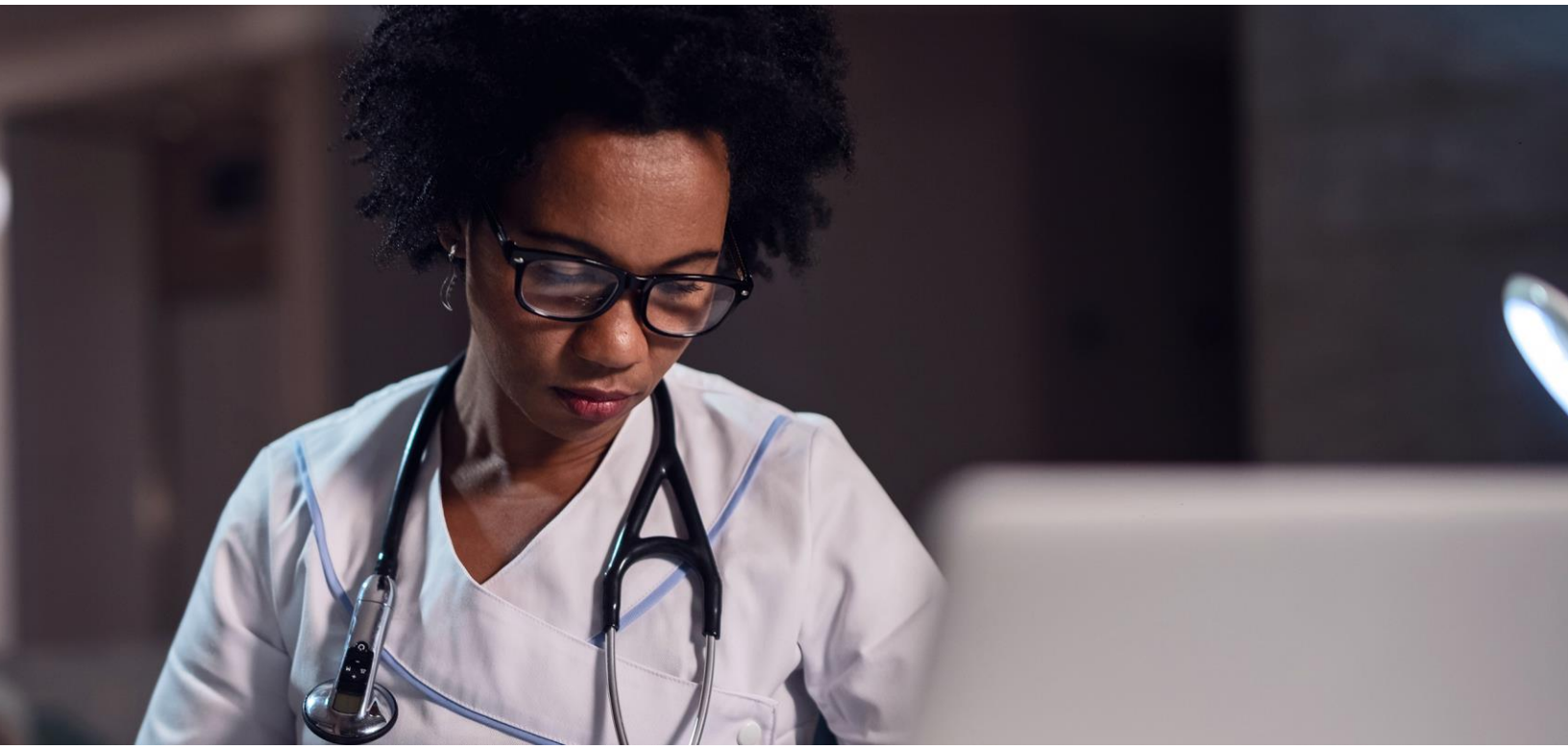

GUIDANCE FOR THE FIELD

Supporting Implementation of the National Sexual Assault Medical Forensic Examinations (SAFE)Protocol

Suggested Next Steps in Training and Technical Assistance

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Contents

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Executive Summary

In 2018, the Urban Institute and the International Association of Forensic Nurses (IAFN) were funded by the Office on Violence Against Women to conduct an evaluation of the Sexual Assault Medical Forensic Exam (SAFE) Protocol with the aim of understanding the extent to which its provisions have been implemented across the United States. Using information from this evaluation, this report provides guidance to the field on next steps for supporting SAFE Protocol implementation for future training and technical assistance efforts. The below information summarizes the recommendations made throughout the report.

Report Highlights and Recommendations

Training and technical assistance providers focused on building stakeholder *knowledge* should consider the following recommendations:

- Identify topics or sections with low scores (table 1) for increased attention or emphasis during training.
- Tailor enhanced efforts to build knowledge around specific areas of the SAFE Protocol based on which stakeholder group is the target of training and technical assistance efforts.
- Consider addressing some information differently. Considering all stakeholder groups had lower scores for coordinated team approaches and SAMFE payment practices, these topics may require more time during trainings, or the information may need to be presented differently.

Training and technical assistance providers focused on building stakeholder *familiarity* should consider the following recommendations:

- Give more attention to culturally responsive care and to the needs of LGBTQIA+ and gender nonconforming people, people with different abilities and disabilities, and non-English speakers, and create new presentation tactics for training and technical assistance in these areas. All respondent groups demonstrated low levels of familiarity with these topics.
- Conduct outreach to LGBTQIA+ survivors, survivors with disabilities, and survivors who do not speak English to tailor enhanced local efforts to build familiarity on culturally responsive practices and specialized processes for these groups.

- Conduct further exploration in your own community to understand why VAWA administrators and SANE respondents have slightly more positive views of what their communities are familiar with than SA coalitions and victim advocate respondents, respectively. Additionally, compare these stakeholder groups' reported familiarity with the knowledge section above to gain better insight on the community's actual familiarity with elements of the SAFE Protocol.

Training and technical assistance providers focused on improving stakeholders' *implementation* of the SAFE Protocol should consider the following recommendations:

- Actively increase awareness of all policies and procedures specific to providing services to victims of sexual assault. Provide transparent communication, training, and education among all multidisciplinary-team stakeholders regarding the importance of implementing the SAFE Protocol or policies and procedures outlined by state-specific protocols.
- Collaborate and establish healthy partnerships with community-based service agencies to provide quality resources for LGBTQIA+ people, people with varying abilities/disabilities, and non–English speaking people.
- Collaborate and establish healthy partnerships with culturally responsive service agencies to inform and contribute to training and technical assistance.
- Establish policies and procedures to implement nonoccupational postexposure prophylaxis treatments for human immunodeficiency virus. All service providers, in accordance with the SAFE Protocol, should receive up-to-date training and education on properly screening patients for human immunodeficiency virus, be able to provide rationale for and education on administration, and effectively offer patients follow-up services before discharging them.

Training and technical assistance providers working to help communities *adopt* the SAFE Protocol should consider the following recommendations based on notable barriers to successful implementation and lessons learned from common facilitators:

- To the extent possible, develop training or make other efforts to assist communities in securing reliable and ongoing funding that allows for focused SANE efforts. SANE programs report that funding instability and low organizational capacities complicate their adoption of the SAFE Protocol.
- Center the expertise and leadership of victim advocates when developing trainings focused on coordinated responses to sexual assault. All respondents indicated that the work of

community-based sexual assault advocates had been instrumental in implementing components of the SAFE Protocol.

- Target efforts toward groups that stakeholders reported were not fully assisting with SAFE Protocol implementation in their community/jurisdiction. These groups may need additional support and guidance.

Supporting Implementation of the National Sexual Assault Medical Forensic Examination (SAFE) Protocol

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, particularly for sexual assault nurse examiners (SANEs) completing medical forensic examinations. In 2018, the Urban Institute and the International Association of Forensic Nurses (IAFN) 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 system at the state and local levels. In this report, using information from this evaluation, we describe stakeholders' reported familiarity with and knowledge, implementation, and adoption of the SAFE Protocol, and we provide guidance and recommendations for efforts to promulgate it through training and technical assistance. We understand that as you read through this report, some of the lessons will ring true for your jurisdiction and others will not. We encourage you to consider all the information and how it might be best applied to stakeholders in your jurisdiction.

The SAFE Protocol provides direction to those in the sexual assault response system—sexual assault nurse examiners (SANEs), victim advocates, law enforcement, prosecutors, and so on—on various issues related to community-based approaches and the sexual assault medical forensic exam (SAMFE) process. It is divided into three sections (OVW 2013). First, the overarching issues section covers coordinated team approaches, options for reporting to law enforcement, victim-centered care, informed consent, confidentiality, and payment for SAMFEs. Second, the operational issues section outlines best practices for SANEs, facilities where SAMFEs are conducted, equipment and supply needs, sexual assault evidence collection kits, timing considerations around evidence collection, and procedures for maintaining evidence integrity. Third, the examination process section provides direction for each step of the SAMFE process, including initial connection with survivors, proper

incident and medical-history documentation, best practices for collecting photographic evidence, guidance on medical care and treatment during examination, and preparation for court testimony. Since 2004, the Office on Violence Against Women has funded IAFN to implement the SAFE (Sexual Assault Forensic Examiner) technical assistance project, and through the inception of this project, IAFN has delivered training and technical assistance to more than 51,000 people in the sexual assault response system, including forensic nurses and other multidisciplinary stakeholders (e.g., advocates, law enforcement).

Report Roadmap

The guidance in this report presents state and local-level stakeholders' reported familiarity with and knowledge, implementation, and adoption (defined in terms of barriers and facilitators) of the SAFE Protocol. Each section begins with topline recommendations gleaned from our analysis of the data relevant to that topic, followed by specific findings that led to those recommendations. Findings are provided for each type of stakeholder included in the study: state sexual assault (SA) coalitions, state Violence Against Women Act (VAWA) administrators, practicing SANEs, and local victim advocates from nonprofit, community-based sexual assault service providers. For some sections, we point to additional detail about the topic provided in the table and figures in appendix A for readers interested in more granular information. Box 1 describes our methods and data collection activities for the current study.

BOX 1

Evaluation of the Implementation of the SAFE Protocol

Urban and the International Association of Forensic Nurses' evaluation of the SAFE Protocol was a cross-sectional, mixed-methods study incorporating the perspectives of multiple stakeholders at the state and local levels. We conducted the following data collection activities (see our associated brief for a full description of the study methods):

- **A census of state sexual assault coalitions.** We invited 56 state sexual assault coalitions to participate in an online survey; 48 completed surveys, yielding an 86 percent response rate.
- **A census of state Violence Against Women Act administrators.** We invited 56 VAWA administrators to participate in an online survey; 47 completed surveys, yielding an 84 percent response rate.
- **A national survey of sexual assault nurse examiner programs.** We invited representatives from 598 SANE programs to participate in an online survey; 379 programs participated, yielding a 63 percent response rate.

- **A survey of advocates from nonprofit sexual assault service providers and rape crisis centers.** We invited representatives from 364 local nonprofit, community-based victim advocacy programs from the same jurisdictions as participating SANE programs (referred by participating SANEs or identified through internet searches) to participate in an online survey; 261 participated, yielding a 72 percent response rate.
- **Case studies with local stakeholders involved in sexual assault responses.** We conducted virtual case studies in four jurisdictions involving observations of multidisciplinary team (or sexual assault response team) meetings and semistructured interviews with stakeholders involved in local sexual assault responses. Interviews were conducted with 35 stakeholders: 6 SANEs and 1 social worker from 4 SANE programs; 8 victim advocates from 5 advocacy programs; 5 detectives and 1 chief of police from 6 law enforcement agencies; 5 prosecutors and 1 victim witness advocate from 4 prosecutor offices; 2 crime lab representatives from 2 state crime labs; and 6 administrators (a victim compensation administrator, a Title IX coordinator, a governor's office representative, a state forensic nursing coordinator, and two local SART coordinators).

A note on survivor participation: we are committed to including the voices of those most affected by the sexual assault response system—survivors of sexual assault—when conducting research on these issues. 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. Because of 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 identify survivors interested in speaking with us. Stakeholders reported survivors were reluctant to meet virtually rather than in person. We acknowledge this is a limitation of this project.

Knowledge of the SAFE Protocol

Training and technical assistance providers focused on building stakeholder *knowledge* should consider the following recommendations:

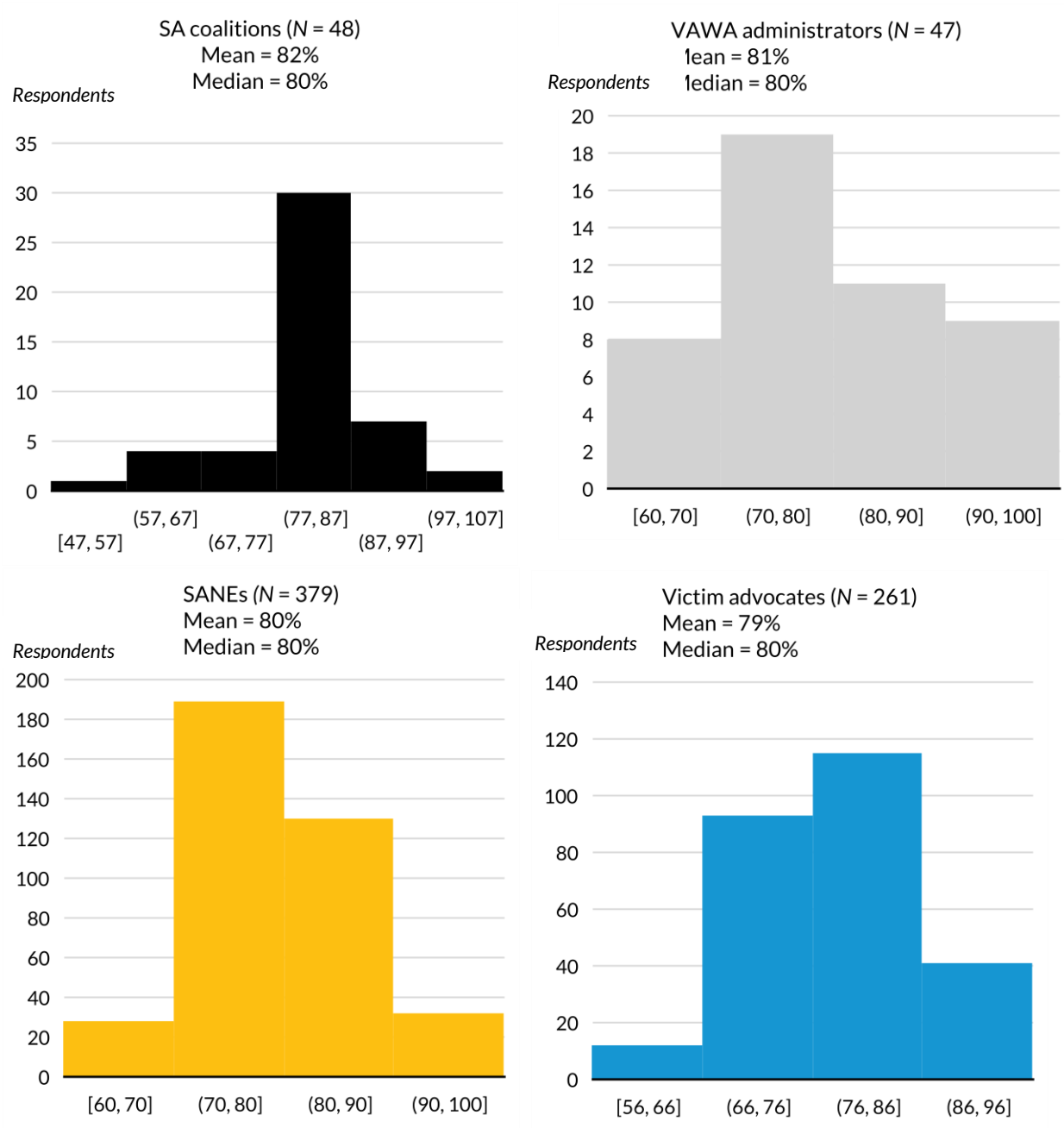
- *Identify topics or sections with low scores (table 1) for increased attention or emphasis during training.*
- *Tailor enhanced efforts to build knowledge around specific areas of the SAFE Protocol based on which stakeholder group is the target of training and technical assistance efforts.*
- *Consider addressing some information differently. Considering all stakeholder groups had lower scores for coordinated team approaches and SAMFE payment practices, these topics may require more time during trainings, or the information may need to be presented differently.*

We assessed survey respondents' knowledge of the SAFE Protocol via tests consisting of multiple-choice, select-all-that-apply, and true/false questions. SANE and advocate tests included 25 questions,

and VAWA administrator and SA coalition tests included 15 questions. Questions asked respondents about the following topics covered in the SAFE Protocol: coordinated team approaches, victim-centered care, informed consent, confidentiality, reporting to law enforcement, sexual assault forensic examiners, payment practices for covering SAMFEs, sexual assault evidence collection kits, timing and documentation considerations for collecting evidence, exam equipment and supplies, and exam facilities (the last two sections were only asked in the SANE and victim advocate tests). Overall results of the knowledge test for all four groups of survey respondents are presented in figure 1; each score represents the percentage of correct answers for each participant. **On average, all respondents would earn a B grade on the knowledge test.**

FIGURE 1

Survey Respondents' Scores on a Test about the SAFE Protocol



Sources: Urban and International Association of Forensic Nurses surveys of SA coalitions, VAWA administrators, SANEs, and victim advocates administered between June 2019 and August 2020.

Notes: SA = sexual assault. SANEs = sexual assault nurse examiners. SAFE Protocol = National Protocol for Sexual Assault Medical Forensic Examinations. VAWA = Violence Against Women Act.

We learn more about what stakeholders know when we dig deeper and examine test scores by question subsections. Table 1 shows the three knowledge subsections for which each stakeholder group had the highest and lowest scores. **All four stakeholder groups had questions about sexual assault forensic examiners in their three highest-scoring sections based on average test scores** (as either first- or second-highest scores). SANEs' and advocates' highest average scores were on the equipment and supplies section, and SA coalitions and VAWA administrators scored high on informed consent. Three categories of respondents—VAWA administrators, SANEs, and advocates—had victim-centered care as their third-highest-average subsection score, whereas SA coalitions had reporting to law enforcement as their third-highest section.

Survey respondents knew the least about coordinated team approaches and information about SAMFE payment practices; all four stakeholders had these among their three lowest-scoring subsections. Sexual assault coalitions and VAWA administrators also had low scores on confidentiality, and SANEs knew less about the minimum federal requirements for kit contents and advocates knew less about the informed consent process.

If interested, you can dig even deeper still on stakeholder knowledge. Table A.1 in appendix A presents the individual test questions and the percentage of each stakeholder group that answered each question correctly.

TABLE 1

Highest and Lowest Average Scores for Knowledge Subsections for Sexual Assault Coalitions, VAWA Administrators, SANEs, and Victim Advocates

	SA coalitions	VAWA administrators	SANEs	Victim advocates
Highest-scoring sections				
Sexual assault forensic examiners	2nd highest score	Highest subsection score on average	2nd highest score	2nd highest score
Informed consent	Highest subsection score on average	2nd highest score	--	--
Victim-centered care	--	3rd highest score	3rd highest score	3rd highest score
Reporting to law enforcement	3rd highest score	--	--	--
Equipment and supplies	--	--	Highest subsection score on average	Highest subsection score on average
Lowest-scoring sections				
Payment practices	Lowest subsection score on average	Lowest subsection score on average	2nd lowest score	2nd lowest score
Coordinated team approach	2nd lowest score	3rd lowest score	Lowest subsection score on average	Lowest subsection score on average
Confidentiality	3rd lowest score	2nd lowest score	--	--
Sexual assault kits	--	--	3rd lowest score	--
Informed consent	--	--	--	3rd lowest score

Sources Urban and International Association of Forensic Nurses surveys of SA Coalitions, VAWA administrators, SANEs, and victim advocates administered between June 2019 and August 2020.

Notes: Cells are shaded for readability. SA = sexual assault. SANEs = sexual assault nurse examiners. VAWA = Violence Against Women Act. *N* ranged from 41–48 for SA coalitions, 44–46 for VAWA administrators, 343–79 for SANEs, and 241–61 for Advocates. 0–7 SA coalition responses, 1–3 VAWA administrator responses, 0–36 SANE responses, and 0-20 victim advocate responses were missing.

Familiarity with the SAFE Protocol

Training and technical assistance providers focused on building stakeholder *familiarity* should consider the following recommendations:

- *Give more attention to culturally responsive care and to the needs of LGBTQIA+ and gender nonconforming people, people with different abilities and disabilities, and non-English speakers, and create new presentation tactics for training and technical assistance in these areas. All respondent groups demonstrated low levels of familiarity with these topics.*
- *Conduct outreach to LGBTQIA+ survivors, survivors with disabilities, and survivors who do not speak English to tailor enhanced local efforts to build familiarity on culturally responsive practices and specialized processes for these groups.*
- *Conduct further exploration in your own community to understand why VAWA administrators and SANE respondents have slightly more positive views of what their communities are familiar with than SA coalitions and victim advocate respondents, respectively. Additionally, compare these stakeholder groups' reported familiarity with the knowledge section above to gain better insight on the community's actual familiarity with elements of the SAFE Protocol.*

We assessed familiarity with the SAFE Protocol via a set of questions asking SA coalitions and VAWA administrators to estimate the shares of communities and jurisdictions in their states that were familiar with the SAFE Protocol's recommendations (options were 0–25 percent of communities, 26–50 percent, 51–75 percent, and 76-100 percent). We asked SANEs and advocates to estimate the level of familiarity that stakeholders in the sexual assault response systems in their communities and jurisdictions had with the SAFE Protocol's recommendations (options were very familiar, somewhat familiar, neutral, somewhat unfamiliar, and very unfamiliar). Questions about all three sections of the SAFE Protocol were rated: we asked about 13 elements of the overarching issues section, 5 elements of the operational issues section, and 10 elements of the exam process section. Box 2 provides details about the topics covered in each section. Each group of survey respondents—VAWA administrators, representatives from state sexual assault coalitions, representatives from local SANE programs, and corresponding local victim advocates—have informed perspectives around the issues being reported here and were chosen for their expertise in the sexual assault response field. Each group of respondents should be informed about and aware of the SAFE Protocol implementation in their community or jurisdiction.

BOX 2

Questions Asked of Survey Respondents by SAFE Protocol Section

The survey questions about the overarching issues section included the following elements:

- SARTs or other formalized multidisciplinary-team approaches for first responders
- provision of victim-centered care
- responsiveness to needs of non–English speaking victims, LGBTQIA+ and gender nonconforming victims, and victims with disabilities
- informed consent
- confidentiality practices
- reporting options
- providing exams free of charge
- providing exams free of charge without requiring survivors to report to police
- billing procedures
- chain of custody
- anonymous reporting options

The survey questions about the operational issues section included the following elements:

- trainings for SANEs
- culturally responsive services
- medical equipment and supplies
- evidence integrity
- timing around evidence collection

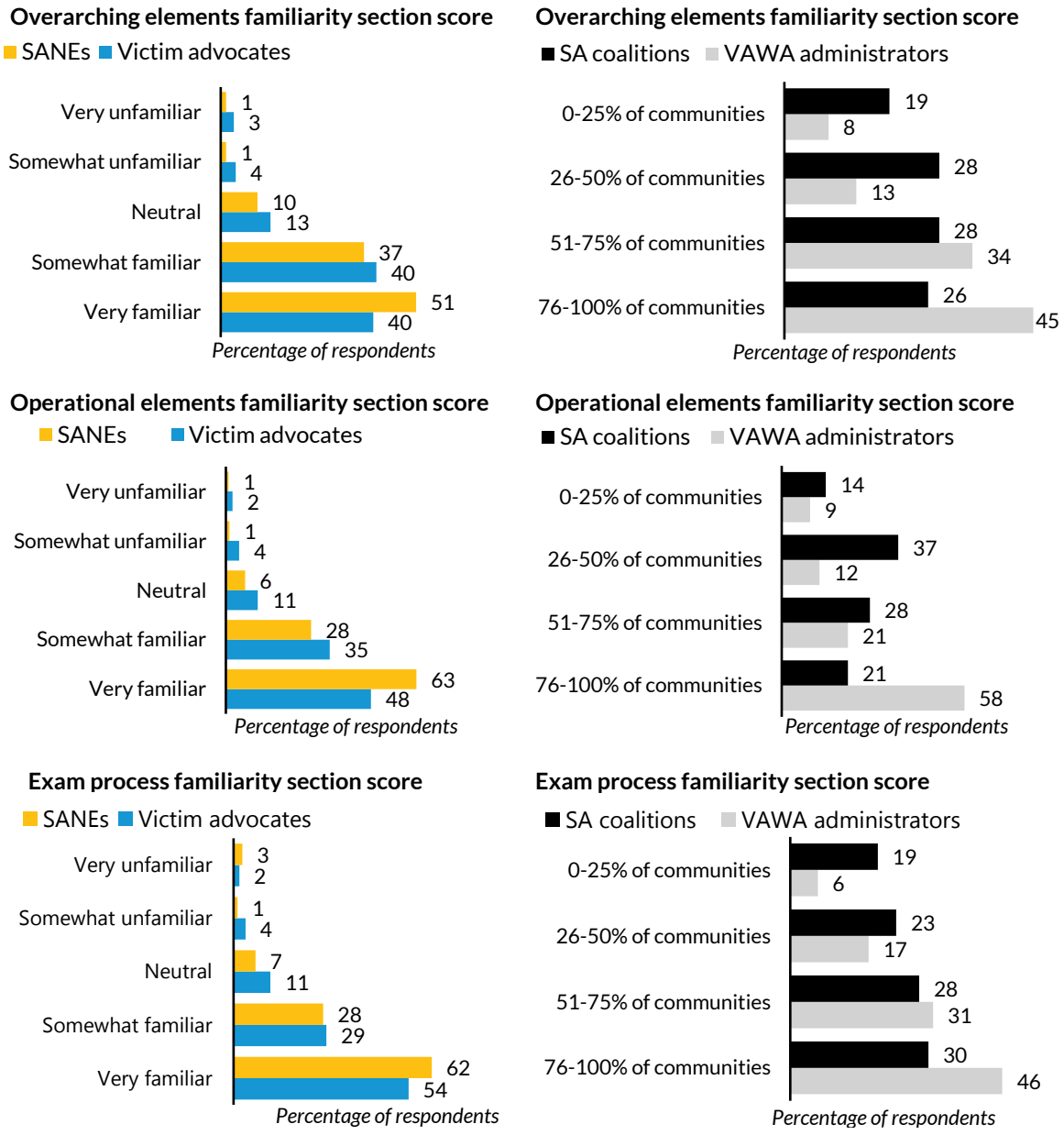
The survey questions about the exam process section included the following elements:

- triage and intake procedures
- provision of court testimony by medical forensic examiners
- SAMFE documentation
- assaults facilitated by drugs/alcohol
- evaluation and preventative treatment for sexually transmitted infections
- risk assessment and preventative treatment for human immunodeficiency virus
- pregnancy evaluation and preventative treatment options
- referrals to community victim services

Figure 2 presents average familiarity scores across the three sections of the SAFE Protocol for each respondent group. Overall, results show that VAWA administrators (for their states' communities) and SANEs (for their local communities) reported higher levels of familiarity than SA coalitions and victim advocates, respectively. At the state level, 79 percent of VAWA administrators reported that 51 percent or more of the communities in their state were familiar with overarching and operational issues of the SAFE Protocol, and 77 percent reported that 51 percent or more of the communities in their state were familiar with exam process elements. In contrast, only 54 percent of SA coalitions reported that 51 percent or more of the communities in their state were familiar with overarching issues, 49 percent reported that 51 percent or more were familiar with operational issues, and 58 percent reported that 51 percent or more were familiar with the exam process elements. At the local level, 88 percent of SANEs reported that their community was somewhat or very familiar with the overarching issues in the SAFE Protocol (compared with 80 percent of advocates), 91 percent of SANEs reported that their community was somewhat or very familiar with operational issues (compared with 83 percent of advocates), and 90 percent of SANEs reported that their community was somewhat or very familiar with exam process elements (compared with 83 percent of advocates).

FIGURE 2

Summary Familiarity Section Scores among Local-Level Stakeholders (SANEs and Victim Advocates) and State-Level Stakeholders (SA Coalitions and VAWA Administrators)



Sources: Urban and International Association of Forensic Nurses surveys of SA coalitions, VAWA administrators, SANEs, and victim advocates administered between June 2019 and August 2020.

Notes: SA = sexual assault. SANEs = sexual assault nurse examiners. VAWA = Violence Against Women Act. Top left chart: SANE *N* = 348, victim advocate *N* = 233; 31 SANE and 28 advocate responses were missing. Top right chart: SA coalition *N* = 43, VAWA administrator *N* = 38; 5 SA coalition and 9 VAWA responses were missing. Center left chart: SANE *N* = 343, advocate *N* = 226; 36 SANE and 35 advocate responses were missing. Center right chart: SA coalition *N* = 43, VAWA administrator *N* = 33; 5 SA coalition and 14 VAWA administrator responses were missing. Bottom left chart: SANE *N* = 338, advocate *N* = 219; 41 SANE and 42 advocate responses were missing. Bottom right chart: SA coalition *N* = 43, VAWA administrator *N* = 45; 5 SA coalition and 2 VAWA administrator responses were missing.

Individual Elements

Across all surveys, respondents thought their communities were most familiar with the SAFE Protocol's recommendations about processes for referring survivors to community victim services, free exams, and kit integrity, and that their communities were least familiar with the recommendations about the needs of LGBTQIA+ people, culturally responsive care, the needs of people with varying abilities/disabilities, and non-English speakers. These findings are summarized below, but you can find the specific familiarity ratings for each element of the three SAFE Protocol sections for all four respondent groups in figures A.1 through A.6 (in appendix A).

VAWA Administrator Respondents

The SAFE Protocol elements that the largest proportions of VAWA administrators reported 51 percent or more of the communities in their state were familiar with included referral processes to community victim services (85 percent of VAWA administrators), free exams (82 percent), and kit integrity (82 percent). The elements that the smallest proportions of VAWA administrators reported community familiarity with were LGBTQIA+ needs (59 percent), medical forensic examiner court testimony (63 percent), and responsiveness to the needs of people with varying abilities/disabilities (66 percent).

Sexual Assault Coalition Respondents

The SAFE Protocol elements that the largest proportions of SA coalition respondents reported 51 percent or more of the communities in their state were familiar with included evaluations for sexually transmitted infections (65 percent of SA coalitions), free exams (64 percent), preventative treatment for sexually transmitted infections (63 percent), and referrals to community victim services (63 percent). The elements that the smallest proportions of SA coalition respondents reported community familiarity with were culturally responsive services (32 percent), LGBTQIA+ needs (33 percent), and responsiveness to the needs of people with varying abilities/disabilities (38 percent).

Victim Advocate Respondents

The SAFE Protocol elements that the largest proportions of victim advocates believed their communities were somewhat or very familiar with were referrals to community victim services (90 percent of advocates), SAMFE timing for evidence collection (90 percent), and kit integrity (88 percent). The elements that the smallest proportion of advocates reported their communities were familiar with

were the SAFE Protocol's recommendations about LGBTQIA+ needs (66 percent), non-English speakers (70 percent), and anonymous reporting (70 percent).

SANE Respondents

The SAFE Protocol elements that the largest proportions of SANEs believed their communities were very or somewhat familiar with were about chain of custody (95 percent of SANEs), SAMFE timing for evidence collection (94 percent), kit integrity (93 percent), and reporting options (93 percent). The elements that the smallest proportions of SANEs reported their communities were familiar with were the SAFE Protocol's recommendations about LGBTQIA+ needs (77 percent), sexual assault response teams (78 percent), and preventative treatment for human immunodeficiency virus (81 percent).

Implementation of the SAFE Protocol

Training and technical assistance providers focused on improving stakeholders' *implementation* of the SAFE Protocol should consider the following recommendations:

- *Actively increase awareness of all policies and procedures specific to providing services to victims of sexual assault. Provide transparent communication, training, and education among all multidisciplinary-team stakeholders regarding the importance of implementing the SAFE Protocol or policies and procedures outlined by state-specific protocols.*
- *Collaborate and establish healthy partnerships with community-based service agencies to provide quality resources for LGBTQIA+ people, people with varying abilities/disabilities, and non–English speaking people.*
- *Collaborate and establish healthy partnerships with culturally responsive service agencies to inform and contribute to training and technical assistance.*
- *Establish policies and procedures to implement nonoccupational postexposure prophylaxis treatments for human immunodeficiency virus. All service providers, in accordance with the SAFE Protocol, should receive up-to-date training and education on properly screening patients for human immunodeficiency virus, be able to provide rationale for and education on administration, and effectively offer patients follow-up services before discharging them.*

We asked SA coalitions and VAWA administrators to estimate what percentage of the communities/jurisdictions in their state were implementing specific provisions of the SAFE Protocol (0–

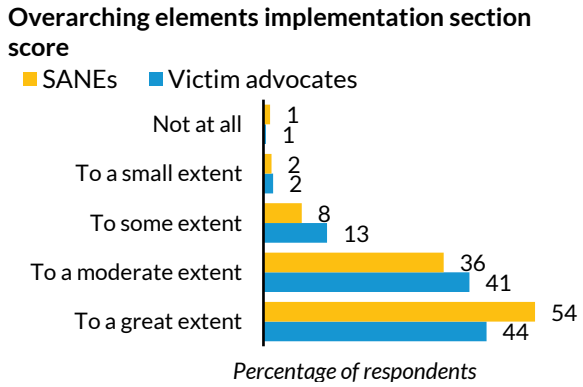
25 percent of communities, 26–50 percent, 51–75 percent, or 76–100 percent). We asked SANEs and victim advocates to estimate the extent of implementation of SAFE Protocol provisions in their community/jurisdiction (options were to a great extent, to a moderate extent, to some extent, to a small extent, or not at all).

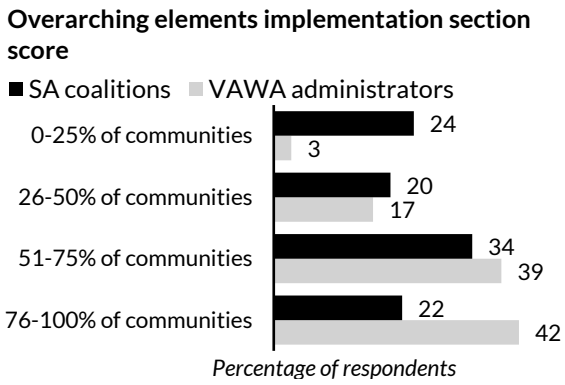
Figure 3 presents average implementation scores across the three sections of the SAFE Protocol for each respondent group. VAWA administrators reported that more of their communities were implementing SAFE Protocol provisions than did SA coalitions for overarching elements, operational elements, and exam process elements. Specifically, 81 percent of VAWA administrators reported that 51 percent or more of the communities in their state were implementing overarching elements, 82 percent reported that 51 percent or more were implementing operational elements, and 77 percent reported that 51 percent or more were implementing the exam process elements. In contrast, only 56 percent of SA coalitions reported that 51 percent or more of the communities in their state were implementing overarching elements, 56 percent of coalitions said 51 percent or more were implementing operational elements, and 63 percent reported that 51 percent or more were implementing exam process elements.

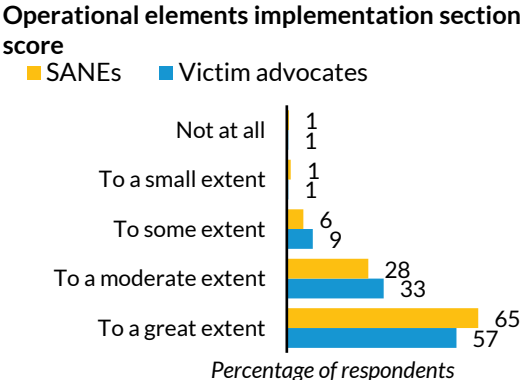
Local-level respondents (SANEs and victim advocates) gave more similar estimates of SAFE Protocol implementation than state-level respondents (SA coalitions and VAWA administrators). Similar proportions of SANEs and victim advocates reported that their communities were implementing provisions of the protocol to a moderate or great extent. Ninety percent of SANEs and 85 percent of advocates reported that their communities were implementing overarching elements to a moderate or great extent, 93 percent of SANEs and 90 percent of advocates reported that their communities were implementing operational elements to a moderate or great extent, and 90 percent of SANEs and 88 percent of advocates reported that their communities were implementing exam process elements to a moderate or great extent.

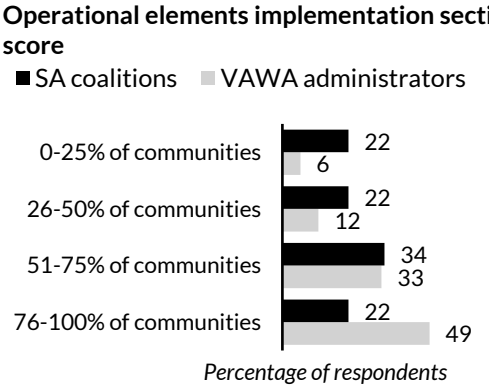
FIGURE 3

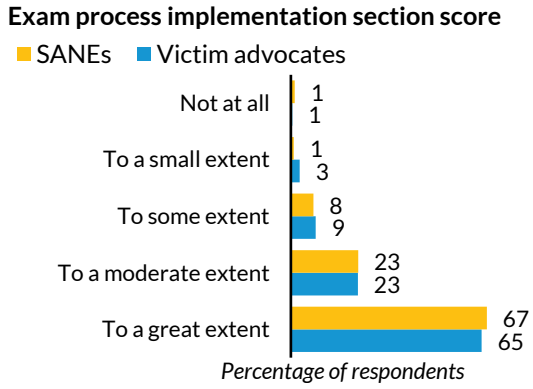
Summary Implementation Section Scores among Local-Level Stakeholders (SANEs and Victim Advocates) and State-Level Stakeholders (SA Coalitions and VAWA Administrators)

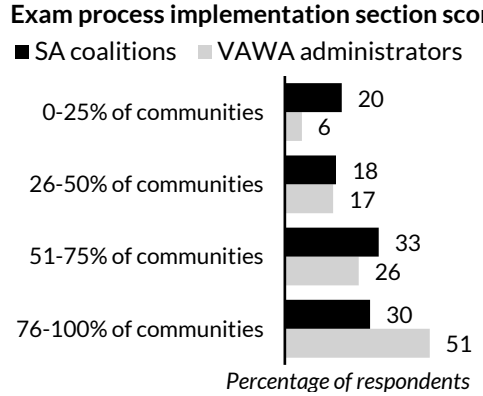












Sources: Urban and International Association of Forensic Nurses surveys of SA coalitions, VAWA administrators, SANEs, and victim advocates administered between June 2019 and August 2020.

Notes: Top left chart: SANE *N* = 314, advocate *N* = 206; 65 SANE and 55 advocate responses were missing. Top right chart: SA coalition *N* = 41, VAWA administrator *N* = 36; 7 SA coalition and 11 VAWA responses were missing. Center left chart: SANE *N* = 304, advocate *N* = 204; 75 SANE and 57 advocate responses were missing. Center right chart: SA coalition *N* = 41, VAWA administrator *N* = 33; 7 SA coalition and 14 VAWA responses were missing. Bottom left chart: SANE *N* = 300, advocate *N* = 201; 79 SANE and 60 advocate response(s) were missing. Bottom right chart: SA coalition *N* = 40, VAWA administrator *N* = 35; 8 SA coalition and 12 VAWA responses were missing.

Individual Elements

Most respondents thought their communities/jurisdictions had fully implemented the SAFE Protocol's recommendations about free exams, kit integrity, referrals to victim service providers, and preventative treatment for sexually transmitted infections. Fewer respondents thought their communities/jurisdictions had fully implemented the protocol's recommendations about the needs of LGBTQIA+ people, culturally responsive services, and preventative treatment for human immunodeficiency virus**.** These findings are summarized below, and you can find the specific implementation ratings for each element in the three SAFE Protocol sections for all four respondent groups in figures A.7 through A.12 (in appendix A).

VAWA Administrator Respondents

The SAFE Protocol elements that the largest proportions of VAWA administrators reported that 51 percent or more of the communities in their state were implementing were the recommendations about kit integrity (88 percent of VAWA administrators), training for medical forensic examinations (88 percent), and chain of custody (87 percent). The elements that the smallest proportions of VAWA administrators reported 51 percent or more of communities were implementing were the recommendations about responsiveness to the needs of people with varying abilities/disabilities (52 percent), LGBTQIA+ needs (55 percent), and non-English speakers (55 percent).

Sexual Assault Coalition Respondents

The SAFE Protocol elements that the largest proportions of SA coalitions reported that 51 percent or more of the communities in their state were implementing were the recommendations about free exams (69 percent of SA coalitions), evaluations for sexually transmitted infections (69 percent), and reporting (68 percent). The elements that the smallest proportions of SA coalitions reported 51 percent or more of communities were implementing were the recommendations about sexual assault response teams (30 percent), LGBTQIA+ needs (31 percent), culturally responsive services (32 percent), and non–English speakers (32 percent).

Victim Advocate Respondents

The SAFE Protocol elements that the largest proportions of victim advocates reported their communities were implementing to a moderate or great extent were about kit integrity (94 percent of

advocates), SAMFE timing for evidence collection (92 percent), and SAMFE equipment/supplies (92 percent). The elements that the smallest proportions of advocates reported their communities were implementing were responsiveness to the needs of non–English speakers (57 percent), LGBTQIA+ needs (62 percent), and the needs of people with varying abilities/disabilities (62 percent).

SANE Respondents

The SAFE Protocol elements that the largest proportions of SANEs reported their communities were implementing to a moderate or great extent were about chain of custody (94 percent of SANEs), kit integrity (93 percent), SAMFE timing of evidence collection (93 percent), and referrals to victim service providers (93 percent). The elements that the smallest proportions of SANEs reported their communities were implementing were about responsiveness to LGBTQIA+ needs (66 percent), the needs of non–English speakers (73 percent), and the needs of people with varying abilities/disabilities (73 percent).

Barriers to and Facilitators of Implementation of the SAFE Protocol

Training and technical assistance providers working to help communities *adopt* the SAFE Protocol should consider the following recommendations based on notable barriers to successful implementation and lessons learned from common facilitators:

- *To the extent possible, develop training or make other efforts to assist communities in securing reliable and ongoing funding that allows for focused SANE efforts. SANE programs report that funding instability and low organizational capacities complicate their adoption of the SAFE Protocol.*
- *Center the expertise and leadership of victim advocates when developing trainings focused on coordinated responses to sexual assault. All respondents indicated that the work of community-based sexual assault advocates had been instrumental in implementing components of the SAFE Protocol.*
- *Target efforts toward groups that stakeholders reported were not fully assisting with SAFE Protocol implementation in their community/jurisdiction. These groups may need additional support and guidance.*

We asked survey respondents to report the extent to which a set of factors and activities—such as coordinated community efforts and use of victim-centered approaches—were barriers to or supportive

of implementing the SAFE Protocol. Table 2 presents the top three barriers to and the top three facilitators of implementing the SAFE Protocol as reported by SA coalitions, VAWA administrators, SANEs, and victim advocates.

The most significant barriers to successfully implementing SAFE Protocol provisions involved funding stability, organizational capacity, and trust from victims. SANEs reported that the capacity needed to fully implement provisions and funding stability were the largest barriers to fully adopting the SAFE Protocol. Unlike SANEs, victim advocates and SA coalitions highlighted a lack of trust from sexual assault survivors as the top barrier to implementing the SAFE Protocol.[1] Though SA coalitions, VAWA administrators, and advocates did not rank state/tribal law around implementation in their top three barriers to implementing the SAFE Protocol, SANE respondents considered it their third-most-significant barrier.

Three out of the four respondent groups (SA coalitions, VAWA administrators, and victim advocates) considered the work of community-based sexual assault advocates the top facilitator in the adoption of SAFE Protocol provisions—only SANEs ranked their own activities as forensic nurses as the top facilitator. Respondents were mixed regarding what they considered the second-most-important facilitator to the implementation of the SAFE Protocol. Sexual assault coalitions and advocates both ranked the accessibility of community-based sexual assault advocates as the second-most-important facilitator, whereas VAWA administrators consider victim-centered approaches by stakeholders involved in responding to sexual assault to be the second-most-important facilitator.

TABLE 2

Top Barriers to and Facilitators of SAFE Protocol Implementation as Reported by SA Coalitions, VAWA Administrators, SANEs, and Victim Advocates

	SA coalitions	VAWA administrators	SANEs	Victim advocates
Top barriers				
Stability of funding to implement the provisions	Worst barrier reported on average	--	2nd worst barrier	--
Capacity to fully implement provisions	2nd worst barrier	3rd worst barrier	Worst barrier reported on average	2nd worst barrier
Health care facility administrator activities (e.g., responsibilities related to health care facility operations)	3rd worst barrier	2nd worst barrier	--	3rd worst barrier
Trust from victims of SA	--	Worst barrier reported on average	--	Worst barrier reported on average
State/tribal law around implementation	--	--	3rd worst barrier	--
Top facilitators				
Community-based sexual assault advocates' activities	Top facilitator reported on average	Top facilitator reported on average	2nd best facilitator	Top facilitator reported on average
Accessibility of community-based sexual assault advocates	2nd best facilitator	3rd best facilitator	--	2nd best facilitator
Use of victim-centered approaches	3rd best facilitator	2nd best facilitator	--	--
SANEs'/sexual assault forensic examiners'/SAEs/FNEs' activities	--	--	Top facilitator reported on average	3rd best facilitator
Professionals knowledge around timing for collecting evidence	--	--	3rd best facilitator	--

Sources: Urban and International Association of Forensic Nurses surveys of SA coalitions, VAWA administrators, SANEs, and victim advocates administered between June 2019 and August 2020.

Notes: Cells are shaded for readability. FNE = forensic nurse examiner. SA = sexual assault. SAE = sexual assault examiner. SAFE Protocol = National Protocol for Sexual Assault Medical Forensic Examinations. SANEs = sexual assault nurse examiners. VAWA = Violence Against Women Act. SA coalition *N* = 47, VAWA *N* = 38, SANE *N* = 344, advocate *N* = 229. One SA coalition response, 9 VAWA responses, 35 SANE responses, and 32 advocate responses were missing.

Stakeholder Assistance with SAFE Protocol Implementation

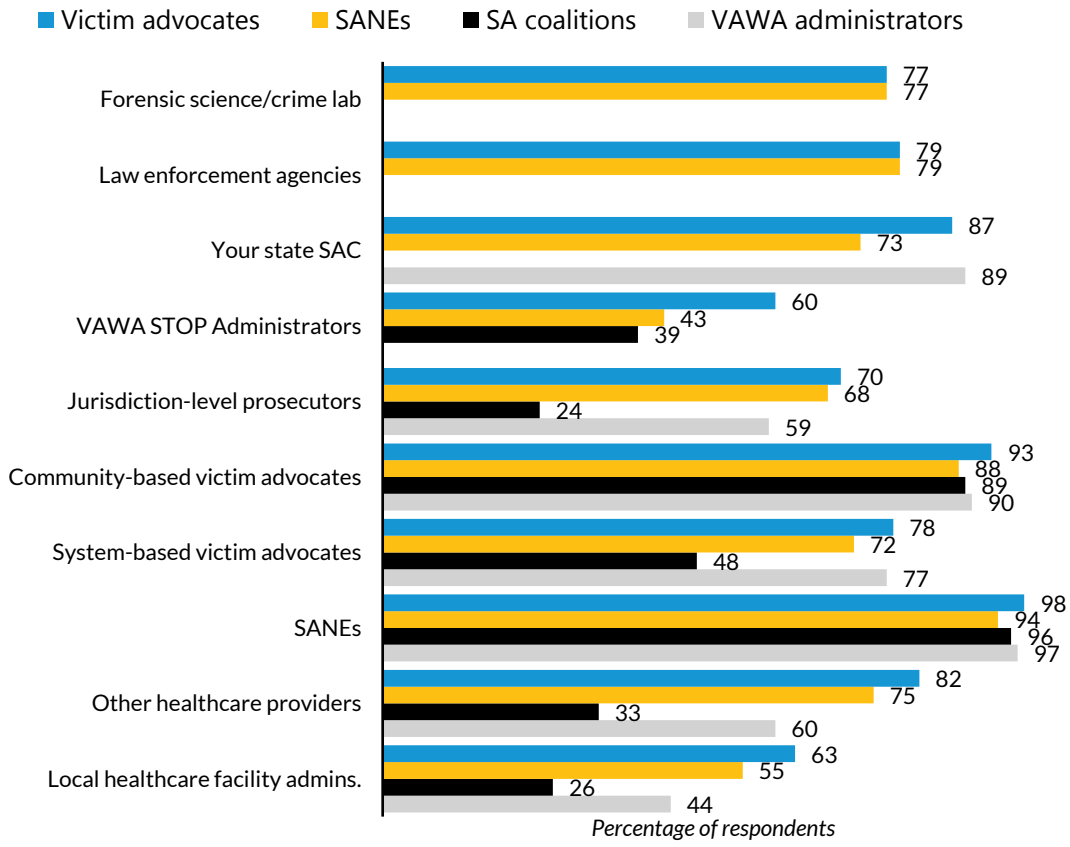
Survey respondents assessed whether particular stakeholder groups assisted with SAFE protocol implementation in response to the question: "To what extent do the following stakeholders assist with implementation of the recommendations contained in the SAFE Protocol?" They selected from

response options of do not assist, slightly assist, moderately assist, fully assist, and I don't know. SANEs and victim advocates were asked about more types of stakeholder groups than VAWA administrators and SA coalitions, and VAWA administrators and SA coalitions did not rate themselves.

Figure 4 shows the percentages of respondents reporting that stakeholder groups moderately or fully assisted with SAFE Protocol implementation. **SANEs were identified the most as assisting with SAFE Protocol implementation by all survey respondents (SANEs, victim advocates, VAWA administrators, and SA coalitions), followed by community-based victim advocates**. Local health care facility administrators, VAWA STOP (Services, Training, Officers, and Prosecutors) administrators, and jurisdiction-level prosecutors received lower ratings on their assistance in implementing the SAFE Protocol.

FIGURE 4

Shares of Victim Advocates, SANEs, SA Coalitions, and VAWA Administrators Reporting That Different Stakeholders Moderately or Fully Assist with SAFE Protocol Implementation



Sources: Urban and International Association of Forensic Nurses surveys of SA coalitions, VAWA administrators, SANEs, and victim advocates.

Notes: SA = sexual assault. SANEs = sexual assault nurse examiners. VAWA = Violence Against Women Act. STOP = Services, Training, Officers, Prosecutors. SAC = sexual assault coalition. SA coalition *N* = 47, VAWA *N* = 40, VAWA; one SA coalition response and 7 VAWA responses were missing. *N* ranged from 163–333 for SANEs and 79–209 for advocates; 46–216 SANE responses and 52–182 advocate responses were missing.

Appendix A. Supplemental Tables and Figures

TABLE A.1

Individual Knowledge Questions with Percentage Correct by Respondent Group

Percentage correct out of nonmissing items for each question across all four surveys.

	SA coalitions	VAWA administrators	SANEs	Victim advocates
Topic: sexual assault forensic examiners				
What are SANEs? Please select one option. ▪ Registered nurses who receive specialized education and clinical requirements to perform SAMFEs ▪ Experienced nurses who have treated sexual assault victims before ▪ Any nurse who regularly conducts SAMFEs ▪ A compassionate nurse who treats and collects evidence from sexual assault patients	96%	100%	98%	98%
Topic: Coordinated team approach				
The purpose of the sexual assault medical forensic exam (SAMFE) is to address patients' health care needs and collect evidence, when appropriate, for potential use within the criminal justice system. ▪ True ▪ False	96%	96%	97%	97%
The purpose of a Sexual Assault Response Team (SART)/Sexual Assault Response and Resource Team (SARRT) is: Please select all that apply. ▪ To coordinate immediate interventions and services for victims ▪ To promote efforts to improve comprehensive responses to sexual violence ▪ To bring together professionals involved in immediate response to disclosures of sexual assault ▪ To be involved in a sexual assault case from initial contact through close	44%	51%	37%	36%

	SA coalitions	VAWA administrators	SANEs	Victim advocates
At a minimum, which of the following disciplines should be included in a SART/SARRT? Please select all that apply. ▪ System-based and community-based victim advocates ▪ Health care providers ▪ Law enforcement representatives ▪ Crime lab personnel ▪ Family members of the victim ▪ Prosecutors ▪ Defense Attorneys	NA	NA	27%	36%
Topic: victim-centered care				
Having victims wait for a period of time to be evaluated at a medical facility could lead to re-victimization. ▪ True ▪ False	NA	NA	96%	94%
In what way might a victim of sexual assault typically react after experiencing a sexual assault? Please select only one option. ▪ Crying ▪ Aversion to touch ▪ Silence ▪ Wanting to be touched ▪ There is no 'typical' response	NA	NA	97%	98%
Which of the following may impact a person's experience with sexual assault and the aftermath? Please select all that apply. ▪ Age ▪ Gender identity or expression ▪ Immigration status ▪ Ability/disability ▪ Race/ethnicity ▪ Military status ▪ Language (English proficiency)	96%	96%	91%	95%
How can culturally responsive care be incorporated into sexual assault response protocols? Please select one option. ▪ By identifying different populations that exist in your jurisdiction and determining what information responders should have readily available to help serve patients from those populations ▪ By going into communities in your area and asking people about their history with the health care system and sexual assault ▪ Culturally responsive care is not an important factor as long as the exam is completed in a timely manner ▪ None of the above	73%	87%	96%	90%

	SA coalitions	VAWA administrators	SANEs	Victim advocates
Victims should be given the option to have a victim advocate present during the SAMFE. ▪ True ▪ False	NA	NA	99%	98%
Topic: **informed consent**				
In regard to the SAMFE, at what stages of the exam must an examiner obtain consent? Please select one option. ▪ Once at the beginning of the exam and once in the middle ▪ Before the exam begins only ▪ Before the exam begins and as appropriate throughout the exam ▪ Before and after the exam ▪ Informed consent is not necessary for the exam - it should be done as directed by law enforcement	94%	93%	98%	97%
Patients can decline any part or all of the exam. ▪ True ▪ False	100%	100%	100%	100%
What is included in an informed consent process? Please select all that apply. ▪ Making patients aware that declining a procedure may negatively affect the usefulness of evidence ▪ Providing information on whether communications are confidential ▪ Providing information about the SAMFE in a language they understand ▪ Assessing patients' ability and legal capacity to provide informed consent ▪ Explaining what is about to happen in clear and understandable language ▪ Making sure that the patient's breath or serum alcohol level is below .08 before they can provide informed consent	NA	NA	34%	15%
Topic: **confidentiality**				
Community-based advocates have some level of confidentiality with victims, and the extent of confidentiality varies by community and state law. ▪ True ▪ False	NA	NA	85%	85%
System-based advocates (based in police departments or prosecutor offices) have higher levels of confidentiality with victims than community-based advocates. ▪ True ▪ False	NA	NA	83%	91%

	SA coalitions	VAWA administrators	SANEs	Victim advocates
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) forbids hospitals and other health care providers to alert a victim advocacy organization to the presence of a victim of sexual assault at the hospital. ▪ True ▪ False	77%	69%	86%	82%
Topic: reporting to law enforcement				
Revisions of VAWA have opened different avenues for victim reporting. In some states, victims are able to report anonymously, meaning the evidence collected from them can be shared with police without the victim identifying her/himself or providing a statement to police. ▪ True ▪ False	94%	83%	88%	88%
SANE/SAFEs must call the police if an adult patient presents to the hospital as a sexual assault victim and wants to get a SAMFE. ▪ True ▪ False	NA	NA	84%	85%
Topic: payment for the examination under VAWA				
Victims must report their sexual assault to the police in order to avoid being billed for the SAMFE. ▪ True ▪ False	98%	100%	97%	95%
States are permitted to use STOP program funds to pay for exams if they meet which of the following conditions? Please select all that apply. ▪ The exam is performed by a trained examiner for victims of sexual assault ▪ The crime is reported to law enforcement ▪ All parts of the exam are covered by the hospital ▪ Medications are included as part of the exam for free ▪ The state does not require victims to seek reimbursement from their insurance	32%	33%	12%	13%
Many jurisdictions do not pay for medical care provided as part of the medical forensic examination. ▪ True ▪ False	72%	60%	64%	59%
Topic: facilities				

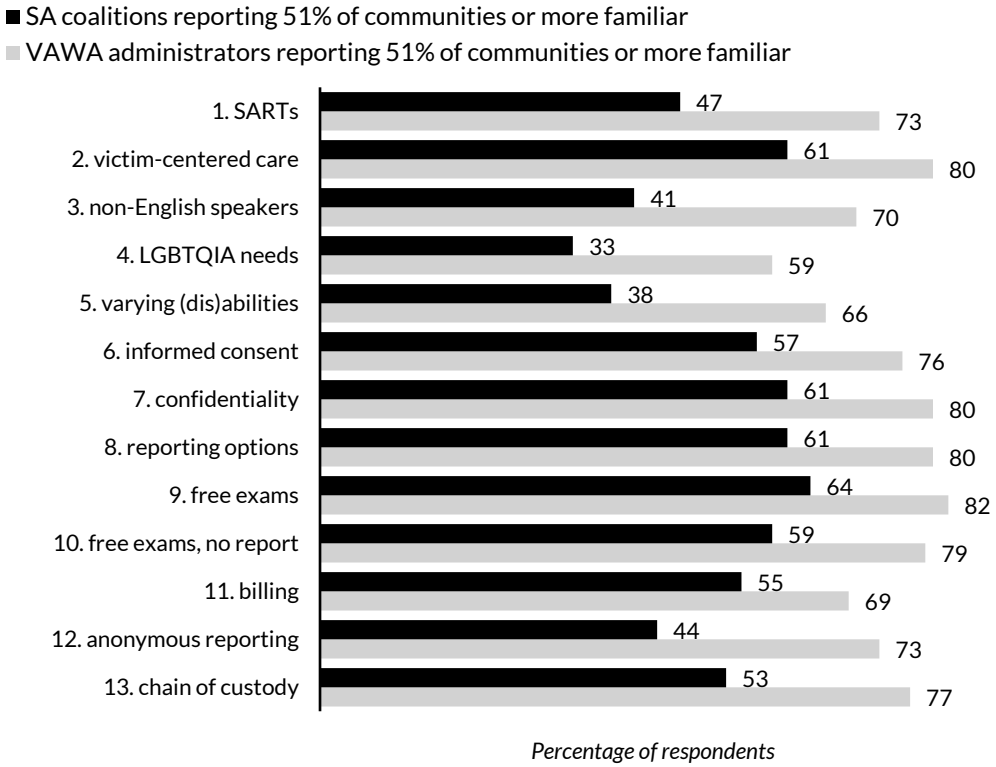
	SA coalitions	VAWA administrators	SANEs	Victim advocates
SARTs should decide which sexual assault exam location/setting best serves community needs. ▪ True ▪ False	NA	NA	82%	81%
Topic: equipment and supplies				
Exam sites should have proper equipment and supplies to facilitate a comprehensive SAMFE. ▪ True ▪ False	NA	NA	100%	100%
Topic: sexual assault evidence collection kit				
According to the SAFE Protocol guidelines, at minimum, sexual assault evidence collection kit (SAK) contents include: Please select all that apply. ▪ An instruction sheet or checklist ▪ Materials for collecting and preserving vaginal/cervical/penile swabs ▪ Materials for collecting and preserving oral swabs ▪ Materials for collecting and preserving patients' clothing and underwear ▪ Forms that facilitate evidence collection and analysis ▪ There is no guidance on what a SAK should contain	79%	80%	70%	82%
Topic: timing and documentation for collecting evidence				
Recommended timeframes for evidence collection and SAK storage policies vary by jurisdiction and local policy. ▪ True ▪ False	70%	67%	83%	61%
Examiners should document in their notes whether they believe the victim is credible, based on observations made during the exam. ▪ True ▪ False	96%	91%	99%	96%

Note: Correct answers are shaded grey.

Familiarity Individual Elements

FIGURE A.1

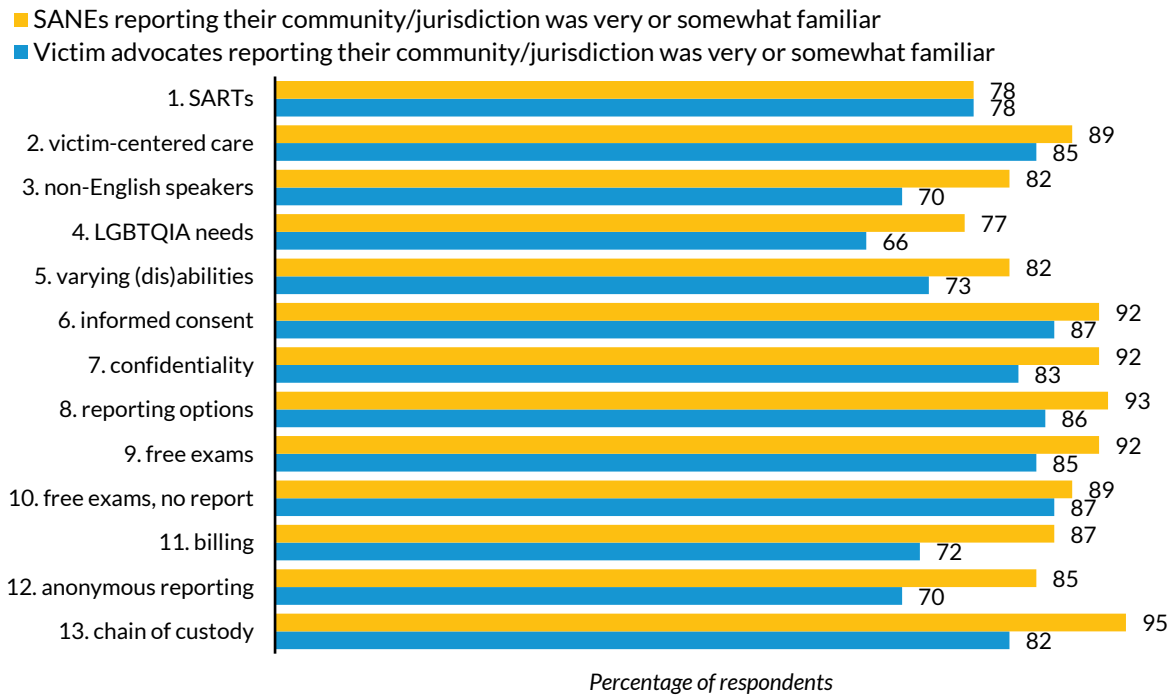
Overarching Elements Familiarity: Sexual Assault Coalitions and VAWA Administrators



Source: Urban and International Association of Forensic Nurses surveys of SA coalitions and VAWA administrators.
Notes: SA = sexual assault. SARTs = sexual assault response teams. VAWA = Violence Against Women Act. N=43, SA Coalition; N=38, VAWA. 5 SA Coalition and 9 VAWA responses were missing.

FIGURE A.2

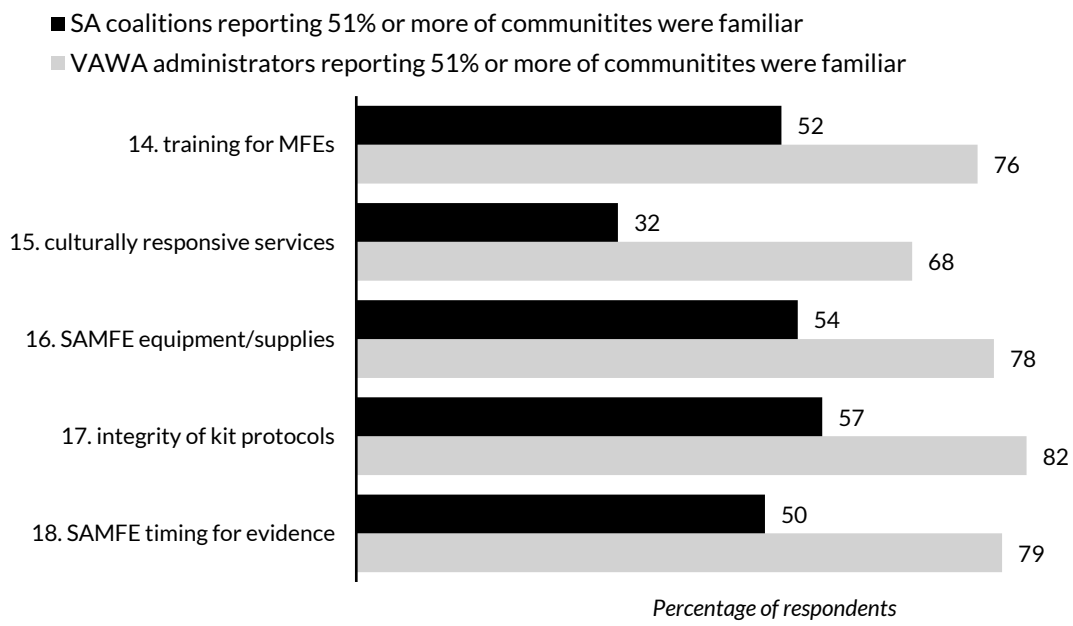
Overarching Elements Familiarity: SANEs and Victim Advocates



Sources: Urban and International Association of Forensic Nurses surveys of SANEs and victim advocates.
Notes: SANEs = sexual assault nurse examiners. SARTs = sexual assault response teams. N ranged from 333-345 for SANE; N ranged from 214-231 for Advocate. 34-46 SANE and 30-47 Advocate response(s) were missing.

FIGURE A.3

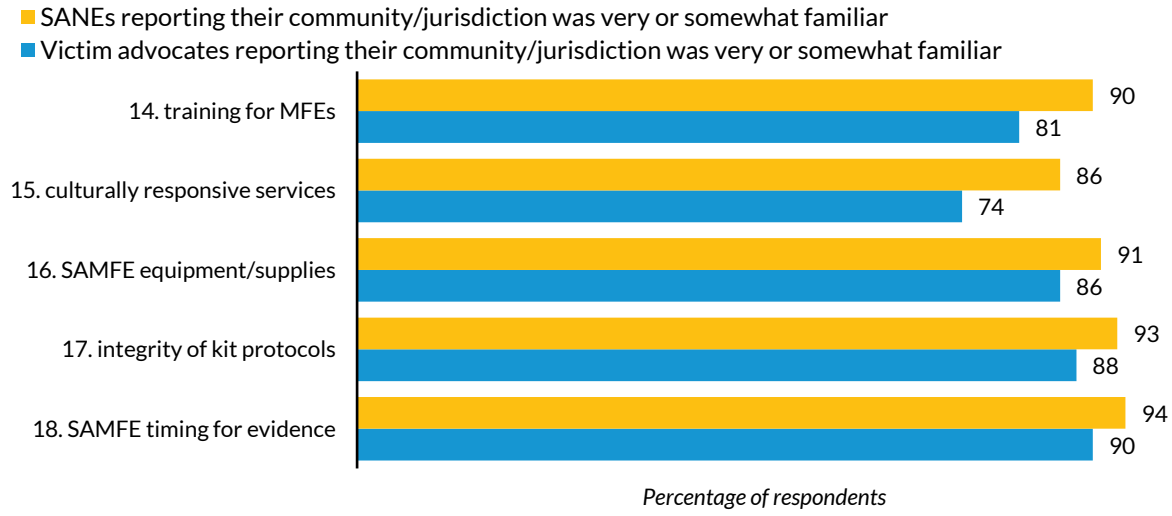
Operational Elements Familiarity: Sexual Assault Coalitions and VAWA Administrators



Source: Urban and International Association of Forensic Nurses surveys of SA coalitions and VAWA administrators.
Notes: MFEs = medical forensic examinations. SA = sexual assault. SAMFE = sexual assault medical forensic examination. VAWA = Violence Against Women Act. N=43, SA Coalition; N=33, VAWA. 5 SA Coalition and 14 VAWA responses were missing.

FIGURE A.4

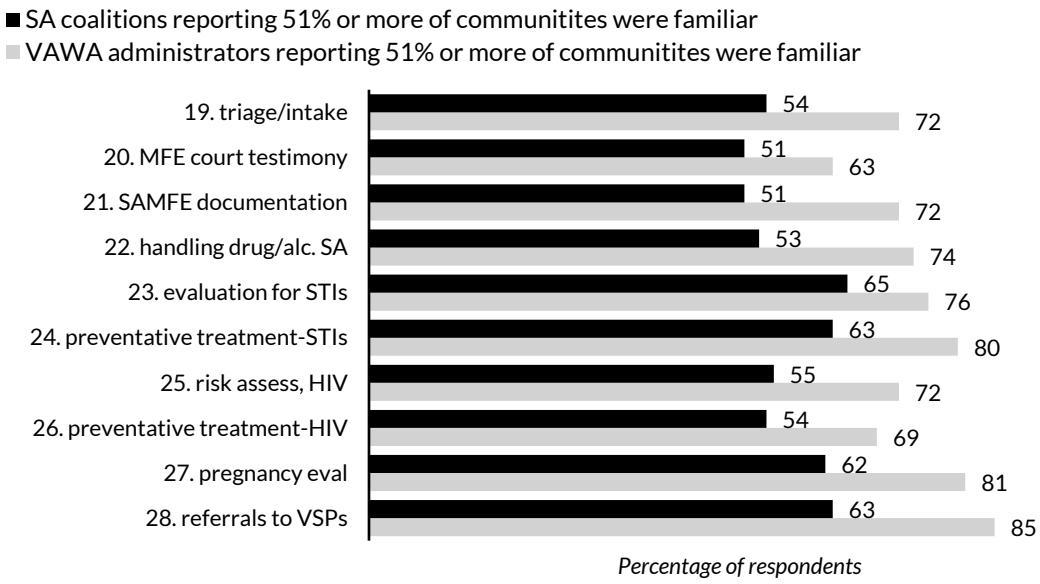
Operational Elements Familiarity: SANEs and Victim Advocates



Sources: Urban and International Association of Forensic Nurses surveys of SANEs and victim advocates.
Note: SANEs = sexual assault nurse examiners. N ranged from 335-342 for SANE; N ranged from 215-219 for Advocate. 37-44 SANE and 42-46 Advocate response(s) were missing.

FIGURE A.5

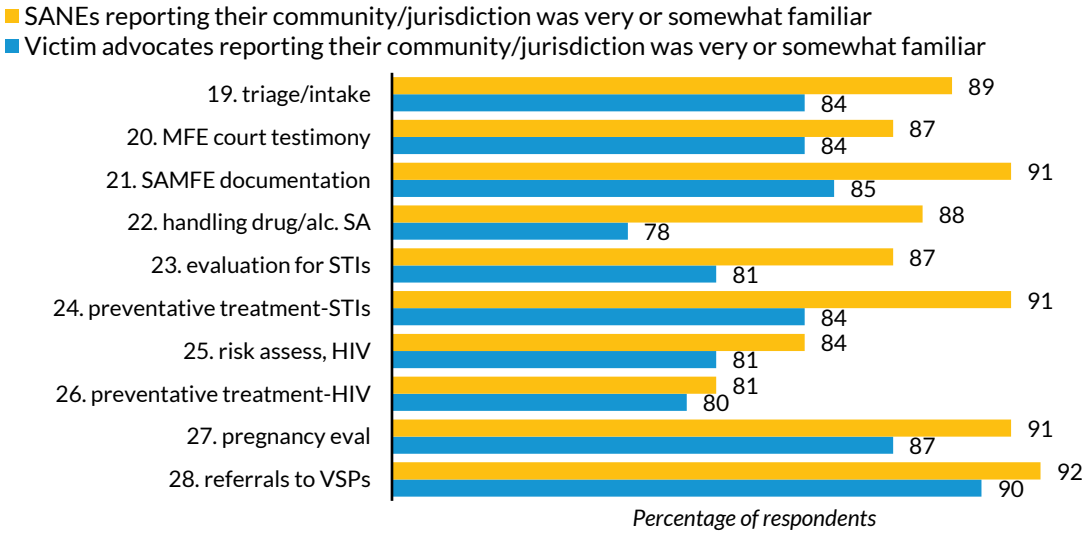
Exam Process Elements Familiarity: Sexual Assault Coalitions and VAWA Administrators



Sources: Urban and International Association of Forensic Nurses surveys of SA coalitions and VAWA administrators.
Notes: HIV = human immunodeficiency virus. SA = sexual assault. STIs = sexually transmitted infections. VAWA = Violence Against Women Act. VSPs = victim service providers. N=43, SA Coalition; N=45, VAWA. 5 SA Coalition and 2 VAWA response(s) were missing

FIGURE A.6

Exam Process Elements Familiarity: SANEs and Victim Advocates

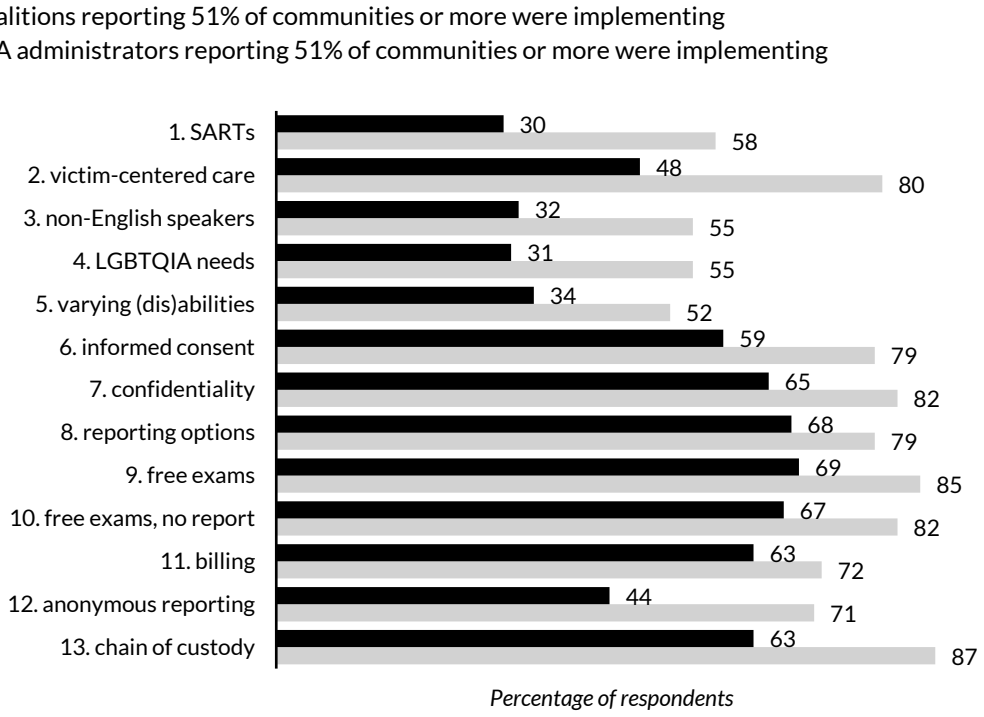


Sources: Urban and International Association of Forensic Nurses surveys of SANEs and victim advocates.
Notes: HIV = human immunodeficiency virus. MFE = medical forensic examination. SA = sexual assault. SAMFE = sexual assault medical forensic examination. SANEs = sexual assault nurse examiners. STIs = sexually transmitted infections. VSPs = victim service providers. N ranged from 331-337 for SANE; N ranged from 202-219 for Advocate. 42-48 SANE and 42-59 Advocate responses were missing.

Implementation Individual Elements

FIGURE A.7

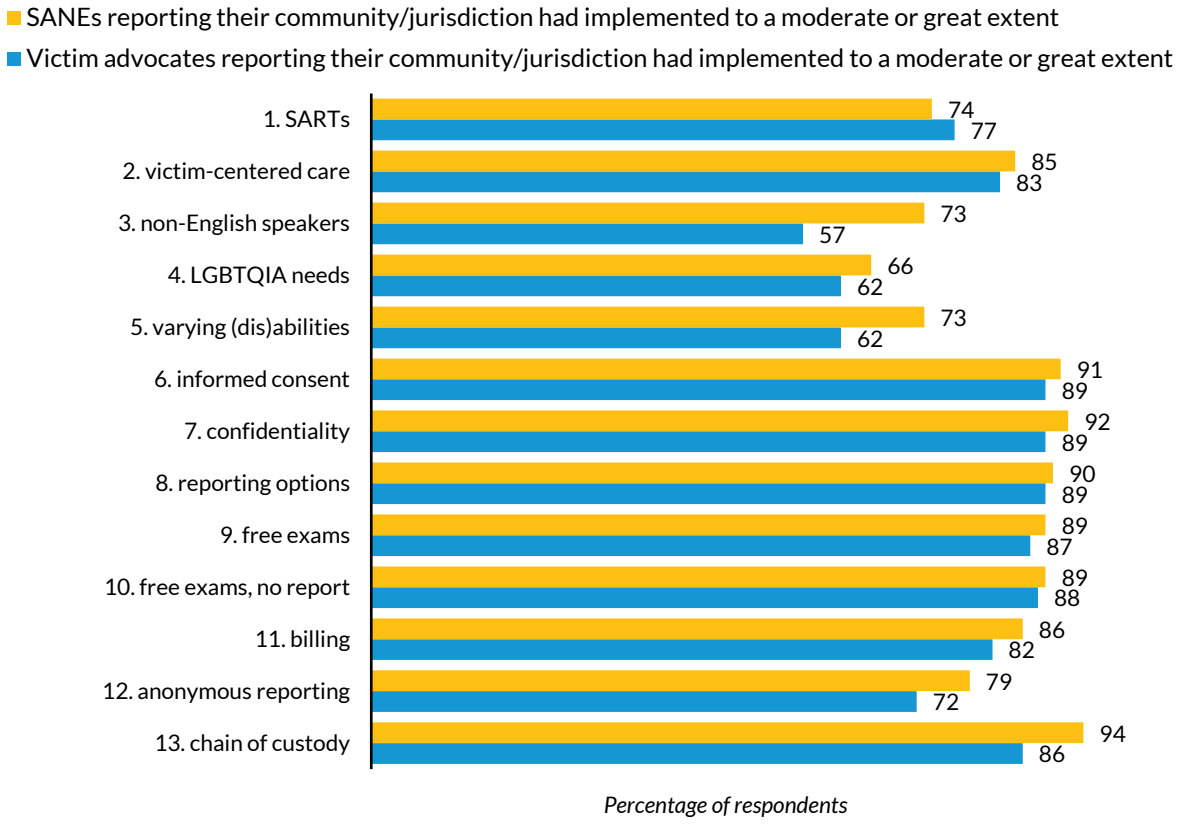
Overarching Elements Implementation: Sexual Assault Coalitions and VAWA Administrators



Sources: Urban and International Association of Forensic Nurses surveys of SA coalitions and VAWA administrators.
Note: SA = sexual assault. SARTs = sexual assault response teams. VAWA = Violence Against Women Act. N=41, SA Coalition; N=36, VAWA. 7 SA Coalition and 11 VAWA response(s) were missing

FIGURE A.8

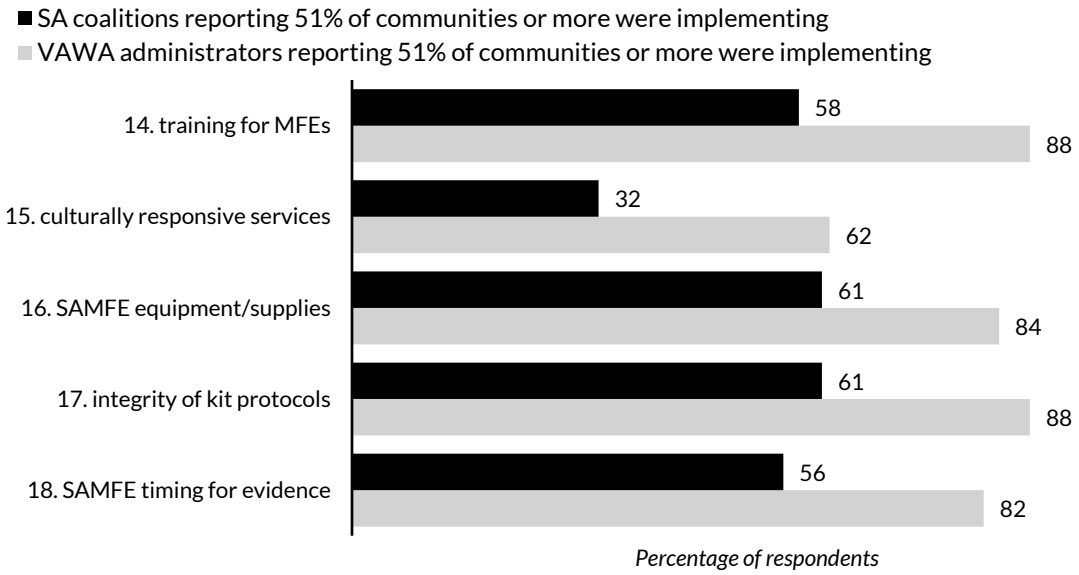
Overarching Elements Implementation: SANEs and Victim Advocates



Sources: Urban and International Association of Forensic Nurses surveys of SANEs and victim advocates.
Notes: SANEs = sexual assault nurse examiners. SARTs = sexual assault response teams. N ranged from 293-307 for SANE; N ranged from 187-204 for Advocate. 72-86 SANE and 57-74 Advocate response(s) were missing.

FIGURE A.9

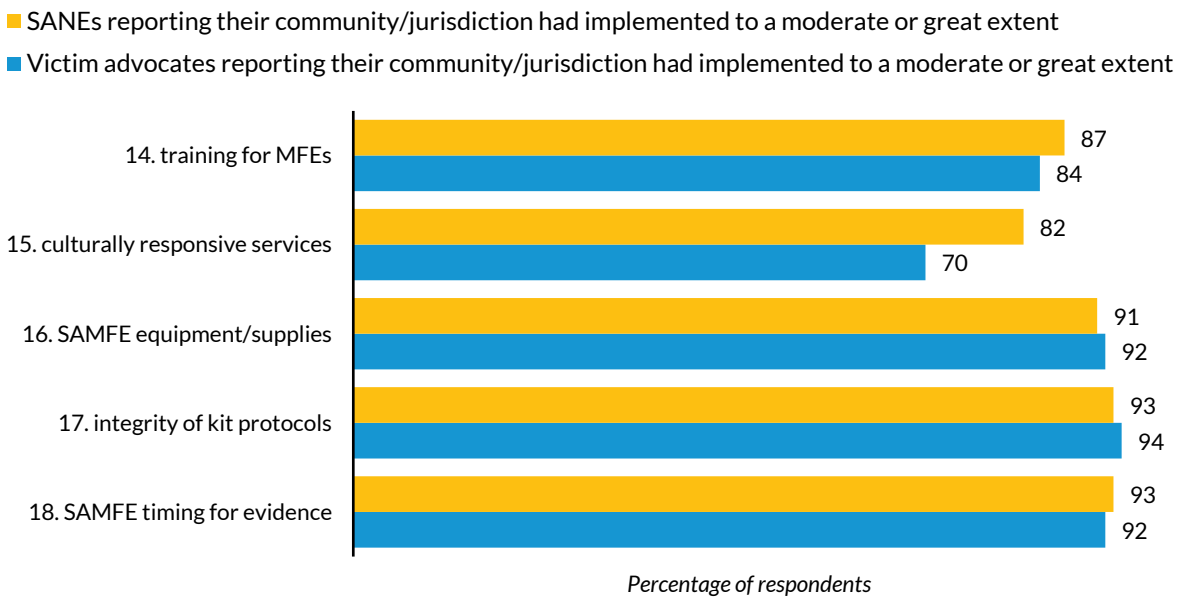
Operational Elements Implementation: Sexual Assault Coalitions and VAWA Administrators



Sources: Urban and International Association of Forensic Nurses surveys of SA coalitions and VAWA administrators.
Notes: MFEs = medical forensic examinations. SA = sexual assault. SAMFE = sexual assault medical forensic examination. VAWA = Violence Against Women Act. N=41, SA Coalition; N=33, VAWA. 7 SA Coalition and 14 VAWA responses were missing.

FIGURE A.10

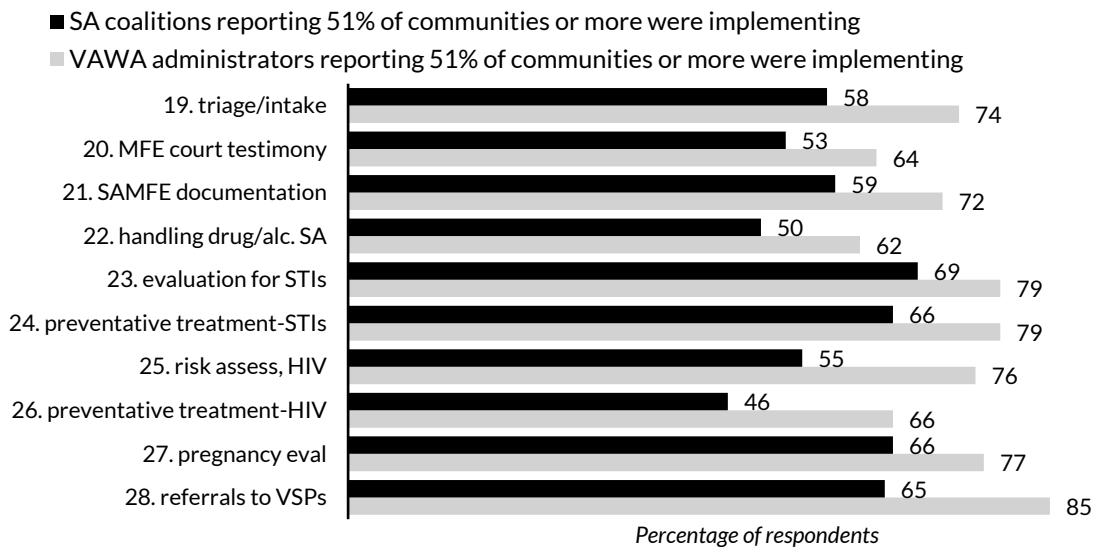
Operational Elements Implementation: SANEs and Victim Advocates



Sources: Urban and International Association of Forensic Nurses surveys of SANEs and victim advocates.
Notes: MFEs = medical forensic examinations. SAMFEs = sexual assault medical forensic examinations. SANEs = sexual assault nurse examiners. N ranged from 294-302 for SANE; N ranged from 189-197 for Advocate. 77-85 SANE and 64-72 Advocate responses were missing.

FIGURE A.11

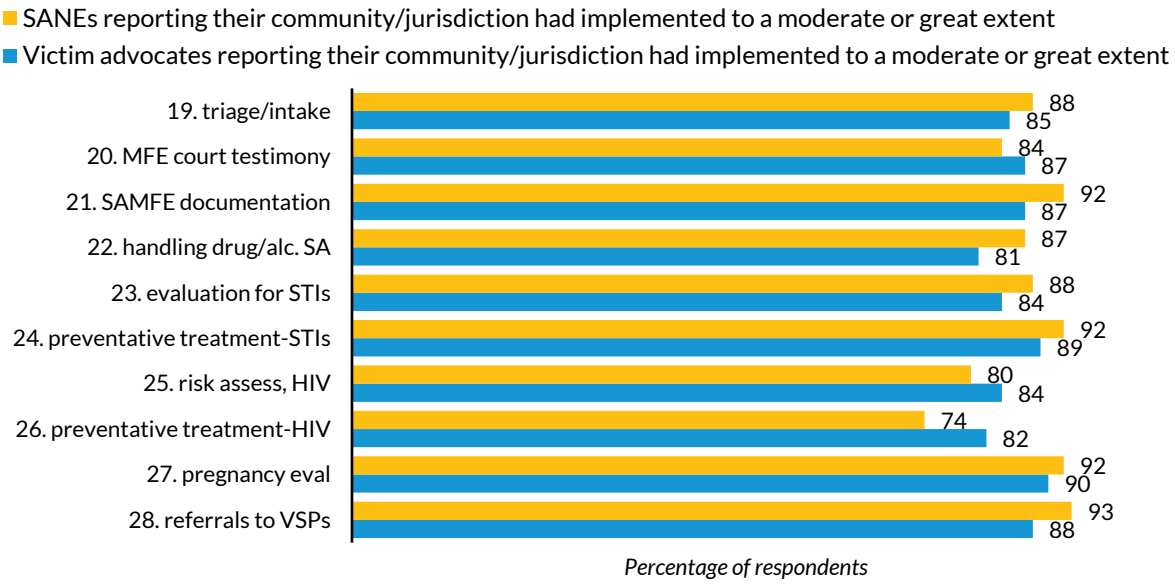
Exam Process Elements Implementation: Sexual Assault Coalitions and VAWA Administrators



Sources: Urban and International Association of Forensic Nurses surveys of SA coalitions and VAWA administrators.
Notes: HIV = human immunodeficiency virus. MFE = medical forensic examination. SA = sexual assault. SAMFE = sexual assault medical forensic examination. STIs = sexually transmitted infections. VAWA = Violence Against Women Act. VSPs = victim service providers. N=40, SA Coalition; N=35, VAWA. 8 SA Coalition and 12 VAWA responses were missing.

FIGURE A.12

Exam Process Elements Implementation: SANEs and Victim Advocates



Source: Urban and International Association of Forensic Nurses surveys of SANEs and victim advocates.
Note: HIV = human immunodeficiency virus. MFE = medical forensic examination. SA = sexual assault. SAMFE = sexual assault medical forensic examination. SANEs = sexual assault nurse examiners. STIs = sexually transmitted infections. VSPs = victim service providers. N ranged from 291-301 for SANE; N ranged from 178-201 for Advocate. 78-88 SANE and 60-83 Advocate responses were missing.

Note

[1] Notably, in our case studies, stakeholders reported challenges with establishing trust and creating a comfortable environment with survivors. This was especially true for law enforcement professionals, who reported instances where survivors were not comfortable speaking with them.

Reference

OVW (Office on Violence Against Women). 2013. *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents.* 2nd ed. Washington, DC: US Department of Justice, Office on Violence Against Women.

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.

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