connected to the counseling center. At her most recent visit she was doing significantly better, having responded well to the anti-depressant, sleeping better, without recurrent migraines, and doing better in school.

The desired outcomes of care in this case were achieved. NT received appropriate medical care for her acute injuries. More chronic issues were attended to as they developed. The decision to manage NT's migraines utilizing the support of the counseling center achieved a resolution of her headaches without the need for additional prescription medication. Sexually transmitted infection and pregnancy were prevented. Lastly, NT remained in school.

Analysis

SANE programs were started in an effort to improve forensic evidence collection, but over the years they have evolved and become a model for victim-centered care. This is

particularly true in light of the low conviction rates for reporting victims. While at one time it may have been hoped that the legal system would bring closure to a victim post assault, it is now recognized that care in an environment that focuses on providing comprehensive and compassionate medical care to the victims is more important to their future health.

NT's response to her assault was not significantly different from that experienced by many other victims. Unlike an emergency room setting where she would likely have had only one visit, NT was seen for multiple visits in the clinic. Efforts were made to meet both the acute and long-term physical and emotional needs of the victim. This was enhanced through the provision of care from a nurse experienced in sexual assault. From the initial presentation, all staff worked collaboratively to treat NT with compassion so as to not to add to the trauma of her experience. Providing the services of an advocate in the immediate post assault period was intended to further support this approach. Practitioners now recognize that when a victim agrees to counseling, it is best to immediately accommodate the patient. The ability to offer this service in a timely manner grew out of a collaborative understanding among practitioners in the clinic and counseling center regarding the trauma response among survivors.

Providing sexual assault care in a primary care setting permits a different focus on care than the emergency room. From the first visit, medical prevention measures were initiated. The SANE also used follow up visits as an opportunity to complete other important preventative health care such as the patient's annual exam and to re-evaluate the patient in a less acute setting. The advanced practice role offered unique advantages in this setting as all medical care, prescriptions and follow-up could be provided independently by one practitioner. This approach allowed for the development of a trusting relationship with the victim and for the observation of subtle changes in the patient's response to trauma.

Despite this approach it is unknown what health care concerns this patient may experience several years down the road. Since she was seen at a campus clinic the ability to follow this patient post-graduation is not possible and is a limit to being able to impact any long-term health related concerns. It would be hoped that the initial care she received over several visits will positively impact her future health.

Self Reflection

This particular SANE program was started to improve the immediate medical response to sexual assault in an outpatient setting. While the cooperation among the staff might seem obvious it actually grew out of a persistent effort by the SANE program coordinator to overcome staff resistance, educate clinic personnel, and develop the necessary relationships with other departments. Nurturing such a team approach required years of groundwork prior to seeing the first sexual assault victim as part of a SANE program and continues to require efforts to sustain this level of collaboration.

After lengthy efforts to establish best practices for sexual assault care in a non-emergency room setting, I was motivated to develop resources for others. As exemplified in this case, there are very specific interventions that can be taken to reduce both the short and long term health consequences for a rape survivor. It did not make sense to me that each SANE program would need to develop their program from scratch as we had. One of the principle accomplishments I feel I have had as chair of the Attorney General's Sexual Assault Task Force Medical Forensic Committee (MFC) is to develop a standardized consent, forensic documentation form, and discharge instruction sheet to be utilized statewide. These documents were created to addressing potential medical problems through the use of documents that create consistent care based on evidenced-based practice.

Additional efforts through work in the Task Force have begun to move from influencing acute care to addressing more chronic health conditions that have a public health consequence, which I believe is an important role of the advanced practice nurse. When I first became chair of the MFC, SANEs never considered addressing HIV risk other than to recommend an HIV test. After emphasizing the public health issues related to sexual assault and developing an HIV post-exposure prophylaxis guideline, SANEs now collaborate with physicians to ensure that HIV drugs are administered post-assault in high risk situations. I don't believe the topic of working on HIV issues in my residency would have come about without first establishing interest among SANEs in HIV.

My residency experiences in health policy have been invaluable opportunities to better understand the processes necessary to gain significant and widespread legislative changes that can impact post-assault health care outcomes. My future goal is to help measure the services provided by SANEs in Oregon and to utilize this information to support the expansion of SANE programs statewide. Some of these efforts will likely occur through legislative channels and data on the value of SANEs will be imperative. If the link between early interventions in addressing the needs of sexual assault victims can be shown to decrease chronic medical conditions, and improve quality of life for the victim, as well as decrease utilization of medical resources for chronic conditions, legislative funding of these programs may be sustained or even expanded.

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Running Head: HEALTH DISPARITIES

N790 Clinical Residency

Case Report: Health Disparities Among Native American Women in Oregon

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Population Description

Significance of health disparity

The epidemic of sexual assault against Native American women in the state of Oregon and communities across this country is a significant health concern and social crisis. Interpersonal violence is widely recognized as a major public health problem for Native Americans (Yuan, Koss, Polacco, & Goldman, 2006). According to Clairmont (2008), sexual violence against Native American women is one of the most devastating threats to contemporary Indigenous culture. There are alarming disparities in the provision of sexual assault services provided to women from Native American communities (Wahab & Olson, 2004). Multiple factors are thought to contribute to this disparity from the distinct history and culture and often separate language of these women, to the historical relations with both state and federal agencies, and finally to the complexities of the criminal jurisdiction issues in Indian Country (Bongar White, White, Deer, & White Eagle, 2008).

Epidemiology

In the United States, there are 512 federally-recognized native groups and 365 state-recognized Indian tribes, who speak a combined total of 200 different languages (Wahab & Olson, 2004). Oregon is home to ten federally recognized Indian tribes and Native Americans can be found residing in all 36 Oregon counties. According to the 2000 census, the state's Indian population was 45,211, with a current estimate of 50,000, a figure comprising approximately 1.6% of Oregon's total population. Nearly 50% of these individuals are members of Oregon tribes, while the others are members of tribes in other states, members of non-recognized tribes, or those who self-identify as "Indian" for the census (State of Oregon, Oregon Blue Book, 2008).

Native American women are sexually assaulted at greater than twice the rate of other women in the United States (Amnesty International, 2006; Bongar White et al., 2008; Tjaden & Thoennes, 2000). In fact, the highest rate of violence of any ethnic or racial group in the United States has been found among Native women (Wahab & Olson, 2004). Furthermore, the lifetime risk of rape for Native American women is more than 1 in 3 (Wahab & Olson). Few of these rapes are ever reported. The prevalence rates of sexual assault against Native women may be even higher than estimated given the significant underreporting that occurs (Bongar White et al., 2008). Unlike other women in this country experiencing sexual violence, these indigenous women are more likely to be sexually assaulted by a man of another race, by multiple perpetrators, in a public space, with a weapon, and to suffer injuries as a result of the sexual assault (Bongar White et al.).

One of the most striking statistics surrounding sexual violence and Native American women is that nearly 86% of rapes are perpetrated by non-Native men (Amnesty International, 2006; Wahab & Olson, 2004). Nearly 4 in 5 American Indian victims of sexual assault will describe the offender as white (Clairmont, 2008). Under federal law, tribal courts are prohibited from trying these non-Indian suspects. If federal prosecutors decline to prosecute cases involving non-Native perpetrators Indigenous survivors are left with no further recourse under criminal law within the United States (Wahab & Olson).

Case Analysis

History, social, and cultural context

The current state of sexual violence among women in Native American communities is at odds with the historical image of this indigenous population. Prior to colonization, sexual assault was virtually nonexistent within tribal societies as a result of traditional values and belief

systems based in gender equality (Clairmont, 2008). Women were valued as sacred and critical to the completeness and prosperity of the family unit and the overall community (Clairmont). Evidence suggests that violence against women was rare and, when it occurred, was often severely punished (Amnesty International, 2006).

The consequences of colonization have resulted in profound changes in gender roles among Native American people (Amnesty International, 2006). Historically, despite the important role of women in Indian culture, government officials insisted on dealing with only male members of the community and missionaries pressured indigenous women into assuming traditional female roles (Amnesty International). Overtime, Native American women became subject to oppression, violence and dehumanization (Clairmont, 2008). The perception and experience that remains is that of a dominant culture that continues to devalue and marginalize this segment of the population (Bonger White et al., 2008). Given the historical role of women in Indian society, many believe that the rape of an Indian woman is an assault on both on her and on her community (Clairmont).

There are a number of suspected risk factors for sexual violence against Native American women. This includes institutional oppression such as racism, classism, and sexism stemming from a history of colonization and exploitation (Wahab & Olson, 2004). Bohn (2003) found that among 30 midwestern Native American women, all of those abused as children were subsequently abused as adults. Yuan (2006) studied 1,368 individuals from six tribes and concluded the strongest predictor of sexual assault among Native women was being separated or divorced. Women with higher tribal identity were also at increased risk of being raped (Yuan). The phenomenon of sexual revictimization was confirmed in the same study which showed that

multiple types of childhood maltreatment, including physical, sexual, and emotional abuse and physical neglect, contributed to increased risks of subsequent assault (Yuan).

Further risk for sexual assault results from many tribal communities suffering from high rates of poverty and unemployment. Additional risk has occurred from the historical destruction of Indigenous families (Wahab & Olson, 2004). Much of this arose from 19th century federal efforts to assimilate Natives by removing children and placing them in boarding schools. Not only were families torn apart, but children were subjected to physical and sexual abuse in these educational settings (Amnesty International, 2006).

Alcohol is thought to play a particularly important role in the prevalence of interpersonal violence among Native American women (Wahab & Olson, 2004). Yuan (2006) reported that alcohol dependence is a significant risk factor for sexual assault among Native women. This stems from the fact that alcohol abuse is the single most important health problem within Indian communities (Wahab & Olson, 2004). The historical significance of the introduction of alcohol to Native American tribes during colonization had a lasting impact on these communities.

Significant barriers exist with regard to the reporting of sexual violence among this population. This includes distrust of non-Native resources, fear of ostracism within their community, concern over the risk of losing children, shame, and guilt (Bonger White et al., 2008; Wahab & Olson, 2004). Confidentiality concerns within tribal communities, difficulty discussing a sexual assault, and fear of arrest on other charges (e.g. public intoxication, outstanding warrants, etc) further limits reporting (Bonger White et al., 2008). Other unique barriers include language, culture and value differences. Lastly, issues of access to medical resources, insurance, and health care delivery models all influence reporting rates (Wahab & Olson, 2004).

Adequate response to a sexual assault is absent in most Indian communities. There is often a lack of strong sexual assault codes, shortages of tribal law enforcement personnel, deficiencies in 911 systems, and shortages of jails (Bongar White et al., 2008). Additionally, there is limited access to sexual assault specific training for officers or nurses and a lack of appropriate forensic evidence collection equipment (Bongar White et al.).

In many communities, the Indian Health Service is the sole health care provider for tribal members. Amnesty International (2006) found that in many of the healthcare facilities on these reservations, there were no clear protocols available for appropriate sexual assault care and victims were not consistently provided a forensic exam. A 2005 survey found only 1 in 3 facilities had a sexual assault protocol available for emergency services staff (Amnesty International).

The medical response to sexual assault on tribal lands should follow the Sexual Assault Nurse Examiner (SANE) model for best practices, by using specially trained nurses to perform forensic examinations (Clairmont, 2008). Unfortunately, one of the primary problems of recruiting and retaining trained SANEs in tribal communities is the challenge of certification (Clairmont). SANEs are required to perform a minimum number of examinations to maintain their certification. In small tribal communities with low reporting rates this may result in SANEs who are unable to maintain the requirements for certification (Clairmont). In an Indian Health Service survey, only 44% of facilities had any member on staff trained to provide appropriate care for a victim of sexual violence (Amnesty International, 2006). When exams cannot be conducted at facilities on reservations, sexual assault victims are left traveling hundreds of miles to unfamiliar facilities where culturally appropriate care may not always be available (Amnesty

International). Subsequently, some victims may choose not to make the trip to another healthcare facility, while others will endure long waits for care (Amnesty International).

From a legal perspective, many outdated tribal laws related to rape are still on record in much of Indian Country. This includes laws that retain marital immunity which protects a man from being prosecuted for raping his wife (Deer & White Eagle, 2008). Other laws perpetuate beliefs that victim's lie about sexual assault and thus, a report of rape necessitates corroboration of the victim's statement by a third party. Still other rulings require prompt reporting of the crime despite experiences that suggest most victims wait to seek care or report an assault. Lastly, even though most sexual assault victims do not have visible injuries, older laws still exist requiring a level of victim injury to support a claim of sexual assault (Deer & White Eagle).

Response to sexual assaults of Native American women is further complicated by the circumstances surrounding the location and ethnic status of the perpetrator. Sexual assault survivors must navigate a complex judicial system of tribal, state, and federal law. Confusion over jurisdiction can result in a delayed, inadequate or failed response as tribal and state boundaries are often not the same (Wahab & Olson, 2004). In addition, the U.S. Supreme Court decision *Oliphant v. Suquamish*, 435 U.S. 191 (1978) prohibits tribal governments from prosecuting a perpetrator who is not considered "Indian" (Clairmont, 2008). Even when the assault is reported, the Indian Civil Rights Act restricts the maximum sentence an Indian defendant can receive in tribal court for any single crime committed in Indian Country to up to one year of imprisonment and a \$5,000 fine (Clairmont; Wahab & Olson).

To further complicate matters, in 1953 under Public Law 280, the federal government transferred criminal jurisdiction over all crimes committed in Indian Country to certain states (Deer, Goldberg, Valdez Singleton, & White Eagle, 2007). In Oregon, all Indian Country

reservations, except Warm Springs, are affected by this mandatory ruling. The only exclusion is for crimes committed on tribal land that are of a national interest. It is important to note, Indian Nations were not consulted regarding this legal decision (Gardner & Pecos Melton, 2004).

Intervention Strategies

Strategies identified

In 2008, both the Office on Violence Against Women and the Tribal and Policy Institute collaborated to release a comprehensive series of recommendations that provide a roadmap for improving tribal response to sexual assault (Bonger White et al., 2008; Clairmont, 2008; Deer & White Eagle, 2008). Most importantly, tribal governments were encouraged to create and implement policies and programs that meet the specific values and capacities of their communities. These efforts support grassroots changes that are not dictated by an outside non-Native agency.

Four specific strategic areas are addressed. Communities are encouraged to start with efforts to draft or revise criminal law as it pertains to sexual violence in their tribes (Deer & White Eagle, 2008). Once there is a strong foundation in criminal law, the creation of policies to allow tribal law enforcement agencies to enforce the laws is advised (Bonger White et al., 2008). Next, specific guidelines to assist prosecution in holding offenders accountable while maintaining compassion for victims as they navigate the judicial system should be implemented (Bonger White et al.). Lastly, and the area most relevant to the DNP, are recommendations for a Sexual Assault Response Team to establish a coordinated effort among law enforcement, prosecution, SANEs and advocates to provide victim-centered care (Clairmont, 2008).

Expected outcomes

The outcomes of these strategies are to institute effective and consistent policies and procedures for the investigation, prosecution, and provision of medical services in sexual assault cases (Clairmont, 2008). While it may take time to implement all of these recommendations, they do reflect similar successful efforts in non-Native communities to address sexual violence. Most importantly they allow for outcomes that best reflect tribal values while maintaining a victim-centered approach.

*Implications for Nursing**Advanced practice*

The changes recommended offer significant opportunities for nursing. Tribal and non-tribal health care workers have an opportunity to develop collaborative relationships to provide comprehensive post assault care. Nursing's participation as a member of the Sexual Assault Response Teams within these tribes or in nearby communities serving Indigenous populations is critical to the success of a victim-centered model of care (Bonger White et al., 2008).

Advanced practice nurses can impact issues of sexual assault among Native American women through leadership in the clinical, teaching, policy, and research arenas. Advanced practice nurses bring a vast amount of expertise to providing high quality, culturally appropriate post assault care. They can be a valuable resource in training other health care members and in taking a leadership role in the formation of Sexual Assault Response Teams (SARTs). They can support the inclusion of health disparities curriculum among both undergraduate and graduate nursing course work. They can participate at the community level to encourage healthy dialogue regarding the needs of Native American women in their communities. Advanced practice nurses can contribute to research in areas of barriers to care, disparities in services, and tribal variability

which would go a long way towards better understand sexual violence among Native American women (Wahab & Olson, 2004).

Health Policy

Given the alarming statistics regarding sexual assault in Indian Country, health policies need to be pursued that support the funding of SANE and SART programs. Even more critical are policies aimed at primary prevention of sexual violence on tribal lands. Given the realities of alcohol related health problems among Natives, health policy agendas regarding sexual violence would benefit from addressing policies that support alcohol related education and treatment. Just as important are other policy initiatives that aim to lift Native Americans out of poverty.

Self Reflection

My experience providing primary care as an Adult Nurse Practitioner and SANE has provided an excellent foundation for work in the area of sexual violence. Developing a SANE program has allowed me to gain experience working collaboratively with a multidisciplinary team that includes law enforcement, prosecution, and advocates. My work with the Oregon Attorney General's Sexual Assault Task Force [AG's SATF] has provided further opportunity at the state level to gain exposure to individuals and organizations working in the areas of offender management, child abuse, legislative policy, criminal justice, victim response, and prevention.

My ability to contribute effectively in the concerns of Native American victims of sexual assault lies in gaining additional experience with the needs of this population. Several years ago, the AG's SATF created an Indian Country Work Group in an effort to address issues regarding sexual assault response in Indian Country. Participation in this sub-committee would provide an excellent opportunity to begin to fully understand the needs of the Native American population with regard to sexual violence. Towards this same end, the Medical Forensic Committee which I

chair has made an effort to invite staff from the Oregon Law Center to discuss collaboration on issues of indigenous populations in Oregon specific to facilitating access to SANE services and providing culturally appropriate care. As an advanced practice nurse there is the opportunity to provide further leadership in this area through continued support and partnership with the Oregon Law Center. Additionally, the Medical Forensic Committee could develop best-practice guidelines specific to the Native American population to assist SANEs in providing appropriate medical services to this population

While I have gained considerable experience at the state level regarding sexual violence, I envision involvement at the national level to be the next logical step in expanding my confidence and expertise. The International Association of Forensic Nurses (IAFN) is an organization dedicated to establishing evidenced-based nursing practice, addressing primary prevention, and supporting education and training with regard to issues of sexual violence. There are many opportunities for me to be involved in education, training, and research in this organization.

More specific to Native American women, would be to explore grant funding from the Department of Justice, Office on Violence Against Women. An organization such as the AG's SATF has the credibility and resources to allow me an opportunity to collaborate on securing grants that could expand services, educate tribal members, and support research in this area.

Lastly, I am most attracted to solutions at the population level. This would likely involve gaining expertise in health policy. At the national level, there are opportunities for internships and fellowships, particularly for those interested in working with underserved populations, of which Indian populations are one. I would like to explore such opportunities with the hope of making a lasting impact on issues of sexual violence, particularly among vulnerable populations.

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Running Head: HUMAN TRAFFICKING

N790 Clinical Residency

Case Report: Human Trafficking

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Case description, literature, and justification for selection

Human trafficking is the modern day equivalent of slavery. It has become one of the fastest growing criminal industries in the world, surpassed only by drug dealing (US Department of Health & Human Services [US HHS], 2008c). Recruited through force, fraud, or coercion, human trafficking is a most extreme form of labor exploitation (American Civil Liberty Union, [ACLU], 2007). According to the U.S. Department of State (2008), 600,000 to 800,000 victims are trafficked across international borders annually. That does not account for trafficking that occurs within countries. The U.S. alone has an estimated 14,500 to 17,500 victims of trafficking enter the country each year and the average age of a victim is 20 years old (ACLU).

Sex trafficking is a form of human trafficking in which a victim performing commercial sex acts is either induced to do so by force or is under the age of 18 (ACLU, 2007). Sex trafficking disproportionately affects women and young girls (US HHS, 2008d). In addition to prostitution, sex trafficking includes other forms of exploitation such as pornography, mail-order brides, and sex tourism (US HHS). Internationally, such activity has become an \$8 billion dollar industry (May, 2006).

Domestic sex trafficking, particular among minors, is of growing concern in this country. For those working with homeless teens it is of major concern. Many child trafficking victims suffer physical and sexual abuse during formative years and have very distinct medical and psychological needs (US HHS, 2008b). Fully one-third of the estimated 2.8 million children living on the streets of this country will have been lured into prostitution within 48 hours of leaving home (Shared Hope International, 2007).

Ana (not her real name) is a 24 year old refugee from Serbia. She was just 14 years old when she became a victim of human trafficking. As a young child she was sexual abused by her father. As a teen, she was taken to Germany and forced to engage in the commercial sex industry. For the next five years she remained enslaved and a victim of a large sex trade operation. Eventually Ana was rescued from her situation and went on to testify against sex traffickers responsible for her exploitation. Following their conviction and imprisonment it became apparent that she could not safely return to her home.

In 2008, Ana was given refugee status in the United States. She came to this country knowing she would never be able to see her family again. In an effort to ease her transition into the United States, Ana was temporarily placed with a family in this country. Her host had been a Peace Corp volunteer to Serbia years ago. She was enlisted to house Ana until she relocated to an apartment and continued her schooling.

This case was selected as an example of the complexities in the care that may present with victims of sexual assault. It builds on the advanced practice nurses prior experiences with sexual assault, while addressing more complicated national and international legal issues, extensive medical screening and preventions concerns, broader cultural and language barriers, and challenging family and individual safety concerns.

Ana first presented to the clinic as a new patient and desired to establish care. She was accompanied by her host who assisted in translating. Initially, Ana was very hesitant to discuss her history of sex trafficking. The patient's presenting complaint was dysmenorrhea and her physical exam was benign. She arrived with no medical records other than a single piece of paper with a few screening tests done as part of her immigration. It was at that initial visit that her host provided some brief details of Ana's circumstances.

Ana's initial visit was devoted to obtaining an initial health history, performing a physical exam, including pelvic exam, obtaining appropriate lab testing, and providing treatment for her dysmenorrhea. She was quite pleasant, very cooperative, but quiet. She expressed concern about the quality of her English and deferred some questioning to her host for answering.

Ana returned alone to two subsequent office visits. On each occasion, her specific concerns were addressed while allowing her an opportunity to discuss her transition to the U.S. At successive visits she became less conscious of the language barrier, more relaxed, and increasingly talkative. It was not long after arriving in this country that she realized that she could not afford the price of American cigarettes. At her second visit she had come in to discuss smoking cessation, a habit she had picked up as a sex worker. At this visit she was given further opportunity to discuss the circumstances surrounding her refugee status. While still not discussing sex trafficking she did begin to talk about her family and her hope of connecting with them by phone.

It was not until her third visit that Ana opened up regarding her experiences in the sex trade industry. She explained that while she had recently been able to contact her family by phone, for safety reasons, she had to tell them she was living in a different country. It became clear that Ana was never going to be able to visit her family, nor would they ever be able to see her. It was at this time that she also confirmed the sex trafficking history previously provided by her host guardian.

Analysis

From the beginning it was clear Ana had significant physical and mental health risks related to her history of sexual exploitation. Studies have demonstrated a risk between HIV and other drug resistant strains of sexually transmitted infections and sex trafficking (US Department

of State, 2007). HIV risk under these conditions can range from 38% to as high as 90% depending upon the country in which the sexual exploitation occurs (US Department of State). HIV risk is further increased if a victim is prostituted prior to 15 years of age, as Ana had been (US Department of State). Additionally, 45 percent of sex trafficked women will acquire Human Papilloma Virus (HPV), often diagnosed at later stages and with higher risk for cervical cancer acquisition (US Department of State; Willis & Levy, 2002). Ana had not had a pelvic exam done in years. Her only recent sexually transmitted infection (STI) screenings were HIV and RPR tests prior to entering the United States. A Pap smear and additional STI tests were obtained at her first visit based on the little history that was provided by her host.

Other reproductive health risks in this population include increased risks of menstrual disorders, hepatitis B, pelvic inflammatory disease, and pregnancy (U.S. Department of State, 2007). Forced terminations, often performed by unqualified individuals, may result in sepsis, incomplete abortion, hemorrhage, pelvic injury, or even maternal death (Zimmerman, 2006). Ana acknowledged having had two abortions in her mid teens and was without any current contraception. At her first visit she was started on oral contraceptives for both treatment of dysmenorrhea and contraception.

Other physical and mental health risks in sex trafficked individuals include, sleeping and eating disorders, neurological and gastrointestinal complaints, Post-Traumatic Stress Disorder, addictions, injuries, infertility, and communicable diseases (Barrows & Finger, 2008; US HHS, 2008d; U.S. Department of State, 2007). Upon entering the United States, Ana had a CXR presumably to screen for tuberculosis. Over the course of several visits, Ana received a thorough physical exam, extensive laboratory testing, and finally mental health evaluation and referral

information. Symptoms of depression and Post-Traumatic stress disorder will continue to need careful monitoring over futures visits and necessitate adjustments to the patient's treatment plan.

The advanced practice nurse, based on prior knowledge in working with sexual assault victims, was keenly aware of the consequences of the wrong approach to care that might affect this patient's willingness to return for follow up care. Like many sexual assault victims, Ana was unlikely to self identify as a victim of human trafficking. It is probable that she had an initial distrust of the healthcare system in this country and had legitimate concerns about confidentiality. In addition, the patient's many years as a sex worker and recent refugee status made it apparent that all of the patient's needs were not going to be met in a single visit.

Interventions

Ana's care was a challenge from her first visit. Without the patient initially offering any indication that she was a victim of sex trafficking, her immediate concerns needed to be addressed while being cognizant of the increased physical and psychological trauma that she had likely experienced. Her recent arrival to the U.S. just six weeks prior, her lack of familiarity with this country's healthcare system, and the language barrier suggested that the best approach to her care would be to establish a trusting relationship with the advanced practice nurse and to prioritize her needs. She was scheduled for follow-up visits in an effort to monitor her health, but also to establish a rapport in the hope of being able to begin to address her ongoing needs related to the trauma of the sexual exploitation and subsequent relocation.

Best practice interventions to assist victims of sex trafficking, such as Ana, were enacted with the passage of the Trafficking Victims Protection Act of 2000 and reauthorized in 2003 and 2005 (U.S. Department of Health and Human Services, 2008e). Specific efforts are focused on the areas of prevention, protection, prosecution, and re-integration. It is important that the

advanced practice nurse be aware of the medical and legal issues affecting such sex trafficking victims.

Prevention efforts center on an awareness campaign aimed at educating women regarding the risks of sex trafficking, coercive techniques of criminals, victim rights and resources (Academy for Educational Development, 2006). Additionally in several cities across the country, the US Department of Health & Human Resources initiated a “Rescue and Restore Campaign” focusing on educating health care providers, social workers, and law enforcement to identify potential victims of human trafficking (US HHS, 2008a).

In the U.S., protection efforts focus on making available to refugees assistance with housing, food stamps, and health benefits (ACLU, 2007). Safety is a primary concern, both immediately and long term. The Office to Monitor and Combat Trafficking in Persons (2008) has developed specific safety protocols. These guidelines outline the expectations in addressing both the physical and psychological needs of the victim, as well as comprehensive procedures for shelters and personnel.

The United States has made significant progress in recent years to address prosecution efforts related to sex trafficking. The Trafficking Victims Protection Act (TVPA) criminalizes human trafficking with regards to “forced labor, involuntary servitude, peonage, and slavery” (ACLU, 2007, p. 3). Victims can seek restitution and civil penalties from their traffickers (ACLU). While human trafficking is now a federal offense, 30 states have also enacted state laws against such crimes. These efforts will allow prosecutors to work more effectively with local law enforcement (Donovan, 2008).

The advanced practice role with this patient required the use of best practice care adopted from prior experience with sexual assault victims. The priorities focused on meeting Ana’s

immediate medical needs, while striving to address her ongoing emotional and physical needs with the assistance of appropriate support resources. Her immediate safety had been addressed at an international level, but it is likely there is the potential for it to be of an ongoing concern. Legal issues had already been addressed prior to Ana's entry into this country. In the future it is anticipated she will remain involved with the legal system depending on the type of visa she received and laws surrounding any permanent resident status.

Evaluation

While Ana's refugee status in the United States is newly established and her medical care is ongoing, the outcomes for her situation thus far should be considered reflective of best practices. She has been removed from the bondage of her traffickers, and even defied the odds and has seen her traffickers punished for their crimes. Current laws have been utilized to provide her with asylum and relocate her to a safe environment with support services.

With regard to her medical needs, she was referred to a medical provider with sexual assault specific training and knowledge in human trafficking- a rarity in most health care settings. The medical care and screening Ana received reflects an understanding of specific health care risks, as well as physical and emotional needs associated with long term sexual victimization. A trusting relationship between the patient and provider has been established to foster ongoing follow-up.

The relatively recent attention paid to this population presents significant opportunities for the DNP. Ana's situation is not unique to primary care in this country, though without a clear understanding of the prevalence and specific needs of this population, such victimization likely goes unrecognized. It is important for the advanced practice nurse to consider human trafficking crimes committed against their internationally born patients, but also among those born on

American soil. While it appears there have been strides made in legal reforms to address the problems of human trafficking, there remains a necessity for greater involvement from the medical community.

Efforts at screening tools based on care models for sexual assault victims have been recommended, but there is a need for outcome data on the effectiveness of these tools in the human trafficking population. Little is currently understood about variations in culture, sex, or age among victims. There are extensive opportunities to educate the public about this problem. In addition, the DNP is in an optimal position to lead interdisciplinary efforts with policy makers, law enforcement, and social service organizations to address these issues.

Self Reflection

Ana's case reflects an opportunity and a challenge as both an advanced practice nurse and a Sexual Assault Nurse Examiner. Clearly, my prior work with victims of sexual assault was important, but even more invaluable was my expanded role in working with the Attorney General's Sexual Assault Task Force and the experience of my residency with the Department of Human Services last term. Since last fall and prior to caring for Ana, I was fortunate enough to have attended a human trafficking educational presentation led by the FBI, engaged in dialogue with the Oregon Law Center regarding cultural issues related the sexual victimization, and researched screening tools for sexual assault, of which human trafficking was included.

While the above opportunities proved extremely useful in providing Ana's care, preparing this case report exposed other knowledge gaps. There is much about international law, variations in visas, and asylum issues that I do not fully understand and would benefit from learning in working with this population. In Ana's situation, there is more to be learned about additional medical risks for a new immigrant, as well as the local and national resources

available. More specific to my clinic are needs to educate staff, from the receptionist to the nurses, regarding human trafficking so that an approach to all interactions avoids re-victimization.

There are also potential research opportunities that offer occasions for growth as a DNP that can be garnered from this case and pursued as part of a larger study of the human trafficking population. This might include interdisciplinary efforts at measuring patient outcomes, identifying best practices, and developing outreach programs.

The experience of working with Ana reaffirms the important role and expertise the DNP can bring to improving the care provided to a broad range of victims of sexual violence. In addition, it also reinforces the need for future involvement and the potential for leadership by the DNP in efforts to improve the lives of this vulnerable population.

While Ana's situation is tragic, she is fortunate to have escaped her position of servitude. It would be naïve to believe that her relatively smooth transition to life in the United States suggests the end to her troubles. This case of human trafficking reflects a severe deprivation of human rights that began with an innocent child and ended with the unfortunate separation of a young woman from her family and country.

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Running Head: LEADERSHIP

N790 Clinical Residency

Case Report: Leadership

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Today's healthcare organizations need nurse leaders who can advance nursing care, advocate for the nursing profession, and positively influence healthcare (Frankel, 2008). Porter-O'Grady (2003) defines leadership as a "multifaceted process of identifying a goal or target, motivating other people to act, and providing support and motivation to achieve mutually negotiated goals (p. 105)." An effective leader is capable of making decisions, delegating appropriately, resolving differences, and acting with integrity (McGuire & Kinnerly, 2006). According to Frankel, advanced practice nurses have the education and expertise to function in leadership roles that promote positive outcomes, ensure the utilization of best practices, develop the expertise of others, and enable a collaborative approach to clinical care.

Case Study

ST was 20 years old when she presented 10 hours post-assault for medical care after being sexually assaulted the night before. She had been drinking at a party and at approximately 1:30am went outside alone. After walking for awhile she tried to return to the party, but was confused and lost. For over an hour, ST continued to wander the streets looking for the house she had left. At one point two young men approached her in a car. She tried to get directions from them, but was grabbed by one of the men, taken to a darkened alley, and orally sodomized.

ST was seen by the Sexual Assault Nurse Examiner (SANE) and a clinic nurse practitioner working towards her SANE certification which required three precepted exams. A history of the assault, a physical exam, and forensic evidence collection was obtained by the NP with oversight by the SANE. Law enforcement arrived, interviewed the victim, and picked up the Sexual Assault Forensic Evidence (SAFE) kit. An advocate was contacted and met with the victim and referrals to the Counseling Center and Student Life services were provided. Lastly,

without revealing confidential information, the student's professor was contacted and an extension was provided for an upcoming final exam.

Rationale for Case Study Selection

This case was chosen as an example of leadership after several years of effort to develop a SANE program in a campus-based clinic. Precepting a nurse practitioner to become a SANE was a symbolic milestone in this journey. The ability to have a co-worker trained and capable of collecting forensic evidence would not have come to fruition without the leadership necessary to overcome numerous obstacles. This specific case exemplifies the move to an evidenced based approach to sexual assault care with the capacity for forensic evidence collection and an interdisciplinary approach to care. The case also reflects all the elements of the type of SANE program initially envisioned, that is, victim-centered care, collaboration with campus and community resources, and support of the criminal justice system. The care provided to this victim and the training of a future SANE reflects the leadership necessary to develop a sustainable program.

Decision Making

Decision making in the case evolved from a national standard of care for the acute victim of sexual assault. This could not have been realized without a significant amount of time and energy being invested in planning, communication, and collaboration, as well as training, equipment, and program development. Furthermore, for this to occur successfully, an individual had to emerge as an identified leader from within the small group of original program supporters. This ultimately came from one of the organization's advanced practice nurses.

Additional decision making considerations were based on a desire to offer victim driven care throughout the exam. Leadership responsibilities required guiding the newly trained nurse to

perform a proper exam and evidence collection. This exam would later have to pass a certification review by the Oregon State Board of Nursing SANE Commission and potentially withstand judicial scrutiny in the court of law. All of this was particularly challenging to achieve as meeting the needs of a traumatized victim was paramount.

The most important stakeholder in this case was the victim, with whom every effort was made to provide compassionate care. Additionally, this case involved an advocate, counselor, Dean of Students, professor, police officer, prosecutor, and other clinic staff. At the periphery of this case was the campus and larger community that were potentially affected by the possibility of having two perpetrators at large. Lastly, there was a stakeholder in the nurse practitioner who needed to meet her SANE certification requirements.

Once the victim had chosen to report the assault to law enforcement, the authority for decision making became much more complex. Strict protocols for evidence collection needed to be followed. Maintaining chain of custody during the evidence collection was critical. Having both the SANE and precepted nurse involved in the exam had the potential to complicate this process and necessitated strict attention to documentation. Once the evidence was turned over to law enforcement and the details of the assault reached the prosecution, control of the process shifted significantly from the victim to the District Attorney's office.

Strategies used during this decision making process mandated maintaining a clear understanding of the role of the SANE and the other NP during the examination process. It required presenting a confident demeanor with regard to teaching the details of the forensic exam and in interactions with law enforcement, while at the same time supporting both an anxious nurse performing her first SANE exam and a traumatized patient. All of this occurred while

negotiating the additional needs of law enforcement to interview the victim and an advocate to support the patient.

Evaluate the outcomes and potential implications

This case reflects an achievement that started with a vision of providing a broad range of victim-centered post-sexual assault services and culminated with a successful campus-based SANE program. The greatest leadership challenge was to look beyond the emergency room SANE program model and create a clinic based model of care that exceeded the expectations of traditional sexual assault services. This required translating an idea into a plan acceptable to multiple stakeholders- students, administration, staff, law enforcement, and prosecution. Additional challenges required following strict forensic evidence collection procedures related to documentation, storage, and transfer of materials, all of which was created through collaboration with the state forensic lab, police evidence storage staff, and campus attorney.

The provision of post- assault care outlined in this case was achieved repeatedly over the next several years as multiple sexual assault victims received services utilizing evidence based sexual assault protocols. In addition, five clinic nurses successfully completed their SANE certification. The implications have been significant as this program went on to becoming a model for similar programs in Oregon and a resource nationally.

Leadership Style

There are many types of nursing leadership styles. This case study and discussion focuses on transformational leadership which I believe reflects my leadership style. According to Valentine (2000), transformational leadership's value to nursing lies in the ability of this approach to promote improved patient outcomes through cooperative care that also empowers others. The success of this SANE program required collaborative care from many disciplines and

could not have been achieved without a leader to bring along many other individuals both inside and outside the organization. This particular leadership style can encourage change within an organization and is appropriate to today's dynamic health care system (Valentine). Forensic nursing certainly is a new and evolving concept to nursing and in need of innovative leadership at many levels.

Transformational leadership was first described by James McGregor Burns in 1978 and later extended by Bernard Bass (Stewart, 2006). Burns first introduced the concepts of transformational leadership in his groundbreaking descriptive research on political leaders, but the idea has since evolved to be utilized within organizations, an idea which is more appropriate to this discussion (Stewart). This model acknowledges the importance of uniting the concepts of both leader and follower (Stewart). In my organization, I was the primary advocate for a SANE program, but my success was intricately linked to those around me. Leadership often took the form of moving others along a continuum from skeptic to supporter, demonstrating patience, integrity, and competence throughout the process.

Burns emphasizes social change and moral leadership that encourages leaders to accept responsibility for their leadership. The SANE program is very much about addressing a social problem and required a personal motivation based on concern over the consequences of sexual violence in society. Furthermore, there was no mandate from administration to develop this program and thus, necessitated greater voice and active leadership on the part of the program leader.

The transformational model allows that such leadership can be learned and developed over time and does not require an individual to be born with such qualities (Stewart). My core leadership qualities were acquired through years of working as an advanced practice nurse.

My capacity as a leader evolved over time and built on each successive achievement in creating this SANE program. Involvement in the Attorney General's Sexual Assault Task Force pushed me into a leadership position that was initially at the edge of my comfort level and ultimately proved to be a growth experience. I have progressed from committee membership to Steering Committee and Medical Forensic Chair, and more recently a Sexual Assault Task Force faculty member. My residency has provided me with expanded opportunities in the legislative and public policy arenas.

Wolf, Boland & Ankerman (1994) outline a number of important assumptions as part of the transformational model. First, is that under this model the quality of patient care delivered within an organization must be maintained or improved. This requires interventions that promote excellence in care and optimize patient outcomes. For this SANE program, strategies for change were thoughtfully outlined and initiated very slowly over a period of several years before success was achieved. Very high standards were set for each aspect of the program's implementation and success at one stage was achieved before moving on to the next phase.

The second assumption acknowledges that financial resources are likely to diminish over time (Wolf et al., 1994). This necessitates an understanding of the need for effective resource utilization within an organization. It was understood from the beginning that there were limited resources to assist with development of this SANE program. As the leader of this project, a budget was developed and the upstart costs were carefully spread out over the initial planning years. Fortunately, the costs to sustain the program remained minimal. Additionally, outside funding resources were identified early on in the process.

Lastly, there is the ideal that both patient and staff satisfaction must be maintained or improved (Wolf et al., 1994). This is critical to acknowledging the need to provide patient care

based on best practices and to promote strategies that support staff development (Wolf et al.). Providing sexual assault victims with a full range of post-assault care options necessitated the development of a SANE program. Additionally, experienced staff was given an opportunity to expand their professional skills through training and mentoring. What was not initially appreciated, but later proved essential was the shared core value of compassionate care of sexual assault victims which proved to be a to be a valuable asset.

My leadership style reflects the transformational leadership ideal that Bass describes as an individual who can offer an organization an optimistic approach to influencing care. That is, despite many obstacles, I believe I demonstrated the confidence, patience, and perseverance to achieve a significant change in clinic services. Bass (1990) explains that this type of leadership derives from the foundation that vision and passion for an idea can produce change and convert followers through the enthusiasm and commitment exhibited by the leader. The DNP program has allowed me to expand my vision of a single SANE program into issues of sexual violence at the larger population and policy level.

Self-reflection

Involvement in ST's case obligated me to have first obtained a clinic position as an expert in the provision of medical care for a sexual assault victim. To successfully precept an experienced advanced practice nurse necessitated that I have already earned the respect of this individual as a competent practitioner. Additionally, it was important to impart a professional demeanor in working with the patient, advocate, law enforcement, and other campus resources, not just with this patient, but across many patients and with many other collaborators in the process.

Functioning as a mentor during ST's exam required I first lead by example which was achieved through my own training and successful completion of several prior SANE exams. It was important for me as the program leader to create opportunities for another nurse to achieve her SANE certification, which was a complicated process of advocating for training and coordinating access to exams in a busy clinic. Finally, it was critical to allow the precepted nurse independence in learning the forensic evidence process while caring for ST and at the same time not allowing for failure on the part of the newly trained SANE.

I do not believe anyone involved in the initial planning stages of this SANE program anticipated the tremendous amount of work and organization that would be required for success. This may have proved beneficial. It allowed for enthusiasm to be established in the early stages yet, as the process became more complicated it provided a tremendous opportunity to further develop my leadership skills as an advanced practice nurse.

I had not entered the process determined to be its leader, but as the planning process slowed and other staff re-evaluated their commitment to the process, it became apparent that a key motivated leader needed to emerge to continue the change effort. These events ultimately helped me achieve a high level of success in my nursing career and have additionally been a valuable contribution to my success as a DNP student.

In this leadership position, the single most significant barrier which took months to overcome and nearly derailed the process was the struggle to access precepted forensic exams to meet the clinical requirements for SANE certification. Without a SANE on staff, the local emergency room was enlisted to help the clinic staff obtain training. This required developing contacts, working with administration to develop a contract, and being on-call to observe sexual assault exams. This was complicated by an emergency room staff that had no incentive to assist

the campus nurses in achieving certification and therefore became all the more challenging as a leader.

As the SANE program began to succeed, care was taken to support staff that had initially lost interest with the program, but who eventually received their SANE certification. As the program expanded, there evolved a growing interest from campus organizations, the media, and other campuses, both statewide and nationally. This provided another opportunity to develop a leadership role as a resource to other organizations. Ultimately, my responsibilities expanded to involve participation in sexual assault work at the campus, community and state level.

The informal feedback regarding this program was that success occurred as the result of efforts to utilize effective communication, understand the organizational supports, emphasis training, and establish leadership. An important measure of success for many stakeholders was achieved with the utilization of clinic resources for services that students valued and were patient focused. A more formal acknowledgement of leadership came with the receipt of an outstanding employee award - the first ever given on campus to either a physician or nurse.

My engagement with those in the community working to end sexual violence has greatly influenced how I might respond to future leadership opportunities as a DNP. It has provided me with a tremendous amount of experience in organizational change, health policy, and evidenced based clinical practice. I have been able to work with multiple other disciplines and have developed important relationships with people and organizations that should allow me to expand my leadership impact into areas beyond the field of sexual violence. Most importantly, I believe I have developed a leadership style that can empower others, create mutual respect, and inspire change.

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Running head: ORGANIZATIONAL CHANGE

Organizational Change Case Study

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Introduction

Summary of the Problem

At a campus-based health center, students that presented acutely for sexual assault follow-up received fragmented and inconsistent medical care without the option of forensic evidence collection. In general, clinicians lacked the knowledge to best care for sexual assault victims and more specifically, lacked the specialized training necessary to collect forensic evidence which would preserve future reporting options for the victim.

Significance of the problem at a local and national level

For the purposes of this paper the discussion will focus on female rape victims given that sexual assault occurs at a significantly higher rate in women than men. Statistics from the U.S. Department of Justice indicate 2.8 percent of college females are victims of either an attempted or completed sexual assault in any given nine month academic year (Fisher, Cullen, & Turner, 2000). Though this number appears small, when factored for multi-rape victims, it translates into nearly 35.3 incidents per 1,000 students (Fisher et al.). This in turn equates to approximately 350 assaults per year on an average size campus of 10,000 (Fisher et al.). Even more alarming is the public health crisis that these figures represent when factored into the millions of women on college campuses.

In an Institute of Higher Education survey of a broad range of two and four year public and private colleges, it was found that more than 25 percent of college-aged women reported experiences that met the legal definitions of either rape or attempted rape (Karjane, Fisher, & Cullen, 2005). Additional summaries of sexual victimization on campuses report that 25 percent of women will experience an attempted or completed rape sometime during their college career (California Campus Sexual Assault Task Force, 2004; Fisher et al., 2000).

In Oregon, one in every six adult women has been a victim of rape at some point in her lifetime (Kilpatrick & Ruggiero, 2003). Based on the 2000 Oregon census, that translates into approximately 230,000 sexual assaults and is considered a conservative estimate (Kilpatrick & Ruggiero). In the county which is home to the university discussed in this change effort, there is an estimated 22,000 female residents that have ever been raped (Attorney General's Sexual Assault Task Force, 2005).

In addition to understanding the scope of sexual violence against women, it is also critical to consider the response. A recent study of emergency room visits for assault estimates that approximately 143,647 sexual assaults were seen in emergency rooms between 2001 and 2002 (Saltzman et al., 2007). Care of sexual assault victims in this setting is not ideal. Historically, rape victims have received a lower standard of care in emergency rooms as compared to other emergency room patients (Taylor, 2002). Sexual assault victims in emergency rooms suffer long waits; go up to 12 hours without food, drink, or toileting; and have their injuries considered less serious as other trauma victims (Taylor).

The National Institute of Justice's report, *Sexual Assault on Campuses: What Colleges and Universities Are Doing About It* (Karjane, Fisher, & Cullen, 2005) lists the provision of Sexual Assault Nurse Examiner (SANE) services as one of the most promising practices of the report. Additionally, the Attorney General's Sexual Assault Task Force *Guidelines for Comprehensive Sexual Assault Response and Prevention on Campus* (2006) recommends medical providers treating sexual assault victims obtain sexual assault specific training and that forensic evidence be collected by certified Sexual Assault Nurse Examiners.

A Sexual Assault Nurse Examiner is a registered nurse with specialized training in the care of the sexual assault victim and the collection of forensic evidence (Ferguson, 2006). Certification requires completion of a 40 hour didactic SANE training course with a clinical

rotation establishing competency in the forensic exam. In Oregon, additional hours are required to be spent with law enforcement, victim advocates, and prosecution.

A 2003 study funded by the National Institute of Justice evaluated the efficacy of SANE care on medical care, victim services, law enforcement and prosecution (Crandall & Helitzer, 2003). The results support SANE programs as having a positive impact on the quality of medical services, including provision of emergency contraception and sexually transmitted infection prevention. In addition, a superior quality of forensic evidence was collected, enhancing law enforcements work and increasing the conviction rate and length of sentencing (Crandall & Helitzer). Another study of 515 forensic evidence kits found that SANEs were more accurate and complete in the performance of evidence collection as compared to either non-SANEs or physicians (Sievers, 2003).

Description of the change process and outcomes (intended and actual)

The initial organizational change effort was established with a relatively simple goal: to train nurse practitioners as Sexual Assault Nurse Examiners in an effort to improve patient care. Administrative support was easily attained as the training provided continuing education hours, was offered locally, and available free of charge. At the time, the intended outcome of SANE certification was believed to be reasonably easy to obtain.

Over the months that followed this organizational change effort took on a different form when it became apparent that the SANE certification process and implementation of the program was much more complicated than originally anticipated. The actual change process evolved into the need to understand complicated details of forensic evidence collection and to establish clinic-wide collaboration to develop procedures for triage, clinical care, and billing. In addition, it was necessary to build relationships with stakeholders such as student groups, law enforcement, victim advocates and the District Attorney's office. It was at this point that the process slowed,

staff re-evaluated their commitment to the process, and a key motivated leader emerged to continue the change effort.

A two year process of patiently moving forward followed and in the end a successful SANE program emerged. Even at this time, additional unanticipated outcomes occurred. As the SANE program succeeded, staff that had initially lost interest with the work of building the program returned and received SANE certification. The SANE program expanded and there evolved a growing interest from campus organizations, the media, and other campuses, both statewide and nationally, to further understand the role of the SANE and to solicit advice in improving their own response to sexual assault. The primary patient care responsibilities of the SANE expanded to involve participation in sexual assault work at the campus, community and state level.

Analysis

Ecological perspective

Sexual violence is a complex interplay of individual, interpersonal, community, and socio-cultural issues (Dahlberg & Krug, 2006). Individual factors that influence risk for victimization include issues that suggest increased vulnerability such as excessive alcohol use, young age, and prior history of sexual assault. Interpersonal factors that shape experiences are peer pressure, intimate partner interactions, fraternity and sorority relationships, bystander behaviors, and family. At the community level, there has often been an indifferent response from law enforcement, an unsupportive reaction from prosecution, and generally low conviction rates (Centers for Disease Control and Prevention, 2004). This occurs in an environment of easy access to alcohol, high density living, and limited parental contact. From a global socio-cultural perspective, issues of gender inequality, societal norms, and a culture of silence exist as macro-level influences (Centers for Disease Control and Prevention). This is often compounded by a

widespread distrust by victims towards law enforcement and ignorance about the prosecutorial process.

Within this continuum lies an organizational model with similar layers of interconnectedness. The targeted outcome of the relationships at this level is to provide a victim-centered medical response for the sexual assault survivor. Interpersonal relationships that affect this effort are medical and nursing staff cohesiveness; staff attitudes and personal experiences with victimization that they bring to the organization; and the role of the SANE within the campus and community sexual assault response teams. The organizational structure includes university conduct codes and alcohol policies; student mobility and social isolation on a large campus; and federal reporting laws regarding campus violence. The response to sexual assault at this level is further influenced by limited clinic hours, funding issues, staff training and patient access, and the general bureaucracy of a large educational institution. At the macrosystem level (Bronfenbrenner, 1979) there is a climate of pervasive underage and binge drinking, a Greek culture of secrecy, and the mystic of the untouchable athlete. Lastly, there is the campus, and more specifically the clinic, mission to support and enhance the university experience of the student.

Forces at work

From both national level and campus specific perspectives the reality of sexual assault (i.e. the statistics of rape) became a major preceding force contributing to the identified problem. Additional external forces included technological advances in DNA analysis and federal legislation impacting sexual assault nurse examiner programs (Telsavaara, 2006). Concurrently, there was an identified political climate in the state mandating improvements in the care of sexual assault victims. These events coincided with campus-specific projects among students and staff which formed the collective momentum to address the care provided to sexual assault

victims. Internal forces included personnel in key positions within both administration and the medical staff that were critical catalysts in moving forward with a SANE program. At the same time, the existing financial climate necessitated looking for reimbursement for sexual assault services. Gaps in medical services to sexual assault victims had already been identified by an interdepartmental committee which further supported buy-in for change by clinic staff. Additionally, the existing patient flow for a sexual assault victim as it impacted triage, scheduling, and staffing resources was poorly organized, inadequately planned, and not victim-driven. Lastly yet most importantly, the existing system needed change as it required the victim to be transferred to an emergency room setting if they desired forensic evidence collection.

Barriers

Barriers are the opposing forces in this process. The single most significant barrier which took months to overcome and nearly derailed the process was the struggle to access precepted forensic exams to meet the clinical requirements for SANE certification by the Oregon State Board of Nursing. Without a SANE on staff, the local emergency room was enlisted to help the clinic staff obtain training. This required developing contacts, writing a contract, and being on-call to observe sexual assault exams. This was complicated by an emergency room staff that had no incentive to assist the nurses in achieving certification.

Additionally, there were limited resources to assist in the early stages of the SANE program development. At the time, the only SANE programs in the state were emergency room based. This required a lengthy process of developing the initial policies, procedures and documentation without the benefit of clinic-based models. Legal issues with evidence collection and storage had to be reviewed by both the university's legal counsel and local law enforcement. Skepticism from some groups on campus and in the community was overcome through multiple, thoughtfully organized meetings. The issue of health center staff apprehension, particularly as

implementation neared, was diminished through SANE visits to staff meetings, task specific reference sheets, and the SANE volunteering to be on-call for patients and to provide staff support.

A potential barrier that was never realized, but is worth mentioning, was the hiring of a new clinic director who was initially skeptical of the SANE program. Despite any skepticism he may have had about the feasibility of such a complex initiative, by the time he arrived the change effort was already moving forward, was left to continue, and was ultimately recognized to be well implemented and successful.

Stakeholders

Two non-clinical staff members were interviewed as stakeholders in the change effort. Initially, neither was aware of any problem with the care of sexual assault patients. As non-clinicians they were satisfied with the current system of care so long as the patient was able to access clinic services. The ultimate success of the program was thought to have evolved from a slow, thoughtful implementation of what they came to believe was a valuable service sustained by small group of committed staff. Their measure of success was the meeting of an expectation that clinic resources be utilized for services that students value, are patient-focused, and financially self-sustaining.

Systems Level Inputs and Outputs

Inputs and outputs can be categorized into six major systems: administrative, financial, personnel, client, scheduling, and equipment. As noted by Cusins (1994), the action of one system is part of a complex larger set of systems. Administrative inputs include laws, the mission statement and clinic vision, and decisions on resource allocation which leads to outputs of SANE policies, procedures and budgets. Financial inputs are student fees, the budget, billing documents, and investments in training with outputs such as equipment purchases,

reimbursement, and personnel skill development. These outputs directly affect inputs into the personnel system of trained and certified clinic staff and patient interactions with outputs of referrals, community interactions, billable services and job satisfaction. Client inputs include patient preferences, health belief systems, and medical-forensic exams resulting in outputs of staff contacts, counseling referrals, judicial system interactions, and patient satisfaction.

Scheduling inputs are clinician work schedules, appointment schedules, and schedule changes necessary to accommodate the sexual assault victim affecting outputs of cancelled appointments, rescheduled appointments with other providers, and overtime. Equipment inputs include the Sexual Assault Forensic Evidence kit, storage lockers, and supplies which create outputs of clinic expenses, DNA evidence collection, investigations, and criminal sanctions.

Root Cause Analysis

The same six systems level factors mentioned above also relate to the root causes of this problem condition. Overlapping shortcomings in all these areas contributed to the identification of the need for change. Administratively, the clinic had a quality assurance study outlining deficiencies in care of rape victims with no sexual assault guidelines and no forensic collection policy. Financially, no funds were budgeted for sexual assault training or equipment, no billing system existed, and the existing structure resulted in financial losses related to the writing off of expenses for sexual assault care. Client issues include statistics on campus sexual assault and victims seeking a full range of post-assault medical services at the clinic. The most significant personnel issue was the absence of certified SANEs, but later came to include a lack of adequate training of staff from reception to lab and from triage to medical records. From a scheduling perspective, there was no consistent approach to patient triage and the use of urgent care and work-in appointments for sexual assault care was unsatisfactory. Equipment issues were the lack of evidence storage lockers, evidence dryers, SAFE kits and other supplies.

Organizational Readiness to Change

Organizational readiness to change was a fortuitist combination of events occurring in a small window of opportunity that was used advantageously by key players. It included staff motivation for change, institutional resources, personnel skills and attributes, and a receptive organizational climate (Lehman, 2002). It all began when outside SANE training at no cost to the institution became available. At the same time an interim director was supportive of the concept of SANE and qualified veteran nurses were interested in professional growth and motivated to be trained. Institutionally, physical space was available for evidence lockers and to conduct exams. What was not initially appreciated, but later proved to be a valuable asset, was that clinic staff was fundamentally supportive of the idea of compassionate care of sexual assault victims.

Strategies for change were thoughtfully outlined and initiated very slowly over a period of several years before success was achieved. Very high standards were set for each aspect of the program's implementation and success at one stage was achieved before moving on.

Conclusions

Sustainability

Sustainability of the SANE program will always be a challenge and require ongoing monitoring. The initial success on campus, in the community and its reputation among other universities should motivate the clinic to continue to offer support. The neutral to positive financial impact to the clinic ought to prevent the clinic from returning to the prior system of care which was fiscally unsound.

Dependency on one key individual for the success of any program is undesirable. In the short term, the clinic's efforts to certify two more nurses and train an additional two nurses as SANEs should ensure a steady supply of staff to share the workload. Future efforts should be

made to enlist program support at all levels in the organization. Feedback loops at various levels are an important concept in Systems Theory and could provide a mechanism for periodic examination of the program through a continuous quality improvement process (Cusins, 1994).

The organizational change effort to implement a Sexual Assault Nurse Examiner program was successful at addressing the root causes of the underlying problem and can be best described as a “planned change” (Tomey, 2004). It took change agents several years to appropriately address all the systems level issues impacting the root causes, but in the end they were adequately identified and appropriately addressed. Since there were numerous areas needing attention in this change effort, many aspects were worked on simultaneously, delegated to others, and addressed using a variety of identified internal and external resources.

Throughout this process there were many levels of commitment among the staff as described by Tomey (2004). There did not appear to be any overt resisters, though both skeptics and observers were identified. Action was taken to move skeptics along a continuum of acceptance of the organizational change and some observers became committed as incremental successes in the program occurred. From the original group of champions of the change effort there emerged an identified leader.

As outlined in Lewin’s force field analysis, this change effort required driving forces from many systems to overcome a variety of internal and external opposing forces (Baulcomb, 2003). The system level successes came from efforts to utilize effective communication, understand the organizational supports, emphasis training, and establish leadership. Throughout the process the organizational change project had relevancy to this patient population and required a complex system of interactions to advance as part of a dynamic process.

Resources

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Running Head: Independent Case Report

Independent Case Report

Evaluating Campus-based Sexual Assault Nurse Examiner Effectiveness

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Evaluating Campus-based Sexual Assault Nurse Examiner Effectiveness

Clinical Problem

Rape is a public health concern of significant magnitude in the United States and affects nearly 1 million American women annually (Resnick et al., 2000). United States Department of Justice (2006) data reveal that forcible rape accounts for approximately 6.5% of all violent crimes. The Federal Bureau of Investigation asserted that sexual assault is the least reported of all violent crimes (U.S. Department of Justice). A National Women's Study concluded that only one of five victims reported a sexual assault to law enforcement (Resnick et al.).

While victims of sexual assault have traditionally received post assault care in emergency room settings, research has shown that survivors do not receive the services they require (Campbell et al., 2006). In this setting, victims are often cared for by untrained health care providers who have been found to provide improper documentation of the sexual assault details and exam, neglect emotional needs, and participate in victim blaming (Taylor, 2002).

Historically at Oregon colleges and on most campuses nationwide, students presenting acutely following sexual assault to campus-based health centers receive fragmented and inconsistent medical care without the option of forensic evidence collection. In general, clinicians lack the knowledge to best care for sexual assault victims and more specifically, lack the specialized training necessary to collect forensic evidence that would preserve future reporting options (Patterson, Campbell & Townsend, 2006).

Sexual Assault Nurse Examiner (SANE) programs were formed in the 1970s to address the need for comprehensive sexual assault care (Campbell et al., 2005). SANEs are specially trained in forensic evidence collection, trauma response, and expert testimony (Patterson et al., 2006). The SANE's role includes providing impartial documentation of the assault, medical and

injury care, proper evidence preservation, and appropriate referrals (Ferguson, 2006; Taylor, 2002). The goals of these programs are to minimize trauma, expand use of community resources, and facilitate the investigation and prosecution of offenders (J. Cole & Logan, 2008). Taylor identifies SANEs as critical to facilitating a positive experience for a sexual assault survivor and contributing to a more rapid and adaptive resolution to the assault.

According to Ferguson (2006), advanced practice nurses are ideally suited to care for survivors of sexual assault in community-based settings given their advanced education in anatomy and physiology, physical assessment, and mental health evaluation. The purpose of this practice improvement project is to examine SANE services provided by nurse practitioners in a campus-based health center on an Oregon campus. The clinical inquiry project question is whether the provision of a physical exam, evidence collection, sexually transmitted infection treatment, emergency contraception, and referral for survivors of sexual assault presenting to the university's health center differ pre and post implementation of a SANE program.

The student leading this inquiry project is the same individual who started this campus SANE program. As the first SANE program of its kind in Oregon and one of only a few nationwide, there is significant interest in the results of such a clinical inquiry project. It is important to examine the outcome of this program, as similar programs are being implemented on other campuses. Finally, there is strong support from the Oregon Attorney General's Sexual Assault Task Force for the advancement of knowledge in the area of Sexual Assault Nurse Examiner programs in this state.

Conceptual Framework

According to Wasco (2003), empowerment can help mediate the effects of sexual violence and is a useful construct in examining comprehensive care for a sexual assault victim.

Finfgeld (2004) provides a framework (see Figure 1) that is particularly well suited to illustrating sexual victimization and the interconnection between survivor, community response, and outcomes.

Sadan (1997/2004) describes empowerment as a transition from a situation of powerlessness to a position of relative control over one's life, destiny, and environment. Critical to sexual assault is the additional tenet that this process can include either an actual or *perceived* ability to control aspects of one's life (Sadan). Furthermore, although empowerment cannot be imparted to individuals, there are means by which people can empower themselves (Wallerstein, 2006). Enhancement and utilization of internal resources that promote healthy responses to coping post assault are critical aspects of empowerment.

There are several assumed and defining attributes to empowerment theory that are pertinent to sexual assault (Finfgeld, 2004; Napier, 2006; Sadan, 1997/2004):

1. Empowerment resides in an individual. It is not a product of heredity and the potential for empowerment exists in every person.
2. Empowerment is a process that encourages internal resource utilization to strive for power sharing and participatory decision making.
3. Empowerment does not ascribe blame for powerlessness.
4. Empowerment is a dynamic process that aims to increase personal and political power of individuals or groups to improve the lives of the similarly oppressed.

Finfgeld (2004) proposes four levels of empowerment: participating, choosing, supporting, and negotiating. In sexual assault, the first level may simply be the victim's willingness to present to a clinic for post-assault care. It reflects a demonstration of courage in confronting their victimization. At the second level, survivors are asserting themselves through

shared decision making and choosing options (often regarding law enforcement reporting). This level implies a level of trust by the victim and commitment to care by the SANE to avoid revictimization. The third level requires engagement by the survivor in issues beyond his/her personal needs and may include efforts toward social activism. The lines between the organization and the oppressed may begin to blur, given the obligations of the SANE to both the survivor and community. The fourth level involves a shift in perception by the oppressed leading to a sense of justice by the victim and others. It is not always possible to achieve this aspect of empowerment. In sexual assault, it may occur at a later stage of the medical-legal process when a satisfactory outcome is achieved, which may or may not include perpetrator conviction.

The outcomes of empowerment are not always easy to define, and because it is a dynamic process, there are no absolute outcomes (Sadan, 1997/2004). Yet, the theory retains the capacity to successfully describe individuals or groups under changing circumstances. In some situations empowerment may be simply an intermediary step toward health outcomes (Wallerstein, 2006). Sometimes empowerment is merely an individual or collective effort to improve one's life and environment and it is the process that can be as important as the outcome (Sadan; Wallerstein). Empowerment encompasses a principle of self determination that should allow a victim to choose post assault care options linked to meaningful outcomes in their lives. With this in mind, empowerment theory would support the victim who chooses not to proceed with reporting an assault to law enforcement.

The concepts of empowerment theory are generalizable to sexual assault, as they are grounded in issues affecting vulnerable populations. With regard to sexual victimization, empowerment theory allows for a greater understanding of the integral connection between sexual assault and the larger ecological framework of the society in which it occurs.

Empowerment theory acknowledges the relationship between individuals and the social and political context of their lives. That is, the private and public, or the personal and the political, are intimately connected in society (Sadan).

Review of the Literature

In a National Violence Against Women survey, only 36% of victims over the age of 18 received medical care following their assault (Tjaden & Thoennes, 1998). Resnick et al. (2000) found that reporting victims were nine times more likely to receive medical care than non-reporters. Over 4 million adult women in the United States have been sexually assaulted without having ever received medical care to address rape related outcomes (Resnick et al.). Many others received care too late to benefit from pregnancy or infection prevention treatment (Patterson et al., 2006; Campbell et al., 2005).

According to the U.S. Department of Justice (2006), rape is the most common violent crime on campuses in this country. College women are vulnerable given the increase in dating and sexual relationships during this time period (Nasta et al., 2005). In an Institute of Higher Education survey, it was found that more than 25% of college-aged women reported experiences that met the legal definitions of either rape or attempted rape (Karjane, Fisher, & Cullen, 2005). Women in sororities are at even higher risk for sexual victimization than other college women (Anderson, & Danis, 2007).

Statistics from the U.S. Department of Justice indicate 2.8% of college females are victims of either an attempted or completed sexual assault in any given academic year (Fisher, Cullen, & Turner, 2000). When factored for multi-rape victims, it translates into nearly 35.3 incidents per 1,000 students (Fisher et al.). This in turn equates to approximately 350 assaults per

year on an average size campus of 10,000 (Fisher et al.). Less than 5% of these rapes will be reported to law enforcement (T. Cole, 2006).

In a study of emergency room visits for assault approximately 143,647 sexual assaults were seen in the nation's emergency rooms between 2001 and 2002 (Saltzman et al., 2007). Rape victims seen in emergency rooms have received a lower standard of care as compared to other emergency room patients (Patterson et al., 2006; Taylor, 2002). Victims of sexual assault suffer long emergency room waits; go up to 12 hours without food, drink, or toileting; and have their injuries considered less serious than other trauma victims (Taylor). Campbell et al. (2005) reported that contact with the medical system often resulted in feelings of guilt, disappointment, distrust, and a reluctance to seek further help. The experiences of victims in emergency room settings or with law enforcement often make it less likely a sexual assault victim will seek medical care or report the crime.

Forensic evidence collection is essential to efforts to pursue further investigation and prosecution. Due to complex social issues surrounding sexual assault, many offenses are never reported (Scott, & Beaman, 2004). Victims are reluctant to report an assault for fear of criminal justice system mistreatment and perpetrator retaliation (Clay-Warner, & Burt, 2005). Legal reforms have attempted to remove barriers to victim reporting through changes in evidentiary requirements, establishment of rape shield statutes, and the redefining of definitions of rape (Clay-Warner, & Burt).

Law enforcement involvement in forensic evidence collection can be a deterrent to victim consent. While Johnston (2005) reported favorable results of SANE services in one program, 72% of the victims regretted having reported to law enforcement. Findings of a National Women's Study support SANE programs that allow for the collection of forensic evidence

without the need for the victim to immediately report the assault to law enforcement (Resnick et al., 2000).

In the immediate post assault period 50% of victims have evidence of physical trauma, nearly 30% will contract a sexually transmitted infection, and up to 5% become pregnant (Resnick et al., 2000). Over the years, sexual assault victims have been found to have 2.5 times higher utilization of medical services than non-victims for such things as chronic illnesses and self-destructive behavior (Resnick et al.).

The National Institute of Justice's report, *Sexual Assault on Campuses: What Colleges and Universities Are Doing About It* (Karjane et al., 2005) lists the provision of SANE services as one of the most promising practices of the report. The Attorney General's Sexual Assault Task Force *Guidelines for Comprehensive Sexual Assault Response and Prevention on Campus* (2006) recommends medical providers treating victims of rape obtain sexual assault specific training and that forensic evidence be collected by certified SANEs.

A 2003 study funded by the National Institute of Justice evaluated the efficacy of SANE care on medical care, victim services, law enforcement and prosecution (Crandall, & Helitzer, 2003). The results support SANE programs as having a positive impact on the quality of medical services, including provision of emergency contraception and sexually transmitted infection prevention. In addition, a superior quality of forensic evidence was collected, enhancing law enforcements work and increasing the conviction rate and length of sentencing (Crandall, & Helitzer; Plichta, Clements, & Houseman, 2007; Stermac, Dunlap, & Bainbridge, 2005). Another study of 515 forensic evidence kits found that SANEs were more accurate and complete in the performance of evidence collection as compared to either non-SANEs or physicians (Sievers, Murphy, & Miller, 2003).

Campbell et al. (2005) noted that SANE programs in existence less than 5 years were more likely to have been created to provide better medical care as compared to older programs that were initiated as a result of physician resistance to testifying. Another study found that attending to a victim's emotional needs, supporting empowerment of survivors, and changing community reactions to rape survivors were the most important values to many SANE programs (Patterson et al., 2006).

Presently, research examining the actual clinical practices of SANE programs is limited (Campbell et al., 2005; Patterson et al., 2006; Sievers, Murphy, & Miller, 2003; Stermac et al., 2005). In addition, there has been insufficient research on the function of programs providing sexual assault services over time (Campbell, 2005). Research is needed to examine emerging SANE programs to evaluate current service provision as compared to the goals of the initial programs (Patterson et al.). Historically, many sexual assault victims on campuses choose not to report an assault. Resnick et al. (2000) stresses the importance of gathering data on non-reporting victims to better understand the full spectrum of assault victims. Campbell et al. (2005) emphasizes the need to examine innovative programs that address sexual assault care, including campus-based SANE programs.

According to Stermac et al. (2005), although SANE programs are slowly developing and their clinical usefulness has been reported, there remains a lack of empirical research in this field. Even as the scope of practice for SANEs has become better defined, research on actual evidenced-based SANE practices is missing (Stermac et al.). Ledray (2005) stresses the need for a scientific examination of the impact of SANE programs. Since its inception in 2005, the *Journal of Forensic Nursing* has published no articles on SANE services in campus-based

healthcare settings. A review of the *Journal of American College Health* from 2003-2008 reveals an absence of articles on SANE programs at the university level.

Other Evidence

In Oregon, passage of HB2154 in 2007 legislates a major change in practice with regard to sexual assault care. This legislation allows victims of sexual assault to consent to the collection of a rape kit regardless of whether the victim reports the assault to law enforcement (Attorney General's Sexual Assault Task Force [AG's SATF], 2007). HB2154 will ensure that the collection of a forensic evidence kit is done in a manner that protects the victim's identity (Oregon State Legislature, 2007).

The bill further outlines the conditions under which the Department of Justice will reimburse medical providers for sexual assault examinations and thus, eliminate charges to the victim for these services (Oregon Department of Justice, 2003). This bill was designed to promote the preservation of valuable forensic evidence through the immediate collection of a rape kit (AG's SATF, 2007). Should a victim later decide to report the assault, law enforcement and prosecutors would then have access to evidence that could potentially contribute to a successful investigation and prosecution (AG's SATF). Eliminating law enforcement authorization of the SAFE kit under this law provides survivors the option of having evidence collected while giving them time to come forward in the aftermath of a sexual assault (AG's SATF).

Summary

The literature suggests that SANE services are a superior means of providing post-assault care to victims of sexual assault. University settings are home to a group of individuals at high risk of sexual assault. Providing limited services by untrained health care professionals or

deferring responsibility for care of rape victims to local emergency rooms does not reflect best practice medical care for the students attending these institutions. Survivors of sexual assault deserve to be offered a comprehensive range of post-assault services on campus. Implementing SANE services in a non-emergency room setting offers the potential to expand the provision of comprehensive, compassionate post-assault care while still preserving all options for a victim of sexual assault who may desire forensic evidence collection.

Ultimately, SANE services aim to influence the empowerment process in sexual assault and the social structure in which this powerlessness exists. It starts with a SANE program philosophy that acknowledges a process that may begin with a perpetrator's advanced planning, use of coercion or force and search for a vulnerable victim. It includes understanding a victim's survival strategies, decisions to disclose, seek help, and attempt to cope (Wasco, 2003). It encompasses an awareness of societal responses that may include both victim blaming and relieving the perpetrator of responsibility.

As efforts are made to document the value of evidenced-based practices for SANE programs in general, there is an even greater need for research on the effectiveness of campus-based SANE programs. With only 15% of sexual assaults reported to law enforcement, the public, and more specifically universities, must question the safety of their communities and researchers must identify programs that can impact this pattern of violence. This clinical inquiry project is an opportunity to fill a gap in the available research on the effectiveness of SANE services in college-based clinic settings. As this gap in research is filled, university health centers will have further evidence to support the establishment of SANE programs to better meet the needs of the students they serve.

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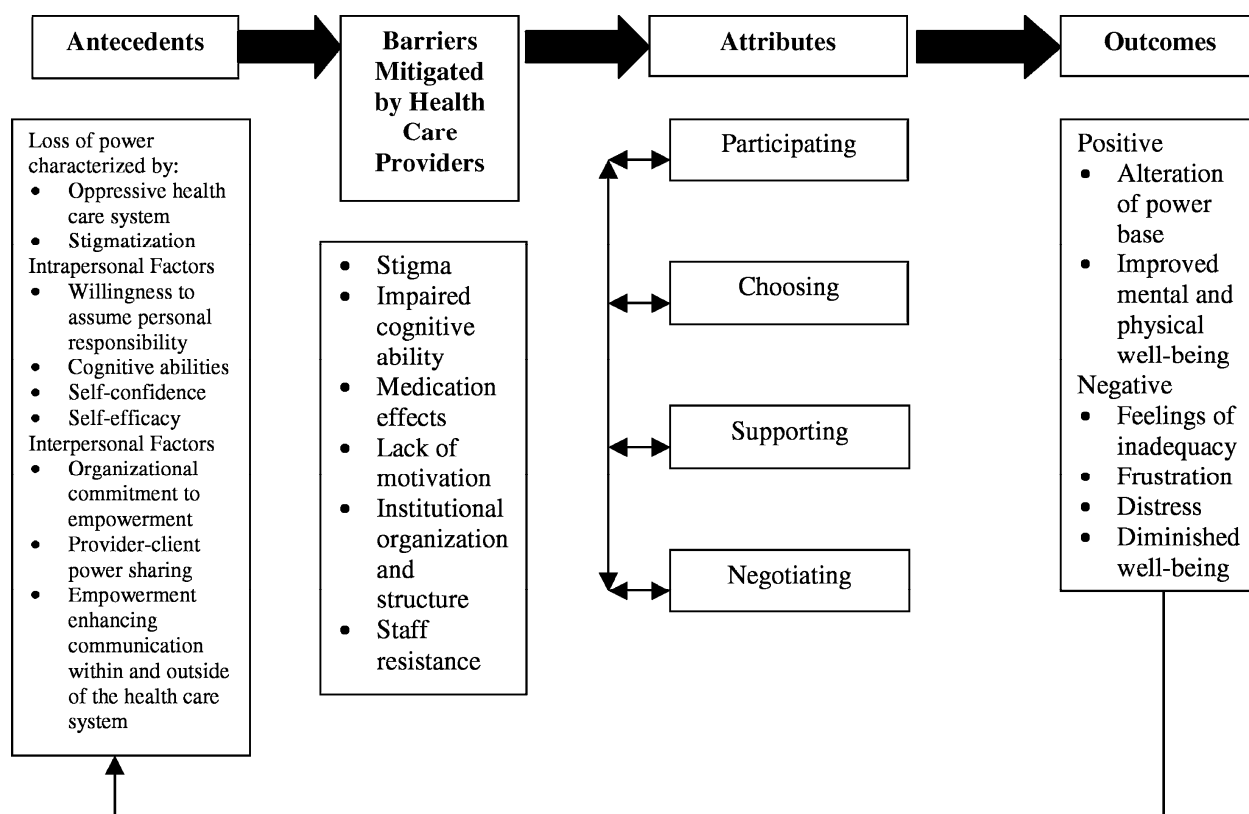
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Appendix A

Figure 1. Empowerment Model for Individuals: interconnection between survivor, community response and outcomes in sexual victimization.



Note. From “Empowerment of Individuals With Enduring Mental Health Problems: Results from concept analyses and qualitative investigations,” by Deborah L. Finfgeld, 2004, *Advances in Nursing Science*, 27(1), p, 49. Copyright 2004 by Lippincott Williams & Wilkins, Inc.

Appendix B

Synopsis			Findings		Clinical Applicability
Citation Author & Year	Clinical Question Hypothesis, Variables under study	Design Design Sample Population Would you change anything?	Credibility Rigor in data collection & analysis	Significance Statistical & clinical significance Level of Evidence	Applicability To whom and under what situations could findings apply? Can these be applied to your inquiry?
Acierno, Resnick, Kilpatrick, Saunders & Best, 2000	What are the risk factors for rape, physical assault, and PTSD	4,009 female adults Change: include more diversity and low educational level respondents	Highly structured telephone interview to collect multivariate data. Excellent sample size. Low attrition rate in study. Analysis: determined odds ratios utilizing sound analytical methods.	Level: VI: Longitudinal study. Statistically significant results utilizing odds ratios. Clinical significance: No new ideas. Adds to the body of research in this area.	Females, > 18 years of age. No significant contribution to clinical inquiry.
Campbell et al., 2005	Examination of SANE organizational features: program history, structure, goals and community relationships.	110 randomly selected SANE programs nationwide. Phone survey. No change. Excellent effort to increase response rate compared to other studies.	Investigators followed research validated telephone interviewing methodology. Utilized a survey tool with documented high reliability. Analysis presented for entire sample and then significant differences as a function of length of program existence. Utilized means, standard deviations, and percentages of SANE programs' structure, function, and operation.	Level VI: Qualitative study.	Applicable to SANE programs serving non-pediatric sexual assault victims. Helpful historical data regarding existing SANE programs in the U.S.

Synopsis			Findings		Clinical Applicability
Citation Author & Year	Clinical Question Hypothesis, Variables under study	Design Design Sample Population Would you change anything?	Credibility Rigor in data collection & analysis	Significance Statistical & clinical significance Level of Evidence	Applicability To whom and under what situations could findings apply? Can these be applied to your inquiry?
Campbell, 2005	Do victims receive the services they need? How are they treated by social system personnel in these contacts? What is the impact of these interactions on women's psychological well-being?	81 female rape survivors seeking follow-up care over a six month period at two large, urban emergency room sites. No change.	Extremely high participation rates from both hospitals. Thorough data collection procedures. Comprehensive data elicited from respondents with follow up validation data collected. Kappa statistical analysis demonstrated excellent inter-rater agreement and statistically significant results in many areas. Lower kappa statistical score results were discussed in detail with pertinent analysis.	Level: VI: Descriptive qualitative study. Statistically significant results found in service delivery evaluation. Clinically important results regarding rape victim re-victimization in the legal system.	Female rape victims seen for follow up care in emergency rooms in urban locations. Very pertinent to clinical inquiry with regard to sexual assault victim's experiences with law enforcement.

Synopsis			Findings		Clinical Applicability
Citation Author & Year	Clinical Question Hypothesis, Variables under study	Design Design Sample Population Would you change anything?	Credibility Rigor in data collection & analysis	Significance Statistical & clinical significance Level of Evidence	Applicability To whom and under what situations could findings apply? Can these be applied to your inquiry?
Campbell et al., 2006	Evaluated the consistency of Sexual Assault Nurse Examiner (SANE) services among different programs.	Population: 110 of 288 identified SANE programs. Excellent sampling of a broad range of SANE programs. Extensive efforts to identify SANE programs in the U.S. Same national survey data used in Campbell et al., 2005 article. No change	Investigators followed research validated telephone interviewing methodology. Utilized a survey tool with documented high reliability. Two data analysis programs used. Very detailed analysis results provided. .	Level VI: Qualitative study. Statistically significant results found ($p < .0001$) Clinically important variations in SANE program services identified.	Non-pediatric sexual assault victims. Largely reflective of emergency room Sexual Assault Nurse Examiner (SANE) programs which provides data for comparison in clinical inquiry.

Synopsis			Findings		Clinical Applicability
Citation Author & Year	Clinical Question Hypothesis, Variables under study	Design Design Sample Population Would you change anything?	Credibility Rigor in data collection & analysis	Significance Statistical & clinical significance Level of Evidence	Applicability To whom and under what situations could findings apply? Can these be applied to your inquiry?
Clay-Warner & Burt, 2005	Has the overall likelihood of rape reporting changed since the advent of reforms? Has the gap between the reporting of simple and aggravated rape narrowed since the passage of statutory reforms?	Population: 8,000 participants in the National Violence Against Women Survey representing a total of 824 rapes. Change: would have tried to survey persons that may not have access to a telephone.	Data: Randomly administered telephone survey. Control variables used in survey. The study looked at victim data which is more likely to reflect rape statistics as compared to official data, as most assault victims do not report to law enforcement. Scholarly analysis.	Level: VI Results statistically significant $p < 0.05$ with odds ratio reflecting significant effects of reforms on reporting behaviors. Study is limited by the need for recollection of a prior history of assault, i.e. memory decay. Clinical significance: Study adds to previous body of research that suggests reforms have been partially successful in changing victim reporting behavior.	Applicability: Females, >18 years of age Very relevant: Study is useful to clinical inquiry as it is very pertinent in supporting that legal reforms have been successful in increasing the post assault reporting rate. Only national representative survey of its kind.

Synopsis			Findings		Clinical Applicability
Citation Author & Year	Clinical Question Hypothesis, Variables under study	Design Design Sample Population Would you change anything?	Credibility Rigor in data collection & analysis	Significance Statistical & clinical significance Level of Evidence	Applicability To whom and under what situations could findings apply? Can these be applied to your inquiry?
J. Cole & Logan, 2008	Do SANE programs and SANE's experience conflict with victim advocacy groups regarding roles, professional boundaries, and working relationships? What is the nature and frequency of any such conflicts?	231 randomly selected SANE programs out of a total of 549 in the U.S. Survey of 231 SANE program coordinators conducted between Feb. and Aug., 2005. No change.	Data: Randomly selected non-overlapping sample (50% of all U.S. programs drawn by state) with 95.6% of the sample responding. Strong piloting phase for measures and reliability maintained at 90% or higher on a minimum of 20% of respondents. SANE coordinators were surveyed at each participating program Scholarly analysis.	Level IV Data analysis: quantitative, and consisted of simple response percentages from SANE Coordinator surveys, along with descriptive data regarding the services provided by participating SANE programs reported by percentage. No statistical analysis of data was done. Survey responses and descriptive data were used to form recommendations regarding potentially effective conflict resolution strategies with victim advocacy groups and for recommendations on increasing effective SANE program practices	SANE and SART program coordinators, SANEs, and other professionals and volunteers engaged in victim advocacy and sexual assault support services. The information is very relevant as effective coordination or services with stakeholders involved in various aspects of sexual assault and service provision (SANEs, advocates, law enforcement, etc.) is key to successful post assault care.

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Flowe., Ebbesen, & Putcha-Bhagavatula, 2007	Are women with more extensive sexual histories more likely to report rape?	Population: Two study groups: First, 217 female undergraduates. Second, 97 college women and 36 prostitutes, exotic dancers and women in alcohol/drug treatment Change: Keep college students separate from other community members.	Data collection: Complex scenarios utilizing participant control of choices in decision making. Analysis lacked sophistication.	Level VI Results not statistically significant. Clinical significance: limited by use of scenarios rather than review of real rape cases for false reporting rates. No new information. The effect of sexual experience on rape reporting could not be determined. Less generalizable to sex workers, exotic dancers, and women in alcohol/drug treatment given small sample size studied.	College aged women with varied sexual histories. Clinical Inquiry: Helpful explanation of rape shield laws limiting the introduction of victim sexual history in rape trials, which is pertinent to the physical exam portion of the clinical inquiry. Actual study results less applicable to clinical inquiry.
Humphrey & White, 2000	What are the risk factors for future victimization in college aged women?	1,569 randomly selected female university students ages 18-20 at the start of the study. No change.	Data collection: Reliable and relevant survey tool utilized. Limited by recall bias, though efforts made to overcome this. Subjects followed for five years with low attrition rate. Analysis: Three sets of analysis performed using sound methods.	Level VI: Longitudinal study Statistically significant results. Clinical significance: Important victimization risk factors identified. Important population of study.	Undergraduate students in state-supported universities. Clinical Inquiry: Applicable study. The lack of reporting of assaults by college aged women is integral to the clinical inquiry project population.

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Johnson., 2005	<p>What are the valid quality indicators for evaluation of the care and treatment of sexual assault?</p> <p>Comparison of identifiable structure, process, and outcome indicators in a community SART program</p>	<p>Study done in a single community-based SART program (N=1).</p> <p>Archival records review and follow-up telephone survey on 17 female sexual assault victims served by the SART during 2003 - 2005</p> <p>Change: Consider adding more programs for comparison analysis.</p>	<p>Study uses 3 surveys with items adapted from Ledray's SANE Operational Guide (1999). Although not validated, the surveys had been used in other SART program evaluations, and were reviewed for completeness and accuracy by a university nursing faculty expert on SART/SANE.</p>	<p>Level IV</p> <p>Analysis is quantitative.</p> <p>Statistical significance: Simplistic, descriptive analysis</p> <p>Clinical significance: excellence information for program evaluation.</p>	<p>Has direct applicability to SANE/SART program goals of providing effective and comprehensive sexual assault response services to victims. Similar to goals of the SANE program to be studied in the clinical inquiry.</p>

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Loh, Gidycz, Lobo, & Luthra, 2005	What are the risk factors for sexual assault perpetration?	325 undergraduate men Change: Would have used multiple sites to increase sample size and diversity of study participants.	Several validated scales were used for data collection. Very thorough and scholarly data analysis.	Level VI: Retrospective and prospective study. Results statistically significant with regard to predictors of sexually aggressive behavior in young males. Clinical significance: helpful information for use in a college-based SANE program.	Applies to college men. Not applicable to clinical inquiry. More valuable in sexual assault prevention programs for men.
McGregor, Le, Marion, & Wiebe, 1999	Is the documentation of physical injury associated with a positive legal outcome in cases of sexual assault?	Population: 95 of 114 cases of sexual assault with a police report from one sexual assault clinic. Change: Add comparison populations from other jurisdictions. Would not include child sexual assault with adult sexual assault. Should be a separate study.	Lacks rigor. Data collection: Injury scoring system designed by four physicians. No mention of the validity of this scoring system. Injury evaluation done from review of records rather than at the time of actual patient encounter, which could limit the accuracy of the injury evaluation.	Level IV: Retrospective cohort study. Statistically significant results ($p < .001$) using regression analysis. Clinical significance: Supports the myth that injury=assault and non-injury=no assault within the confines of the judicial system. Old study.	Applies to sexual assault victims > 10 years of age of either gender reporting an assault to law enforcement. Supports the role of documentation of a physical exam in sexual assault which is a key component of the clinical inquiry. Limited in generalizability as most assaults have no injury. Includes children younger than those to be evaluated in clinical inquiry.

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Nasta et al., 2005	Assess sexual victimization of college women and use of campus resources.	Design: Cross-sectional survey design. 234 upper-class undergraduate women at a private northeastern university. Changes: Would have surveyed a broader group of students.	Rigor: Convenience sample. Pilot study preceded final study. Data Collection: Written, confidential questionnaire. Analysis: Fisher's exact test.	Level VI Statistical significance: Not all results statistically significant. Clinical Significance: Reaffirms many prior studies regarding underreporting of assaults.	Applicable to private university, undergraduate students. Helpful background data on college women experiences with sexual violence, though limits on generalizability.
Patterson, Campbell, & Townsend., 2006	Do SANE program goals and philosophy's affect patient care practices for sexual assault victims?	Same 110 SANE programs sampled in the Campbell et al., 2005 and Campbell et al., 2006 studies above. No Change.	Different data than analyzed by Campbell focuses on three sections of a larger study of ten topics regarding SANE programs. Carefully constructed data collection tool based on prior national sampling surveys. Data analysis subjected to reliability and testing with confirmed results. No Change.	Level: VI Four of five variables studied showed statistical significant ($p < 0.5$). Clinical significance: Important to the understanding of the impact a SANE program's philosophy on sexual assault patient care practices.	Sexual assault victims seeking follow up care at a facility with a SANE program. Very applicable to clinical inquiry. Demonstrated that prosecution motivated SANE programs less comprehensive in sexual assault services compared to SANE programs with emphasis on victims well being.

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Plichta, Clements, & Houseman, 2007.	How do the structural and process characteristics of SANE service provision affect the quality of the services provided in hospital emergency room settings? Examines the characteristics of emergency rooms and their associated models of care.	65 out of 82 emergency rooms (76%) in Virginia were surveyed. No change.	Survey was developed using current research and materials from several authoritative experts in the areas of sexual assault treatment, SANE programs, emergency room operations and services, and other relevant sources. The survey has not been validated. The analysis was thorough and scholarly.	Level VI Statistical analysis of results using Kruskal-Wallis H-test and Fisher's exact test. Statistical analysis tests are supposed to be similar to Chi-square and ANOVA. Some results presented were statistically significant. Clinical Significance: Results indicate that emergency rooms offering full-time SANE services were significantly more likely to provide essential support and treatment to sexual assault victims across a range of needs.	Applicability: Emergency rooms providing SANE services. The implication for this study is that a service organization's commitment to maintaining a full-service SANE improves the likelihood that essential and effective services will be available and utilized and outcomes for patients will be much improved. Useful to clinical inquiry to understand current SANE programs.

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Resnick et al., 2000	What proportion of adult rape victims in the U.S receives timely medical care regardless of injury status and formal reporting status?	Population: 3,006 adult women enrolled as part of a larger National Women's Study Change: include more diversity and lower educational level respondents.	A survey research firm conducted all sampling and interviews. Four stages of sampling construction utilized. Excellent sample size. Sound statistical analysis using multivariable logistic regression.	Level IV: Cross-sectional, longitudinal study. Statistically significant results show a positive correlation with reporting to law enforcement and fear of sexually transmitted disease ($p < 0.05$) as being strong indicators of victims receiving post-rape medical care. Clinically important to better understand victims motivations for seeking medical care post assault.	Applies to adult, female, victims >18 years of age. Investigation results apply significantly to the clinical inquiry question as they support public health efforts to increase the proportion of rape victims receiving immediate post rape medical care.

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Saltzman et. al., 2007	Descriptive analysis of sexual assault cases treated in emergency departments and analysis of the services and associated health care burden.	Nationally representative sample of hospitals (66/100) accessing records of 62,093 hospital emergency room patients and 3,893 non-fatal sexual assault victims for the years 2001 & 2002. Rates calculated per 100,000 population from 2001-2002 U.S. Census estimates. No Change.	Study utilized a stratified probability sampling strategy. Data was archival and the records for 2002 were reviewed by 4 of the 6 authors for accuracy and reliability. A direct variance estimation procedure was used to calculate 95% confidence intervals and account for the complex sample design	Level IV. Results are descriptive and quantitative. Results statistical significance. Clinical significance for hospital emergency room SANE programs.	The findings are applicable to emergency room SANE programs regarding the description of the number and type of sexual assault services rendered in emergency room settings and the associated costs and burdens they place on the providers. Helpful background data on other types of SANE programs than that being studied in the clinical inquiry.

Synopsis			Findings		Clinical Applicability
Citation Author & Year	Clinical Question Hypothesis, Variables under study	Design Design Sample Population Would you change anything?	Credibility Rigor in data collection & analysis	Significance Statistical & clinical significance Level of Evidence	Applicability To whom and under what situations could findings apply? Can these be applied to your inquiry?
Scott & Beaman, 2004	Do demographic or situational factors affect injury, victim resistance, completion of assault and charges?	Population: 108 sexual assault victims reporting to a police department during a six month period. Change: limit study to adult patients. Caucasians overrepresented. Would diversify study population.	Lacked rigor in data collection: Relied on estimates if some data missing. Physical injury measured from victim reports rather than from physical exam documentation which is likely to be unreliable.	Level VI Not all results statistically significant. Clinical significance limited as information less likely to be accurate from victim reports, as compared to objective documentation by a medical provider.	Female rape victims >13 years of age, reporting to law enforcement. Lacks pertinence to clinical inquiry given lack of rigor. Unusually high number of stranger rapes included (43.5%) which limits generalizability.
Sievers, Murphy, & Miller, 2003	Do SANEs provide more effective, accurate, and complete evidence collection compared to non-SANE trained physicians and nurses?	515 sexual assault evidence kits submitted to 3 Colorado Bureau of Investigation laboratories between Oct. 1999 and April, 2002. No Change.	Data was archival and consisted of the information provided by the evidence collection kits. Data was subjected to an audit designed by the forensic lab and the state SANE coordinator that evaluated completeness, chain of custody, accuracy, and detail. Audit seems likely to be reliable as it was conducted by forensics experts without apparent bias for or against SANE or non-SANE kit providers.	Level VI Audit questions were analyzed by using cross-tabulations, Pearson, Chi-Square, and percentage. Of the results, 9 of 10 audit questions were statistically significant and 8 of 10 had clinical significance indicating that SANE prepared kits were more timely, complete, detailed, and accurate than those prepared by non-SANE providers.	Findings are applicable to all settings and situations involving sexual assault evidence collection. Pertinent to clinical inquiry which aims to compare evidence collection among SANEs, non-SANEs and physicians.

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Stermac, Dunlap & Bainbridge, 2005	Description of SANE services and practices	Descriptive, exploratory study of a hospital-based SANE program (N=1). Archival records review and analysis of 1,018 female sexual assault victims using the SANE services at the clinic between 1998 and 2001. No Change.	Data drawn from intake records and medical exam records. Medical chart review data likely to be reliable as documentation comes from medical staff rather than victim reports, and the retrospective records reviews were preformed by medical staff and collected by trained research assistants.	Level VI Descriptive, exploratory study. No statistical significance calculated. Clinical significance: valuable given large number of records reviewed. Limitation: participants drawn from a single setting and as such the results may not be generalizable to other demographic populations.	Applicable to all SANE programs as best practice guidelines for evidence collection are the same regardless of setting. Valuable as a source of validation for other descriptive studies examining SANE services and practices. Adds to the literature base and understanding regarding SANEs which is important to clinical inquiry.
Telsavaara, T.& Arrigo, B., 2006	What is the soundness of the 2004 "Justice for All" Act addressing the backlog of DNA evidence from rape cases?	Federal backlog of DNA evidence kits sitting in crime laboratories around the country.	No data collection or analysis. Outstanding review of a pivotal piece of legislation that greatly impacted the growth of SANE programs in this country and the subsequent impact on law enforcement, court systems, corrections, and juvenile justice	Level VII No statistical analysis. Article is a legislative review and opinion piece. Clinical significance: Understanding of this piece of legislation illuminates the history behind the multidisciplinary approach to sexual assault follow-up.	Applies to all sexual assault victims in the U.S. that have had rape kits collected. Very applicable to clinical inquiry. Addresses a pivotal piece of federal legislation affecting rape kit collection that is pertinent to clinical inquiry.

Running head: SEXUAL ASSAULT

Sexual Assault and Confidentiality: An Ethics Case Study

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Abstract

Confidentiality is a critical aspect of patient care. In forensic nursing ethical dilemmas in confidentiality can arise when conflict exists between respecting a patient's confidentiality and protecting the public's safety. An ethics case model can be useful in reviewing a clinical case to help guide an appropriate course of action. This paper examines a sexual assault case in which a victim chose not to report to law enforcement, yet the Sexual Assault Nurse Examiner identified potential public safety concerns.

Sexual Assault and Confidentiality: An Ethics Case Study

Introduction

Confidentiality is a critical aspect of patient care. In forensic nursing ethical dilemmas in confidentiality can arise when conflict exists between respecting a patient's confidentiality and protecting the public's safety. Most clinical settings are guided by the Health Insurance and Portability and Accountability Act (HIPAA), which allows for disclosure of protected health information under rare circumstances in some sexual assault cases. By contrast, university-based health centers operate under the Family Educational Rights and Privacy Act (FERPA). FERPA legislation is primarily designed to protect the academic records of a student and is less well suited for guiding clinical care.

This paper reviews an ethical case involving confidentiality with a sexual assault victim seeking care at a university-based health center. Jonsen, Siegler and Winslade (2006) provide a practical technique utilized here for reviewing an ethical conflict in clinical medicine. Jonsen et al. outline four topics- medical indications, patient preferences, quality of life and contextual features that are essential to review in every ethics case.

Case and Dilemma

Mary (not her real name) is a 20 year old college student presenting to her university's health center for evaluation following a sexual assault. She is accessing services at the encouragement of friends. The previous evening she consumed multiple shots of alcohol over a two hour period. After midnight, while walking home alone, she is startled by a stranger, pushed to the ground, and raped. Following the assault, she

returned home, did not seek care at the local emergency room, and did not report the incident to law enforcement.

Mary's arrival 12 hours post-assault is well within the 84-hour time frame which allows for the collection of forensic evidence. Under state law at the time, a Sexual Assault Forensic Evidence (SAFE) kit can only be collected with the consent of law enforcement, requiring the Sexual Assault Nurse Examiner (SANE) to notify the local police department. After completing an initial history, Mary receives a medical exam, emergency contraception, sexually transmitted infection prophylaxis, as well as multiple referrals to support services on campus and in the community

Within a few days of Mary's initial visit, a local newspaper runs an article about another student reporting an attempted rape to law enforcement. This incident occurred in the same vicinity that Mary describes her assault as taking place. In light of this development, what is the Sexual Assault Nurse Examiner's obligation to share confidential patient information regarding a sexual assault when the victim declines to report to law enforcement and a potential serial rapist at large in the community?

Review of Topics

Medical Indications

Upon presentation, Mary appears alert, oriented, and competent to make her own medical decisions. She carries a bag of clothing worn the night before, appears disheveled, and has visible abrasions. Though she is cooperative, her affect is flat and she exhibits very little eye contact, talking no more than to simply answer the SANE's questions. Mary is initially screened for mandatory reporting which includes any victim that is mentally ill or disabled, less than 18 years of age, elderly, or assaulted with the

use of a deadly weapon (Attorney General's Sexual Assault Task Force Medical Forensic Committee, 2006). Mary meets none of the screening criteria.

Patient Preferences

Though Mary does not have to report to law enforcement to access state funds to pay for the cost of her care, at the time of Mary's visit, state law did stipulate that she must consent to reporting to law enforcement in order for a SAFE kit to be obtained for evidence collection. Upon learning this information, Mary indicates she no longer wants to have forensic evidence collected. Mary acknowledges understanding that time-sensitive evidence will be lost if she chooses not have a SAFE kit collected at this time. Though she declines the forensic evidence collection, she agrees to a full medical exam.

Quality of Life

Mary's quality of life has the potential to be affected in both the short and long term. Upon presentation she is clearly traumatized. Her affect suggests potential for depression and post traumatic stress disorder. Given the violent nature of the assault and her demeanor, Mary appears to be in a fragile state. Any decision to involve law enforcement has serious consequences with regard to the victim's confidentiality, and it is clear from her behavior that she wants the details of this assault kept private. Once in the legal system, the potential for much more information to become available to multiple parties is possible. In Mary's situation, this could be especially difficult for her to handle.

Contextual Features

Though the SANE tries to provide a victim-centered approach to care, it is likely the knowledge of the second report of an alleged rape unduly influences the SANE's desire to see this crime reported. It is probable that the SANE suspects that the most likely outcome of sharing this information with the victim is to have her consider talking with law enforcement, which in fact is exactly what happens. The SANE's role in terms of any legal obligation to report to law enforcement is not fully understood as these events unfold.

Case Analysis

Mary sought care at a university health center. Consequently, her medical records fall under the guidance of the federal Family Educational Rights and Privacy Act (FERPA) rather than the Health Insurance and Portability and Accountability Act (HIPAA). Since Mary is over 18 years of age, FERPA requires written permission from Mary, not her parents, to release any information from her educational record, including her medical record (U.S. Department of Education, 2007). FERPA allows for the disclosure of records without consent in such cases as a judicial order or subpoena, health and safety emergency, or in conjunction with the juvenile justice system (U.S. Department of Education). The threat of a potential serial rapist in the community does not clearly qualify as a rationale to breach confidentiality under FERPA. This federal legislation, intended to monitor access to student's academic records, is difficult to interpret in complex situations involving higher education medical records at campus-based healthcare facilities.

If Mary reports the assault to law enforcement the burden of determining the significance of an alleged second assault in the community falls on law enforcement, eliminating the dilemma for the nurse regarding a breach in confidentiality. Given the many complicated scenarios that can occur in any sexual assault case, one might conclude the best interests of the patient and the nurse are served by encouraging all sexual assault victims to report to law enforcement at the time of presentation. While convenient, this assumption, does not meet the expectations of the nurse's professional responsibilities to the patient.

Both trustworthiness and respect for patient autonomy necessitates that all the options for care are truthfully outlined to the patient (Kipnis, 2006). This is the fundamental foundation of informed consent. Forensic evidence collection is not only very invasive, but involves the collection of DNA material, the most personal of patient data. A victim-centered approach to sexual assault care requires the patient be in control of the decision making process with regard to both evidence collection and law enforcement reporting as long as no legal requirements for mandatory reporting exist (Attorney General's Sexual Assault Task Force, 2006).

Sharing information is a difficult decision with respect to confidentiality. In a landmark California Supreme Court ruling, *Tarasoff v. Regents of the University of California*, 551 P.2d 334, 131 Cal. Rptr. 14 (1976), the court ruled that with regard to confidentiality, "the protective privilege ends where the public peril begins" (Gostin, 2002, p. 11). Supportive of this interpretation, Jonsen et al. (2006) advises that since not all jurisdictions accept the Tarasoff precedent, it is prudent to seek an ethics consultation or legal advice in similar uncertain situations. Unlike the Tarasoff case,

Mary's case has no single, identifiable third party at risk of injury that which would require consideration of direct notification of law enforcement.

Despite the serious nature of the circumstances surrounding this assault and the desire to prevent further public harm, a breach in confidentiality is not the only potential course of action available. In Mary's case, the concerns regarding law enforcement notification were resolved through a course of action that might be summarized as the *deliberative* model of a provider-patient relationship (Balint, 2006). Balint explains that a deliberative approach to interacting with a patient assumes a respectful, collaborative, patient-provider relationship exists that analyses the information at hand and results in a joint decision. In this situation, the patient's initial decision to not report is respected. As new information became available it is shared with the victim, eventually resulting in a patient-driven decision to disclose to law enforcement. The critical limitation to this approach is the loss of forensic evidence that occurs with delayed reporting.

Ethical dilemmas regarding confidentiality can arise when there is a conflict between respecting a patient's confidentiality and the need to disclose patient information (Beech, 2007). In such cases, the principles of absolute versus limited confidentiality are at odds. For the clinician, the desire to protect the patient must be weighed against the need to protect the public from peril (Abbo & Volandes, 2006).

In *A Defense of Unqualified Confidentiality*, Kipnis (2006) maintains that unqualified confidentiality is the only effective means of protecting third parties in a healthcare setting. Kipnis asserts that a duty by clinicians to warn third parties does not necessarily afford added protection to those at-risk contending, that a no-exceptions confidentiality rule has a higher likelihood of encouraging patients to be forthcoming

about health information. This is based on the premise that the potential for a breach in confidentiality by a medical provider informing a third party risks deterring future patients from disclosure. Underlining this argument is an interpretation of the priority rule to “do no harm,” implying that patient autonomy trumps all other concerns (McGregor, 2006).

An opposing and more conventional wisdom regarding ethics in medical confidentiality suggests that confidentiality is “a stringent, but not unlimited, ethical obligation” (Jonsen et al., 2006, p. 172). Jonsen et al. outline two justifications for the exception to confidentiality: concern for the safety of a specific person and concern for the welfare of the public. Such an approach is illustrated by the Tarasoff ruling in which the court identified the duty to protect an endangered third party as superior to the protective privilege to patient confidentiality when the potential for serious public harm exists (Gostin, 2002).

Implications for Clinical Forensic Nursing Practice

Both the American Medical Association and the American Nurses’ Association recognize exceptions to patient confidentiality in their respective Code of Ethics (American Medical Association House of Delegates, 2006; Cochran, 1999). These codes acknowledge the complex nature of patient confidentiality issues. In the end, a nurse’s duty to patient confidentiality must be carefully weighed against a possible greater obligation, in rare circumstances, to disclose information to third parties.

This ethics case study illustrates the need for Sexual Assault Nurse Examiners to understand the legal requirements of confidentiality. Sexual Assault Response Teams consisting of nursing, law enforcement, prosecution, and advocacy personnel are an excellent forum to discuss the limits of each member’s confidentiality when faced with a

sexual assault case. Written protocols addressing confidentiality and consent that adhere to institutional and state laws should be developed collectively.

While campus-based health clinics are subject to confidentiality requirements, U.S. Department of Education FERPA regulations differ somewhat from HIPPA rules and necessitate additional considerations. Sexual Assault Nurse Examiners need to become familiar with the unique aspects of these regulations at the same time remembering the essence of sexual assault care is maintaining a victim-centered approach that respects patient autonomy.

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SCHOOL OF NURSING
Ashland Klamath Falls La Grande Portland

DNP Clinical Inquiry Project Report & DNP Portfolio Approval

Student Name: CYNTHIA SMITH

Degree: Doctor of Nursing Practice

Title of Study:

Evaluating Campus-based Sexual Assault
Nurse Examiner Effectiveness

APPROVED:

Committee Chair: KATHERINE Crabtree Signature: Katherine Crabtree
(name and credentials) DNSc, APRN, BC, FAAN

Committee Member: MARIA Sstrom Signature: [Signature]
(name and credentials)

Committee Member: _____ Signature: _____
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Michael R. Bleich, PhD, RN, MPH, FAAN
Dean, School of Nursing

Signature: Michael R. Bleich

Date: 4/1/09

Submit completed original form to the Graduate Program office.