



# Sustaining Community-Based Approaches for Survivors of Sexual Assault

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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 this evaluation, this brief addresses the key components of sustaining a community-based response to survivors of sexual assault and the necessity of improving services to be inclusive of all survivors.

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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 goal of a community-based response to sexual assault is to make it easier for survivors to get the help they need for their mental and physical health recovery. The immediate aftermath of an assault is extremely challenging for survivors, as they face many obstacles and decisions. They are left to decide whether to immediately seek medical care, reach out to a hotline, connect with advocacy organizations, contact the police, or forgo services. The number of considerations survivors face at this moment can be overwhelming, including experiences their communities may have had with systemic racism and police brutality, their own experiences with medical care, their citizenship status, their gender identity, and their sexuality (Zweig et al. 2021). In fact, most survivors choose not to reach out to any formal sources of help (Langton 2011).

## Brief Roadmap

In this brief, we begin by defining community-based responses to sexual assault and provide evidence of how such responses benefit survivors. We then document five key components of the sustainability of community-based approaches using findings from Urban and IAFN's SAFE Protocol study: local partnerships; improving services for resilient, marginalized communities; funding; training; and written policy. We end by providing recommendations for improving these components in practice. Box 1 documents the methods of the SAFE Protocol study.

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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 sexual assault response team 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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## Community-Based Responses to Sexual Assault

Community-based responses to sexual assault are services that support a survivor in getting their immediate and long-term needs met after an assault. Survivors may need to be connected to health care and advocacy services to get the physical and mental help they need to recover. In this brief, we refer to SANEs and victim advocates as community-based responders.<sup>1</sup>

### Sexual Assault Nurse Examiners and Sexual Assault Forensic Examiners

SANEs, in addition to other specially trained health care providers, are intended to be the first step in providing medical care to survivors after an assault. They conduct sexual assault medical forensic exams (SAMFEs) for two reasons: to support the survivor in getting the medical care they need, and to collect forensic evidence from the survivor (to be used in a legal process if the survivor chooses to report their assault to the police). SANEs provide community- and hospital-based services that are not directly tied to police agencies; the decision to get an exam puts the survivor at the center of a SANE’s care and shifts them into a community-based response, instead of a criminal legal one (Zweig et al. 2021).

SANEs offer patient-centered care that is empowering and supports the survivor’s psychological recovery (Campbell et al. 2008; Campbell, Patterson, and Litchy 2005; Ericksen et al. 2002; Ledray, Faugno, and Speck 2001). Research shows that survivors of sexual assault are treated faster and have shorter wait times in hospitals that have SANE programs (Stermac and Stripe 2002), that SANE examiners collect better evidence than providers that are not specially trained (Ledray and Simmelink 1997; Sievers, Murphy, and Miller 2003), and that survivors are connected to more services and

resources (like victim advocates and legal services) in their communities when they are treated by SANEs (Crandall and Helitzer 2003).

## Victim Advocates

Community-based advocates are service providers that emphasize survivors' choices (Zweig et al. 2021) and support them through their options and process of healing, be it through the mental health system, housing system, medical system, and/or criminal legal system (Martin 2005). Victim advocates offer safety and crisis intervention, individual advocacy (including case management), emotional support (including support groups and counseling), legal advocacy, and assistance getting financial compensation (Zweig and Yahner 2013).

Advocates honor and respect that survivors know what is best for them and should be in control of their own healing. By providing accurate information and consistent support, advocates' support becomes a healing process in itself (Campbell et al. 2001; Wasco et al. 2004). Research shows that sexual assault survivors who worked with advocates are less likely to report feeling bad about themselves (60 percent of those who worked with advocates compared with 83 percent of those that did not), feeling guilty (59 percent compared with 81 percent), and feeling depressed (53 percent compared with 88 percent) (Campbell 2006).

## Elements of Sustainability

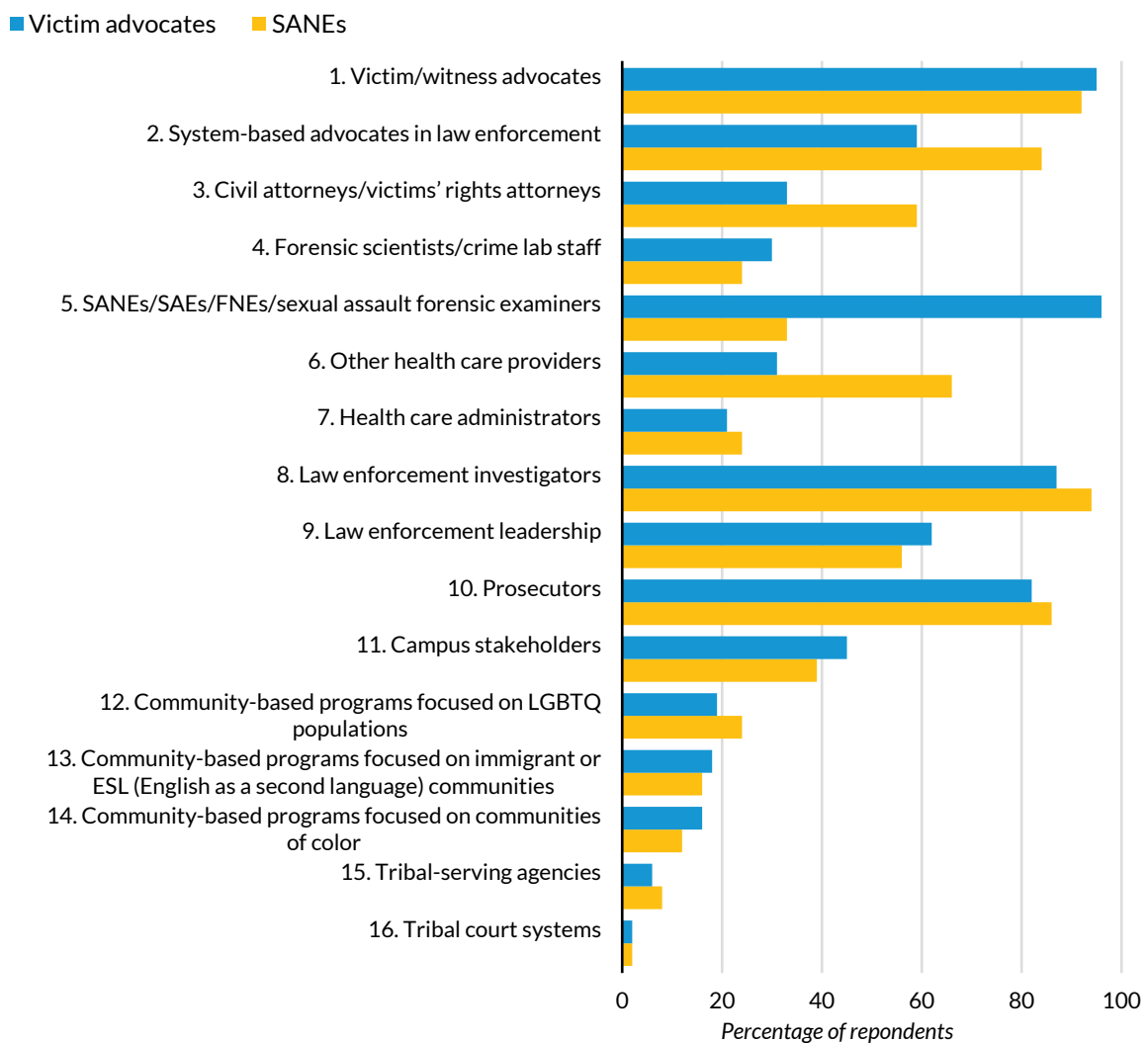
We propose a conceptual framework of sustainability that includes five key elements for community-based responses to sexual assault: local partnerships; improving services for resilient, marginalized communities; funding; training; and written policy. These elements were confirmed through the data from this project. **Local partnerships** allow stakeholders to collaborate and provide a more cohesive system of support for survivors. **Improving services for resilient, marginalized communities** allows all survivors to get the support they need to heal. **Funding** pays for the programs that cover staff time, onboarding and training, and coordinator positions. **Training** ensures the longevity and consistent use of best practices. **Written policies** codify best practices and standards for working with survivors.

### Local Partnerships

Sexual assault response teams (SARTs) and multidisciplinary teams (MDTs) are groups of local sexual assault responders whose goal is to provide a comprehensive and seamless response to sexual assault (Martin 2005). The SAFE Protocol recommends that these teams include SANEs, victim advocates, law enforcement officers, and prosecutors, among other stakeholders (OVW 2013). One of the rationales for these teams is that sexual assault survivors will receive comprehensive services that reduce the number of times they have to retell their story to service providers (O'Sullivan and Carlton 2001). When these teams are implemented well, they are victim centered and trauma informed,<sup>2</sup> improve survivors' experiences with getting help across stakeholder agencies (Greeson and Campbell 2013), and improve collaboration among stakeholders. But the existence of SARTs or MDTs does not necessarily lead to improvements in the well-being of survivors. To have a beneficial SART or MDT, stakeholders must respect and value each other's perspectives while prioritizing and centering the needs of survivors in their community as core aspects of their jobs (Cole 2018).

In our surveys, 92 percent of SANEs and 96 percent of advocates reported being part of a formal multidisciplinary team (e.g., a SART, MDT, or sexual assault response and resource team), and the most commonly identified members were victim advocates (reported by 92 percent of SANEs and 95 percent of advocates) and law enforcement (reported by 94 percent of SANEs and 87 percent of advocates). Ninety-six percent of advocates reported SANEs in their formal multidisciplinary teams, whereas only 33 percent of SANE respondents did (figure 1). In addition, all survey respondents—sexual assault coalitions, state VAWA administrators, SANEs, and victim advocates—rated the activities of community-based sexual assault advocates and of SANEs as most important in responding to sexual assault in their community.

**FIGURE 1**  
**Percentages of Victim Advocates and SANEs Reporting Members of Their SARTs**



**Source:** Surveys of SANEs and victim advocates conducted by Urban and the International Association of Forensic Nurses.  
**Notes:** SANE= sexual assault nurse examiner. Victim advocate N = 238; SANE N = 348. Thirty-one SANE responses and 29 victim advocate responses were missing; 4 Victim Advocate responses were “I don’t know.”

We observed SART meetings and asked site stakeholders questions about the SART in each of our four case study sites. Though the vision and mission differed for each SART across the four sites, there was a consistent emphasis on collaboration, improving communication between all agencies, sharing resources and knowledge, and supporting survivors. According to stakeholders, the aspects of SARTs that contribute to sustainability are the **variety of sexual assault response trainings** made available to SART members, the **relationships and connections** formed between local stakeholders, the ways in which **survivor choice is centered** and understood by all stakeholders, and the **service gaps they fill** for each other. First, all four of the sites discussed trainings that members of their SART have done for them, and the benefits they have seen from those trainings. Information about victim-centered and trauma-informed care was specifically highlighted, and one stakeholder said that the more cross-discipline education law enforcement receives on survivors, the gentler they become with them. Second, SARTs create lasting relationships among local stakeholders that help ensure every stakeholder knows who to call and the role they and other people will play for the survivor. Third, all site stakeholders said that their SART has helped them become more attentive to victims' needs. Stakeholders from all sites mentioned that because of their SART, they always tell survivors about their right to have an advocate and then allow the survivor to choose their next steps in the process. Finally, stakeholders said that they rely on each other to help fill gaps for the survivor if their agency does not offer the services needed. For example, stakeholders said that SANEs are especially helpful in filling gaps, bridging gaps between evidence gathering and victim care. Having these formal working relationships improves how survivors are treated and cared for after an assault and helps ensure that local stakeholders feel supported in their work with survivors. Coordination is vital to making sure survivors are supported through their process of healing.

## **Improving Services for Resilient, Marginalized Communities**

Though the benefits of community-based responses to sexual assault are clear, there are still gaps in the services currently provided to survivors. Everyone has a right to thoughtful and appropriate care, but there are several groups of survivors that, although they face higher risk of sexual assault, have reported more barriers to services than other survivors. The SAFE Protocol lays out specific guidelines for developing culturally responsive care for some of these groups, but to sustain community-based responses, survivor services need to be more inclusive to provide consistent care for everyone. These groups include but are not limited to Black women, American Indians and Alaskan Natives, transgender and nonbinary people, people in the sex work industry, people who immigrate to the United States, and people with disabilities.

### **BLACK WOMEN**

Black women face racism and sexism, creating an intersection of oppression that exposes them to higher risk of sexual assault and carries into their treatment after an assault. Black women experience higher rates of sexual assault than white, Asian, and Latina women (Planty et al. 2013), but are less likely to disclose or seek help in the aftermath of an assault (Tilman et al. 2010). Campbell and colleagues (2001) asked 102 sexual assault survivors (51 percent African American) seeking help from community providers to rate their experiences from very healing to very hurtful, and about half rated their

experiences with the medical system as hurtful (52 percent) and almost a third rated their experiences with the medical system as very hurtful (Campbell et al. 2001). Black women are also more likely to have had negative experiences with mental health professionals and social services that create an emotional barrier to accessing these services. In addition, Black women report they do not reach out to rape crisis centers that are predominately white because they believe that their needs and concerns will be overlooked and not addressed (Washington 2001), they are worried they will be unjustly accused of being the perpetrator of a crime, they do not receive culturally competent resources, and they do not feel the health care system provides a safe environment for them.<sup>3</sup>

#### AMERICAN INDIANS AND ALASKAN NATIVES

American Indians and Alaskan Natives are at higher risk of sexual violence than any other racial or ethnic group (56 percent of American Indian and Alaskan Native women report having experienced a rape or sexual assault in their lifetime), an effect of the historical trauma that Indigenous people continue to experience in the United States (Rosay 2016). Indigenous survivors also face unique and heightened barriers in getting health services related to language, health literacy, values, culture, and fear of being identified when seeking help in a small, tight-knit community (Benoit, Carroll, and Chaudhry 2003; Bletzer and Koss 2006; Rosay 2016). American Indian and Alaskan Native survivors report experiencing racism, victim blaming, prejudice or other unfair treatment, loss of children to authorities, and geographic isolation when accessing survivor services. In addition, getting access to 24-hour emergency services, health clinics, and trained SANEs can be difficult; consequently, victims living on reservations have had to travel elsewhere to receive an exam, and they may not have access to transportation and may not be familiar with or trust the local non-Native community.<sup>4</sup>

#### TRANSGENDER AND NONBINARY PEOPLE

Forty-seven percent of transgender people have been sexually assaulted, and 53 percent of Black transgender women have (James et al. 2016). The National Transgender Discrimination Survey found that 19 percent of respondents had been refused care by medical providers because of their gender identity, 28 percent had experienced harassment in a medical setting, and 28 percent had postponed medical care because of discrimination (Grant et al. 2011). It is important to understand why transgender and nonbinary survivors may be reluctant to access medical care. Transgender and nonbinary survivors that do seek formal services report harmful practices and lack of cultural competence among providers, including providers using incorrect pronouns and lacking gender-affirming care (Seelman 2015). They also report being profiled as sex workers, particularly transgender women of color (Amnesty International 2005).

#### SEX WORKERS

People who work in the sex work industry face an estimated lifetime prevalence of sexual violence of 45 to 75 percent and report challenges with accessing necessary services, reporting violence, and victim blaming (Deering et al. 2014). In addition, the criminalization of sex work often directs sex workers to the criminal legal system instead of survivor services, which facilitates police violence against sex workers (Thukral and Ditmore 2003; Villacampa and Torres 2019).

## PEOPLE WHO HAVE IMMIGRATED

People who have immigrated, including people who are undocumented, face legal pressures and uncertainty about their rights to receive care without interacting with law enforcement or immigration services. Survivors who immigrate to the United States report that the services they do seek are ill equipped to meet their needs, which include providers that speak their language and culturally relevant care (Orloff 2013).

## PEOPLE WITH DISABILITIES

People with disabilities face higher risk of sexual assault and abuse than people without disabilities, and people with developmental disabilities are less likely to receive victim services and supports (Nosek et al. 2006). The lack of trained service providers means that people with developmental disabilities are often treated in child advocacy centers, which are not appropriate for adults (Nosek et al. 2006). Lastly, there are barriers to referrals because few places accommodate survivors with physical needs or survivors who need interpreters (Stromsness 1993; Swedlund and Nosek 2000).

## FINDINGS FROM OUR STUDY

During surveys, we asked SANEs and advocates to estimate how familiar their communities were with the SAFE Protocol's recommendations. SANEs and advocates consistently rated their communities as least familiar with the protocol's recommendations about LGBTQIA+ needs, culturally responsive care, needs of people with disabilities, and non-English speakers (see [our guidebook](#) for a full description of community familiarity with the protocol). In addition, the least commonly identified SART members (see figure 1) were community-based programs focused on LGBTQIA+ needs (reported by 24 percent of SANEs and 19 percent of victim advocates), immigrants or English language learners (reported by 16 percent of SANEs and 18 percent of victim advocates), communities of color (reported by 12 percent of SANEs and 16 percent of victim advocates), and tribal-serving agencies (reported by 8 percent of SANEs and 6 percent of victim advocates).

During case study interviews in four jurisdictions, we asked site stakeholders questions about the inclusivity of their services. All the victim advocates we spoke with said they know of LGBTQIA+ services in their area and/or have specific trainings for their staff on working with LGBTQIA+ survivors. However, one stakeholder said they would want to add more people of color and LGBTQIA+ advocates, because survivors often want someone who is not white and/or straight to support them through the healing process. A second stakeholder from a different site said they worried that LGBTQIA+ people were not coming in for SANE exams because they worried about how they would be treated. A third stakeholder from a third site said they had conducted an internal study on their response to survivors that found they had a poor response to people of color, especially Black, Latinx, and immigrant populations. All stakeholders who raised these issues said they were working to do more outreach and trainings to make their services more inclusive.



## Funding

Sustained funding is critical to the long-term survival of community-based responses to sexual assault, particularly SANE programs and victim services/advocacy. The vast majority of the work provided by these programs is reliant on external funding because the services are provided to survivors free of charge and do not generate revenues for their organizations. Although only four SANE programs included in our national survey of SANE programs reported ever having to halt services because of funding lapses,<sup>5</sup> many SANE programs do not receive program-related funding (for example, to cover coordinator positions, operational roles, training, etc.) beyond what is reimbursable for the SAMFE (which may or may not fully cover the hospital costs and treatment or a nurse's time). SANEs and advocates we surveyed reported various sources of funding (table 1), though 40 percent of SANE programs reported not receiving any funding from the major federal and state-level sources.

The Victims of Crime Act Crime Victim Assistance Program was the most commonly reported funding source for SANE programs (35 percent) and victim service programs (92 percent). VAWA funding streams were also cited as primary funding sources for victim services but less so for SANE programs: 12 percent of SANE programs and 47 percent of victim service programs reported receiving funding from the VAWA STOP (Services, Training, Officers, and Prosecutors) Formula Grant Program; 5 percent of SANE programs and 37 percent of victim service programs reported receiving funding from the VAWA Sexual Assault Services Formula Grant Program; and 7 percent of SANE programs and 33 percent of victim service programs reported receiving funding from the VAWA discretionary grant program. State budgets provide more dollars for victim service programs than SANE programs. One-third of victim service programs and 12 percent of SANE programs receive funds directly from their state's budget. One in five SANE programs and just over one-third of victim service programs receive funding from other sources, such as private foundations, hospitals that host SANE programs, and other federal/state departments (e.g., health departments).

TABLE 1

## Percentages of SANEs and Victim Advocates Reporting Their Funding Sources

	SANEs (n=340)	Victim advocates (n=230)
VAWA: Stop Violence Against Women Formula Grant Program	12%	47%
VAWA: SAS Formula Grant Program	5%	37%
OVW/VAWA discretionary grant program	7%	33%
VOCA: Crime victim assistance funding	35%	92%
Bureau of Justice Assistance, Sexual Assault Kit Initiative	2%	5%
Byrne grants	1%	1%
Funding directly from the state budget	12%	34%
Other	22%	36%
None of the above	40%	0%

**Source:** Surveys of SANEs and victim advocates conducted by Urban and the International Association of Forensic Nurses.

**Notes:** OVW = Office on Violence Against Women. SAS = sexual assault services. VAWA = Violence Against Women Act. VOCA = Victims of Crime Act. Respondents could select more than one answer, so percentages do not add up to 100. This table excludes reimbursement from state-designated public payers for sexual assault medical forensic exams. There were 4 missing responses from SANEs and 3 from victim advocates. There were 35 “I don’t know” responses from SANEs and 28 from victim advocates.

Although most programs reported receiving some sort of funding support, grant funding is year-to-year and a stakeholder from one case study site remarked that their long-term plan was to write a lot of grants, while one from a different site said they relied heavily on grants and that they must ensure those are renewed on time when it came to planning for sustainability. Another stakeholder in a third site remarked that funding is always an issue and that federal grants are important to keeping their SANE program robust. Stakeholders from all four case study sites identified the need for more resources, with SANEs from three of the four sites specifically naming funding or more money as a concern around sustainability or long-term planning needs. Lastly, all sites were able to name ways they would enhance their offerings, namely by growing their staffing numbers, if they were able to have additional funding. For example, participants frequently referenced more nurses, more advocates, a more diverse workforce, and providing follow-up care.

## Training

Trainings ensure that all stakeholders are using best practices consistently in a community and across the United States. The Sexual Assault Demonstration Initiative, funded by the Office on Violence Against Women, published a training manual for new victim advocates. The manual offers a curriculum for supporting survivors of sexual violence that covers trauma-informed care, an anti-oppression framework, rape culture, ethical commitments, active listening, collaboration with other systems, and many other topics. It begins by recommending that each advocacy organization set policies and procedures to support continuous training for all staff (SADI 2020). IAFN has an established set of

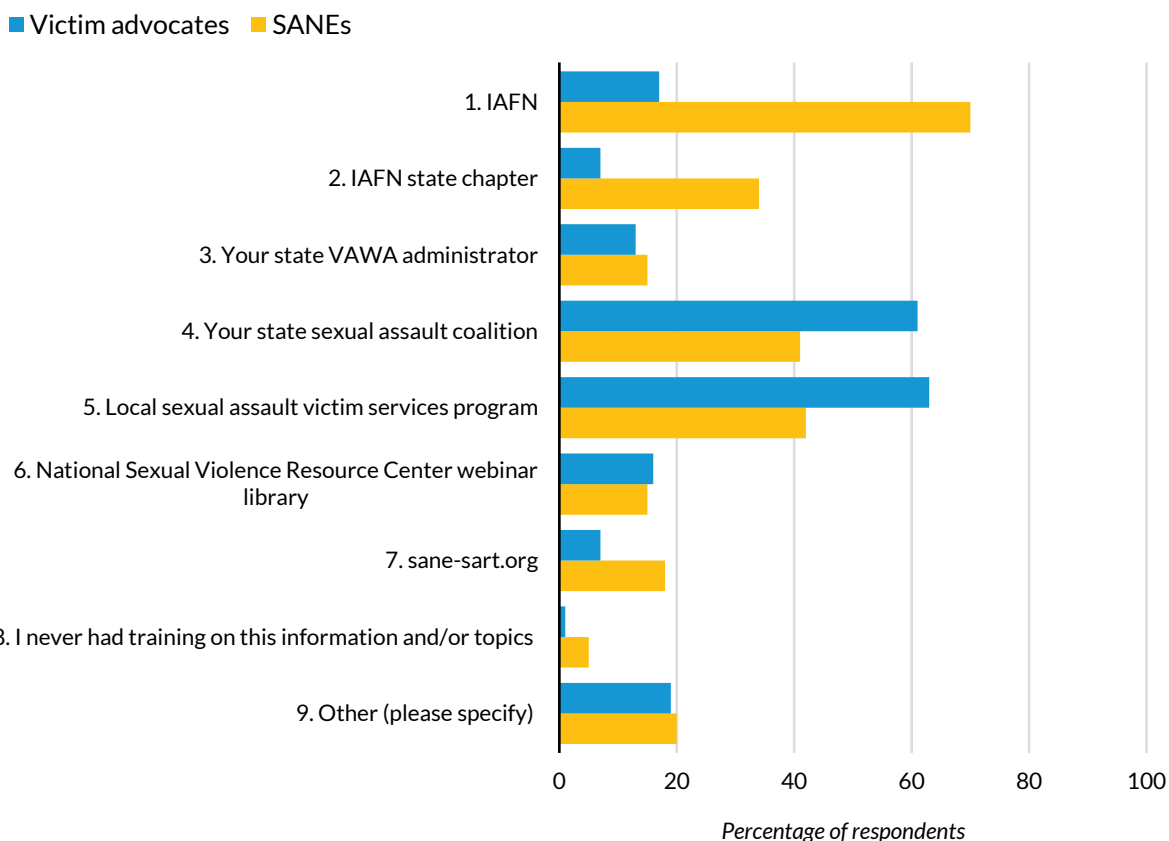
educational guidelines for SANEs to provide a solid foundation for SANE education. The goals of the guidelines are to provide registered nurses and advanced practice nurses with the knowledge and skills to provide comprehensive, victim-centered, coordinated care to patients being evaluated for sexual assault or suspected of having been sexually assaulted (IAFN 2018). These guidelines outline minimum requirements and recommendations for beginning practicing as a SANE, which include 40 hours of didactic coursework and a clinical hands-on skills component and which highlight continuing education as required to maintain a nursing license and certification. These trainings and training standards aim to provide a holistic approach to preserving the lives of victims, their families, and communities affected by violence.

Seventy percent of SANEs reported receiving trainings on the SAFE Protocol from IAFN, 42 percent reported that their local sexual assault victim services program provided those trainings, and 41 percent reported that state sexual assault coalitions did so. The majority of advocates, on the other hand, reported receiving trainings from their local sexual assault victim services program (63 percent) and state sexual assault coalitions (61 percent) (figure 2).

Additionally, SANEs and advocates often collaborate to deliver training and education related to providing quality, trauma-informed care, and resources to partners serving victims of sexual assault. In one case study site, all local sexual assault responders had to complete a 60-hour training on cultural humility, LGBTQIA+ survivors, how to complete forms (e.g., crime victims' compensation, consent, medical forensic records, etc.), and how to be more sensitive toward people. In all four case study sites, SANEs had to complete extensive training through IAFN (described above). When stakeholders were asked about their plans for training longevity or future requirements, however, none had a clear avenue for continuing their current level of training, though one stakeholder did mention relying on peer-to-peer trainings as new people joined the organization.

FIGURE 2

**Percentages of SANEs and Victim Advocates Reporting on Who Conducted Their Trainings on the SAFE Protocol**



**Sources:** Surveys of SANEs and victim advocates conducted by Urban and the International Association of Forensic Nurses.  
**Notes:** IAFN = International Association of Forensic Nurses. SAFE = sexual assault medical forensic exam. SANE = sexual assault nurse examiner. VAWA = Violence Against Women Act. Victim advocate N = 155; SANE N = 334. Thirty-three SANE and 99 victim advocate responses were missing; 12 SANE and 7 victim advocate responses were “I don't know.”

### Written Policy

Written policies are key to defining expectations, roles, and activities for local sexual assault stakeholders. They encode standards for working with survivors and ensure consistent and maintainable care. The SAFE Protocol is a written policy that is used in tandem with state and local policies related to sexual assault response and is used to inform state-level SAFE protocols that set state-specific standards.

The SAFE Protocol was first published in 2004 and was updated in 2013 by the US Department of Justice Office on Violence Against Women. It was developed in coordination with advocates, medical personnel, law enforcement representatives, prosecutors, forensic scientists, and others at the national, local, and tribal levels. It covers activities from first contact with victims through follow-up care and postexam activities like examiner testimony. The protocol prioritizes survivors’ safety and comfort

while ensuring accurate and objective documentation, collection, and preservation of evidence. It recommends a multidisciplinary, coordinated team approach in addressing sexual assault and lays out a framework of victim-centered care that addresses survivors' needs and preferences in culturally sound ways.

The SAFE Protocol also includes guidance for communities that choose to draft and implement jurisdiction-specific written protocols. Table 2 illustrates how the recommendations and guidance of the SAFE Protocol are reflected in jurisdiction-level administrative policies as reported by SANEs and advocates. Some elements of the protocol have been widely included in local policies on sexual assault response. Over 80 percent of SANEs and advocates reported that their written policies specify a time frame for conducting exams after an assault and that they specify elements of care, including a victim's access to information, that SAMFEs be provided by trained examiners, and that exams be provided free of charge and regardless of whether a survivor decides to report to police. In addition, over 80 percent of SANEs and advocates reported that policies on kits include details on storage times, locations, and chain-of-custody procedures. Elements not allowed by VAWA and the SAFE Protocol are still present in some policies, but at lower rates. For example, 17 percent of SANEs and 18 percent of advocates reported law enforcement authorizations for SAMFEs and 7 percent of SANEs and 10 percent of advocates reported requirements to report assaults to law enforcement in order to access exams free of charge. These data demonstrate the degree of alignment between local policies and the SAFE Protocol but do not indicate whether these were adopted *because* of the protocol or whether they existed at the local level before the protocol.

Information from our site visits provides more illustrative detail on the benefits of the SAFE Protocol and of written policies for responding to sexual assault in general. Stakeholders note that written policies are important for the guidance they provide new hires. The policies are important for shaping practice and add validity to processes. One stakeholder noted that it is especially useful to point to the SAFE Protocol when providing court testimony and when collaborating at the state level. Another stakeholder noted that written policies take away bias and give the SAMFE credibility because it is a set, standard process. A third stakeholder said that written policy is the only way some partners will be moved because they need a formal structure.

TABLE 2

**Shares of SANEs and Victim Advocates Reporting Administrative Policies in Their Jurisdictions:  
Access to SAMFEs, Payment Practices, and Handling SAMFEs**

	SANEs	Victim advocates
Elements of care	82%	93%
LEAs authorize SAMFEs	17%	18%
Specifies time frame	83%	86%
Victims – access to info	81%	85%
Victims able to track	53%	60%
SAMFEs provided by trained examiners (SANE/FNE/sexual assault forensic examiner)	69%	81%
Requires that victims be transferred to facility with SANE	53%	67%
Requires SAMFEs with or without report to LEA	86%	97%
Requires identical SAMFEs with or without report	86%	95%
Mandates reports to LEA	19%	22%
Allows anonymous reporting	63%	67%
Exam free of charge	87%	91%
Identifies a public-funded payer for SAMFEs	76%	80%
Report required before free exam	7%	10%
Location of SAKs, no report to LEA	81%	88%
SAK storage time, no report to LEA	80%	84%
SAK storage time, report to LEA	72%	91%
Medical facilities store evidence	23%	45%
Medical facilities follow chain of custody	84%	95%
Testing required	37%	44%
Testing required within certain time frame	53%	60%
Victims can request anonymous public documents	72%	86%
Communication to advocates is confidential	88%	92%

**Sources:** Surveys of SANEs and victim advocates conducted by Urban and the International Association of Forensic Nurses.

**Notes:** FNE = forensic nurse examiner. LEA = law enforcement agency. SAKs = sexual assault kits. SAMFEs = sexual assault medical forensic examination. SANE = sexual assault nurse examiner. SANE *N* = 337; victim advocate *N* = 205. Thirty-two SANE responses and 33 advocate responses were missing, and 10 SANE responses and 23 advocate responses were “I don’t know.”

## Conclusion and Recommendations

The five elements of the sustainability of community-based approaches that we describe—local partnerships; improving services for resilient, marginalized communities; funding; training; and written policies—are essential to ensuring that communities’ responses to sexual assault survivors are maintained. Below are recommendations for sustaining community-based sexual assault response programs and expanding them to be more inclusive. Each recommendation aligns with and supports

provisions of the SAFE Protocol, and applying them will improve the implementation of the SAFE Protocol. The recommendations are as follows:

- Form partnerships with existing identity- and community-based organizations to serve survivors with resilient and marginalized identities in jurisdictions across the United States; funnel sustainable funding sources to these organizations; and hire more staff who are Black, LGBTQIA+, and American Indian and Alaskan Native and staff who have disabilities.
- Make sure local partnerships are beneficial for survivors through trainings on trauma-informed care, mutually respectful relationships, and emphasis on the varying needs of survivors.
- Prioritize culturally responsive care for Black people, Indigenous people, and other people of color, LGBTQIA+ people, American Indians and Alaskan Natives, people with disabilities, people in the sex work industry, and people who have immigrated. Create new presentation and outreach strategies to promote education and use of existing services.
- Conduct outreach to community members and survivors to learn what they want and need in a community-based response to sexual assault and work to fund their priorities.
- Create more sustainable funding streams for SANE and victim advocacy programs, including expanding their services to be more inclusive, funding the costs of SART and MDT functions, and funding programming and training and education.
- Conduct training and education across disciplines and across the community in the sexual assault response system.
- Connect with statewide SANE coordinators and/or state sexual assault coalitions, which can help advocate for policy change, funding opportunities, and other avenues for sustainability.
- Encode beneficial practices into written policies to ensure local stakeholders respond with consistency.

## Notes

- <sup>1</sup> Some jurisdictions use the term sexual assault forensic examiners, or SAFEs, to refer to their nurses that conduct sexual assault medical forensic exams.
- <sup>2</sup> Victim-centered care requires that during response, stakeholders respect victims' privacy, agency, and priorities and clearly communicate the purposes of procedures related to various services or elements of the sexual assault response system. Trauma-informed responses recognize that the level of physical and psychological trauma—and the victim demeanor and behavior affected by that trauma—will vary from person to person. An approach that is victim centered *and* trauma informed ensures the victim feels empowered, has access to resources, and will not be subject to judgement based on myths of credible victim behaviors.
- <sup>3</sup> "For Many Black Survivors, Reporting Raises Complicated Issues," Rape, Abuse & Incest National Network, June 19, 2020, <https://www.rainn.org/news/many-black-survivors-reporting-raises-complicated-issues>.
- <sup>4</sup> Darakshan Raja, "The barriers American Indian woman face in accessing sexual assault exams and services," *Urban Wire* (blog), Urban Institute, May 30, 2014, <https://www.urban.org/urban-wire/barriers-american-indian-women-face-accessing-sexual-assault-exams-and-services>.
- <sup>5</sup> Although a small number of programs in the study had to halt services for any reason (n = 24), 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, which may or not have been because of funding issues.

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