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National Training Standards for Sexual Assault Medical Forensic Examiners



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National Training Standards for Sexual Assault Medical Forensic Examiners

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Foreword

A National Protocol for Sexual Assault Medical Forensic Examinations was released in September 2004; it provides details on the roles of responders to sexual assault as part of a coordinated community response. *National Training Standards for Sexual Assault Medical Forensic Examiners* is a companion to the protocol and includes recommendations for training objectives and topics that will enable an examiner to carry out the recommendations. The protocol and standards both take a victim-centered approach to sexual assault forensic examinations and also emphasize offender accountability. We hope the addition of these standards will be useful for communities that wish to establish or enhance training programs for forensic examiners.

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Introduction

National Training Standards for Sexual Assault Medical Forensic Examiners offers a framework for the specialized education of health care providers who wish to practice as sexual assault forensic examiners (SAFEs).¹ The standards provide guidelines to prepare SAFE candidates to work in coordination with other responders to meet the health care, forensic, and information needs of adult and adolescent sexual assault patients who present for the medical forensic examination.² They are intended to guide those who develop, revise, coordinate, and/or conduct SAFE training regarding the minimum levels of instruction necessary to prepare candidates for their role. This is intended as a suggested guideline and it is not required.

Although these standards do not make a recommendation regarding the length of time that should be allotted for initial SAFE education, it is currently accepted among most organizations and individuals who provide basic training that the didactic portion should be at least 40 hours or the equivalent of a semester/quarter.

Background

The Office on Violence Against Women (OVW) developed the standards under the direction of the Attorney General pursuant to the Violence Against Women Act of 2000.³ They are based on recommendations in *A National Protocol for Sexual Assault Medical Forensic Examinations (Adults/Adolescents)*,⁴ which describes the examination process and associated responsibilities of health care personnel, as well as the responses of other professionals related to this process.⁵ In creating these standards, OVW collaborated with the International Association of Forensic Nurses (IAFN) to gather input from veteran SAFE trainers and SAFEs (both nurses and physicians), sexual assault survivors, sexual assault victim advocates, law enforcement representatives, prosecutors, and forensic scientists. Feedback on drafts of the standards was sought from the above individuals as well as from a number of national, state, and local organizations that deal with sexual assault issues.

¹ Some communities refer to SAFEs by different terms/acronyms based on the discipline of practitioners and/or specialized education and clinical experience. For example, sexual assault nurse examiners (SANEs) are registered nurses and advanced practice nurses (can include nurse practitioners and nurse midwives) who receive specialized education and fulfill clinical requirements to perform these exams. Some nurses have been certified to perform adolescent and adult exams (referred to as SANE–Adult and Adolescent or SANE–A) through the International Association of Forensic Nurses (IAFN). Others are specially educated and fulfill clinical requirements as forensic nurse examiners (FNEs), enabling them to collect forensic evidence for a variety of crimes. SAFEs and sexual assault examiners (SAEs) are often used broadly to denote health care providers (e.g., physicians, physician assistants, nurses, nurse practitioners, or midwives) who are specially educated and clinically prepared to perform this examination.

² The term “patient” is commonly used in this document to denote persons who disclose that they recently have been sexually assaulted and who present for a medical forensic examination. There are occasions, however, where the term “victim” is used rather than “patient.” The use of the term “victim” is simply meant to acknowledge that persons who disclose they have been sexually assaulted should have access to certain services and interventions designed to help them be safe, recover, and seek justice.

³ The statutory requirement to develop a national recommended standard for training health care professionals who perform these examinations can be found in Section 1405 of the Violence Against Women Act of 2000, Public Law 106–386. The statutory requirement also mandates the development of a national protocol for these examinations and related recommended training for all health care students.

⁴ In the protocol and in this document, adolescents are distinguished from prepubertal children who require a pediatric examination. The focus of both these documents is on the examination of females who have experienced the onset of menarche and males who have reached puberty. However, age can play a role in whether a person is treated as a child or as an adolescent. For example, some adolescent girls may not menstruate until their later teen years. Although the physical development level of these patients must be taken into account when performing the examination, they should otherwise be treated as adolescents rather than children. Legally, jurisdictions vary in the age at which they consider individuals to be minors, laws on child sexual abuse, mandatory reporting policies for sexual abuse and assault of minors, instances in which minors can consent to treatment and evidence collection without parental/guardian involvement, and the scope of confidentiality that minors are afforded. Involved responders should be well versed in their jurisdictional laws and policies regarding the above issues, screening procedures for determining whether a pediatric examination is needed (particularly in the case of younger adolescents), and local protocols for response to prepubertal victims. Examination sites should follow jurisdictional laws regarding parental/guardian consent.

⁵ Refer to the protocol for an explanation of terms as well as recommendations specific to each component of the examination process.

The standards recommend, rather than mandate, minimum guidelines for didactic and clinical preparation of SAFEs. This document is meant to be a tool to assist in the development or revision of SAFE training programs across the country. Because the standards are minimum recommendations, they enable those that create and provide basic SAFE education to mold training programs that address community-specific needs and issues.

OVW intends that use of these standards across all U.S. jurisdictions⁶ will result in increased uniformity of SAFEs' knowledge and skills. The goal is that every person who reports or discloses a recent sexual assault will have access to a specially educated and clinically prepared SAFE who can validate and address their health concerns, minimize their trauma, promote their healing, and maximize the detection, collection, preservation, and documentation of physical evidence related to the assault for potential use by the legal system. Uniformity in SAFE training can aid in evaluating the effectiveness of examiner response. In addition, the use of these standards is meant to support a coordinated community response to sexual assault and promote responses that recognize and address the unique needs and circumstances of each patient.

Overall Recommendations

A number of broad-based recommendations are offered below to help those involved in the development, revision, coordination, and/or delivery of training programs for SAFEs.

1. Create a foundation for training that supports a coordinated multidisciplinary approach.

The training team should be multidisciplinary. Clearly, education for SAFE candidates should include training and information from health care providers who are veteran SAFEs. Training and information should also come from seasoned practitioners from disciplines beyond health care who have a role in the examination process. These practitioners primarily include community-based sexual assault victim advocates (from local programs and state, territorial, and tribal sexual assault coalitions),⁷ law enforcement representatives, prosecutors, and forensic scientists. Others may be involved in the training program, depending on the topical area discussed (e.g., emergency medical services (EMS) technicians, hospital emergency department staff, forensic photographers, vendors for specific products used during the examination, toxicologists and pharmacologists, criminal justice-based victim-witness specialists, and responders who can address the needs of specific populations in the community such as military personnel and their dependents and college students). The involvement of these practitioners in training should be more than an introduction of their agencies and roles. All responders must learn how to work collaboratively throughout the examination process to assist patients and facilitate collection of evidence. Coordination and collaboration can be demonstrated through role modeling of trainers. Involving trainers from other

⁶ The term "jurisdiction" may be used in two ways in this document. One is to broadly describe a community that has power to govern or legislate for itself. For example, a jurisdiction may be a locality, state, territory, tribal land, or federal land. The term also describes the authority to interpret and apply laws and is used in this context mainly when identifying who has "jurisdiction" over a particular case.

⁷ Jurisdictions developing a SAFE training program that do not have a local community-based sexual assault advocacy program may question the appropriateness of using trainers who represent other victim service entities (e.g., those based in the criminal justice system, examination facility, social services, or other agency). Although it may be helpful to include them on the training team, it is recommended that they not replace trainers who are community-based sexual assault victim advocates. It is critical that SAFE candidates understand what victim advocacy for sexual assault patients fully entails and its relevance to a victim-centered examination process. Trainers who are community-based sexual assault victim advocates are typically best positioned to help candidates meet this objective due to their training; primary mission of supporting victims' needs and wishes; range of services they are accustomed to providing victims and their significant others before, during, and after the examination process; and capacity to talk with patients with some degree of confidentiality. (See the protocol, pages 18–19 and 34–35, for a discussion of the roles of victim service providers/advocates.) If a local community-based sexual assault advocacy program does not exist, the state, tribal, or territorial sexual assault coalition that serves the jurisdiction may be willing to be involved in the training. Alternately, a community-based advocate trainer from another jurisdiction might be considered. It is recommended that any involved advocates/victim service providers coordinate their presentations so that SAFE candidates appreciate the scope and limitations of each of their roles and how they can work together to provide optimal services to patients.

disciplines that have a role in the examination process also helps SAFE candidates understand that they have partners in this work and additional support networks.

To help ensure the cohesiveness of a training program involving multiple presenters, it is helpful to use a facilitator who is a SAFE to oversee the entire training process and highlight the connections between topical areas. Other disciplines and agencies, such as community-based sexual assault programs and state, territorial, or tribal sexual assault coalitions, might be involved in coordination that involves sponsoring the training; recruiting, screening, and registering trainees; and handling other logistics.

Training should stress the importance of SAFEs understanding their roles and the roles of other members of the sexual assault response team (SART).⁸ This information can build SAFEs' knowledge of how to maintain professional boundaries and preserve their objectivity throughout the examination process and beyond. It can help avoid problems that sometimes arise when disciplines are asked to coordinate and/or collaborate, such as the blurring of roles or collusion among responders (rather than each working in the best interests of patients).

2. Find ways to incorporate the voices of survivors of sexual assault into training.

Incorporating survivor input into the training program can help SAFE candidates learn about patients' experiences during the examination process. It also will allow the candidates to hear first hand what was helpful and not helpful to patients and what could be improved to help them in the future. There are numerous ways to involve survivors in training. They may be willing to be panelists or individual speakers (either in person or through video or audio conferencing) or they may prefer to provide input without being physically present at the training (e.g., by providing a letter about their experiences that could be read aloud to SAFE candidates or providing a videotape or audiotape recording that could be aired). Some survivors may want to offer input but remain anonymous. It can be useful to work with the community-based advocacy program to solicit survivor involvement—advocates may be able to help identify survivors who are willing and able to provide input, help them prepare, and provide them with emotional support if needed.

3. Establish trainer qualifications and methods to ensure the quality of trainers and training.

Trainer qualifications should be developed. It is essential that SAFE trainers, as well as those involved in the development, revision, and coordination of training programs:

- Recognize that female and male health care providers from a variety of disciplines in health care can be educated and clinically prepared to be SAFEs (noting that the examination should be done with equal competence regardless of the health care discipline of the examiner);
- Recognize that SAFE trainers can come from a variety of disciplines in health care;⁹
- Understand that medical forensic examinations of sexual assault patients are performed within a health care framework governed by professional standards of care;
- Embrace a holistic approach to restoring and promoting the biological, psychological, and social health of patients throughout the examination process; and

⁸ A SART provides multidisciplinary, specialized, and immediate response to persons who disclose they recently have been sexually assaulted. The team typically includes health care personnel, law enforcement representatives, community-based victim advocates, prosecutors, and forensic scientists (although prosecutors and forensic scientists are usually available for consultation rather than actively involved at this stage). Where they exist, these types of teams vary in what they are called, how they operate, the extent of their activities, and the composition of members. Jurisdictions that do not have a SART may have a more informal network of professionals who work together to respond to these cases.

⁹ SAFEs and SAFE trainers might be registered and advanced practice nurses, physicians, and physician assistants.

- Understand the crucial role that SAFE training programs play in educating SAFEs to provide objective¹⁰ forensic evaluation and health care in a competent, compassionate, and victim-centered manner.

In particular, trainers should:

- Have significant experience in the topical areas in which they are providing training (e.g., trainers who are SAFEs should have considerable experience in all aspects of care for sexual assault patients, including performing examinations, evaluating and managing patients, coordinating responses with other professionals, and preparing for and testifying in court);¹¹
- Provide training appropriate to their expertise and discipline-specific role (e.g., training that addresses legal issues and the impact of evidentiary findings on a legal case should be done primarily by an attorney, although a SAFE may assist with this discussion);
- Be familiar with pertinent medical, scientific, and forensic literature (including the ability to understand the scientific methods described and to critically evaluate the literature);
- Be aware of variations in practices and policies related to the examination process across the country;
- Be skilled in how to sensitively and appropriately address cultural concerns that arise for patients during the examination process, knowledgeable about how to teach SAFE candidates these skills, and able to address SAFE candidates' cultural needs and concerns during training;¹²
- Evaluate, on an ongoing basis, any myths and biases they personally hold related to sexual violence that could hinder their ability to train SAFE candidates; and
- Have experience in facilitating group discussions, knowledge of/experience with adult learning theory, and the capacity to help trainees evolve in attitude, knowledge, and ability.

Methods to ensure the quality of training and trainers should be developed. It is imperative to evaluate the quality of education provided through each training program. Programs are urged to develop measurable learning objectives that specify the desired knowledge, skills, or attitudes that SAFE candidates are to gain through each training module. Evaluation can help ensure that these training objectives are being met and facilitate continuous improvement of the program. Examples of some evaluative tools include pretests of SAFE candidates; posttraining evaluations of SAFE candidates that focus on their level of knowledge of the examination process, their fit with the field, and their level of satisfaction with the training and trainers; and longitudinal evaluation of the effectiveness of the training program in preparing SAFE candidates for their role.

¹⁰ The terms "objectivity"/"objective" and "neutrality"/"neutral" are used interchangeably in the protocol, but it is important to recognize that there is some difference in opinion in the field about whether these terms have the same meaning when referring to SAFE activities.

¹¹ Currently, there is no national standard accepted across health care disciplines that quantifies a minimum level of education and clinical experience required for SAFE trainers, except that they should have completed the necessary basic education and clinical practice to become a SAFE. However, those who contributed to the development of this document expressed concern about the quality of education provided and subsequent competency of SAFE candidates if trainers do not have sufficient expertise.

¹² In this document and in the protocol, discussions about cultural issues refer not only to ethnic, racial, and religious groups, but also to any group that has "learned beliefs, traditions, and guides for behaving and interpreting behavior that are shared among members" (A. Blue, The Provision of Culturally Competent Care, from the Medical University of South Carolina Web site at www.musc.edu/deansclerkship/recultur.html). Examples of other groups might include, but are not limited to, senior citizens, deaf and hard-of-hearing communities, populations with differing sexual orientations, the homeless, military personnel and their dependents, adolescents, and prison inmates. Individuals often belong to multiple cultural groups.

4. Consider how to recruit and screen SAFE candidates, assess their needs prior to training, provide opportunities to apply skills learned, and maintain competency after the initial training.

A plan to recruit and screen health care providers interested in becoming SAFEs should be established. Some initial questions to answer when creating a plan include who will conduct the recruitment and screening (e.g., individual examiner programs or those coordinating trainings) and what selection criteria will be used. Jurisdictions should strive to recruit SAFEs who collectively represent the diversity of the community they serve. Planners should make sure that recruiting and screening approaches used do not perpetuate biases against particular groups. Through recruitment and screening, potential candidates should be fully informed of what being a SAFE involves (e.g., initial and ongoing education and clinical practice needed, the work itself, and the time commitment).

In preparation for each training program, trainers should assess the needs of attending SAFE candidates. The assessment might entail understanding the level of candidates' experiences and competency; becoming familiar with local, state, territorial, tribal, and federal statutes and protocols that affect examination procedures, local practices, and forms related to the examination; and learning about the needs of specific populations in the community.

Opportunities to practice skills learned during the didactic training should be provided. A great deal of information is presented to SAFE candidates during classroom education. To increase their capacity to absorb and apply this information, candidates should have sufficient and varied chances to translate knowledge into action. Opportunities can be provided during classroom education through mechanisms that include, but are not limited to, role play, use of case studies, demonstrations using models, mock trials, and periodic testing. In addition, the clinical practicum should include more extensive hands-on opportunities (see *Clinical Practice Content—Recommendations*). Those developing training curriculums must carefully consider which training tools are best suited to maximize absorption and application of information for each topic area.

Jurisdictions and examiner programs should consider how to enhance competencies of SAFEs after the initial didactic training and clinical practice. Continuing education is necessary to build upon SAFEs' knowledge; keep them current with technology, science, documentation, and promising practices; and refresh skills that were gained in basic training. One-on-one supervision and mentoring is critical to allow veteran examiners to evaluate the individual performance of newer SAFEs, answer case-specific questions that arise, and consider how to promote their professional development. Quality assurance and peer review processes should be implemented in some form to help maintain the highest quality care for patients.

5. Build the capacity of SAFE candidates to provide culturally competent care.

A culturally competent SAFE sensitively and appropriately addresses patients' cultural needs and concerns. To build SAFE candidates' capacity to be culturally competent, trainers are encouraged to incorporate cultural issues into each training module. To that end, each section under *Didactic Content—Recommended Topics* in this document includes a bulleted list of "cultural competency issues." In addition, *A.2. Victim-Centered Care* looks more broadly at cultural and other individual considerations that may affect how the examination is conducted. Trainers also should discuss with SAFE candidates approaches to rectifying situations in which sensitive and culturally appropriate responses may have been lacking. Those developing training programs are urged to seek out the expertise of professionals who can speak to the cultural issues facing the jurisdictions to be served by the SAFE candidates. Not only can they suggest information and resources that

are critical for SAFE candidates, they also may be willing to serve as presenters. To be most effective, this self-exploration should be ongoing and supported by local SARTs.

6. Incorporate evidence-based information into the training program as much as possible.

SAFE candidates should be educated about cutting-edge research and evidence-based information on best practices (to the extent it is available) that can guide evidence collection and care of sexual assault patients. Evidence-based information and education can also be used to correct victim-blaming attitudes that SAFE candidates may hold. Not only should SAFEs have access to this type of data during training, they should also be encouraged to stay informed about new research/data that could impact their work.

7. Instruct SAFE candidates to select language that fits their role and is unbiased.

Not only is careful selection of words critical in examination documentation, but it is also important in verbal communications between SANEs, patients, and other responders. For example, SAFEs should be taught to avoid saying that a patient “alleged” or “claimed,” since these terms could be perceived as implying that they question the veracity of the patient’s account. “Said” might be a more objective choice for SAFEs. Trainers should encourage SAFE candidates to use language that accurately and precisely reflects the patient history, medical forensic findings, and evidence-based conclusions within the scope of the SAFE role.

8. Incorporate into training discussions on controversies regarding best practice.

Although there is much agreement across the country regarding acceptable and best practices in the examination process, SAFE candidates must understand that there are also areas of disagreement among practitioners (many of which are recorded in the protocol). For example, there is some debate about whether asking for pubic hair samples on a case-by-case basis is more appropriate than routinely asking for them during the initial examination (see the protocol, page 95). Trainers must stay current on areas for which there is no consensus about best practices and must help SAFE candidates understand the importance of following jurisdictional laws and policies as well as working with the local SART (or, if a SART does not exist, other involved responders) to make decisions about an appropriate response in a particular situation.

Didactic Content—Recommended Topics¹³

Note:¹⁴ As a prerequisite or foundation for the didactic training, SAFE candidates should be educated about basic issues related to sexual violence. Information might include, but not be limited to, data on the incidence and prevalence of sexual violence (focusing on the crime itself, the offenders, and the victims), common myths and facts, the dynamics and impact of sexual victimization, offender typology and treatment approaches, community resources and protocols for comprehensive response, and the relationship of sexual violence to/differences from domestic violence, dating violence, and stalking.

At some point during training, SAFE candidates should be taught about stress reactions they may experience in the course of working as a SAFE. Methods to prevent and cope with these reactions should be identified. Possible topics of discussion include, but are not limited to, an explanation of vicarious trauma and compassion fatigue, factors that could potentially impact a SAFE's capacity to cope with trauma and stress, the importance of debriefing after examinations and court testimony and building networks of support, and other resources for SAFEs if they experience these types of reactions. It is important to acknowledge that examiners differ in the amount of secondary trauma they can handle at any given time, in how they cope when working with traumatized patients and with suspects, in what helps them defuse, in what triggers their feelings of being traumatized, and in what will help them when they are experiencing trauma.

SECTION A. OVERARCHING ISSUES

1. Coordinated Team Approach (See page 23 of the protocol.)

Trainers. Representation from the local SART/responding agencies, including a SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), a law enforcement representative, a prosecutor, a forensic scientist, and a SART coordinator if one exists. Including others as trainers may depend on who else frequently is involved in local response to sexual assault cases (e.g., EMS technicians or emergency department staff) and the unique characteristics of the jurisdiction (e.g., if it includes tribal lands, colleges, or military installations that have their own response systems for these types of cases). Also, consider including professionals who can address cultural competency issues. Trainers should have experience working in coordination with responders from other disciplines to assist sexual assault patients and facilitate evidence collection. It would be useful to create a forum during training so that survivors can provide SAFE candidates with input on this issue.

Training objectives. To teach SAFE candidates to:

1. Differentiate between the dual purposes of the examination, which are to address the needs of both the patient and the justice system.
2. Understand how a coordinated, multidisciplinary approach to the examination process can help to simultaneously achieve these dual purposes.
3. Identify key responders and their roles and boundaries.
4. Understand the importance of measuring the effectiveness of coordination efforts.

¹³ The standards do not make recommendations about the order of presentation of topical areas during training, methods of presentation, or when an issue that may be common to several topical areas should be discussed.

¹⁴ The two topical areas in this note are recommended for discussion, but were not included as chapters in the protocol.

Topics:

- The medical forensic examination in the context of a comprehensive community response to sexual assault. The scope of the examination process in terms of addressing the needs of the patient and the justice system. Its connection to other components of response.
- Related jurisdictional laws and policies. If applicable, related cross-jurisdictional issues (e.g., if an incident occurs on tribal land, a tribal agency may initially respond but the case becomes the jurisdiction of the state or federal agencies).
- Definition of a SART and an overview of models and options.
- Development and implementation of a SART, including any jurisdictional mandates.
- Sustenance of an existing SART.
- Roles, goals, and boundaries of typical SART members.
- Additional local professionals who might be involved in response during the examination process.
- Multidisciplinary communication procedures during the initial response. (Also see *C.1. and C.2. Initial Contact/Triage and Intake.*)
- Collaboration without collusion.
- Approaches to keeping up to date on research, technology, and promising practices.
- Quality assurance measures of coordinated response.

Cultural competency issues:

- SARTs representing the diversity of the community being served, with an understanding that diversity is more than simply ethnicity, race, and religion (see footnote 12).
- Identifying and addressing the diverse needs of the community and adjusting operations and practices as appropriate.

2. Victim-Centered Care (See page 27 of the protocol.)¹⁵

Trainers. A SANE–A or SAFE with equivalent training/clinical and forensic experience and a community-based advocate (see footnote 7). It would be particularly useful to create a forum during training so that survivors can provide SAFE candidates with input on this issue. Also, consider including professionals who can address cultural competency issues.

Training objectives. To teach SAFE candidates to:

1. Identify key elements of a victim-centered medical forensic examination.
2. Understand how to deliver victim-centered care to patients.
3. Understand the importance of and methods to fully inform patients of their options during the examination process, affirm their right to make their own decisions, and respect their choices. (Also see *A.3. Informed Consent.*)
4. Identify information that patients may find useful during and after the examination process.

¹⁵ A “victim-centered” approach as used in the protocol and in these standards recognizes that sexual assault patients are central participants in the medical forensic examination process and deserve timely, compassionate, respectful, and appropriate care. They have the right to be well informed in order to make decisions about their participation in the various components of the process. A victim-centered approach also recognizes that the response must be adapted to address the needs and circumstances of each patient.

Topics:

- Use of the term “victim” instead of “patient” in this training module (“victim” acknowledges that individuals who disclose they have been sexually assaulted should have access to certain services and interventions designed to help them be safe, recover, and seek justice).
- Triage procedures and issues such as prioritizing these cases and offering privacy and support. Patient safety, privacy, and comfort throughout the examination process.
- Extent of victim services offered, differences between community-based and system-based advocates, and procedures for involving advocates.
- Interaction with patients and their significant others: empathy/reflective listening, helping patients maintain their dignity, identifying and addressing patients’ needs in conjunction with other responders, and SAFEs’ professionalism and objectivity.
- Explanation to patients regarding what is entailed in the examination, its purpose, and available options.
- Affirmation of patients’ rights to make their own decisions related to the examination process and respect for their choices (in this regard, SAFE candidates must be careful not to allow their experiences to influence patients’ decisions).
- Cultural and other individual considerations that may affect how the examination is conducted. Appropriate questions to ask so that a patient’s needs and circumstances can be determined.
- Information that patients can review at their convenience.¹⁶
- Variation in level of information that patients may want at the time of the examination, methods of delivery of the information, and their capacity to make informed decisions during the examination (e.g., due to being overwhelmed or frightened).

Cultural competency issues:

- Identifying and respecting patients’ individual/cultural differences.
- Providing culturally and developmentally appropriate explanations to patients.
- The ability of responders and patients to speak a common language and to have appropriate alternative methods to communicate (e.g., language interpretation by a trained interpreter rather than a patient’s family member or friend as well as provision of translated materials). It is critical that interpreters be linguistically and culturally competent.
- Training interpreters to work with sexual assault patients and to understand the scope of their role during the medical forensic examination. Encouraging interpreters to participate in communitywide SAFE/SART trainings.
- SAFE education on the diversity of the community, including recognizing and addressing differences within specific populations.
- SAFE education on myths, biases, and issues of diversity and oppression (recognizing that SAFE candidates bring their own biases to the examination process).
- Recognizing that some patients may request an examiner of a specific gender, race, etc., and the possible reasons for such requests. Paying attention to patients’ verbal and nonverbal behaviors for signs of resistance and/or fears that suggest an examiner of a specific background might be helpful. Such requests should be respected if possible (e.g., if staffing is available to accommodate the request).

¹⁶ Topics might include: information about the crime itself, common reactions to sexual assault along with signs and symptoms of traumatic response, safety planning options, consent issues, scope of confidentiality, availability and benefits of community-based advocates, reporting to law enforcement, participation in a criminal investigation, specifics of examination procedures, local and facility practices related to payment for the examination, presence of family and friends during the examination, testing and treatment options related to sexually transmitted infections (STIs), HIV, and pregnancy, and other applicable resources (e.g., for counseling) and remedies (e.g., civil).

3. Informed Consent (See page 39 of the protocol.)

Trainers. A SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), a law enforcement representative, and a civil attorney (e.g., from a state, territorial, or tribal sexual assault coalition or a hospital). Consider including professionals who can address cultural competency issues.

Training objectives. To teach SAFE candidates to:

1. Identify information that patients need so they can make informed decisions about their medical care and forensic evidence collection, as well as their involvement in the legal system.
2. Identify local regulations and statutes concerning informed consent.
3. Understand the dynamics of providing patients with information to make informed decisions before and throughout the examination.

Topics:

- Related state, territorial, tribal, and federal laws, guidelines, and regulations, including those that apply to youth and vulnerable adults. If applicable, related cross-jurisdictional issues.
- Related facility/examiner program policies and procedures.
- Logistics of seeking verbal and written consent, including forms and the need to balance patients' potentially traumatized state with the requirement of informed consent.
- Use of interpreters when seeking informed consent.
- Coordination with other responders to seek patients' informed consent.
- Impact of the patient accepting or declining part or all of the examination (e.g., on the legal case, quality of care, or payment for the examination by the jurisdiction).¹⁷ Providing this information to patients in a nonjudgmental way. Respect for patients' choices.
- Procedures that apply when authorization from guardians/parents is needed beyond patients' consent (noting that the examination should never be done against the will of the patient).
- Procedures in situations where patients do not or cannot consent themselves (e.g., due to being unconscious or drug impaired or having a disability that effects their cognitive capacity).

Cultural competency issues:

- Addressing language differences and barriers, literacy issues, and disability issues with regard to consent forms and communicating information to patients.
- Providing culturally and developmentally appropriate explanations to patients.
- Recognizing and addressing related concerns about immigration/legal status.

4. Confidentiality (See page 43 of the protocol.)

Trainers. A SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), and a civil attorney (e.g., from a state, tribal, or territorial sexual assault coalition or a hospital).

Training objectives. To teach SAFE candidates to:

1. Identify the extent and limits of confidentiality surrounding the medical forensic examination.

¹⁷ Note the potential for examiner or system bias if a patient chooses not to proceed with part or all of the examination. SAFE candidates should strive to remain objective, respect patient decisions, and avoid becoming biased.

2. Understand how to address the confidentiality issues that arise in these cases.

Topics:

- Jurisdictional laws related to the release, distribution, and duplication of medical records, forensic documentation, forensic photographic and video images, and forensic evidence. If applicable, related cross-jurisdictional issues.
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA): how to navigate it and issues and concerns as they apply to the examination process.
- Procedures for seeking authorization to release information/evidence. Explanation of adequate release.
- Scope of confidentiality of different SART members and systems that patients interact with in the course of the examination process. Explanation of the scope to patients.
- Difference between community-based and system-based advocates in terms of confidentiality. Difference between “confidential” and “privileged” communications between individuals who disclose sexual assault and community-based advocates. Applicable jurisdictional laws related to privileged communications.
- Scope of confidentiality/policies when patients appear intent on harming themselves or someone else.
- Confidentiality in difficult/complex situations (e.g., in communities that have small populations or are isolated, residents tend to know one another and word of a crime may travel quickly).
- Confidentiality when providing followup care and forensic documentation.
- Confidentiality when debriefing about cases.
- Confidentiality issues related to identifying data when using case information during trainings or peer reviews (e.g., discuss the need to get a patient’s signed consent if identifying data will be used).
- Patient consent for trainee participation in the examination process (including medical/nursing students, licensed health care providers in formal training, and examiners in training).
- Applicable facility/examiner program policies (e.g., restricted access to medical records related to the examination, response to subpoenas, and procedures for film development).

Cultural competency issues:

- Providing culturally and developmentally appropriate explanations to patients.

5. Reporting to Law Enforcement (See page 45 of the protocol.)

Trainers. A law enforcement representative, a prosecutor, a SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), and a SART coordinator if one exists. Also, consider including professionals who can address cultural competency issues.

Training objectives. To teach SAFE candidates to:

1. Be familiar with relevant statutes and regulations concerning sexual assault.
2. Be familiar with the patients’ bill of rights and the crime victims’ bill of rights.
3. Understand how to articulate to patients their options regarding reporting and the potential impact of their decisions.
4. Understand common issues and concerns that patients may have related to making the decision to report and why some choose not to report.

Topics:

- Related laws and regulations. Existing mandatory reporting laws for sexual assault incidents.
- Reporting requirements and payment for the examination.
- If applicable, related cross-jurisdictional issues.
- Components of a criminal investigation. Note that the examination is one part of a comprehensive criminal investigation.
- Issues and fears that individuals who disclose sexual assault incidents may have about reporting.
- Blind reports and nonidentifying reports.¹⁸
- Delayed reporting and whether there are jurisdictional statutes of limitations for reporting. Maintenance of chain of custody of evidence and evidence storage issues in unreported cases.
- Potential consequences of reporting and not reporting. Provision of this information to patients and respect for their decisions on reporting. (See A.6. *Payment for the Examination Under VAWA* for more information on how reporting/not reporting can impact payment.)
- Issues that may arise with patients who are illegal immigrants.
- Potential impact on a case if a patient has outstanding warrants.

Cultural competency issues:

- Understanding the fear and/or distrust of law enforcement by some patients and differing views of the criminal justice systems that different populations may hold.
- Providing culturally and developmentally appropriate explanations to patients.

6. Payment for the Examination Under VAWA (See page 49 of the protocol.)

Trainers. A SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), and a relevant government entity.¹⁹

Training objectives. To teach SAFE candidates to:

1. Identify links between the examination and payment for services.
2. Understand the VAWA provisions related to payment for the examination.
3. Understand how to help patients access crime victim compensation and other financial assistance resources.
4. Recognize the importance of maintaining victim-centered care despite reimbursement issues.

Topics:

- Jurisdictional and/or facility/examiner program policies addressing coverage of examination costs: who is responsible to pay for the various components of the examination, impact of

¹⁸ See the protocol, page 46.

¹⁹ Under the Violence Against Women Act (VAWA), grantees of the STOP Violence Against Women Formula Grant Program must meet certain requirements concerning payment for the forensic medical exam in order to receive funds. The STOP Program is a formula grant program that provides funds to all states, territories, and the District of Columbia. Each of these entities certifies each year that it is in compliance with the requirements of VAWA. Specifically, the state, territory, or the District of Columbia must certify that it or another governmental entity "incurs the full out-of-pocket cost of forensic medical exams" for victims of sexual assault. The particular government entity responsible for payment differs from state to state.

reporting/not reporting on payment, and specifics for billing each entity.²⁰ If applicable, related cross-jurisdictional issues.

- Applicable provisions and definitions relating to payment for the examination under VAWA and other relevant legislation.
- Crime victim compensation process: eligibility, access, and who can assist patients with navigating this process. Other financial assistance resources.
- Issues and concerns related to payment: patient and provider perspectives.

Cultural competency issues:

- Socioeconomic status and the ability to pay for services should not be an issue.
- Providing culturally and developmentally appropriate explanations to patients.

SECTION B. OPERATIONAL ISSUES

1. Sexual Assault Forensic Examiners *(See page 53 of the protocol.)*

Note: This document does not include standards corresponding to this portion of Section B in the protocol because it involves only a few training issues that are covered sufficiently in other sections of this document.

2. Facilities *(See page 57 of the protocol.)*

Note: This document does not include standards corresponding to this portion of Section B in the protocol because it involves only a few training issues that are covered sufficiently in other sections of this document.

3. Equipment and Supplies *(See page 61 of the protocol.)*

Note: This document does not include standards corresponding to this portion of Section B in the protocol because it involves only a few training issues that are covered sufficiently in other sections of this document.

4. Sexual Assault Evidence Collection Kit *(See page 65 of the protocol.)*

Trainers. A SANE–A or SAFE with equivalent training/clinical and forensic experience, a forensic scientist/crime lab representative (from labs designated by the jurisdictions involved to process sexual assault evidence collection kits), and a law enforcement representative and/or prosecutor. Also, consider including professionals who can address cultural competency issues. Trainers should be familiar with kits used by jurisdictions in which SAFE candidates intend to serve. It would be useful to create a forum during training so that survivors can provide candidates with input on this issue.

Training objectives. To teach SAFE candidates to:

1. Understand how to complete evidence collection (as required by the kit) in an effective and efficient manner.

²⁰ In many jurisdictions, medical and forensic examination components are interwoven and one entity assumes most or all of the costs (with the exception of expenses they deem unrelated to evidence gathering). In other jurisdictions, these components may be differentiated in payment and documentation structures.

2. Identify kit components (requested evidence and information) and rationale for collection of each component according to jurisdictional policy.
3. Understand that while the kit is a tool of the criminal justice system to facilitate the standardized collection of evidence and information, the medical forensic history is critical in determining what evidence should be collected in each case.

Topics:

- Jurisdictional and facility requirements and protocols related to the kit. If applicable, related cross-jurisdictional issues.
- Process of acquiring a kit (e.g., knowing how to obtain it), storage requirements, securing the chain of evidence, and any issues regarding expiration date.
- Components of the kit and rationale (research based where applicable) for evidence collection.
- Integration of evidence collection into the examination (how and why).
- Techniques in accordance with local protocol for evidence collection, handling, and labeling. (Also see *C.6. Examination and Evidence Collection Procedures*.)
- Potential impact of each piece of collected evidence on a criminal investigation.
- Forms included in the kit and how forensic scientists use supplied documentation.
- Importance of the medical forensic history in determining what is collected in each case.
- Identification and collection of evidence not guided by or requested in the kit.
- Explanation to patients of each step of kit collection, rationale behind collection, and potential postexamination uses of the kit (how and by whom it is used).

Cultural competency issues:

- Providing culturally and developmentally appropriate explanations to patients.
- Understanding how cultural issues can influence a patient's choice of what should be collected (e.g., a patient may believe that hair is sacred and therefore be reluctant to provide a hair sample), how it is collected (e.g., cultural beliefs may preclude a member of the opposite sex from being present when a patient disrobes), or how comfortable a patient is with having certain evidence collected.
- Understanding body image issues and building patients' comfort in having evidence collected for the kit.
- Adaptation and/or modification to the evidence collection process, which may be needed to address patients' individual needs.

5. Timing Considerations for Collecting Evidence and Patient Care (See page 67 of the protocol.)

Trainers. A SANE–A or SAFE with equivalent training/clinical and forensic experience, a forensic scientist, a law enforcement representative, and a community-based advocate (see footnote 7).

Training objectives. To teach SAFE candidates to:

1. Be familiar with local protocols and current science and technology related to outside limits for obtaining forensic evidence.
2. Recognize that the case history, the timeliness of the initial examination, and the examiner's critical thinking skills determine when to collect evidence and what evidence to collect (along with patients' reactions to the process and willingness to have evidence collected).
3. Understand that timing of the examination can also impact patient care and that timing is important in followup patient care.

Topics:

- Relevant jurisdictional policies and protocols. If applicable, related cross-jurisdictional issues.
- Factors that influence when to collect evidence and what evidence to collect (case-by-case consideration).
- The importance of prompt examination and documentation to minimize loss of evidence.
- Current science and technology related to timing considerations for detecting and collecting evidence, time sensitivity when collecting different types of evidence (e.g., DNA evidence on clothing might be found even after the clothing is laundered), and jurisdictional access to current science and technology.
- Items that the local crime lab deems mandatory (e.g., reference DNA), regardless of timing considerations.
- The role of other responders in timely evidence collection (e.g., law enforcement representatives conducting the field investigation) and coordination among them to make forensic decisions and share information, as appropriate.
- Timing of followup forensic documentation, if indicated (e.g., explanation about if and when documentation of the developing or healing injuries and resolution of healing should occur). (Also see *C.10. Discharge and Followup*.)
- Issues in caring for patients that may be impacted by the timing of the examination and followup testing/treatment (e.g., whether prophylactic medications will be effective or followup medical appointments are recommended).
- Provision of information to patients on the impact of timing on evidence collection and care.

Cultural competency issues:

- Explaining timing issues related to evidence collection and patient care in a culturally competent and developmentally appropriate manner.

6. Evidence Integrity (See page 69 of the protocol.)

Trainers. A team of a SANE–A or SAFE with equivalent training/clinical and forensic experience, a forensic scientist, a law enforcement representative, and a prosecutor.

Training objectives. To teach SAFE candidates to:

1. Identify the role of the SAFE in maintaining the integrity and chain of custody of the evidence.
2. Understand how to maintain evidence integrity and the chain of custody of evidence.

Topics:

- Explanation of the importance of maintaining evidence integrity and the chain of custody in these cases.
- Jurisdictional policies for drying, packaging, labeling, and sealing evidence.
- Ways in which evidence can be lost biologically or rendered inadmissible. Steps necessary to prevent such a loss of evidence.
- Jurisdictional policies for transferring evidence to a law enforcement representative, appropriate crime lab, or other designated storage site.
- Jurisdictional storage policies, including policies in cases where patients are undecided about reporting (e.g., whether evidence in undecided cases can be stored, and where/for how long it can be stored). Procedures for patients to request return of personal items held as evidence.
- Maintenance and documentation of chain of custody.

- Jurisdictional policies about destroying evidence when a report is not made and law enforcement does not take custody of the evidence.
- If applicable, related cross-jurisdictional issues.

SECTION C. THE EXAMINATION PROCESS

1. Initial Contact (See page 73 of the protocol.)

2. Triage and Intake (See page 77 of the protocol.)

Trainers. A team that minimally includes a SANE–A or SAFE with equivalent training/clinical and forensic experience, a law enforcement representative, and a community-based advocate (see footnote 7). It may also be helpful to include trainers from other disciplines who are frequently involved in initial contact/triage and intake in the jurisdictions where the SAFE candidates will serve (e.g., an EMS technician or relevant hospital emergency department staff). Consider including professionals who can address cultural competency issues. It would be particularly useful to create a forum during training so that survivors can provide SAFE candidates with input on this issue.

Training objectives. To teach SAFE candidates to:

1. Identify roles and boundaries of each responder during initial contact and during triage/intake.
2. Understand the importance of a multidisciplinary coordinated response at this stage.
3. Recognize critical elements of initial response, triage, and intake.
4. Understand how to carry out SAFE responsibilities during initial contact/triage and intake, paying particular attention to the immediate needs and concerns of each patient.

Topics:

- Related roles and boundaries of each discipline (e.g., role of health care providers upon initial contact with patients to assess acute medical needs).
- Collaboration among responders during initial contact with patients and during triage/intake. Some built-in flexibility in the response protocol may be necessary; the key is to ensure that deviation from the protocol does no harm to patients.
- Relevant jurisdictional statutes and policies, including those that determine response during initial contact and during triage/intake (e.g., who has authority) and those that support multidisciplinary coordination. If applicable, related cross-jurisdictional issues.
- Critical elements of initial response that facilitate safety, meet emergent medical needs, offer support, preserve evidence, and secure the chain of custody of evidence.
- Initial assessment of patients' language; physical, mental, and developmental abilities; and need for assistance.
- Provision of nonjudgmental, compassionate, competent, and culturally sensitive response to patients during initial contact and during triage/intake. (Also see A.2. *Victim-Centered Care*.)
- Patient empowerment to make choices about reporting, evidence collection, and health care; acceptance of patients' decisions (e.g., they may not feel ready to report to law enforcement); and respect for their choices.

Cultural competency issues:

- The elements of a culturally competent initial response and how such elements can be realized.
- Providing culturally and developmentally appropriate explanations to patients.
- Assessing the cultural makeup of the community.
- Using available resources for various patient populations.
- Recognizing individuals' right to self-identify needs.
- Understanding issues that can arise when agencies from more than one jurisdiction are involved in a case (e.g., on Indian reservations, military installations, national parks or other federal government property, school campuses, in federal cases, or when case circumstances cross jurisdictional boundaries).

3. Documentation by Health Care Personnel (See page 79 of the protocol.)

Trainers. A health care provider, a SANE–A or SAFE with equivalent training/clinical and forensic experience, and a prosecutor.

Training objectives. To teach SAFE candidates to:

1. Identify all components of medical and forensic documentation necessary within the jurisdiction/facility/examiner program.
2. Understand how to produce thorough, precise, accurate, unbiased, and objective documentation for the medical forensic record.
3. Be familiar with quality assurance²¹ plans of the jurisdiction/facility/examiner program and relevant jurisdictional regulations or interpretations related to SAFE documentation, such as peer review, meeting activities, attendants, incident reports, and supervision.

Topics:

- Jurisdictional, facility, and examiner program policies related to what to document and how to document.
- Methods of recording information—written (checklists, narratives, forms or other notation that is handwritten, typewritten, computer generated, or transcribed from dictation), diagrammatic (drawn or indicated on anatomic diagrams), and photographic (film or digital; still or video).
- Confidentiality issues, including HIPAA concerns. (Also see *A.4. Confidentiality*.)
- Documentation of patients' informed consent or lack of consent to any part or all of the examination. Documentation of release of information.
- Documentation of forensic/medical history.
- Documentation of examination findings.
- Consistency between written and diagrammatic documentation and photography.
- Jurisdictional and facility/examiner program policies on access, management, and distribution of records. (See *C.11. Examiner Court Appearances* for information on response to subpoenas.) If applicable, related cross-jurisdictional issues.
- SAFE objectivity and accuracy.
- Terminology and language.
- Options for quality assurance and review and improvement of SAFE documentation.

²¹ The health care field might find it more appropriate to use the terms “continuous quality improvement” (CQI) or “performance improvement” (PI).

Cultural competency issues:

- Reviewing documentation for inappropriate language and biases.

4. The Medical Forensic History (See page 81 of the protocol.)

Trainers. A SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), a law enforcement representative, and a prosecutor. Also, consider including professionals who can address cultural competency issues. It would be useful to create a forum so that survivors can provide SAFE candidates with input on this issue.

Training objectives. To teach SAFE candidates to:

1. Define the difference between medical and forensic history taking.
2. Be aware of the potential emotional impact of the history taking process on patients.
3. Be familiar with the roles of individuals who can provide support and advocacy to patients during history taking or who can gather information from patients, as well as the possible impact of their involvement in this process.
4. Understand how to obtain and document a comprehensive forensic history as it relates to the assault, including pertinent medical and developmental history.
5. Build their forensic history interviewing skills.

Topics:

- Medical history related to the assault versus general medical and developmental history.
- Potential impact of trauma on memory, cognitive functioning, and communications.
- Patient needs prior to and during history taking and possible emotional impact of this process.
- Jurisdictional methods/protocols used to obtain and record information. If applicable, related cross-jurisdictional issues.
- Elements of the medical forensic history according to relevant jurisdictional protocols.
- The importance of an accurate and unbiased account.
- Boundary issues for SAFEs (e.g., be careful not to influence patient's answers or ask investigative questions).
- Connection between the history and subsequent examiner actions (e.g., if a patient indicated that the assailant had contact with a specific body area, the SAFE should examine that area using the most appropriate techniques for visualization of injuries and then document findings).
- Scope of confidentiality of different SART members during the medical forensic history. (Also see *A.4. Confidentiality*.)
- Roles and responsibilities of advocates during the medical forensic history.
- Decisionmaking related to who can be present during the examination and related to history taking. Potential impact on the legal case of different individuals being present during history taking (e.g., a community-based advocate, systems-based advocate, family members, friends, or other support persons).²²
- Coordination between law enforcement representatives and SAFEs regarding the logistics of medical forensic history taking and investigative interviewing.

²² Patients should be aware that government-based service providers/advocates typically cannot offer confidentiality to patients, whereas community-based advocates usually can provide some degree of confidentiality. If a victim service provider/advocate who is not from a community-based program offers to accompany a patient during the medical forensic history or other parts of the examination, the SAFE examiner and patient should understand the potential impact of the victim service provider/advocate's presence on the legal case (e.g., they might be asked to testify as to what the patient said or how the patient behaved). See the protocol, pages 18–19 and 34–35, for more information on the roles of victim service providers/advocates.

Cultural competency issues:

- Cultural safety for patients throughout the history taking process.
- Asking questions in culturally and developmentally appropriate ways.
- Unbiased history taking and documentation that is free of inappropriate language.

5. Photography (See page 85 of the protocol.)

Trainers. A SANE–A or SAFE with equivalent training/clinical and forensic experience, a prosecutor, a forensic photography expert, a law enforcement representative, a community-based advocate (see footnote 7), and related vendors. Also, consider including professionals who can address cultural competency issues. It would be useful to create a forum so that survivors can provide SAFE candidates with input on this issue.

Training objectives. To teach SAFE candidates to:

1. Use basic forensic photography techniques.
2. Understand the appropriate uses of forensic photography in these cases.
3. Understand how to identify and obtain additional photographic expertise/resources as needed.

Topics:

- Local policies related to the extent of forensic photography necessary in these cases and to photographers (e.g., who can take these photographs). If applicable, related cross-jurisdictional issues.
- Choice of equipment and resources.
- Basic photographic skills.
- Specialized forensic photography skills.
- Potential use of photodocumentation by the criminal justice system.
- Informed consent to take and release photographs. Potential impact on patients.
- Management of photographs taken during the initial examination (e.g., maintaining the chain of custody, film development, storage, handling requests for photographs, and privacy).
- Followup photographs and their management.
- Resources for documentation needs (e.g., to fully document bite marks).
- Photographic quality assurance, including technical (exposure, lighting, sharpness, color fidelity, and composition) and content (adequate views, consistency with written/diagrammatic descriptions, and proper interpretation) review.

Cultural competency issues:

- Explaining the purpose of and procedures for forensic photography in a culturally and developmentally appropriate manner.
- Recognizing ways in which culture may influence patients' decisions regarding photography.

6. Exam and Evidence Collection Procedures (See page 89 of the protocol.)

Trainers. A SANE–A or SAFE with equivalent training/clinical and forensic experience, a forensic scientist (from the jurisdictional crime lab), a community-based advocate (see footnote 7), a law enforcement representative, and a prosecutor. Also, consider including professionals who can address cultural competency issues. It would be useful to create a forum so that survivors can provide SAFE candidates with input on this issue.

Training objectives. To teach SAFE candidates to:

1. Define the purpose of the medical forensic examination.
2. Understand how to appropriately collect forensic evidence from patients.
3. Take steps to anticipate, identify, collect, document, preserve, label, and store all potential evidence with attention to the chain of custody.
4. Understand how to perform a comprehensive physical examination and document findings.

Topics:

- Integration of the comprehensive physical assessment and evidence collection with compassion and emotional support.
- Mechanisms of injury, normal variations, and terminology.
- Prevention of exposure to potentially infectious materials.
- Avoidance of contamination in every medical or evidentiary procedure.
- Broad spectrum of potential evidence and physical findings in these cases and the potential impact of evidence on an investigation.
- Limitation of the SAFE's capacity to identify DNA evidence and match trace evidence and the role of the forensic scientist/crime lab in identifying and determining the presence of biological or trace evidence.
- Evidence pertinent to the issue of whether a patient consented to sexual contact with a suspect.
- Steps involved in evidence collection.
- Equipment needed and techniques for the visualization of injuries and evidence.
- Adaptation of the examination and evidence collection due to patients' individual needs.
- Documentation of patient behavior during the examination and evidence collection for forensic purposes (e.g., to support excited utterances).
- Maintenance of the chain of custody of evidence. (Also see *B.6. Evidence Integrity*.)
- Methods to explain procedures to patients and seek informed consent throughout the examination and evidence collection.
- Patients' right to accept or decline any or all parts of the examination and potential impact of their decisions on criminal justice proceedings. (Also see *A.3. Informed Consent*.)
- Role of advocates during the examination and evidence collection.²³
- Interpretation of visible examination findings and conclusions according to local policies.
- Language used to relate findings to law enforcement representatives.
- Issues that may arise when conducting suspect examinations (e.g., coordination with law enforcement, what to collect, costs, location of examinations, access to suspect evidence collection kits, and understanding that suspects may be the best source of probative evidence).

Cultural competency issues:

- Adaptation and/or modifications to the examination process that may be needed to address patients' individual needs.
- Providing culturally and developmentally appropriate explanations to patients regarding the purpose of the examination and evidence collection procedures.
- Ways in which culture may influence patients' decisions, the manner in which evidence is collected (e.g., cultural beliefs may preclude a member of the opposite sex from being present

²³ See footnote 22.

when a patient disrobes), or what is collected (e.g., a patient may believe that hair is sacred and be reluctant or decline to have hair evidence collected).

7. Drug-Facilitated Sexual Assault (See page 101 of the protocol.)

Trainers. A SANE–A or SAFE with equivalent training/clinical and forensic experience (or another healthcare provider with expertise in this area) and other knowledgeable individuals from law enforcement, community-based advocacy (see footnote 7), crime lab/toxicology, and/or pharmacology. It would be useful to create a forum so that survivors can provide SAFE candidates with input on this issue.

Training objectives. To teach SAFE candidates to:

1. Define drug-facilitated sexual assault.
2. Identify and document signs and symptoms of a clinical presentation of drug-facilitated sexual assault.
3. Understand the circumstances in which toxicology collection and testing may be indicated.
4. Understand how to seek informed consent from patients to collect toxicology samples.
5. Understand how to collect toxicology samples.
6. Be aware of relevant jurisdictional procedures on collecting, packaging, storing, and transferring these samples.

Topics:

- Definition of drug-facilitated sexual assault and differences between investigating a drug-facilitated case from other types of sexual assault cases.
- Clinical presentation, including signs and symptoms.
- Circumstances in which toxicology testing may be indicated and the difference between need for sample for medical purposes versus forensic purposes.
- Full range of issues related to informed patient consent to collect and release toxicology samples. (Also see A.3. *Informed Consent*.) Potential impact of toxicology testing on the patient and on criminal justice proceedings.
- Situations in which patients are unable to provide informed consent (e.g., if a patient is under the influence of a controlled substance or is unconscious).
- Jurisdictional issues related to collecting, documenting, packaging, storing, and transferring samples and maintaining the chain of custody. If applicable, related cross-jurisdictional issues.
- Techniques for the collection of toxicology samples.
- Voluntary versus involuntary ingestion and the impact on testing, investigating, and prosecuting drug-facilitated sexual assault.
- Toxicology lab options and payment responsibility.
- History taking in drug-facilitated cases (e.g., there may be gaps in a patient's memory).
- Importance of working as a team with other involved professionals to respond in a way that is victim centered and useful in facilitating the criminal investigation. Benefits of an advocate's presence in these cases.

Cultural competency issues:

- Conducting an investigation that is not judgmental of the patient.
- Understanding the prevalence of recreational drug use in a specific community, as well as the offender population that targets recreational drug users.
- Providing culturally and developmentally appropriate explanations to patients.

8. Sexually Transmitted Infection (STI) Evaluation and Care (See page 105 of the protocol.)

Trainers. A SANE–A or SAFE with equivalent training/clinical and forensic experience (or another healthcare provider with expertise in this area) and a community-based advocate (see footnote 7).

Training objectives. To teach SAFE candidates to:

1. Identify and document signs and symptoms of the clinical presentation of STIs.
2. Be knowledgeable about the prevalence of STIs in the local community.
3. Be familiar with strengths and limitations of the most currently accepted testing and treatment methodologies and techniques.
4. Understand how to evaluate and treat patients for STIs.
5. Understand how to articulate to patients what they need to know about STIs and HIV.
6. Identify resources for STI and HIV testing, including confidential sites.
7. Identify resources that may assist with financial concerns related to STI and HIV testing and care (e.g., crime victims' compensation) and how to help patients access these resources.

Topics:

- Signs, symptoms, and transmission of STIs.
- Incidence/prevalence and morbidity in a specific community according to age, gender, and ethnicity. Any known related drug resistance in the community.
- Current guidelines for testing, prophylaxis, and treatment (initial and followup screening/care).
- Related policies of the jurisdiction, facility, and examiner program. If applicable, related cross-jurisdictional issues.
- Specific information related to testing (i.e., indications for testing and testing methods and techniques, including strengths and limitations of each). Potential legal impact of test results.
- Specific information related to prophylaxis and treatment (i.e., methods and techniques, including strengths, limitations, and side effects of each). Willingness of a patient to follow up for assessment and care and/or the location in which the assault occurred may influence the choice of medical prophylaxis/treatment offered.
- Risk of exposure to HIV and assessment of the need for postexposure prophylaxis. Treatment and followup medical care. Importance of providing patients with all pertinent information to aid them in making an informed decision about prophylaxis.
- Followup medical screening and care related to the risk of STI transmission.
- Community resources. Regulations concerning confidential testing and mandatory reporting.
- Financial assistance resources (e.g., crime victim compensation) for costs related to testing for and care of STIs and HIV (e.g., hepatitis B shots).
- Approaches for articulating to patients the prevalence of STIs in their community and their risk, their partners' risk, testing, prophylaxis, treatment options, followup medical screening and care, financial assistance, and referrals.

Cultural competency issues:

- Addressing cultural beliefs, if any, related to STIs and HIV.
- Discussing STIs and HIV with patients in a culturally and developmentally appropriate manner.

9. Pregnancy Risk Evaluation and Care (See page 111 of the protocol.)

Trainers. A SANE–A or SAFE with equivalent training/clinical and forensic experience (or another healthcare provider with expertise in this area) and a community-based advocate (see footnote 7). Also, consider including professionals who can address cultural competency issues.

Training objectives. To teach SAFE candidates to:

1. Understand how to convey to patients the science behind reproduction.
2. Understand how to assess belief systems (examiner and patient) related to reproduction.
3. Understand how to recognize patients' level of understanding related to pregnancy and how to articulate medical definitions of terms that may be confusing.
4. Understand how to discuss with patients the full range of treatment options and potential outcomes for each option.
5. Be familiar with local resources.

Topics.²⁴

- Infertility/fertility of the assailant and patient.
- Sexual function and dysfunction.
- Treatment options and outcomes.
- Followup care.
- Resources available, both at the facility and locally.
- Relationship building with individuals who have the resources and coping with resource limitations.
- Discussion of pertinent information with patients.

Cultural competency issues:

- Discussing the possibility of pregnancy and treatment options in a culturally and developmentally appropriate manner.
- Understanding cultural (particularly religious) beliefs related to pregnancy in the community being served and relaying the science behind reproduction in a format that is culturally understandable.
- Understanding patients' individual beliefs related to pregnancy.

10. Discharge and Followup (See page 113 of the protocol.)

Trainers. A team that includes, at a minimum, a SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), and a law enforcement representative. These team members often provide patients with discharge instructions or followup information at the time of their release from the examination facility.

Training objectives. To teach SAFE candidates to:

1. Be familiar with the safety, medical, law enforcement, advocacy, mental health, and other (e.g., housing) issues to be addressed with patients at the time of discharge.

²⁴ The National Sexual Violence Resource Center offers detailed information about sexual assault and pregnancy on its Web site at www.nsvrc.org. The American College of Emergency Physicians also offers guidance on this topic in its publication *Evaluation and Management of the Sexually Assaulted or Abused Patient*, available through its Web site at www.acep.org/NR/rdonlyres/11E6C08D-6EE7-4EE2-8E59-5E8E6E684E43/0/sxa_handbook.pdf.

2. Understand how to discuss with patients all aspects of postexamination care and forensic documentation, and recommended followup appointments and procedures. Recognize that one approach will not fit all patients; rather, patients will require tailor-made discharge plans that address their individual needs and circumstances and the specifics of their cases.
3. Understand the scope of multidisciplinary coordination needed during the discharge process.

Topics:

- Related policies of the jurisdiction, facilities, and examiner programs.
- How the discharge plan will be designed. Forms and multidisciplinary checklists.
- Safety planning.
- Medical and forensic discharge instructions.²⁵
- Medical and forensic followup (viewed as part of the medical forensic examination process).
- Discharge instructions and followup related to victim advocacy and mental health care.
- Discharge instructions and followup related to the criminal justice system (beyond forensic documentation).
- Discharge instructions and followup related to payment for examination costs and use of crime victim compensation.
- Other referrals.
- Multidisciplinary coordination needed during the discharge process. If applicable, related cross-jurisdictional issues.

Cultural competency issues:

- Using culturally and developmentally appropriate terms.
- Providing discharge instructions in community-specific languages.

11. Examiner Court Appearances (See page 117 of the protocol.)

Trainers. A prosecutor; a SANE–A or SAFE with equivalent training/clinical, forensic, and testimony experience; a forensic scientist; other attorneys; a community-based advocate (see footnote 7); and a victim-witness specialist from the criminal justice system.

Training objectives. To teach SAFE candidates to:

1. Understand the SAFE's role in the courtroom as an expert or factual witness.
2. Develop basic testimony skills.

Topics:

- Preparation for testimony, including review of reports, anticipation of likely defense and prosecution questions, and creation of a curriculum vitae, reference lists (e.g., of supporting articles and case rulings), and a summary of testifying experience.
- Differences between an expert and a percipient or factual witness.
- Use of documentation in court and avoidance of inappropriate language.
- Potential outcomes/impact of SAFE testimony. Court rulings in related cases.

²⁵ Several other training areas address specific issues related to followup, including A.2 *Victim-Centered Care*, A.4 *Confidentiality*, B.5 *Timing Considerations for Collecting Evidence and Patient Care*, C.5 *Photography*, C.8 *STI Evaluation and Care*, and C.9 *Pregnancy Risk Evaluation and Care*.

- Subpoenas: the process, including the differences between criminal and civil investigations and appropriate response procedures to subpoenas in each case, and consequences of not sharing requested information or of subpoenaed individuals who do not show up for court.
- Basic judicial process, including players' roles, legal terminology, and the differences between criminal and civil processes.
- Proper behavior and appropriate attire in court.
- Use of plain language to explain medical forensic terms and processes.
- Maintenance of an objective status.
- Pretrial communication/contact with attorneys.
- High-profile cases: effective approaches to dealing with these cases, potential impact of these cases on the field, and management of the stress of being involved in such a case.
- Mock trial and other tools to demonstrate the judicial process and testimony skills.

Cultural competency issues:

- Providing nonbiased testimony.
- Using culturally and developmentally appropriate terms when testifying.

Clinical Practice Content—Recommendations

These clinical practice recommendations are meant to supplement the didactic training recommendations. It is important to note that the recommendations in this section reflect minimal clinical practice content. Each jurisdiction/examiner program can evaluate the standards set forth and consider if there should be additional training requirements for their SAFEs.

It is useful if clinical practice is completed shortly after the completion of didactic training (e.g., within 6 months) to maximize the retention of knowledge and skills gained during the training.

Trainers. See areas of clinical practice below. Need varies for certain types of instructors, observers, and/or demonstrations by different responders.

Training objectives. To provide SAFE candidates supervised opportunities to:

1. Apply information and practice skills learned during the didactic training in order to prepare for their role as examiners.
2. Practice the general clinical skills that may be used in the course of a sexual assault medical forensic examination process.

Areas of clinical practice:

- Application of general related clinical skills (e.g., visual, palpation, and auditory) to be completed with instruction by an experienced SAFE, registered or advanced practice nurse, or physician. Skills include but are not limited to:
 - Performing a detailed anogenital and oral evaluation and using a speculum, visualization, palpation, and other supportive techniques and equipment (e.g., tongue depressor or anoscope);
 - Physical diagnosis (especially in anogenital and oral examinations);
 - Determining normal, abnormal, and normal variant; and
 - Understanding mechanisms of injury and forming differential diagnoses.
- Application of clinical skills related to the examination: performing sexual assault medical forensic examinations of both female and male patients, including kit collection and documentation per jurisdictional protocols and procedures. This should be observed by and demonstrated to an experienced SAFE.
- Performance of required clinical skills until competency is demonstrated (competence is defined by the standards set by the local SAFE program and the legislated or professional organization from which the candidate is seeking certification).
- Practice in photodocumentation with supervision and evaluation by an experienced SAFE.
- Observation of sexual assault criminal trial proceedings.
- Observation of the related procedures and processes in the crime lab, law enforcement agencies, advocacy agencies, and other relevant agencies.
- Practice in documentation/chart review and involving experienced colleagues in the review process, with the goal of improving documentation.

- Ongoing education (both refresher courses and advanced training), supervision, and mentoring to facilitate consistently high-quality performance by SAFEs.

Cultural competency issues:

- See issues presented under the *Didactic Content—Recommended Topics*.

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