An Evaluation of the Implementation of the Sexual Assault Medical Forensic Exam (SAFE) Protocol

Methods, Data Collection Activities, and Participants

Janine Zweig
URBAN INSTITUTE

Erica Henderson
URBAN INSTITUTE

Lauren Farrell
URBAN INSTITUTE

Melanie Langness
URBAN INSTITUTE

Nicole Stahlmann
INTERNATIONAL ASSOCIATION OF FORENSIC NURSES

Emily Tiry
URBAN INSTITUTE

Kelly Walsh
URBAN INSTITUTE

July 2021

Released in 2013, the second edition of the National Protocol for Sexual Assault Medical Forensic Examinations, or SAFE Protocol, is a voluntary guide developed by the Department of Justice that local jurisdictions and states can use to inform their responses to sexual assault. It institutionalizes best practices around survivor care and evidence collection,[1] particularly for sexual assault nurse examiners (SANEs) completing medical forensic examinations. In 2018, the Urban Institute and the International Association of Forensic Nurses were funded by the Office on Violence Against Women to evaluate the SAFE Protocol with the aim of understanding the *extent* to which its provisions have been implemented across the United States. Our mixed-methods study incorporated the perspectives of multiple stakeholders in the sexual assault response

[1] We use the term survivor to describe a person who has experienced victimization. In this brief, we use the terms survivor, patient, and victim interchangeably where it is relevant to do so to describe people who have experienced sexual violence.

system at the state and local levels. In this brief, we describe the methods, data collection activities, and participants of that study.

Introduction

The purpose of our study was to understand the extent to which the SAFE Protocol has been implemented across the country. This was a cross-sectional, mixed-methods study that incorporated the perspectives of multiple stakeholders at the state and local levels with unique roles in the sexual assault response system to understand their views on how the SAFE Protocol has been implemented. Each of the stakeholders we collected data from plays a role by supporting implementation of or directly executing components of the SAFE Protocol.

First, we conducted censuses of state sexual assault coalitions and state Violence Against Women Act (VAWA) administrators. Next, knowing that different stakeholders in the same community might view the uptake of innovations differently, we examined local SAFE Protocol implementation from the perspectives of two local service providers in each jurisdiction-based sexual assault response system. The objective was to first conduct a national survey of SANE programs in communities by surveying a representative from each SANE program in the universe of programs across the United States, and to then survey a corresponding local victim advocate (from a nonprofit sexual assault service provider/rape crisis center) in each program's community. Lastly, we conducted virtual case studies in four jurisdictions involving semistructured interviews with multidisciplinary stakeholders involved in local sexual assault responses.

Measuring more than one stakeholder's view on a community's sexual assault response is important to have a fuller view of a given place's response. Each stakeholder has a different role with different goals. Also, people may be prone to social desirability bias, which in this case might lead people to report greater adoption of the SAFE Protocol than is evidenced in their jurisdictions. For the surveys, we chose to include victim advocates as the second reporters (after SANEs) on communities' sexual assault responses. They play a particularly crucial role in the process and their perceptions of protocol implementation are critical for four reasons: (1) they, like SANEs, work with survivors regardless of whether the survivor reports a sexual assault to police, (2) they do not have a stake in the criminal justice process, (3) they are beholden only to survivors and their needs, and (4) they may be most willing to be critical of the response system because their primary role is to support survivors' needs.

Survey Procedures and Sampling

To gather information around SAFE Protocol implementation from state-level perspectives, we conducted censuses of VAWA administrators and state sexual assault coalitions. We received current lists of VAWA administrators from the Office on Violence Against Women and of contacts at state sexual assault coalitions from the National Sexual Violence Resource Center. We then contacted each coalition to determine the best person to complete the survey based on their role in supporting the implementation of SAFE Protocol components. Surveys were sent to all VAWA administrators and

sexual assault coalitions across the country. Both censuses were conducted between June 2019 and August 2019.

To understand how the SAFE Protocol is being implemented at the local level, we first surveyed representatives from SANE programs. We used the International Association of Forensic Nurses' voluntary national Forensic Nursing Program Directory (as of August 2019) as a sampling frame to identify US SANE programs to administer the national survey to. We examined the directory for duplicate entries and used best efforts via email, mail, and phone contacts to verify program existence and contact information. We identified a main contact person for each program to receive the survey. In cases where the program coordinator was a practicing SANE, we had that person complete the survey. If the coordinator was not a SANE, we asked for the program's most experienced SANE to complete the survey. We sent surveys to all programs for which we had valid contact information.

At the end of the SANE program survey, we received a snowball sampling referral from each responding SANE to a local victim advocate. The last section of the survey asked the following: "As part of this research study, we will also be conducting a national survey of community-based victim advocates from local nonprofit sexual assault service agencies/rape crisis centers. To assist with this task, *please provide us with the name and contact information* of a nonprofit sexual assault service agency that provides medical advocacy during your exams in your community/jurisdiction." We also asked responding SANEs whether we had their permission to indicate to advocates that they had referred us. We verified the provided referral information via email and phone contacts. If a responding SANE did not provide such referral information, we conducted an internet search to identify relevant local nonprofit sexual assault service providers in the SANE program's geographic area and conducted cold outreach to these providers to identify the best person to complete the advocate survey. The survey was designed to be completed by a victim advocate from the local nonprofit sexual assault program/rape crisis center who oversaw/coordinated a sexual assault medical forensic exam (SAMFE) accompaniment/advocacy program or who provided SAMFE accompaniment/advocacy themselves. We sent surveys to all programs for which we had valid contact information, but we were unable to identify corresponding advocacy programs for 14 jurisdictions. The national survey of SANE programs was administered from October 2019 through August 2020, and the corresponding victim advocate surveys were administered from December 2019 through August 2020.

All four surveys—the censuses of VAWA administrators and the state sexual assault coalitions and the surveys of SANE programs and corresponding advocates—were conducted via Qualtrics online survey software. Survey questions asked each respondent about their background; their organization's background; state laws and policies related to sexual assault response; their knowledge of and familiarity with SAFE Protocol provisions; their perceptions of the extent to which particular SAFE Protocol provisions had been implemented (at the state and local levels, as appropriate); their perceptions of which stakeholders supported or were barriers to implementation; SAMFE payment practices; kit storage practices; survivor reporting options; trainings received and provided; and resources. SANEs and advocates were also asked whether their jurisdictions had sexual assault response teams and multidisciplinary teams and, if so, who was involved, program structures and

staffing;, how many survivors were served by their programs, and additional barriers to and supports for implementation of components of the SAFE Protocol facing their jurisdiction.

We sent respondents initial emails signed by Urban, the International Association of Forensic Nurses, the National Sexual Violence Resource Center, and the Office on Violence Against Women explaining the study goals, their participants' rights, and individualized links to the online survey so we could monitor nonresponse. We contacted nonresponders multiple times via email (from Urban, and also from International Association of Forensic Nurses leadership for SANEs and the National Sexual Violence Resource Center for victim advocates) and personal phone contact to boost response rates. Table 1 shows final survey sample sizes and response rates.

TABLE 1

Survey Sample Sizes and Response Rates

	Total surveys sent	Number of surveys 100 percent complete	Number of partially completed surveys[a]	Total completed surveys	Response rates (%)
State sexual assault coalitions	56	47	1	48	86
VAWA administrators	56	43	4	47	84
SANE programs	598	350	29	379	63
Victim advocates	365	228	33	261	72

Source: Urban and International Association of Forensic Nurses research team.

Notes: SANE = sexual assault nurse examiner. VAWA = Violence Against Women Act. [a] Partially completed surveys were those between 50–99 percent complete. For all surveys, this group was included in final response rates and survey analyses.

SANE Program and Victim Advocate Survey Sample Characteristics

Table 2 shows the characteristics of the responding SANE programs and of individual SANE and victim advocate participants. Thirty-seven percent of the 379 responding SANE programs were in the South, 13 percent were in the Northeast, 32 percent were in the Midwest, and 18 percent were in the West. The proportions of participating programs by region very closely mirrors the proportions of programs by region in the overall target sample of 598 programs. For the overall sample, 214 programs (36 percent) were in the South, 93 (16 percent) were in the Northeast, 185 (31 percent) were in the Midwest, and 106 (18 percent) were in the West.

Most programs had been in operation for a long time: approximately one-third started before 2000, approximately one-third started between 2000 and 2009, and approximately one-third started between 2010 and 2020, and most (93 percent) had never had to completely halt their services at any time for any reason. Only 56 of the programs (15 percent) were started within the five years before data collection. A majority of programs (78 percent) were hospital based, and 11 percent were based in the community. Over half of programs (54 percent) served more than 100 clients per year.

TABLE 2

Characteristics of the SANE and Victim Advocate Survey Samples

	N	%
SANE programs		
Region (n=379)		
Northeast	51	13.5
Midwest	120	31.7
South	139	36.7
West	69	18.2
Year established (n=322)		
Before 2000	114	35.4
2000–2009	104	32.3
2010–2020	104	32.3
Patients seen annually: sexual assault (n=378)		
<= 100	175	46.3
101–200	93	24.6
>200	110	29.1
Location of services (n=377)		
Hospital	293	77.7
Community based	40	10.6
Other	44	11.7
Ever completely halted services (n=359)		
Yes	24	6.7
No	335	93.3
Sexual assault nurse examiners		
Primary position or title (n=377)		
SANE/SAFE/FNE/SAE	50	13.3
SANE/SAFE program coordinator/manager/director	190	50.4
Forensic nursing program coordinator/manager/director	113	30.0
Other	24	6.4
Years of experience as a SANE/SAFE/FNE/SAE (n=378)		
Less than 1 year	6	1.6
1–2 years	32	8.5
3–5 years	87	23.0
6–9 years	65	17.2
10 or more years	188	49.7
Victim advocates		
Primary position or title (n=257)		
Victim advocate	47	18.3
Advocacy program coordinator	110	42.8
Executive director	31	12.1
Other	69	26.8
Years of experience as a victim advocate (n=257)		
Less than 1 year	9	3.5
1–2 years	33	12.8
3–5 years	78	30.4
6–9 years	45	17.5
10 or more years	92	35.8

Source: Urban and International Association of Forensic Nurses research team.

Notes: FNE = forensic nurse examiner. SAE = sexual assault examiner. SAFE = sexual assault forensic examiner. SANE = sexual assault nurse examiner.

Eighty percent of individual SANE respondents were program coordinators or managing directors of some sort, and one-half had been practicing forensic nursing for 10 or more years. Less than 2 percent of SANEs had been practicing for less than a year. Forty-three percent of victim service provider respondents were advocacy program coordinators, 18 percent were victim advocates, 12 percent were agency executive directors, and 27 percent held some other agency position (e.g., program manager, assistant director, director of sexual assault services). Just over one-third of victim advocate respondents had 10 or more years of experience, and roughly 4 percent of the sample had been in the field for less than a year.

Case Study Procedures and Sampling

We identified case study jurisdictions based on three criteria: (1) local SANEs and victim advocates both reported that the jurisdiction was implementing the SAFE Protocol particularly well, (2) the jurisdiction's SANE program had been operating for at least two years (to ensure it was an established program), and (3) the jurisdiction had a sexual assault response team or multidisciplinary team focused on responding to sexual assault. From those criteria, we identified one jurisdiction each from four regions of the country: the West, Northeast, South, and Midwest. Case studies were conducted between December 2020 and March 2021.

We conducted semistructured interviews via videoconference with local stakeholders to inquire about the following aspects of their local sexual assault response:[1] the multidisciplinary response team; SAMFE payment mechanisms; victim-centered care; operational issues with the SAMFE; kit handling and storage practices; adoption and sustainability of practices, policies, and resources related to the SAFE Protocol; and the criminal legal system response. We interviewed 35 stakeholders across the four case study sites. Table 3 identifies the types of stakeholders interviewed across the four sites. We had the goal of interviewing *at least* SANEs and advocates, relevant law enforcement, representatives from crime labs, and prosecutors; we were also able to interview stakeholders who were identified by SANEs and advocates as integral to their local sexual assault response.

Twenty-six case study interviewees identified as cisgender women, six interviewees identified as cisgender men, and three respondents indicated they preferred not to provide an answer about this. Few respondents identified as people of color (three identified as Hispanic/Latinx, one identified as Asian/Middle Eastern, and identified as was Native American), and the remaining sample identified as white. Most respondents were ages 26 to 55 (16 were 26 to 45 and 10 were 46 to 55), with few reporting they were younger than 26 or older than 55 (two were 18 to 25, five were 56 to 65, and two were older than 65).

TABLE 3

Types of Stakeholders by Case Study Site

	Site 1	Site 2	Site 3	Site 4	Total
Type of stakeholder					
SANE	2	1	1	2	**6**
Social worker affiliated with SANE program	0	1	0	0	**1**
Community-based victim advocate	2	2	2	2	**8**
Victim/witness advocate	0	0	0	1	**1**
Law enforcement professional[a]	2	1	1	2	**6**
Prosecutor	1	2	1	1	**5**
Crime lab representative	0	1	1	0	**2**
Local SART coordinator[b]	0	0	1	1	**2**
Title IX coordinator	0	0	0	1	**1**
State-level representative	0	1[c]	1[d]	1[e]	**3**
Total	**7**	**9**	**8**	**11**	**35**

Source: Urban and International Association of Forensic Nurses research team.

Notes: SANE = sexual assault nurse examiner. SART = sexual assault response team.

[a] These included five detectives and one chief of police.

[b] Some local SART coordinators also played another role in the system. As such, we interviewed the SART coordinator in each of the four sites (the SART coordinator was an advocate in site 1 and a SANE in site 2).

[c] This was a governor's office representative.

[d] This was a state forensic nursing coordinator.

[e] This was a victim compensation administrator.

We also conducted observations of one multidisciplinary team or sexual assault response team meeting in each case study jurisdiction. During each observation, we took qualitative notes documenting what and how information was shared, the nature of participants' interactions, challenges with the process of the meeting, and other observations that pointed to the relationships among and collaboration between team members. Specific sexual assault cases were not discussed during the meetings we observed. Table 4 shows the number and type of stakeholders who attended the meetings by site. Three of the meetings were led by advocates and one was led by a SANE. Across sites, stakeholders appeared comfortable and familiar with each other, shared updates from their organizations, and discussed local and state policies being implemented or planned.

TABLE 4

Types of Stakeholders Attending the Multidisciplinary Team and Sexual Assault Response Team Meetings by Case Study Site

	Site 1	Site 2	Site 3	Site 4	Total
Type of stakeholder					
SANE	1	3	3	2	**9**
Social worker affiliated with SANE program	0	1	0	0	**1**
Community-based victim advocate	2	5	4	2	**13**
Victim/witness advocate	1	1	0	0	**2**
Law enforcement professional	1	5	3	2	**11**
Prosecutor	2	4	2	1	**9**
Crime lab representative	0	2	1	0	**3**
Local SART coordinator	0	0	0	1	**1**
Title IX coordinator	0	0	0	1	**1**
Domestic abuse response team	1	0	0	0	**1**
Total	**8**	**21**	**13**	**9**	**51**

Source: Urban and International Association of Forensic Nurses research team.
Notes: SANE = sexual assault nurse examiner. SART = sexual assault response team.

We are committed to including the voices of those most affected by the sexual assault response system—sexual assault survivors themselves—when conducting research on these issues. Accordingly, at each case study site, we asked local stakeholders to help us identify and recruit survivors so we could hear about the services and responses they encountered in their community from their perspective. Potential participants were offered $40 in appreciation of their time and expertise. Owing to complications of the COVID-19 pandemic (e.g., stakeholders reported having less contact with survivors during this time) and because interviews were being conducted virtually, stakeholders were unable to successfully identify survivors interested in speaking with us. Stakeholders reported that survivors were reluctant to meet virtually rather than in person. We acknowledge this is a limitation of this project.

Note

[1] Case studies were originally planned to be conducted in person across two to three days in local communities. We conducted them virtually because of the COVID-19 pandemic.

About the Authors

Janine Zweig is associate vice president for Justice Policy at the Urban Institute. She has conducted research on violent victimization, particularly sexual and intimate partner violence, and has evaluated several provisions of and initiatives related to the Violence Against Women and Prison Rape Elimination Acts and the Office for Victims of Crime's Vision 21.

Erica Henderson is a research associate in the Justice Policy Center, where she uses quantitative and qualitative methods to collect and analyze research data related to crime victimization, juvenile justice, and creating solutions to problems affecting vulnerable populations.

Lauren Farrell is a policy analyst in the Justice Policy Center and chairs the community-engaged methods users' group. Her research is focused on community engagement, innovative programming for youth development, and community-based supports for survivors and justice-involved people.

Melanie Langness is a policy analyst in the Justice Policy Center, where her research focuses on analyzing systems of violence and harm while centering community-engaged methods and a trauma-informed lens. Their recent work includes an evaluation of an abusive partner intervention program and ongoing technical capacity–building work with victim service organizations in Washington, DC.

Nicole Stahlmann is the forensic nursing director with the International Association of Forensic Nurses, overseeing and managing grant-funded projects and providing training, education, and technical assistance. She continues to practice clinically, providing care for patients who have experienced violence.

Emily Tiry is a senior research associate in the Justice Policy Center. Her research focuses on criminal case processing, responses to victimization, and advancing the use of data in the criminal justice system.

Kelly Walsh is a principal policy associate in the Urban Institute's Research to Action Lab and the Justice Policy Center. She is an interdisciplinary researcher, evaluator, and technical assistance provider with expertise in forensic science, justice system errors, and outcomes-based contracting.

Acknowledgments

This project was supported by Grant No. 2018-SI-AX-0002 awarded by the Office on Violence Against Women, US Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the authors and do not necessarily reflect the views of the US Department of Justice or those of the Urban Institute, its trustees, or its funders. We are grateful to the Office on Violence Against Women and to all our funders, who make it possible for Urban to advance its mission.

Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

We are grateful to the Office on Violence Against Women and to all our funders, who make it possible for Urban to advance its mission. We would like to thank the following former and current project members for their assistance with this study: Sara Bastomski, Kim Day, Storm Ervin, Jahnavi Jagannath, Colette Marcellin, Mari McGilton, Susan Nembhard, Karmen Perry, Krista White, and Rebecca Wong. We would also like to thank the members of our advisory board—Bethany Backes, Rebecca Campbell, Ilse Knecht, Sally Laskey, Jennifer Long, Jennifer Pierce-Weeks, and Jordan Satinsky—for their invaluable contributions to this study, without which it would not have been possible. Lastly, we would like to thank all those across the country that took the time to complete our surveys and to speak with us to share about their experiences related to this study.

500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.

Copyright © July 2021. Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.