



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

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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,<sup>1</sup> 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. Using information from that evaluation, this brief examines stakeholders' awareness of the SAFE Protocol and effective implementation and their perspectives on the protocol's strengths and challenges.

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

# Introduction

The Department of Justice developed the SAFE Protocol for health care providers, victim advocates, and criminal legal stakeholders involved in the sexual assault response system to use as guidance in serving adult and adolescent victims (OVW 2013). The focus was to establish a collaborative and systematic approach among multidisciplinary teams (MDTs) to restore survivors health and well-being and bring justice to survivors in prosecuting those who commit sexual violence. The SAFE Protocol was first released in 2004 and was updated to include changes from the Violence Against Women and Department of Justice Reauthorization Act of 2005 and again in 2013. Since 2007, more than 45,000 copies of the protocol have been distributed by IAFN and it has been made available for download on SAFETa.org, which has had nearly 1 million unique visits. In addition to distributing the SAFE Protocol, IAFN has delivered training and technical assistance to more than 51,000 people in the sexual assault response system (including SANEs, victim advocates, and law enforcement). The reach of the SAFE Protocol highlights the importance of establishing best practices and ensuring multidisciplinary efforts and resources are collaborative, equitable, accessible, victim centered, and trauma informed. Victim-centered care requires that stakeholders responding to sexual assault respect victims' privacy, agency, and priorities and clearly communicate the purpose of exam or medical and evidentiary procedures before initiating them. Trauma-informed responses recognize that the level of physical and psychological trauma—and the demeanor and behavior of victims affected by that trauma—will vary from person to person. A victim-centered *and* trauma-informed approach ensures the victim feels empowered, has access to resources, and will not be subject to judgement based on myths of credible victim behaviors.

The SAFE Protocol is divided into three sections, each of which focuses on the victim by ensuring stakeholders take a trauma-informed, victim-centered approach to providing care. The three sections are as follows:

- The **overarching issues** section begins with a simple description of the sexual assault medical forensic examination (SAMFE), key collaborators and community stakeholders essential to caring for victims of sexual assault, sexual assault response teams (SARTS) and sexual assault response resource teams, victim-centered care, survivors' rights related to receiving services, options for reporting an assault to law enforcement, and Violence Against Women Act provisions related to payment for SAMFEs.
- The **operational issues** section covers topics specifically directed to sexual assault nurse examiners (SANEs) and sexual assault forensic examiners, SANEs' programmatic needs, and operational requirements. This section also outlines best practices for sexual assault evidence collection kits, considerations for evidence collection, and evidence integrity.
- The **medical forensic examination process** section covers the entirety of the examination process. It outlines the SAMFE, starting with the initial encounter with a survivor, information and guidance related to prioritizing encounters with survivors, and connecting with SANEs and advocacy. It also covers aspects of medical forensic documentation; obtaining a survivor's

medical forensic history; evidence collection (which includes obtaining photographs and appropriately collecting, maintaining, and releasing evidence); providing education to the survivor about sexually transmitted infections, human immunodeficiency virus, and pregnancy evaluation; and discharge education and follow-up care.

## Brief Roadmap

This brief examines the implementation of the SAFE Protocol in four sections and concludes with recommendations for improving SAFE Protocol implementation. We first describe stakeholders' **awareness of the SAFE Protocol**, including their knowledge of, familiarity with, and implementation of its provisions. Then, we present stakeholders' perspectives on **implementation strengths** and **implementation challenges**. Strengths and challenges are captured for each of the three sections of the SAFE Protocol described above (overarching issues, operational issues, and the medical forensic exam process). We conclude with stakeholders' perceptions of **survivors' concerns and challenges**. The findings presented in this brief stem from surveys of SANEs and victim advocates and case studies in four jurisdictions with local stakeholders involved in sexual assault response. Box 1 describes these methods in greater detail.

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### 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.

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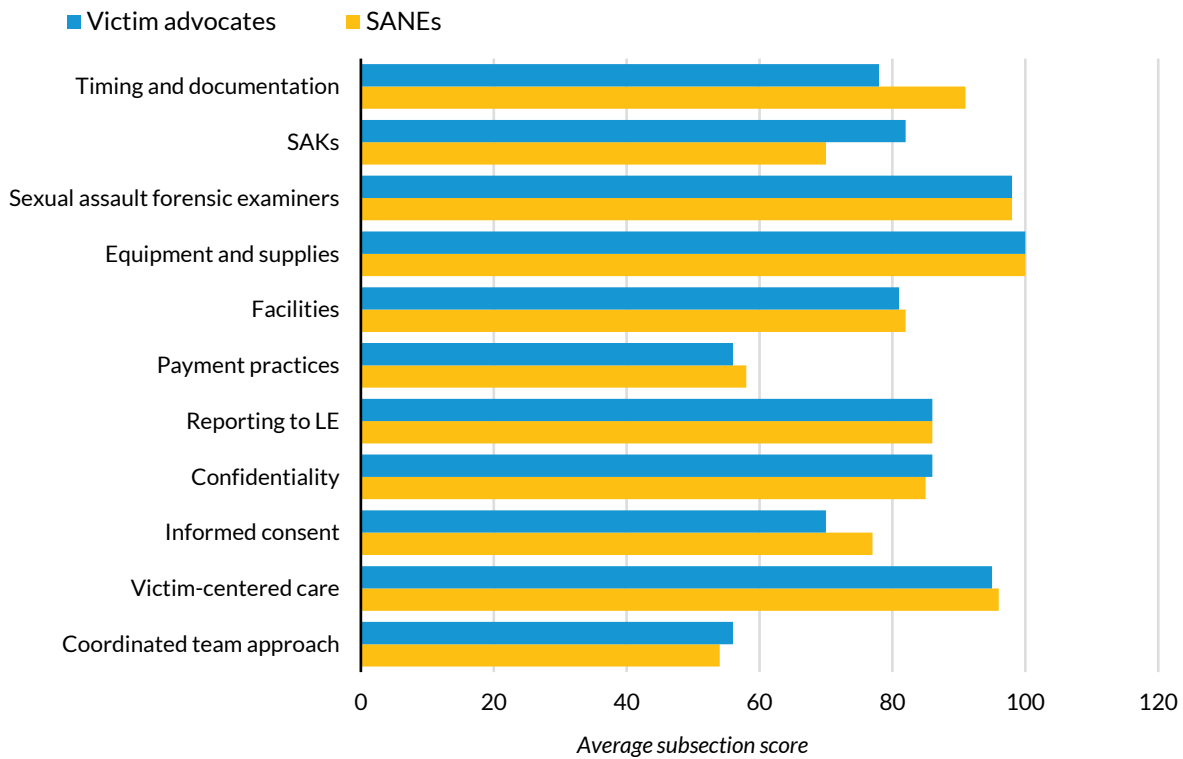
## Awareness of Protocol

**Survey insights** include findings on stakeholder knowledge about, familiarity with, and implementation of the SAFE Protocol. These aspects are important for jurisdictions wanting to enhance their response to sexual assault and effectively serve survivors. In order to understand how local-level professionals involved in sexual assault responses were learning about the SAFE Protocol, we asked SANEs and victim advocates how they had received trainings on the protocol's content. Of the respondents that had received training, 70 percent of SANEs had received training from IAFN and 63 percent of victim advocates had received training from a local sexual assault victim services program. When asked what methods they used to stay up to date on the SAFE Protocol, 81 percent of SANEs reported conferences and 81 percent reported trainings; 76 percent of victim advocates reported that trainings were their primary way of staying up to date on the SAFE Protocol.

We assessed SANEs' and advocates' knowledge of the SAFE Protocol using tests consisting of 25 multiple-choice, select-all-that-apply, and true/false 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-related considerations for collecting evidence, exam equipment and supplies, and exam facilities. Overall, SANEs and advocates had median scores of 80. Figure 1 presents SANEs' and advocates' average test scores across the test subsections. SANEs and advocates seemed to know more about equipment and supplies, sexual assault forensic examiners, and victim-centered care. They knew less about payment practices and coordinated team approaches.

FIGURE 1

Average Scores for the Knowledge Subsections of Urban Institute and International Association of Forensic Nurses Surveys of Victim Advocates and Sexual Assault Nurse Examiners



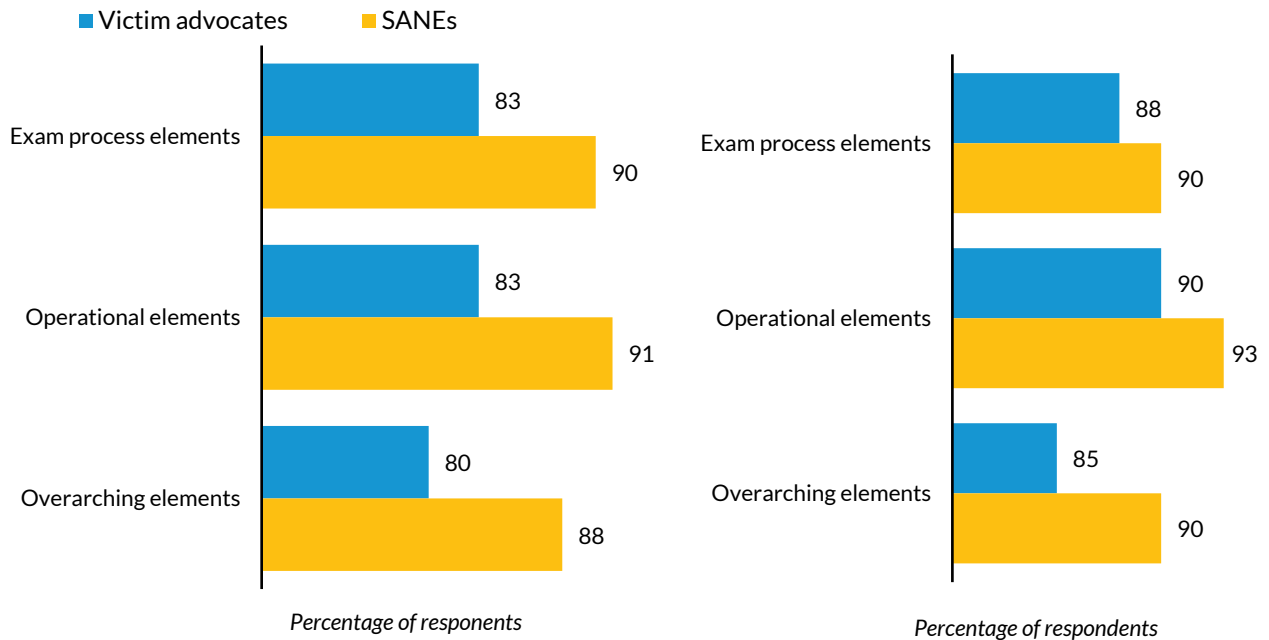
Sources: Urban and International Association of Forensic Nurses surveys of SANEs and victim advocates.

Notes: LE = law enforcement. SAK = sexual assault kit. SANE = sexual assault nurse examiner. N ranged from 343–379 for SANEs and 241–261 for victim advocates. Zero to 36 SANE responses and 0–20 advocate response(s) were missing.

We also learned about the extent to which stakeholders’ communities were familiar with and were implementing the SAFE Protocol’s *overarching*, *operational*, and *exam process* elements. Figure 2 presents SANEs’ and advocates’ perceptions of their local communities’ levels of SAFE Protocol familiarity and implementation. The majority of SANEs and advocates reported that their jurisdictions were somewhat or very familiar with SAFE Protocol provisions and were implementing them to a moderate or great extent. Larger proportions of SANEs than advocates reported that their jurisdictions were familiar with and implementing the protocol’s overarching, operational, and exam process elements.

FIGURE 2

**Shares of Victim Advocates and Sexual Assault Nurse Examiners Reporting That Their Jurisdiction Was Somewhat or Very Familiar with the SAFE Protocol (Left) and That Their Jurisdiction Was Implementing the SAFE Protocol to a Great or Moderate Extent (Right)**



Sources: Urban and International Association of Forensic Nurses surveys of SANEs and victim advocates.

Notes: Left: N = 338–348, SANEs; N = 219–233, victim advocates. Thirty-one to 41 SANE responses and 28–42 advocate response(s) were missing. Right: N = 300–314, SANEs; N = 201–206, victim advocates. Sixty-five to 79 SANE responses and 55–60 advocate response(s) were missing.

**Case study insights** in four jurisdictions revealed more about stakeholders’ familiarity with and implementation of the SAFE Protocol. Most advocates, law enforcement officers, and prosecutors interviewed did not know much about the SAFE Protocol when we asked specifically about it using its formal name. Some were vaguely familiar with it and mentioned having heard about it in their SART meetings, some reported that they followed their state’s own protocol, and others had never heard of the SAFE Protocol. Though this seems to contrast with the levels of familiarity advocates indicated on the survey, we only interviewed advocates from four jurisdictions and the survey included far more advocates.

Unlike advocates, officers, and prosecutors, during case study interviews, SANEs reported being very familiar with the SAFE Protocol and reported using it for training purposes, to testify in court, and when conducting exams. State-level administrators were also familiar with the protocol. They indicated having received information from IAFN and staying up to date on any changes to the protocol. They also play a role in updating state protocols and training other stakeholders. Notably, prosecutors in one site reported using the protocol in court to demonstrate to juries how methodical and reliable SAMFEs are.

Although victim advocates, law enforcement professionals, and most prosecutors we interviewed seemed to lack familiarity with the SAFE Protocol by name, they did report practicing several of its provisions in their day-to-day work responding to sexual assaults. Thus, though they reported actively implementing some of its provisions, using the title SAFE Protocol did not resonate with them. For example, stakeholders reported changing their state funding and payment practices to ensure patients are not billed, tightening up their response to sexual assault, and updating their state and county protocols to ensure they are in line with elements of the national SAFE Protocol. In addition, all four case study sites have active, well-functioning SARTs—a key recommendation and component of the SAFE Protocol—that meet regularly to discuss and improve local responses to sexual assault.

## Stakeholder Perspectives on Implementation Strengths

During our case study interviews, local stakeholders involved in responses to sexual assault identified several implementation strengths. We discuss these strengths here as they relate to the SAFE Protocol's three sections: overarching issues, operational issues, and the medical forensic exam process. Overall, elements that strengthened the implementation of the guidance in the SAFE Protocol are related to the ability of local stakeholders to collaborate, trust each other, and understand and have clearly defined roles in the sexual assault response system.

### Strengths Related to the Overarching Issues Section of the SAFE Protocol

The coordinated team approach, usually operationalized as a SART or MDT, was considered an important source of implementation strengths. This approach creates a platform for collaboration that extends beyond what can happen through traditional job duties. Described by one stakeholder as the “key to everything,” the cross-stakeholder collaboration that occurs in a SART or MDT is credited by stakeholders with building relationships, fostering trust, helping to clearly define roles, and creating spaces for exchanging important information and raising up challenges or improvements that need to be made to improve local responses to sexual assault. One prosecutor said, “It's invaluable to have all the players there at the same time.”

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*The key to a well-functioning SART is having all of [the] necessary partners at the table. Core partners are really important, they provide different perspectives, when someone is siloed, things fall apart. The SART in [my jurisdiction] is constantly inviting more when there is turnover and they are dedicated to relationship building. They have built trust and can talk through important issues and do it respectfully. Also key is strong leadership, that does not get defensive. —SART coordinator*

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Several interviewees noted that the personal relationships created and fostered by SARTs or MDTs improve communication in operational settings. When challenges arise in regular scopes of work, partners know they can reach out to a colleague in another agency or sector for support or advice. A victim advocate shared, “[We have] good working relationships—can just call one another.”

Good collaboration can also foster flexibility and an ability to clearly define individual roles. **Flexibility** and a **willingness to change** are key to identifying things that are not working as they should and strategies to improve practice and protocol implementation. Clearly defined roles help everyone understand how their capacities and expertise play a role in local responses to sexual assault.

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*What’s so great about [my county] is that we all know our individual roles that we play for the victim. –Victim advocate*

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Interviewees were asked whether the practices of their sexual assault response partners (e.g., SANEs, law enforcement, prosecutors, and advocates) were victim centered in their work. Though we did not quantify which category of stakeholder received the most affirmative responses, we can note that partners were considered victim centered by their peers if they had been through trainings and/or were active participants in a SART and/or MDT. The SAFE Protocol includes guidance on creating a **victim-centered reporting process** that does not link availability of services to decisions to report. Each member of a SART or MDT plays an integral role in supporting survivors’ choices of reporting assaults to law enforcement or not engaging in the criminal legal process. This role could include supporting a survivor with an SAMFE (e.g., treatment) or providing resources, information, and advocacy services. Whether the survivor engages with the criminal legal system, their choice must be fully supported. Interviewees in our case study sites described various reporting models that were being implemented, and nearly all those models decoupled services and treatment from the decision to report to law enforcement. In one site, law enforcement expressed support for those models, noted the value of the training they had received on the need for and effectiveness of different reporting options, and noted that they had seen positive outcomes by adopting those practices.



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*I work with [my jurisdiction's police department]. They have done ... training, which has completely had a 180 impact on them. They come in with an approach of you don't have to report right now, but here is what it would look like. Build rapport, no paperwork, actually having a conversation and provide care to the victim. [I am] shocked with transformation ... [the] PD [police department] especially is victim centered. I can call them and feel comfortable talking about a process. –SANE*

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## **Strengths Related to the Operational Issues Section of the SAFE Protocol**

Case study interviewees said that SANEs in their jurisdictions demonstrated the skills and competencies articulated in the SAFE Protocol's operational issues section. In almost every site, interviewees described SANEs as critical to the provision of victim-centered care and to the collection and preservation of forensic evidence. Advocates appreciated that SANEs offer support as well as the medical forensic examination. One victim advocate said the following:

The SANEs' role is very victim centered, they are there for the evidence collection and make that clear, but are also very clear that they're there to support just as much as the advocates. I would say the victim-centered piece is pretty equal to the advocates ... [We have] gained a better relationship over the years, a better understanding of what the goals are for the client. [I] try to check in with SANEs and make sure they're on the same page about what they can do for a survivor.

Overall, law enforcement partners made mostly positive statements about their SANE partners. They appreciated that SANEs are trained to preserve evidence, take statements, and care for the survivor. To officers, they are seen as resources that bring skills to the earliest moments of sexual assault responses, can inform investigations, and provide care to survivors. Prosecutors tended to value how SANEs provide corroborating evidence and can clearly explain evidence and injuries to a trier of fact, such as a jury or judge.

We've had great luck and experiences with any SANE. In investigations, they bridge the gap of contact, professionalism, evidence gathering in very specific manner that is defensible. Their training is often better than what officers are receiving, they are an excellent resource. They are experts and they do a very thorough exam. May have to wait sometimes for a SANE to be available, because the service they provide are as a specially trained person. Occasionally a SANE is not available, but that is getting better. –Law enforcement professional

When the job is done well it makes the case stronger. They take the protocol very seriously and follow proper procedures for evidence collection which helps the case. Jury always wants corroborating evidence, getting that physical evidence is the best evidence they can get. More they do, the better evidence I have. They also do a good job testifying and explaining injuries and evidence. –Prosecutor

## Strengths Related to the Medical Forensic Exam Process Section of the SAFE Protocol

The sexual assault medical forensic exam process, and the implementation strengths associated with it, were discussed very little in our interviews. This owed in part to how topics were prioritized for discussion and to how prescribed the exam process is. In all of the sites we conducted interviews in, the exam process is clearly defined. This includes the information provided to victims during the exam, the medical care provided, and a standardized evidence collection kit. Interviewees highlighted several strengths associated with having the exam conducted in the first place. These included the potential for collecting forensic evidence that can corroborate a survivor's account, the ability for reported assaults to progress through the legal system, and the medical care received.

The exam-related strengths that SANEs, SART coordinators, and victim advocates reported focused more on survivor health, safety, and personal agency in contributing to legal responses to cases (in cases survivors decide to report). These strengths include the benefits of medical care for injuries and treatment for sexually transmitted infections. One stakeholder noted that for victims who choose to seek a legal response to their assault, the decision to submit to an exam may help them feel that they are supporting that response.

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*From a victim perspective, the exam makes a big difference in them knowing that they're okay. For victims who do wish to make the report to [law enforcement], it helps them to know that they were part of trying to make a successful prosecution. —SART coordinator*

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Law enforcement and prosecutors were more likely to identify exam-related strengths associated with case processing in the criminal legal system, although prosecutors' opinions were mixed on whether the kit actually made a difference in the final disposition of a case, with one questioning whether there were differences in cases with and without kits.

If someone has had the SAMFE, they are more inclined to continue that process forward. We will send anonymous kits to exam, but if they have gone through the process they are more willing to at least meet with [law enforcement] to hear options. —Law enforcement professional

Kit doesn't have an effect on whether a victim wants to go forward or not but it can have a big effect on their ability to go forward in a case. There are many reasons why someone may not have gone to the hospital—that doesn't mean it didn't happen. But it can affect the ability to move the case forward. —Prosecutor

If they don't have a kit, then obviously it is a lack of evidence. Juries like and want physical evidence so if they don't have it then [we] have to explain why. And a lot of times the kits don't

have evidence or DNA, so they need to explain to the jury why. And a lot of times they do find evidence and that is always wonderful. –Prosecutor

## Stakeholder Perspectives on Implementation Challenges

We asked stakeholders in the case study jurisdictions about their perceptions of challenges to implementing SAFE Protocol provisions. Again, we organize these challenges as they relate to each section of the SAFE Protocol itself: overarching issues, operational issues, and the medical forensic exam process. The uneven landscape of familiarity and awareness of the SAFE Protocol across the stakeholders can create challenges to effective and proper implementation of best practice. Overall, elements that have created barriers or challenges to implementation of the SAFE Protocol are related to lack of communication and collaboration and lack of training and education, including not providing a victim-centered, trauma-informed approach.

### Challenges Related to the Overarching Issues Section of the SAFE Protocol

Each stakeholder expressed challenges related to implementing the SAFE Protocol, particularly around its overarching elements. Many of these challenges reflect an absence of strengths identified in the previous section. Most stakeholders identified **lack of communication and collaboration** between partner agencies as a concern. Specifically, advocates expressed concerns related to **communication, lack of or limited resources available**, and **connecting with survivors**, especially since the start of the COVID-19 pandemic. Prosecutors identified **communication** as a challenge, especially because of COVID.

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*A challenge during COVID is that a lot is done over Zoom. [It's] not the same. [We] can't connect with the person the same way. –Prosecutor*

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Multiple stakeholders identified challenges related to the **lack of training and education around victim-centered, trauma-informed care** for law enforcement officers. This was not universally expressed across all sites and stakeholders, especially in sites where law enforcement had received training on these issues. The lack of training encompassed **funding** for training and the size of the department or city. One victim advocate described challenges related to law enforcement in their jurisdiction:

Law enforcement officers are not victim centered, not trauma informed, or culturally relevant. They are not sensitive to culture and don't respect tribal court. And clients can tell, they don't believe they will be treated as fairly as everyone else. Law enforcement doesn't honor protection orders issued by their judge, don't feel it's real, don't follow through ... It's a problem if this

negativity reaches the victim, they don't need that added stress of an officer and not protecting them. There are some officers that are trying and some officers have been kind, available, provided resources, and have been professional.

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*Some agencies just don't have the money or manpower to do a lot with training. Some may not even be aware of what trauma informed means. [There] was an issue with problematic questioning a few months ago, [we] reached out and had a conversation with the agency. The sergeant called back and asked to train their staff. –SANE*

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Similar to stakeholders' perception of law enforcement officers, some prosecutors were viewed as not being victim centered or trauma informed. One interviewee expressed that prosecutors' goal is to prosecute and to see a case through, meaning the process does not always feel victim centered. A victim-centered approach recognizes that there are many reasons a victim may not pursue or support the investigation and prosecution of their assault. These could include inadequate connection to support resources, negative experiences during any part of the response, reluctance to participate in a process that could take years, or opinions on the ability of the criminal legal system to produce justice.

### **Challenges Related to the Operational Issues Section of the SAFE Protocol**

Very few stakeholders addressed challenges related to equipment/supply needs, issues with evidence collection kits, or facilities, subjects outlined in the operational elements of the SAFE Protocol. Most SANEs reported that the largest challenge is the limited number of SANEs trained to conduct an SAMFE. Some SANEs reported high turnover, which can lead to gaps in service and challenges for maintaining consistency in implementing best practices.

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*By not having [forensic nurse examiners] trained and available in all jurisdictions, patients have to make travel and this isn't ideal.*

–SANE

*[There's] not enough focus on taking care of the providers. [The] really high turnover means people don't have great experiences and things get missed. [It's an] extremely traumatic job.*

–SANE

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## Challenges Related to the Medical Forensic Exam Process Section of the SAFE Protocol

Interviewees reported some challenges related to exam process elements. The exam can be a time-consuming and difficult process for a survivor to experience. It can usually last several hours, more if a provider has to travel to the exam location and the process involves physically invasive procedures, such as imaging (e.g., an X-ray or CT scan). Working through language barriers can also prolong the exam for non-English speaking survivors.

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*The exam is thorough, but it can be challenging for victims to go through.*

*–Title IX coordinator*

*[We have] Spanish-speaking interpreters at hospital plus blue phone language line. This does create a barrier and a longer exam, but is an option.*

*–Victim advocate*

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Survivors who delay seeking care may miss their window to receive the SAMFE. Because of the natural degradation of the biological evidence, complete SAMFEs with evidence collection are rarely conducted later than 120 hours after an assault. Survivors who seek care after that time may still receive medical care and supportive services but may not have the option to receive a complete SAMFE.

## Stakeholders' Perceptions of Survivors' Concerns and Challenges

Almost all stakeholders in case study sites perceived challenges related to survivors' concerns, a variety of which were related to overarching elements of the SAFE Protocol. Reporting to law enforcement and repercussions of reporting were two primary themes. One detective mentioned that more often than not, victims do not share concerns with the police or detectives; rather, they share that information with nurses.

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*Common concerns from survivors are repercussions of what's going to happen if they report, a lot of familial concerns depending on who the abuser is, who to disclose the incident to. There is a lot of terror behind moving forward in the court system, not being believed. The process itself being drawn out, especially with COVID. That one comment from any one person that's just slightly "we don't believe you" just shuts them completely down.*

*—Victim advocate*

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The lack of SANEs trained to conduct SAMFEs can cause survivors to wait longer periods to be seen and can mean they may receive SAMFE care from untrained health care professionals. Causes of SANE scarcity were captured by the study survey. We asked respondents whether their program had ever completely halted services for any reason. Among the 379 SANEs that responded, only 24 (7 percent) stated that their program had halted services. Reasons included funding lapses (4 programs), lack of support from hospital administration (9 programs), lack of support from emergency departments (6 programs), and lack of trained SANEs (17 programs).<sup>1</sup> Some respondents reported that services had been halted because of natural disasters, the COVID-19 pandemic, and the inability of programs to meet legal standards.

Regarding the exam process elements of the SAFE Protocol, stakeholders reported that survivors had concerns and challenges about the **uncertainty of the exam process** and **knowing the outcome of the SAMFE** (such as overall health and safety, pregnancy, and concerns about sexually transmitted infections). The SAMFE cannot be used to determine whether someone has been assaulted because the evidence collected must be considered along with all other evidence and the context of the case. The presence or absence of DNA or injuries does not necessarily suggest the presence or absence of an assault, but the detection of that evidence, when combined with other case factors, may contribute to such a finding.

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*They would hope that when nurses do the exam that they can know positively whether someone assaulted them or not (something [SANEs] are not able to say). —SANE coordinator*

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Overall, stakeholders perceived survivors' concerns as relating to reporting to law enforcement, repercussions for reporting to law enforcement, the uncertainty of the exam process, and knowing the outcome of the SAMFE, all elements outlined in the SAFE Protocol.

## Conclusion and Recommendations

Findings from this study speak to SAFE Protocol implementation across the country, and we attempted to understand it based on the three sections of the protocol: overarching, operational, and exam process elements. Here we draw three conclusions related to implementation and make corresponding recommendations for policy and practice.

**First, SANEs participating in a national survey of SANE programs and advocates from their communities demonstrated high levels of knowledge about the SAFE Protocol, and most SANEs and advocates reported that their jurisdictions were somewhat or very familiar with the protocol's provisions and were implementing them to a moderate or great extent.** Findings from conversations with stakeholders in four case study sites align with the survey findings in that the sites have implemented several elements of the protocol. Stakeholders other than SANEs, however, did not connect the SAFE Protocol explicitly by name with elements of their responses to sexual assault—they think of these as individual elements, not part of a larger protocol. They expressed that they may not have been aware of or were unfamiliar with the protocol, despite having implemented provisions of it in their day-to-day work. Recommendations related to this first finding are as follows:

- *Recommendation for SART practice:* make connections between day-to-day best practices taking place in communities and how they are promulgated in the SAFE Protocol. Doing this would help more stakeholders recognize their role—and stake—in the SAFE Protocol's implementation.
- *Recommendation for SART and technical-assistance-provider practice:* create, or continue to create, written local policy that aligns with elements of the SAFE Protocol (e.g., multiple reporting options, defined payment and reimbursement policies, well-identified resources for the SAMFE, resources available to connect survivors with advocacy, and survivor consent options for each avenue of the response). Identify champions of the policies, train SART/MDT members on the policies, and even consider training those outside the SART/MDT that are involved in responding to sexual assault (e.g., law enforcement agencies that do not attend team meetings or agencies outside the jurisdiction, campus sexual assault response teams that do not attend, etc.).

**Second, members of local sexual assault response systems say collaboration is a fundamental strength of effective responses to sexual assault and increases the likelihood that responses will be victim centered and trauma informed.** SARTs and MDTs are sources of information sharing, improved practice, and alignment with SAFE Protocol provisions. Challenges to implementing SAFE Protocol provisions arise when collaboration or communication among stakeholders is absent. Recommendations related to this second finding are as follows:

- *Recommendation for policy:* increase existing funding sources and identify new ones that support the structures and functions of SARTs/MDTs and training for their members through specified

support to the agencies involved in those collaborative teams. Funding for these efforts is critical, as collaborative bodies are fundamental to best practice in responding to sexual assault.

- *Recommendation for SART practice:* clearly define SART/MDT members' roles and cross-train members on one another's roles and responsibilities related to responding to sexual assault. Encourage a model of transparency and open communication between all partners while ensuring patient privacy and confidentiality is maintained. When members understand and trust one another and have clearly defined roles, survivors are more likely to experience victim-centered and trauma-informed care.

**Third, stakeholders viewed survivors' concerns as centered around reporting assaults to law enforcement (including fears about the legal process and concerns about being believed) and a lack of information about the SAMFE process.** Recommendations related to this third finding are as follows:

- *Recommendation for technical-assistance-provider practice:* develop easily accessible, culturally relevant materials or training tools that can help SANEs, advocates, police officers, and others who have contact with victims at the earliest stages so they can better educate them on their options around reporting to law enforcement and what to expect during an SAMFE.
- *Recommendation for law enforcement practice:* seek effective trainings on victim-centered, trauma-informed responses, specifically models that decouple the SAMFE and the reporting process.

## Note

- <sup>1</sup> Although only a small number of programs in the study had to halt services for any reason, during our initial sample frame outreach we were able to identify a number of programs that were defunct (n=41) and not included in the final sample.

## 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

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