

**Maryland Sexual Assault Forensic Examiner
(SAFE) Programs
Statewide Needs Assessment**

*Conducted November 2002
By the Maryland Coalition Against Sexual Assault*

Introduction

Rape and sexual assault are violent crimes motivated by the intent to control, overpower and humiliate. An estimated 302,100 women and 92,700 men are forcibly raped each year in the United States¹. According to *Crime in Maryland, 2000 Uniform Crime Report*, 1,508 actual forcible rapes were reported in the State of Maryland. This represents a 2 percent increase over 1999. The highest occurrence of rapes was in Baltimore City, where 366 were reported. Baltimore County reported 240, Prince Georges reported 228, Montgomery reported 177, and Anne Arundel reported 117.

Rape is most costly of all crimes to its victims. Total costs are estimated to be \$127 billion a year in the United States, excluding the costs of child sexual abuse.² Sexual violence has an impact on the medical system, because 36.2% of rape victims who are assaulted state that they were physically injured during the attack as well. Of these women, 31% stated that they required medical care. Of the women that received medical care, 79.6% went to the hospital; 59.2% saw a private physician; 22.4% required physical therapy; 20.4% required an ambulance or paramedic to get to the hospital; and 18.4% required a dental visit.³ Hence, it is vital that hospitals be equipped and prepared to respond to the victims that come to them for help.

All SAFE programs in Maryland are located within an existing hospital. Most are located within the hospital's emergency department, which offers a secure site, and is open 24 hours a day. Physicians are available to treat victim injuries, and examiners can conduct evidentiary exams and treat victims for STIs (sexually transmitted infections) and pregnancy concerns. A Forensic Nurse Examiner (FNE) is a registered nurse, R.N. who has advanced education in forensic examination of sexual assault victims and has the ability to be an expert witness. In Maryland, FNEs work within a SAFE program to complete medical forensic examinations. Forensic examiners conduct evidentiary exams, where evidence is collected with more accuracy and precision due to their specialized training.

Sexual Assault Forensic Examiner (SAFE) Programs are important because it tells their community that sexual assault and rape are serious crimes that will be handled with the utmost care and concern for the victim and for the safety of the entire community. When trained nurse examiners are involved, studies have shown that this leads to increased prosecution. When perpetrators are held accountable and punished for their crime, this makes for a safer community.

The Maryland Coalition Against Sexual Assault (MCASA) is federally recognized as the official statewide sexual assault coalition in Maryland. MCASA is a membership organization that includes the State's nineteen rape crisis centers, criminal justice agencies, mental health and health care providers, educators, survivors of sexual violence and other concerned individuals. Established in 1982 as a private, not-for-profit 501(c)(3) organization, MCASA represents the unified voice and

¹ Tjaden, Patricia & Thoennes, Nancy. Prevalence, Incidence and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey. Washington, D.C.: National Institute of Justice, U.S. Department of Justice. 1998.

² Miller, Cohen, Wiersama, 1996. Victim Costs and Consequences—A New Look, Office of Justice Programs, Natl. Institute of Justice. Klein Associates. The 1988 Working Woman Survey Report, 1988.

³ Tjaden, Patricia & Thoennes, Nancy. Prevalence, Incidence and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey. Washington, D.C.: National Institute of Justice, U.S. Department of Justice. 1998.

combined energy of all of its members working to eliminate sexual violence in the State of Maryland through public education, training and advocacy.

During the 2001-2002 fiscal year, MCASA received a Violence Against Women Act (VAWA) grant to conduct a needs assessment of the current Sexual Assault Forensic Examiner (SAFE) programs in Maryland. Carey Goryl was hired as MCASA's SAFE/SART Coordinator to help communities with their own existing Sexual Assault Response Team (SART) or to create new ones in counties that were working without this model. In addition, this position was charged with developing and administering the needs assessment project and to help many of the recommendations become a reality. From September 1, 2002 through November 6, 2002 sixteen (16) active programs as well as four (4) developing programs were visited and assessed through an in-person interview with the SAFE program coordinator. *See Appendix A for a copy of the assessment tool.*

This report reviews the findings of the Maryland SAFE Programs Needs Assessment⁴ and includes information on the following:

- Maryland SAFE Programs – Listing of all Maryland SAFE programs along with a brief overview of each program
- Barriers and Problems Facing SAFE Programs
- The SAFE Vision – Summary of how Forensic Nurse Examiners (FNEs) envision the future of SAFE programs
- Keys Issues and Recommendations – Detailed articulation of recurrent themes identified as part of the assessment project and recommendations for next steps
- Conclusion
- Appendix

⁴ Terminology in this assessment was specifically chosen. In the immediate aftermath of a sexual assault, many survivors do not yet call themselves survivors, so the word “victim” is used intentionally. SAFE programs also do not use the word survivor; therefore, “sexual assault patient” has been used intentionally. Lastly, to honor the changes made recently by the Maryland Board of Nursing, SAFE Nurses will be referred to as Forensic Nurse Examiners (FNE). The program name, “SAFE Program,” will continue to be utilized by most hospitals, as that is the name with which the community is familiar. Therefore, this assessment will refer to the programs as SAFE programs that operate with Forensic Nurse Examiners.

Maryland SAFE Programs

Maryland currently has eighteen (18) active SAFE programs that serve 20 jurisdictions, as well as two (2) developing SAFE programs. The remaining four (4) jurisdictions, Dorchester, Garrett, Somerset and Talbot, do not have a designated SAFE program, but are affiliated with neighboring programs. It has been noted that while Franklin Square Medical Center in Baltimore does not have a “SAFE Program” it does utilize a combination of SAFE nurses and a Pediatrician to conduct evidentiary exams on acute child sexual assault cases. Below is a brief overview of each SAFE program.

Active Programs:

Memorial Hospital of Cumberland, Allegany County: The program officially began in 1999 although nurses had been trained and in dialogue with the hospital since 1995. The program currently operates with one FNE and has a partnership with Garrett Hospital to service sexual assault patients there as well. The exams are done outside of the emergency department (ED) in a separate office within the hospital, combined with the domestic violence program. The program sees a fair number of patients from West Virginia and Pennsylvania as well. The program sees acute (assault has occurred within 72 hours) and non-acute (assault occur more than 72 hours ago) sexual assault patients of all ages.

North Arundel Hospital, Anne Arundel County: The program began in May 1997. It sees sexual assault patients in the emergency department, and also has its own small office to store equipment and files. The program must set up the SAFE exam room with equipment and supplies each time there is a patient. There is dialogue beginning between North Arundel and Anne Arundel Hospital about the potential for two SAFE Programs within the same county but in differing health systems. The program sees only acute sexual assault patients 13 years and older and will assist the on-call pediatrician with acute pediatric sexual assaults.

Mercy Medical Center, Baltimore City: The program began in 1994 and serves as the largest program in the state both in terms of staff size and numbers of patients seen per year. Mercy’s SAFE Program is seen as the primary training center for Forensic Nurse Examiners. The Coordinator plays a significant role in FNE certification training and also opens Mercy’s program to outside FNEs so that they can complete their observation clinicals. The program offers photo forensic documentation to domestic violence cases, conducts suspect examinations, and in addition to working with the Baltimore City PD, also works with the US Attorney’s Office, FBI and Department of Corrections. The program has been moved several times within the emergency department during the past year as the ED has undergone renovation. The program sees only acute sexual assault patients 13 years and older.

Greater Baltimore Medical Center, Baltimore County: The program began as a joint operation with Mercy Medical Center. In 1998 these two programs separated and now continue to function as separate entities. There is one full-time Coordinator /Forensic Nurse Examiner who coordinates the program and also responds to the majority of SAFE calls. This program has a strong relationship with the county police and has made it possible for law enforcement to finish reports while waiting for the exam to be completed. The program sees only acute sexual assault patients 13 years and older.

Calvert Memorial Hospital, Calvert County: The program began in 1995 as a result of collaboration between the Calvert Sheriff Department and local Child Protective Service Program. The program was initially funded by a partnership grant with St. Mary's Hospital. After the grant term ended the two hospitals separated and continued with their own SAFE programs. The program sees acute sexual assault patients of all ages.

Memorial Hospital of Easton, Caroline County: The program began in 1997 and serves Caroline County as well as the four surrounding counties on the Eastern Shore, Dorchester, Kent, Queen Anne's and Talbot. The program lacks a designated Program Coordinator and therefore two FNEs run the program together. The program sees only acute sexual assault patients 13 years and older, but has partnered with the local Child Advocacy Center to provide non-acute forensic examination for children.

Carroll County General Hospital, Carroll County: The program began in October 1999 after several years of trying to start a SAFE program. The program now prides itself on their cohesive group of nine FNEs and expansion into a Pediatric Program within the past year. This program is also making attempts to organize the community and hopes to implement a SART team. The program sees acute and non-acute sexual assault patients of all ages.

Union Hospital, Cecil County: The program began in June 2002 after several years of training nurses, but not being able to establish a program. The catalyst for this program's development was the updated Board of Nursing regulations that stipulated only FNEs and/or Physicians are able to perform sexual assault forensic exams⁵. This means that emergency room nurses will not be able to take part in a forensic examination if they are not FNE certified by the Board. Great strides have been made in the past year to get the program (newest in the state) in full operation. The program sees only acute sexual assault patients 13 years and older.

Civista Medical Center, Charles County: The program began in 1993 as the first SAFE program in the state. The Charles Sheriff's Department approached the local crisis center and hospital after hearing about Fairfax Virginia's Nurse Examiner Program and suggested that a program be established in Charles County. The program continues to function using a SART model with monthly meetings that include FNEs, local law enforcement and the crisis center. The program sees acute and non-acute sexual assault patients of all ages, as well as in the past taking non-acute child sexual abuse cases from Calvert County.

Frederick Memorial Hospital, Frederick County: The program began in 1998 after the local rape crisis center and the hospital co-wrote a Victims Of Crime Act (VOCA) grant. The program has worked hard to lead its county's SART and has quarterly meetings with many local agencies, including local law enforcement and the rape crisis center. The program sees acute and non-acute sexual assault patients from all age groups.

Upper Chesapeake Health System, Harford County: The program began in 1997 and currently operates as a fully functioning dual system between both Harford Memorial Hospital and Upper Chesapeake Hospital. FNEs are on-call between both hospitals and share duties. The program sees only acute sexual assault patients 13 years and older, and will assist the pediatric physician with acute victims 12 and under.

⁵ Maryland Board of Nursing. Forensic Nurse Examiner Updated Regulations to be in effect March 2003.

Howard County General Hospital, Howard County: The program began in 1999 in partnership with the local rape crisis center that secured the funding through VOCA. The SAFE Program has a private room in the ER where all equipment is stored, locked, and is available to the SA patient, FNE, Advocate, and police to conduct all aspects of care to those seeking our services. FNEs are contractual employees and all are employed either full or part time by the hospital as hospital nurses. The program sees only acute sexual assault patients from all age groups.

Shady Grove Adventist Hospital, Montgomery County: The program began in 1996 with one FNE at its direction. In time, staff turnover caused the program to be put on hold for several months while a new Coordinator was secured. In the fall of 2002, a new part time Coordinator was hired and many updates and internal audits were conducted. The program sees all acute and non-acute sexual assault patients of all ages, noting a high percentage of child sexual abuse cases.

Prince George's Hospital Center, Prince George's County: The program began in 1998 and while the program struggled at first, it now operates as the second busiest SAFE programs in the state. In a unique position to be housed within Prince George's Sexual Assault Center within the hospital, this program has a close connection with its advocate/companion program. The program sees acute and non-acute sexual assault patients of all ages.

St. Mary's Hospital, St. Mary's County: The program began in 1996 in partnership with Calvert Memorial Hospital after applying jointly for a VOCA grant. Once the grant ended, the two hospitals separated their programs and funding. St. Mary's secured another VOCA grant, but with staff turnover, the program no longer had FNEs and the program was put on hold in the summer of 2002. Three new nurses have completed their training and are finishing clinicals for FNE certification. The hospital hopes to have the SAFE program fully operational by Spring 2003. Several more nurses are scheduled to begin training this spring.

Peninsula Regional Medical Center, Wicomico County: The program began in 2000 while a single nurse worked on policies and procedures and with the hospital administration. Staff turnover within the emergency department has slowed the progress towards becoming fully operational. Several other nurses have gone through training and are working on finishing their clinicals. A concern was raised that the SAFE program's medscope is owned by the Child Advocacy Center and once that center has an exam site, the SAFE program will lose their medscope. The program currently sees all acute and *some* non-acute sexual assault patients of all ages.

Atlantic General, Worcester County: A brand new program beginning in 2003, it has three nurses who have completed their training and are finishing, or have finished, clinicals through Mercy Medical Center and neighboring programs.

Developing Programs:

Kent/Queen Anne's Hospital, Ken/Queen Anne Counties: The program began in 1997 when the hospital created its Forensic Care Services program combining sexual assault, domestic violence and mental health responses under one department staffed by one nurse. The program began conducting SAFE exams while simultaneously creating policies and procedures for the entire program. Due to staff turnover, the program was put on hold in 2002.

Washington County Hospital, Washington County (no site visit conducted): Nurses have started the administrative process of getting the SAFE program running and the SART developed. Four nurses have been through the training and are working on finishing clinicals through nearby hospitals. The

hospital's administration has recently made the opening of the SAFE program a priority after securing a generous donation to purchase all needed equipment. The SAFE program is scheduled to open Summer 2003 and will see acute cases for victims 13 and older.

Barriers and Problems Facing SAFE Programs

As part of the needs assessment, each SAFE program was asked what barriers or problems they face in administering their hospital's SAFE program. There were many similarities in the answers given by each program and so responses have been grouped together below:

Training and Certification

Some SAFE programs spoke about the difficulty of completing the clinical requirements for state FNE certification. Maryland requires that nurses perform three adult forensic evidentiary exams a year for adult certification and three pediatric forensic evidentiary exams for Pediatric certification, as well as other various meetings with local law enforcement, crime lab and rape crisis centers to obtain state certification. Some programs are not seeing enough sexual assault patients in order to meet the minimum requirements of exams completed per year for each nurse. The new regulations from the Board of Nursing should alleviate some of this concern by allowing smaller program to observe three forensic evidentiary exams on adults and an additional three observations on children if applying for a pediatric certification, plus perform 10 speculum examinations to apply for certification.⁶

Many FNEs also addressed the lack of advanced practice training available. At present time, options for advanced practice training include repeating the basic FNE training or traveling out of state. Several other states do offer some advanced training, but most nurses would be forced to pay for this out of their own pockets.

Staffing of SAFE Programs

The high turnover of FNEs is of serious concern to many programs. The average "lifespan" of a FNE is reported to be 2 years. There are little to no safeguards in place, such as structured and routine debriefing, to keep nurses from burning out and there is little being done to address the impact of this work, such as vicarious traumatization. There is a deep seated mindset that nurses, especially emergency room nurses, be able to handle the trauma and repeated occurrence of abuse with little help from others. Commitment levels are high, although several nurses report the "wear and tear" they experience and feelings of exhaustion.

There is a nationwide deficit of nurses, and the SAFE programs are not immune to this reality. With little financial incentives to ask nurses to take on the added burden and responsibility of forensic examination, nurses continue to work in these programs in large part due to their generous commitment, kindness, compassion and a desire to see justice served. With a lack of nurses in their own programs, it also becomes difficult for programs to partner with Child Advocacy Centers if their own program does not see pediatric cases.

Equipment and Resources

Many programs report a lack of equipment or other resources. While the needs varied, they included lack of access to food for patients, monies for the transportation of victims (when police were unavailable), lack of refrigeration for kits where programs found it necessary, no known lab to analyze for rape drugs or the money to pay for it, or a general lack of fully functioning basic equipment.

⁶ Maryland Board of Nursing. Forensic Nurse Examiner Updated Regulations to be in effect March 2003.

Systems

Several coordinators identified that they are seeing an increase in the number of victims who do not want to report to the police. Other coordinators reported a conflict when the victim did report to the police, but the police would not authorize a kit to be completed. In these cases, FNEs report feeling disheartened and frustrated when cases were unfounded by the police, the victim recants, or it is determined that the case is based on a false report.

Additionally, several programs reported problems with kits being picked up in a timely manner; some report it taking as long as six months. Nurses also hear that the kits are not getting to the crime lab within a reasonable amount of time, or at all, especially if another county's law enforcement personnel has to travel to pick up the kit.

Lastly, coordinators spoke about the many rape myths that exist in hospital staff and police. For example, hospital staff avoids sexual assault patients or make negative, judgmental and blaming comments. Coordinators are concerned that this may jeopardize the longevity of the program if the hospital in general is blaming of victims or does not value that SAFE program.

SAFE Vision

As part of the needs assessment, each SAFE program was asked about their vision, specifically, “Ideally, where do you see the SAFE program in five years?” Again, there were many similar responses, which are grouped together and summarized below:

Greater Improvement in Service Delivery

Program Coordinators spoke about the need to decrease the time that victims spent waiting for a forensic exam. They reported that most of their patients had already spent hours with the police and that often a FNE was not dispatched until the police were completely finished with their interview. Once a FNE is dispatched, it may take up to an hour for the nurse to respond and sometimes it can take even longer. Additionally, some victims may have to continue to wait if the SAFE program has to find an available room and/or set up all equipment and supplies to preserve chain of custody. It was not uncommon to hear that victims remain at the hospital anywhere from four to eight hours.

In order to be more victim-centered, FNEs also need to have support to treat the victims that do not want to file a police report. In most hospitals, when a victim does not report they are treated as a “GYN patient” and seen by the ED physician. In some cases, the FNE will assist the physician. FNE Coordinators see the unease the hospital staff have with sexual assault patients and realize that FNEs have the additional training to treat and care for sexual assault patients. In addition, if FNEs were able to see those victims who do not want to report, a complete head-to-toe assessment, photographic documentation and written documentation could still be recorded of the assault. This would be extremely beneficial to victims who may change their mind about reporting to the police.

Expand role of FNE

Forensic Nurse Examiners have expressed the desire to expand the role of the FNE. Many spoke of their vision of incorporating services to other populations, such as Domestic Violence patients and Elder Abuse patients. Many FNEs articulated that the hospital might not be the first place where these patients come for help. They suggested that FNEs gain privileges off site to be able to care for those patients in their own settings, especially in cases where it would be difficult to transport elderly patients.

The Coordinators also spoke of their desire to be in the community and offer education to various groups. Many nurses are already educating their local police academies, and presenting to colleges and other community groups. There was a sense of responsibility that nurses shared to take part in preventing sexual assault and decreasing the number of patients they see. Some expressed trouble with getting access to younger populations and also acknowledged a duplication of services if the local rape crisis center or health department is already giving these educational presentations. In the future, many Coordinators would like to be an active part of this community education and hope that it will also strengthen community support of the SAFE programs.

Enhance Current Systems and Maintain the Basics

Many programs are looking to improve their practice. One way of improving practice is to increase communications with the crime lab, whether local or state level. There was discussion that some programs want consistent feedback from the lab. Programs would like to know if their efforts at evidence collection are yielding any useful evidence and if there are procedures that need to be improved.

Some SAFE programs are located within the Emergency Department; some directly outside of the Emergency Department and other programs are completely separate from the Emergency Department. Several hospitals housing SAFE programs are currently renovating their Emergency Departments and the SAFE program will have a designated room and possibly their own office. This is tremendous improvement as it shows the level of commitment from these hospitals. All of the programs discussed either a lack of space to conduct exams, lack of space to conduct programmatic business, and/or discussed that the designated area is simply too hectic and chaotic when tending to victims of sexual assault. For those programs where the lack of space was most evident, it was suggested the SAFE Program be moved out of Emergency Department, or at a minimum, allow it to have its own designated space.

Of course, the most basic of all needs to SAFE Programs are more FNEs and more funding. In the future, programs hope to see that SAFE programs have secure and adequate funding to maintain and operate and that the hospital they are housed within acknowledges and honors their work and invests in the program. Lastly, the SAFE program vision includes programs that will be fully staffed with the appropriate number of FNEs for their county so that burn out is reduced, nurses maintain their certification competencies, and continue to provide a high quality of medical forensic evidence collection.

Key Issues and Recommendations

After completing the assessment interviews, a preliminary report was created and delivered to FNEs across the state in regional forum presentations. The following recommendations are a result of those assessments and the programmatic needs highlighted by FNE coordinators. SAFE programs will work with these recommendations voluntarily, as all of their involvement is vital to meet statewide success and longevity.

Training and Education:

In the state and across the country, there is a lack of advanced and affordable training for professionals in the field of Sexual Assault Forensic Examination. Since forensic nursing is one of the fastest growing fields in nursing, training and education has not been able to stay ahead of this growth. While many educational avenues in Maryland are currently being developed, access to a full range of training is a concern and need for FNEs. This concern and others addressed in the Barriers and Problems Section of this paper give basis for the following recommendations:

Recommendation:

- **Encourage Orientation Sessions to Nurses** who are considering becoming Forensic Nurse Examiners. Orientation sessions would provide potential forensic examiners with adequate information about the realities and pressures of being an FNE including the impact of vicarious traumatization and the resources available to support FNEs.
- **Have annual didactic Adult and Pediatric FNE trainings.** Annual adult and pediatric trainings using the two uniform RN-FNE Training Program curriculums approved by the Board of Nursing would increase the opportunities to train nurses to become certified FNEs.
- **Encourage Advanced Training/ Refresher courses** to seasoned Forensic Nurse Examiners. Advanced training would allow already certified FNEs to enhance their clinical skills and maintain continuing education certification requirements without retaking the basic 40-hour FNE training.
- **Offer support and training for FNE's interested in community education.** Many FNEs report a strong desire to educate the community about sexual assault and SAFE programs, yet for some, experience in public presentation is limited. Training FNEs to develop effective and concise presentations is one way to offer support to FNEs who are new to public speaking. In addition, creation of a standard presentation outline would ensure that audiences across the state are getting the best, most complete and accurate information as possible
- **Explore options for SAFE programs to begin their community education within their own hospital community.** SAFE programs play an important role in responding to sexual assault, yet the programs are still underutilized and much of the hospital staff seems unaware of its existence. Having FNEs begin their community education efforts within the hospital that houses their SAFE program may help to promote the SAFE program, reduce the negative responses that hospital staff have towards sexual assault patients, and garner support for the SAFE program. It was also noted that Ambulance Providers would also benefit from this type of education.

Coordination:

Many of the programs do not have a full time coordinator dedicated solely to oversight of the SAFE program. However, communities where SAFE programs are the most successful are the same communities that have a dedicated coordinator who can manage the SAFE program as well as serve as a liaison to various community organizations such as SARTs. The importance of every SAFE program having a coordinator is also underscored by the newly updated Maryland Board of Nursing regulations that outlines the required duties a coordinator must perform in order for SAFE nurses to get their FNE certification. This means that in order for a nurse to now become certified, they must practice under a coordinator who has experience in forensic examinations who (1) has responsibility for oversight and administration of the program, (2) verifies the qualifications and certifications of FNEs, (3) administers and manages the FNE practice, (4) approves practice protocols and standards of care, (5) interfaces with law enforcement, State's Attorney Offices and community resource groups, (6) if hosting a FNE training, must follow the Board-approved training program, and (7) facilitates reimbursement for FNE services by cooperating with the facility's billing department.⁷

Recommendation:

- **Encourage all hospitals to fund a full time SAFE Coordinator position.** Most Program Coordinators are allotted anywhere from four to 24 hours a week to coordinate the SAFE Program. Due to the new Maryland Board of Nursing regulations, not funding a full time coordinator *may* jeopardize the sustainability of the SAFE program. There are strong concerns that most programs will not be able to afford this.
- **Offer technical assistance to coordinators through MCASA's SAFE/SART coordinator** regarding the management, organization and sustainability of their program.

Communication:

Communication between the SAFE programs is inconsistent - some programs are in close contact, while others are isolated. Many programs have created innovative ways to solve problems or streamline procedures, yet this information has no way of being disseminated across the state with ease. The Maryland State Standards Task Force (MSSTF) was developed 6 years ago to be a place where SAFE programs could communicate and share information. These meetings are held bi-monthly and usually in Baltimore. Some programs are faced with having to travel long distances, while they may or may not be compensated for their time or travel. Unfortunately, these meetings are no longer regularly attended by a majority of SAFE programs and therefore, the MSSTF is no longer functioning as the best means of meeting the needs of SAFE programs.

Recommendation:

- **Consider methods of communication that are more easily accessed by all SAFE programs.** Creating new means of statewide communication such as a newsletter and list serve specifically for Maryland FNEs would increase information sharing throughout the state and ensure that all SAFE programs are getting consistent information.
- **Improve the functioning of the Maryland State Standards Task Force.** Encourage the MSSTF meetings to rotate around the state and distribute minutes and agendas through the statewide listserv. Ask FNEs to help clarify what this group's purpose or mission shall be in the future.

⁷ Maryland Board of Nursing. Forensic Nurse Examiner Updated Regulations to be in effect March 2003.

- **Consider MCASA as the central repository** for model policies and procedures, best practices and other pertinent information to SAFE programs. MCASA can serve as the central point of information and facilitate that communication. The SAFE/SART Coordinator can support this function.

Data Collection:

Important and valuable data is collected in only a few programs with a myriad of different methods of tracking, analyzing and reporting information. These differences in the ways in which data is collected means that the information cannot be consolidated or compared statewide. In addition, SAFE hospitals are the only place where information can be gathered regarding the number of patients that identify as a sexual assault patient, but choose not to proceed with a forensic exam for whatever reason. Currently, the only information that is being recorded, if it is being tracked at all, is data on the sexual assault patients that do have forensic exams conducted. Data from hospital SAFE programs is an untapped avenue that could offer greater understanding of the scope of sexual assault and the effectiveness of SAFE programs.

Recommendation:

- **Explore options to standardize data collection and have one central repository of that data.** Most of the programs capture basic types of demographic data, but reporting of this data seems scattered and inconsistent. A standard data collection form would allow the same types of information to be collected and compared statewide. MCASA could serve as a central repository for the information and assist with the development of a standardized data collection tool and database system.
- **Consider a centralized database system and facilitate training for FNEs.** A centralized database system would allow for easy access to statewide information regarding SAFE programs as well as allow reports to be generated for individual programs. A web-based data collection system that all programs could log into via the Internet would be one way to create such a statewide database. Confidentiality issues would need to be addressed, although there is precedent of other states having already established a web-based database system. SAFE programs will also need to address any confidentiality concerns through their Internal Review Boards
- **Encourage the collection of data from all sexual assault exams including those that are not reported to the police.** Potentially half of all sexual assault patients coming into our hospitals are missed, because when a forensic exam is not conducted, the medical exam is categorized as anything but an assault. The implications are great if programs can factually state how many sexual assault victims they are actually treating.
- **Consider training the Coding & Billing Departments** in hospitals to correctly code and bill (when necessary) all cases of sexual violence. Currently the International Classification of Diseases, 9th Edition—Clinical Manual (ICD9-CM) is not being fully utilized in hospital coding departments. Many cases are being given a generic code that makes it impossible to distinguish treatment of sexual assault patients from other types of patients. Providing education for people who code patient charts on this specific insurance code will make it easier to track the number of sexual offense cases to which hospitals response. Billing departments would also need to be trained to balance confidentiality of sexual assault patients and the need to bill for anything not covered by the Department of Mental Health (DHMH).

Standardization:

After review of Maryland's SAFE Programs' policies and procedures, many gaps and inconsistencies were identified. *See Appendix B for suggested components of model policies and procedures.* For example, the age of "pediatric" patients varies with each hospital and few policy standards seem to exist. Although similar, each program has created unique policies and procedures and forms.

Recommendation:

- **Encourage the creation of model "Policy and Procedures"** for all SAFE programs to utilize across the state, *allowing flexibility* for individual hospital differences. Model policies and procedures would help to ensure that sexual assault patients would receive the same standard of care regardless of where in the State they are victimized. The Violence Against Women Office⁸ is currently developing a national SANE protocol. This product will also be helpful in assisting Maryland SAFE programs. However, in order for this recommendation to be realized, FNEs must come to some consensus on the best ways to respond to a variety of issues. These issues include but are not limited to:
 1. Reporting all rapes/sexual assaults to the police. There are a myriad of codes, articles, and opinions about whether medical professionals have to report rape and sexual assault and in which cases are FNEs mandated to report. The complexity depends on the factors of the assault, age or if a person is considered a vulnerable adult. Some programs report all sexual assault cases to the police, while many do not.
 2. Testing for STIs during a forensic exam if prophylactics are dispensed. There are many pros and cons to this issue. Most programs are testing for STIs and some are not.
 3. Collecting wet mounts or acid Phosphatase to test for the presence of sperm (motile). Again, several programs are collecting wet mounts for this purpose, while several are not. FNEs should discuss if this is a necessary procedure. Discussions should also include what benefit are victims and/or prosecutors getting from this information, and if it is ever held against a victim if there are no motile sperm initially identified. There are also many pros and cons to this issue.
 4. The use of Woods Lamps. A study in 1999 that found the Woods Lamp unreliable in detecting semen. FNEs should discuss what the Woods Lamp (or similar devices) will detect and its limitations and should also explore if there are better tools available.
 5. FNEs providing medical screenings. Nurses are capable and equipped to conduct medical screenings and are specially trained to work with sexual assault patients.

⁸ Since its inception in 1995, the Violence Against Women Office, now the Office on Violence Against Women (the Office) has handled the Department's legal and policy issues regarding violence against women, coordinated Departmental efforts, provided national and international leadership, received international visitors interested in learning about the federal government's role in addressing violence against women, and responded to requests for information regarding violence against women. The Office works closely with other components of OJP, the Office of Legal Policy, the Office of Legislative Affairs, the Office of Intergovernmental Affairs, the Immigration and Naturalization Office, the Executive Office for United States Attorneys, U.S. Attorneys' Offices, and state, tribal and local jurisdictions to implement the mandates of the Violence Against Women Act and subsequent legislation.

Hospital administrations and their interpretation of EMTALA⁹ will play a role in this discussion.

6. Responding to patients who refuse kits, i.e. children. There needs to be some consensus regarding a SAFE program's consent policy? To what extent will an exam be forced on someone who is unwilling? What is in the best interest for the patient? The community?
7. Creating consistency in the storage of hospital SAFE files and other documentation. The ways in which files are kept confidential vary tremendously between programs.

SART Development:

Research shows that it takes a coordinated community approach to effectively deal with the multiple needs of a sexual assault victim and to prosecute the offender. According to the Urban Institute's 2000 Report: *Evaluation of the STOP Formula Grants*, the conviction rates in rape cases increased dramatically in the communities that chose to formally organize a Sexual Assault Response Team (SART). One reason cited for the increase is that there is a greater likelihood that the victim is more willing to cooperate and stay involved in the investigation and prosecution of the case. A SART is a multidisciplinary team that works collaboratively to provide specialized services for victims of sexual assault. At a minimum the SART should include the FNE, a rape crisis advocate, a law enforcement officer, and a prosecutor. Other members may include domestic violence victim advocates, state crime laboratory personnel, clergy, and social services staff¹⁰. These team members work together to care for victims, collect evidence and to ultimately increase the prosecution rate of offenders. In Maryland only four of the 24 jurisdictions have a formal SART and there is no official statewide coordination.

Recommendation:

- **Create a standard "System Response" model** or SART manual and offer technical assistance to counties that are interested in implementing a SART. Standard statewide SART policies and procedures would help to jumpstart the development of a local county SART by outlining the various steps needed to implement a Sexual Assault Response Team. Additionally, adoption of model SART practices would help to ensure that sexual assault victims receive the same standard response regardless of where in the State they are victimized.
- **Explore ways to develop a Sexual Assault Response Team in each of Maryland's 24 jurisdictions.** Creation of SARTs in every jurisdiction will help to increase prosecution of sex crimes as well as better support sexual assault victims. It will also provide a forum for evaluation of the effectiveness of the local sexual assault response system.
- **Encourage the critical examination of current sexual assault response practices to ensure that they are the most conducive to the support of victims and prosecution of sex crimes.** Using model SART policies and procedures to guide the implementation

⁹ EMTALA (Emergency Medical Treatment and Active Labor Act, also known as COBRA or the Patient Anti-Dumping Law) is a statute, which governs when, and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when he is in an unstable medical condition.

¹⁰ Ledray, Linda E. (1999) "Sexual Assault: Clinical Issues: Date rape drug alert." *Journal of Emergency Nursing*. Volume 17, Number 1, pp. 1-2

of a local SART will be a beginning, but each local team will also have to come to some consensus on the best ways to respond to a variety of issues such as:

1. Clarification of the roles and responsibilities of each SART member including FNE, Law Enforcement and crisis center advocate. Teams should specifically discuss procedures regarding dispatch of team members and a collaborative response to victims. Each SART member provides a victim with specialized services and no other team member should deny the victim access to those services. Most jurisdictions are not following the recommended collaborative model.
2. The storage of *completed* forensic exam kits may offer an additional opportunity for victims to decide to proceed with legal action against the perpetrator. One SAFE program in conjunction with the local law enforcement has already implemented a temporary storage policy that is working to increase the rates of sex crimes prosecution in their county.
3. Partnership between Child Advocacy Centers (CAC) and SAFE programs. Currently, there is no uniformity on CAC collaboration, as it depends greatly on the county. A dialogue should begin about what is best for victims and the programs when negotiating this issue with CACs.

Funding:

There are two main ways in which SAFE programs are funded. It is either funded by a grant from the Department of Human Resources that administers Victims of Crime Act (VOCA) monies (These grants are usually written in partnership with the local rape crisis center) or the program is funded entirely by the hospital to varying degrees and grant writing is a skill with which many SAFE Coordinators are not familiar. Yet, most programs are expected to find their own funding and write their own grants in the time allotted for “administrative” time.

There also exists the problem of minimal funding on a national or statewide level for SAFE programs. With budget cuts projected for the next several years, it is also a serious concern that funding for these programs will only become more competitive. There are hopes that the DNA Sexual Assault Justice Act of 2003 (or more commonly known as the Biden Bill or Debbie Smith Act) will be passed this year. *See Appendix C for more information on the Sexual Assault Justice Act of 2003.* However, Maryland cannot take this as a definite future source for funding. If passed the Act will authorize \$150 million in new funding over five years for grants to establish and maintain sexual assault exam programs that provide communities with nurses trained specifically in how to collect and handle forensic evidence as well as how to treat the physical and emotional needs of sexual assault victims. Eligible grantees include existing programs, state sexual assault coalitions and universities.

Recommendation:

- **Train SAFE Coordinators in the art of grant writing.** There are many sources, tools and workshops that teach non-profits how to write for grants. This type of information could also be offered to Coordinators who are in the position of securing their own funding.
- **Offer a Grant Template for future grants.** Many grants require similar line items. Creating a template for all SAFE programs to use as a guide and then modify for their own program would save time in the writing process.

- **Encourage the development stronger partnerships with the local rape crisis center for possible collaboration on future grants.** If the relationship is strong and mutually beneficial, crisis centers may be receptive to collaborative grant arrangements.
- **Continue to work with the Department of Health and Mental Hygiene in getting cases reimbursed.** It is important that FNEs fully understand and utilize the reimbursement process, follow up with cases that are denied by DHMH and resolve any reporting problems. If there is a necessary procedure or recurrent procedure that is not covered by the reimbursement regulations, then these need to be addressed with DHMH.
- **Explore possibilities to strengthen relationship with the Criminal Injuries Compensation Board.** This is a potential funding source for certain items that cannot be covered by any other funding source.

Evaluation:

Since many of the SAFE programs are relatively new and there is minimal research being conducted, it will be crucial to the longevity of SAFE Programs to evaluate their effectiveness and impact on the systems they are trying to serve (victims, law enforcement, and prosecution). Considerable attention needs to be given to evaluating SAFE programs and give greater motion to quality improvement.

Recommendation:

- **Consider the evaluation of SAFE Programs through several perspectives** (patient, police, crisis advocate and FNE). Mechanisms should be constructed for gathering of evaluative information regarding the success and impact of SAFE programs. It would be useful to elicit feedback from all the outside groups or individuals that interact with SAFE programs including victims, police and prosecutors. Development of tracking and evaluative tools may link back to the topic of data collection.
- **Consider conducting a SART evaluation** for those counties with a sexual assault response team to measure its effectiveness in improving the sexual assault response system. Like SAFE programs, SARTs, of which FNEs are a key member, vary greatly from county to county with some SARTs relegating their interagency involvement to memorandums of understanding, while others have regular face to face meetings where cases and procedures are reviewed and critiqued.
- **Explore mechanisms to ensure that FNEs maintain high ethical standards of practice.** The Maryland Board of Nursing is an agency that only responds to formal complaints filed. Other ways to proactively critique FNE practice should be put in place to prevent errors or misconduct before they occur.

Conclusion:

With ten years of experience, Maryland has paved new paths for victims of sexual assault through the development of Sexual Assault Forensic Examination programs. This assessment recognizes that Maryland SAFE programs have made tremendous strides despite numerous barriers and acknowledges and honors FNEs for their hard work. SAFE programs have completed their work often times in isolation from the rest of the state, with few resources, and intermittent communication. The programs found ways to interact as often as they could and encouraged the Maryland Board of Nursing to regulate and certify their practice. The success of Maryland's SAFE programs has been due to FNEs' generous commitment and dedication to victims and their desire to see justice served.

Now and in the years to come, the Maryland Coalition Against Sexual Assault will join SAFE programs in their efforts to support existing programs, encourage development of new programs, and keep Maryland moving forward in the establishment of sexual assault response teams. In the SAFE Coordinators' own words, the future of SAFE programs will be victim-centered, the role of the FNE will be expanded, and response systems will be enhanced, while always maintaining the foundation and basics of the SAFE program. MCASA hopes to serve as a mechanism to facilitate and coordinate this vision on behalf of the SAFE programs by funding opportunities, networking SAFE programs, facilitating communication, organizing advanced trainings, serving as a central repository for information, offering technical assistance and serving as the statewide link for all Maryland programs to the SAFE/SART community across the country.

Appendix A

Interview Assessment Tool

Date of Interview: _____

Hospital: _____

Name of Examiner Program: _____

SANE Coordinator: _____

Address: _____

Email address: _____

Phone: _____ Fax: _____

SANE Coordinator's Supervisor Name: _____

History of this SANE Program: (i.e. inception, coordinators, funding, etc).

Year program was founded: _____

Number of Forensic Nurses: _____

Mailing list for the newsletter and important SANE training updates? Yes No

What type of data is tracked and how? _____

How many sexual assaults were reported to the hospital in 2001? _____ 2002 _____

How many of the kits then go on to trial? _____

Police Contact Person: _____

Any other contacts: _____

Do you have a med scope (or similar) and a Woods Lamp? _____

Do you do "wet preps" and look for semen? _____

Where do you store your completed evidence kits? _____

Are there ever problems with kits being picked up? _____

How do you handle, when the survivor is convinced they do not want to report? _____

Are there any problems with reimbursement? _____

Are all survivors offered EC? _____

Are advocates from the local RCC called every time? _____

Copy of protocols obtained: Yes No

Where do you see the program going in the next five years? _____

What are some barriers or problems to address? _____

Any additional comments? _____

Appendix B

Model Policies and Procedures:

Below is a list of suggested components for model SAFE policies and procedures recommended by the Office for Victims of Crime¹¹ and supplemented by existing policies and procedures of Maryland SAFE programs.

- Triaging SA patients
- Consenting to exam and Non Compliant Patients
- Drug and alcohol screening
- Forensic exam procedure and the collection of evidence
- HIV
- Sexually Transmitted Infections (STI)
- Emergency Contraception
- Admitting SA Patient for further care
- Laboratory Procedures
- Toluidine Blue Procedure
- Photographing Procedure
- Suspect Exam Procedure
- Ultraviolet light source Procedure
- Pediatric SA Patients
- Treating SA Patients who do not get a Forensic Exam
- Discharge Procedure
- Scheduling
- Mandatory Reporting
- Data Collection Procedure
- Record keeping and filing
- Role of FNE
- FNE Competencies
- Dispatching advocate
- Checklist for completion of medical forensic exam and corresponding documentation.

¹¹ Ledray, Linda, PhD, RN, FAAN. The Sexual Assault Nurse Examiners Development and Operation Guide. Office of Victims of Crime, Office of Justice Programs, US Department of Justice.

The DNA Sexual Assault Justice Act of 2003

DNA Survey: Requires the Department of Justice to perform a nationwide survey to assess the backlog of untested rape kits sitting in police department case files across the country and authorizes \$500,000 to conduct the survey.

Funding:

Debbie Smith DNA Backlog Grants:

- Reauthorizes the 2000 DNA Analysis Backlog Elimination Act to provide \$275 million in new funding over five years for grants to states and local jurisdictions for DNA analysis of formerly unprocessed evidence in rape cases. Costs of DNA analysis range from \$500 to \$1,500 per case based on the type of evidence available for testing and estimates of the backlog range from 180,000 to 500,000 nationwide.
- Authorizes \$60 million in new funding over five years for grants to states fund DNA analysis of convicted felons and inputting the resulting DNA profiles into state and national DNA databases.
- **Sexual Assault Forensic Exam Program Grants:** Authorizes \$150 million in new funding over five years for grants to establish and maintain sexual assault exam programs that provide communities with nurses trained specifically in how to collect and handle forensic evidence as well as how to treat the physical and emotional needs of sexual assault victims. Eligible grantees include existing programs, state sexual assault coalitions and universities.
- **Training Grants:** Authorizes \$50 million in new funding over five years for grants to train law enforcement and first responders in collection and handling of DNA evidence in sexual assault cases and the recognition of drug-related sexual assaults. Funding can also be used to train prosecutors on the use of DNA samples as forensic evidence in criminal proceedings.
- Authorizes \$10 million in funding for an update of the national DNA database (CODIS) and \$500,000 for DNA testing of felons convicted of federal offenses.

Access to grants: Allows local jurisdictions and tribes to apply directly for grants to fund testing of DNA samples in cold cases.

Quality Assurance Protocols: Requires DOJ to develop national quality assurance protocols for the collection of DNA evidence at crime scenes and conditions grants on compliance with DOJ protocols for training of sexual assault examiners.

Preventing Future Backlogs: Amends the 2000 DNA Analysis Backlog Elimination Act to require timely analysis of DNA evidence in sexual assault cases, and requires certification from grantees that within three years of the application all DNA evidence in sexual assault cases will be forwarded to a qualified crime labs for testing within six months.

Statute of Limitations: Authorizes federal John Doe indictments allowing issuance of an indictment against an unknown suspect based on DNA evidence in order to toll the statute of limitations until a suspect is located through a DNA match.

Privacy: Implements new privacy safeguards for DNA evidence and DNA profiles and increases the criminal penalties for any misuse or unauthorized dissemination of DNA information.