The State of the State

Sexual Assault Forensic Examiner (SAFE) Programs in Maryland

SAFE

Prepared by the Maryland Coalition Against Sexual Assault (MCASA)
with funding from the Governor's Office of Crime Control and Prevention

mcasa
Maryland Coalition Against Sexual Assault

TABLE OF CONTENTS

INTRODUCTION

The last statewide assessment of Sexual Assault Forensic Examiner (SAFE) programs undertaken by the Maryland Coalition Against Sexual Assault (MCASA) was completed in November 2002. Almost 10 years later, we wanted to better understand the number of sexual assault patients seen in SAFE programs, the specific responsibilities held by SAFE coordinators, program protocols, and any obstacles or challenges faced by SAFE programs as they strive to provide care for sexual assault patients and assist the criminal justice process through thorough documentation and testimony.

The 2002 assessment reported concerns regarding insufficient training and certification, difficulty maintaining staffing (high attrition levels), inadequate funding for equipment and other resources, as well as systems challenges such as balancing the needs of the victim[1] with those of law enforcement, particularly regarding reporting options.

The 2011 survey results indicate that there continues to be challenges with Forensic Nurse Examiner (FNE) training and certification, staffing, and for some programs, resources. (Although a dearth of equipment and resources seems to be a problem facing fewer programs now than in 2002.) However, systems difficulties were not reported and interdisciplinary partnerships were rated as mostly positive. This may in part be due to new policies such as those which resulted from the 2005 reauthorization of the federal Violence Against Women Act (VAWA), as well as increased collaborative Sexual Assault Response and Resource Team (SARRT) -based responses, which is both a national and statewide trend. SARRTs are multidisciplinary teams within a jurisdiction providing a victim-centered, offender accountability-focused response to sexual violence in a community. Members typically include at least one of the following: forensic nurses, victim advocates, prosecutors and law enforcement. In Maryland, sexual assault victims wishing to be examined by a specially-trained forensic nurse must receive their exams at a designated hospital with a SAFE program. There is at least one SAFE program in each county of Maryland.

HISTORY/ BACKGROUND

The first SAFE programs began in Minneapolis, Memphis and Texas in the mid to late 1970s. In 1992, the International Association of Forensic Nurses (IAFN) was founded. The first two SAFE programs in Maryland were at Civista Hospital (Charles County) and Mercy Medical Center (Baltimore City), both of which began in the mid-1990s. The first pediatric SAFE program was established in 1993 at Civista Hospital.

SAFE programs in Maryland are at varying degrees of development and size. The newest SAFE program in Maryland began in Garrett County in 2008, and at the date of this report that program includes one FNE-A/P[2] who is on call 24 hours per day, 7 days per week.

In Maryland, hospital facilities and child advocacy centers are reimbursed by the Maryland Department of Health and Mental Hygiene (DHMH), Sexual Assault Reimbursement Unit (SARU) for performing sexual assault forensic exams; neither patients nor their insurance are billed.

- In FY10, the SARU processed 3,307 rape, sexual assault, and child sexual abuse claims.
- In FY10, the average cost/claim was:
  - $437 (all claims)
  - $752 (hospital)
  - $204 (professional)
- In FY10, the total number of hospital claims was 1,406 (43%). The total number of professional claims was 1,901 (57%).
- In FY10, the total program expenditure was approximately $1,445,180. Hospital claims totaled $1,057,917 (73%), and professional claims totaled $387,263 (27%).

For more information on Maryland regulations regarding physician and hospital charges for sexual assault patient care, see Rape and Sexual Offenses—Physician and Hospital Charges COMAR 10.12.02.

[1]For the purposes of this report, we have chosen to use the words "victim" or "patient" instead of "survivor" or "victim/survivor" because "victim" is the term used by Maryland law and "patient" is the term used by medical practitioners such as FNEs. We acknowledge that some people who have experienced sexual assault prefer "survivor" and encourage respect for these choices.

[2]FNE-A refers to FNEs who are certified to conduct exams on adults and adolescents from age 13 and up. FNE-P refers to FNEs who are certified to conduct exams on children below the age of 13. In the state of Maryland, a nurse must first complete training for the FNE-A certification prior to commencing training for the FNE-P certification.

METHODOLOGY

The 62 question 2011 survey instrument was drafted based on questions posed to other SAFE coordinators in early 2011 by a fellow coordinator who was seeking information on statewide practices to help develop and improve her own program, questions from MCASA's 2002 assessment, and other topics derived from recent technical assistance requests. The draft was reviewed by MCASA leadership, the Maryland Board of Nursing (MBON), the Governor's Office of Crime Control and Prevention (GOCCP) and two SAFE Coordinators before being finalized and made available to all Maryland SAFE coordinators via SurveyMonkey for their participation.

The survey was available online solely for SAFE coordinators from April 2011 until August 2011. Participants were not required to complete the entire survey in one sitting, which would have been prohibitive to their schedules. Email reminders were sent, and phone calls were made to SAFE Coordinators who did not respond.

At the time of the survey distribution, there were 22 SAFE Coordinators in the state, and 17 participated in the survey.

Some caveats regarding the participation rate include:

- Several of the questions posed to other coordinators in early 2011 were identical to questions in the online survey. Because one coordinator submitted her responses to those questions but not to the online survey, the total number of respondents for several questions is 18.

- Five participants did not complete the final third of the survey; thus, the total number of responses for many questions is 12 or 13.

- The five programs for which there is no data reported are Atlantic General Hospital based in Worcester County, Greater Baltimore Medical Center based in Baltimore County, Franklin Square Hospital Center (a pediatric program) based in Baltimore County, Harford Memorial Hospital/Upper Chesapeake Health System based in Harford County, and University of Maryland Medical Center (a pediatric program with no designated SAFE Coordinator).

- Although the overall population of SAFE coordinators is small, and there was not 100% participation, there is representation from all regions of the state and from all sizes and types of programs. Therefore, the averages reported in this document may still be interpreted as an accurate picture of the state and status of SAFE programs in the state of Maryland. However, when total numbers are reported (such as the total number of exams conducted) the reader should remember that totals do not include data for five of the state's SAFE programs.

- When an "average" number is reported, it is the mean number, or the quotient of the sum of multiple quantities and their number.

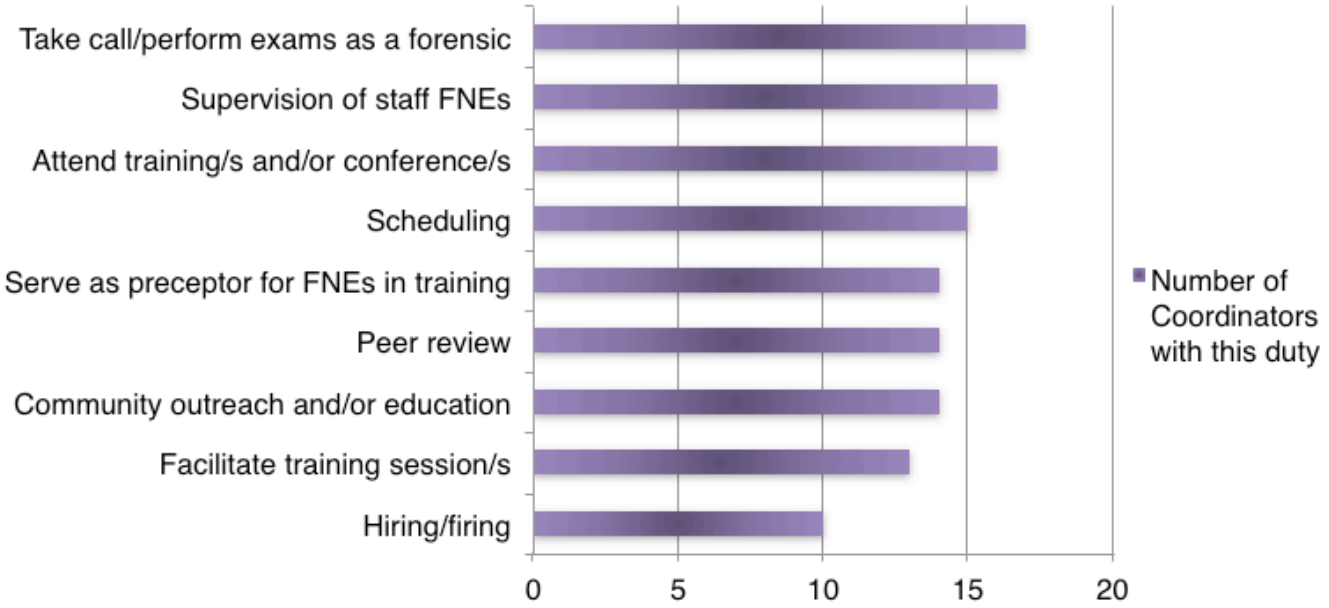
RESULTS

The following is a summary of survey results. The findings are organized into the following eight categories: Role, Administration, Patient Data, Program Protocol, Human Resources, SARRT and Community Partnerships, Professional Development, and Challenges.

ROLE

SAFE coordinators have a variety of responsibilities. Less than one in four SAFE coordinators work full-time as a coordinator; more than 75% divide their time between their SAFE role and their other (often primary) registered nursing jobs. While many work full or nearly full-time as a general emergency room nurse, others work in departments such as Occupational Health and Labor & Delivery.

SAFE Coordinator Responsibilities



In addition to those cited above, respondents also listed the following as additional roles they serve:

- Policy development and implementation
- Grant writing and grant management
- SARRT coordination
- Budget management
- Payroll
- Serving on various hospital, community- and state-based committees (such as child abuse or domestic violence groups)

SAFE coordinators, in their role as FNEs, also testify in court trials as fact and/or expert witnesses. The primary distinction between fact witnesses and expert witnesses is that an expert witness may provide an opinion, while fact witnesses must limit their testimony to personal observations. The average number of times a SAFE coordinator has testified is 30; and most often they are used as expert witnesses rather than fact witnesses.

ADMINISTRATION

Management

At least 50% of programs are managed by their hospital's Emergency Department. One SAFE Coordinator manages her own program within the hospital, and five did not indicate which department manages the program.

Funding

Fourteen (77%) of the programs have received grants to support their operations. The most common grants received were Violence Against Women Act Services Training Officers Prosecutors (STOP) Grants, Victims of Crime Act Grants and the Maryland Victims of Crime Grant, all of which are administered by GOCCP. One program received funding from DHMH and one received a private grant from Verizon. Another is now run as a hospital "Community Benefits Program," which is a program that undertakes activities to address community needs often with only partial or no compensation for their services.

Grants that support SAFE programs typically do not fund the entire program. Typically a grant will pay for training, equipment or research, but will not cover, for example, salary for the SAFE coordinator or the staff forensic nurses, which is typically absorbed by the hospital itself.

Billing

Sixty-one percent of programs' hospital billing departments process SAFE billing for reimbursement by DHMH; three coordinators are responsible for processing their own billing to DHMH; and one program uses a combined approach.

Seventy-five percent of total respondents' programs have their own cost center, which keeps their billing system separate from other hospital categories.

Emergency Department

Most (69%) SAFE Coordinators seem very satisfied with the level of support they receive from their emergency department administration, with one stating:

"I am supported by my director in every way – clinically, administratively and educationally." Two respondents did indicate that they were dissatisfied with the level of support, with one respondent noting that staff is often overtasked and occasionally micromanaged, both of which have led to attrition. Two answers to this question were "neutral" in tone; the qualitative response did not indicate a favorable or unfavorable view of the emergency department administration.

Hospital Administration

As for the general hospital administration, slightly less than half (46%) of SAFE coordinators report being pleased with the level of support they receive; with several indicating that they receive "full" or "100%" support from their administrations. However, the remaining responses were more nuanced, with several SAFE coordinators reporting that hospital administrators could be more financially supportive and better recognize the time it takes to run an effective SAFE program. One SAFE coordinator noted that while verbal support was provided, "the supplies, adequate office and exam space has not been a priority. Repeated requests are denied due to budget issues." One respondent noted a need for data on other programs in the state, such as that gleaned through this survey, so that she can more effectively advocate for her own SAFE program within her facility.

Facilities

Fifty-three percent of respondents have a designated SAFE exam room and 85 percent have a designated office for the SAFE program.

Maryland's Department of Health and Mental Hygiene regulations require the following of hospitals and physicians for sexual assault patients: "The victim shall be considered an emergency patient with special needs. The victim shall be taken immediately to a quiet private area where tests and examinations will be performed on the victim. ..." COMAR 10.12.02.03(A)

PATIENT DATA

All respondents indicated that they track data on their programs' patients.

Approximately one-third (30%) of programs only track data via a hospital-based record or data system; while the other 70% use specifically-developed databases, spreadsheets, paper records or a combination of hospital-based and SAFE program-based systems. About one-fourth of programs only use paper documentation such as log books.

The charts below show the number of patients seen by SAFE programs statewide and several variables pertaining to those patients. "Acute" pediatric exams refer to those performed less than 120 hours after the assault, while "chronic" refers to exams performed after 120 hours.

Respondents were also asked which part/s of the exam patients commonly refuse -- photography and rectal examinations were the most commonly cited, although many respondents indicated that patients either consent to "all" or "none" of the exam.

Sexual Assault Patient Data, All

2010 Data	All sexual assault patients seen	Male sexual assault patients seen	Sexual assault patients who received medical forensic exams	Sexual assault patients who received medical treatment only	Exams for which a victim advocate was present	Sexual assault patients who received a "Jane/John Doe"[3] SAFE exam	"Jane/John Doe" patients who converted to a law enforcement report at a later date
Total	2,032	95	1,179	125	488	221	57
Range	10-850	0-33	10-499	0-87	0-160	0-147	0-46
Average	156	8	98	10	54	18	5

Pediatric Sexual Assault Patient Data

2010 Data	Acute pediatric sexual assault patients seen	Average # of hours spent on an acute pediatric exam	Chronic pediatric sexual assault patients seen	Average # of hours spent on a chronic pediatric exam
Total	105	N/A	172	N/A
Range	1 to 33	2 to 4	5 to 88	1 to 3
Average	13	3	22	2

[3]A "Jane Doe" or "John Doe" exam is the common name for the sexual assault examination of a patient who chooses to have forensic evidence collected without revealing identifying information to law enforcement. In Maryland, a "property-held" number is assigned to the evidence and is not be connected to the patient's identity. This is the state of Maryland's policy developed to be compliant with the 2005 federal Violence Against Women Act Reauthorization under which U.S. states may not "require a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam, reimbursed for charges incurred on account of such an exam, or both" 42 U.S.C. § 3796gg-4(d).

We have chosen to use the term "Jane/John Doe" instead of "anonymous report" in this document for two reasons: one, it is used more often in common parlance, and two, because "anonymous" implies that the victim has never disclosed her identity, even though s/he has, to the hospital.

PROGRAM PROTOCOL

Suspect Exams

Approximately 50% of Maryland SAFE programs also conduct forensic medical exams on suspected offenders (also known as "suspect exams"). Of those who do not, several respondents indicated that they would be willing to do so. One program specifically offered to conduct suspect exams, but local law enforcement chose not to use them in that capacity. Another respondent noted that they would be willing to do so only if there was reimbursement (such as from the state) for the services provided.

Testing

For adult/adolescent sexual assault patients, 50% of programs always test for blood alcohol level, 50% of programs always do a urine drug toxicology screen, and 33% of programs presumptively and prophylactically treat for Sexually Transmitted Infections (STIs) without testing. Two programs also noted that a pregnancy (hCG, or human chorionic gonadotropin) test is also always administered to female sexual assault patients. Several programs noted that none of these tests are "always" done, but rather the decision is made on a case-by-case basis based on the patient's clinical history and indications. One program only routinely tests for blood alcohol level if the patient arrives within 24 hours of the reported sexual assault, and one only routinely tests for pregnancy, with the other tests being administered on a case-by-case basis.

The survey instrument did not drill down to determine the reasoning behind opting for or against various tests. Toxicology samples for alcohol and drugs should only be tested at the hospital if there is medical reason to do so. If the need for testing is solely forensic, the samples should be kept separate and sent off site for testing (National Protocol For Sexual Assault Medical Forensic Examinations of Adults/Adolescents, 2004). It should also be noted that a sexual assault patient's pregnancy or sexually transmitted infection may have resulted from consensual sexual activity prior to or after the incident of sexual assault.

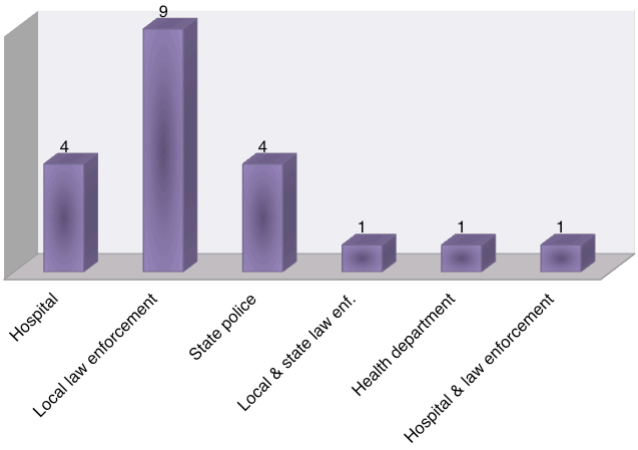
Follow-Up

Patient follow-up procedures vary, although most provide comprehensive discharge paperwork including referrals. The majority of programs rely on other agencies for patient follow-up, such as the local rape crisis and recovery center to provide follow up counseling or the local Health Department for STI/HIV testing and follow-up care. One program offers exams on site in five to six weeks for STI testing.

SAFE Kit Storage Location and Length

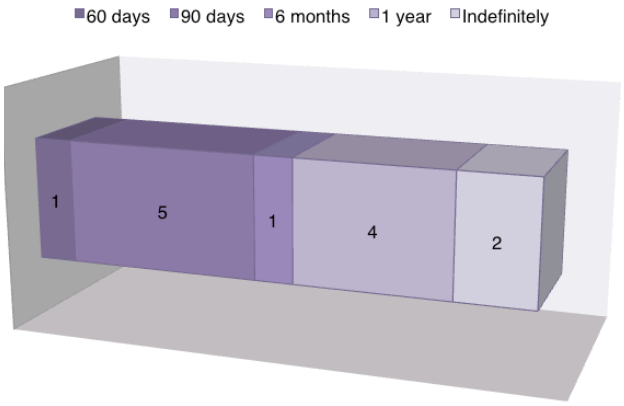
SAFE kits in Maryland are most often stored in law enforcement facilities. This is consistent with best practice recommendations from End Violence Against Women (EVAW) International, which is the national training and technical assistance provider on the forensic requirements of the 2005 Violence Against Women Act reauthorization. Some hospitals only store the kits when they are Jane Doe kits. However, other jurisdictions allow law enforcement to store the Jane Doe kits using a property-held versus a police report number. (SAFE exam when survivor reports to law enforcement, Memorandum of Law, Sexual Assault Legal Institute, 2010).

Where are SAFE kits stored



GOCCP recommends a minimum of 90 days storage for Jane Doe SAFE kits (Maryland VAWA Forensic Compliance Guidelines, 2009). However, slightly more than half of respondents' jurisdictions are storing the kits for longer periods of time. Longer storage is consistent with national best practice guidelines which recommend that kits be stored for the length of the statute of limitations or "as long as possible." (EVAW International, 2011). There is no statute of limitations on felony offenses in the state of Maryland. The Florida Council on Sexual Violence recommends storage for 15 months—three months past the one year anniversary of the assault, which can be an emotional trigger for many survivors.

How long are "Jane Doe" kits stored in your jurisdiction?



Victim Notification of Kit Destruction

Approximately half of the respondents indicated that victims are notified before their kits are destroyed, which would happen in the case of a Jane Doe report that has reached the end of the jurisdiction's kit storage protocol (as above). One respondent indicated that survivors are not notified and 30% were unsure. Of those who indicated that victims are notified pre-destruction, the jurisdictional agency responsible for doing so may be the Crime Lab, the SAFE Program or the rape crisis and recovery center.

As with SAFE kit storage, national best practice guidelines also indicate that kit destruction should be the responsibility of law enforcement rather than healthcare facilities or rape crisis and recovery centers because law enforcement agencies already have existing procedures for forensic evidence destruction whereas most hospitals or advocacy centers do not. (EVAW International, 2011)

Victim Advocates Routinely Called

Eleven programs indicated that a victim advocate is routinely called when a sexual assault patient presents at the hospital. Two programs reported that they are only called if the patient requests one and four did not answer this question.

All members of a coordinated team, such as a SARRT, should be able to describe their role and offer their services to the victim if s/he consents. The National Protocol For Sexual Assault Medical Forensic Examinations of Adults/Adolescents (2004) recommends that forensic medical providers "involve victim service providers/advocates in the exam process as soon after a victim discloses an assault as possible. Victims have the right to accept or decline victim services."

Obtaining Forensic Medical Records

Patients who have had SAFE exams at most hospitals are directed to undertake the same process as anyone requesting medical records. One respondent indicated that only emergency department records are available, not the "forensic file." One said she is not sure what patients would receive. Another respondent said the survivor would have to contact police if s/he wanted her/his SAFE record. One said genital photos would not be available. One said they had not yet considered how the records would be made available if the report was a Jane Doe report.

HUMAN RESOURCES

SAFE coordinators are paid between 2 and 40 hours per week for their role as coordinator. (The average is 16.) **ALL** respondents say they at least on occasion work more hours than what they are paid, with four saying they "always" do and three saying they "usually" do. The average weekly hours actually worked in the SAFE coordinator role is 18.

> **"The position needs to be at least a .5 [FTE] or more if you want to advance a program."**

Other staffing data include:

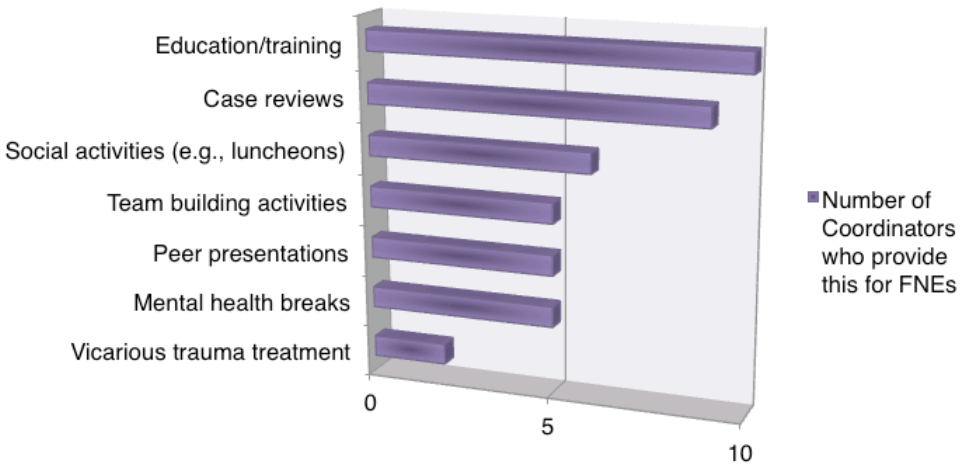
- The average per hour on call rate is $3.30.
- The average number of FNE-As on staff (who take call) per program is 8 (range from 1-33).
- The average number of FNE-Ps on staff (who take call) per program is 3 (range from 0-10).
- The average minimum number of required on-call hours per month is 159 (range from 0 to 720).
- The average number of hours FNEs are actually on call per month is 167.
- The average # of FNEs on call at any time is 1.

> **"We are a small program and I have so many ideas and not enough hours."**

About half of the respondents (54%) indicated that they have FNEs sign a new contract upon hire. The topics covered in the contract include minimum hours required, number of months/years required to stay in that specific SAFE program, the amount owed back to the facility for education if the contract is not fulfilled, court testimony liability if the FNE leaves program, minimum amount of exams required per quarter, call expectations, as well as requirements to participate in the local SARRT and Child Abuse Medical Professionals (CHAMP) TeleCAM peer review.[4]

Forensic nursing is an emotionally- and at times physically-tasking job, requiring on-call hours in the middle of the night. Often, staff FNEs are not as connected to the SARRT and other community systems as the SAFE coordinator. However, SAFE coordinators do organize various activities to help support their staff FNEs and keep them motivated, knowledgeable, and engaged.

Maintaining Staff Morale and Job Satisfaction



[4]TeleCAM is a secure and HIPAA-compliant Web-based application that allows Maryland health care professionals to upload case information (including photographs) and receive rapid feedback from Maryland CHAMP faculty. A Maryland CHAMP Provider refers to any physician or pediatric forensic nurse (FNE-P, PNP, etc.) who performs medical evaluations of children with suspected abuse in the State of Maryland in conjunction with local law enforcement and child protective services. CHAMP providers may or may not receive salary support from the CHAMP program. See http://mdchamp.org/ for more information.

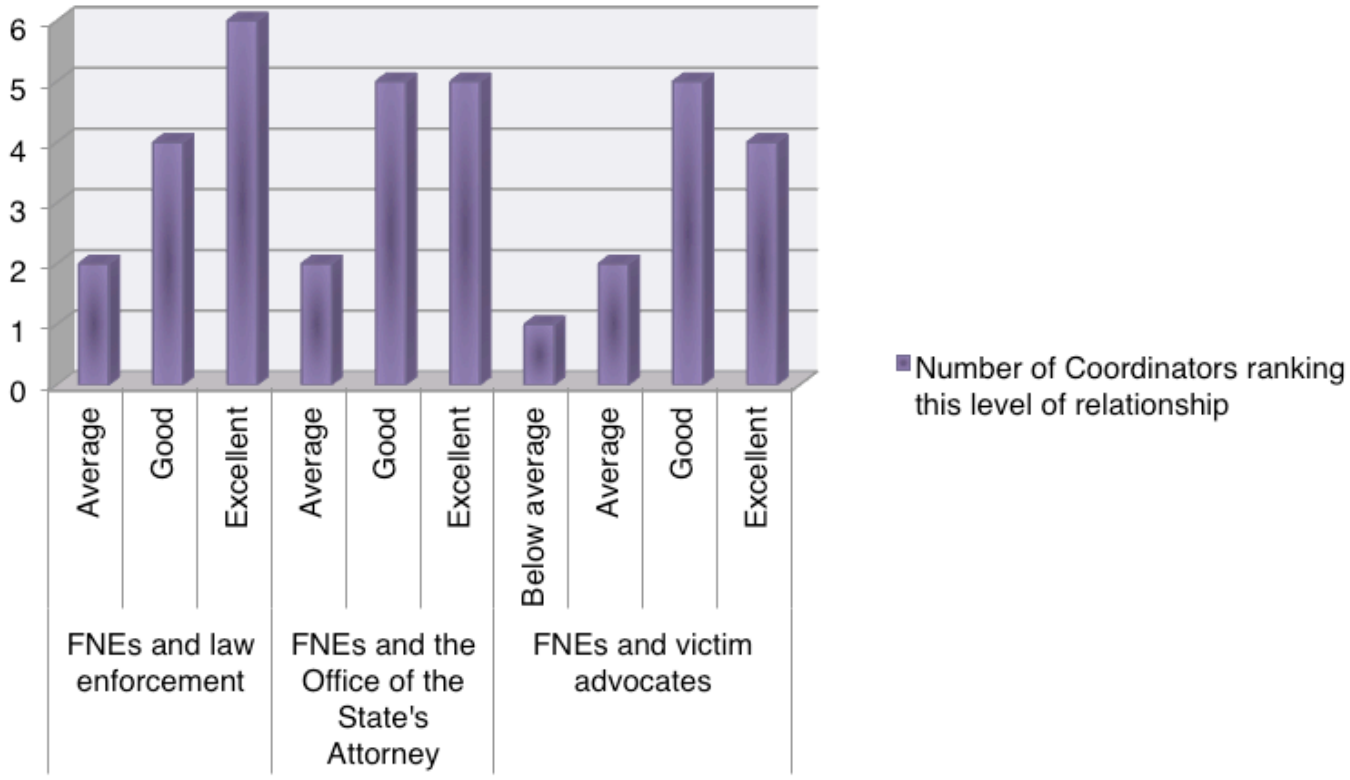
SARRT & COMMUNITY PARTNERSHIPS

The majority of respondents are members of a local SARRT. Approximately 41 percent of the respondents who identified themselves as an active member of a local SARRT also serve as the team coordinator. Most teams meet either monthly or bi-monthly, with several teams meeting quarterly.

Fifty-four percent of the SARRTs have a current memorandum of understanding, while three do not and two were unsure.

The 2002 evaluation indicated some degree of conflict between forensic nurses and police largely surrounding police not authorizing evidence kits to be collected after a victim reported a sexual assault (law enforcement authorization is no longer a requirement for a SAFE exam under VAWA 2005). The respondents to the 2011 survey ranked their relationship with law enforcement fairly high, as can be seen in the following chart.

Communication & Cooperation Levels Between FNEs and Community Partners



PROFESSIONAL DEVELOPMENT

Only approximately half (53%) of the respondents indicated that they are members of the IAFN, which is the professional membership organization for forensic nurses and publisher of the only peer-reviewed journal of forensic nursing. Several of the SAFE coordinators are also members of other organizations such as MCASA or the Emergency Nurses Association (ENA).

The survey asked about what topics SAFE coordinators and staff FNEs would need more training. All answers received are listed verbatim below. The topics which were suggested more than once are indicated with "x2" after the text.

On what topics would you, as a coordinator, like more training?

- Grant writing, submission, and management. (x2)
- Budget education.
- Leadership, retention strategies for non-busy programs.
- Maintaining the momentum and interest of the SAFE nurses.
- Forensic photography, specifically pertaining to bruise photos, genital photos, and photos of overweight patients.
- Staff meeting trainings.
- Leadership training.
- Expert documentation with photography.
- Becoming a debriefing expert.
- Updates from Maryland crime labs.
- Documentation to prevent legal action.
- Courtroom.
- Descriptions of injuries.
- Any product or procedure changes or upgrades.

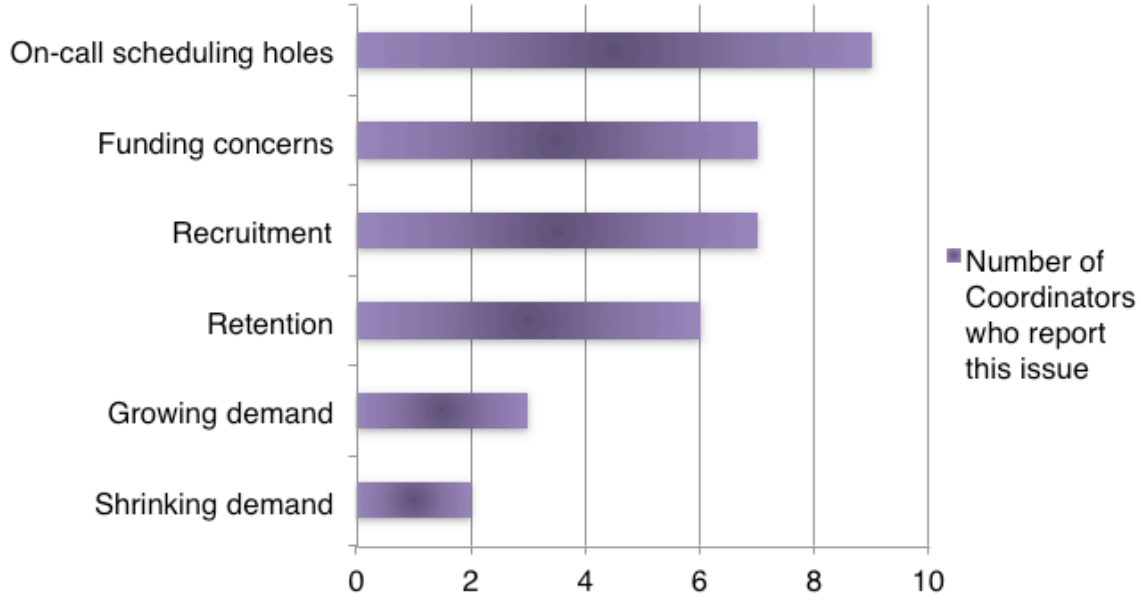
On what topics do you think your FNEs need more training?

- Photography and use of our camera, importance of camera for peer review. (x2)
- Expert testimony, preparation for cases, annual review for FNE's with photographs and case reviews.
- My staff is offered all of the training listed plus many other areas.
- Forensic wound documentation.
- Forensic photography with digital camera. Being able to determine whether what they are seeing is actual genital injury or not, and how to best document the injury. How to best document bruises, cuts, lacerations to the body (written documentation).
- Hymen description, correct identification and documentation of injuries.
- Everything; we get little money to attend ongoing education, and I feel this is so important to our self-esteem, court proceedings, morale etc.
- Injury identification is always important.
- Domestic violence.
- Confidence building, mock case, courtroom preparation, and testifying do & don'ts.

CHALLENGES

Sustainability concerns face most SAFE programs in the state, which is true across the nation as well. On call scheduling gaps were identified by 75% of Maryland SAFE coordinators as a challenge. This is a problem for smaller programs in smaller jurisdictions. One respondent noted that she has particular difficulty filling holiday call hours because no holiday call incentive pay is given.

Sustainability Challenges for SAFE Programs



Additionally, the numbers and types of examinations needed each year were mentioned as a barrier for FNEs maintaining licensure in rural programs. At time of this report's printing, the Maryland Board of Nursing is considering changes to these requirements.

"The legal practice requirements make it very difficult to maintain and sustain rural SAFE programs."

Another challenge listed under "other" was lack of funding for ongoing education, which was a need identified in the 2002 evaluation as well.

CONCLUSION

The survey data reported here indicates that SAFE programs in Maryland have come a long way since our last study in 2002, with five additional programs having been created, SARRT teams having expanded, improved cross-disciplinary relationships and enhanced service delivery for sexual assault patients. However, this survey only addresses SAFE coordinators' perspectives, and thus does not include the points of view of other professionals working within the anti-sexual assault field in Maryland. Thus, more research is needed. Challenges also continue to exist in the areas of funding, sustainability, training and the fine-tuning of protocol. We have provided several recommendations on these points in the following section.

RECOMMENDATIONS

The results of the survey illustrate the need to address SAFE program funding, sustainability, training, and protocol issues, all of which are interrelated. For example, funding issues impact the ability to pay coordinators' and staff FNE salaries, and staffing impacts sustainability. Funding and number of hours available to work in part determines whether FNEs are trained regularly and well. Training levels impact SAFE program protocol, in that best practice procedures consistent with current research are more likely to be enacted under programs whose staff is well-trained.

1. Funding

Additional funding for SAFE programs and their SAFE coordinators will improve the management and the consistency of programs. MCASA recommends that there be AT LEAST one half-time (20 hours per week) SAFE coordinator in each jurisdiction. Also, grant writing and grant management workshops should be made available to SAFE coordinators and medical directors to allow program managers to seek supportive funds.

2. Sustainability

A large number of the SAFE programs in Maryland have a very small number of FNEs on staff. High turnover due to burnout has an impact on the availability and consistency of SAFE services to the community. MCASA recommends additional outreach to interested registered nurses in Maryland to recruit those who may be interested in becoming an FNE. Also, staff morale and job satisfaction are critical elements for SAFE coordinators and hospital administrators to consider. Group activities such as team retreats, mental health breaks and treatment, incentive pay, and engagement with community systems such as SARRT, may all help sustain an FNE's interest in SAFE nursing work.

3. Training

Training beyond that which is covered in the didactic and clinical portions of the standardized FNE-A and FNE-P training courses is needed for both SAFE coordinators and staff FNEs. Many SAFE coordinators are placed into a leadership role due to their level of experience or proficiency in conducting SAFE exams but have very little experience as a manager or leader. Trainings which aid SAFE coordinators in their efforts to run quality SAFE programs and provide appropriate levels of support for their staff will foster more consistency and stability for patients. Also, all FNEs need regular training updates to keep consistent with current research and best practice for evidence collection, injury documentation, court testimony and sexual assault patient care.

4. Protocol

While most respondents indicated that they routinely offer a victim advocate if the patient wishes for one to be present, advocates were present for less than half of the exams performed in 2010. While this may be a result of patient choice/being uncomfortable with another person in the exam room, the way that victim advocacy services are offered and provided should also be considered in each community to ensure the most victim-centered response. Victim advocacy services have been proven to make a positive impact on a sexual assault survivor's experience of the medical and criminal justice systems.

Survivors who had the assistance of an advocate were significantly more likely to have police reports taken and were less likely to be treated negatively by police officers. These women also reported less distress after their contact with the legal system. Similarly, survivors who worked with an advocate during their emergency department care received more medical services…reported significantly fewer negative interpersonal interactions with medical system personnel, and reported less distress from their medical contact experiences.

Campbell, Rebecca. "Rape Survivor's Experiences with the Legal and Medical Systems: Do Rape Victim Advocates Make a Difference?" Violence Against Women 12 (2006).

While many programs routinely test for drugs and alcohol, the reason for the toxicology specimen testing must be clearly medical (toxicology specimen collection can be forensic, medical, or both). As is noted in the National Protocol:

Keep medical specimens separate from forensic specimens obtained during the exam. Specimens collected for medical purposes should be kept and processed at the medical facility, and specimens collected for forensic analysis should be transferred to the crime laboratory or other specified laboratories for analysis (with patients' consent).

National Protocol For Sexual Assault Medical Forensic Examinations of Adults/Adolescents (2004)

RECOMMENDED READING

Anonymous Sexual Assault Forensic Exams When Victim/Survivor Has Reported SA to Law Enforcement, 2010, Memorandum of Law, Sexual Assault Legal Institute

Campbell, Rebecca. The Effectiveness of Sexual Assault Nurse Examiner (SANE) Programs, 2004

Greeson, Campbell, and Cobes. Step-by-Step Practitioner Toolkit for Evaluating the Work of Sexual Assault Nurse Examiner (SANE) Programs in the Criminal Justice System, 2008

Jane Doe Exams as a "Last Resort", Memorandum of Law, Sexual Assault Legal Institute, 2010

Mandatory Reporting and Forensic Nurse Examiners and Other Health Care Providers, 2008, Memorandum of Law, Sexual Assault Legal Institute

National Protocol For Sexual Assault Medical Forensic Examinations of Adults/Adolescents, 2004

Position statement on collaboration with victim advocates, International Association of Forensic Nurses, 2008

SANE Sustainability Technical Assistance Bulletin Series, 2009, National Sexual Violence Resource Center

TERMS AND ACRONYMS

SAFE: Sexual Assault Forensic Examiner or Sexual Assault Forensic Exam. Most SAFE professionals in Maryland are forensic nurses or FNEs.

FNE: Forensic Nurse Examiner, the official name for forensic nurses in the state of Maryland

FNE-A: A Forensic Nurse Examiner certified to examine adults and adolescent patients (age 13 and over)

FNE-P: A Forensic Nurse Examiner certified to examine pediatric patients (age 12 and under)

SAFE Coordinator: An FNE which manages the forensic nursing program at a specific facility (typically hospitals)

MBON: Maryland Board of Nursing

GOCCP: Governor's Office of Crime Control and Prevention

SARRT: Sexual Assault Response and Resource Team (also called SART); a multidisciplinary team within a jurisdiction providing a victim-centered, offender accountability-focused response to sexual violence in a community. Members typically include at least one of the following: forensic nurses, victim advocates, prosecutors, and law enforcement, in addition to other professions.

"Jane/John Doe" Exam: "Jane Doe" or "John Doe" exam is the common name for the sexual assault examination of a patient who chooses to have forensic evidence collected without revealing identifying information to law enforcement.

SANE: Sexual Assault Nurse Examiner (what FNEs are called in most other areas of the United States)

THANK YOU Thank you to all of the Maryland SAFE coordinators for their participation in this survey, and even more importantly for the effort and dedication they put forward day-in and day-out to providing compassionate care for survivors and strong evidence collection to improve criminal justice outcomes.

Thank you to the Maryland Governor's Office of Crime Control and Prevention for funding this survey and report.

Preparation of this document was supported by grant number VAWA-2010-1421, awarded by the Governor's Office on Crime Control & Prevention (GOCCP). The opinions, findings and conclusions expressed in this document are those of the author(s) and do not necessarily represent the official position or policies of GOCCP.

MARYLAND SAFE PROGRAMS

County or Counties Served	Hospital
Allegany	Western MD Regional Medical Center
Anne Arundel, North	Baltimore Washington Medical Center
Anne Arundel, South	Anne Arundel Medical Center
Baltimore City	Mercy Medical Center
Baltimore City	University of Maryland Medical Center (Pediatric)
Baltimore County	Franklin Square Hospital Center (Pediatric)
Baltimore County	Greater Baltimore Medical Center
Calvert	Calvert Memorial Hospital
Caroline, Dorchester, Talbot	Memorial Hospital of Easton & Dorchester General
Carroll	Carroll Hospital Center
Cecil	Union Hospital
Charles	Civista Medical Center
Frederick	Frederick Memorial Hospital
Garrett	Garrett County Health Department
Harford	Upper Chesapeake Health System/Harford Memorial
Howard	Howard County General Hospital
Kent & Queen Anne's	Chester River Health System
Montgomery	Shady Grove Adventist Hospital
Prince George's	Prince George's Hospital Center
St. Mary's	St. Mary's Hospital
Washington	Meritus Medical Center
Wicomico, Somerset	Peninsula Regional Medical Center
Worcester, Somerset	Atlantic General Hospital

2011 SAFE COORDINATOR SURVEY

2011 SAFE Coordinator Survey

Introduction

The Maryland Coalition Against Sexual Assault (MCASA) needs your help to strengthen the sexual assault services net statewide.

We would like to ask your participation in the 2011 SAFE Coordinator survey which has been funded by the Governor's Office on Crime Control and Prevention (GOCCP). The results will provide a comparison to a similar study conducted by MCASA in 2002 and will be helpful in identifying common challenges, success and opportunities for SAFE program statewide.

We have developed the survey in cooperation with FNEs from around the state, and with input from the Maryland Board of Nursing and the Department of Health and Mental Hygiene. We look forward to sharing the results of the study in a published report to be issued in the summer of 2011.

The survey is comprehensive and will take approximately 20 minutes to complete. You do NOT need to complete it all in one sitting. If you exit the survey before you're done, simply re-open your email message and click on the survey link to start where you left off. Rest assured that the results will be published anonymously, but we have asked for your name and hospital so that we can follow up to guarantee 100% participation--this will ensure we obtain the most accurate picture of SAFE programs across our state.

If you have any questions, please feel free to contact me directly at acardone@mcasa.org or at 410.974.4507. Thank you again for your participation!

SAFE Coordinator

1. Your name

2. In what year did you become a

FNE-A

FNE-P

2011 SAFE Coordinator Survey

3. What do you do in your role as SAFE Coordinator?

- [ ] Attend training/s and/or conference/s
- [ ] Community outreach and/or education
- [ ] Facilitate training session/s
- [ ] Hiring/firing
- [ ] Peer review
- [ ] Serve as preceptor for FNEs in training
- [ ] Scheduling
- [ ] Supervision
- [ ] Take call/perform exams as a forensic nurse
- [ ] Other (please specify)

4. How many hours per week are you paid for being Coordinator?

5. Do you work more hours than what you are paid for as Coordinator?

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

Comments

If more hours than paid as coordinator

6. On average, how many hours per week do you work as a SAFE Coordinator?

SAFE Coordinator, continued

7. Do you also work as an RN clinically?

- ◯ Yes
- ◯ No

If yes, how many hours per week do you work as an RN?

2011 SAFE Coordinator Survey

8. Approximately how many times in your career have you testified in court on a sexual assault case?

9. If you know, how many times have you testified as a

Fact witness?

Expert witness?

Both?

SAFE Program

10. Name of hospital/facility

11. How do you track data on your SAFE program?

- [ ] Hospital-based record/data system
- [ ] System you have developed (please describe below)
- [ ] I do not track data on our program
- [ ] Other (please describe below)

Please describe

12. Has your SAFE program received any grants?

- ◯ Yes
- ◯ No
- ◯ Unsure

If yes, please list grant funding sources to the best of your ability:

13. Do you/does your hospital conduct SAFE exams on suspected offenders?

- ◯ Yes
- ◯ No
- ◯ Unsure

Comments

SAFE Adult/Adolescent Programs

2011 SAFE Coordinator Survey

If you do not currently coordinate an adult/adolescent SAFE program, please skip to the end of this page and click "next."

14. Year your Adult/Adolescent SAFE program began?

15. For this question, please answer in total numbers, not percentages. If you do not know the exact number, please provide the best estimate for each question. Remember that this set of questions pertains only to adult/adolescent patients, not pediatric.

For the year 2010, how many:

Total sexual assault patients did you see?

Male sexual assault patients did you see?

Received forensic SAFE exams?

Received medical treatment only?

Received a "Jane Doe" or "John Doe" SAFE exam?

Converted a Jane/John Doe to a law enforcement report at a later date?

For how many exams was a victim advocate present?

16. On adult/adolescent SAFE patients do you always test for the following:

- [ ] Blood alcohol level?
- [ ] Urine drug toxicology screen?
- [ ] Sexually transmitted infections?

Comments

17. What is your program's protocol in regards to providing follow-up with sexual assault patients?

18. Are your SAFE kits stored:

- [ ] In the hospital?
- [ ] By local law enforcement?
- [ ] By state police?
- [ ] Other (please specify)

2011 SAFE Coordinator Survey

19. For how long are "Jane Doe" kits stored in your jurisdiction?

- ◯ 30 days
- ◯ 60 days
- ◯ 90 days
- ◯ 6 months
- ◯ 1 year
- ◯ 2 years
- ◯ Unsure
- ◯ Other (please specify)

20. Are victims notified before their kits are destroyed?

- ◯ Yes
- ◯ No
- ◯ Unsure

If yes, which agency contacts them?

21. Does your hospital/facility routinely call a victim advocate when a sexual assault patient arrives?

- ◯ Yes
- ◯ No

If no, describe how the decision is made whether to call a victim advocate:

22. To which part/s of the SAFE exam do patients most commonly refuse or have trouble consenting, if any?

23. Please explain the process by which a sexual assault patient would obtain access to her/his records and what records they would be able to receive:

2011 SAFE Coordinator Survey

SAFE Pediatric Program

If you do not currently coordinate a pediatric SAFE program, please skip to the end of this page and click "next."

24. Year your pediatric SAFE program began?

25. Please provide actual numbers (not percentages) for the following. If you do not know the exact number, please provide the best estimate.

Number of acute (<72 hours) pediatric sexual assault patients in 2010:

Average # of hours spent on an acute pediatric exam:

Number of chronic (>72 hours) pediatric sexual assault patients in 2010:

Average # of hours spent on a chronic pediatric exam:

SAFE Staffing, Facilities, Administration

26. Please provide current numerical data for the following questions:

Number of FNE-As on staff:

Number of FNE-As who take call:

Number of FNE-Ps on staff:

Number of FNE-Ps who take call:

Minimum number of required on-call hours per month:

On average, how many hours per month do your FNEs take call?

On average, how many hours per week do your FNEs work as staff RNs and/or primary/"other" job?

27. Do you have a designated SAFE exam room that is used only for SAFE patients?

- ◯ Yes
- ◯ No

28. Do you have a designated office for your SAFE program?

- ◯ Yes
- ◯ No

If yes, is it near your exam room?

2011 SAFE Coordinator Survey

29. Is every SAFE patient first seen by an Emergency Department (ED) provider for medical clearance?

- ◯ Yes
- ◯ No

If no, please explain

30. Is your SAFE program managed by the ED?

- ◯ Yes
- ◯ No

If no, where?

31. Please describe how your work is supported (or not) by your ED administration.

32. Please describe how your work is supported (or not) by your hospital/facility's administration.

33. Does your SAFE program have its own cost center?

- ◯ Yes
- ◯ No
- ◯ Unsure

34. Who does the billing for your SAFE exams?

- ☐ SAFE Coordinator
- ☐ Billing department
- ☐ Other (please specify)

35. What is your hourly on-call pay rate?

2011 SAFE Coordinator Survey

36. What/how do you pay your FNEs when doing a case?

- [ ] Flat dollar amount per case
- [ ] Hourly rate plus differential
- [ ] Flat hourly rate no differential
- [ ] Extra for holiday, weekend, night, or being a preceptor
- [ ] Other (please specify)

37. How many FNEs do you typically have on call at any time?

38. Do you utilize more than one FNE during the exam?

- ◯ Yes
- ◯ No

If yes, please explain

39. Do you utilize another staff member/s (not FNE) to help with exam procedures?

- ◯ Yes
- ◯ No

If yes, please explain

40. Do you have your new FNEs sign a contract upon hire?

- ◯ Yes
- ◯ No

If sign contract

2011 SAFE Coordinator Survey

41. What does the contract include?

- [ ] Minimum hours required
- [ ] Number of months/years required to stay in SAFE program
- [ ] Amount owed back to facility if doesn't fulfill contract
- [ ] How long after FNE certification does RN get reimbursed for class/clinical education
- [ ] Amount RN is reimbursed for education
- [ ] Other (please specify)

SAFE Staffing, Facilities, Administration continued

42. Has your SAFE program experienced any of the following sustainability issues in the past or currently?

- [ ] Recruitment
- [ ] Retention
- [ ] On-call scheduling holes
- [ ] Shrinking demand
- [ ] Growing demand
- [ ] Funding concerns
- [ ] Other (please specify)

43. How do you maintain FNE staff morale and job satisfaction?

- [ ] Case reviews
- [ ] Education/training
- [ ] Mental health breaks
- [ ] Peer presentations
- [ ] Social activities (e.g., luncheons)
- [ ] Team building activities
- [ ] Vicarious trauma treatment
- [ ] Other (please specify)

2011 SAFE Coordinator Survey

SAR(R)Ts and Professional Networks

44. Do you actively participate in your local Sexual Assault Response & Resource Team (SART or SARRT)?

- ◯ Yes
- ◯ No

If no, why?

45. Who is the coordinator of your SAR(R)T? (List name and/or professional title.)

46. How often does your SAR(R)T meet?

- ◯ Monthly
- ◯ Every other month
- ◯ Quarterly
- ◯ Irregularly
- ◯ There is no SAR(R)T in my jurisdiction
- ◯ Other (please specify)

47. Who are the members of your SAR(R)T?

- ☐ Crime lab personnel
- ☐ Forensic nurse/s
- ☐ Law enforcement
- ☐ Military personnel
- ☐ Physician/s
- ☐ Probation & parole
- ☐ State's Attorney's office
- ☐ University staff
- ☐ Victim advocate/s
- ☐ Other (please specify)

2011 SAFE Coordinator Survey

48. Does your SAR(R)T have a current signed Memorandum of Understanding (MOU)?

- ◯ Yes
- ◯ No
- ◯ Unsure

If yes, when was it last revised?

49. In your jurisdiction, how would you rate the communication & cooperation levels between:

	1: Very poor	2: Below average	3: Average	4: Good	5: Excellent
FNEs and law enforcement	◯	◯	◯	◯	◯
FNEs and the Office of the State's Attorney	◯	◯	◯	◯	◯
FNEs and victim advocates	◯	◯	◯	◯	◯

Further comments on communication between FNEs and community partners in your jurisdiction?

50. Do you actively participate in Maryland Board of Nursing (MBON) meetings?

- ◯ Yes
- ◯ No

If no, why?

51. Are you a member of the International Association of Forensic Nurses (IAFN)?

- ◯ Yes
- ◯ No

If no, why?

52. Are you a member of the MD-DC chapter of IAFN?

- ◯ Yes
- ◯ No

If no, why?

2011 SAFE Coordinator Survey

53. Do you subscribe to the national [IAFN_SANE] listserv?

- ◯ Yes
- ◯ No

If no, why?

54. Are you a member of any other professional membership association or violence against women organization (such as MCASA)?

- ◯ Yes
- ◯ No

If yes, please list memberships

55. Do you subscribe to any academic journals or other publications regarding forensic nursing practice and/or sexual assault?

- ◯ Yes
- ◯ No

If yes, please list subscriptions

56. For pediatric programs only:

	Yes	No
Do you actively participate with CHAMP?	◯	◯
Do you use Telecam?	◯	◯

Comments

MCASA and other statewide efforts

2011 SAFE Coordinator Survey

57. Have you visited the new wiki site for SAFE coordinators? (safefnemaryland.pbworks.com)

- ◯ Yes
- ◯ No

If no, why?

58. Have you attended any statewide SAFE coordinator meetings in 2011?

- ◯ Yes
- ◯ No

If no, why?

59. On what topics would you, as a Coordinator, like more training? (You may list topics not specific to FNE practice, such as leadership training)

60. On what topics do you think your FNEs need more training?

61. Are there any technical assistance or training efforts that MCASA could potentially make available that are not currently provided? If so, please make suggestions here.

Closing

2011 SAFE Coordinator Survey

62. If you have other comments about this survey, your role as a coordinator, or FNE practice in the state of Maryland, please use the space below.

Thank you very much for your participation. Please email Amanda Cardone, SAFE/SART Manager at acardone@mcasa.org if you have any questions.

SAFE

mcasa
Maryland Coalition Against Sexual Assault

mcasa.org | 410-974-4507 | info@mcasa.org

1517 gov. ritchie highway, suite 207
arnold, maryland 21012