

# SEXUAL ASSAULT REPORT™

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## State of SANE Programs in the U.S.

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### Introduction

More than one in three women and one in four men experience sexual violence during their lifetime (Smith, et al. 2018). The Centers for Disease Control and Prevention report that, from January 2017 to December 2019, 173,244 female patients visited emergency departments for sexual violence, as did 23,071 male patients (D’Inverno, Idaikkadar & Houry, 2021). For survivors seeking medical help, sexual assault medical forensic examinations (SAMFEs) are a critical step for accessing advocacy, treatment, and recovery services. Sexual assault nurse examiners (SANEs), other specially trained medical personnel, or emergency department personnel perform SAMFEs, which involve medical services and forensic evidence collection.

From 2018 to 2021, the Urban Institute (Urban) collaborated with the International Association of Forensic Nurses (IAFN), to conduct a comprehensive, national-level study of the implementation of the U.S. Department of Justice Office on Violence Against Women (OVW) National Protocol for Sexual Assault Medical Forensic Examinations: Adult/Adolescents 2nd Edition.

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### *In Their Own Words*

## Perception of Strengths Among Women With Histories of Addiction and Victimization

Stephanie Lim, Laura Siller and Katie M. Edwards

An important yet understudied component of recovery following victimization is the identification of personal strengths (Dutton, 2000). The purpose of the current study was to explore what women in recovery from addiction and domestic and/or sexual violence victimization perceived to be their strengths. Participants were 59 women living in a sober living home who completed a baseline survey assessing victimization, addiction, and other psychosocial characteristics. At the end of the survey, women were asked an open-ended question inquiring about what they felt were their strengths. A content analysis revealed six overarching themes that emerged from the data including: (1) interpersonal strengths (e.g., having social support, being a good mother, having good communication skills, being supportive); (2) intrapersonal strengths (e.g., empathy, perseverance, introspectiveness); (3) recovery; (4) work ethic; (5) spiritual connection; and (6) other (e.g., survivor, athlete). Helping women to identify their strengths, including those identified by women in the current study, may enhance the effectiveness of interventions. These data also have important implications for developing strengths-based assessment tools specifically for women with histories of victimization and addiction.

Domestic and sexual violence (DSV) victimization and addiction co-occur at high rates (Covington, 2008; Devries, et al. 2014; Edwards, et al. 2017). Much of the research on addiction focuses on risk factors and/or factors that contribute to relapse (Branson, et al. 2013), while significantly less research focuses on competencies and resources that women can use to maintain sobriety. Women in recovery from both addiction and trauma bring with them assets and strengths that facilitate healing despite experiencing trauma (Anderson, Renner & Dais, 2012). Yet research on strengths among women in recovery from both addiction and DSV rarely focuses on what women perceive as their strengths. Rather, most research use quantitative methods (e.g., Recovery Strengths Questionnaire, Resilience Scale, Connor-Davidson Resilience Scale) to assess how strengths relate to psychological distress (Humphreys, 2003; Anderson, et al. 2012). Finally, we are only aware of one study (Call & Nelson, 2007) that has specifically examined perceptions of strengths among women with histories of both addiction and victimization: the current study addresses these gaps in the literature.

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(SAFE Protocol). The goal was to assess the extent to which states, territories, and local jurisdictions respond to sexual assault in accordance with the Protocol's guidelines. The current article presents data obtained on SANE programs in the United States as of 2020, stakeholder perceptions' of SANEs, and SANE-identified supports, barriers, and needs. Throughout this document, we use the terms survivor, patient, and victim interchangeably in places where it is relevant to do so to describe people who have experienced sexual violence.

### **SANEs and SANE Programs**

SANEs are specially trained nurses who provide comprehensive psychological, medical, and forensic services for victims of sexual assault (Campbell, et al. 2011). SANE programs emerged in the 1970s in response to challenges in the investigative handling of sexual assault crimes and survivors' experiences with seeking care (Little, 2001). Prior to the creation of SANE programs, survivors of sexual assault were referred to hospital emergency departments for treatment and forensic evidence collection. However, these patients face unique challenges in emergency departments including: staff who are inadequately trained in treating victims; low prioritization compared to other patients; and long wait times which lead to prolonged exposure to the chaotic environment of the emergency department. All of this denies patients the comfort and privacy they need after an assault (Ahrens, et al. 2000; Ledray & Simmelink, 1997; Lenehan, 1991). These experiences can influence victims' reluctance to seek future care or participate in criminal justice proceedings (Campbell, 2008).

SANE programs were designed to prioritize the holistic well-being of survivors (Zweig, et al. 2020). These programs aim to provide free medical care and encourage timelier visits (Ahrens, et al. 2000). At a minimum, prior to practicing in the expanded role of the SANE, each program in the U.S. requires Registered Nurses with at least two years' nursing practice to undergo specialized didactic and clinical training that meets the IAFN SANE Education Guidelines (IAFN, 2018). For a nurse to become certified as a Sexual Assault Nurse Examiner - Adult/Adolescent (SANE-A®), they must meet the eligibility requirements to sit for and successfully complete the certification examination. There are

some states that have unique credentialing requirements for a nurse to practice within that state as a SANE. Requirements could include an application and fee process, nursing license verification, background check with fingerprinting, a specific number of hours to observe and perform a specific number of SAMFES, or observation hours with partners.

### **The Effectiveness of SANE Programs**

Over the past 30 years, research has shown SANEs lead to more robust psychological recovery for survivors (Campbell, Patterson & Litchy, 2005; Ericksen, et al. 2002; Ledray, Faugno & Speck, 2001). SANEs treat survivors of sexual assault with compassion (Campbell, Greeson & Fehler-Cabral, 2013; Fehler-Cabral, Campbell & Patterson, 2011), see patients more quickly than programs without SANEs (Stermac & Stirpe, 2002), collect higher quality evidence for investigation/prosecution (Sievers, Murphy & Miller, 2003), and connect survivors more thoroughly with victim advocates and other community services (Crandall & Helitzer, 2003). They also serve a key role in collaborating with multidisciplinary groups of community stakeholders involved in the sexual assault response, including victim advocates, law enforcement professionals, and prosecutors, to create a more coordinated approach to treatment, investigation, and prosecution (Ahrens, et al. 2000; Greeson & Campbell, 2014). Although not all SANE programs or SANEs are the same — and outcomes may differ by jurisdiction — research has revealed the overall impact of SANE programs to be positive. Below, we present a national portrait of SANE programs and their characteristics, as of 2020.

### **Methods**

This was a cross-sectional, mixed-methods study that sought to examine the national implementation of the SAFE Protocol. In this paper, we describe findings from three data collection strategies conducted as part of this assessment: a national survey of SANE programs; a survey of victim advocates; and four case studies in local jurisdictions.

We used the voluntary IAFN national Forensic Nursing Program directory (as of August 2019) as a sampling frame to identify SANE programs for the national survey. We examined the directory for duplicate entries, and cleaned it by verifying — or attempting to verify —

the existence and contact information of the SANE programs via email and phone contacts. We also identified a main contact person for each program to receive the survey, which we defined as the SANE coordinator if they were a practicing SANE. If the coordinator was not a SANE, we asked for the most experienced SANE from the program to complete the survey. Surveys were sent to all programs that had valid contact information. To obtain our sample for the survey of victim advocates, the last section of the SANE survey asked respondents for a snowball sampling referral to a local non-profit sexual assault service provider with whom they worked and who provided exam accompaniment/advocacy program services. If a responding SANE did not provide such referral information, we conducted geographically-based Internet searches to identify relevant local nonprofit sexual assault service providers in the SANE program's catchment area.

Surveys of SANEs and victim advocates were conducted via Qualtrics online survey software. Respondents were sent initial emails signed by the Urban Institute, IAFN, the National Sexual Violence Resource Center, and the Office on Violence Against Women (the study funder) explaining the goals of the study, their rights as participants, and individualized links to the online survey so that nonresponse could be monitored. The national survey of SANE programs was administered from October 2019 through August 2020, and corresponding victim advocate surveys were administered between December 2019 and August 2020. Non-responders were contacted multiple times via email and personal phone contact in order to boost response rates. The national survey of SANE programs was sent to 598 verified programs. Representatives from 379 programs completed the survey (a 63% response rate). We sent surveys to 365 victim advocates (corresponding sexual assault service providers were not identified for 14 SANE programs) and 261 completed the survey (a 72% response rate).

Case study jurisdictions were identified based on the following criteria: (1) both local SANEs and victim advocates reported the community as implementing the SAFE Protocol particularly well; (2) the SANE program had been in operation for at least two years (to ensure it was an established program); and (3) the community had a multidisciplinary team (MDT) focused on

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sexual assault response. Of those that met these criteria, we identified one jurisdiction representing each of four different regions of the country: the West, Northeast, South, and Midwest.

We virtually (via videoconference) conducted semi-structured interviews with local stakeholders to ask questions about the local sexual assault response including the MDT approach; examination payment mechanisms; the presence of victim-centered care which prioritizes the needs and concerns of victims; operational issues with the examination; kit handling and storage; the adoption and sustainability of SAFE protocol practices; and the criminal legal system response. We interviewed 35 stakeholders across the four case study sites, including: six SANEs and one hospital social worker; eight victim advocates; five detectives and one chief of police; five prosecutors and one victim witness advocate, two crime lab representatives, and six administrators (a victim compensation coordinator, Title IX coordinator, governor's office representative, state forensic nursing coordinator, and two sexual assault response teams [SART] coordinators).

Three-quarters of respondents identified as cisgender women (n = 26); six respondents 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 were Hispanic/Latinx, one was Asian/Middle Eastern, and one was Native American); the remaining sample identified as white. Most respondents were ages 26 to 55 (16 were ages 26 to 45 and 10 were ages 46 to 55), with few reporting ages younger or older than that (two were ages 18 to 25, five were ages 56 to 65, and two were over age 65).

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. 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. Due to challenges of the COVID-19 pandemic (e.g., stakeholders reported having less contact with survivors during this time, and interviews were being conducted virtually), stakeholders were unable to successfully identify survivors interested

in speaking with us. Stakeholders reported survivors were reluctant to meet virtually rather than in person. This is a known study limitation.

### Location and Service Area

Among the 379 programs surveyed, 139 are located in the South, 120 are in the Midwest, 69 are in the West, and 51 are in the Northeast. Of these, 202 programs (53%) serve multiple counties; 73 (19%) serve only one county; 33 (9%) serve multiple counties and a military base; 26 (7%) serve multiple counties and an American Indian/Alaskan Native community; and 19 (5%) serve multiple counties, *i.e.*, an American Indian/Alaskan Native community, and a military base. A small number of programs indicated that they serve only one city, one American Indian/Alaskan Native community, or one military base. Overall, the majority of SANE programs serve multiple counties.

Historically, hospitals have been the primary location for most SANE programs (DOJ, 2013). Similarly, of the 379 SANE programs surveyed, several served patients in multiple locations with nearly all (n = 329) SANEs seeing patients in hospitals. In contrast, 42 see patients in community-based health clinics, 37 see patients in rape crisis centers, 35 see patients in community-based non-health centers, 15 see patients in child advocacy centers, 10 see patients in mobile examination units, six see patients in college/university health clinics, five see patients in correctional facilities, four see patients in free-standing SANE programs, and one SANE sees patients in the coroners' offices. When asked about the *primary* location where they see patients, most of the 377 SANEs respondents identified a hospital (n = 297, 79%). Another 28 (7%) identified a community-based non-health site (such as a family justice center), 25 (7%) identified a rape crisis center, 20 (5%) said a community-based clinic, and seven (2%) responded with another primary location (e.g., police departments and free-standing SANE programs).

### Program History, Size, and Funding

Based on respondents who indicated what year their program was founded (87% of the total sample), the number of SANE programs increased primarily during the 1990s, with many programs being founded between 1990 and 2009 (63%). Specifically, seven programs were founded between 1970 and 1979, eight between 1980 and 1989, 102 between 1990 and 1999, and 106

between 2000 and 2009. Just under one-third of programs (n = 105) were founded between 2010 and 2019, and one program was founded in 2020. Few SANE programs were relatively new; only 57 (17% percent) were founded within the past five years.

We asked respondents if their program had ever completely halted services for any reason. Among the 359 SANEs responding, only 24 (7%) stated that their program had halted services. Reasons included funding lapses (four programs), lack of support from hospital administration (nine programs), lack of support from emergency departments (six programs), and lack of trained SANEs (17 programs). Some respondents reported halting services due to natural disasters, the COVID-19 pandemic, and the inability to meet legal program standards. Although the number of programs revealing a halt in services is low, during our initial survey outreach we were able to identify a number of programs that were either defunct or only served children (n = 88) that were not included in the final sample.

We asked respondents to estimate the number of sexual assault patients their programs serve in a one-year period. Of the 378 respondents, 72 (19%) reported seeing more than 300 patients/year, 38 (10%) see 201 to 300 patients/year, 93 (25%) see 101 to 200 sexual assault patients/year, 79 (21%) see 51 to 100 patients/year, 61 (16%) see 26 to 50 patients/year, and 35 (9%) see fewer than 25 sexual assault patients a year.

All programs surveyed serve adult sexual assault patients, but many also serve other types of patients as well. Of the 364 SANEs who provided this information, 273 (75%) serve child victims of sexual assault/abuse, 258 (71%) serve victims of human trafficking, 220 (60%) serve victims of domestic/interpersonal violence, 204 (56%) conduct suspect examinations/third party examinations, 179 (49%) serve vulnerable/disabled adult victims of abuse, 168 (46%) serve victims of elder abuse/neglect, 166 (46%) serve child victims of maltreatment, and 124 (34%) serve patients with trauma/traumatic injuries. A small number of programs indicated serving victims of strangulation, gunshot and stab wounds, and physical assaults. Due to co-occurring/polyvictimizing events, some programs noted serving all types of patients if a sexual assault was involved. Overall, nearly all SANE programs serve a variety of types of patients who have experienced victimization; only six programs reported *only* serving adult sexual assault patients.

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SANE program funding is often based on federal government grants; many of these grants stem from the Violence Against Women Act (VAWA) and the Victims of Crime Act (VOCA). Of the 340 respondents, 120 SANE programs (35%) receive funding from VOCA crime victim assistance grants; 42 (12%) are funded directly from the state budget; 39 (11%) receive funding from VAWA STOP formula grants; 23 (7%) receive funding from OVW/VAWA discretionary grant programs; 22 (6%) receive funding from local or state funds; 18 (5%) receive funding from VAWA SASP – Sexual Assault Services formula grant

ing around the country (DOJ, 2013). As of June 2021, IAFN recognizes 1,511 nurses as SANE-A® certified. We asked SANE programs about their certification. Of the 377 who responded, 23 (6%) stated SANE-A® certification was required to practice in their program, 349 (93%) had no such requirement, and five (1%) were uncertain about program certification requirements. Regarding nursing experience, of the 379 respondents, 34 (9%) said three or more years' nursing experience was the hiring minimum for their program, 209 (55%) reported two years of nursing experience was a hiring minimum, 77 (20%) reported one year of required nursing experience, 48 (13%) reported no minimum requirement,

(EVAWI)), and 19 (6%) had never been trained on the SAFE Protocol.

### Stakeholder Perceptions of SANES

Across the case study sites, stakeholders perceived SANES as a positive and even “invaluable” force working to address sexual assault in their jurisdictions. SANES are viewed as the “experts” for all things involving the SAMFE. Some stakeholders report seeing SANES as champions for survivors of sexual assault in the medical arena. The stakeholders we interviewed stated that SANES often bring trauma-informed and victim-centered care to the sexual assault response process. In states where SANES can be trained as forensic interviewers, law enforcement and prosecutor interviewees spoke to the benefit of having SANES act as forensic interviewers and as credible witnesses when testifying in court proceedings, which strengthens legal cases. According to one law enforcement professional, SANES are those stakeholders “bridg[ing] the gap of contact, professionalism, and evidence gathering” when working with survivors of sexual assault. These positive views of SANES and their work translate to positive views about how SANES facilitate collaboration across jurisdictions. SANE coordinators and/or program managers in some jurisdictions are seen as the glue for stakeholder collaborations; they often facilitate SART and MDT meetings at these sites.

Although most stakeholders spoke highly of SANES, some challenges remain. Of the issues that respondents shared, many related to the SANE program design and its effect on SANE availability. Forensic nursing programs that staff SANES on a part-time or per-diem basis — or programs that use an on-call structure — may face SANE shortages and patient wait times that frustrate stakeholders, particularly victim advocates. Some victim advocates additionally shared frustration with the fact that SANES are not bringing them into the sexual assault response as early as they should (*i.e.*, to provide advocacy and support during the SAMFE process). This may result in SANES hearing more information or more backstory from a patient than advocates or law enforcement due to the nature of their acute response which can create a barrier to development of long-term supportive advocacy. These perceptions demonstrate

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Program; 14 (4%) receive funding from private foundations; 11 (3%) receive funding from their hospital; and a smaller number of respondents (n = 6; 2%) receive funding from the Bureau of Justice Assistance Sexual Assault Kit Initiative and Byrne grants. Other funding sources included city/county budgets and federal funding sources (including the Department of Defense, the Office of Victim Services and Justice Grants, the Department of Justice, and the Health Resources and Services Administration).

### Staffing

SANE programs use a variety of staffing models, even within the same program. Most respondents (n = 297; 75%) reported their SANE program is staffed by on-call/as-needed staff that were not full time, and not scheduled for a specific shift. Next, 143 (38% percent) reported their program is staffed by full time staff, 82 (22%) reported their program is staffed by nurses on shift but not full time, and 20 (5%) reported other staffing configurations, including 24/7 on-call SANES, independently contracted SANES, and staffing by day-of-the-week (*i.e.*, full-time staff during weekdays, part-time staff during weekends).

The SAFE Protocol mentions that IAFN SANE-A® board certifications are increas-

seven (2%) reported they did not know if their program had a minimum practice requirement, and four programs answered in other ways (*e.g.*, 18 months required, one year specifically in the ER, NP licensure).

One of the many ways in which the SAFE Protocol has been disseminated is through trainings to SANE programs and local sexual assault response teams. Of the 334 respondents who provided this information about SAFE Protocol training, 234 SANE programs (70%) reported having received trainings from IAFN; 140 (42%) received trainings from local sexual assault victim services programs; 137 (41%) received trainings from their state sexual assault coalition; 114 (34%) received trainings from their state IAFN chapter; 59 (18%) received trainings from [sane-sart.org](http://sane-sart.org); 50 (15%) received trainings from National Sexual Violence Resource Center (NSVRC) webinars; 49 (15%) received trainings from their state VAWA administrators; 34 (10%) received trainings from their SANE program or program coordinator; 11 (3%) had SAFE Protocol trainings by a SART/MDT partner (attorney general's office, law enforcement, advocacy center, etc.); a smaller number of programs had other trainings (including independent study, federal government trainings, and End Violence Against Women International

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that there must be clear communication structures and response procedures to mitigate the possibility of all parties not being brought into the sexual assault response process at the necessary and recommended stages. Finally, some stakeholders noted that many SANE programs face issues with representation from diverse populations and language barriers, as most of the forensic nurses they work with are white, English-speaking women.

### **SANE Program Needs, Barriers, and Supports**

Through both the survey of SANE programs and interviews with SANES, we gathered data on barriers and supports for the implementation of the SAFE Protocol in communities, and challenges and needs related to SANE program operation. SANE survey respondents were asked to rate 33 factors that may affect SAFE Protocol implementation on a scale from 1 to 5, with 1 being a major barrier and 5 being a major support. Based on the average rating across all factors, capacity (*e.g.*, sufficient staff, program, and community resources, such as training, facilities, and equipment) was the top-reported barrier by SANES. This was followed by stability of funding to implement the Protocol's provisions, state/tribal law around implementation, availability of continued training for SANES, and training availability to become a SANE. Overall, barriers centered around insufficient resources, including funding, staff, and training opportunities.

Across all 33 factors, on average, the primary factor supporting SAFE Protocol implementation was SANES' work. This was followed by the work of non-profit sexual assault victim service organizations/agencies (*e.g.*, rape crisis centers, sexual assault service centers), professionals in the response systems' (*e.g.*, SANES, advocates, police) knowledge of timing for collecting evidence, professionals in the response systems' knowledge of sexual assault kit storage and retention policies, and professionals in the response systems' knowledge of timing for the examination. Other than SANES' work and knowledge around various policies and practices, advocacy organizations and the work they do was rated as a major support for the implementation of SAFE Protocol practices in communities and jurisdictions.

Interview data found similar barriers and supports for SANES and SANE programs. SANES reported staffing to be a challenge. They identified program stability as problematic when a jurisdiction lacks a sufficient number of trained nurses. This situation creates access issues for survivors as they may have to travel farther distances to receive a SAMFE by a trained nurse. Lack of transportation in rural areas was also identified as a challenge; patients may not seek services or return for follow-up care if they cannot access a SANE program via accessible transportation. Another barrier SANES noted was working with stakeholders who may lack knowledge of, or fail to demonstrate, trauma-informed care. SANES stated that partners in their jurisdiction who exhibit a lack of trauma-informed care may negatively affect survivors and their experiences with pursuing care after a sexual assault and cause them to experience secondary victimization.

tion about their rights; setting expectations; and being available to answer questions. SANES also noted the importance of meeting patients where they are by setting aside their own expectations and instead focusing on what patients identify as their needs and values, and of emphasizing that the patient controls their own examination process. This may involve allowing the patient to define what success looks like and what outcome they want to achieve. One last facilitator to SANES' work was the ability to provide free exams and services without the survivor having to file an official police report. SANES believed that these types of payment and reporting structures have encouraged more patients to get exams.

### **Discussion**

SANE programs vary greatly in several areas, including size, location, number and types of patients served, staffing, and required training and experience. Despite

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## ***SANES highlighted the importance of strong communication and collaboration between professionals involved in the sexual assault response.***

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SANES also described the COVID-19 pandemic as a challenge. Multiple sites acknowledged difficulty connecting and working with other stakeholders during this period. Not only was it more difficult to contact professionals during the pandemic, advocates in some jurisdictions were not permitted to be physically present in the hospital during the SAMFE process. In these instances, SANES reported attempting to connect with advocates via Zoom, but that workarounds was not nearly as effective as being in-person; the resulting relationships between survivors and advocates suffered.

As for supports, SANES reported that collaboration and strong relationships with other stakeholders was a major support. They stated that, to best serve survivors, all community stakeholders must clearly understand the work and their role, while also engaging in cross training. SANES identified building rapport with the survivor as a key factor in conducting a successful examination. Steps reported in building rapport included providing a comfortable, private environment that was safe and secure; providing patients with informa-

these differences, programs involved in this study agreed on potential challenges and barriers, and beneficial factors.

First, SANES highlighted the importance of strong communication and collaboration between professionals involved in the sexual assault response. Other stakeholders also noted the important role SANES play in coordinating community responses. Community representatives who believed positive relationships existed among their stakeholders reported this as a primary support in their work; those who did not have those relationships reported that it hindered their response and ability to successfully serve survivors. One venue for developing these relationships is within the SART and/or MDT. When asked, 94% of SANE survey respondents reported that their program participates in a formal MDT. These groups allow professionals to engage in cross-training and establish open lines of communication that may facilitate coordinated care for survivors. SARTs that use formal structures and institutionalize collaborative processes have been found

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to be effective at improving victims' help-seeking experiences, victims' participation in the criminal justice system, police processing of cases, and prosecution of cases (Greeson, et al. 2016).

SANEs and community professionals highlighted other issues regarding program staffing, access, and resources. Experts report a national shortage of nurses and doctors who are trained to conduct SAMFEs (Kaplan, Wong & Murphy, 2021). SANEs and other stakeholders involved in the sexual assault response consistently reported the need for more trained nurses and the funding to expand staff and training opportunities. Study participants stated that they aspired to have the funds and resources

case study programs reported concern that vicarious trauma may become a significant issue, leading to a high rate of staff turnover. Respondents proposed that when SANEs are supported in this career they are more resilient to job stressors. Having a sufficient number of trained SANEs and established supports — such as practices that encourage self-care, mental health resources, and designated staff to talk to — can decrease burnout among these professionals. Hospitals and other places employing SANEs should be aware of this vicarious trauma and have the proper resources in place to mitigate these effects.

SANEs have been found to improve survivors' experiences with seeking care after a sexual assault. The identified areas and needs should guide communities and

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***Representation among staff was also mentioned as a challenge in places that serve diverse populations. Language barriers can create an additional obstacle for survivors seeking care and oftentimes survivors may feel more comfortable being seen by someone with a similar background.***

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to expand their program and offer additional training. These challenges may create access issues. When a lack of programs staffed by trained nurses means that a survivor must travel long distances to receive a SAMFE, the lack of access may deter the survivor from seeking services and can also lead to issues of equity in more rural areas where transportation may be an issue. In addition, an understaffed program may lengthen the wait times for survivors if no trained nurse is available to conduct an examination. Representation among staff was also mentioned as a challenge in places that serve diverse populations. Language barriers can create an additional obstacle for survivors seeking care and oftentimes survivors may feel more comfortable being seen by someone with a similar background. If possible, SANE programs should work to diversify their staff.

A final area highlighted by study participants was the need for staff support. SANEs work in an environment where they must maintain a professional response to acts of trauma and violence, and research has shown that SANEs experience high rates of vicarious trauma (Raunick, et al. 2015; Wies & Coy, 2013). Some SANEs from the

jurisdictions across the U.S. as they establish, expand, and operate SANE programs to effectively and successfully serve survivors of sexual assault. Reducing the barriers and challenges and increasing support for these programs can enhance community response and help survivors heal.

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