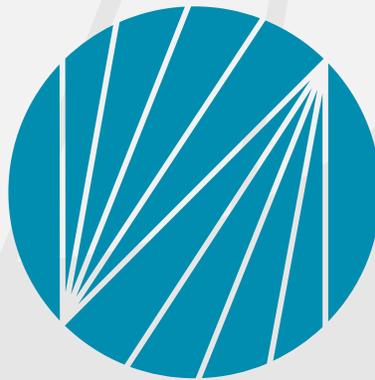


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How SAFE is New York City? Sexual Assault Services in Emergency Departments

**A Research Report
from the New York City Alliance
Against Sexual Assault**



How SAFE is New York City: Sexual Assault Services in Emergency Departments

By Deborah Fry



**New York City Alliance
Against Sexual Assault**

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Foreword

I am pleased to present *How SAFE is NYC? Sexual Assault Services in Emergency Departments*, the first comprehensive research report from the New York City Alliance Against Sexual Assault on New York City's acute care response to sexual violence. The Alliance is unique in New York State since we conduct sound evidence-based research and systems-based advocacy to ensure that *all* survivors have access to the best care. The Alliance is one of two New York State-certified Sexual Assault Examiner Training Programs in the city that train health clinicians to provide specialized care to sexual assault patients. We develop trainings and foster collaboration among healthcare, rape crisis and criminal justice personnel to improve their response to sexual assault survivors.

This report underscores how Sexual Assault Forensic Examiner (SAFE) Centers of Excellence provide the most comprehensive care for sexual assault patients in the acute care setting in NYC. However, the findings also document unequal access to these programs. SAFE Centers of Excellence are scattered throughout the five boroughs in no systematic fashion. Current ambulance guidelines dictate that sexual assault patients be brought to the facility nearest to patient pick-up location, regardless of SAFE program availability. Sexual assault victims who choose walk-in service at an ED generally do not know that specialized services do exist for their care or even where they are located. As a result, it is possible that sexual assault patients go to facilities without specially trained staff or victim advocates to help them through the emergency department process.

This groundbreaking study by the Alliance provides an assessment of the services available for sexual assault patients in NYC's emergency departments. We hope this study will serve as a baseline for future outcomes studies and as an impetus for a strategic plan to improve care. The companion study, *A Room of Our Own: Survivors Evaluate Services*, examines survivors' experiences when they sought care immediately after a sexual assault, in hospitals and rape crisis centers and with the law enforcement and criminal justice systems. Together these reports highlight the progress toward quality care for victims of sexual violence and the deficiencies that still exist. These findings give policy makers, service providers and advocates concrete data on which to base their efforts to create the best medical treatment, forensic evidence collection, advocacy and follow-up care in all hospitals. We hope you will join us in the movement to ensure best care for *all* survivors in NYC.



Harriet Lessel, Executive Director
New York City Alliance Against Sexual Assault
February 2007

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This study was conducted by Deborah Fry, Research Director at the New York City Alliance Against Sexual Assault.

This study would not have been possible without the dedicated volunteer work of Sara Kane, a graduate from the John Jay College of Criminal Justice, who conducted field work and provided comments on drafts of the final report.

The Alliance is indebted to the many hospital professionals, in both ED and SAFE Programs, the directors and staff who gave their time and expertise in the completion of our survey.

Special thanks to: the pilot sites for the study who gave us excellent feedback on the survey instrument; the Operations, Standards and Training Committee and the Criminal Justice Collaboration Committee for their valuable insight on the survey instrument and implementation strategies; and all the stakeholders from the medical field who commented on drafts of this report.

The Alliance's Research Advisory Committee provides their guidance and feedback on all of our research projects, including this study: Larry Busching (Chief, Family Court Division of the NYC Law Department and a member of the Alliance's Board of Directors); Susan Xenarios, LCSW (Director of the Crime Victims Treatment Center at St. Luke's-Roosevelt Hospital and a member of the Alliance's Board of Directors); Donna Gaffney, MA, MSc, RN, DNSc (Associate Professor, Seton Hall University); Victoria Frye, MPH, DrPH (Research Investigator at the NY Academy of Medicine); Catherine Stayton, MPH, DrPH (Director of the Injury Epidemiology Unit, Bureau of Epidemiology Services, NYC Department of Health and Mental Hygiene); Cari Olson, MPH (Injury Epidemiology Research Director, Injury Epidemiology Unit, Bureau of Epidemiology Services, NYC Department of Health and Mental Hygiene); Marielis Rivera, MPH (Health Educator at the South Bronx Health Center for Children and Families); Karen Terry, PhD (Deputy Executive Officer, Program of Doctoral Studies in Criminal Justice at John Jay College of Criminal Justice); and Heath Grant, MA, MPhil, PhD (Assistant Professor at the John Jay College of Criminal Justice). We are particularly indebted to Dr. Terry and Dr. Grant for their support on the conceptualization of this project as a baseline for outcomes research.

Additional thanks also go to the following Alliance staff: Tamara Pollak, MPH, RN (Training and Education Director) for her guidance and expertise throughout the entire study; Jennifer Tierney (Communications Director) for her editorial support, Harriet Lessel, LCSW (Executive Director) for her unwavering vision, support and patience throughout the research process, Daisy Deomampo, MA (Research Associate) for her feedback on the final report, Katie Bower, MSW, a 2006 social work policy student from Columbia University for her feedback and collaboration in drafts of the final report; and Lauren Mills, a 2007 social work policy student from Columbia University for writing the timeline and several text boxes and feedback support on the final report. A big thank you to Emily Fries for her help in compiling the references for this report.

We also thank the New York State Department of Health for their feedback on the report and assistance to hospitals in developing Centers of Excellence.

Finally, our sincere gratitude is expressed to our funder, the New York State Department of Criminal Justice Services, whose staff recognized that this study will provide a strong foundation for all future efforts to better serve survivors of sexual violence.

About the Author

Deborah Fry is the Research Director at the New York City Alliance Against Sexual Assault. At the Alliance, Deborah works on citywide research projects, all geared to helping improve service delivery for survivors in NYC and evaluating current prevention and intervention programs. Current projects include this study and *A Room of Our Own: Survivors Evaluate Services*. In addition to conducting primary research, Deborah also provides research technical assistance to the NYC rape crisis programs. Deborah has a Masters of Arts degree from the Maxwell School of Citizenship and Public Affairs at Syracuse University and her Masters in Public Health from Columbia University. Deborah was also a Fulbright Research Scholar from 2001 to 2002.

Table of Contents

Foreword	i	Table 7: Testing for STIs by Hospital ED Type	21
Acknowledgments	ii	Table 8: Storage of NYS Sexual Offense Evidence Collection Kits, Chain of Evidence and Patient Notification	30
Glossary	iii	Table 9: Follow-up Care by Hospital ED Type	36
Executive Summary	1	Table 10: Types and Availability of Victim Advocates by Hospital ED Type	38
Introduction	5	Table 11: Quality Assurance Variables by Hospital Type	42
Medical care	13	Table 12: Summary of Recommendations Based on Study Findings	49
Forensic Evidence Collection	23		
Information, Advocacy and Follow-up Care	33	Figures	
Quality Assurance	41	Figure 1: Availability of Literature for Sexual Assault Patients by Hospital ED Type	34
Implications	45	Figure 2: Percentage of EDs with On-call Schedules for Victim Advocates by Borough	39
References	51		
Appendix A: Methodology	55	Text Boxes	
Appendix B: Survey Instrument	59	Pioneers in Best Care: The First SAFE Programs in NYC	8
Appendix C: Timeline of Legislation	67	A Brief History of Emergency Contraception in New York State	18
		Magnification for Injury Detection: The Use of Colposcopy with Sexual Assault Patients	26
Tables		The Importance of Rape Crisis Advocates	40
Table 1: Emergency Department Survey Response Rates by Borough	10	Quality Assurance Frameworks	43
Table 2: Overview of Reported ED Level of Service by Hospital Type and Borough	11		
Table 3: Percentage of EDs with On-call and Back-up On-call Schedules for SAFE Clinicians	14		
Table 4: Amount of Time Before SAFE or On-call Doctor Arrives at ED Once Called	15		
Table 5: Average Length of Stay in ED and Exam Time by Hospital Type	17		
Table 6: Reported Minimum Ages for Using Adult Protocol for Sexual Assault Patients	19		

Glossary

ADA	Assistant District Attorney	NYS DCJS	New York State Division of Criminal Justice Services
AI	Appreciative Inquiry	NYS DOH	New York State Department of Health
CAC	Child Advocacy Center	NYS Protocol	NYS Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault
CME	Continuing Medical Education	QA	Quality Assurance
COPE	Client-Oriented, Provider-Efficient Services	QI	Quality Improvement
CVB	Crime Victims Board	RCP	Rape Crisis Program
DCJS	Division of Criminal Justice Services	SAE	Sexual Assault Examiner
DFSA	Drug Facilitated Sexual Assault	SAFE clinician	Sexual Assault Forensic Examiner
DOH	Department of Health	SAFE Program	Sexual Assault Forensic Examiner Program
ED	Emergency Department	SANE	Sexual Assault Nurse Examiner
HHC	Health and Hospitals Corporation	SARA	Sexual Assault Reform Act
HIV PEP	HIV Post Exposure Prophylaxis	SART	Sexual Assault Response Team
IAFN	International Association of Forensic Nurses	STDs	Sexually Transmitted Diseases
MRDD	Mental Retardation/ Developmental Disability	STIs	Sexually Transmitted Infections
Non-SAFE	Hospital emergency department <i>without</i> a certified SAFE program	VCT	Voluntary Counseling and Testing
		WL	Wood's Lamp

Executive Summary

“...And he raped her. When he was gone she called 911 and the police came and took her to the hospital. And then something remarkable happened. She was treated with sensitivity and great care by people whose only duties were to look after her...explaining what was happening and giving her back her sense of dignity and safety.” (Quindlen, 1994).

Public attention was drawn to the development of Sexual Assault Examiner Programs in 1994, when Anna Quindlen described the Tulsa, Oklahoma, Sexual Assault Nurse Examiner program in a *New York Times* editorial (October 19, 1994). Quindlen contrasted the Tulsa program with a negative experience reported by a rape survivor in a Brooklyn hospital. She was writing about a problem well understood by rape crisis advocates: how getting help sometimes made it worse for rape victims.

Ten years later, Sexual Assault Forensic Examiner (SAFE) programs, as they are known in New York, have come to national prominence as one way to accomplish the collaboration between victim advocates, the healthcare sector and the criminal justice system promoted by the Violence Against Women Act. However, it is clear that optimal medical care and forensic evidence collection still do not routinely occur in hospital emergency departments.

This study was conducted to map what services currently exist in NYC emergency departments (EDs) for patients reporting a sexual assault. ED Directors or SAFE Medical Directors from 39 of the 63 emergency departments in the city were interviewed in-person or by telephone. Randomly chosen practitioners were also interviewed from 23 of the 39 EDs that responded to the survey. The survey consisted of 104 questions on the details of patient care for sexual assault victims in the acute care setting. The survey was piloted and data collected over eight months from April 2005 to December 2005. All, but one, of the currently certified SAFE Centers of Excellence participated in the study. We can infer those emergency departments that did

not respond are likely not to offer comprehensive care for sexual assault patients.

New York City has more EDs than any other city in the United States. Its large population and concentration of many public and private EDs present unique challenges for the provision of the best care for all sexual assault survivors. This report provides a comprehensive assessment of the acute sexual assault services available through NYC emergency departments. Chapter 1 defines the evidence base for SAFE programs and describes SAFE program components. Chapter 2 presents key findings regarding the medical care of sexual assault patients. Chapter 3 details the research findings related to forensic evidence collection and chain of evidence maintenance. Chapter 4 examines findings around advocacy, information-giving and follow-up care for sexual assault survivors. Chapter 5 explores the data around quality assurance and discusses ways to improve the acute care response. Chapter 6 concludes the report with implications of the findings for advocacy and future research. This is the second mapping of the acute sexual assault services available in NYC. The first was conducted by the Rape Treatment Consortium in partnership with the Barnard/Columbia Center for Urban Policy in 1996. The Consortium interviewed via phone and through mail surveys social workers and other hospital staff at 45 hospitals. They asked questions on eight areas: forensically trained personnel, site of exam, advocates, training, follow-up care, administration, financial support and outreach and education. This effort by the Consortium served as formative research for this comprehensive study.

Key Terms Used in This Report

This report looks at the difference between emergency departments with specialized sexual assault programs called Sexual Assault Forensic Examiner (SAFE) Centers and those who offer a varying

degree of such services. In this report we refer to SAFE Centers and SAFE programs also as SAFE Centers of Excellence, a designation given by the New York State Department of Health (NYS DOH) for programs that meet certain criteria for comprehensive care to sexual assault patients in the acute care setting. SAFE Centers of Excellence also include Sexual Assault Response Teams (SART), a model of comprehensive care across a network of hospitals. SARTs exist primarily at public hospitals in each borough, except Staten Island.

Furthermore, there are also Sexual Assault Examiner (SAE) programs in the city. These programs are funded through the New York State Division of Criminal Justice Services. All of these programs are also SAFE Centers of Excellence except for one. In this report, SAFE Centers also refers to these SAE programs. To make this even more confusing, many other states refer to their specialized programs as Sexual Assault Nurse Examiner (SANE) programs. We use the term SAFE in New York State because other clinicians, not just nurses, can be specially trained to provide comprehensive care to sexual assault patients in the acute care setting.

Specially trained doctors, nurses, nurse practitioners and physicians assistants are also called SAFEs, or Sexual Assault Forensic Examiners. To distinguish between SAFEs that are programs and SAFEs that are practitioners, we utilize the term SAFE clinician to refer to specially trained hospital staff.

In this report, the term victim advocate refers to hospital social workers, other hospital staff and volunteers who provide crisis counseling and advocacy services to sexual assault patients in the acute care setting. Those who undergo 40 hours of training at a local rape crisis program to provide advocacy services in the emergency department are called volunteer victim advocates.

Key Findings

The Sexual Assault Forensic Examiner (SAFE) and Sexual Assault Response Team (SART) Programs surveyed offer the most comprehensive care to sexual assault patients in NYC's emergency departments.

Eleven emergency departments in study were SAFE Centers of Excellence (which includes Sexual Assault Response Teams, or SARTs), and 28 emergency departments are non-SAFE, meaning that they do not have a NYS DOH-certified comprehensive Sexual Assault Examiner Program in place at their emergency department. The SAFE and SART Programs surveyed all utilize specially trained doctors and nurses to conduct rape exams. These programs are more likely to have specialized equipment, such as colposcopes and swab dryers, than non-SAFE/SART programs. SAFE/SART programs also report providing more information, advocacy and follow-up care for patients reporting a sexual assault than non-SAFE/SART emergency departments.

All public hospitals surveyed provide comprehensive care for sexual assault patients in their emergency departments.

Ten public hospital emergency departments were surveyed, half of which had a SAFE Center of Excellence at the time of this study. Along with a few pioneering private hospital emergency departments, the public hospitals have been the leaders in providing specialized care for sexual assault patients in NYC. All of the public hospitals surveyed reported having SAFE clinicians and nearly all reported having specialized equipment. All public hospitals surveyed also utilize victim advocates and reported that they refer all patients for follow-up counseling. These public emergency departments also report always using the standardized NYS Evidence Collection Kit and Drug Facilitated Sexual Assault Kit (DFSA), and all report that they have capacity to store DFSA kits at their emergency departments. The public emergency departments also report systems of quality assurance for sexual assault services and routine chart audits on sexual assault cases.

SAFE programs are scattered throughout the city in no systematic fashion.

All of the 11 SAFE Centers of Excellence as of December 1, 2005 are represented in this study. Most of these specialized emergency departments are located in Manhattan (46%) and Brooklyn (27%), with many fewer in the Bronx (18%) and Queens (9%). One hospital emergency department on Staten Island has received funding to begin a SAFE program. According to ambulance rules, a sexual assault patient must be transported to the facility nearest to the pick-up locations. Given the haphazard location of SAFE/SART programs across NYC, many sexual assault victims may have *unequal* access to the best medical care, based on where programs are located. Furthermore, many patients also walk into emergency departments without knowledge of whether they have specialized services. There has been no public information campaign about what SAFE Centers are and where they are located. As of February 2007, five additional emergency departments have become SAFE Centers of Excellence, totaling 17 EDs (NYS DOH, 2006a).

The majority of emergency departments surveyed utilize rape victim advocates, although very few have only volunteer advocates.

All of the SAFE Centers of Excellence use victim advocates for sexual assault patients, as do 85.7% of non-SAFE emergency departments. Another 31.4% of all EDs report only utilizing volunteer community advocates. Most EDs (48.5%) report using a combination of hospital social workers, other hospital staff and volunteer advocates. Our companion report, *A Room of Our Own: Survivors Evaluate Services*, documents how the presence of a *volunteer* victim advocate had a statistically significant impact on the survivors' satisfaction with the care they received at the hospital.

Emergency departments with SAFE programs are more likely to have specialized equipment or other enhancements for forensic evidence collection.

Emergency departments surveyed with a SAFE program are more likely to report dedicated colposcopes that can magnify injuries (100% vs. 28.6%), swab dryers that shorten exam time and ensure that swabs are dried before being put in the evidence collection kit (72.7% vs. 11%), and Woods lamps that can detect fluids including semen on the body and clothes (90.9% vs. 67.8%). Emergency departments surveyed with SAFE programs are also more likely than emergency departments without SAFE programs to report having a procedure in place for photo documentation of injuries (100% vs. 85.7%), a record log of the release of an evidence kit to the police that ensures the chain of evidence is maintained (100% vs. 81.5%), the capacity to store evidence kits for longer than three months (90.9% vs. 33.3%), and a medical staff person who has been trained in testifying in court (100% vs. 60.7%). All these elements can factor into criminal justice outcomes.

Emergency contraception and HIV post-exposure prophylaxis (PEP) is provided in nearly all EDs surveyed, regardless of the presence of a SAFE program.

All of the hospital emergency departments surveyed, regardless of whether they have a SAFE or SART program, reported routinely providing emergency contraception to sexual assault patients. All of the SAFE programs surveyed report that the emergency contraception is obtained from the hospital staff, whereas 7.1% of non-SAFE programs report that the patient must obtain the EC from an in-house pharmacy. Overall, 97.4% of the emergency departments surveyed report providing sexual assault patients with HIV post-exposure prophylaxis, where medically indicated. However, SAFE programs report that they always make follow-up appointments for HIV PEP, compared to only 60.7% of non-SAFE programs.

Chapter 1: Introduction

Defining SAFE/SART Programs

In New York State, many hospitals have developed Sexual Assault Forensic Examiner (SAFE) programs, also called Sexual Assault Nurse Examiner (SANE) programs, to provide specialized care to sexual assault patients. NYS legislation enacted in 2000, known as the Sexual Assault Reform Act (SARA), mandates that the NYS Department of Health (NYS DOH) formally designate hospital emergency departments as the sites of 24-hour SAFE programs. Hospitals interested in applying for designation as SAFE Programs must meet specific criteria and submit applications to the NYS DOH.

According to the NYS DOH *Protocol for Acute Care of the Adult Patient Reporting Sexual Assault*, “the primary mission of a SAFE program is to provide immediate, compassionate, culturally sensitive and comprehensive forensic evaluation and treatment by specially trained sexual assault forensic examiners in a private, supportive setting to all victims of sexual assault, regardless of whether or not they choose to report to law enforcement. Specifically, the goals of the SAFE program are to:

1. Provide timely, compassionate, patient-centered care in a private setting that provides emotional support and reduces further trauma to the patient;
2. Provide quality medical care to the patient who reports sexual assault, including evaluation, treatment, referral and follow-up;
3. Ensure the quality of collection, documentation, preservation and custody of physical evidence by utilizing a trained and New York State Department of Health (DOH) certified sexual assault forensic examiner to perform the exam, which may lead to increased rates of identification, prosecution and conviction of sexual assault perpetrators;
4. Utilize an interdisciplinary approach by working with rape crisis centers and other service providers, law enforcement and prosecutors’

offices to effectively meet the needs of sexual assault victims and the community;

5. Provide expert testimony when needed if the survivor chooses to report the crime to law enforcement; and,
6. Improve and standardize data collection regarding the incidence of sexual assault victims seeking treatment in hospital emergency departments” (NYS DOH, 2004).

The NYS DOH protocol also details the standard for treatment of survivors in emergency departments throughout the state. To become a Sexual Assault Forensic Examiner, a health clinician should attend a NYS DOH-certified training program, such as the training program offered through the NYC Alliance Against Sexual Assault, which is a five-day comprehensive course on medical and forensic treatment. These health clinicians must then complete a preceptorship or ‘mentoring’ with a certified examiner to complete the process. If a health clinician was trained as a SAFE elsewhere, they can have their training reviewed by a NYS DOH certified training program to become certified in NYS. Furthermore, if a health clinician is certified by the International Association of Forensic Nurses (IAFN), they are eligible to apply to NYS DOH to become a certified SAFE clinician. An emergency department can have a SAFE-trained examiner, even if they do not have a full SAFE program.

To become a specialized SAFE Center of Excellence designated by NYS DOH, a hospital or other center must meet the following criteria beyond what is required by state law:

1. Maintain a designated and appropriately equipped private room in or near the hospital’s emergency department to meet the specialized needs of sexual assault patients. Accommodations must include access to a shower and be handicap accessible.

2. Maintain a supply of and provide an initial supply to patients, as medically indicated, of prophylaxis for HIV.
3. Establish an organized program/service specifically to carry out and oversee the provision of sexual assault services. This would include the development and implementation of policies and procedures detailing staffing requirements, initiating and conducting community outreach programs, participating in an organized data collection system, and routinely following-up with patients/law enforcement officials and crime laboratory personnel regarding the credibility of evidence collection activities.
4. Designate a program coordinator to exercise administrative and clinical oversight for the program.
5. Ensure that the program includes a cohort of specially trained Sexual Assault Forensic Examiners (SAFEs) who have been prepared through an intensive classroom and preceptor training program and have been certified by NYS DOH to conduct sexual assault exams.
6. Establish/participate in an interdisciplinary taskforce that includes local rape crisis centers, other service agencies, and law enforcement representatives/local prosecutors to develop services that meet community needs and to ensure that quality victim services are available.
7. Provide Sexual Assault Forensic Examiners on-site or on-call available to the patient within 60 minutes of arriving at the hospital, except under exigent circumstances.
8. Routinely use the New York State Evidence Collection Kit, if the patient consents to having evidence collected.
9. Coordinate outreach activities in the community and with other hospitals to share best practices, provide training opportunities and promote the availability of programs, to the extent feasible.
10. Participate in regional and statewide quality assurance initiatives designed to measure program effectiveness and meet reporting requirements (NYS DOH, 2004).

In February 2005, NYC Mayor Michael Bloomberg issued a mandate for all eleven Health and Hospital Corporation (HHC) emergency departments (NYC's public hospitals) to develop SAFE Centers of Excellence by September 2005 (NYC, 2005). Each of the emergency departments complied with this mandate facilitating the development of HHC Sexual Assault Response Teams (SART) in Bronx, Brooklyn, Manhattan and Queens. The HHC SARTs operate similarly to SAFE programs, except that the SAFE clinicians and victim advocates can travel to any of the HHC hospitals within a specific borough to provide care.

Regardless of whether a hospital emergency department has a SAFE or SART program, every hospital in New York State must ensure that all victims of rape or sexual assault who present at the hospital are provided with care that is comprehensive and consistent with current standards of practice. By Public Health Law (Section 2805-i) entitled Treatment of Sexual Offense Victims and Maintenance of Evidence in a Sexual Offense (2002), every hospital in New York State must provide treatment to victims of a sexual offense and be responsible for:

1. Maintaining sexual offense evidence and chain of custody, and
2. contacting a rape crisis program or victim assistance organization, if any, providing victim assistance to the geographic area served by the hospital to establish the coordination of non-medical services to sexual offense victims who request such coordination and services.

Thus, by law, the patient must be told about the local rape crisis services and given the option of a rape crisis advocate to accompany him/her during the exam if s/he wishes. Furthermore, in 2003, Local Law 26 was passed, which states that New York City requires hospitals to provide victims with information about emergency contraception and to document whether or not emergency contraception was given to rape victims when medically appropriate (NYC Council, 2006a). The NYS Department of Health was charged with developing and producing informational materials on emergency contraception to be used by all hospitals in New York State. These materials are currently available in eight languages.

National and Local Evolution of SAFE/SART Programs

In the past, victims of sexual assault seeking medical attention often experienced victim-blaming attitudes and substandard care. Rape Crisis Programs arose in the 1970s both nationally and in NYC as a movement to provide care to sexual assault survivors. These victim advocates then began to develop local, state and national reforms to address standard-of-care problems within hospitals. Within the last thirty years, SANE/SAFE programs have been created throughout the United States. There were only three known programs in the 1970s, 13 by the end of the 1980s, 86 by the mid-1990s, and the current estimate of national SANE programs numbers more than 450 (Campbell, Patterson & Lichty, 2005; Ledray, 2005). In 1992, the first international meeting of SANEs was held with representatives from the US and Canada, and the International Association of Forensic Nurses was formed (Campbell, Patterson & Lichty, 2005).

Many hospitals in NYC operate Sexual Assault Response Teams (SARTs). A SART brings together professionals to work with a patient reporting sexual assault. This team traditionally includes acute care professionals, victim advocates, the police and prosecutors. This model is used by many states with mandated reporting laws (e.g., if a patient presents for care following a sexual assault, a healthcare provider must first involve law enforcement before conducting a forensic exam). New York State does not have a mandated reporting law for sexual assault, so SARTs look slightly different than in other localities. Therefore, in NYC, a hospital that participates in a SART shares Sexual Assault Forensic Examiners with other hospitals in the network. This allows for a core team of specially trained medical professionals to respond to in-network health facilities. The SAFE responds to a case of sexual assault with a victim advocate. The SARTs work closely with both law enforcement and criminal justice, but it is still the victim's choice to report the case. The New York State Department of Health (NYS DOH) refers to SARTs as 'regional network models' (NYS DOH, 2004).

Overall, 17.9% (7/39) of the EDs in this study's sample participate in a SART. SARTs exist in the

public hospitals, though some private hospitals may also share examiners in the same network. Mayor Bloomberg announced a strategy to expand SART programs to public hospitals citywide. As of fall 2005, SART programs existed in Brooklyn and the Bronx and had been launched in Manhattan and Queens (NYC, 2005). There are no public hospitals in Staten Island.

The first SART program began in NYC in 2004 in the Bronx as a joint initiative through the Mayor's office and the Health and Hospitals Corporation (HHC), which runs the public hospitals. The Bronx SART program consists of the three public hospitals in the Bronx, a team of 15-20 SAFE Examiners and a cadre of volunteer advocates. Anytime a patient reporting a sexual assault is seen at any of the three public hospitals, an on-call SAFE responds to the hospital within an hour on average and on-call advocates respond on average within 20 minutes.

In its first eight months, the Bronx SART program treated more than 200 sexual assault patients (Mayor's Office, 2005). According to the Mayor's Office, the Bronx SART examined more than 90% of the presenting sexual assault patients within one hour, compared to 63% in 2003 before the hospitals became a SART program. Furthermore, 83% of the sexual assault patients were examined for evidence of microscopic genital injury using a colposcope, compared to 29% in 2003 (NYC, 2005).

The number of specialized training programs throughout the country is slowly increasing. There are currently five training programs in New York State certified by the NYS DOH, two of which are in NYC. These training programs provide 40 hours of training to clinicians interested in being certified as specialized sexual assault forensic examiners. The training includes evidence collection techniques, the use of specialized equipment, chain-of-evidence requirements, expert testimony, injury detection and treatment, pregnancy and STI prophylaxis, caring for traumatized patients in the acute care setting, and crisis intervention.

Pioneers in Best Care: The First SAFE Programs in NYC

The first specialized sexual assault examiner program in New York developed as a pilot program at New York City's Bellevue Hospital in 1987.

Bellevue's sexual assault examiner program developed under the auspices of the hospital's advocacy and counseling program, Victims of Violent Assault Assistance Program (VoVAAP). This specialized acute care response program was the outgrowth of an earlier program VoVAPP initiated to provide follow-up services to sexual assault patients who had received treatment in the emergency department. The two nurse practitioners directing this follow-up care program in the mid-1980s noted that their patients consistently reported receiving poor care in the emergency room. Time and again, patients identified a poor standard of care: untrained medical residents conducting post-sexual assault exams; patients forced to wait for hours before receiving care in the emergency department; patients felt re-victimized by the comments and actions of medical staff; and, due to a lack of training, clinicians were not adept at collecting evidence for Vitullo kits (the sexual assault evidence collection kit in use at that time).

In response to this patient feedback, VoVAPP's director, Melissa Mertz, MSW, and the two nurse practitioners from the follow-up program, Verna Robertson and Susan Merguerian, secured funding from the New York State Crime Victims Board (NYS CVB) to develop a pilot sexual assault examiner program. The three clinicians traveled to Amarillo, Texas to observe one of the few national programs at this time providing state-of-the-art care to sexual assault victims in conjunction with law enforcement, prosecutors and crime lab personnel. Upon their return, with the funding from CVB and support from Lewis Goldfrank, M.D., Medical Director of Bellevue's E.D., and Linda Fairstein, Esq., Assistant District Attorney, New York County, these three women

established New York's first multi-disciplinary sexual assault examiner program. In addition to ensuring that trained, mid-level nurse practitioners were on call to respond to sexual assault patients in Bellevue's emergency room 24 hours a day, seven days a week, the program worked closely with law enforcement, counseling, and criminal justice professionals to improve care for sexual assault patients.

Following the establishment of this program, Ms. Merguerian was invited to participate in the Governor's Task Force on Rape and Sexual Assault, a multidisciplinary task force established by executive order in July, 1989 for the purpose of developing a standardized best practice protocol care of sexual assault patients. Led by Kathi Montesano-Ostrander, Director of Rape Crisis Programs for the New York State Department of Health, this task force succeeded in designing New York State's first "Adult Sexual Assault Evidence Collection Protocol." This document served as a critical step toward improving acute care of sexual assault patients in New York State.

In 1990, based on recommendations made by the Task Force, Governor Cuomo's administration approved funding for manufacturing sexual assault evidence kits, as well as training to accompany the best-practice protocol. Ms. Merguerian and Ms. Montesano-Ostrander conducted this training throughout ten regions in NYS thereby pioneering the Sexual Assault Forensic Examiner programs of today.

On October 14, 1994, the *New York Times* published Anna Quindlen's Op-ed "After the Rape." The column described the humiliating and traumatic experience of a rape victim in a New York City emergency room. This was the same year the Violence Against Women Act (VAWA) was made a federal law, a landmark piece of legislation that sought to improve criminal justice and community-based responses to domestic violence, dating violence, sexual assault and stalk-

Pioneers in Best Care *(continued)*

ing in the United States. These were two of the major events that mobilized the New York City Rape Treatment Consortium to develop specialized sexual assault forensic examiner (SAFE) programs in hospital emergency departments in New York City.

Lucy Friedman, the director of Victim's Services, assembled the consortium in 1994 to implement SAFE programs in New York City Hospitals. The consortium was comprised of rape crisis service providers, the Manhattan District Attorney's office, the NYPD, and the New York City Health and Hospital Corporation (HHC). Susan Xenarios, the then director of the Rape Crisis Intervention/ Crime Victim Assessment Project at St. Luke's-Roosevelt Hospital Center, and other members of the consortium began planning and gaining support for the next Sexual Assault Forensic Examiner (SAFE) program in New York City to be piloted at St. Luke's-Roosevelt Hospital.

The consortium conducted a needs assessment of services for survivors in NYC and identified gaps in the system of care, such as the lack of specially trained acute care providers. The consortium's goal was to establish a SAFE program in every borough. DCJS provided a small grant of \$100,000 to develop the St. Luke's SAFE program, which was successfully established in 1997. Columbia University hosted a three-day training for clinicians, and eight examiners were credentialed by the hospital to respond to sexual assault patients on an on-call basis. Donna Gaffney developed the training curriculum for SAFE clinicians specifically for NYS and was among the people at the state level (along with DOH and DCJS) to develop and pilot the curriculum. Ms. Gaffney, who still offers the SAFE training program in collaboration with the Alliance and Seton Hall University, is a member of the the Alliance's Research Advisory Committee. A physician appointed to be the medical director of the SAFE program supervised the examiners.

In 1998, Long Island College Hospital started a SAFE program in Brooklyn. Shortly after, Beth Israel Hospital developed a SAFE program as well, enabling the program to be accessed by different neighborhoods of Manhattan. The training for examiners also expanded. Currently, St. Luke's-Roosevelt is the only teaching hospital in the country to mandate a five-day training for all first year residents. While not all the residents will go on to become certified SAFE examiners, the training translates into better medical practices and understanding of treating survivors of sexual assault.

On April 1, 2004, North Central Bronx Hospital (NCB) became the first member of the Sexual Assault Response Team (SART) and the first SAFE program to be certified by the New York State Department of Health. Dr. Bridgitte Alexander, an emergency room physician, researched SAFE programs in New York City and advocated for the development of a program at NCB. She is currently the Medical Director of the SART program at NCB. The program was funded by the Mayor's office and DCJS. In November of 2005, Karen Carroll was hired as the associate director of the SART program, allowing the program to be the first one to ensure coverage for rape victims twenty four hours a day seven days a week with backup. Ms. Carroll is on call twenty-four hours, so that if more than one person needs an exam, there will be a SAFE examiner on call. Ms. Carroll will be available for back-up, so a patient will not wait more than 60 minutes for an exam. SART programs in Brooklyn, Queens and Manhattan are working to follow this model.

Nearly 20 years after the advent of Bellevue's program, there are currently 17 EDs with SAFE centers in New York City hospitals (NYS DOH, 2006a). Advocacy work continues to determine the critical number of specialized programs needed to ensure that every sexual assault patient has access to specialized services.

Victim Advocates

Victim advocates are an integral part of SAFE and SART programs. They provide emotional support to victims of sexual assault in the hospital setting. Advocates accompany victims from the initial contact and the actual exam through discharge and follow-up. The more specialized and trained both sexual assault examiners and volunteer rape advocates are, the better services victims receive at the hospital. In New York City, victim advocates are either community volunteers who complete a 40-hour training administered by their local rape crisis program and overseen by the NYS DOH, or they are hospital social workers. There are currently 20 NYS DOH-funded rape crisis centers in NYC. Ten of these provide emergency room volunteer advocacy services to a total of 24 emergency departments throughout the city. There is at least one hospital in NYC that trains ancillary emergency room staff (patient-care technicians) to serve as victim advocates. All of the SAFE and SART programs in NYC are located within emergency departments. As of December 2006, 17 hospital emergency departments had earned the NYS DOH designation as SAFE Centers of Excellence in NYC (NYSDOH, 2006). This number represents 27% of the emergency departments in the city. Some hospitals may have some specific components of SAFE services available to survivors, such as utilizing rape crisis advocates, but do not have a comprehensive program in place.

Mapping Acute Care Services in NYC

This study comprehensively maps acute care service delivery in NYC for sexual assault survivors. A 104 question survey was used to interview in-person ED administrators or SAFE Medical Directors at 39 of the 63 EDs (62%) within the 5 boroughs. The survey questions were developed by examining several protocols and resources for the acute care of the sexual assault survivor (see the detailed Methodology in Appendix A).

Table 1: Emergency Department Survey Response Rates by Borough

	Response Rate % (proportion)
Total Sample	62% (39/63)
Bronx	40% (4/10)
Brooklyn	61.1% (11/18)
Manhattan	73.6% (14/19)
Queens	69.2% (9/13)
Staten Island	33.3% (1/3)
Public Hospitals	83.3% (10/12)
Private Hospitals	57% (29/51)

As seen in Table 1, the total response rate for the study was 62%, with the highest number of ED Directors responding from hospitals in Manhattan (74%) and from public hospitals (83%). Throughout the report, Bronx and Staten Island numbers are excluded from analyses where indicated due to small sample size and to protect confidentiality. For this study, data was collected for eight months from April 2005 to December 2005.

Respondents were asked if their hospital was a NYS DOH-certified SAFE Center of Excellence. Table 2 presents the distribution of SAFE Centers of Excellence and non-SAFE hospital EDs by hospital type (public and private) and borough. Less than a third (28.2%) of all emergency departments surveyed have a comprehensive SAFE Center of Excellence to care for sexual assault patients. With no NYS DOH-certified SAFE Center of Excellence on Staten Island.

Table 2: Overview of Reported Emergency Department Level of Service by Hospital Type and Borough

	Total n = 39	Public Hospitals n = 10	Private Hospitals n = 29	Bronx n=4	Brooklyn n=11	Manhattan n=14	Queens n=9	Staten Island n=1
SAFE Center of Excellence	28.2% (11/39)	50% (5/10)	20.7% (6/29)	25% (1/4)	36.4% (4/11)	35.7% (5/14)	11.1% (1/9)	0
Non-SAFE	71.8% (28/39)	50% (5/10)	79.3% (23/29)	75% (3/4)	63.6% (7/11)	64.3% (9/14)	88.8% (8/9)	100% (1/1)

The response rate for certified SAFE Centers of Excellence for this study was 100%: 10 hospitals representing 11 emergency departments were certified by December 2005. We can safely assume that the remainder of emergency departments are non-SAFE. While some of the non-responding hospital emergency departments in the study

have taken steps to develop SAFE programs (such as utilizing volunteer victim advocates or training healthcare providers as SAFE clinicians), none offer comprehensive SAFE services. The question arises if several boroughs have unequal access to specialized acute care for sexual assault patients.

Chapter 2: Medical Care

It is important for sexual assault patients to seek medical care after an assault. According to the *NYS Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*, “A health care assessment and evaluation must be offered to all patients reporting sexual assault, regardless of the length of time which may have elapsed between the assault and the examination” (NYS DOH, 2004).

Triage

For sexual assault patients, their first point of contact within a hospital emergency department is triage. According to the *NYS Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*, patients should be triaged immediately (NYS DOH, 2004). In a SAFE Center, once the patient is triaged, the on-call SAFE clinician is called to see the patient. In a non-SAFE program, an attending physician or medical provider will see the patient. Both SAFE and non-SAFE programs may also call a volunteer victim advocate to stay with the patient through the process of the medical exam and treatment. SAFE Centers of Excellence are required to utilize victim advocates (volunteer or hospital staff). The role and importance of advocates will be covered in-depth in Chapter 4.

This study assessed the following with regards to triage and availability of specialized staff to treat sexual assault patients: 1) whether the ED has SAFE clinicians; 2) how SAFE clinicians are trained, supported and retained; 3) the percentage of EDs that have an on-call schedule for SAFE clinicians; 4) the percentage of EDs that have a back-up on-call schedule for SAFE clinicians; 5) how long it takes for the on-call SAFE or clinician (in non-SAFE emergency departments) to arrive; and 6) how long it takes for the SART to arrive.

Examiners

Description of a SAFE Examiner

In New York State, clinicians become certified Sexual Assault Forensic Examiners by taking a five-day training course from a NYS Department of Health-certified SAFE training program and by completing a preceptorship. The five-day course covers all the topics relevant to treating a sexual assault patient in a timely and sensitive manner. The preceptorship is the process through which new examiners demonstrate that they are proficient in clinical competencies through mentored hands-on clinical experiences supervised by an experienced clinician. To promote continued learning, SAFE clinicians must complete a minimum of fifteen hours of continuing education in the field of forensic science within three years.

Availability of SAFE Clinicians

Overall, 26 of the 39 emergency departments (66.7%) have SAFE clinicians. As expected, all of the SAFE Centers of Excellence had SAFE clinicians, as did all the public hospitals surveyed. A larger proportion of Manhattan EDs had SAFE clinicians (92.9%) than those in Brooklyn (63.6%) and Queens (33.3%).

Among emergency departments with SAFE clinicians, 46.1% (12 EDs) have between 1-10 SAFE clinicians working at their hospitals, and another 46.1% reported from 11-20. In comparison, SART programs counted an average of 17 SAFE clinicians available, with a range from 15-20.

SAFE Certification Rates

It is possible for a doctor or nurse to take the five-day SAFE training course but not complete the preceptorship. We asked how many SAFE clinicians at the hospital are DOH-certified.

We found that while 82% of SAFE Centers of Excellence had 11-20 SAFE clinicians, not all were certified. Overall, 48.7% of the administrators surveyed report that their emergency department does not have any certified SAFE clinicians. Six of those emergency departments have SAFE clinicians who have completed the course but have not been precepted, and 13 have no SAFE clinicians (certified or not). This pattern of having a majority of uncertified SAFE clinicians is common across hospital type, borough and level of services offered.

Hospital administrators also were asked how they maintained professional education for SAFE clinicians:

- Nine EDs specifically mentioned NYC Alliance Against Sexual Assault trainings;
- Twelve routinely conduct in-service trainings;
- Five routinely conduct chart reviews;
- Four conduct meetings on a regular basis;
- Two regularly reviewed and updated protocols; and
- One attended conferences related to the issue of the acute care of the sexual assault patient or sent SAFE clinicians.

Availability of Specialized Staff

SAFE Centers of Excellence must be available 24 hours a day. On-call schedules for SAFE clinicians meet these requirements. In Table 3, we see that all of the SAFE Centers of Excellence have an on-call examiner schedule, and 63.6% have a back-up on-call schedule. Among non-SAFE programs, 15 EDs have trained SAFE clinicians, of which only two (13.3%) have on-call schedules for those examiners, with the difference between SAFE and non-SAFE EDs being statistically significant. While these EDs have some specific services available for response to sexual violence, they cannot guarantee 24-hour coverage. The majority (60%) of public EDs sampled have an on-call schedule, compared to 44% of private EDs.

Respondents were also asked about their 'Plan B,' should their on-call and/or back-up on-call schedules fail. The majority of respondents reported that the ER attending physician would see the patient. Several other respondents reported that the OB/GYN resident would render treatment. While all EDs could treat the patient, it was not guaranteed that the provider would have any specialized experience with sexual assault survivors and forensic evidence.

Table 3: Percentage of EDs with On-call and Back-Up On-Call Schedules for SAFE Clinicians

	SAFE Center of Excellence (n=11)	Non-SAFE (n=15)
On-call schedule for SAFE Clinicians	100% (11/11)***	13.3% (2/15)
Back-up on-call schedule for SAFE Clinicians	63.6% (7/11)***	6.7% (1/15)

*** p<.001

How long it takes specialized staff to arrive

Specialized care requires that trained professionals be available to conduct the medical and forensic exam of the sexual assault patient. However, this requirement can mean longer waits for the patient. The NYS protocol (which the NYS DOH recommends all New York emergency departments use; SAFE Centers of Excellence are required to have hospital protocols that are consistent with this protocol) for treating sexual assault patients stipulates that on-call SAFE clinicians arrive at the hospital within 60 minutes (NYS DOH, 2004). Table 4 shows the amount of time before examiner arrives for SAFE and non-safe EDs. Other questions were asked of respondents who answered that they participated in a SART. Five of the seven ED respondents answered the question “How long does it take the SART to

arrive once called?” All five respondents answered that it took approximately 31-45 minutes

While emergency departments without certified SAFE programs are able, on average, to respond to patients within a shorter timeframe than certified programs, they do so without providing specialized care. At non-SAFE hospitals an emergency department clinician treats the sexual assault patient and conducts the forensic exam, even if they have not received specialized training. Given that only two non-SAFE emergency departments have on-call schedules for their specially trained SAFE clinicians, a sexual assault patient may present at the hospital when this specially trained clinician is not working, which means that another health care provider would see the patient whether they have received specialized training or not.

Table 4: Amount of Time Before SAFE or On-Call Doctor Arrives at ED Once Called

	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)
How long before SAFE or on call doctor arrives at ED?		
1–15 minutes	9.1% (1/11)	17.8% (5/28)
16–30 minutes	18.2% (2/11)	10.7% (3/28)
31–45 minutes	36.4% (4/11)	17.8% (5/28)
46–60 minutes	9.1% (1/11)	3.6% (1/28)
1–2 hours	9.1% (1/11)	—
N/A always on staff	18.2% (2/11)	50% (14/28)

Exam Area

The actual physical space in which a sexual assault patient is cared for is considered a critical component of best care. A designated space helps ensure privacy after the victim’s traumatic experience and to maintain the chain of custody for forensic evidence collection. This section covers:

- 1) The percentage of EDs with private rooms with doors designated for patients reporting a sexual assault;
- 2) the percentage of EDs offering treatment in a private area of the hospital;
- 3) the percentage of EDs with private rooms with showers;
- 4) the percentage of EDs with available showers nearby the exam area; and
- 5) the percentage of EDs with handicap-accessible private rooms or areas.

Availability of private exam rooms

Treatment in a private room is a necessity, not a luxury, for rape victims. First and foremost, it offers discretion they need. Private rooms also allow victims to stay in one place throughout the course of the examination.

Every ED surveyed (n=39) had a handicap-accessible private room with a door available for treating patients reporting a sexual assault, and all reported that sexual assault patients are treated in a private area of the hospital either 'most of the time' or 'always.' While all EDs have a room available, it may be used for other patients when there are no sexual assault patients.

Availability of showers

SAFE Centers of Excellence had a higher proportion of private rooms equipped with showers (45.5%) than non-SAFE EDs (14.2%). Among the boroughs, Brooklyn had the highest number (45.5%) of specially equipped rooms, compared to 14.3% in Manhattan and none in Queens.

If the private rooms did not have a shower, respondents were asked the availability of nearby showers. All of the Centers of Excellence without an in-room shower had one available nearby. However, 62.5% (15/24) of non-SAFE EDs reported that they did not have any shower available for patients to use after the exam.

Medical Treatment

One of the most important aspects of the acute care of sexual assault patients is ensuring that they receive medical attention for any injuries and prophylaxis for sexually transmitted infections. This section describes hospital ED administrator reports of:

- 1) the average length of stay in the ED for a patient reporting a sexual assault; 2) the average length of time to conduct the exam; 3) administration of pregnancy tests when applicable; 4) provision of emergency contraception, when applicable; 5) availability of emergency contraception directly from the health staff, at an in-house pharmacy or at an outside pharmacy; 6) routine testing for STIs; 7) provision of STI prophylaxis; and 8) provision of HIV prophylaxis, when applicable.

Length of Stay and Exam

One of the reasons that SAFE programs began was that exams done in a sensitive, comprehensive and victim-centered manner can take several hours. The variability in the amount of evidence collection and injury treatment for individual patients accounts for discrepancies in exam times. Table 5 shows that at SAFE Centers of Excellence most sexual assault victims (54.5%) are in the ED for an average four to six hours, whereas at non-SAFEs ED visits last from two to four hours (50%). Likewise, the average length of stay in the EDs in Queens tends to be on the lower end of the spectrum (44.4% spend up to two hours and 44.4% spend two to four hours), while 45.5% of EDs surveyed in Brooklyn report that patients stay four to six hours.

Table 5: Average Length of Stay in ED and Exam Time by Hospital ED Type

	Total for all EDs in Sample (n=39)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)	Public Hospital EDs (n=10)	Private Hospital EDs (n= 29)
Average length of stay for patient in ED?					
0–2 hours	10.3% (4/39)	—	14.2% (4/28)	10% (1/10)	11.5% (3/29)
2–4 hours	48.7% (19/39)	45.5% (5/11)	50% (14/28)	70% (7/10)	46.2% (12/29)
4–6 hours	33.3% (13/39)	54.5% (6/11)	25% (7/28)	20% (2/10)	42.3% (11/29)
I don't know	7.7% (3/39)	—	10.7% (3/28)	—	—
Average amount of time to do the exam?					
0–1 hours	48.7% (19/39)	18.2% (2/11)**	60.7% (17/28)	20% (2/10)***	58.6% (17/29)
1–2 hours	35.9% (14/39)	45.5% (5/11)	32.1% (9/28)	40% (4/10)	34.5% (10/29)
2–3 hours	15.4% (6/39)	36.4% (4/11)	7.1% (2/28)	40% (4/10)	6.9% (2/29)

p<.01 *p<.001

For SAFE Centers of Excellence nearly one-half (45.5%) report that the average amount of time to do the exam is one to two hours, and 36.4% report an average of two to three hours. In comparison, over half (60.7%) of EDs that are non-SAFE sites report under one hour, with the difference between SAFE and non-SAFE programs being statistically significant. The public EDs report longer exam times (40% report two to three hours) than private EDs (only 6.9% report such time). This difference

between public and private hospitals on length of exam is statistically significant (p<.001), meaning it is highly unlikely that it occurred by chance. Brooklyn and Manhattan report similar responses, and nearly three-quarters of EDs in Queens report an average exam time up to two hours.

A Brief History of Emergency Contraception in New York State

“Bleeding and traumatized after being raped by an acquaintance, the 18-year-old valedictorian gathered clumps of her ripped-out hair and gripped it tightly, barely able to comprehend what had just occurred. Then one question jolted her from the fog: What if, in addition to everything else she had just endured, her rapist had impregnated her?” (AP Wire, 2007)

Emergency Contraception (EC) is a critical component of compassionate care for patients who have experienced sexual violence. For some patients, EC can help restore a sense of control following a truly violating trauma. As such, offering and providing EC to sexual assault patients is often an essential, empowering aspect of acute medical care.

The first documented case of doctors prescribing hormonal EC to sexual assault patients was published in the 1960s. By the late 1990s, additional research firmly established hormonal EC as a safe and effective regimen (Kaiser Family Foundation, 1997). Such research inspired well-organized advocacy to ensure that the Food and Drug Administration (FDA) approved a product for the purpose of emergency contraception. Prior to this time, EC was available only through “off-label” use of oral contraceptive pills. Off-label use of approved medications is a common and legal practice, and some hospital emergency rooms were providing sexual assault patients with emergency contraception in this way. However, lack of a FDA product specifically marketed as hormonal EC was seen as a barrier to EC becoming part of universal best care.

Largely as the result of a citizen petition filed with the FDA by the Center for Reproductive Law and Policy on behalf of a coalition of leading medical and public health groups, in September 1998, the Food and Drug Administration (FDA) approved the PREVEN™ Emergency Contraceptive Kit (PPFA, 2003; FDA, 1998). Preven packaged the Yuzpe hormonal regimen (four tablets containing ethinyl estradiol 0.05 mg and levonorgestrel 0.25 mg) with a home pregnancy test kit.

In 1999, the Food and Drug Administration (FDA) approved Plan B, the first progestin-only emergency contraceptive product. Close to the same time the FDA approved Plan B, a World Health Organization-supported study concluded that the

Plan B regimen is more effective and has fewer side effects than the Yuzpe method of emergency contraception (Task Force on Postovulatory Methods of Fertility Regulation, 1998).

Development, FDA approval, and marketing of Plan B contributed to increased efforts by sexual assault victim advocates to ensure that all sexual assault patients in New York City and in the state were offered and provided with emergency contraception when they sought acute medical care. Advocates successfully lobbied the Office of the New York State State Comptroller (OSC) by exposing the economic cost associated with unintended pregnancy following sexual assault. A study published in the International Journal of Fertile Women’s Medicine found that 1-5% of sexual assaults result in pregnancy (Patel et al., 2004). With heightened awareness of the cost of unintended pregnancy resulting from sexual assault, in 2003 the OSC issued a report stating that increased access to EC could save New York State \$450 million in one year (OSC, 2003).

On the heels of that report, the New York City Council passed three bills to provide women expanded access to emergency contraception. This legislation 1) made EC available at all New York City Department of Health and Mental Hygiene (DOHMH) operated health care facilities; 2) required pharmacies in NYC to post signs about the availability of EC; and 3) required hospitals to give rape survivors information about EC (NY City Council, 2006b). However, it was not until 2005 that the state passed Public Health Law 2805, which required all emergency rooms to provide information about EC and dispense it upon request (NYS DOH, 2005).

On August 24, 2006, the FDA approved Plan B for sale without a prescription to individuals 18 years and older. In December of 2006, EC became available in New York pharmacies. Effective February 1, 2007, Medicaid will cover Plan B for women without a prescription in New York (Pharmacy Access Partnership, 2007). This is a progressive state policy that will help ensure that all women, including survivors of sexual violence who do not access emergency medical care, have expanded access to EC.

Adult versus Child Protocols

The medical and forensic needs of child sexual abuse patients are distinct from those of adult sexual assault patients. As such, in 1996 the New York state departments of health and social services developed the *Child and Adolescent Sexual Offense Protocol* (OTDA, 1996). This protocol, now under revision, guides clinicians to provide best care and evidence collection for child sexual abuse. However, though the revised edition is not yet public, the currently circulated protocol does not prescribe guidelines to help clinicians determine when to use the child/adolescent versus adult protocol. In other words, the protocol does not prescribe an age cut-off for the either of the protocols. Instead, the protocols leave room for clinician discretion when choosing the most appropriate protocol. Similarly, the *New York State Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault* does not indicate an age cutoff for using the adult protocol, as the authors recognize that the age at which the adult protocol is appropriate often depends on the circumstances in the case. For example, an 11-year post-pubertal female who is sexually assaulted by her boyfriend in many ways is better served by exam and evidence collection described in the *Adult* protocol. However, if that same child revealed at age 11 that she was being assaulted by her uncle, and that this sexual abuse had been occurring for several months, then the exam and evidence collection described in the *Child/Adolescent* protocol

would likely be more appropriate (though this determination remains subjective).

For the purpose of this research project, respondents were asked two questions about how their ED determines when to follow the *Child and Adolescent Sexual Offense Protocol* versus the *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*. Specifically, respondents were asked: what determines using the child or adult protocol for treating patients reporting a sexual assault; and if the ED has a minimum age for using the NYS adult protocol.

The majority of EDs (53.8%) use age to determine whether they use the child or adult protocol. Most (48.5%) reported that clinicians follow the adult protocol for patients 18 years and older, although there were a variety of responses ranging from 12 to 21 years of age. All the SAFE Centers of Excellence responded that they use the adult protocol for patients who are 13 years of age and older; some hospitals said they found it appropriate to follow the adult protocol for patients as young as twelve (Table 7). However, EDs without specialized sexual assault services overwhelmingly answered that they followed the adult protocol for patients 18 and older. Emergency departments in public hospitals tended to report following the adult protocol for younger patients, whereas those in private hospitals began using the adult protocol with older teens. Brooklyn and Manhattan both replied with a range of answers, but in Queens 88.9% reported 18 as the minimum age.

Table 6: Reported Minimum Ages for Using Adult Protocol for Sexual Assault Patients

	Total for all EDs (n=33)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=22)	Public Hospital EDs (n=10)	Private Hospital EDs (n= 23)
Minimum Age for Using Adult Protocol?					
12	15.2% (5/33)	36.4% (4/11)***	4.5% (1/22)	10% (1/10)*	17.4% (4/23)
13	27.3% (9/33)	63.6% (7/11)	9.1% (2/22)	60% (6/10)	13.0% (3/23)
17	6.1% (2/33)	—	9.1% (2/22)	—	8.7% (2/23)
18	48.5% (16/33)	—	72.7% (16/22)	30% (3/10)	56.5% (13/23)
21	3% (1/33)	—	4.5% (1/22)	—	4.3% (1/23)

***p<.001 t-test between SAFE and non-SAFE, *p<.05 t-test between public and private

Other protocols

Two specific questions were asked about treating special populations of sexual assault patients: 1) does the ED have a specific protocol on how to obtain consent for a forensic exam from mentally retarded or developmentally disabled (MRDD) patients reporting a sexual assault, and 2) does the ED have a specific protocol on how to obtain consent for a forensic exam from patients reporting a sexual assault who are under the influence of drugs or alcohol.

Over half (56.4%) of the EDs surveyed reported specific protocols for treating patients with mental retardation/development disabilities (MRDD) who report a sexual assault. Those that did not stated that they had no *specific* protocols for sexual assault but general ones for working with MRDD patients. Fifty-one percent of the EDs responded that they had specific protocols in place for treating a patient who is under the influence of drugs or alcohol while reporting a sexual assault.

Emergency Contraception

All of the EDs in the sample reported routinely providing sexual assault patients with emergency contraception. Nearly all (92.3%) of the EDs reported that the emergency contraception is obtained directly from the health staff in the emergency department. In addition, all of the EDs also reported giving the patient a pregnancy test (if they were not already pregnant).

Sexually Transmitted Infections (STIs)

Providing Prophylaxis

It is considered best care to provide prophylaxis (preventive medicine) for sexual assault survivors to prevent sexually transmitted infections from occurring as a result of the assault. Clinicians should offer (and, with the patient's consent, provide) sexual assault patients prophylaxis for HIV, gonorrhea, Chlamydia, hepatitis B (if not vaccinated) and trichomonas/bacterial vaginosis. Though not a sexually transmitted infection, clinicians should also offer patients prophylaxis for tetanus when appropriate.

Patients are provided with HIV post-exposure prophylaxis, also called HIV PEP, in 100% of the SAFE Centers of Excellence and 97.4% of non-SAFE EDS. All private EDs routinely provide HIV PEP, compared to 90% of public EDs surveyed. Most of the non-SAFE Eds (92.8%) routinely provide prophylaxis to sexual assault patients for STIs, compared to 100% of SAFE Centers of Excellence. All public EDs, compared to 93.1% of private, offer prophylaxis.

STI Testing

There is a current national debate about whether to test patients for STIs. One of the major issues in this debate is whether the test results can be brought up in court since they could prove that an STI was present *prior* to the sexual assault. Another reason cited for not testing is the difficulty following up with sexual assault patients should their STI tests come back positive. Furthermore, many programs do not conduct rapid HIV tests because the trauma related to the assault makes it difficult to do voluntary counseling and testing (VCT) in the emergency department. Patients are always offered prophylaxis and follow-up baseline testing within the next several days.

Advocates in favor of testing for STIs argue that the role of SAFE clinicians is to provide as much information as possible to law enforcement so that if the case goes to trial, the jury has as much evidence as possible. They also argue that sometimes evidence collection occurs after the incubation period of an STI and that some STIs, like trichomoniasis, can be found immediately after sexual intercourse and could be linked to the perpetrator.

The *NYS Protocol for Acute Care of the Adult Patient Reporting a Sexual Assault* states:

“routine testing for gonorrhea, Chlamydia and syphilis is *not* recommended. In general, testing for sexually transmissible diseases at the time of initial exam usually ascertains a patient had an STD before the assault. Prior exposure to a sexually transmissible disease can be used to bias a

jury against a patient in court. All patients are given medication, as if infected, so testing a patient does not change the course of treatment. Examiners must inform patients of the possible risks of contracting a sexually transmissible disease, and provide them the information with which to make informed decisions regarding testing and treatment: *antibiotic prophylaxis is standard care*” (emphasis added, NYS DOH, 2004).

Furthermore, the NYS protocol elaborates on the testing for HIV, hepatitis B and hepatitis C by saying:

“HIV, hepatitis B, and hepatitis C can be serious and life-threatening consequences of exposure to blood and/or body fluids of a carrier. The patient must be offered testing for HIV, hepatitis B, and hepatitis C at the time of the health care and evidentiary exam.” Lastly, the

protocol states, “Trichomonas and bacterial vaginosis can be diagnosed or ruled out by a wet prep done in the emergency department, and treatment provided if positive” (NYS DOH, 2004).

Table 7 illustrates whether sexual assault patients are tested for STIs in the ED and for which STIs cultures are taken. A little over half (66.6%) of respondents reported testing for STIs. Of those, nearly all test for gonorrhea and Chlamydia (92.3% and 96.2% respectively). A much smaller percentage of respondents reported testing for hepatitis C, conducting a rapid HIV test or a wet prep for either trichomonas and/or bacterial vaginosis (15.4%, 19.2% and 19.2% respectively). Furthermore, the majority (89.7%) of EDs reported providing the patient with prophylaxis for STIs.

A much smaller percentage of the SAFE Centers of Excellence tested for STIs than non-SAFE EDs (36.4% vs. 78.5%). Among the four SAFE Centers of

Table 7: Testing for STIs by Hospital ED Type

	Total Sample (n=39)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)	Public Hospital EDs (n=10)	Private Hospital EDs (n=29)
Do you test for STI's?					
Yes	66.6% (26/39)	36.4% (4/11)	78.5% (22/28)	50% (5/10)	72.4% (21/29)
I don't know	—	—	3.5% (1/28)	—	3.4% (1/29)
Test for Hep B	38.5% (10/26)	25% (1/4)	40.9% (9/22)	40% (2/5)	38.1% (8/21)
Hep C	15.4% (4/26)	25% (1/4)	13.6% (3/22)	40% (2/5)	9.5% (2/21)
Gonorrhea	92.3% (24/26)	100% (4/4)	90.9% (20/22)	80% (4/5)	95.2% (20/21)
Chlamydia	96.2% (25/26)	100% (4/4)	95.4% (21/22)	80% (4/5)	100% (21/21)
Syphilis	53.8% (14/26)	25% (1/4)	59.1% (13/22)	40% (2/5)	57.1% (12/21)
Rapid HIV Testing	19.2% (5/26)	0	22.7% (5/22)	0	23.8% (5/21)
Trichomonas and/or Bacterial Vaginosis	19.2% (5/26)	75% (3/4)	9.1% (2/22)	40% (2/5)	14.3% (3/21)

Excellence that do test for STIs (36.4%), all test for gonorrhea and Chlamydia, and one tests for hep B, hep C and syphilis. A much larger percentage (78.5%) of non-SAFE EDs routinely test for STIs. Of these, 90.9% test for gonorrhea, 95.4% test for Chlamydia, and only 13.6% test for Hep C. Half (50%) of the public EDs surveyed, and nearly three-quarters (72.4%) of the private EDs test for STIs. None of the public EDs surveyed conduct rapid HIV testing compared to nearly a quarter (23.8%) of private EDs.

Safe Discharge

It is important to ensure the safety of patients reporting a sexual assault. Appropriate and safe discharge was measured with five indicators: 1) discharge destination inquiries, 2) allowance of overnight stays for sexual assault patients because of safety concerns, 3) provision of transportation for sexual assault patients leaving the ED, 4) availability of replacement clothing, and 5) routine follow-up outreach to sexual assault patients the next day.

The *NYS Protocol for Acute Care of the Adult Patient Reporting Sexual Assault* states that the “hospital must provide each patient with an appropriate and safe discharge, including: medical transfer as necessary, necessary and appropriate follow-up care/referrals, hospital contact person to assist with release or disposal of sexual offense evidence, suitable attire, and transportation or appropriate arrangement as necessary to meet patient needs” (NYS DOH, 2004).

Furthermore, for SAFE Centers of Excellence, the emergency department must report to the NYS DOH that “safe discharge is assured for the patient” (NYS DOH, 2004).

Most EDs surveyed (84.6%) always inquire about the victim’s discharge destination, and none reported never asking. Furthermore, all EDs allow an overnight stay until the patient can secure a safe location. All SAFE Centers of Excellence reported ‘always’ inquiring about a victim’s discharge destination, compared to 78.5% of non-SAFE EDs. All of the public hospitals also ‘always’ inquire, compared to 79.3% of private hospitals.

Most of the EDs surveyed (76.9%) reported routinely securing transportation home for patients reporting a sexual assault. All of the public hospitals routinely secure transportation, compared to 69% of private EDs. The majority of SAFE Centers of Excellence (91%), and non-SAFE EDs 74% do so, as well.

Often the clothing that a sexual assault patient wears into the ED is retained for evidence. We asked how often replacement clothing was made available to sexual assault patients. All of the SAFE Centers of Excellence reported having replacement clothing ‘always’ (81.8%) or ‘most of the time’ (18.2%) for patients. Among non-SAFE EDs, half (50%) reported ‘always’ having replacement clothing available, 32.1% reported having clothing ‘most of the time,’ 14.2% reported ‘sometimes’ and one ED reported ‘never’ having replacement clothing available. Similar proportions of public and private EDs reported always having replacement clothing: 60% of public EDs and 58.6% of private EDs.

A smaller percentage (64.1%) follow up the next day to ensure the patient’s safety after discharge. Nearly all of the SAFE Centers of Excellence (91%) followed up with the patient the next day to ensure their safety, compared to 53.5% of non-SAFE EDs. Eighty percent of the public EDs and a little more than half (58.6%) of the private EDs followed up with the patient the following day ($p < .05$). Again, Brooklyn (72.7%) and Manhattan (77%) were similar in the percentages of surveyed EDs that followed up with patients. Many respondents mentioned that if the emergency department did follow-up, it was the social worker’s responsibility.

Chapter 3: Forensic Evidence Collection

An important component in helping a sexual assault case in the criminal justice process is in the collection of DNA evidence during a sexual assault exam. DNA has become an essential element when trying to match an offender to a crime.

In 2006, the statute of limitations for rape cases was lifted in New York. In September 2002, Congress passed a law to assess the backlog of DNA analysis of rape kit samples and to improve investigation and prosecution of sexual assault cases with DNA evidence (Library of Congress, 2002). In October 2004, Congress passed the Justice For All Act, which provides funds to assess DNA backlogs, to enhance DNA laboratories, and to help laboratories comply with Federal code.

When a sexual assault victim enters a NYS hospital, it must follow state guidelines on how to treat the patient, including gathering forensic evidence, if the patient decides to report the crime. The New York State Department of Health, in conjunction with the New York State Division of Criminal Justice Services (DCJS) and the state crime labs developed a Sexual Offense Evidence Collection Kit. While most materials/supplies used in collection of forensic evidence are routinely found in hospital emergency departments, the use of a standardized kit provides the following benefits:

- Standardization of evidence collection procedures across the state;
- At the time of crisis/need, everything needed to perform the exam is “in the box;”
- The knowledge is current and applicable to any hospital in New York State; and
- Standardization of procedures and materials in evidence collection yields better outcomes for survivors in court (NYS DOH, 2004).

Kits are provided by the New York State Division of Criminal Justice Services at no cost to hospitals in the state. If the assault occurred within 96 hours, an evidence collection kit should be used. The kit

includes instructions on how to collect forensic data, including how to collect hair samples, swab samples, and how to close and store evidence.

If a patient was under the influence of drugs during the assault, the examiner can decide to use a Drug Facilitated Sexual Assault Evidence Collection Kit. This kit includes the collection of blood and urine samples from the patient.

Since physical evidence is short-lived, forensic photography can also document injuries. If the patient consents, the examiner will photograph the injuries, using a scale for measurement reference, to show the court the extent of the injuries at the time of the exam. Photographs offer an accurate record of the injuries for the court and jury.

Collecting forensic data and maintaining the chain of evidence collection is crucial to each criminal justice case. A hospital is required to follow NYS protocols to help sustain the integrity of the data. Any violation can result in the evidence being inadmissible in court. According to the Department of Health’s *NYS Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*, a hospital’s protocol should include the following:

- During the patient consent process, a patient should understand the importance of forensic data collection;
- A patient must consent to the use of the NYS Sexual Offense Evidence Collection Kit, so that data can be collected;
- A patient must consent to the use of photography for the purpose of collecting forensic evidence;
- Photographs must be documented with the date and the signature of who took the photographs;
- Photographs must be placed and recorded properly with the chart, following all appropriate procedures;

- If necessary, photographs must be developed following all appropriate procedures;
- To maintain the chain of evidence, each specimen collected during an exam must be accounted for, sealed appropriately, and can never be left alone with a patient. A patient, a patient's family member, or an advocate cannot transport the evidence, as it can only be transported by the examiner;
- The hospital must seek consent to store the evidence collected or hand it over to law enforcement;
- If the patient has agreed to the data collection but not reporting the incident to the police, the hospital must store the Sexual Assault Evidence Collection Kit at least thirty days in locked storage;
- If the Drug-Facilitated Sexual Assault Evidence Collection Kit is used, then the hospital must store this at least thirty days in locked, refrigerated storage;
- After thirty days, if the patient does not want to report the incident to the police, the hospital can discard the evidence;
- The hospital is required to hire someone to coordinate the hospital procedures and storage, law enforcement and forensic laboratories (NYS DOH, 2004).

NYS Sexual Offense Evidence Collection Kit

There are ten steps to follow in the NYS Sexual Offense Evidence Collection Kit:

1. Obtaining oral swabs and smears;
2. Obtaining trace evidence by having the patient undress over a sheet of white paper to collect any hairs or other evidence;
3. Step 3 includes examining clothing and underwear using a Wood's lamp and collecting and packaging clothing that may contain evidence;
4. Step 4 involves collecting debris from the patient's body;

5. Step 5 includes examining dried secretions of blood or semen and/or bite marks including matted material on pubic or head hair and taking swabs as needed;
6. Step 6 involves taking fingernail scrapings;
7. Step 7 includes pulling head hairs;
8. Step 8 involves combing the pubic hair so that any loose hairs or debris will fall onto the white paper;
9. Step 9 includes pulling pubic hairs, if needed, and conducting the external genital exam and finally,
10. Step 10 involves collecting anal swabs and smears.

We collected information on ten indicators related to use of evidence collection kits: 1) if the ED uses the NYS Sexual Offense Evidence Collection Kit; 2) if the examiners follow all the steps listed in this kit, and if not, which steps do they not follow and why; 3) if the ED uses the NYS Drug-Facilitated Sexual Assault (DFSA) Kit; 4) if the examiners follow all the steps listed in the kit; 5) if the ED has the capacity to store kits in locked storage and keep DFSA kits refrigerated as well; 6) if the ED keeps a record log for the release of forensic evidence to law enforcement; 7) on average, how long they can store forensic evidence kits; and 8) if the ED contacts victims prior to throwing away kits.

Nearly all hospitals surveyed (94.9%) use the NYS Sexual Offense Evidence Collection Kit, with one ED Director stating the hospital does not use the kit and one who did not know if the standardized kit was used. The majority (71.8%) routinely follow all the steps listed in the kit, when applicable.

However, 11 ED Directors, including seven at SAFE Centers of Excellence, stated that they did not follow all the steps in the kit. All of those who did not follow the steps in the kit reported that they did not pull head or pubic hairs. This is in accordance with the NYS DOH Protocol, which states,

“it is recommended that pubic hair standards **not** be pulled during the initial medical exam. They can be pulled at a later date (if the pros-

ecution requests these samples and the victim consents to the procedure)” (emphasis original, NYS DOH, 2004).

The Protocol also goes on to state that

“pulled hair standards for evidence collection are considered by many to be very traumatic to the victims of sexual assault. The examiner must use his/her professional judgment regarding whether or not to complete this step, based upon the physical and/or emotional well-being and preference of the victim. Hairs can be pulled at a later date, if needed” (NYS DOH, 2004, p. 36).

Drug Facilitated Sexual Assault Kits

There has been an increase in the involuntary administration of some drugs, such as gamma hydroxybutyrate [GHB], Ketamine, flunitrazepam (Rohypnol), and Benadryl often in the presence of alcohol to render a person incapacitated and more susceptible to sexual assault. Many of these drugs are available over-the-counter. The use of these drugs results in a loss of consciousness, memory loss and incapacitation. The result is that many victims of drug-facilitated sexual assault may not remember the assault itself (NYS DOH, 2004).

In November 2003, the New York State Division of Criminal Justice Services (NYS DCJS) announced the availability of a standardized Drug Facilitated Sexual Assault (DFSA) evidence collection kit. The kits are provided free to hospitals in New York State and should be used only in cases where there is a suspicion of drug-facilitated sexual assault. The collection can be done up to 96 hours after the ingestion of the suspected drug, as many drugs will stay in the body’s system for up to four days. As with all forensic evidence collection, permission must be obtained from the patient.

The NYS Protocol stresses that the examiner should assess the possibility of a drug-facilitated assault. Hospitals are given a drug-facilitated sexual assault alert sheet that highlights the signs that determine if a sexual assault may have been drug-facilitated including: memory loss, confusion,

impaired motor skills, reduced inhibition, dizziness, drowsiness, impaired judgment, and/or intoxication disproportionate to the amount of alcohol consumed (NYS DOH, 2004).

Drug Facilitated Sexual Assault (DFSA) Evidence Collection Kits are used by 84.6% of the hospitals, when necessary. However, four emergency departments reported not using the standardized DFSA kit, and two EDs reported that they did not know if they used the standardized DFSA kit; all six were non-SAFE sites.

Specialized Equipment and Injury Documentation

Injury documentation is an important component of both medical treatment and forensic evidence collection. Oftentimes, injury documentation and forensic evidence collection is enhanced with specialized equipment. We measured the following indicators of injury documentation and specialized equipment: 1) if the ED has a dedicated colposcope, a magnification tool to find genital injuries, to use for patients reporting a sexual assault and whether or not it can photo-document; 2) if the ED has swab dryers; 3) if the ED has an ultraviolet light or Wood’s lamp; 4) if there is a standard procedure for photo documentation; 5) if the ED has a camera to photograph injuries and what type; 6) if the ED uses a ruler or scale as measurement reference for injury documentation in photos; 7) if the program routinely labels photos with the patient name or ID number and date; 8) if the ED uses Toluidine blue for injury detection; and 9) if the ED uses a standardized comprehensive care form (their own or from NYS DOH) to document evidence collection and injury.

Specialized equipment

Colposcopes

Specialized equipment is required to properly perform the forensic exam. However, most hospitals do not have such equipment.

Colposcopy is a diagnostic procedure in which a colposcope is used to examine an illuminated, magnified view of the cervix, the tissue of the vagina,

and vulva. The colposcope basically functions as a lighted binocular microscope, helping to identify possible injuries (see box for more information).

All of the SAFE Centers of Excellence have a dedicated colposcope to use only with sexual assault patients. However, only 28.6% non-SAFE EDs surveyed have a dedicated colposcope for use with sexual assault patients. A much larger proportion of public hospitals, as compared to private hospitals, have a dedicated colposcope (90% vs. 34.5%). Furthermore, the majority of surveyed EDs in Manhattan (64.3%) have a dedicated colposcope, compared to 45.5% in Brooklyn and 33.3% in Queens.

It is important for the colposcope to be able to photo-document. The majority of EDs with coloscopes have this capability.

Swab Dryers

The Sexual Offense Evidence Collection Kit requires the collection of several swabs. The swabs must be completely dry before being inserted into the evidence collection kit. Air-drying swabs take about an hour. Waiting for a number of swabs to air-dry can unnecessarily prolong a lengthy and uncomfortable exam. Swab dryers may reduce the exam's duration and ensure that swabs are thoroughly dry before being included in the evidence collection kit.

About three-quarters of SAFE Centers of Excellence (72.7%) reported having swab dryers, compared to only 10.7% of non-SAFE EDs. More than one quarter of the EDs in Brooklyn (27.3%) and Manhattan (28.6%) but only 11.1% in Queens have swab dryers.

Wood's Lamp

The Wood's lamp (WL) is a source of ultraviolet radiation emitting wavelengths of approximately 320 to 400 nm. The WL makes many substances fluorescent, including semen (Santucci, et al., 1999). It is small, relatively inexpensive, safe, and easy to use in the emergency department setting. Consequently, it is often an integral part of sexual assault evaluations (Santucci et al, 1999). Nearly all of the SAFE Centers of Excellence (90.9%) and two-thirds (67.8%) of non-SAFE EDs have a WL or ultraviolet light to detect semen on clothing and the body that is otherwise invisible to the naked eye. Nine of 10 public EDs surveyed (90%) have a WL, compared to 71% of private hospitals. The proportion of EDs in Brooklyn (81.8%) and in Manhattan (85.7%) with the lamps is much higher than in Queens (33.3%).

Photo documentation

When injuries are found during a sexual assault physical examination, they should be photographed in addition to written descriptions and body diagrams. This is important for both genital and non-genital injuries. According to the NYS DOH Protocol, "external genital injuries may be photographed using the same techniques as non-genital injuries or using a colposcope with photographic capability, whereas vaginal, cervical, and anal injuries will require use of a colposcope and/or anoscope with photographic capability" (NYS DOH, 2004).

The NYS DOH protocol also highlights the importance of photography in the acute care setting:

Magnification for Injury Detection: The Use of Colposcopy with Sexual Assault Patients

A colposcope is a piece of medical equipment that magnifies genital tissue. In the context of the sexual assault exam, it enhances identification of genital trauma. A colposcope is a binocular system with a built-in light source that consists of magnifying lenses of varying strength. Coloscopes are usually mounted on a stand, and most models have adapters so that cameras or video equipment can be attached to capture images. Such photo evidence can prove useful in prosecution of sexual assault

cases. Moreover, if the images can be viewed via a video monitor, the patient has the option of viewing the examination if s/he so wishes. A video monitor also provides the examiner with an opportunity to maneuver based on what they see on the monitor rather than through the bifocal lenses.

The colposcope allows examiners to view microscopic lacerations and injuries not apparent to the naked eye. In a California study of 131 patients

Magnification (*continued*)

who were raped and seen at the hospital within 48 hours, the use of a colposcope found that 114, or 87%, had positive findings of injury (Slaughter & Brown, 1992). In a study comparing the finding of injuries by colposcope versus visualization alone, researchers found that the colposcope improved detection of genital trauma in adult female sexual assault victims, as compared with a visual examination alone at a statistically significant level (Lena-han, Ernst & Johnson, 1998).

There are many advantages to utilizing a colposcope in sexual assault examinations:

- Colposcopy is a non-invasive technique that can improve injury detection with minimal discomfort for the survivor.
- The enhanced lighting and magnification provided by colposcopy improve both the medical and forensic examination.
- Photographs of injuries detected by colposcopy are useful evidence and good tools for teaching about genital injury, forensic photography and documentation (Templeton & Williams, 2006).

Review and interpretation of colposcopic images, however, is a trained skill. This is underscored by a 1994 study conducted to determine the agreement between examiners on findings represented by colposcopic images. Medical interns were asked to interpret colposcopic photographs without any specific training. The study found that the interns' interpretations were only slightly better than the random chance of accurate and inaccurate judgments (Braydon, 1994 as cited in Templeton & Williams, 2006).

Until recently, no studies had examined whether detection of microscopic genital injury in adult sexual assault patients is consistent with the experience of sexual assault. In other words, few studies have been conducted examining the presence of microscopic genital injury following consensual versus forced sex. However, a recent study conducted by Anderson and colleagues (2006) found no statistical difference in the presence of injury between consensual and nonconsensual groups of patients. This study included a prospective group of 46 women who were examined within 24 hours of having consensual sex and a retrospective chart review of 56 women over a one-year period who presented at the emergency department following a reported sexual assault (Anderson, McClain &

Riviello, 2006). Despite these findings, there was a statistically significant group difference in the injuries to the labia minora found only among subjects in the nonconsensual group (Anderson, McClain & Riviello, 2006). The authors concluded that these findings reinforce the importance of a thorough, careful genital examination of both the internal and external genitalia as part of the standardized sexual assault exam.

While the majority of research on colposcopy in the context of sexual assault focuses on the forensic utility of enhanced visualization of genital injury, one recent study actually focused on the mental health impact colposcopy can have on sexual assault patients. This study, conducted by Mears and colleagues (2003), involved girls aged 11 to 18 years who had been referred to a medical center for evaluation and treatment of sexual abuse. Before examining the patients in the study, clinicians conducted several pre-exam evaluations to determine the level of anticipation, anxiety and stress these girls were experiencing. Then, before the exam, each girl was engaged in a standardized educational session in which she learned about genital anatomy, discussed abuse issues and learned information about sexually transmitted infections. After that, clinicians carried out a medical and forensic exam that included video colposcopy. Seventy-nine percent of the girls chose to watch the colposcopic exam on video while it was being performed. The study found that there was a significant reduction in anxiety from pre-examination to post-examination, and the patient's feelings about the medical exam were significantly more positive following the exam. (Mears, Heflin, Finkel, Deblinger & Steer, 2003).

Finally, there is some debate currently in the New York City about whether a medscope (adapted from dental practice) might be a more useful tool for sexual assault forensic exams as compared to the colposcope. Some studies report that the medscope has a greater depth of field than the colposcope, and is easier to use to document injuries on other parts of the body. It is also easier to operate and requires less skill than the colposcope. However, colposcope manufacturers are also designing new instruments tailored to forensic use for "the highest quality of photo documentation, evidence preservation and the usefulness of the images for trial" (Little, 2001, p13). Programs in New York City are exploring both these technologies to maximize photodocumentation of genital injury in sexual assault patients. (Rape Crisis Network Europe, 2003)

1. Much physical evidence is short-lived, and, if not recorded, may be lost.
2. The appearance of injuries can change significantly with time.
3. Photographs create a permanent record of the acute injury and reduce subjectivity.
4. Photographs serve as an aid to memory.
5. They permit the court and jurors to see the evidence “as it was” (NYS DOH, 2004).

According to the protocol,

“conventional 35mm cameras are preferred for legal work, and 35mm film (ISO 100 or 200) for slides are preferred. These cameras allow the use of interchangeable lenses (e.g., macro) and flashes (e.g., ring flashes), which produce better results for close-up work. The image quality cannot be viewed until a later date because of film development. Many hospitals do not have access to police or other secure photo labs, and patient confidentiality and the chain of custody preclude commercial photo shops from handling such material” (NYS DOH, 2004).

The NYS DOH Protocol suggests contacting local criminal justice agencies on the use of digital cameras:

“although digital cameras are widely available, they have not yet been ‘fully tried and tested’ in the legal arena. Prior to a decision regarding whether to use digital photography, seek guidance from the local District Attorney and courts as to the admissibility of digital photographs as evidence in a particular jurisdiction” (NYS DOH, 2004).

The protocol goes on to state that “instant” cameras, such as Polaroid, are commonly found in emergency departments and clinics where victims are examined. These cameras allow the image to be viewed immediately, and eliminate concerns about developing images outside the facility.

The image quality and color reproduction tends to be less reliable than conventional cameras. Most colposcopes can use either Polaroid-type or 35mm cameras (NYS DOH, 2004).

In this study, all of the hospitals surveyed use cameras to photograph injuries. Many EDs use Polaroid cameras (41%), and 20.5% use digital cameras. Approximately 38.5% use more than one type, either Polaroid, digital, or 35mm. Among hospital emergency departments that use digital cameras, 100% are private hospitals, and half (50%) are SAFE Centers of Excellence. The majority of the hospital EDs using digital cameras exclusively are located in Manhattan (62.5%).

Nearly all hospitals (97.4%) routinely label photographs, and 89.7% have a standard procedure for photo documentation. All four hospitals without a standard procedure in place for photo documentation, all are non-SAFE EDs. The majority of surveyed hospital EDs (69.2%) use a ruler or scale in the photo for reference.

Toluidine Blue for Injury Detection

In the context of a sexual assault forensic examination, the dye Toluidine blue is used to locate and document injuries. Because the dye is selectively taken up by injured tissue, micro abrasions and lacerations can be visualized after the genital and perianal area are stained with Toluidine blue and then destained. Any remaining blue after destaining is indicative of cellular damage. The use of Toluidine blue dye is controversial in some jurisdictions (e.g., it may be perceived by the court as changing the appearance of the tissue) and not universally used. Only three of the EDs surveyed (7.7%) use Toluidine blue to illustrate abrasions and other injuries: two SAFE Centers of Excellence and one non-SAFE ED.

Injury Documentation

The *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault* includes a Comprehensive Sexual Assault Assessment Form in the Appendix (NYS DOH, 2004). This three-page form includes sections on the initial assessment, pertinent past medical history, sexual assault history, physical examination, examination techniques, diagnostic tests, STI prophylaxis, HIV PEP, post-coital contraception, referrals given and chain of custody and ends with the provider's signature. This form is a blueprint for all the information that should be recorded during a sexual assault exam.

All 39 hospitals use a comprehensive care form to document evidence collection and the forensic exam. The majority of hospital EDs (71.8%) use the NYS DOH Comprehensive Sexual Assault Assessment Form included in the Protocol; 25.6% use a form developed by their hospital for the assessment; and one ED uses both. The majority (81.5%) of non-SAFE EDs use the form available in the NYS DOH Protocol, whereas only 45.5% of SAFE Centers of Excellence use the NYS DOH comprehensive form. The majority of EDs that use the NYS DOH form are private EDs (82.8%); 60% of public EDs use their own form.

Evidence Storage

All of the EDs surveyed have the capacity to store the NYS Sexual Offense Evidence Collection Kits in locked cabinets. Nearly all (89.7%) store the kits within the hospital, while 10.3% (4 EDs) turn the kits over to law enforcement immediately. It is unclear whether these four emergency departments are obtaining patient consent prior to doing so. In New York, a patient may consent to having evidence collected and *not* consent to reporting the crime.

When this happens, the kits should be securely stored at the hospital and turned over to the police *only* when the patient consents to release of the kit thereby involving law enforcement.

Due to survey limitations, we were unable to follow-up about why certain programs reported not storing kits. Further research should explore this finding.

Similarly, if the DFSA kit is not immediately handed over to a police officer for transport to the NY Crime Lab, the sealed kit must be placed in a secure and refrigerated area to maintain the quality of the blood and urine samples taken. In this sample, 79.4% of EDs have the capacity to store DFSA kits in refrigerated secure storage. Four SAFE Centers of Excellence and two non-SAFE EDs were unable to securely store DFSA kits in refrigerated areas.

NYS law requires that hospitals store the NYS Sexual Offense Evidence Collection Kits for at least 30 days. Among hospitals surveyed, only four non-SAFE hospitals (11.4%) stored kits less than 30 days, and three non-SAFE EDs (8.6%) did not know how long they were stored. The rest of the hospitals stored the kits at least 30 days, with 37.1% storing them for one to three months. Table 8 details how long, on average, the surveyed hospital EDs store Sexual Offense Evidence Collection Kits and how many notify victims prior to throwing kits away in addition to other variables. Only eight of the surveyed hospitals notify the victim prior to discarding the kits, four SAFE Centers of Excellence and four non-SAFE hospitals.

Table 8: Storage of NYS Sexual Offense Evidence Collection Kits, Chain of Evidence and Patient Notification

	Total Sample (n=39)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)	Public Hospital EDs (n=10)	Private Hospital EDs (n=29)
Use NYS Collection kit? <i>Yes</i> <i>I don't know</i>	94.9% (37/39) 2.6% (1/39)	100% (11/11) —	92.8% (26/28) 3.5% (1/28)	100% (10/10) —	93.1% (27/29) 3.4% (1/29)
Use the NYS DFSA kit? <i>Yes</i> <i>I don't know</i>	84.6% (33/39) 5.1% (2/39)	100% (11/11) —	78.5% (22/28) 7.1% (2/28)	100% (10/10)* —	79.3% (23/29) 6.9% (2/29)
Capacity to store DFSA kits? <i>Yes</i> <i>I don't know</i>	79.4% (27/34) 2.9% (1/34)	60% (6/10) —	87.5% (21/24) 4.1% (1/24)	100% (10/10)* —	72% (18/25) 4% (1/25)
Record log of release <i>Yes</i> <i>I don't know</i>	86.8% (33/38) 2.6% (1/38)	100% (11/11) —	81.5% (22/27) 3.7% (1/27)	90% (9/10) —	85.7% (24/28) 3.6% (1/28)
Store evidence kits? <i>Store kits</i> <i>Turn over to police</i>	89.7% (35/39) 10.3% (4/39)	100% (11/11) —	85.7% (24/28) 14.2% (4/28)	100% —	86.2% (25/29) 13.8% (4/29)
How long store kits? <i>Less than 1 month</i> <i>1–3 months</i> <i>4–6 months</i> <i>7–12 months</i> <i>1–5 years</i> <i>I don't know</i>	11.4% (4/35) 37.1% (13/35) 25.7% (9/35) 2.9% (1/35) 14.3% (5/35) 8.6% (3/35)	— 9.1% (1/11) 45.5% (5/11) 9.1% (1/11) 36.4% (4/11) —	16.6% (4/28) 50% (12/24) 16.6% (4/24) — 4.1% (1/24) 12.5% (3/24)	— 30% (3/10) 30% (3/10) 10% (1/10) 20% (2/10) 10% (1/10)	16% (4/25) 40% (10/25) 24% (6/25) — 12% (3/25) 8% (2/25)
Contact victim prior to throwing away kits <i>Yes</i> <i>I don't know</i>	22.9% (8/35) 25.7% (9/35)	36.4% (4/11)** —	16.6% (4/24) 37.5% (9/24)	50% (5/10)* 20% (2/10)	12% (3/25) 28% (7/25)
Has anyone been trained to testify in court?	71.8% (28/39)	100% (11/11)	60.7% (17/28)	100% (10/10)**	62.1% (18/29)

* p<.05, ** p<.01 t-test run between SAFE and non-SAFE and between private and public EDs

Maintaining the Chain of Evidence

Accurately maintaining and accounting for sexual assault evidence is essential for the evidence to be useful in a court of law. The “chain of custody” is a legal term describing the movement, location, and succession of people responsible for the sexual assault evidence (NYS DOH, 2004). According to the NYS Protocol,

“in order to maintain the chain of custody, an evidence collection kit and the specimens it contains must be accounted for from the moment collection begins until the moment it is introduced in court as evidence. Each item of evidence must be labeled with the initials of everyone who handled it, the date, a description and source of the specimen, the name of the examiner, and the name of the patient. Evidence not included in the kit (e.g., clothing, photographs, etc.) must be individually packaged, sealed and labeled with a description of the item. Providers must have specific protocols in place to insure confidentiality and maintain the chain of custody of the evidence... Maintaining the chain of custody during the examination is the sole responsibility of the examiner, and requires no outside assistance” (NYS DOH, 2004).

In this study, most EDs (86.8%) keep a record log of all evidence that is turned over to law enforcement. As seen in Table 8, all of the SAFE Centers of Excellence maintain a record, whereas two non-SAFE EDs report that they do not have a record log that documents the release of forensic evidence to law enforcement. SAFE clinicians are often called upon to testify on the physical findings of an exam in a court of law. The majority of the hospitals surveyed (71.8%) have trained staff how to testify in court about medical evidence, including all of the SAFE Centers of Excellence.

Chapter 4: Information, Advocacy and Follow-up Care

Availability of Information

Providing written information to sexual assault patients in their native language is an important component of quality care. Research has shown that trauma impacts the way a person retains information. For sexual assault patients who have just experienced a very serious trauma, retaining complicated medical and other information may be difficult, which underlies the importance of having low-literacy written materials available.

To assess the availability of information we measured the availability of: 1) literature on follow-up counseling, 2) Crime Victims Board claim forms in the Emergency Department, 3) literature on emergency contraception, 4) literature on HIV/PEP, 5) literature on STIs, 6) information on reporting to the police and 7) all the above in languages other than English.

Follow-up Counseling and EC Literature

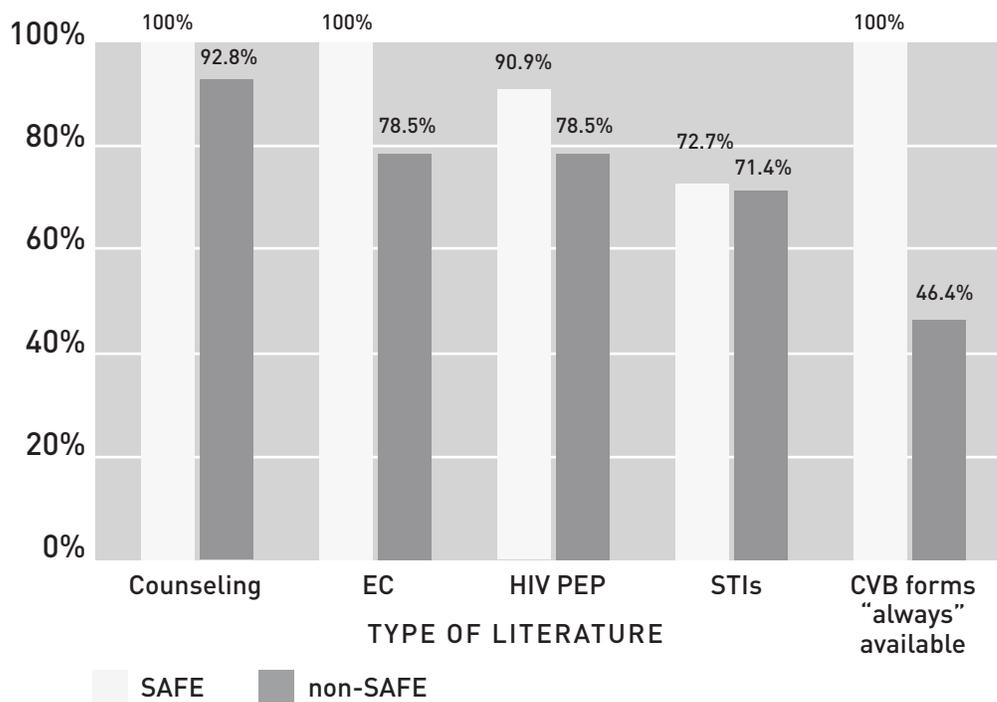
Most hospitals provided written information on follow-up counseling (94.9%) and have resources in languages other than English (81.1%), including all SAFE Centers of Excellence and all public hospitals. Of the emergency departments that provide this information in languages other than English, most EDs report offering it in Spanish (93.3%).

Emergency contraception literature is available in 84.6% of the EDs surveyed. This literature is available in all SAFE Centers of Excellence, in 78.5% of non-SAFE EDs, in 80% of public EDs and 86.2% of private EDs. Among EDs with this literature available, 78.8% report having it in languages other than English. Many of these EDs reported available literature in all the NYS DOH-published languages, including: Spanish, Chinese, Korean, Creole, Hindi, Arabic, and Russian.

Crime Victims Board Claim Forms

Crime Victims Board claim forms should also be available in the emergency department. The Forensic Reimbursement Act allows hospitals to be reimbursed up to \$800.00 for medical services provided to victims of sexual assault. Previously, victims of sexual assault were forced to pay their own medical expenses. The Forensic Reimbursement Act means that the victim does not have to apply to the Crime Victims Board (CVB) directly for a forensic exam. The CVB does offer compensation for other expenses incurred as a result of the crime to victims, and CVB claim forms should be available to patients in all EDs. A little more than half (61.5%) of the EDs reported having the Crime Victims Board claim forms available. When asked how often CVB forms are available, all of the SAFE Centers of Excellence reported 'always,' compared to only 46.4% of non-SAFE EDs (Chart 1). Twenty percent (21.4%) of non-SAFE EDs reported they did not know if the claim forms were available for sexual assault patients.

Figure 1: Availability of Literature for Sexual Assault Patients by Hospital ED Type



HIV PEP Information

Sexual assault patients who receive HIV post-exposure prophylaxis (PEP) also need written information on the treatment and follow-up. PEP is a 28-day treatment of combination antiretroviral drugs taken twice a day as a preventative measure against HIV infection after exposure. The efficacy of PEP has been widely debated, but its biological plausibility has been accepted based on scientific findings from data sources, such as case-controlled studies of occupational exposure, animals with exposure to the simian immunodeficiency virus (SIV), and mother-to-child transmission. Risk reduction was found from 25.1% to 9.3% [CDC, 2005].

If the patient has opted for the HIV PEP, the ED clinician would prescribe an HIV PEP starter kit, which will be given to the patient at the ED with further instructions to return for follow-up care. At the first follow-up visit, the patient will be offered HIV baseline testing. During follow-up visits, the patient will also be provided with the remaining doses of HIV PEP, or if they are HIV positive, with appropriate treatment. The follow-up care also includes subsequent HIV tests after the preliminary baseline HIV test, to check for any HIV infection from the assault. Providing information to the sexual assault patient in the ED is crucial given all the follow-up that needs to occur after the initial visit.

Most EDs surveyed (82.1%) provide literature about HIV PEP medications. As indicated in Chart 1, 90.9% of SAFE Centers of Excellence and 78.5% non-SAFE EDs provide written information on HIV PEP.

Furthermore, 70% of public hospital EDs surveyed and 86.2% of private hospital EDs provided this information. Among EDs that provide this information, 65.6% reported that it was also available in languages other than English. Of those that provide the information in languages other than English, the languages most frequently reported include Spanish (95.2%), Russian (28.5%) and Korean (23.8%).

It is also important to provide literature on other sexually transmitted infections (STIs), since the patient will either be tested and/or provided prophylaxis for many possible STIs. Nearly three-quarters of the EDs surveyed (71.8%) reported providing literature on STIs to sexual assault patients. As seen in Figure 1, SAFE Centers of Excellence and non-SAFE EDs almost equally provide this information (72.7% and 71.4%). Half of the public EDs reported providing this information, while 79.3% of private EDs make this information available to patients. Among EDs with this literature available, 72.4% reported providing it in other languages. All of these EDs report having the literature in Spanish and 19% in Russian.

All surveyed hospitals provide information to victims of sexual assault about police involvement.

Referral for Follow-up Care

We asked if the ED provided follow-up care services for sexual assault survivors: 1) follow-up appointments for HIV PEP; 2) referral to follow-up counseling at an in-house rape crisis program, an in-house social work program, a local rape crisis program, another program or a combination of these; 3) follow-up with patients regarding referrals and a timeframe; and 4) long-term follow-up care.

HIV PEP Follow-Up

When asked how often, on average, the staff in the emergency department makes a follow-up HIV PEP appointment for patients, 100% of SAFE Centers of Excellence reported 'always' doing so, compared to only 60.7% of non-SAFE EDs. Similarly, 100% of public hospital EDs, compared to 62.1% of private ones, make follow-up appointments for HIV PEP. Several EDs reported that they only provide the patient with the information for follow-up services. Others were unsure who made the appointment, and many suggested that the social work department usually makes those appointments.

Counseling Referrals

Table 10 shows the percentage of EDs surveyed that provided referrals for counseling and where the patients were referred. Overall, 94.9% of the EDs surveyed refer sexual assault patients for follow-up counseling. The majority of patients were referred to either an in-house rape crisis program (35.1%) or a local rape crisis program (29.7%). More of the public hospital EDs surveyed referred sexual assault patients to in-house social workers than private hospital EDs (30% vs. 14.8%).

Overall, 68.4% of the hospitals surveyed were able to routinely 'check in' with patients after discharge regarding their referrals. Most of the SAFE Centers of Excellence (90.9%) and 57.6% of non-SAFE EDs reported being able to check-in with patients. Of these hospitals, the majority (57.7%) call within 24 hours.

Table 9: Follow-up Care by Hospital ED Type

	Total Sample (n=39)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)	Public Hospital EDs (n=10)	Private Hospital EDs (n=29)
Refer patients for follow-up counseling	94.9% (37/39)	100% (11/11)	92.8% (26/28)	100%(10/10)	93.1% (27/29)
Where do you refer?					
<i>In-house rape crisis</i>	35.1% (13/37)	90.9% (10/11)***	11.5% (3/26)	50% (5/10)	29.6% (8/27)
<i>In-house social worker</i>	18.9% (7/37)	9.1% (1/11)	23.1% (6/26)	30% (3/10)	14.8% (4/27)
<i>Local rape crisis</i>	29.7% (11/37)	—	42.3% (11/26)	—	40.7%(11/27)
<i>Other</i>	8.1% (3/37)	—	11.5% (3/26)	10% (1/10)	7.4% (2/27)
<i>Combination</i>	8.1% (3/37)	—	11.5% (3/26)	10% (1/10)	7.4% (2/27)
Check-in with patients regarding their referrals	68.4% (26/38)	90.9% (10/11)	57.6% (15/26)	100%(10/10)**	59.3% (16/27)
If yes, how long after the patient leaves the ED do you check-in?					
<i>Within 24 hours</i>	57.7% (15/26)	60% (6/10)	56.2% (9/16)	60% (6/10)	56.3% (9/16)
<i>Within 48 hours</i>	19.2% (5/26)	30% (3/10)	12.5% (2/16)	20% (2/10)	18.8% (3/16)
<i>Within 1 week</i>	11.5% (3/26)	10% (1/10)	12.5% (2/16)	10% (1/10)	12.5% (2/16)
<i>I don't know</i>	11.5% (3/26)	—	18.7% (3/16)	10% (1/10)	12.5% (2/16)
Able to conduct long term follow-up?					
<i>Yes</i>	26.3% (10/38)	36.4% (4/11)	23.1% (6/26)	40% (4/10)**	21.4% (6/28)
<i>I don't know</i>	13.2% (5/38)	—	15.3% (4/26)	—	17.9% (5/28)

** p<.01, *** p<.001 t-test run between SAFE and non-SAFE and between private and public EDs

Very few (26.3%) of the EDs surveyed reported being able to conduct long-term follow-up with sexual assault patients. A larger percentage of SAFE Centers (36.4%) than of non-SAFE EDs (23.1%) reported being able to conduct long-term follow-up. Similarly, more public EDs (40%) reported being able to conduct long-term follow-up than private EDs (21.4%).

Victim Advocates

Once a sexual assault victim arrives at the hospital, best practice requires that a victim advocate be called. Research has clearly established that advocates are indispensable for victim-centered care (see box on Victim Advocates).

The most common type of victim advocates is a volunteer who works with local rape crisis programs and undergoes a mandatory, 40-hour training. Research demonstrates that volunteer rape victim

advocates improve survivors' satisfaction with the care they receive in the acute care setting at a statistically significant level (see the Alliance's companion study, *A Room of Our Own: Survivors Evaluate Services*). After training, advocates are on-call during specific time periods and report to the emergency department whenever a patient reporting a sexual assault arrives. In addition to volunteers, victim advocates may also be hospital social workers, other hospital staff or a combination of these.

According to the 2004 *National Protocol for Sexual Assault Medical Forensic Examinations*, services offered by volunteer advocates during the exam process may include:

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

To measure the services offered by victim advocates in EDs, we collected the following data: 1) the percentage of EDs that work with victim advocates to support sexual assault patients, 2) the type of victim advocates that are used, 3) the extent of victim advocate training, including the 40-hour rape crisis training, 4) how often, on average, the physical exam begins before the victim advocate is present, 5) the percentage of EDs that have an on-call schedule for victim advocates, and 6) the percentage of EDs that have a back-up, on-call schedule for victim advocates.

Types and Training of Advocates

As seen in Table 10, the majority of EDs surveyed use victim advocates to help support sexual assault survivors. About three in ten (31.4%) use only volunteer advocates. One-fifth (20%) only use hospital social workers or other hospital staff as their victim advocates.

Table 10: Types and Availability of Victim Advocates by Hospital ED Type

	Total Sample (n=39)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)	Public Hospital EDs (n=10)	Private Hospital EDs (n=29)
ED use victim advocates?	89.7% [35/39]	100% [11/11]	85.7% [24/28]	100% [10/10]**	86.2% [25/29]
What are these victim advocates?					
<i>Hospital SW</i>	17.1% [6/35]	9.1% [1/11]	20.8% [5/24]	10% [1/10]	20% [5/25]
<i>Other hospital staff</i>	2.9% [1/35]	9.1% [1/11]	—	10% [1/10]	—
<i>Volunteer advocates</i>	31.4% [11/35]	36.4% [4/11]	29.1% [7/24]	20% [2/10]	36% [9/25]
<i>Combination</i>	48.6% [17/35]	45.5% [5/11]	50% [12/24]	60% [6/10]	44% [11/25]
How many of these victim advocates receive the 40 hour training?					
<i>All</i>	48.6% [17/35]	72.7% [8/11]**	37.5% [9/24]	50% [5/10]	48% [12/25]
<i>Most</i>	8.6% [3/35]	18.2% [2/11]	4.1% [1/24]	20% [2/10]	4% [1/25]
<i>Some</i>	8.6% [3/35]	—	12.5% [3/24]	—	12% [3/25]
<i>None</i>	17.1% [6/35]	9.1% [1/11]	20.8% [5/24]	20% [2/10]	16% [4/25]
<i>I don't know</i>	17.1% [6/35]	—	25% [6/24]	10% [1/10]	20% [5/25]
On call schedule for victim advocates?	80% [28/35]	90.9% [10/11]	75% [18/24]	90% [9/10]	76% [19/25]
Back-up on-call schedule for victim advocates?					
<i>Yes</i>	62.9% [22/35]	90% [9/10]	72.2% [13/18]	88.8% [8/9]**	73.6% [14/19]
<i>I don't know</i>	8.6% [3/35]	10% [1/10]	11.1% [2/18]	—	15.7% [3/19]
How often exam begins before advocate is present?					
<i>Always</i>	15.4% [6/39]	—	21.4% [6/28]	—	21.4% [6/28]
<i>Most of the Time</i>	12.8% [5/39]	—	17.8% [5/28]	—	17.9% [5/28]
<i>Sometimes</i>	28.2% [11/39]	18.2% [2/11]*	32.1% [9/28]	40% [4/10]*	25.0% [7/28]
<i>Rarely</i>	28.2% [11/39]	54.5% [6/11]	17.8% [5/28]	30% [3/10]	28.6% [8/28]
<i>Never</i>	12.8% [5/39]	27.3% [3/11]	7.1% [2/28]	30% [3/10]	7.1% [2/28]
<i>I don't know</i>	2.6% [1/39]	—	3.5% [1/28]	—	—

* p<.05, ** p<.01, t-test run between SAFE and non-SAFE and between private and public EDs

Many EDs (48.6%) use a combination of hospital social workers, staff and volunteer advocates. Nearly half (45.5%) of the SAFE Centers of Excellence report utilizing a combination of volunteer advocates and hospital social workers, 36% use only volunteer advocates, and 18.1% use only hospital staff. A similar pattern emerges among non-SAFE EDs with half (50%) reporting that their advocates comprise both hospital staff and volunteer advocates. Timing appears to ultimately determine which type of advocate a victim receives: hospital social workers are usually assigned in the day; rape crisis programs provide volunteer advocates on nights and weekends.

Many public (60%) and private (44%) EDs use a combination of volunteer advocates and hospital staff, as well as EDs in Brooklyn (40%) and Manhattan (64.3%). However, significantly more Queens EDs (57.1%) use hospital social workers than those in the other boroughs ($p < .01$).

Less than half (48.6%) of the EDs surveyed reported that 'all' of the victim advocates who work with sexual assault survivors in their ED have received the 40-hour training offered through rape crisis programs throughout the City. Seventeen percent of the respondents reported that none of the victim advocates had received the training, and another seventeen percent did not know if the advocates they work with had received the training.

The majority of EDs (56.4%) reported that the exam began 'sometimes,' 'most of the time,' or 'always' before the victim advocate was present.

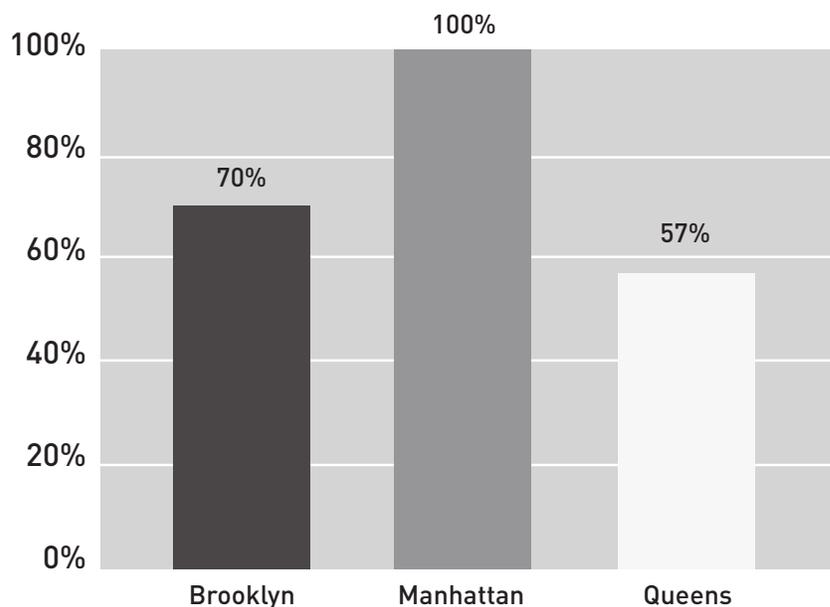
Availability of Victim Advocates

When a patient seeks acute care services for a sexual assault, the triage nurse should alert the on-call SAFE or attending doctor and a victim advocate. Advocates accompany the patient and act as a liaison with doctors and police.

Having an on-call schedule is important to provide 24-hour advocate coverage for sexual assault patients. Eighty percent of EDs surveyed reported having an on-call schedule for their victim advocates. More SAFE Centers of Excellence reported having on-call schedules for advocates than non-SAFE EDs (90.9% vs. 75%). Likewise, more public EDs reported having on-call schedules for their advocates than private EDs (90% vs. 76%).

Figure 2 shows the percentage of EDs with an on-call schedule for victim advocates by borough. All of the Manhattan EDs surveyed have an on-call schedule for victim advocates, compared to 57% of Queens EDs and 70% in Brooklyn.

Figure 2: Percentage of EDs with On-call Schedule for Victim Advocates by Borough



Rape Crisis Advocates: Evidence-Based Best Practice

“Hospitals need to acknowledge that people who were raped before rape advocates evolved, were considered the instigators and this is something we will always live with...”
—50-year-old female (New York City Alliance Against Sexual Assault, 2007)

Rape crisis advocates provide emotional support to a victim of sexual assault in the hospital setting and may accompany victims from the initial contact and the actual exam to discharge and follow-up. Since they are not affiliated with law enforcement or criminal justice agencies, advocates can provide emotional support to the victim while remaining separate from the criminal investigation (Carmody, 2006). At the same time advocates also work to prevent what is called “secondary victimization,” or the insensitive, victim-blaming behaviors of service providers and responders that increase the trauma of the rape (Campbell, 2006).

Recent research has focused on the effectiveness of rape crisis advocates to both improve service delivery to survivors and to prevent secondary victimizations in the law enforcement and acute care settings. A study conducted by Rebecca Campbell (2006) interviewed eighty-one survivors in hospitals after an assault about the services received from legal and medical system personnel and how they were treated during these interactions. Findings showed that survivors who had the assistance of a rape crisis advocate were more likely to have police reports taken and less likely to be treated negatively by the police (Campbell, 2006).

Likewise, survivors who were accompanied by an advocate in the emergency department were significantly more likely to receive information on STDs and the risk of HIV, and were more likely to receive STD prophylaxis and emergency contraception than women from the hospital who did not have a rape crisis advocate present (Campbell, 2006). Also, victims who worked with advocates were less likely to report being treated impersonally or coldly by hospital staff, being asked how they were dressed at the time of the assault, or asked about prior sexual

histories than survivors who did not work with a victim advocate (Campbell, 2006). In the hospital that did not utilize victim advocates, survivors were significantly more likely to be asked by medical staff if they had responded sexually to the assault than survivors who worked with victim advocates (Campbell, 2006). Lastly, survivors who did not have a rape crisis advocate were more likely to report blaming themselves for the assault and were significantly more likely to state that they were reluctant to seek further help (Campbell, 2006).

In our companion study, *A Room of Our Own: Survivors Evaluate Services*, sexual assault survivors in NYC were significantly more satisfied with the care they received at the hospital if a rape crisis advocate was present (New York City Alliance Against Sexual Assault, 2007). When survivors were asked what recommendations they had for improving care at the hospital level in NYC, the most frequent recommendation was to have rape crisis advocates available for survivors (New York City Alliance Against Sexual Assault, 2007).

Rape crisis advocates also positively impact chart documentation in the acute care setting. In a study conducted at the Sexual Assault Violence Intervention (SAVI) program at Mt. Sinai Hospital, 153 sexual assault patient charts were reviewed from 1998 to 2002. The study examined inappropriate documentation, which was defined as either 1) inclusion of a medical and forensic history that contained an interview/investigation outside the purview of patient diagnosis and care, or 2) the use of judgmental terminology such as the word “alleged” or the use of evaluative and/or interpretive words in the patient’s story was undermined or minimized by the clinician (Kahn & Frounfelker, 2005). The study found that the presence of a volunteer rape crisis advocate was a statistically significant protective factor leading to a decreased likelihood of the use of the word “alleged” in the chart documentation of sexual assault patients (Kahn & Frounfelker, 2005).

Chapter 5: Quality Assurance

Quality Assurance (QA), also known as Quality Improvement, is the systematic process of measuring quality in services with the desire to improve those services. Quality Assurance in the treatment of sexual assault patients in the acute care setting is an important but often overlooked process.

For QA, we measured: 1) whether the ED participated in an interdisciplinary taskforce focused on sexual violence; 2) whether the ED had done any community outreach about their services in the last six months; 3) among SAFE EDs, whether all staff received an orientation to the program; 4) whether the hospital ED ran into problems releasing information or evidence to detectives or Assistant District Attorney's (ADAs); 5) whether there was an established system of QA in place for patients reporting a sexual assault; 6) whether chart audits were routinely conducted on sexual assault patients; 7) whether they have conducted a patient satisfaction survey in the last two years; and 8) whether there was collection of any additional data beyond diagnostic codes.

DOH-certified SAFE Centers of Excellence are required to participate in an interdisciplinary taskforce that includes local rape crisis programs, law enforcement representatives and local prosecutors to develop services that meet community needs and to ensure that quality victim services are available. These taskforce meetings can also serve as a forum for issues that arise in clinical practice or with law enforcement or criminal justice.

Many EDs surveyed (64.5%) reported participating on an interdisciplinary taskforce. Of these, 35% participate monthly; 60% participate every two to six months, on average; and 5% participate every six to twelve months. Nearly all the SAFE Centers of Excellence (81.8%) participate in one of these taskforces, compared to 57.8% of non-SAFE EDs.

Outreach to the community about the services offered to sexual assault patients can help ensure quality by engaging the community in discussions

about ED services. All of the SAFE Centers of Excellence had conducted outreach in the community in the six months preceding the survey, compared to only 35% of non-SAFE EDs. Most, or 70%, of the public hospital EDs and half (50%) of the private EDs reported conducting outreach.

It is crucial that the entire ED staff knows if there is a specialized SAFE Center in a hospital ED or a trained SAFE clinician working there. When patients walk into the emergency department or come from another department, they need these specialized services. It is also important that all members of the ED are trained on the protocols so they can provide care for sexual assault patients consistent with established standards. We asked whether an orientation had been given to the entire ED on their services. Nearly all (90.9%) of the SAFE Centers of Excellence had given all ED staff an orientation to the SAFE services, and all of the non-SAFE EDs with several trained examiners gave an orientation to other ED staff on the SAFE services they offered in their hospital.

Only a small percentage of EDs (20.5%) reported problems releasing information to detectives or ADAs. When asked what these problems entailed, half reported that police officers demand evidence without the patient's consent or the provider's opinion on the case. Another 25% mentioned that the risk management and hospital records departments sometimes pose barriers to detectives and ADAs. One respondent also reported that the Department of Corrections requested information on prisoners who were patients.

Nearly three-quarters (71.8%) of EDs sampled have an established system of quality assurance specific to patients reporting sexual assault. Most SAFE Centers of Excellence (90.9%) have established QA systems, compared to 64.2% of non-SAFE EDs (Table 11). All public hospital EDs have established QA systems, compared to 62.1% of private hospital EDs.

Table 11: Quality Assurance Variables by Hospital Type

	Total Sample (n=39)	SAFE Center of Excellence EDs (n=11)	Non-SAFE EDs (n=28)	Public Hospital EDs (n=10)	Private Hospital EDs (n=29)
Established system of QA for patients reporting sexual assault? <i>Yes</i>	71.8% (28/39)	90.9% (10/11)	64.2% (18/28)	100%(10/10)***	62.1% (18/29)
Chart audits routinely conducted on patients reporting sexual as- sault? <i>Yes</i> <i>I don't know</i>	71.8% (28/39) 2.6% (1/39)	90.9% (10/11) —	64.2% (18/28) 3.5% (1/28)	100% (10/10)** —	62.1% (18/29) 3.4% (1/29)
Collection of any ad- ditional data beyond diagnostic codes? <i>Yes</i> <i>I don't know</i>	28.2% (11/39) 7.7% (3/39)	54.5% (6/11) —	17.8% (5/28) 10.7% (3/28)	30% (3/10) —	27.6% (8/29) —

** p<.01, *** p<.001 t-test between private and public EDs

A chart audit is an examination of medical records (electronic and/or hard copy), to determine what has been done and to see if it can be done better (Duke University Medical Center, 2005). EDs that have protocols for the care of sexual assault patients can use audits to assess how well they are following these protocols. Many of the EDs surveyed (71.8%) routinely conduct audits on sexual assault

patient charts. SAFE Centers of Excellence are more likely to conduct audits than non-SAFE EDs (90.9% vs. 64.2%). Similarly, all public EDs reported that they conduct sexual assault-specific chart audits, compared to 62.1% of private EDs. Only one ED has conducted a patient satisfaction survey in the last two years.

Quality Assurance Frameworks

Quality in healthcare is often defined as providing client-centered services and meeting clients' needs (Berwick et al., 1990 as cited in Engenderhealth, 2003). There are many reasons to work toward improving quality in the acute care setting: improved quality safeguards the health of both clients and staff, attracts clients, maintains the organization's strengths and leads to savings (less repeat work and waste) and in the field of acute care response to sexual violence may decrease the secondary victimization experienced by survivors by reducing victim-blaming and insensitive behaviors on the part of health care staff. Quality assurance is an effort that seeks to continuously do things better until they are done right the first time, every time (Engenderhealth, 2003).

There are three major frameworks of quality assurance that will be described here: 1) COPE: Client-Oriented, Provider-Efficient Services, 2) PI: Performance Improvement, and 3) AI: Appreciative Inquiry.

COPE, which stands for Client-Oriented and Provider-Efficient Services, is a trademark of Engenderhealth and has been used to improve health care services in many developing countries. COPE is a participatory quality assurance framework embodied by the idea that changes in quality will be most successful and lasting when they are initiated by staff working together within the facility, using their expertise to identify problems and develop recommendations for solving these problems (Engenderhealth, 2003). The definition of quality in COPE incorporates clients' rights to quality care and staff needs for the support (supervision, training, supplies and equipment) that will ensure their clients receive that level of care (Engenderhealth, 2003).

COPE is a quality improvement (QI) framework in that it defines quality services using clients' rights as the overarching standard and assessing them through client interviews, staff self-assessments, and community activities (Engenderhealth, 2003). The main question in QI is what steps can we take to make sure we do the right thing in the right way (Engenderhealth, 2003)? The COPE handbook includes sample tools and exercises to facilitate the COPE process at any health facility.

Performance Improvement, or PI, is a performance-driven measure that defines desired performance through the standards set by stakeholders and asks the question: what is needed to improve performance? Results are achieved through a systematic process that: 1) considers the institutional context; 2) describes desired performance; 3) identifies gaps between desired and actual performance; 4) identifies root causes; 5) selects, designs, and implements interventions to fix the root causes; and 6) measures changes in performance (Engenderhealth, 2003).

Appreciative Inquiry, or AI, is a capacity-building process that focuses on an organization's strengths developed by David Cooperrider of Case Western Reserve University. In AI, this process has four stages known as the discovery, dream, design and destiny phases (the 4-D cycle). **Discover:** The identification of organizational processes that work well. **Dream:** The envisioning of processes that would work well in the future. **Design:** Planning and prioritizing processes that would work well. **Destiny:** The implementation (execution) of the proposed design (AI Commons, 2007). The basic idea is to create organizations around what works, rather than trying to fix existing problems.

More than one quarter (28.2%) of the EDs collect additional data beyond diagnostic codes on patients reporting sexual assaults. More than half (54.5%) of the SAFE Centers of Excellence collect additional data on their patients, compared to 17.8% of non-SAFE EDs. Among those collecting additional data, they reported the following types of information:

- If HIV PEP was offered,
- If EC was offered,
- Time of arrival of patient being seen,

- If a victim advocate was present,
- If there were any weapons involved in the assault,
- If STI prophylaxis was refused,
- If STI prophylaxis was administered,
- Social work referrals made,
- Demographics and variables around the assault (stranger or acquaintance),
- If the colposcope was used, and
- If photos were taken.

Chapter 6: Implications

This study provides a snapshot of services available to sexual assault victims in New York City's emergency departments, including the strengths and weaknesses of current resources in the acute care setting. The implications of these findings in each of the five areas researched will be discussed: 1) availability of Sexual Assault Forensic Examiner Programs in NYC; 2) medical care for sexual assault patients; 3) forensic evidence collection; 4) information, advocacy and follow-up services; and 5) quality assurance.

Availability of Sexual Assault Forensic Examiner Programs in NYC

A survivor of sexual assault in New York City could receive very different health care depending on which hospital they visit. The results of this study demonstrate that SAFE Centers of Excellence provide the most comprehensive care for sexual assault patients; such programs should be available and accessible to *all* New Yorkers.

Currently, these programs are distributed in a non-systematic fashion throughout the city. There are two important areas to be addressed:

1. What is the number of SAFE programs that are still needed in NYC, and where should they be located?
2. How can New Yorkers know about and access these programs when they are needed?

Access to SAFE Programs

While it is important to have SAFE programs in place, it is equally important that sexual assault patients be seen at these programs instead of at emergency departments without specialized services. There are three main issues related to the accessibility of SAFE programs: 1) ambulance destination designation for SAFE Centers, 2) hospital-

to-hospital transfer agreements, and 3) increased public knowledge about SAFE programs and where they are located.

Unless a patient requests transport to a specific facility, FDNY EMS must transport sexual assault patients to the nearest 911-receiving ED, regardless of whether or not other local facilities provide more specialized care for sexual assault. According to hospitals and, ultimately, the state, all emergency department facilities must be able to medically manage sexual assault patients. Granting SAFE Centers of Excellence status as EMS destinations will facilitate transport of medically stable sexual assault patients to the nearest SAFE center. Moving such a designation forward will involve collaboration between FDNY EMS, the Regional Emergency Medical Services Council of New York City (REMSCO), the Regional Medical Advisory Committee (REMAC), and the State DOH Bureau of EMS (New York City Alliance Against Sexual Assault, 2005a).

Issues affecting sexual assault patients who “walk in” to emergency rooms

Some sexual assault patients are not brought to the hospital by an ambulance but instead walk into the ED. In order for sexual assault patients to have access to the best care available at SAFE Centers, transfer agreements need to be put in place to transport a stable patient from a non-SAFE to a SAFE Center. The logistics of transferring patients from hospitals without SAFE programs to designated SAFE Centers involves careful consideration of the Emergency Medical Treatment and Active Labor Act (EMTALA) and medical transfer rules.

EMTALA, which applies to all hospitals that participate in the federal Medicare program, imposes two primary obligations on those hospitals. First, when an individual presents for treatment at a hospital's emergency room, “the hospital must provide for an appropriate medical screening examination...to determine whether or not an emergency medical

condition” exists (42 U.S.C. § 1395dd(a)). Second, if the screening examination indicates that an emergency medical condition does exist, the hospital ordinarily must “stabilize the medical condition” before transferring or discharging the patient (Id. § 1395dd(b)(1)(A)). With respect to facilitating a SAFE Center model, EMTALA would require a “fast-track” screening examination by non-SAFE facilities for those patients who agree to be transferred to SAFE Centers for their care.

Public Knowledge of SAFE Programs

Although transfer protocols are critical, they should exist only as a back-up plan. The SAFE Center model should depend more strongly on the public *knowing* where specialized care exists, so that sexual assault patients pursue care at SAFE centers first, not requiring a transfer. As such, facilitating the SAFE Center model will also require the development of a communication campaign that informs the public about what SAFE Centers are and where they exist.

City Commitment to SAFE Programs

The New York City Health and Hospital Corporation’s (HHC) commitment to developing SAFE programs in all public hospitals appears to be unique nationally. Leadership from the Mayor’s office has jump-started efforts in every HHC hospital to improve services to rape victims. The value of one-time federal or city discretionary funding spearheaded by the Mayor’s office for these initiatives cannot be overstated, as funding of SAFE programs continues to be an ongoing struggle.

Leadership and political will go a long way toward large-scale changes, such as developing SAFE programs in multiple emergency departments. The findings of this study underscore how public hospitals have made tremendous strides in providing care for survivors of sexual violence. This is due, in part, to the dedication of key policymakers and government officials.

The next step toward ensuring universal access to the best standard of care for all sexual assault victims in New York City will involve detailed conversation and brainstorming among many key stakeholders. The SAFE Center model, as described above, will require tremendous cooperation between hospital systems and the nurturing of new partnerships. It also must allow for the development of new SAFE programs in underserved areas. This means building in a mechanism for new examiners to train and new programs to develop, while still ensuring best care for all. This may require collaborative agreements, and allowing new SAFE examiners to complete preceptorships at established SAFE programs in order to staff newly forming programs.

Only the sustained political will and social commitment can ensure that *all* sexual assault patients in New York City receive the same standard of care, no matter where they are treated. The city should continue to support these programs.

Medical Care for Sexual Assault Patients

We found that SAFE Centers of Excellence reported providing medical care that closely mirrors the NYS DOH’s *Protocol for the Acute Care of the Adult Patient Reporting a Sexual Assault*—the best practice standard of care in NYS (2004). A few issues raised in the data that should be further examined include: 1) preceptorship of SAFE clinicians, 2) ongoing training of SAFE clinicians, 3) testing versus providing prophylaxis for STIs, and 4) guiding principles for either the referral of child/adolescent cases to Child Advocacy Centers or their treatment at SAFE Centers.

More providers than ever are taking the five-day SAFE training course, but the number of NYS DOH-certified SAFE providers is still low. Upon completion of the SAFE course, all providers must be precepted (i.e. supervised doing a certain number of exams and passing all the proficiencies required to become a certified SAFE clinician). For hospitals with a small number of experienced SAFE clinicians or those just beginning a SAFE program, it may be impossible to find someone within their own hospital who can act as a preceptor. Due to the complica

tions of credentialing, it is hard for outside doctors to come into a new hospital in order to act as a preceptor. Further research should be conducted on how to ensure acumen of SAFE clinicians.

The NYS DOH Protocol states that SAFE clinicians must engage in ongoing learning around sexual assault. However, we found that many EDs are not able to offer these opportunities to their examiners in a systematic fashion. Sustained training needs to be provided to SAFE clinicians, such as continuing education credentialing like Continuing Medical Education (CME) credits for local sexual assault-focused forums, conferences and workshops.

Many hospital EDs report following varied protocols around the acute care response for STIs for sexual assault patients. This is congruent with the current national debate around STI testing. While the NYS DOH protocol is very clear on what should be done, it is important to conduct research-to-practice forums around what is prosecutorially evidence-based.

ED administrators and examiners did not provide consistent answers when asked about adult versus child protocols usage in the management of sexual assault cases. Furthermore, there are not any written guidelines on how to determine when a patient should be treated using the adult protocol. A workgroup with clinicians should be held to establish guidelines on when to refer child/teen cases to Child Advocacy Centers (CACs) and when to treat at SAFE Centers.

Forensic Evidence Collection

SAFE Centers of Excellence reported in this study that they collect forensic evidence within the guidelines as set for by the NYS DOH's Protocol (2004). A few areas for further clarification include: 1) whether kits are stored or turned directly over to the police, 2) using standardized evidence collection kits, 3) length of kit storage time, and 4) contacting victims prior to throwing away kits.

New York State is a non-mandatory reporting state, meaning that sexual assault patients decide if they want to report assaults to law enforcement. When ED directors and practitioners were asked if they stored kits, many replied that they turn all the kits

over to the police. More research needs to be conducted to determine whether they do this with the patient's consent. Also, these kits are free through the New York State Division of Criminal Justice Services (DCJS) and help ensure that all evidence collection occurs in a systematic and controlled fashion. Unlike our results, no hospitals should be reporting that they do not use these kits, including the Drug Facilitated Sexual Assault Kit.

Several hospital EDs reported storing kits for less than 30 days, the current mandatory time required. More research should be done to find out barriers to storing kits. If it is a logistical issue, then these issues should be addressed.

Very few EDs, including SAFE Centers of Excellence, reported contacting a victim prior to throwing away their evidence collection kit. More discussion should determine if there are ways to follow-up with these patients about the disposal of their kits. Specifically, qualitative research with survivors would be helpful to determine best practice for contacting patients who choose to store evidence collection kits at the hospital.

Information, Advocacy and Follow-Up

Consistently, SAFE Centers of Excellence reported providing information, advocacy and follow-up services more often than non-SAFE EDs. Related implications include: 1) 24-hour coverage by advocates, 2) volunteer versus hospital social workers or hospital staff as victim advocates, 3) the provision of standardized low-literacy literature for sexual assault patients, 4) the provision of these materials in languages other than English, and 5) the difficulties of follow-up.

The crucial role of advocates in terms of providing quality treatment and eventual recovery from trauma cannot be overstated. Based on the research showing the importance of rape crisis advocates, all EDs in NYC should use victim advocates. In order for this to occur, more rape crisis programs need to be established outside of Manhattan, and more funding needs to be given to existing rape crisis programs so that they can expand their advocate services to more emergency departments.

Many hospitals use a mixture of volunteer community members, hospital social workers and other hospital staff to provide advocacy for sexual assault patients in the emergency department. More research is needed to elicit what difference on the quality of care, if any, results from using hospital staff as advocates versus volunteer rape crisis advocates.

There is a great need for victims of sexual assault to receive adequate information both verbally and in the form of pamphlets regarding follow-up care for sexual assault, HIV testing, and STIs. While many EDs report providing literature in different languages, this varied across hospitals. Aside from the NYS DOH-produced literature on emergency contraception, there seems to be no standardized literature available to patients reporting a sexual assault. Furthermore, it is unclear whether the brochures used for all topics have been developed with low-literacy populations in mind. More standardized literature should be developed, using a health communication framework that includes gathering input from SAFE programs, rape crisis programs, survivors and other key stakeholders on language. Brochures are especially needed on HIV PEP and STIs.

It is also crucial that resources be available in a multitude of languages. The population of New York City is very diverse and inhabitants include individuals from 180 countries worldwide. Additionally, according to the U.S. Census 2000, 48% of individuals living in New York City spoke a language other than English in their homes. The diverse NYC population should have full access to all services and assistance possible following a sexual assault. Hospitals must increase the amount of literature

they provide to non-English speaking individuals regarding follow-up care, HIV medication, and STIs. This means that all of the patient literature should be translated into several key languages, such as Spanish and Chinese, among others.

Follow-up with sexual assault patients is very low for both specialized SAFE programs and for non-SAFE EDs. The reasons are well-understood, as patients often do not want to be contacted after they are seen in the ED. Further research needs to be conducted to analyze if there are methods of follow-up that would be acceptable to sexual assault patients.

Quality Assurance

Quality assurance is an area where much more work can be done on the part of SAFE Centers to measure the quality of care provided to patients and to work towards improvement. One recommendation would be to adapt a quality improvement manual, such as the Client-Oriented and Provider-Efficient Services (COPE) framework described in chapter 5, to the specific needs of Sexual Assault Forensic Examiner Programs. This would allow more quality assurance exercises to take place within EDs for the treatment of patients reporting sexual assaults and the crucial inclusion of survivor input into these services.

Table 12: Summary of Recommendation Based on Study Findings

Availability of SAFE Programs	Medical Treatment	Forensic Evidence Collection	Information, Advocacy and Follow-Up	Quality Assurance
Establish critical number of SAFE Centers in NYC.	Research on how to ensure acumen of SAFE clinicians.	Follow-up research on hospitals' protocols and procedures on releasing evidence collection kits to the police.	Work towards ensuring all EDs in NYC utilize victim advocates for sexual assault patients by creating more RCPs and providing more funding to current RCPs to expand their coverage.	Develop QI manual, such as COPE, that is specific to SAFE Centers.
Develop ambulance destination designation for SAFE Centers.	The Alliance and other organizations provide continuing education credentialing for sexual assault forums, conferences and workshops.	Outreach to all EDs on the availability of the free standardized NYS Sexual Offense Evidence Collection Kit and the DFSA Kit.	Research to determine if sexual assault patients are differently impacted by staff social workers versus volunteer victim advocates.	Include survivors in quality improvement exercises.
Develop transfer protocols for patients from non-SAFE to SAFE Centers.	Conduct research to practice forum for providers about the current prosecutorial evidence-base for testing vs. not testing for STIs.	More research on hospital barriers to storing kits.	Use a health communication framework to develop standardized low-literacy brochures for sexual assault patients on HIV PEP and STIs as well as other relevant issues.	
Develop communications campaign to let New Yorkers know what SAFE Programs are and where they exist.	Develop workgroup to establish guidelines on when to refer child/teen cases to CACs and when to treat at SAFE Centers.	Qualitative research with survivors to determine best practice with regard to contacting patients before discarding evidence collection kits.	Use a health communication framework to develop standardized low-literacy brochures for sexual assault patients in languages other than English.	
			Conduct research on the barriers to follow-up and methods that would be acceptable to sexual assault patients.	

We have made great strides in establishing best care guidelines for sexual assault patients in NYC's emergency departments. Since the first mapping of services conducted by the Rape Treatment Consortium in 1996, we have established more

comprehensive SAFE programs to care for sexual assault patients. As advocates, policymakers, city officials and community members, we now must work to ensure that all New Yorkers have access to these services.

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Appendix A: Methodology

The research question for this study was: What are the enhancements (including and beyond the mandated NYS protocol) that hospital EDs in New York City have made for treating patients reporting sexual assault?

One of the goals of the Alliance is to improve the care that sexual assault survivors receive in New York City so that every survivor has access to the care they need. Knowing the current state of care will allow the Alliance to help make improvements by leveraging more financial support for EDs and by providing trainings for hospital personnel on topics related to the care of sexual assault survivors.

Survey Development

The survey questions were developed by examining several protocols and resources for the acute care of sexual assault survivors including:

1. NYS Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault,
2. The New York State Sexual Assault Reform Act (SARA), Sexual Assault Forensic Examiner (SAFE) Program from the New York State Department of Health (appendix in the NYS protocol),
3. The U.S. Department of Justice's National Protocol for Sexual Assault Medical Forensic Examinations,
4. New York State Public Health Law; Section 2805-i; Treatment of sexual offense patients and maintenance of evidence in sexual offense, including Sections 2805-l (4-b) and 2805-l (5); Establishment of hospital-based Sexual Assault Forensic Examiner Programs (appendix in NYS protocol),
5. New York State Department of Health Guidelines for HIV post-exposure prophylaxis (appendix in NYS protocol), and
6. Teenagers, Health Care and the Law: A guide to the Law on Minors' Rights in New York State published by the New York Civil Liberties Union Reproductive Rights Project.

Members of the NYS Division of Criminal Justice Services Sexual Assault Examiners Listserv were asked for ideas to help in the development of survey questions on forensic evidence collection and possible chain-of-evidence problems at the hospital end.

Once a final draft of the survey was completed and reviewed by the Research Team, the survey instrument was presented to two committees for review and comment: the Operations, Standards and Training Committee and the Criminal Justice Collaboration Project Committee. These two committees looked at the draft version of the survey in depth and were asked to provide answers to the following questions:

1. Survey quality: Does the survey cover all key topic areas related to SAFE centers? Is the length appropriate to cover all main topics? Is there anything missing that we should add?
2. Gradation of importance: Which of the topics and/or questions on the survey is the most important? Should some sections of the survey carry more weight than others? If so, which ones and why?
3. Administering the survey: We plan to have student research assistants administer the survey to a designated hospital official. Who should be the designated hospital official? Will one person be able to complete the entire survey? Will one person be willing to sit with the research assistant until the survey is completed?
4. Buy-in: How can we ensure buy-in from all hospital administrators so that we can have completed surveys for every emergency room? Will any of the questions encourage biased answers (i.e., to make the hospital look good)? How can we avoid this bias?

Comments from these two committees were incorporated into the survey draft.

Survey Pilot

Five EDs participated in the pilot of the hospital survey representing Brooklyn, Manhattan and Queens. Three of the EDs were public and two were private.

These sites went through the survey question-by-question with the interviewer and answered for their institution. Several questions also were asked about the structure of the survey including:

1. Was the terminology for the questions appropriate?
2. Were there questions I should have asked?
3. Are there any questions I can eliminate?
4. Did any of the questions seem confusing or inappropriate?
5. Do you have any ideas of a second respondent who is not in an administrative position that we could also give the survey to? (This role should be similar across all hospitals.)

The survey took approximately 30 minutes for the respondents to complete. Changes and suggestions were incorporated into the final draft of the survey.

The Alliance's Research Advisory Committee also reviewed the survey drafts and provided comments that were incorporated into the final survey.

Sampling

The universe of hospital EDs in NYC was used as the sample framework. Using the EMS ambulance directory from 2004 and cross-checking with the NYC Department of Health and Mental Hygiene's hospital emergency department list, the final sample size was 64 EDs. Veterans' Hospitals were included, as they provide acute medical care. One

hospital emergency department was excluded from the final sample size as it had closed down recently, making the final sample size 63 EDs.

A research assistant from John Jay College of Criminal Justice was trained to conduct in-person or telephone interviews with the survey. All EDs were notified of the survey by initial letters and were contacted via phone and email by the Research Assistant. When designing the survey, there was a concern about whom to interview. It was felt that administrator responses might be different from examiner responses, and the Research Team was uncertain if one respondent would be able to answer all of the questions. Thus, two respondents from each ED were interviewed, one administrator and one provider.

The first survey was conducted with either the Emergency Department Director or the SAFE Medical Director or Coordinator. Upon completion of the first interview, the respondent was asked for the name and contact information of the second, provider respondent. To ensure comparability across hospitals, a random day of the week and hour of the day were drawn separately from a hat to help identify provider respondents. Administrator respondents were asked to provide the name and contact information for the person that was working the previous Tuesday at 8pm who would have conducted an exam if a survivor had come into the ED at that time. The provider was then contacted to complete the same survey.

The administrator responses have been used throughout the report for several reasons: 1) there was a larger sample size with administrator respondents (39 versus 23 providers) and 2) t-tests have indicated few variables for which administrator and provider responses were statistically significantly different (table 1). Providers were less likely to know the answers to certain questions, such as whether community outreach was conducted, whether there was a specific protocol for working with victims who are Mentally Retarded or Developmentally Disabled (MRDD) and whether they were able to conduct long-term follow up. Both the community outreach and the long-term follow-up may be outside of the purview of the provider's job.

Table 1: Comparison of Administrator and Provider Responses

Question	Administrators (n=23) % (n)	Provider (n=23) % (n)	t-test (n=23) (95% CI)
Participate in interdisciplinary taskforce? Yes <i>I don't know</i>	68.4% (13/19) —	63.6% (14/22) 31.8% (7/22)	2.73** [-3.43, -.47]
Community Outreach in the last 6 months? Yes <i>I don't know</i>	73.7% (14/19) —	22.7% (5/22) 36.4% (8/22)	3.95*** [-4.10, -1.28]
Do you have a specific protocol for treating MRDD patients? Yes <i>I don't know</i>	60.9% (14/23) —	34.8% (8/23) 21.7% (5/23)	2.68** [-2.77, -.35]
Do you check-in with patients regarding their referrals?	77.3% (17/22)	27.3% (6/22)	3.74*** [-.769, - .231]
Are you able to conduct long term follow-up? Yes <i>I don't know</i>	31.8% (7/22) 4.5% (1/22)	26.1% (6/23) 26.1% (6/23)	2.00** [-2.72, .022]

** significant at the .01 level

*** significant at the .001 level

Some hospitals have more than one ED in different locations across the City. It is important to note that the sample was based on EDs, not hospitals. The Research Assistant followed up with non-repondents at least five times. Due to the chaotic nature of EDs and quick turnover, it was difficult to gather survey interviews from all administrators.

Table 2: Emergency Department Survey Response Rates by Borough

	Response Rate % (proportion)
Total Sample	62% (39/63)
Bronx	40% (4/10)
Brooklyn	66.6% (12/18)
Manhattan	73.6% (14/19)
Queens	61.5% (8/13)
Staten Island	33.3% (1/3)
Public Hospitals	83.3% (10/12)
Private Hospitals	57% (29/51)

Data was collected for eight months from April 2005 to December 2005. A total of 39 hospital EDs completed the survey. Twenty-three hospital EDs completed both the administrator and provider surveys. The total survey response rate for NYC EDs was 62% (Table 2). This is comparable to a national study with a 66% response rate on a mail survey to Sexual Assault Nurse Examiner programs (Ciancone et al. 2000). Although in person administered surveys have higher response rates, the lower response rate in this sample is due to the difficulty tracking down hospital administrators and providers given the nature of their mobile work (i.e. they are not typically in an office with a computer and phone). Many administrators and providers indicated initial willingness to take the survey, but due to time constraints and difficulty in setting up interviews, they were not able to complete the survey within the study timeframe.

Public hospitals had twice the response rate of private hospitals (83.3% versus 46%). As the findings demonstrate, significant strides have been made for treating sexual assault patients in public hospitals. This could impact response rates. EDs that have established programs or that have made enhancements may have been more likely to participate in the survey for two reasons: 1) there is a designated point person for the SAFE program in

the hospital who might have more time to participate in a survey that is focused on the treatment of sexual assault patients, and 2) they provide more services and are thus more open about the services they provide.

The response rate for Certified SAFE Centers of Excellence for this study was 100%. Thus, we can safely assume that the remainder of emergency departments are non-SAFE and do not offer comprehensive services for sexual assault patients (not including the six additional EDs that have been certified as of December 2006).

The data were analyzed using SPSS 11.5 for Windows. Independent t-tests were used to test the difference in means and the significance level is reported at the .05, .01 or .001 levels as indicated in the report. One-way ANOVA was used to test difference between borough means (Manhattan, Brooklyn and Queens). Further examination of differences was conducted using Tukey's Ad hoc comparison with equal variances assumed.

Appendix B: Survey Instrument

* This survey is copyrighted. Please do not replicate the survey in whole or part without prior permission from the New York City Alliance Against Sexual Assault (contact research@nycagainstrape.org)

Satisfaction with Services in New York City

This is a non-judgmental, confidential survey to capture the procedures followed by hospitals when treating a sexually assaulted patient. Only the researchers will know the hospital's name. The hospital's name will not be named in any published or non-published reports. We are hoping to use this data to advocate for increased funding and training for hospital EDs to treat sexual assault patients.

SECTION 1: SAFE PROGRAMS

1. Does your hospital have a Sexual Assault Forensic Examiner's Program certified by the Department of Health as a Center of Excellence?
 Yes No I don't know
2. Does your hospital incorporate a protocol (similar to a Department of Health Sexual Assault Forensic Examiner's Program) for treating patients reporting a sexual assault?
 Yes No **(Skip to #7)**
3. How many years has the SAFE program been in place at your hospital?
 Less than one year
 1-2 years
 2-3 years
 3-5 years
 More than 5 years
 I don't know
4. Does your SAFE program participate in an interdisciplinary taskforce that includes criminal justice and rape crisis center staff?
 Yes No I don't know

5. If Yes, how often, on average?
 Every month Every 2-6 months
 Every 6-12 months Every year
 Other (specify)
6. In the last six months, has your SAFE program done any outreach in the community?
 Yes No I don't know

SECTION 2: STAFFING

7. Does your emergency department have in-house Sexual Assault Forensic Examiners?
 Yes No **(Skip to #17)**
8. What is the role of the SAFE coordinator?
 Administrative
 SAFE Examiner
 Both
 Other
9. How many Sexual Assault Examiners work at your hospital?
_____ (fill in the blank)
10. I understand many examiners have received the 5-day training but are still going through their preceptorship with the goal of applying for NYS DOH certification. How many SAFE examiners in your program have earned NYS DOH certification?
_____ (fill in the blank)
11. How does your organization ensure ongoing learning or training for SAFE's?

12. We understand that there may be a high turnover for SAFE's. How do you retain SAFE's?

- Monthly meetings
- Competitive salary
- Other _____

13. Does your emergency department have an on-call schedule for Sexual Assault Examiners?

- Yes
- No

14. Does your emergency department have a back-up on-call schedule for Sexual Assault Examiners?

- Yes
- No

15. What is Plan B if there is no on-call or backup on-call staff?

16. Do all doctors and nurses in the emergency room, regardless if they are part of the SAFE program, receive an orientation to the SAFE program?

- Yes
- No

SECTION 3: SART

17. Does your emergency room department participate in a Sexual Assault Response Team (SART) program?

- Yes
- No **(Skip to Question 20)**

18. On average, how long does it take the SART to arrive at the hospital once they are called?

- 1-15 minutes
- 16-30 minutes
- 31-45 minutes
- 46-60 minutes
- 1-2 hours
- more than 2 hours

19. How many years has the SART program been in place at your hospital?

- Less than 1 month
- 1-3 months
- 3-6 months
- 6-12 months
- more than 1 year

20. How many SAFE's are available through the SART program? _____

SECTION 4: VICTIM ADVOCATES

21. Does your Emergency Department use victim advocates?

- Yes
- No **(Go to Question 26; skip 27)**

22. Are these victim advocates hospital social workers, other hospital staff, rape crisis advocates, or a combination?

- Hospital social workers
- Other hospital staff
- Rape Crisis advocates
- Combination
- Other (specify)

23. Would you say that all, most, some or none of the victim advocates (including Social Workers) have received the 40-hour rape crisis training?

- All
- Most
- Some
- None
- I don't know

24. Does your emergency department have an on-call schedule for victim advocates?

- Yes
- No
- I don't know

25. Does your emergency department have a back-up on-call schedule for rape crisis advocates?

- Yes
- No
- I don't know

SECTION 5: TIMELY TREATMENT

26. What is the average time for a sexual assault patient to be in the waiting room before being seen by a nurse or doctor?

- 1-15 minutes
- 15-30 minutes
- 31-45 minutes
- 46-60 minutes
- more than one hour

27. I know sometimes there are circumstances beyond hospital control that delay an advocate from arriving in a timely manner. How often would you say the physical exam begins before the victim advocate is present: Always, most of the time, sometimes or never?
- Always
 - Most of the time
 - Sometimes
 - Rarely
 - Never

28. On average, how long does it take the on-call Sexual Assault Examiner or doctor who handles sexual assault cases to arrive at the hospital once they are called?
- 1–15 minutes
 - 16–30 minutes
 - 31–45 minutes
 - 46–60 minutes
 - 1–2 hours more than 2 hours

29. What is the average length of stay in the ER?
- 0–2 hours
 - 2–4 hours
 - 4–6 hours
 - More than 6 hours
 - I don't know

30. How long does it usually take to do the exam once the SAFE arrives?
- 0–1 hours
 - 1–2 hours
 - 2–3 hours
 - More than 3 hours
 - I don't know

SECTION 6: SPACE

31. Do you have a private room with a door designated for patients reporting sexual assault?
- Yes No I don't know

32. How often would you say that patients reporting sexual assault are seen in a private area of the hospital: Always, most of the time, sometimes or never?
- Always
 - Most of the time
 - Sometimes
 - Never
 - I don't know

33. Does this private room have a shower?
- Yes No I don't know

34. If No, is there a shower available near the private room?
- Yes No I don't know

35. Is the private room or area handicap accessible?
- Yes No I don't know

SECTION 7: SPECIALIZED EQUIPMENT

36. Does your emergency department have a dedicated Colposcope to use for patients reporting sexual assault?
- Yes No I don't know

37. Does this Colposcope have the ability to photograph?
- Yes No I don't know

38. Does your emergency department have a camera to photograph injuries?
- Yes No I don't know

39. If Yes, what type of camera?
- Digital
 - 35mm
 - Polaroid
 - Other

40. Does the program use a ruler or scale (such as a quarter in the picture for reference) for measurement reference for injury documentation?
- Yes No I don't know

41. Does the program routinely label photos with the patient name or ID number and date?
 Yes No I don't know
42. Is there a standard procedure in place regarding photo documentation (i.e. who develops, where they are placed, how they are stored.)
 Yes No I don't know
43. Does your program use Toluidine Blue for injury detection?
 Yes No I don't know
44. Does your program have an ultraviolet light?
 Yes No I don't know
45. Does your program have swab dryers?
 Yes No I don't know
46. If No, what do you use to dry swabs?

SECTION 8: TREATMENT

47. We know that most hospitals have general guidelines for treating MRDD patients. Does your emergency department have a specific protocol on how to obtain consent from mentally retarded or developmentally disabled patients presenting for sexual assault?
 Yes No I don't know
48. Does your emergency department have a protocol on how to obtain consent from patients presenting for sexual assault who are under the influence of drugs or alcohol?
 Yes No I don't know
49. What determines using a child or adult protocol?
 Age Maturity Other
50. Is there a minimum age for using an adult protocol?

51. Would you say that replacement clothing is always, most of the time, sometimes or never available to patients reporting sexual assault in your emergency department?
 Always
 Most of the time
 Sometimes
 Never
52. Would you say that Crime Victims Board claim forms are always, most of the time, sometimes or never available in the emergency department?
 Always
 Most of the time
 Sometimes
 Never
53. Does your emergency department have access to 24-hour translation services?
 Yes No I don't know
54. If yes, do you use a person or a phone translation system?
 Person Phone Both
55. Does your emergency department routinely provide patient literature on counseling services for those who have been sexually assaulted?
 Yes No I don't know
56. Is the counseling services literature translated into any languages other than English?
 Yes No I don't know

If yes, what languages:

57. Does your emergency department give patients reporting sexual assault written information about emergency contraception?
 Yes No I don't know

58. Is the emergency contraception literature translated into any languages other than English?

- Yes No I don't know

If yes, what languages:

59. Is the patient given a pregnancy test, where applicable?

- Yes No I don't know

60. Is the patient reporting a sexual assault provided with emergency contraception always, most of the time, sometimes or never, provided that the patient is not already pregnant?

- Always
 Most of the time
 Sometimes
 Never

61. On average, does the patient obtain the emergency contraception directly from the health staff, at an in-house pharmacy or at an outside pharmacy?

- From health staff
 At in-house pharmacy
 At outside pharmacy

62. Does your emergency department hand out written information about STIs and Hep B?

- Yes No I don't know

63. Is the STI literature translated into any languages other than English?

- Yes No I don't know

If yes, what languages:

64. What STIs are routinely tested for when a patient is reporting a sexual assault?

(See Comprehensive Sexual Assault Assessment Form)

65. Is the patient provided with prophylaxis for STDs and Hepatitis B, where medically feasible?

- Yes No I don't know

66. Does your emergency department hand out written information about HIV Post-Exposure Prophylaxis (HIV PEP) for non-occupational exposure?

- Yes No I don't know

67. Is the HIV PEP literature translated into any languages other than English?

- Yes No I don't know

If yes, what languages:

68. Is the patient provided with prophylaxis for HIV PEP, where medically feasible?

- Yes No I don't know

69. On average, are follow-up appointments made always, most of the time, sometimes or never for the HIV PEP?

- Always
 Most of the time
 Sometimes
 Never

70. Does your emergency department routinely give verbal information to patients reporting sexual assault about reporting to the police?

- Yes No I don't know

SECTION 9: FOLLOW-UP SERVICES

71. On average, do you refer sexual assault patients to a rape crisis program for follow-up counseling?

- Yes No **(Go to Q. 73)**

72. Is this rape crisis counseling referral for:

- An in-house rape crisis program (Skip to #75)
 An in-house social work program
 A local rape crisis program. **(Skip to #75)**

IF THEY ANSWER THAT THEY REFER TO AN **IN-HOUSE SOCIAL WORK PROGRAM**:

73. Is there a local rape crisis program near to the hospital that you know of?

- Yes **(Skip to #76)** No

74. IF ANSWER NO: If there was a local rape crisis program available would you refer patients to this program?

- Yes No

75. Do you routinely 'check in' with patients after they leave the hospital regarding their referrals?

- Yes No **(Skip to #78)**

IF YES:

76. How long after they leave the emergency department do you check in?

- Within 24 hours
 Within 48 hours
 Within 1 week
 Other

We know that for many hospitals, the 'check-in' is the only opportunity for follow-up with the patient.

77. Is your hospital able to conduct any long-term follow-up with patients (i.e. anything after 1 month?)

- Yes No **(Skip to #79)**

IF YES:

78. How long after they are discharged from the ED do you follow-up? _____

SECTION 10: QUALITY OF EVIDENCE COLLECTION

79. Does your emergency department use a standardized comprehensive care form to document evidence collection and injury?

- Yes No I don't know

80. Some hospitals use the NYS Protocol comprehensive care form for documenting injuries, while other hospitals make their own specific injury documentation record. Do you use the NYS Protocol example SAFE form or your own?

- SAFE's
 Hospital's (Ask for a copy of their form.)
 I don't know

81. Does your emergency department use the New York State Sexual Offense Evidence Collection Kit?

- Yes No I don't know

82. Do you follow all the steps listed in the kit?

- Yes **(Go to #84)** No

83. If no, which steps do you not follow and why?

84. Does your emergency department use the New York State Drug-Facilitated Sexual Assault Kit?

- Yes No

85. Do you follow all the steps listed in the kit?

- Yes **(Go to #87)** No

86. If no, which steps do you not follow and why?

87. Do you have the capacity to store DFSA kits in locked, refrigerated storage?

- Yes No I don't know

88. Does your emergency department keep a record log for the release of forensic evidence to law enforcement? (Clothing, kits etc.)

- Yes No I don't know

89. Are forensic evidence kits stored in locked cabinets?

- Yes No I don't know

90. On average, how long do you store forensic evidence kits?

- Less than 30 days
- 1–3 months
- 4–6 months
- 7–12 months
- 1–5 years
- More than 5 years

91. Does your emergency department contact victims prior to throwing away the forensic evidence kits?

- Yes
- No
- I don't know

SECTION 11: SAFE DISCHARGE

92. Does a staff member of the emergency department inquire about the victim's discharge destination always, most of the time, sometimes or never?

- Always
- Most of the time
- Sometimes
- Never
- I don't know

93. Will your emergency department allow an overnight stay of a patient reporting sexual assault until they can secure a safe location?

- Yes
- No
- I don't know

94. Does your emergency department routinely secure transportation for patients reporting sexual assault upon discharge from the hospital?

- Yes
- No
- I don't know

95. Is follow-up outreach to the patient reporting sexual assault routinely conducted the following day to ensure their safety?

- Yes
- No
- I don't know

SECTION 12: QUALITY IMPROVEMENT

96. Do you run into problems releasing information to detectives or ADAs?

- Yes
- No
- I don't know

97. If yes, what problems? How is it usually resolved?

98. Has anyone in your staff been trained to testify in a court of law about medical evidence and collection procedures?

- Yes
- No
- I don't know

99. Is there an established system for quality improvement of care specifically for treating patients reporting sexual assault?

- Yes
- No
- I don't know

100. Are chart audits routinely conducted on patients reporting sexual assault?

- Yes
- No
- I don't know

101. To your knowledge, has your emergency department/SAFE program conducted a satisfaction survey for patients reporting sexual assault in the last two years?

- Yes
- No
- I don't know

102. To your knowledge, does your emergency department/SAFE program collect any additional data (beyond m-stat; complaint codes; drg diagnostic related group codes) about patients reporting sexual assault?

- Yes
- No
- I don't know

103. If Yes, explain.

104. Is there anything else you would like to tell me about any of enhancements made in your ED for treating patients reporting sexual assault?

Thank you for taking time to complete this survey.

Appendix C: Timeline of Legislation and Events around Acute Care for Survivors of Sexual Assault in NYC and NYS

1966 Crime Victim's Board Compensation Established

The New York State Crime Victims Board was created under Article 22 of the Executive Law to compensate innocent victims of crime for unreimbursed out-of-pocket expenses. The board provides substantial financial relief to victims of crime and their families by paying crime-related expenses (NYS CVB, 2006a).

1975 New York Rape Shield Law, Criminal Procedure Code 60.42

Provided for a general rule prohibiting evidence of a victim's prior sexual conduct, with exceptions in certain cases. The statute also provides some procedural protections for the victim and a right to be heard in the proceedings (NYS Assembly, 2006a).

1987 The first specialized sexual assault examiner program in New York City developed as a pilot program at NYC's Bellevue Hospital.

1989 The Governor's Task Force on Rape and Sexual Assault was established by executive order for the purpose of developing a standardized best practice protocol for care of sexual assault patients.

1989 Interviewing in Private Settings, Executive Law Amendment, Article 23, Section 642.2-a

Requires police departments and district attorneys' offices to provide private settings for interviewing victims of sex offenses (NYS OAG, 2006).

1990 Governor Cuomo's administration approved funding for manufacturing sexual assault evidence kits and training to accompany the best practice protocol.

1991 Rape Crisis Center Notification, Executive Law Amendment, Article 23, Section 641.1

Requires police departments to provide victims of sex offenses with written notice of the name, address and telephone number of the nearest rape crisis center (NYS OAG, 2006).

1993 Rape Crisis Counselors' Confidentiality, Civil Practice Law and Rules, Article 45, Section 4510

Established confidentiality privileges for rape crisis counselors (NYS OAG, 2006).

1993 DCJS developed the Sexual Offense Evidence Collection (SOEC) kit to create a standard protocol for hospital personnel to follow in the collection of evidence from those involved in any criminal incident involving a sexual offense. It was established through the cooperative efforts of the State Crime Laboratories, the Division of Criminal Justice Services, the State Police and the Department of Health (NYS DCJS, 2005).

1994 Violence Against Women Act (VAWA)

Passed under the larger Omnibus Crime Control Act, this multi-faceted statute addressed the inequality that women victims of violence encounter in state justice systems. The statute provided funding to states for criminal law enforcement against perpetrators of violence, and for a variety of other services for victims of sexual assault (Sklar & Lustig, 2001).

1994 Public Health Law, section 206(15) Title 10, Subpart 69-5

Established approval guidelines for rape crisis programs for the purpose of rape crisis counselor certification (NYS DOH, 2006b).

1994 DNA Databank

Legislation enacted that authorized the collection of DNA samples from all persons convicted certain felonies including murder, assault, and sex offenses in New York State (NYS Division of State Police, 2006).

2000 DNA Analysis Backlog Elimination Act, H.R. 4640

Authorized the appropriation of \$170 million over fiscal years 2001 through 2004 for grants to states to increase their capability to perform DNA analyses and mandates the collect of DNA samples of violent and sexual offenders (U.S. Department of Justice, 2006a).

2001 Sexual Assault Reform Act (SARA)

First comprehensive reform to Article 130, the article in the penal law defining sex crimes, since it was adopted in 1965. The law defines what constitutes lack of consent and sexual assault (New York City Alliance Against Sexual Assault, 2005b).

2003 Local Law No. 19

Law requires that the Department of Health must make emergency contraception available at every health care facility operated or maintained by the department (NYC Council, 2007).

2003 Local Law No. 25

Law enacted requiring pharmacies in New York City to post signs regarding the sale of emergency contraception (NYC Council, 2006b).

2003 Local Law No. 26

Law states that New York City will only contract with hospitals that provide emergency contraception to rape victims when medically appropriate, and requires hospitals to provide victims with information about emergency contraception (NYC Council, 2006a).

2003 Local Law No. 75

Created to eliminate and prevent employment and housing discrimination for victims of domestic violence, sex offenses and stalking (NYC Council, 2006c).

2003 Forensic Payment Act, Executive Law 631.13

Crime Victims Board began reimbursing service care providers for sexual assault exams. Previously, sexual assault victims were required to pay for their own exam (New York City Alliance Against Sexual Assault, 2005b).

2003 DCJS released a new Drug Facilitated Sexual Assault (DFSA) evidence collection kit to be used in conjunction with the Sexual Offense Evidence Collection kit in cases in which it is suspected that drugs were used to facilitate the assault (NYS DCJS, 2005).

2003 Sexual Assault Reform Act Amendments

A new provision to SARA required hospitals that treat rape victims to provide information on emergency contraception. If the victim requests it, the hospital must provide EC (NYS CVB, 2006c).

2004 Mayor Bloomberg announced a pilot program for the first Sexual Assault Response Team (SART) that will provide forensic and counseling services to rape victims within one hour of arrival at public hospitals in the Bronx (NYC.gov, 2004).

2004 The DOH revised Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault (NYS DOH, 2004).

2004 Justice for All Act, Public Law 108-405

Act created to protect crime victims' rights, eliminate the substantial backlog of DNA samples collected from crime scenes and convicted offenders, and improve and expand the DNA testing capacity of federal, state, and local crime laboratories (U.S. Department of Justice, 2006b).

2005 Violence Against Women and Department of Justice Reauthorization Act, H.R. 3402

Enacted to provide grants to enhance judicial and law enforcement tools to combat violence against women, and improve services for victims of domestic violence, sexual assault, and stalking (The White House, 2005).

2005 NYS Public Health Law; Section 2805-P

Allows information to be provided in emergency rooms and requires emergency rooms to dispense emergency contraception upon request (NYS DOH, 2006b).

2005 The New York State Department of Health AIDS Institute (NYSDOH AI) published revised guidelines that address HIV post-exposure prophylaxis (PEP) following sexual assault. NYSDOH recommends that survivors of sexual assault be treated in an emergency department or equivalent healthcare setting where all appropriate medical resources are available as needed (NYS DOH, 2006b).

2006 Mayor Bloomberg expanded the SART program to hospitals in Manhattan, Brooklyn, and Queens, based on the success of the program in the Bronx (NCDSV, 2006).

2006 DNA Databank Expansion

Legislation passed to expand the DNA databank to roughly triple its size. The criminal DNA database will encompass all persons convicted of felonies and 18 key misdemeanors (NYS Assembly, 2006b).

2006 Eliminating Statute Of Limitations for Sexual Assault Crimes

Eliminated the statute of limitations for the prosecution of, or civil claim against, an action relating to rape in the first degree, a criminal sexual act in the first degree, an aggravated sexual abuse in the first degree, and a course of sexual conduct against a child in the first degree (NYS Assembly, 2006a).

We Need Your Help ▶ Because Sexual Violence Is Still a Problem.

The New York City Alliance Against Sexual Assault develops and advances strategies, policies and responses that prevent sexual violence and limit its destabilizing effects on victims, families and communities. As the only sexual violence organization in the country conducting primary research on sexual violence, we are in a unique position to raise public awareness and

create sustainable change. Our work is made possible by the generous contributions of people like you; people who share the commitment of engaging all communities in addressing sexual violence. Together we can ensure survivors of sexual violence receive the best care and dare to envision a world without sexual violence. All we need is you! Please give today.

Please select how you would like to direct your gift:

- Give to the Alliance / Community Fund
- Innovative Research
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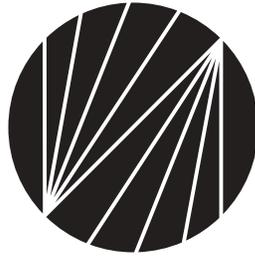
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New York, NY 10014

To learn more about the Alliance or to donate online,
please visit **www.nycagainstrape.org**



**New York City Alliance
Against Sexual Assault**

2005–2007 NYC Alliance Against Sexual Assault

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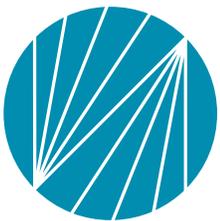
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