ARKANSAS COMMISSION ON CHILD ABUSE, RAPE AND DOMESTIC VIOLENCE

University of Arkansas for Medical Sciences

Healthcare Protocol Manual for Sexual Assault

ARKANSAS COMMISSION ON CHILD ABUSE, RAPE AND DOMESTIC VIOLENCE

The Arkansas General Assembly created the Arkansas Commission on Child Abuse, Rape, and Domestic Violence by Act 727 of 1991. The following groups were merged as a result of this act: the Governor's Task Force on Rape, the Arkansas Child Sexual Abuse Commission, and the Governor's Advisory Committee on Crime. The merger was intended to enhance the coordinated approach in providing services to victims of child abuse, rape, and domestic violence.

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1. Introduction

Sexual violence is a significant and prevalent public health problem. According to the 2010-2012 national Intimate Partner and Sexual Violence Survey, 21.4% of women in Arkansas have been raped at some time in their lives, including completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration. However, this is likely a very conservative estimate because it does not include men, children or other forms of sexual violence. Sexual violence means enormous physical and psychological consequences for victims and their families. It can damage one's sense of safety in the world, self-esteem, educational development and later, the ability to be a productive citizen.

There are many myths about sexual violence that contribute to the pain a victim experiences. For instance, many people believe the majority of sexual assaults are perpetrated by strangers. However, according to the 2010-2012 National Intimate Partner and Sexual Violence Survey, most victims of rape and sexual assault knew the perpetrator. Another common belief is that there is a great deal of false reporting. According to the FBI, "False reports of rape are rare, occurring only 2 to 8 % of the time" (FBI, 1995).

Imagine what it might be like to be a victim of sexual violence who has come to a health care facility for a sexual assault examination. Consider what it must be like to endure such an intrusive examination after surviving the trauma of an assault. Now imagine having to answer a seemingly endless list of questions about this experience to a number of total strangers who may have negative attitudes and beliefs about sexual assault.

Individuals who experience this trauma deserve competent and compassionate care. Having a positive experience with the healthcare and criminal justice system can have a great impact on the healing process for a victim. A victim-centered approach recognizes that people who have been sexually assaulted are central participants in the sexual assault examination process and deserve timely, compassionate and respectful care.

The purpose of this publication is to educate Arkansas healthcare professionals about responding to the needs of adult sexual assault victims. This manual was specifically designed as a guide for health care professionals who respond to victims of sexual assault. It is important to note that the term "victim" is used as well as the term "patient" because this manual addresses a multi-disciplinary response. The term "victim" simply acknowledges that persons who have disclosed sexual assault should have access to needed services in an effort to help them recover, be safe and seek justice. The

term "patient" is used when discussing the role of healthcare providers. We hope this manual will be helpful in assisting communities to develop victim-centered care that is sensitive to the needs of sexual assault patients.

Definitions

The following is intended as an introduction to terms that might be useful to those professionals providing services to sexual assault patients. Many of the terms are explained throughout the text; however, it may be helpful to read over the terms in advance.

A

Abuse: Term used to describe behavior by one party that results in significant negative emotional or physical consequences on another party. Also described as harmful or injurious treatment.

AIDS (Acquired Immuno-deficiency syndrome): Illness triggered by infection with HIV (human immunodeficiency virus). It is transmitted in body fluids, usually blood or semen, through sexual contact or the shared use of needles, accidental needle sticks or contact with contaminated blood. AIDS causes a weakening of the immune system leaving the body vulnerable to opportunistic diseases.

Assault: Arkansas law states a person commits assault: if he recklessly engages in conduct which creates a substantial risk of death or serious physical injury to another person; or which creates a substantial risk of physical injury to another person; or if he purposely creates apprehension of imminent physical injury in another person.

B

Battery: The unlawful touching of another without their consent.

Bindle: a leak proof container/package that securely holds collected evidence, trace materials or foreign matter; can be constructed of clean table paper folded in thirds, then thirds again, then in half.

Bull's eye injury: a patterned injury assuming the shape of the offending object; whether circular, linear oval…; there is a pale center with a hypervascular, petechial or contused surrounding.

C

Care: The concept of 'care' was first defined by Florence Nightingale who stated that care was 'putting the patient in the best possible condition for nature to act upon him'. Care further is defined as "to be concerned or interested"

Chain of custody: Chain of Custody or Chain of Evidence: steps taken to ensure that everyone who has handled/taken possession of a particular piece(s) of evidence along the continuum from initial collection to presentation in court has documented their handling of said evidence in writing, with appropriate signatures, date and time of receipt and release.

Child abuse: Behavior of a parent, guardian or other adult that results in significant negative emotional or physical consequences for a child. Abuse may be identified as emotional abuse, physical abuse, neglect or sexual abuse.

A Child Advocacy/Safety Center (CAC/CSC): A not-for-profit child friendly facility that provides a location for forensic interviews, advocacy services and access to specialized medical examinations and trauma focused mental health services during the course of a child maltreatment investigation.
Child neglect: Failure on the part of a parent, guardian or other adult to provide the necessities of life such as adequate living conditions, nutrition, education, medical care, failure to provide adequate emotional support, stimulation or to adequately supervise or protect the child.

Circumstantial: Usually refers to evidence that is indirect and concerning matters surrounding an event, rather than the event itself. It may or may not be relevant to the situation or case being considered.

Clinical forensic medicine: Study and practice which applies the principles of medicine to patients of trauma, involving the scientific investigation of trauma and the processing of forensic evidence.

Colposcope: A binocular instrument with variable magnification capabilities used to assist in the detection of injuries; can be equipped with a camera or video to provide photo documentation.

Commercial Sexual Exploitation of Children (CSEC): This term refers to a range of crimes and activities involving the sexual abuse or exploitation of a child for the financial benefit of any person or in exchange for anything of value (including monetary and non-monetary benefits) given or received by any person.

Compassion Fatigue: A state experienced by those helping people in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it is traumatizing for the helper.

Confidentiality: Protection of individual's privacy by keeping their private information unknown to others.

Coroner: A public official who is primarily charged with the duty of determining how and why persons under their jurisdiction die. A coroner is generally an elected county official.

Crisis intervention: A facilitated process that brings concerned individuals together to take action to assist with a victim's emotional recovery after a crisis by providing support in a non-judgmental manner while engaging in assessment, treatment, advocacy, planning, etc.

D

Defense wounds: Wounds made as the victim attempts to defend him or herself against an attack. Defense wounds are most often associated with injuries to the hands and arms, but can be on any part of the body that is used as a shield.

DNA (deoxyribonucleic acid): The genetic material contained in the cells of the body which provides the developmental plan that makes each individual unique, with the exception of twins. DNA acts as a 'genetic blueprint'.

Deposition: A sworn statement of evidence. Given under oath and recorded for legal proceedings. It is a method of pretrial discovery in which the statement of a witness is taken under oath in a question and answer format.

Deviate sexual activity: Arkansas law states deviate sexual activity means any act of sexual gratification involving the penetration, however slight, of the anus or mouth of one person by the penis of another person; or the penetration, however slight, of the labia majora or anus of one person by any body member or foreign instrument manipulated by another person.

Domestic violence: A pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners. Also called interpersonal violence or intimate partner violence.

Double-swab Technique: A technique used to collect dried secretions, such as salvia, semen or blood.

Drug-facilitated Sexual Assault (DFSA): The use of drugs or alcohol to facilitate sexual assault. Alcohol is the most frequently used substance, which the victim may consume voluntarily which does not negate the fact that a sexual assault has occurred.

E

Ecchymosis: also referred to as bruises; hemorrhagic area of the skin or mucous membrane; blackish-blue and purple, commonly changing to greenish-brown, then yellow.

Elder abuse: Elder abuse is any form of mistreatment that results in harm or loss to an older person. It is generally divided into the following categories:

- **Physical abuse** is physical force that results in bodily injury, pain, or impairment. It includes assault, battery, and inappropriate restraint.
- **Sexual abuse** is non-consensual sexual contact of any kind with an older person.
- **Domestic violence** is an escalating pattern of violence by an intimate partner where the violence is used to exercise power and control.
- **Psychological abuse** is the willful infliction of mental or emotional anguish by threat, humiliation, or other verbal or nonverbal conduct.
- **Financial abuse** is the illegal or improper use of an older person's funds, property, or resources.
- **Neglect** is the failure of a caregiver to fulfill his or her care giving responsibilities.
- **Self-neglect** is failure to provide for one's own essential needs.

EMT (emergency medical technician): A trained medical technician who provides a wide range of emergency services at the scene, during transport to the hospital or in other locations. An EMT is usually licensed or credentialed after one year of formal education or completion of a recognized training program and/or testing.

Emergency contraception: Used to prevent pregnancy after sexual intercourse by stopping ovulation, fertilization or implantation. It is most effective if taken within 72 hours but has some efficacy out to 120 hour following unprotected sex.

Evidence preservation: The collection, labeling, fixing, packaging and storing of items that will provide for no alteration of the quality or composition of the evidence.

Evidence, trace: The trace evidence section of the Arkansas State Crime Lab analyzes hairs, fibers, gunshot residue, ignitable liquids, glass, paint, soil, lamp filaments, duct tape, plastics and other materials as requested. The forensic biology section analyzes body fluids, blood, semen, saliva, etc.

Evidence, transfer: Physical evidence that is produced by contact of persons or objects. For example, a person brushing against another person might transfer hairs, dirt or debris.

Evidence, transient: A type of physical evidence that is temporary in nature. It is expected to change. Might include things such as temperature, imprints, indentations, odor, etc.

Expert consultant: A person with specialized knowledge or experience that reviews a case to provide analysis. Does not have to be associated with expectation to testify in court.

Expert testimony: Testimony in court by a person with specialized knowledge or experience. The expert witness must possess greater understanding of the subject than the jury. The expert witness is often described as one who can "educate the jury" on the specialized nature of certain information in the case.

F

Female genital mutilation: A term used to refer to the removal of part, or all, of the female genitalia.

Forensic: Belonging to, used in, or suitable for courts of judicature or to public discussion and debate. Comes from a Latin word which means forum or market place where legal disputes were settled in the Roman era.

Forensic Nurse Examiners: A nurse who is with specialized trained in the process of collecting forensic evidence.

G

Gamma Hydroxy Butyrate (GHB): drug used in DFSA; illegal to sell, make or possess in the US. A.K.A.: liquid ecstasy; scoop; easy lay; Georgia Home Boy; Grievous Bodily Harm; Liquid X.

Gerophilia: A desire for sexual relations or activities with elderly persons.

H

HIV (Human immunodeficiency virus): Any of a group of retroviruses that infect and destroy helper T-cells of the immune system.

Hymen: A membranous tissue that partly occludes the external vaginal orifice.

I

Incest: Sexual intercourse, deviate sexual activity or marriage of person 16 years of age or older with a person 16 years of age or older, that is an ancestor or descendant, stepchild or adopted child, brother or sister of the whole or half blood, an uncle, aunt, nephew or niece or a step- grandchild or adopted grandchild.

Informed consent: An ethical and legal principle that requires persons be allowed to make competent decisions about their care.

K

Ketamine: A drug used in DFSA; has a legal use as an animal tranquillizer. A.K.A.: jet, super acid, Special "K", green, K, cat Valium, Kit-Kat.

L

Labia majora: Two rounded folds of tissue that make up the external boundaries of the vulva. They are the visible folds of the adult female genitalia.

Labia minora: Two folds of tissue that lie beneath the labia majora.

M

Malpractice: A professional's improper conduct in performance of duties.

Medicolegal: Pertaining to law and medicine.

Morbidity: State of being diseased. The number of sick persons or cases of disease in relationship to a described population.

Mortality: The death rate. This is the ratio of the number of deaths in a described population.

N

Neglect: Any omission of an act which causes significant negative emotional or physical consequences.

Negligence: Failure to exercise the degree of care that a responsible, prudent person would exercise under the same or similar circumstances. Falls below the established professional standards.

P

Patterned injury: An injury that forms a distinctive shape that reflects the object it is inflicted by. For example, the circular line pattern of a looped electrical cord, used as a weapon to strike.

Pedophilia: A desire for sexual relations or activities with children.

Penetration: Arkansas law states penetration occurs if there is passage into or through, however slight, of the anus or mouth of one person by the penis of another person; or of the labia majora or anus of one person by any body member or foreign instrument manipulated by another person.

Petechia: Pinpoint, flat, round, purplish red spots caused by intradermal or submucous hemorrhage.

Plaintiff: The party that institutes a legal suit in the court system.

Pornography: The depiction of erotic behavior in pictures or writing that is intended to bring about sexual excitement.

Prosecutor: The attorney empowered to act on behalf of the government and the people.

Post-traumatic Stress Disorder (PTSD): an anxiety disorder that can occur following the experience or witnessing of life-threatening events. Victims with PTSD are unable to function at normal levels or have difficulties in one or more areas. The four major symptoms PTSD are: re-experiencing the trauma; social withdrawal; avoidance behaviors and actions; and increased physiological arousal

characteristics. Patients that have been sexually assaulted may experience PTSD related to sexual assault. This is also referred to as Rape Related PTSD.

R

Rape: Arkansas law defines Rape as sexual intercourse or deviate sexual activity by forcible compulsion; or with one who is incapable of consent because they are physically helpless, mentally defective, or mentally incapacitated; or with one who is less than 14 years of age; or with one who is less than eighteen (18) years of age, and the actor is the victim's guardian, uncle, aunt, grandparent, step-grandparent, or grandparent by adoption, brother or sister (whole or half blood) or by adoption, nephew, niece, or first cousin.

Perpetrators of rape may include acquaintances, intimate partners, spouses, family members, personal care assistant, or complete strangers.

Recidivism: The tendency to repeat or relapse into former patterns of behavior or repeat criminal activities.

Registered sex offender: Arkansas law states a person is required to register as a sex offender if the person is adjudicated guilty on or after August 1, 1997, of a sex offense; or is serving a sentence of incarceration, probation, parole, or other form of community supervision as a result of an adjudication of guilt on August 1, 1997, for a sex offense; or is committed following an acquittal on or after August 1, 1997, on the grounds of mental disease or defect for a sex offense; or is serving a commitment as a result of an acquittal on August 1, 1997, on the grounds of mental disease or defect for a sex offense; or was required to be registered under the Habitual Child Sex Offender Registration Act.

Rohypnol: A drug used in DFSA; illegal to sell, make or possess in the US A.K.A.: R-2, Mexican Valium, roofies, rophies, circles, the forget me pill. Rohypnol is the trade name for flunitrazepam which is a sedative-hypnotic benzodiazepine and still prescribed in Europe.

S

Sexual abuse: Involvement in sexual activities of developmentally immature children or adolescents or those unable to comprehend the nature of the activity or to give informed consent or in sexual acts that violate taboos or family relationships.

Sexual assault: A term used to describe any type of forced sexual activity on one person by another. This may include rape or any type of forced sexual contact.

Sexual contact: Arkansas law defines sexual contact as any act of sexual gratification involving the touching, directly or through clothing, of the sex organs, or buttocks, or anus of a person or the breast of a female.

Sexual intercourse: Arkansas law defines sexual intercourse as the penetration, however slight, of the vagina by a penis.

Sexual Assault Evidence Collection Kit: a sealed kit containing bindles or envelopes to hold various biological and reference specimens collected during the evidentiary exam. Also called the rape kit.

Sexual Assault Forensic Examiner (SAFE): see sexual assault nurse examiner

Sexual Assault Nurse Examiner (SANE): A registered nurse who possesses advanced skills in the evaluation of injuries consistent with forced sexual contact. SANE's perform medico-legal examinations, collect legal evidence, utilize psychosocial skills in aiding the patient and participate in legal proceedings as an expert witness in cases involving sexual assault. SANE's can be designated as "A" SANE for those trained in adolescent/adult response (post-pubertal to postmenopausal and other older adult patients) and P-SANE for those trained in pediatric response which also includes adolescent patients (birth to 18)."

Sexual Assault Response Team (SART): A coordinated, multidisciplinary team, which pursues a collaborative investigation, physical examination, treatment, counseling, and prosecution of sexual assault/abuse cases.

Stalking: Crime that occurs when someone knowingly engages in a course of conduct that would place a reasonable person in the victim's position under emotional distress and in fear for his or her safety or a third person's safety.

Subpoena: A paper issued under authority of a court to compel the appearance of a witness at a judicial proceeding, the disobedience of which may be punishable.

T

Tanner Staging: methodology of describing sexual development including breast development, pubic hair distribution, secondary sexual hair distribution, and penile development

Tear: injury of soft tissue resulting from ripping, overstretching, pulling apart, shearing, bending and/or blunt force.

Toluidine Dye (TB Dye): an aqueous, blue dye used to identify abrasions/lacerations by enhancing visualization of the genitalia.

Trafficking of Humans: The U.S. Government defines human trafficking as sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age or the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. (See also Commercial Sexual Exploitation of Children (CSEC).)

V

Verbal abuse: Use of words or language to bring about emotional or psychological injury.

Victim: One who is harmed by an act of another, a circumstance, or a condition.

Violence: Physical force for the purpose of damaging or abusing another person.

Chapter

2

2. Multi-Disciplinary Response

Effective treatment and intervention for sexual assault or abuse patients requires a team effort. Services will be provided by professionals and/or volunteers from differing disciplines. These team members may include representatives from law enforcement, emergency medical services, hospitals/healthcare facilities, physicians, Sexual Assault Nurse Examiners (SANE) and other healthcare professionals, victim advocates, State Crime Lab, mental health and/or disability providers, prosecutors and others. The patient is best served when the participating members of these disciplines strive for a coordinated approach.

Emergency Medical Services (EMS)

Members of EMS will provide initial assessment, stabilization and transport to the hospital if the patient has sustained injuries that require treatment on the scene. EMS may also become involved if the patient or others call for emergency care. The victim may dial 911 or other emergency number and EMS will respond to provide emergency care and transport while maintaining evidence preservation as much as possible.

Since much of Arkansas is served by Emergency First Responders and volunteers, it is essential that these departments and organizations receive training and education about care for sexual assault patients. They are integral partners in the multi-disciplinary response to sexual assault.

Hospitals/Healthcare Facilities

If medical care is required, the patient who has been sexually assaulted will often be treated initially in an Emergency Department. In some cases, care is provided at a community clinic or physician's office. Currently in Arkansas, the majority of forensic evidence collection exams for patients of sexual violence are done in Emergency Departments. A growing trend is to provide these services at sexual assault treatment centers outside the hectic atmosphere of the Emergency Department.

Physicians

Physicians commonly evaluate sexual assault patients in hospital emergency departments, clinics, offices, or child advocacy centers. They may be part of a formal multi-disciplinary team for the

evaluation and management of sexual assault. Physician examiners in most counties are considered part of an ad hoc case-specific team. Their responsibilities are to provide medical evaluations and treatment, interpret forensic findings, access existing systems for their patients, provide or refer for subsequent medical and mental health care, communicate effectively with other involved professionals, and testify in court if needed.

A-SANE

An A-SANE is an RN that has completed a didactic training program, demonstrated competence in the performance of sexual assault medical/forensic examinations of adults and adolescents and the related clinical skills, and has successfully passed the Forensic Nursing Certification Board. For more information go to www.IAFN.org. (International Association of Forensic Nurses, 2018).

P-SANE

A P-SANE is an RN that has completed a didactic training program, demonstrated competence in the performance of sexual assault medical/forensic examinations of pediatric and adolescent patients and the related clinical skills, and has successfully passed the Forensic Nursing Certification Board. For more information go to www.IAFN.org. (International Association of Forensic Nurses, 2018).

The state of Arkansas does not require certification to practice as a SANE or receive reimbursement from Arkansas Crime Victims Reparations Board and the Sexual Assault Reimbursement Program.

Law Enforcement

Representatives of law enforcement may include patrolmen, sheriff's deputies, investigators, detectives or others. In general, their initial responsibility is to protect the victim, protect the crime scene for evidence, collect evidence, take statements, document the circumstances as reported, and to arrange for transport to healthcare facility for examination, care and forensic evidence collection. In many areas, law enforcement will maintain responsibility for any evidence collected at the scene or during the forensic evidence collection exam until it is properly delivered to the Arkansas State Crime Lab for processing. Law Enforcement representatives will then attempt to locate and arrest the person who committed the assault.

Initial Law Enforcement Response: Many sexual assault patients will have their initial contact following the assault with a law enforcement officer. The primary responsibilities of this officer are to ensure the immediate safety and security of the victim, protect the crime scene and to obtain some basic information about the assault in order to apprehend the assailant. Resources and referral information for victim services should be provided. The officer may be able to transport the victim to a designated facility for examination and treatment dependent on agency guidelines.

The responding officer should convey the following information to the sexual assault victim:

- The importance of seeking an immediate medical examination. Despite the period of time elapsed since the assault, forensic evidence may still be gathered by documenting any findings obtained during the examination (i.e.: bruises, lacerations, etc.), photographs, bite-mark impressions (if appropriate) and statements about the assault made by the victim.
- The importance of preserving potentially valuable physical evidence prior to the hospital examination. The officer should explain to the victim that such evidence can be

inadvertently destroyed by activities such as washing, showering, brushing teeth, using mouthwash, douching etc.

- The importance of preserving potentially valuable evidence which may be present on clothing worn during the assault as well as on bedding or other materials involved at the crime scene. The officer should recommend that a change of clothes be brought along to the hospital in the event clothing is collected for evidentiary purposes.

Although intimate details of the sexual assault itself are not needed at this point in the investigation, a preliminary interview with the victim is necessary so that the responding officer is able to relay information that may be vital to the apprehension of the assailant. The preliminary interview should include the following:

- Description of any injuries to the victim.
- A brief description of what happened.
- Where the assault took place.
- The identity or description of the assailant(s), if known.
- Where the assailant(s) lives and/or works, if known.
- The direction in which the assailant left and by what means.
- Whether or not a weapon was involved.

At the examination or treatment facility, the responding officer should provide the healthcare provider with any available information about the assault which may assist in the examination and evidence collection procedures. This procedure also helps to avoid collecting evidence that has already been collected.

Law Enforcement Investigative Interview: Many police departments, especially within large metropolitan areas, have investigators or detectives whose duties include sexual assault investigations. These officers usually do not answer the initial call, but enter the case after the responding officer has written his/her report. Upon arrival at the examination or treatment facility, the investigator should talk with the responding officer and/or healthcare staff to obtain information about the assault and the condition of the victim.

In some cases, the investigator may conduct the follow-up interview after the victim has already been interviewed by the responding officer and the healthcare staff. Therefore, it is very important that the need for this third interview be explained to the victim, especially the reason why more detailed questions must be asked. Intimate details of the attack may be traumatic and embarrassing for the victim to recall. However, the details provide information that the investigator must have in order to develop an accurate picture of the circumstances surrounding the case and to prepare a report for the prosecutor.

General guidelines for the law enforcement investigative interview:

- The interview should be conducted after the medical-legal examination and evidence collection procedures have been completed. In some cases, it may be necessary to delay this interview for several hours or even until the next day. Often, delays at hospitals are caused by the length of time necessary for the medical examination and treatment of the victim and the priorities and demands of a busy Emergency Department.
- If the follow-up interview is conducted at the hospital or examination facility, it must be held in a private setting, where interruption is not likely. If a suitable arrangement cannot be made, the investigator should schedule the interview at a later time and place.

- With the consent of the victim, a support person who may have been present during the medical and evidence collection examination may also be present during this interview.
- The interviewer should be sympathetic and understanding of the victim's trauma while at the same time, effective in collecting all necessary information about the case.
- The interviewer should establish him/herself as an ally of the victim and try to cushion the victim from pressures by family, friends or others, as well as from possible harm or threats made by the assailant.
- The victim should be allowed to tell his/her story without interruption by the interviewer.
- The interviewer should go back over the story and, using the notes taken, ask specific questions covering any areas of the narrative that may have been incomplete or unclear. Be aware that trauma can affect memory recall.
- For children, the best practice is for the interview to be performed prior to the exam, if possible. Otherwise, the medical provider or medical social worker should obtain a medical history focused on information necessary to plan the child's medical care and make a report for investigation. A formal forensic interview should then be conducted by someone with a training specific to the forensic interview of a child which is often available at a community-based children's advocacy center on referral from an investigator. Children should be interviewed alone to avoid distraction or influence (verbal or nonverbal) by another person. Whenever possible, the investigator(s) should be present for the formal forensic interview to ensure all needed information is obtained at this time in order to avoid duplicating the interview process.

Transportation: Transportation should be arranged when the patient is ready to leave the hospital or examination facility. In some cases, this will be provided by a family member, friend or victim advocate who may have been called to the location for support. In other cases, transportation may be provided by the local law enforcement agency.

Victim Advocacy Programs

A sexual assault victim advocate provides crisis intervention and emotional support to victims of sexual violence. Advocates are generally available to respond to the Emergency Department anytime, day or night to provide support through the forensic exam process and assist the victim in making safety arrangements following the exam. Later, the advocate will follow-up with the victim to provide follow-up services, information and referral, and assistance throughout the criminal justice process.

In the aftermath of a rape, the advocate is usually present during the evidence collection and often provides referral information and clothing following the exam. Other assistance may include helping a victim access needed physical and mental health care; referrals of patients to various human services providers, arranging for provision of basic necessities, and assistance with medical care, law enforcement and legal systems with which their case is involved.

Crisis intervention is most effective when it is begun during the first few hours following a sexual assault. The advocate provides immediate support and can play a vital role in preventing the harmful consequences of rape and sexual assault and may decrease the probability of onset of rape-related post-traumatic stress disorder. The survivor has the best chance at emotional recovery if she/he is able to establish a rapport early with an advocate. (NOVA, 2001).

Mental Health Professionals

The role of mental health professionals is to provide supportive and re-integrative services to patients who have been sexual assaulted. These services may be provided immediately after the report of the assault, at the hospital or other facility, or as follow-up service. Counselors may also provide services such as support groups, crisis intervention, treatment or other forms of assistance. Arkansas now has many therapists who are trained in trauma-focused cognitive behavioral therapy. A list of TF-CBT therapists can be obtained at http://www.uams.edu/arbest/map.asp (select "trained clinicians" then click on the desired county).

Prosecutors, Judicial System

Prosecutors are licensed attorneys that represent the State of Arkansas against the accused also known as the defendant. The primary responsibility of prosecution is to see that justice is accomplished. In the case of rape or sexual assault, after an investigation by law enforcement and if there is sufficient evidence to file criminal charges, the prosecutor will file what is called an "information." The prosecutor's job going forward is to handle all aspects of trying the case. The judicial system is a broad term but generally speaking refers to the courts or judges. The judicial system's overall function is the search for "truth and justice" and to prevent future crime by the guilty offender(s).

Forensic Laboratory Scientists

The physical evidence (the sexual assault evidence collection kit and the patient's clothing) will be analyzed by the Arkansas State Crime Laboratory. Other items of evidence (such as bed sheets, vehicle seats, fingerprints, weapons, etc.) may be collected by the law enforcement officer. The items will be examined for body fluids, epithelial (skin) cells, hairs, fibers, debris or any other pertinent information. DNA analysis can be performed on items with semen, saliva, blood, or hairs. DNA analysis can also be performed on items with no body fluid from the perpetrator such as a vaginal swab where digital penetration is alleged. A report will be released to the law enforcement officer who submitted the case and then the analyst will testify in court as to their findings.

Sexual Assault Response Team (SART)

A SART, as defined by National Sexual Violence Resource Center, is a collection of professional service providers and officials that respond essentially as a group, and in a timely fashion, to the various needs of rape victims. At a minimum, core team members on a SART should include:

- Healthcare provider
- Law enforcement
- Prosecutor
- Victim advocates

Chapter

3

3. Comprehensive Treatment

This section is to be used by healthcare providers to ensure comprehensive care of sexual assault patients. When providing medical/forensic care to sexual assault patients, the sensitivity and competency of the care received will begin the process of recovery.

General Information

It is recommended that a healthcare provider (physician, nurse practitioner, or Sexual Assault Nurse Examiner) with specialized education and training in the evaluation and treatment of sexual assault patients complete the examination and provide treatment for these patients. In addition, it is also recommended for these providers to participate in ongoing continuing education specific to the care of sexual assault victims.

Most examinations for adults should be performed in a Sexual Assault Treatment Center or Hospital Emergency Department. These facilities are available 24 hours per day and have the appropriate equipment and staff to conduct the forensic evidence collection examination. Photo-documentation of examination findings is standard of care for sexual assault/abuse examinations in pediatric-aged patients which is often only available in a children's advocacy center or children's hospital emergency department.

Coordinated Team Approach

Recommendations At A Glance:

- Understand the dual purpose of the exam process.
- Be familiar with local services.

A Coordinated Team Approach among involved disciplines is strongly recommended to simultaneously address the needs of both patients and the justice system. Use of a coordinated, multidisciplinary approach in conducting the medical forensic examination can afford patients access to comprehensive immediate care, help minimize trauma they may be experiencing, and encourage the use of community resources. Raising

public awareness about the existence and benefits of a coordinated response to sexual assault may lead more patients to disclose the assault and seek the help they need.

Understand the dual purpose of the exam process.
One purpose is to address the medical needs of individuals disclosing sexual assault. This is by:

- Evaluating and treating injuries;
- Conducting prompt examinations;
- Providing support, crisis intervention, and advocacy;
- Providing prophylaxis against STDs;
- Assessing female patients for pregnancy risk and discussing prophylactic and treatment options, including reproductive health services; and
- Providing follow-up care for medical and emotional needs.

The other purpose is to address justice system needs. This is accomplished by:

- Obtaining a history of the assault;
- Documenting exam findings;
- Properly collecting, handling, preserving evidence; and
- Interpreting and analyzing findings (post exam); and
- Subsequently, presenting findings and providing factual and expert opinion related to the exam and evidence collection.

Be familiar with local support services. Services offered by advocates during the exam process may include:

- Accompanying the patient through each component (advocates may accompany patients from the initial contact and the actual exam through to discharge and follow-up appointments);
- Assisting in coordination of patient transportation to and from the exam site;
- Providing sexual assault patients with crisis intervention and support to help cope with the trauma of the assault and begin the healing process;
- Actively listening to patients to assist in sorting through and identifying their feelings;
- Letting patients know their reactions to the assault are normal and dispelling misconceptions regarding sexual assault;
- Advocating for patient's needs to be identified and their choices to be respected, as well as advocating for appropriate and coordinated response by all involved professionals;
- Supporting patients in voicing their concerns to relevant responders;
- Responding in a sensitive and appropriate manner to sexual assault patients from different backgrounds and circumstances and advocating for the elimination of barriers to communication;
- Serving as an information resource for patients (e.g., to answer questions, explain the importance of prompt law enforcement involvement if the decision is made to report, explain the value of medical and evidence collection procedures, explain legal aspects of the exam, help them understand their options in regard to treatment for STDs, HIV, and pregnancy, and provide referrals);
- Providing replacement clothing when clothing is retained for evidence, as well as toiletries;
- Aiding sexual assault patients in identifying individuals who could support them as they recover (e.g., family members, friends, counselors, employers, religious or spiritual counselors/advisors, and/or teachers);

- Helping patient's families and friends cope with their reactions to the assault, providing information, and increasing their understanding of the type of support sexual assault patients may need from them; and
- Assisting sexual assault patients in planning for their safety and well-being.

Victim-Centered Care

It is critical to respond to individuals disclosing sexual assault in a timely, appropriate, sensitive, and respectful way. Every action taken by responders during the examination process should be useful in facilitating the patient's care and healing as well as the investigation.

All licensed emergency departments shall provide prompt, appropriate emergency medical-legal examinations for sexual assault victims. All victims shall be exempted from the payment of expenses incurred as a result of receiving a medical-legal examination if the victim receives the medical-legal examination within ninety-six (96) hours of the attack. (AR Code12-12-403)

A medical facility or licensed healthcare provider shall not transfer the victim to another medical facility unless the victim or a parent or guardian of a victim under eighteen (18) years of age requests the transfer, or a physician or other qualified medical personnel when a physician is not available has signed a certification that the benefits to the victim's health would outweigh the risks to the victim's health as a result of the transfer; and the transferring medical facility or licensed healthcare provider provides all necessary medical records and ensures that appropriate transportation is available. (AR Code12-12-402)

Recommendations At A Glance:

- Sexual assault patients should have priority as emergency patients.
- Provide privacy.
- Recognize that the medical forensic exam is an interactive process that must be adapted to the needs and circumstances of each patient.
- Interpreter needs should be assessed and provided.
- Recognize it is the patient's decision whether or not, and to what extent, they share personal information.
- Recognize the importance of victim advocates within the exam process.
- Respect patient's request to have a person remain during the exam unless considered harmful.
- Try to limit the number of persons in the exam room during the exam.
- Carefully describe each exam procedure & its purpose.
- Respect sexual assault patient's decisions.
- Integrate medical and forensic exam procedures when possible.
- Assess safety.
- Physical comfort needs should be provided.
- Provide written information for sexual assault patients.
- Be familiar with various cultural issues faced by patients.

Sexual assault patients should have priority as emergency patients. Individuals disclosing a recent sexual assault should be quickly transported to the exam site, promptly evaluated, treated for serious injuries, and undergo a medical forensic exam.

Provide privacy. Use discretion to avoid the embarrassment of being identified as a sexual assault victim in a public setting. Make sure that the first responding health care providers attend to sexual assault patient's initial medical needs and arrange for an on-call advocate to offer onsite support, crisis intervention, and advocacy.

Recognize that the medical forensic exam is an interactive process that must be adapted to the needs and circumstances of each patient. Patient's experiences during the crime and the exam process, as well as their post-assault needs, may be affected by multiple factors. People have their own method of coping with sudden stress. When severely traumatized, they can appear to be calm, indifferent, submissive, jocular, angry, emotionally distraught, or even uncooperative or hostile towards those who are trying to help. Procedures should be adapted to accommodate each individual patient & situation.

Interpreter needs should be assessed and provided. Effective Communication is a critical element of the process and interpreters should be available for those patients in need.

Recognize that it is the patient's decision whether or not, and to what extent, they share personal information. While it is useful for responders to get a full picture of sexual assault patient's circumstances, it is the patient's decision. During the exam process, responders may ask information such as age or whether they think the assault was drug-facilitated. Questions about sexual orientation, religion or previous victimization are not necessary and are strongly discouraged.

Recognize the importance of victim advocates within the exam process. Sexual assault advocacy programs and other victim service programs, offer a range of services before, during, and after the exam process. Ideally, advocates should begin interacting with patients prior to the exam, as soon after disclosure of the assault as possible. Advocates can offer a tangible and personal connection to a long-term source of support and advocacy.

Respect patient's request to have a person remain during the exam unless considered harmful. An exception would be if responders consider the request to be potentially harmful to the patient or the exam process. Patient's requests not to have certain individuals present in the room should also be respected. Examiners should get explicit consent from sexual assault patients to go forward with the exam with another person present.

Try to limit the number of persons in the exam room during the exam. An advocate, personal support person or interpreter is appropriate, but only with patient's permission. The primary reason is to protect patient's privacy. Law enforcement representatives should not be present during the exam. Patient's permission should also be obtained when additional health care personnel are needed for consultation (e.g., a surgeon).

Carefully describe each procedure and its purpose. Some exam procedures may be uncomfortable and painful to patients, considering the nature of the trauma they have experienced. By taking the time to explain each procedure, its purpose and their options, patients may be able to relax, feel more in control of what's occurring, and make decisions about their needs.

Respect sexual assault patient's decisions. Although medical care and evidence collection may be encouraged during the exam process, responders should provide patients with information about all of their options and assess and respect their priorities.

Integrate medical and forensic exam procedures when possible. Medical care and evidence collection procedures can be integrated to maximize efficiency and minimize trauma to sexual assault patients. For example, draw blood needed for medical and evidentiary purposes at the same time. Also, coordinate information gathering by health care and legal personnel to minimize the need for sexual assault patients to repeat their statements.

Patient's safety should be addressed. Upon arrival at the exam site, health care providers should assess the patient's safety concerns. Follow facility policy on response to this and other types of threatening situations. Prior to discharge, assist patient in planning for their safety. Local law enforcement or victim advocates should be able to help a patient develop a safety plan.

Physical comfort needs should be provided. While the patient should not wash, bathe or change clothes prior to the sexual assault examination, provide an opportunity to wash in privacy (offering shower facilities if possible), brush their teeth, change clothes (clean and ideally new replacement clothing should be available), get food and/or a beverage, and make needed phone calls. They may also require assistance arranging for transportation to their home or another location.

Sexual Assault Information Packet

Offer sexual assault patients information that they can review later at their convenience.

- The crime (e.g., facts about sexual assault and related criminal statutes);
- Normal reactions to sexual assault (stressing that it is never the patient's fault), and signs and symptoms of traumatic response;
- Victims' rights;
- Victim support and advocacy services;
- Mental health counseling options and referrals;
- Resources for the patient's significant others;
- The examination—what happened and how evidence/findings will be used;
- Medical discharge and follow-up instructions;
- Planning for their safety and well-being;
- Examination payment and reimbursement information;
- Steps and options in the criminal justice process;
- Civil remedies that may be available to sexual assault victims; and
- Procedures for sexual assault patients to access their medical record or applicable law enforcement reports.

Informed Consent

The process by which fully informed patients participate in choices about their health care. Patients have the legal and ethical right to direct what happens to their body and from the ethical duty of the clinician to involve them in their health care.

Recommendations At A Glance:

- Seek informed consent, as appropriate, throughout the evaluation in accordance with state law and your hospital policy.

- Verbal and written information given to sexual assault patients to facilitate the consent process should be complete, clear, and concise.
- Make sure policies exist to guide seeking informed consent from certain populations.
- Be familiar with statutes and policies governing consent in cases of minor sexual assault patients, vulnerable adult patients, and those who are unconscious or intoxicated.

Seek informed consent as appropriate throughout the evaluation in accordance with state law and your hospital policy. There are two essential but separate consent processes—one for medical evaluation and treatment and another for the forensic exam and evidence collection. Sexual assault patients can decline any part or all of the examination. However, the informed consent process includes making patients aware of the impact of declining a procedure, as it may negatively affect the quality of care and the usefulness of evidence collection. It may also have a negative impact on a criminal investigation and/or prosecution.

Verbal and written information given to sexual assault patients to facilitate the consent process should be complete, clear, and concise. This information, along with consent forms, should be tailored to the communication skill level/modality and language of sexual assault patients. Encourage patients to ask questions. Make sure all signatures and dates needed are obtained on written consent forms and document consent or reasons for declining to consent as appropriate (either on the medical record or forensic report forms).

Make sure policies exist to guide seeking informed consent from those who have difficulty understanding written forms or spoken instructions. It is always important for examiners to assess a patient's ability to provide informed consent. In addition, facilities should have internal policies based on applicable jurisdictional statutes governing informed consent. The medical provider will generally need to assess whether the patient has the cognitive capacity to give consent for the examination, and, if not, the provider should follow their internal policies and jurisdictional statutes. A patient may be unable to give informed consent for a variety of reasons. These include being compromised by intoxicants, being unconscious, being under duress from other party, lack of fluency in the language spoken by the examiner, or inability on the part of the patient to understand the implications of the decision to give his or her consent. When informed consent cannot be given as a result of language differences between patient and examiner, an interpreter should be obtained. When the patient is unable to understand the questions being asked as a result of an intellectual disability (or another condition), the examiner may consider providing an accommodation such as finding someone who is able to explain the process more clearly in a way the patient can understand. Care should be taken not to invite a service provider whose interests may be served by wielding influence over the situation

Policies should include procedures to determine whether or not patients are their own guardians; if there is a guardian, to determine the extent of the guardianship; to obtain consent from a guardian if needed; and what to do if the guardian is not available or is suspected of abuse or neglect. Exam facilities should also have policies in place to address consent for treatment in cases in which patients are unconscious, intoxicated, or under the influence of drugs, and are therefore temporarily incompetent to give consent.

Be familiar with statutes and policies governing consent in cases of minor sexual assault patients, vulnerable adult patients, and those who are unconscious or intoxicated. In cases of adolescent sexual assault patients, jurisdictional statutes governing consent and access to the exam should be followed. For instance, a State statute may allow minors to receive care for STDs and

pregnancy, but not a medical forensic examination without parental or guardian consent. Exceptions to parental consent requirements also exist when the parent or guardian is the suspected offender or where the parent or guardian can't be found and the collection of evidence needs to be done quickly. In such cases, the law generally specifies who may give consent in lieu of the parent or guardian, such as a police officer, representative from the jurisdiction's children's services department, or judge.

In all cases, the medical forensic evaluation should never be done against the will of the patient. Responders should not touch sexual assault patients or otherwise perform exam procedures without their permission. It is not appropriate to physically or chemically restrain a patient to conduct an acute assault exam. Even if, in the case of a child, a parent provides informed consent for an acute sexual assault exam, the minor should assent to the exam if they are developmentally able to do so.

Confidentiality

Confidentiality is the expectation that anything revealed or any services provided will be kept private. Policies to protect the patient's personal health information related to the medical forensic examination must be followed. The confidentiality of records (as well as forensic evidence and photographic and video images) is intricately linked to the scope of patient's consent.

Recommendations At A Glance:

- Be sure jurisdictional policies address confidentiality issues related to the exam process.
- Consider the impact of the Federal privacy laws regarding health information on sexual assault patients.

Be sure that jurisdictional policies address the scope and limitations of confidentiality as it relates to the examination process and with whom information can be legally and ethically shared. Members of a SART or other collaborating responders should inform sexual assault patients of the scope of confidentiality with each responder and be cautious not to exceed the limits of patient consent.

Consider the impact of Federal privacy laws regarding health information on sexual assault patients. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations (found at 45 CFR Parts 160 and 164), established national standards for the protection of certain individually identifiable health information created or held by health care providers, health insurance companies, and health clearinghouses. The impact of these privacy laws on the provision of services to sexual assault patients is unclear, because interpretation of the laws depends on individual situations and the law of the particular State. Responders are encouraged to contact their state healthcare association for further discussion about the impact of the HIPAA regulations on their participation in the exam process.
(U.S. Department of Justice, Office of Violence Against Women, 2004).

Anonymous or Blind Reporting

Communities may want to consider alternatives to reporting such as anonymous or "blind" reporting. This is useful in cases where victims do not want to immediately report or are unsure about reporting, but are willing to make an anonymous report.

To develop an anonymous/blind reporting system, law enforcement agencies can:

- Establish and maintain a policy of patient confidentiality;
- Allow sexual assault patients to disclose the extent of information they wish to provide;
- Accept the information whenever patients are ready to provide it. A delay in disclosure is not an indicator of the validity of the statement;
- Develop procedures and forms to facilitate anonymous information from third parties (e.g., examiners);
- Clarify options with patients for future contact—where, how, and under what circumstances they may be contacted by the law enforcement agency; and
- Maintain these reports in separate files from official complaints to avoid inappropriate use.

Sexual assault patients making anonymous or blind reports and going through the medical forensic exam should be informed about jurisdictional policies regarding storage of evidence and exam payment. In some communities, it is a challenge to find adequate space to hold evidence in cases where a report has not been made.

Promote a victim-centered reporting process. Some approaches for communities to consider:

- Encourage patients to consent to the medical forensic history, an examination, and documentation regardless of whether an evidence collection kit is used.
- Explore the myriad reasons why patients are reluctant to report and how the actions or attitudes of agencies may help perpetuate these fears. Help agencies consider how to reduce reluctance and fears.
- Evaluate local trends regarding reporting and patient's involvement in the criminal justice system. Based on feedback, develop and implement a plan to improve multi-disciplinary response to sexual assault.
- Increase victim-sensitivity education for first responders (e.g., educate law enforcement investigators on interviewing versus interrogating skills, educate health care personnel to be compassionate and not blame patients for the assault, and educate prosecutors to be victim-centered in their approaches).
- Encourage criminal justice statistical reports that accurately reflect the frequency and severity of sexual assaults reported in a jurisdiction.
- Initiate community education, outreach, and services targeting groups that may be reluctant to seek assistance after an assault.
- Offer viable options for reimbursement of exam costs for which patients are responsible.
- Encourage the development of a coordinating council and/or SART to facilitate a more coordinated, victim-centered, comprehensive community response to sexual violence.
- Support the formation of specialized examiner programs, investigative and prosecution units, and sexual assault victim advocacy programs to handle these cases. Specialization can potentially increase the knowledge base and commitment of involved responders, increase adherence to jurisdictional protocols for immediate response to sexual assault, encourage a victim-centered response, and positively advertise services offered.
- Develop jurisdiction-wide public information initiatives on mandatory reporting—mandatory reporters need to know applicable statutes regarding reporting sexual assault cases that involve minors or adults with conditions that result in an inability to protect themselves from abuse. A toll-free hotline number exclusively dedicated to abuse reports may also help simplify reporting and ensure a written report of each case and referrals to appropriate agencies. Such a hotline could be operated at a State, tribal, regional, or local level. To encourage both reporting and follow-through, protective agencies that investigate these cases should work collaboratively

with local law enforcement agencies to ensure that each case is dealt with in the best possible manner and that further harm does not occur.

- In institutional settings such as prisons, jails, immigrant detention centers, nursing homes and assisted living programs, in victim treatment centers, and group homes, ensure that patients can report assaults to outside agencies and are offered protection from retaliation for reporting.
- In each case, strive to create an environment in which patients are encouraged to report and are supported throughout the criminal justice process and beyond. Even in those cases that do not develop beyond an initial report to the police, patients should feel that they are respected.
- After steps have been taken to identify and remove barriers to reporting sexual assaults, educate the public about the potential benefits of reporting, how to go about reporting, what happens once a report is filed, and jurisdictional legal advocacy services available (if any) for sexual assault patients. Build upon already existing public awareness efforts of local advocacy programs.

(Office of Violence Against Women, 2004).

Arkansas Guidelines for "Jane Doe" Rape Kit

On July 31, 2007 Act 676 of 2007 changed the law that required sexual assault victims to report and cooperate with law enforcement for reimbursement of the medical-legal examination. This law now states that a sexual assault victim does not have to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam and to be reimbursed for charges incurred. This law has created the need for guidance on implementation procedures. A committee made up of members from the Arkansas Commission on Child Abuse, Rape and Domestic Violence, Ozark Rape Crisis Center, University of Arkansas for Medical Sciences SANE Program, Arkansas State Crime Lab, Arkansas Department of Finance and Administration, the Arkansas Attorney General's Office and the Office of the Prosecutor Coordinator met over the course of several months and developed the following guidelines:

1. If a sexual assault victim presents for a medical-legal examination (rape kit) and does not want to report to law enforcement, perform the examination regardless. Studies show that victims, who initially do not want to pursue criminal action, may later change their minds.
2. Please keep the rape kit stored in your medical facility for a minimum of 60 days. This allows the victim 60 days to change his/her mind. Should the facility choose to do so, kits may be stored for longer than 60 days. With a rape kit available for later processing, law enforcement and prosecutors will be able to go forward with the case when the victim changes his/her mind.
3. The victim is not to be billed for services. For payment of the medical-legal examination;
   a. Complete the Sexual Assault Reimbursement Form attached to this memo. The form is also available on the Arkansas Attorney General's website at; http://www.arkansasag.gov/pdfs/SARP_Form.pdf
   b. Follow normal procedures in billing. Please note, however, that pursuant to the federal VOCA Crime Bill amendment federally financed benefits programs such as Medicaid, Medicare, Champus, or VA must be billed in cases when the victim is covered by these benefits.
   c. Submit the Sexual Assault Reimbursement Form along with the itemized statement to the Arkansas Crime Victims Reparations Board. Acceptance of payment of the expenses for the medical-legal examination by the Board shall be considered payment in full and bars

any legal action for collection. Questions regarding payment procedures may be directed to the Board staff at (501) 682-1020 or (800) 448-3014

Specific Populations

To gain a basic understanding of potential issues and concerns facing different groups of sexual assault patients, this section explores several specific populations. Clearly, this exploration is not inclusive of all populations of sexual assault patients, but a more comprehensive discussion on this topic is beyond the scope of this document.

Be familiar with issues commonly faced by sexual assault patients from specific populations. It is important to realize that for some patients, certain personal characteristics (e.g., culture, language skills/mode of communication, disability, gender, and age) may strongly influence their experiences in the immediate aftermath of a sexual assault and during the exam process.

Cultural Competency

- Understand that culture can influence beliefs about sexual assault, its victims, and offenders. It can affect health care beliefs and practices related to the assault and medical treatment outcomes. It can also influence beliefs and practices related to emotional healing from an assault. In addition, it can impact beliefs and practices regarding justice in the aftermath of a sexual assault, the response of the criminal justice system, and the willingness of victims to be involved in the system.

- Understand that some patients may be apprehensive about interacting with responders from ethnic and racial backgrounds different from their own. They may fear or distrust responders or assume they will be met with insensitive comments or unfair treatment. They may benefit from responders of the same background or at least who understand their culture.

- Be aware that cultural beliefs may preclude a member of the opposite sex from being present when patients disrobe. Also, it may be uncomfortable for patients from some cultures to speak about the assault with members of the opposite sex.

- Understand that patients may not report or discuss the assault because the stigma associated with it is so overwhelmingly negative. In some cultures, for example, the loss of virginity prior to marriage is devastating and may render patients unacceptable for an honorable marriage. Even discussing an assault or sexual terms may be linked with intense embarrassment and shame in some cultures.

- Recognize that some cultures (e.g., American Indian tribes) may have their own laws and regulations to address sexual assault, in addition to or in place of applicable jurisdictional laws. Responders should be familiar with procedures for coordinating services and interventions for patients from these communities.

- Be aware that beliefs about women, men, sexuality, sexual orientation, race, ethnicity, and religion may vary greatly among patients of different cultural backgrounds. Also, understand

that what helps one patient deal with a traumatic situation like sexual assault may not be the same for another patient.

- Help patients obtain culturally specific assistance and/or provide referrals where they exist.

- Be sensitive and understanding toward patient's language skills and barriers, which may worsen with crisis.

- Make every attempt to provide interpretation services and translated materials for patients who do not speak English. Use certified interpreters when possible and not patient's families or friends. Take the patient's country of origin, acculturation level, and dialect into account when responding or arranging interpretation. Remember to speak directly to patients when interpreters are used.

- Train interpreters about issues related to sexual assault, confidentiality, and cultural concerns whenever they are needed to facilitate communication in these cases.

Sexual Assault Patients with Disabilities

- Understand that patients are diverse and that disability is one aspect of the diversity that medical professionals encounter. There is also much diversity among people with disabilities.

- Be prepared to provide accommodations if requested. Accommodations may include providing written materials in electronic format, reading forms to the patient, providing a sign language interpreter, or facing a hard of hearing person while speaking.

- When requesting sign language interpreters, make sure the interpreter is holds a license to practice in Arkansas and that the person holds a high-level certification. Note that not all individuals who are Deaf or hard-of-hearing understand sign language or can read lips. Other means of communication such as the use of technology may need to be considered.

- Be aware that the risk of criminal victimization (including sexual assault) for people with disabilities is statistically much higher than for people without disabilities. People with disabilities are often victimized repeatedly by the same offender. Personal care assistants, direct support professionals, family members, or friends may be responsible for the sexual assault.

- Respect patient's wishes to have or not have personal care assistants, direct support professionals, family members, or friends present during the exam. Although these individuals may be accustomed to speaking on behalf of persons with disabilities, it is critical that they not influence the statements of patients during the exam process. If professional assistance is required (e.g., from a sign language interpreter or another service provider) this should be arranged.

- Speak directly to patients with disabilities, even when interpreters, intermediaries, or guardians are present.

- Assess a patient's level of ability and need for assistance during the exam process. Explain, the exam procedures to patients and ask what help they require, if any (e.g., people with physical disabilities may need help to get on and off the exam table or to assume positions necessary for the exam). Do not assume the patient will need assistance. Ask for permission before providing assistance, handling a mobility or communication device, or touching a service animal).

- It is critical that communication be as effective for patients with disabilities as it is for those without disabilities. Again, this may require the provision of accommodations such as word boards, speech synthesizers, materials in alternative formats, and access to interpreter services. Responders should familiarize themselves with the basics of communicating with an individual using these strategies or tools. Be aware that some patients with sensory disabilities may prefer communicating through a communication assistant who is familiar with their patterns of speech.

- Do not make assumptions about a person's intellectual ability based on the presence of a physical condition or disability.

- Recognize that, due to the lack of access to health care often experienced by people with disabilities, it may be the first time the patient has had an internal exam or they may have had a negative experience with an exam in the past.

Patients with Intellectual Disabilities

- Follow exam facility and jurisdictional policy for assessing adults' ability to consent to the exam and evidence collection. Again, note that guardians could be offenders.

- The procedure should be explained in detail in language the patient can understand. The patient may have limited knowledge of reproductive health issues and not be able to describe what happened to them. They may not know how they feel about the incident or even identify that a crime was committed against them.

- Keep in mind that, just like nondisabled patients, patients with disabilities may be reluctant to report the crime for fear of not being believed. They may not consent to the exam for fear of losing their independence. For example, they may live independently, but now because of assault, have to enter a long-term care facility if their personal care assistant assaulted them or may need extended hospitalization to treat and allow injuries to heal. This can be traumatic for people to lose their sense of security and familiarity within their environment.

- While a patient's disability may have resulted in them being targeted or more at risk to an assault, it is important to listen to their concerns and what the experience was like for them, and not focus on the disability. Treat them as a person and acknowledge the victimization. Assure them that it is not their fault that they were sexually assaulted. Offer resources on counseling and advocacy if they need support or if they are concerned about their safety in the future.

Male Sexual Assault Patients

- Help male sexual assault patients understand that male sexual assault is not uncommon and that the assault was not their fault. Many male patients focus on the sexual aspect of the assault and overlook other elements such as coercion, power differences, and emotional abuse. Broadening their understanding of sexual assault may help reduce their self-blame.

- Because some male patients may fear public disclosure of the assault and the stigma associated with male sexual victimization, emphasis may need to be placed on the scope of confidentiality of patient information during the exam process.

- Offer male patients assistance in considering how friends and family members will react to the fact that they were sexually assaulted (by a male offender or a female offender).

- Male patients may be less likely than females to seek and receive support from family members and friends, as well as from advocacy and counseling services. Their ability to seek support may vary according to the level of stigmatization they feel, the circumstances of the assault, the sensitivity of care they initially receive, and the appropriateness of referrals provided.

- Encourage advocacy programs and the mental health community to build their capacity to serve male sexual assault patients and increase their accessibility to this population. Requests by male patients to have an advocate of a particular gender should be respected and honored if possible.
  (Lipscomb, 1992)

Adolescent Sexual Assault Patients

- Adolescents may be brought to the exam site by their parents or guardians. The presence of parents or guardians creates an additional challenge for those involved in the exam process because they are often traumatized by their child's victimization.

- Understand that parents or guardians may blame patients for the assault if the patient disobeyed them or engaged in behaviors perceived as increasing risk for victimization.

- Health care providers must assess the physical development of adolescent patients and take their age into consideration when determining appropriate methods of examination and evidence collection. Involved professionals should be well versed in jurisdictional policies related to response to minor patients.

- Recognize that the sexual assault medical forensic evaluation may be the first time an adolescent female patient has an internal exam. There may be a need to go into detail when explaining what to expect.

- Adolescence is often a time of experimentation. Reassure these patients that regardless of their behavior (e.g., using alcohol and drugs, engaging in illegal activities, or hitchhiking), no one has the right to sexually assault them, and they are not to blame for the assault.

- Ideally, attending health care providers should gather information from adolescents without parents or guardians in the room, subject to patient's consent. The concern is that parents or guardians may influence or be perceived as influencing patient's statements.

- Inform patients, particularly those who do not involve parents or guardians in the exam process, of facility billing practices (e.g., that their parents may get a bill or statement of services provided).

Older Sexual Assault Patients

- Keep in mind that the emotional impact of the assault may not be felt by older sexual assault patients until after the exam when they are alone and become aware of their physical limitations, reduced resilience, and mortality. Fear, anger, and depression can be especially severe in older patients who are isolated, have little support, and live on a fixed income.

- Be aware that caretakers may sexually assault their older dependents. Offenders may bring patients to the exam site, and jurisdictional and facility policies should be in place to provide guidance on how staff should screen for and handle situations that are threatening to patients or facility personnel.

- Note that older patients are generally more physically fragile than younger patients and thus may be at risk for tissue or skeletal damage and exacerbation of existing illnesses and limitations.

- Older women are at an increased risk for vaginal tears and injury when they have been vaginally assaulted. Decreased hormonal levels following menopause result in a reduction in vaginal lubrication and cause the vaginal wall to become thinner and more friable. Because of these physiological changes, a Pedersen speculum, which is longer and thinner than the Graves speculum, should be used during the pelvic exam for evidence collection. Special care should also be taken to assess for intravaginal injury. In some older women, examiners will need to simply insert the swabs and avoid the trauma of inserting a speculum. If there are external tears in the introitus, internal injuries must also be considered. The recovery process for older sexual assault patients also tends to be longer than for younger patients.

- Hearing loss and other physical conditions due to advancing age, coupled with the initial reaction to the assault, may render older patients unable to make their needs known, which could result in prolonged or inappropriate treatment. Do not mistake this confusion and distress for senility.

- Health care personnel should follow facility policy for assessing a vulnerable adult's ability to consent to the exam and evidence collection, as well as involving adult protective services.

- Some older patients may want to talk about their perceptions of the role their age and physical condition might have played in making them at risk to an assault. Listen to their concerns and what the experience was like for them. Assure them that it was not their fault they were sexually assaulted. If needed, encourage further discussion on this issue in a counseling/advocacy setting.

- Older patients may be reluctant to report the crime or seek treatment because they fear the loss of independence. Although sometimes relatives wish to place older patients in an assisted living situation after an assault occurs, such an action is not always necessary or useful to a patient's recovery. When a change in living environment is truly needed, assist patients and their relatives in making plans that maximize independence yet enhance safety.

- Encourage use of follow-up medical, legal, and non-legal assistance. Older patients may be reluctant to seek these services or proceed with prosecution. For example, they may rely on family members for transportation and may not want to burden them by asking to be taken to post exam follow-up appointments.
(Office of Violence Against Women, 2004).

Lesbian, gay, bisexual, or transgender (LGBT) victims

- Intake forms and other documents that ask about gender or sex should allow patients to write in a response, or include transgender and intersex options. Make sure questions appropriately distinguish between sexual orientation (the gender(s) someone is attracted to), gender identity (the internal sense of being woman, man, or gender non-conforming), and their sex.

- Always refer to victims by their preferred name and pronoun, even when speaking to others. If unsure of what to call the person or what pronoun to use, ask. (i.e., she/her/hers, he/him/his etc.)

- Treat the knowledge that the person is LGBT as protected medical information subject to all confidentiality and privacy rules. Be aware that companions of LGBT victims may not know their
gender identity or sexual orientation.

Additional suggestions specific to victims who are transgender or gender non-conforming:

- It is critical to not show surprise, shock, dismay, or concern when you are either told or inadvertently discover that a person is transgender. Be particularly attentive to your body language – gasping, sighing, a sharp intake of breath, or widening eyes can all be very upsetting to someone who may worry that you are making a judgment or assessment of their body.

- Understand that transgender people have typically been subject to others' curiosity, prejudice, and violence. Keep in mind that transgender victims may be reluctant to report the crime or consent to the exam for fear of being exposed to inappropriate questions or abuse. If the victim does consent to an exam, it is important to explain what you want to do and why before each step, and respect their right to decline any part of the exam.

- Be aware that transgender individuals may have increased shame or dissociation from their body. Some use nonstandard labels for body parts, and others are unable to discuss sex-related body parts at all. Reflect the victim's language when possible and use alternative means of communication (such as anatomically correct dolls or paper and pen for the victim to write or draw) if necessary.

- Vaginas that have been exposed to testosterone or created surgically are more fragile than vaginas of most non-transgender women and may sustain more damage in an assault. There

may be additional layers of psychological trauma for patients with a male identity or a constructed vagina when they have been vaginally assaulted.

- Transgender male individuals who still have ovaries and a uterus can become pregnant even when they were using testosterone and/or had not been menstruating.
- Transgender people may engage in self-harm as a coping mechanism. However, cutting and genital mutilations are also frequently part of anti-transgender hate crimes. Be nonjudgmental and careful when documenting such injuries.
- Some transgender victims may want to talk about their perceptions of the role their gender identity might have played in making them vulnerable to an assault. Because of their value in possible prosecutions under hate crime laws, document any anti-transgender statements the victim says were made during the assault. Otherwise, listen to the victim's concerns and what the experience was like for them. Assure them that it was not their fault they were sexually assaulted. If needed, encourage discussion in a counseling/advocacy setting on this issue as well as on what might help them feel safer in the future.
- Ensure that all referrals given to a transgender victim have been trained on or have significant experience with the special needs of transgender survivors of sexual assault.
- Include opportunities for LGBT individuals to influence the development of sensitive responses for victims of sexual assault.

Chapter

4

4. Adult Medical/Forensic Exam

Recommendations At A Glance

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- Evidentiary Purpose
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Overview

The sexual assault evidentiary examination goes beyond addressing and treating the sexual assault patient's acute medical needs. The comprehensive examination, referred to as the medical forensic (or medical legal) exam is also used to properly collect, document, preserve, and maintain the chain of custody for evidence collected during the assessment and treatment of a patient presenting post sexual assault. The patient's account of events, the physical findings from the exam, along with the collected evidence, should be correlated to provide information that can be utilized to verify or negate details about the events. The patient needs to understand that the examination is a focused exam and does not provide routine medical care (e.g., pap smear).

In the majority of sexual assault cases the patient knows the suspect. Many suspects will admit to sexual contact; however, they will claim that it was consensual. Evidence collected, documentation of physical findings, and the patient's detailed account will assist in supporting or refuting force and/or coercion. However, the absence of physical trauma does not negate the occurrence of coercion and/or force nor does it prove that the encounter was consensual. Additionally, the presence of physical trauma does not prove that a sexual assault occurred. Correlation of physical findings (or lack of physical findings) with the patient's account of events is the focus of the medical forensic examination. *Therefore, it is necessary that the healthcare provider that takes the patient's history is the same person that performs the examination.* For the purpose of this text, the examiner will be referred to in the female pronoun, though males can perform the exams.

Each examiner will eventually develop a routine and flow for performing medical forensic examinations. It is important that each examiner follow the same sequence with each exam to ensure consistency and to avoid omissions. The exam needs to follow a logical sequence, and flow from least to most invasive questions and physical examination. At any time, the patient has a right to decline a portion of, or the entire exam.

Evidentiary Purpose

It is important to recognize the evidentiary purpose of the exam. During the exam, examiners methodically document physical findings and collect evidence from the patient's body and clothing. The findings in the exam and collected evidence often provide information to help reconstruct details about the events in question in an objective and scientific manner. Healthcare needs and concerns of patients that present in the course of the exam should be addressed prior to discharge and appropriate referrals made. However, patients must understand that the exam does not provide routine medical care. For example, a pap smear will not be done during the female pelvic exam.

Collect as much evidence from patients as possible, guided by the scope of informed consent, the medical forensic history, exam findings, and instructions in the evidence collection kit. Collected evidence is potentially used in four ways in sexual assault cases:

- identification of the suspect;
- documentation of recent sexual contact;
- documentation of injuries, force, threat, or fear; and
- to identify corroboration or contradiction between the patient's account and the evidentiary findings.

Remember, as a forensic examiner your job is to be objective. You advocate for your patient by providing an objective and comprehensive exam; however, as a forensic examiner you are not in the role of patient advocate.

Timing Considerations for Collection of Evidence

Currently the Arkansas Crime Reparations Board can provide reimbursement if the evidence kit is obtained within 96 hours post-assault. This in no way precludes an assessment and examination of a patient reporting sexual assault. Evidence may still be gathered through documentation of physical findings (such as bruises or lacerations), photographs, and statements about the assault made by the

patient. Additionally, the clothing the patient is wearing may contain evidence from the perpetrator and may need to be collected. Law enforcement officers may gather additional evidence such as bedding or towels from the scene.

While evidence collection in pediatric patients is not indicated past the 72 hour time window (96 hours if it is an adolescent girl with a history of vaginal penetration), detailed medical evaluations with photo-documentation of examination findings are still warranted beyond the 72 hour window since healed injuries and STD's could have forensic significance. Incidents involving kidnapping or extensive trauma may still warrant kit collection even if there is uncertainty regarding the time frame. Additionally, if the examiner feels that collecting a kit is warranted then he/she should proceed to do so.

The Arkansas State Crime Laboratory will provide kits free of charge. Kits may be obtained by sending a request to the Arkansas State Crime Laboratory via FAX at (501) 227-0713 or call (501) 227-5747 for an email address. Should any questions arise concerning the utilization of the kit, contact the Crime Laboratory at (501) 227-5747. The tracking of sexual assault evidence kits in the state of Arkansas in compliance with Arkansas Act 1168 of the 2015, 90th General Assembly is now available through a secure online tracking system. Authorized medical, law enforcement, and lab personnel shall manage the status of sexual assault evidence kits under the jurisdiction of their agency. Also, victims of sexual assault can view the history and current status of their sexual assault evidence kit. Healthcare providers will log into the system to accept sexual assault kits that have been sent to their facility.

A physical examination, referrals and follow up appointment should be provided in all cases of sexual assault, regardless of the length of time that has elapsed between the assault and the examination. Some patients may ignore symptoms which would ordinarily indicate serious physical trauma, such as strangulation, internal injuries sustained from blunt force trauma or foreign objects inserted into body orifices. Also, there may be areas of tenderness which will later develop into bruises that are not apparent at the time of initial examination.

Healthcare Providers

Healthcare providers who perform medical forensic examinations should have knowledge and skills in the following areas:

- The dynamics and impact of sexual victimization.
- Jurisdictional laws related to sexual offenses.
- Coordination of the multidisciplinary response, including the roles of each responding agency, and procedures for inter-agency communication.
- The importance of examiner neutrality and objectivity.
- The broad spectrum of potential evidence and physical findings in sexual assault cases.
- Pre-existing needs and circumstances of patients that may affect how the exam is conducted and interpreted.
- Screening, treatment options and procedures for common concerns such as

pregnancy, Sexually Transmitted Diseases (STDs), and Human Immunodeficiency Virus (HIV) infection.

- Equipment, supplies and medication typically utilized for a medical forensic history and examination.
- Precautions to prevent exposure to potentially infectious materials.
- Indications for follow-up health care and referrals.
- Applicable laws and protocols regarding performance of medical forensic exams and standardized forms used to document findings.
- Knowledge about crisis intervention, victim advocates, and referrals, including local resources and procedures for accessing resources.
- The importance of establishing procedures to ensure the quality of the exam and related documentation.
- Examiner court testimony (fact vs. expert witness).
- Applicable research findings, technological advances, evidence-based and promising practices.
- Gathering information from patients for a medical forensic history and utilizing the history as a guide when performing the medical forensic exam.
- Explaining to patients what items need to be collected for evidence and the purposes.
- Explaining the "Jane Doe" option for patients not wanting to report.
- Knowledge about required and optional reporting to law enforcement (LE) representatives and collaboration with LE to optimize the collection of evidence from patients, suspects, and crime scenes.
- Ability to identify and describe pertinent genital and anorectal anatomical structures and external landmarks.
- Identify and document injuries and interpret physical findings; including diagraming on anatomic body maps, providing a written description of the findings and forensic imaging.
- Use and limitations of enhancement techniques for detection of findings (such as Toluidine Blue Dye and/or a colposcope).
- Collect and preserve evidence for analysis by the crime laboratory.
- Collect and preserve toxicology samples in suspected alcohol or drug-facilitated sexual assault cases.
- Maintain and document the chain of custody for evidence.
- Maintain the integrity of the evidence to ensure optimal lab results.
- Recognize evidence-based conclusions and limitations in the analysis of findings.
- Discuss evidentiary findings with investigators, prosecutors, and defense attorneys (according to jurisdictional policy).

The above knowledge and skills are taught as a part of the sexual assault nurse examiner (SANE) training curriculum. To become a SANE in Arkansas, a registered nurse must complete appropriate didactic training that meets criteria set forth by the International Association of Forensic Nurses (IAFN). These courses are 40 hour didactic courses for specific populations – one for adult/adolescent and a separate for pediatric; or a combined course at 64 hours can be completed. To obtain certification, a registered nurse practicing at a minimum of 2 years as a nurse, must complete the appropriate didactic training course, subsequent supervised practice, and successfully pass the International Association of Forensic Nurses (IAFN) certification exam. The title A-SANE (sexual assault nurse examiner for adults and adolescents) and P-SANE (sexual assault nurse examiner for

pediatrics) are protected titles and require successful completion of IAFN requirements. Certification as an A-SANE and/or P-SANE signifies that a sexual assault nurse examiner has demonstrated the highest standards of forensic nursing practice (International Association of Forensic Nurses, 2013). Credentialing through IAFN is highly recommended. In addition, the Arkansas State Board of Nursing Rules and Regulations state that forensic examination and evidence collection is within the scope of practice of registered nurses in Arkansas (ASBN, 1997).

Facilities

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires emergency and ambulatory care facilities to have established policies for identifying and assessing victims of sexual assault. It also requires staff to be trained on these policies. As part of the assessment process, JCAHO requires these facilities to define their responsibilities related to the collection and preservation of evidentiary materials. Facilities should also be familiar with the federal Emergency Medical Treatment and Active Labor Act (EMTALA), which has provisions pertaining to the ability of hospitals to re-route patients with emergency medical conditions. If a transfer from the initial healthcare facility to another healthcare facility that has been designated as a sexual assault examination site is necessary, a protocol that minimizes time delays and loss of evidence should be utilized.

The facility should have procedures in place to accommodate the patient's communication skill level and preferred mode of communication. This is particularly important for patients with communication-related disabilities and non-English speaking patients. Family members and friends should not be used to interpret for the patient.

Room, Equipment and Supplies

The initial examination or triage of sexual assault patients is considered a medical emergency. Although many patients may not have visible signs of physical injury, they will, at the very least, be suffering from emotional trauma. A private location and quiet examination area should be utilized. Establishing a sexual assault response center or designating a private area in or near the Emergency Department is recommended. The designated room should have a pelvic table and attached bathroom to complete the interview, examination, evidence collection, and medication administration. If a designated room is not possible it may be advantageous to have a stocked, mobile cart. (A crash cart works nicely for this purpose). Once the collection process begins, the examiner MUST keep all evidence with him/her at all times. In the event the examiner has to leave the room, the cart could be wheeled with him/her. Whether using a designated exam room or a mobile cart, having all of the supplies accessible is essential. Items to stock in the designated room or on a mobile cart:

- Alcohol prep
- Betadine
- Distilled water
- 3 ml syringes
- Nonpowdered gloves
- Nail clippers
- Tweezers
- Extra swabs

- Blank index cards
- Clear packing tape
- Scaled ruler
- Tape measure/small ruler
- Envelopes
- Blank legal-sized white paper for bindles
- Lunch size paper bags
- Grocery size paper bags
- Roll of table paper
- 2 x 2's
- Lancets
- Dixie cups if no swab dryer available
- Extra pens
- Black Sharpie
- Extra evidence tape
- Required forms to be completed, including consent form(s)

In addition, plan to have the following equipment and supplies readily available for the exam, according to institutional and jurisdictional policies:

- A copy of the most current exam protocol used by the jurisdiction.
- Standard exam room equipment and supplies for a physical assessment and pelvic/rectal exam.
- Comfort supplies for patients, even if minimal. Suggested items include clean and preferably new replacement clothing, toiletries, food and drink, and a phone in a private a location (some advocacy programs will assist with comfort items).
- Sexual assault evidence collection kits and related supplies.
- A method or device to dry evidence. Drying evidence is critical to preventing the growth of mold and bacteria that can destroy an evidentiary sample. With any drying method or device used, ensure that the evidence is not contaminated. If a passive swab dryer is used there should be disposable locks available.
- A camera and related supplies for forensic photography during initial and follow-up examinations. Related supplies might include digital media, batteries and/or charger, a flash, a color bar, and a scale ruler for size reference.
- Laboratory testing supplies that may be needed, but are not included in the evidence collection kit. (i.e. cultures or supplies for toxicology).
- Medications, as appropriate for individual patient needs.
- An alternate light source which can aid in examining patient's bodies, hair, and clothing. It can be used to scan for evidence, such as dried or moist secretions, fluorescent fibers not visible in ambient light, and subtle injury.
- An anoscope may be useful for cases involving anorectal penetration or anal/rectal trauma to assist in visualizing the anal injury and identifying and collecting trace evidence. However, this is a technically advanced procedure and should not be performed unless the examiner is specifically trained in the use of an anoscope.
- Toluidine blue dye.
- For pediatric and adolescent exams, a colposcope or videoscope with the ability to capture magnified images of the ano-genital findings should be used. The colposcope is also preferred, but not required, for adult examination. Although some injuries can be detected visually by examiners without the colposcope, the colposcope enhances identification of microscopic

trauma. Photographic equipment, both still and video can be attached for forensic documentation.
- Evidence log book to record cases, support chain of evidence and track cases.
- Some jurisdictions, particularly those in rural and remote areas, are beginning to utilize advanced technology such as real-time video consultation, storing and forwarding video consultation, and interactive video consultation to support examiners conducting exams. Using this type of technology, examiners can eliminate the barriers of geography and consult with offsite medical experts. Equipment needed to facilitate use of telemedicine may include, but is not limited to, computers, software programs, and the Internet. Jurisdictions that utilize this technology should ensure confidentiality and have written protocols in place.
- Written discharge and educational materials for patients.

Triage

Many hospitals have developed code words to describe the care required for a patient presenting with a history of sexual assault. Designations such as "code R" or "code SA" work well for this purpose. This limits the need for describing the type of care required (sexual assault examination) in a public location where a breach of confidentiality might inadvertently occur. Institutions are encouraged to develop their own plan to ensure privacy.

Acute medical needs take precedence over evidentiary needs. Trauma care and safety needs should be addressed before the interview or evidence collection. Patients should be instructed not to wash, change clothes, urinate, defecate, smoke, drink, eat or take medication until evaluated by an examiner (unless necessary for treating emergency medical issues). If the patient needs to urinate prior to the medical forensic examination ensure that the urine sample is collected properly and the chain of custody is maintained.

The forensic examiner should be involved in all aspects of the medical forensic examination of the sexual assault patient. As soon as possible after the initial triage, management, and stabilization of acute medical problems and before treating non-acute injuries, the evidentiary exam should be conducted. When patients are seriously injured or impaired, examiners must be prepared to work alongside other health care providers who are stabilizing and treating the patient. In such cases, examiners may need to perform exams in a health care facility's emergency department, operating room, recovery room, or intensive care unit.

The importance of having a support person available to sexual assault patients cannot be overemphasized (although family members and friends should **not** be allowed to stay during the forensic interview and examination as it may influence the patient's disclosure). Additionally, these individuals could be subpoenaed as a witness. The use of trained sexual assault victim advocates is preferred. The patient should be asked for their consent to have an advocate present. The victim advocate can provide crisis intervention, support, act as liaison for family or friends of the patient, and provide items such as clothing, and referrals for support groups or counseling services, etc. A victim advocate can also help with other information such as the availability of victim compensation programs or other types of assistance.

Victim advocates are often available through non-profit organizations such as a sexual assault or rape crisis center, children's advocacy center, law enforcement, prosecutor's office or through other

programs. Most advocacy programs provide services during the initial response and evidentiary exam. Comprehensive advocacy programs offer follow-up services, including support for the patient throughout the entire criminal justice process.

Adult patients presenting for medical treatment as the result of a sexual assault, shall decide if they wish to report the incident to a law enforcement agency. The adult patient is not required to report the incident in order to receive a medical forensic examination and treatment. If a victim chooses to report a crime, the report should be made to the law enforcement agency where the assault occurred. Forensic evidence will be collected only with the permission of the patient. However, permission shall not be required in instances where the patient is unconscious, mentally incapable of consent, or intoxicated (Arkansas Attorney General, 2004).

Informed Consent

Prior to providing care, utilize the institution's standardized form(s) to obtain informed consent for the examination process; evidence collection (including any technology); and administration of medications. The full nature of procedures and options should be explained in detail. Some agencies use multiple consents (evidence collection, examination, medication administration, photography, Jane Doe information, etc.) and others utilize a single, comprehensive form. Follow institutional policy. Informed consent should be completed through formal documentation prior to the examination as well as receiving verbal consent from the patient throughout the entire examination process.

Documentation

It is vital that the documentation be thorough, precise, unbiased, and accurate. Examiners are responsible for documenting the medical forensic interview and examination; diagrammatic renderings with body maps; forensic imaging; treatment provided; patient education and documentation required for the evidence collection kit. The medical record is not part of the evidence collection kit. The complete medical forensic record of the sexual assault visit should be maintained separately from the patient's medical record to limit disclosure of unrelated information and to preserve confidentiality. The institution should have clear policies about who is allowed access to these records and under what circumstances.

Interview for Medical Forensic History

The forensic history of the assault is used to guide the exam, evidence collection, treatment and crime lab analysis findings. If an in-depth forensic history will not be performed prior to the medical evaluation, the medical provider will need to obtain enough information to plan the patient's medical care and guide the evidence collection. Collaboration and sharing of information between the medical provider and law enforcement is needed involved, they will collect information from patients for investigative purposes and to help identify the potential apprehend the suspect(s) and plan for the patient's safety. Examiners should focus their history ask only for on information related to treatment and collecting/interpreting physical and lab findings. While information related to patient safety and

evidence collection may need to be asked by the medical provider, asking investigative questions unrelated to the medical care of the patient could be considered is outside of their role and scope of practice. The patient may have difficulty communicating due to their emotional and physical condition. Therefore, there should be no interruptions and no time constraints for the interview and examination (Ledray, 1999).

Specific questions may vary from one jurisdiction to the next, as do forms for recording the history. Examiners should explain that questions, although probing in nature, are routine, necessary and asked during every sexual assault examination. However, in order to establish a rapport with the patient, the questions that are least invasive (medical history) should be asked prior to the more invasive questions (forensic history). The following information should be routinely sought from patients:

Pertinent patient medical history: This includes last menses, recent anal-genital injuries, surgeries, diagnostic procedures, medication, contraception, alcohol/drug use, blood-clotting history, and other medical conditions or treatment, as appropriate. Interpretation of physical findings may be affected by the history provided. Any allergies, especially to medication need to be ascertained as well. Date of the last Tetanus injection and Hepatitis B vaccination status should be obtained.

Date and time of the sexual assault(s): It is essential to know how much time has elapsed between the assault and the physical examination, collection of the evidence, and assessment of injuries. The interpretation of physical findings and evidence analysis is influenced by the passage of time.

Recent consensual sexual activity: This is due to the sensitivity of DNA analysis. Consensual sex consisting of anal, vaginal, and/or oral sex, and whether a condom was used needs to be ascertained. Semen or other bodily fluid may be identified that are not associated with the crime. Once identified, the results can be matched with a consensual partner(s), and then used for elimination purposes and to aid in the interpretation of evidence.

Post-assault activities of patient: Quality of evidence is affected by the patient's activities. It is crucial to know what activities occurred post assault and prior to the examination, including:

- Urination, defecation or vomiting;
- wiping genitals, douching, removing/inserting tampon/sanitary pad/diaphragm, or Nuvaring;
- use of oral rinse/gargle or brushing teeth;
- bathing or showering;
- eating or drinking;
- smoking;
- change of clothing; or
- ingesting drugs or medication (legal, illegal, over the counter or prescribed).

Assault-related patient history: Information such as the location of non-genital or oral injury, tenderness, pain and/or bleeding, and anal-genital injury, pain, and/or bleeding directs evidence collection and medical care. Patients should also be questioned about strangulation since this type of injury can result in airway obstruction if swelling occurs. Strangulation associated symptoms can include: memory loss, lapse of consciousness, vomiting, non-genital injury, pain and/or bleeding. Memory loss and lapse of consciousness, which is also suggestive of a Drug Facilitated Sexual Assault (DFSA) should be extensively evaluated. Additional information on DFSA can be found on page 48.

Suspect information (if known): It is important to seek evidentiary items that contacted or were transferred among patient, suspect(s), and crime scene(s). The gender and number of suspects may

offer guidance to the types and amounts of foreign materials that might be found on the patient's body and clothing. Suspect information gathered during the interview should be limited to issues that will guide the exam and forensic evidence collection.

Nature of the assault: Information about the physical surroundings of the assault(s) (e.g., indoors, outdoors, car, alley, room, rug, dirt, mud, or grass) and methods employed by the suspect is crucial to the detection, collection, and analysis of physical evidence. Methods may include, but are not limited to, use of weapons (threatened and/or injuries inflicted), physical blows, grabbing, holding, pinching, biting, physical restraints, strangulation, burns, threat(s) of harm to the patient or loved ones, and involuntary ingestion of alcohol/drugs. Knowing if suspects may have been injured during the assault may be useful when recovering evidence from patients (e.g., blood or fingernail scrapings) and in the event of an arrest it may provide corroborating support of the incident (e.g., bruising, fingernail marks or bite marks).

Suspicion of alcohol- or drug-facilitated sexual assault (DFSA): It is critical to collect information such as memory loss, lapse of consciousness, or vomiting; if the patient was given food or drink by the suspect; or if the patient voluntarily ingested drugs or alcohol. Collect toxicology samples if there is known or suspected ingestion of drugs or if there was loss of memory or lapse of consciousness. Information related to collection/detection of drugs/alcohol can be addressed to the Arkansas State Crime Lab and additional information on DFSA can be found on page 48.

Description of the sexual assault: An accurate and detailed description in chronological order of occurrence is crucial to detecting, collecting, and analyzing physical evidence, including the transfer of evidence. The description should include:

- penetration of genitalia (vulva and/or vagina of female patient), however slight;
- penetration of the anal opening, however slight;
- oral contact with genitals (of patient's by suspect(s) or of suspect'(s) by patient);
- other contact with genitals (of patient's by suspect(s) or of suspect'(s) by patient);
- oral contact with the anus (of patient's by suspect(s) or of suspect'(s) by patient);
- non-genital act(s); such as licking, kissing, sucking, strangulation; and biting;
- other acts (urination, defecation on patient) or use of objects;
- whether ejaculation occurred and location(s) of ejaculation (e.g., mouth, vagina, genitals, anus/rectum, body surface, clothing, bedding or other); and
- use of condoms and/or lubrication.
- Be aware, the patient may not know all of the above information.

Physical Examination and Evidence Collection

Healthcare providers should remember that sexual assault is a legal matter and not a medical diagnosis. Providers should refrain from expressing an opinion either verbally or in writing.

Questions, as discussed above, are asked from least invasive to more invasive and potentially embarrassing. In the same manner the physical exam should begin with the least invasive and progress to the more invasive forensic examination. Patients should be allowed to stay clothed throughout the questioning and disrobe at the time of the physical examination.

The patient's body is considered the "crime scene". The physical assessment and examination will be guided by the medical forensic history previously provided. The forensic medical examination and evidence collection should be done in tandem as a seamless process to increase efficiency, and decrease omissions and patient anxiety. It is important to wear powder-free gloves and change them throughout the exam/evidence collection, especially between sites. A systematic head-to-toe approach should be consistently utilized, performing the genitalia exam lastly. Patients should always be informed about the examination and the purpose of evidence collection, procedures used to collect evidence, any discomfort that may be involved, and how the medical forensic examination may be used during the investigation and prosecution.

The American College of Emergency Physicians issued general rules for forensic evidence collection:

- There is only one chance to collect.
- When in doubt, collect.
- Air dry, no heat.
- If once living, such as blood and body fluids, refrigerate. However, according to the Arkansas State Crime Lab, completed kits can be stored at room temperature since there are no liquid samples in the Arkansas kit.
- Use paper or glass only, no plastic. Plastic may retain moisture and promote degradation of biological evidence.
- Label, date, seal, and initial everything.
- Separate items collected.
- Do not touch items that may contain fingerprints; package to preserve prints.
- The 96 hour presumptive guideline of collection may change because it was a function of the sensitivity of forensic testing which is constantly advancing.
- Suspect's DNA has been found in the vaginal vault of patients for as long as 3 weeks but can degrade as quickly as 24-48 hours. DNA on clothing items can be identified months or years later.
- Collect samples without water if possible-ease off stain and place in bindle; if needed place one drop of either distilled water or saline solution on a swab to collect.
- Sterile collection is not necessary; however, it is necessary to change gloves between sites to avoid cross-contamination.
- Core evidence needed consist of blood, oral, vaginal, and anal samples, as appropriate.
- Collect appropriate specimens if drug-facilitated sexual assault is a possibility.
- Evidence collection changes as technology changes; keep current and follow universal precautions (American College of American Physicians, 1999).

General physical examination: Note the date and time of the exam, patient's vital signs, physical appearance, general demeanor, behavior, orientation, and condition of clothing on arrival. Record all physical findings including visualized injuries; tenderness on palpation; physiologic changes; and observed foreign materials (e.g. grass, sand, stains, dried or moist secretions, or positive fluorescence) in narrative and on body diagrams.

Collection of Clothes: Collection of clothing and other evidence should be guided by the medical forensic history. Often clothing contains important evidence in a case of sexual assault for the following reasons:

- Clothing provides a surface upon which foreign material can be found, such as the assailant's semen, saliva, blood, hairs, fibers, and debris from the crime scene.

- Damaged or torn clothing is significant and may be evidence of force. It can also provide laboratory standards for comparing trace evidence from the clothing of the patient with evidence collected from the suspect and/or the crime scene.

Prior to the full examination, the healthcare provider should determine if the patient is wearing the same clothing worn during the assault. If so, the clothing should be collected. The forensic scientists at the Crime Lab will examine the clothing for any foreign material, stains or damage. If it is determined that the patient is not wearing the same clothing, the healthcare provider should inquire as to the location of the original clothing. The information about the location of the clothing should be given to the investigating officer so that arrangements to retrieve the clothing can be made. The most common items of clothing that are collected from patients for analysis are underwear and bras. In some cases, guided by history, it is necessary to collect hosiery, blouses, shirts, and/or pants. In rare cases, coats and shoes may need to be collected as well.

In order to minimize the potential for the loss of evidence, the patient should disrobe over a cloth sheet with exam table paper laid over the sheet. This is accomplished by placing a clean cloth sheet on the floor and then placing a sheet of table paper over the cloth. The cloth sheet prevents transfer of debris from the floor to the piece of paper. The patient should disrobe over the piece of paper and any debris that falls from the clothing should be collected in a bindle for the crime laboratory (See Appendix A). Do not shake out the patient's clothing or microscopic evidence will be lost. If it is necessary to cut off items of clothing from the patient, do not cut through existing rips, tears, or stains. Cut close to a seam if possible. Include in the documentation which items of clothing were cut and the location of the cuts.

The clothing should then be collected and packaged according to the following:

- Wet and damp clothing should be air-dried prior to packaging in new paper bags (grocery-type bag).
- Place the underwear in the paper bag marked "UNDERWEAR" provided in the sexual assault evidence collection kit. The underpants should be collected, even if they are not the pair the patient was wearing at the time of the assault. It is possible that secretions or ejaculate may drain from the patient and be found on the underpants.
- If a bra is present, and history dictates the necessity to collect it, then place it in a separate paper bag and label it appropriately.
- Other clothing items should be placed in separate paper bags. It is preferable that each piece of clothing be folded inward, placing a piece of paper against any stain so that the stains are not in contact with the bag or other parts of the clothing.
- Label all bags with the patient's name, the date and time item was collected, the name of the item and the collector's name or initials.
- Seal the bags, using tape. Initial and date over the seal on each bag.

Record all physical findings utilizing the acronym TEARS: T (tearing/lacerations), E (ecchymosis/bruising), A (abrasion), R (redness), and S (swelling). Further assess for foreign materials such as grass, sand, stains, dried or moist secretions. Note areas of tenderness and induration. Carefully inspect the body, including the head, hair, and scalp, and work down from head to toe in a systematic manner assessing for dried or moist secretions and stains (e.g., blood, seminal fluid, sweat and saliva) and other foreign material. Information and/or findings should be noted in the narrative and on body maps.

It may be beneficial to label all envelopes prior to collection, with the patient's name, date and health care provider's name. After envelopes are labeled, the healthcare provider should keep them in view at all times to preserve the chain of evidence. When sealing the evidence collection envelopes, use tape or tap water to seal the pre-gummed flap. DO NOT LICK the flap. Printed patient labels can be applied across the flap and then dated, time-stamped and signed by examiner.

Dried secretion collection procedure: The preferred method is to gently flake off the dried stain into an envelope; however dried secretions can also be collected by slightly moistening a swab with distilled water or a normal saline solution. After moistening, use the double-swab technique in the indicated area and swab the moistened area with a dry swab. Separate swabs should be used for every sample area collected. The swabs should be placed in separate envelopes and sealed, labeled with the patient's name, date and time, collector's name and location of the collection site. Air-dry all specimens, package swabs, label, seal, and initial seals. If dried secretions are on hair (head, facial or pubic) flake off material if possible or cut matted hair only with patient's permission. Place in a separate envelope.

Blood collection procedure: A blood sample is collected from patients for DNA analysis to distinguish the patient's DNA from that of the suspects. A blood card is included in the AR Sexual Assault Evidence Collection kit.

- If drawn blood is not being collected for medical or toxicological purposes, consider dry blood collection because it is a less invasive method of blood collection and is easier to store.
    - Using a Betadine swab, wipe the tip of the left or right ring finger.
    - Using a sterile lancet, prick the finger.
    - While holding the finger over the circles on the blood collection card, milk the finger, allowing two drops of blood to fall in a circle. Repeat procedure for remaining circles. The circles do not need to be filled completely.
    - Air-dry the blood collection card.
    - Place the dried card in the envelope marked "KNOWN BLOOD SAMPLE", seal and label the envelope and return it to the evidence collection kit.

Oral (Buccal) swab collection procedure: This is a part of the evidence required in the AR Sexual Assault Evidence Collection Kit. This sample is taken to retrieve any seminal fluid if an oral assault occurred. Swabs from the oral cavity should be taken first so that the patient can rinse their mouth and/or drink fluids as soon as possible.

- Place swabs together to collect specimen from oral cavity by moving along the gum line; between the gums and cheeks; and under tongue (do not pre-moisten the swabs).
- Attention should be paid to those areas of the mouth where seminal material might remain for the longest amount of time, such as the junction of the gum and teeth.
- Remove dentures and swab with the same swabs.
- The swabs should be allowed to air dry or be placed in a swab dryer especially designed for this purpose. When the oral swabs have dried, they should be inserted in the paper envelope marked "ORAL SWABS". The envelope should be sealed and labeled as previously described and returned to the evidence collection kit.

Use of an Alternate Light Source:
Depending on institutional policy and availability, an alternate light source (ALS) may be used in a darkened room to examine the patient's entire body. Wear recommended glasses (450 nm wavelength). Also, protect the patient's eyes when using ultraviolet light. Specifically examine the head, face, hair, lips, perioral region, and nares; chest and breasts; inner thighs, skin, and other areas indicated by the medical forensic history. Dried semen stains may have a shiny appearance and tend to flake off the

skin or may exhibit an off-white fluorescence with the use of an ALS. Fluorescent areas may appear as smears, streaks or splash marks. Moist or freshly dried semen may not fluoresce. The appearance of fluorescent areas does not confirm the presence of semen, as other substances such as urine or body lotions may fluoresce. Restraint marks, bite marks, recent contusions, and other subtle injuries may be more visible with the aid of an ALS.

Collection of foreign materials and swabs from the surface of the body:
Obtain swabs from any suspicious area that may be a dry or moist secretion or stain; any area that fluoresces with ALS in correlation with the patient history provided; and any area for which patients relate a history or suspicion of bodily fluid transfer (licking, kissing, biting, splashed semen, urine, defecation, or suction injury). Place swabs in a marked envelope, seal and label as previously described and place the envelope in the evidence collection kit.

Bite mark evidence:
Bite marks may be found on patients that have been sexually assaulted. The collection of saliva and photographs of the affected area are the minimum procedures which should be followed in cases where a bite mark is present. Documentation of the bite mark, size, location and description of injury is also needed.

Saliva, like semen, may demonstrate DNA characteristic of their donor. Therefore, the collection of saliva from the bite mark should be made prior to cleansing or dressing the wound. To collect a specimen form the bite mark area, slightly moisten a swab with distilled water and gently swab the affected area. If the skin is broken, swabbing of the actual punctures should be avoided. Air-dry the swabs, place in an envelope marked "BITE AREA", seal and label as previously described and place in evidence collection kit.

If bite photographs are needed it is important that the photographs of the bite marks be taken properly. It is recommended that a representative of the law enforcement or a forensic photographer be consulted on the proper instructions for forensic evidence photography. To demonstrate the size of the bite mark, a ruler or standard should be placed adjacent to but not touching or covering the bite mark and then photographed. An additional photograph without the ruler or standard should also be made. The camera should be placed perpendicular to the bite mark.

Fingernail swabs:
The purpose of collecting swabs from the fingernails is to collect potentially useful evidence of cross-transfer. During the course of a physical crime, the patient will be in contact with the environment as well as with the assailant. Materials such as skin, blood, hairs, soil and fibers (from upholstering, carpeting, blankets, etc.) can occasionally be collected under the fingernails of the patient.

The patient should be asked whether or not they scratched the assailant's face, body or clothing. If fibers or other materials are observed under the patient's fingernails, the under part of the nails should be swabbed, one hand at a time, using a cotton-tipped swab, one for each hand. The patients may want to perform this procedure themselves. The swabs are then packaged back in the original sleeves and placed in an envelope. The envelope should be properly sealed and labeled, being sure to note which hand the evidence was collected from, and placed in evidence collection kit.

Collection of pubic hair combing:
Pubic hair combing is part of the evidence requested in the AR Sexual Assault Collection Kit. Use the comb, paper sheet, and envelope included in the evidence collection kit. This process is intended to

collect hairs that may have been deposited by the perpetrator. This is not a known, pulled hair sample. Pubic hairs should not be cut. Place the unfolded paper sheet under patient's buttocks and comb hair toward paper (patients may comb). Fold comb with debris/hair into paper in the envelope marked "PUBIC HAIR COMBINGS". Package, seal and label as previously discussed. Return the envelope to the evidence collection kit.

Some patients may shave their pubic region and have no hair or stubble. In this case, a visual examination for hair and debris can be done and hairs may be manually placed in the unfolded paper sheet. The paper sheet can then be placed in the envelope, sealed and labeled as previously described, and placed in evidence collection kit.

Assessment of female genitalia for injury:
Make sure to wear gloves throughout the exam and to follow Universal Precautions. Examine the external genitalia and perineal area for injury (TEARS), and foreign materials in the following areas: labia majora, labia minora, clitoral hood and surrounding area. Examine the structures internal to the labia majora: peri-urethral tissue/urethral meatus, hymen, fossa navicularis and posterior fourchette. Examine the buttocks, perianal skin, and anal folds for injury, foreign materials and other findings. Using swabs collect any foreign material and/or secretions as described earlier in this chapter. Document all findings on a body map according to facility's policy. The use of describing position of the noted injury by the hands of a clock is helpful (e.g., 4 cm laceration on labia minora at 3 o'clock). The use of a colposcope during the genital exam of an adult female enhances visualization of microscopic trauma and may be utilized to provide photographic documentation.

Collect female external genital swabs:

- Swab area of labia majora and clitoral hood which are dry-skin areas with two swabs (do not pre-moisten the swabs).
- Air-dry swabs.

Package swabs in one of the paper sleeves marked "VAGINAL/PENILE SWABS." Note on the package that these were swabs of labia majora/external genitalia.

Toluidine blue dye:
Toluidine blue dye (1-% aqueous solution) is controversial in some jurisdictions. It may be perceived by the court as changing the appearance of the tissue and is not universally used. If utilized, it needs to be applied before the internal and speculum examination. Any tears that are illuminated by the dye may be challenged as having been caused by insertion of a speculum if proper sequence is not followed. The solution is a spermicide and should only be applied externally.

- Apply by cotton swab across the fossa navicularis, posterior fourchette and related areas.
- Wait for 1 minute and blot excess dye away with 1% acetic acid solution.
- Recent lacerations will show up bright blue.
- Advise patients that small traces of the dye might shed in their clothing for about 2 days.
- Examiners should be familiar with false positive results (e.g., infections).

Assessment of vagina and cervix and collection of sample:
If the patient is able to tolerate insertion of a vaginal speculum, insert a speculum and examine vagina and cervix for injury, foreign materials, and foreign bodies. When collecting the vaginal specimens, it is important not to irrigate the vaginal vault or to dilute the secretions. It is prudent to collect swabs from both the vagina and cervix if possible.

- Use one swab for the vaginal vault and one swab for the cervix. If the patient cannot tolerate a speculum exam, do 2 deep vaginal swabs and roll the swab while in the vagina to maximize exposure to the surface of the swab for absorption. , swab the vaginal vault and cervix.
- Air-dry the swabs.
- Place the dried swabs in the 2nd paper sleeve, marked "VAGINAL/PENILE SWABS", seal and label the paper sleeve as previously discussed, and return to evidence collection kit.
- Be sure to label the outside of each sleeve as either "internal swabs" or "external swabs"

Please note: if a speculum is used, it is important to document the use of a speculum only after the external genitalia have been visualized and examined. Lubricate the speculum with water only. Do not use gel lubricant.

Assessment of male genitalia:
Make sure to wear gloves throughout the exam and to follow facility's Universal Precautions. Examine the external and perineal area for injury, foreign materials, and other findings, including the urethral meatus, shaft, scrotum, perineum, glands, testes, buttocks, perianal skin and anal folds. Document the findings on a body map and according to facility's policy. For the male patient, the presence of saliva on the penis could indicate that oral-genital contact was made, the presence of vaginal secretions could help corroborate that the penis was introduced into a vaginal orifice and feces or lubricants might be found if rectal penetration occurred.

Collect male external genital swabs:
- Lightly moisten both swabs with distilled water and swab the glans and shaft of the penis.
- Air-dry the swabs.
- Insert the dried swabs into the envelope marked "VAGINAL/PENILE SWABS".
- Seal and label envelope as previously described and return it to the evidence collection kit.

In the rare instance in which a urethral specimen is indicated it is important not to irrigate or dilute the secretions. Using one cotton swab at a time, swab just inside the urethral meatus of the penis. Repeat this procedure with at least one additional swab. After the swabs have air- dried, place the swabs in an envelope and mark it "URETHRAL", seal and label the envelope as previously described and place it in the evidence collection kit.

Collection of rectal sample:
The patient may be placed in a lateral position to increase comfort during the anal/rectal exam and evidence collection. Inspect the anal/rectal area for injury and foreign materials prior to collection of swabs. To obtain rectal swabs:
- Slightly moisten the cotton swabs with distilled water. One cotton swab at a time should be used to swab the rectum. Very slight penetration is adequate.
- Repeat the procedure to obtain the second swab.
- After the rectal swabs have air dried, place the swabs in the envelope marked "RECTAL" and place it in the evidence collection kit.

Other evidence may be collected beyond what is required for the sexual assault evidence collection kit. This could include toxicology samples or other evidence based on the unique history and circumstances of the case.

Obtain Urine Specimen:

Ideally, it is best to obtain the urine specimen after the genitalia examination and evidence collection since evidence can be lost if the patient voids. This is not always possible and therefore a specimen should be collected. In this case the patient should be instructed not to wipe after urinating. The collection does not need to be a clean catch, unless per protocol for pathogens (institutional testing, NOT Arkansas Crime Lab).
Do not include urine specimen in evidence collection kit. The urine specimen may be used to test for STD's, pregnancy, dehydration, and ketosis. Before administration of any prophylactic medication, it is vital to rule out pregnancy.

Urine can also be utilized in cases of suspected Drug-Facilitated Sexual Assault and is discussed on page 48.

Read and follow the State of Arkansas Sexual Assault Evidence Collection Kit Instructions found inside each kit. Be sure to complete the paperwork found in the evidence collection kit (steps 1 and 9 of instructions) in addition to institutional paperwork. Obtain and store the evidence submission sheet, affix evidence seals so that the box is sealed closed (initial and date the seal), affix biohazard seal, and complete information on the top of the kit.

Evidence Integrity:

Follow institutional and jurisdictional policies for drying, packaging, labeling, and sealing evidence. It is critical to air-dry wet evidence at room temperature in an expedited manner that prevents contamination. Ideally, an air dryer that locks can hold the specimens in a secure place, while drying the specimens. Clothing must be kept in sight or locked in a secure location. Jurisdictions and institutions should have policies for handling, securing and locking down evidence, including evidence that cannot be dried thoroughly at the exam site (e.g., wet clothing, tampons, sanitary napkins, tissues, diaphragms, and condoms), as well as for liquid evidence such as urine and blood samples.

Minimize transit time between collection of evidence and transport to the Arkansas Crime Lab. To avoid potential degradation of evidence, it is important to transport kits containing liquid samples and wet evidence in a timely fashion. Only a law enforcement official can transfer evidence from the exam site to the Arkansas State Crime Lab.

In the event that kit transport does not occur in a timely manner, and storage is required, the type of storage will depend on the types of specimens to be stored. The use of dried blood samples on blood collection cards is encouraged because they do not require refrigerated storage. If there is a time delay between evidence collection and submission to the crime lab, urine should be refrigerated or frozen and blood specimens (except blood collection cards) should be refrigerated.

Photography

Taking photographs of patients may be required as part of the medical forensic examination process in sexual assault cases. Photographing injuries may unjustly compromise a case if poor or inadequate photos are taken; therefore, the examiner needs to be trained in forensic photography. Basics of photography are taught in the A-SANE and P-SANE course; however advanced training is essential. Some facilities contact the local police department and request a criminal photographer or crime scene

investigator to come to the facility and take photographs. However, photographs should not be used to interpret subtle and/or nonspecific findings (e.g., erythema or redness).

All photos should be documented and described in correlation to the medical forensic history and exam. In addition to photographing examination findings, some jurisdictions photograph the face of patients for identification purposes (follow institutional policies). Images should be linked to the patient's name; date of exam; and the examiner. Digital imaging can automatically embed the date/time and other required data in each image. This information can be accessed when the image is downloaded onto the computer.

Photograph evidence in place before moving it or collecting it. Do not alter the evidence prior to photographing, and make every effort to minimize background distraction in photographs while maintaining the focus on areas being photographed.

- Take medium-range photographs of each separate injury, including cuts, bruises, swelling, lacerations, and abrasions. Work from one side to the other and then top to bottom, or design a workable method. Be consistent. Take "regional" shots to show injuries in the context and orientation of a body region; these photographs should include easily identifiable anatomical landmarks.
- Take close-up images of specific injuries, with and without the scale (this verifies that the scale was not concealing anything). The scale provides a reference for size. Color scales are useful to provide perspective of the photographed area.
- When photographing a wound, show its relationship to another part of the body.
- In some cases, a full body photograph may be appropriate to show scope of injury or state of clothing. Photos taken solely for the purpose of identification should be done with patients fully clothed or in a gown.
- Photographing close-ups of hands and fingernails may show traces of blood, skin, hair, or damaged/missing nails.
- Photograph marks of restraint or bondage around wrists, ankles, or neck; they may be compared later with the object in question that made the marks.
- Photograph transfer evidence present on the body or clothing, such as dirt, gravel, or vegetation.
- Photograph bite marks.
- All photographs should be clearly labeled and the chain of custody maintained. Do not include photographs in the evidence collection kit sent to the crime lab.
- Follow-up photographs should be taken if new or different evidence on patient's bodies is found post-exam (e.g., bruising may appear days later). In addition to documenting emerging or evolving injuries, follow-up photographs provide documentation of healing or resolving injuries and clarify findings of stable, normal variants in anatomy and nonspecific findings like redness or swelling that could be confused with acute injuries.
- Examiners should take a forensic photography course to expand skills, knowledge and techniques that enhance evidentiary evidence collection and retention.
- Write and maintain policies on use of photography and consider institutional consent form for photography.

Pregnancy Evaluation and Emergency Contraception

Patients of different ages, social, cultural, and religious/spiritual backgrounds may have varying feelings regarding acceptable pregnancy intervention options. Clinicians must be careful not to unduly influence a patient's choice of intervention.

Recommendations at a glance:

- Discuss probability of pregnancy with female sexual assault patients.
- Administer a pregnancy test for all patients with reproductive capability.
- Discuss intervention options.

Any female of reproductive capability (Tanner Stage 3 and above, irrespective of menarche and current contraceptive method) can potentially become pregnant from a single sexual encounter. The risk of pregnancy from sexual assault is estimated to be 2% – 5% and the probability of conception depends on several variables, including:

- use of contraceptives
- regularity of the menstrual cycle
- fertility of the patient and the perpetrator
- time in the cycle of exposure and
- whether the perpetrator ejaculated intravaginally.

Because of genuine fear of pregnancy, and the compounding trauma that a pregnancy could inflict, intervention options should be made clear to the patient. The conversation should include a thorough discussion, including mechanism of action, side effects, benefits, dosing, and follow-up. Information should also be provided in writing.

With the exception of a patient that is already pregnant, all female sexual assault patients should have a pregnancy test conducted. In the case of a pregnant patient, medical management would be best managed by or in collaboration with the patient's obstetrician. Most commercially available urine pregnancy tests are sensitive and will detect pregnancy 7 days after conception, before a menstrual period is missed. If the pregnancy test is positive, emergency contraception is contraindicated and prophylaxis medications need to be re-evaluated.

Emergency contraception (EC), or the "morning-after" pill, is birth control that women can use to prevent pregnancy after unprotected intercourse. EC is 95% effective when taken within 24 hours, and is 88% effective if taken within 72 hours. Although efficacy decreases across time, EC is still considered effective and can be administered up to 120 post-assault. (Follow institutional protocol). EC is not an abortifactant and should not be confused with the "abortion pill" Mifeprex, or RU486. EC works in several ways: by suppressing ovulation, disrupting the development of the endometrial lining to prevent implantation, and altering the effectiveness of tubal transport of the ovum. There is no evidence of increased incidence of ectopic pregnancy and the use of EC cannot interrupt an established pregnancy.

The most common side effects are nausea and vomiting. The frequency of nausea and vomiting with the progestin-only method is significantly lower. Dramamine 25-50 mg, or other antiemetic medication taken 30 minutes before taking a dose of EC, can decrease these problems. If vomiting occurs within one hour after taking either dose, repeat dosing may be considered. (However, it seems reasonable to infer that if gastrointestinal symptoms are estrogen-mediated secondary to an effect on the central nervous system, absorption of the dose should have occurred by the time of emesis).

The Yuzpe regimen, combination oral contraceptive, consists of a 0.5 mg of levonorgestrel and 50 mcg of ethinyl estradiol which can be administered after a negative pregnancy test. The dose is repeated in 12 hours. The combination pill is considered more effective in patients that have a BMI of 30 or greater. The Plan B option consists of two tablets, each containing 0.75 mg of levonorgestrel and is generally preferred to the Yuzpe regimen. Levonorgestrel, a synthetic progesterone hormone is recommended because of its higher efficacy rate, ease of dosing, and fewer side effects, particularly nausea and vomiting. In addition, a World Health Organization (WHO) multicenter randomized trial showed that the dose does not have to be split but can be taken as a single 1.5-mg dose (Plan B One Step). One dose simplifies the EC without causing an increase in side effects. The progesterone only method is available over the counter in pharmacies. No ID or prescription is required.

Emergency Contraception Methods

EC Method	Regimen
Yuzpe Regimen Combination oral contraceptive method	0.1 mg of ethinyl estradiol + 1.0 mg of DL-norgestrel (equivalent to 0.5 mg of levonorgestrel) in two doses taken 12 hours apart
PLAN B Progestin-only method	0.75 levonorgestrel in two doses taken 12 hours apart
PLAN B ONE STEP	1.5 mg of levonorgestrel in a single dose
Ella	30 mg of ulipristal acetate in a single dose

Follow-up Care: The patient should be provided an oral explanation and written information regarding EC. Patients should be informed that there may be heavier or lighter menses than usual and the menses onset may not occur at the expected time. If no bleeding has occurred within three weeks, the patient should be re-evaluated and a repeat pregnancy test performed. **The patient must be advised not to have unprotected intercourse until after the next menses has occurred**, or the repeat pregnancy test is negative.

Drug-Facilitated Sexual Assault (DFSA)

Many drugs are used as "club drugs" to heighten sexual awareness and erotic sensations, however; drugs that are classified as "date rape drugs" and used in the commission of drug facilitated sexual assault (DFSA) have the unique ability to cause antegrade amnesia. Antegrade amnesia causes the patient to forget all or part of the events that occurred while the drug was in effect.

The four most common substances used in DFSA are alcohol, Gamma Hydroxy Butyrate (GHB), rohypnol, and ketamine. Alcohol is the number one substance used in DFSA. A brief discussion

about the other three substances follows; however, the effects of each substance are dependent upon a number of variables including: dose ingested, purity of the drug, and individual factors such as body size, metabolism, concurrent drug(s) and alcohol consumption.

Rohypnol is classified as a Class I narcotic; benzodiazepine; central nervous system (CNS) depressant; which is 7-10 times stronger than Valium. The onset of action is within 30 minutes and peaks in 1-2 hours with a duration of 8-12 hours. However, fatigue, confusion, and inability to focus may last 2 days. Effects of rohypnol ingestion include impaired judgment and motor skills; disinhibition; amnesia; confusion; excitability followed by lethargy; reduced reflexes; dangerous level of hypotension; and coma.

Gamma Hydroxy Butyrate or GHB is classified as a Class I narcotic and is a CNS depressant. Onset of action is 15 to 20 minutes and it peaks in 20-60 minutes with duration of 4-5 hours. Effects of GHB include euphoria, amnesia, hypnosis, depressed respirations, hallucinations, confusion, seizures, nausea and vomiting, coma, and death.

Ketamine is a legal anesthetic, used mostly in pre-op and by veterinarians. Ketamine is related to PCP and has an onset of action in about 30 seconds if used IV and 20 minutes if ingested orally. The duration of action is 30-60 minutes, but amnesia effects may last much longer. The effects of ketamine ingestion include dissociate reaction with dreamlike effects; out of the body experience, amnesia; confusion; paranoia, delirium, hallucinations and the patient may become combative with excessive drooling.

Drugging should be recognized as a separate and distinct act of victimization and is a separate crime. It is a crime at both the State and Federal level. In Arkansas it is prosecuted under Arkansas Code Annotated § 5-13-210 and is a Class Y felony if a person introduces a controlled substance into the body of another person without that other person's knowledge or consent with the purpose of:
(1) Committing any felony sexual offense, as defined in Arkansas law;
(2) Engaging in any unlawful sexual act, as defined in § 5-14-101 et seq.;
(3) Engaging in any unlawful sexual contact, as defined in § 5-14-101; or
(4) Engaging in any act involving a child engaging in sexually explicit conduct, as defined in § 5-27-302.

It is also important to document a patient's voluntary use of drugs and alcohol. Patients should understand that information related to voluntary alcohol or drug use may be used to undermine their credibility in court, but also that in some instances it might be helpful in prosecuting a case by documenting their vulnerability. Some patients may self-medicate to cope with post-assault trauma and require immediate medical treatment. In addition, ingestion of drugs and/or alcohol during this period may affect the quality of evidence and negatively impact patient's ability to make informed decisions about treatment and evidence collection.

Routine toxicology testing is not recommended. However, if any of the following situations occurred then toxicology is warranted:

- If a patient's medical condition appears to warrant toxicology screening for optimal care (e.g., the patient presents with drowsiness, fatigue, light-headedness, dizziness, physiologic instability, memory loss, impaired motor skills or severe intoxication).
- If a patient suspects drug involvement, especially if the patient reports a lack of recollection of the event(s).
- If a patient or accompanying persons states the patient was or may have been drugged.

Toxicology testing procedures should be explained to patients. Seek informed consent from patients to collect toxicology samples. Patients should understand the following:

- The purpose of toxicology testing and the scope of confidentiality of test results.
- The ability to detect and identify drugs and alcohol depends on collection of urine and/or blood within a limited time period following ingestion.
- There is no guarantee that testing will reveal that drugs were used to facilitate the assault.
- Testing may or may not be limited to drugs commonly used to facilitate sexual assault and may reveal other drugs or alcohol that patient ingested, including those that were voluntarily ingested.
- Test results showing voluntary use of drugs and/or alcohol may be discoverable by the defense and used to attempt to discredit patients or to question their ability to accurately perceive the events in question (however, these results could also help substantiate that voluntary drug and/or alcohol use sufficiently impaired patient's consent and prevented legal consent).
- Declining testing when indicated by circumstances as described above may negatively impact the investigation and/or prosecution.

With DFSA the examiner may not be able to use the patient's history as a guide for the medical forensic examination so it is imperative to be thorough, collecting all specimens, and inspecting the entire body and clothing. Extreme patience is required in interviewing due to patient's inability to remember, and hence uncertainty, of events that occurred and incomplete timeline. Reassure the patient that "I don't know" is a perfectly acceptable answer and record the answer in quotation marks.

Toxicology samples should be collected as soon as possible after a suspected drug-facilitated case is identified and informed consent is obtained, even if patients are undecided about reporting to law enforcement. The sooner specimens are obtained the greater the chances of detecting substances since they are quickly eliminated from the body. The length of time that drugs used in the commission of DFSA remain in urine or blood depends on a number of variables (e.g., the type and amount of drug ingested, patient's body size and rate of metabolism, whether patients had a full stomach, and whether they previously urinated). Urine allows for a longer window of detection of drugs opposed to blood.

Ideally, the first available urine sample of 30 cc of urine should be obtained and packaged in a clean glass or plastic, leak proof container for transport to the crime lab. The patient should not urinate until after evidence is collected. However, if the patient previously urinated, the number of times that urination occurred prior to collection of the sample should be documented. Do NOT put urine into the Sexual Assault Evidence Kit. Label, sign, seal and maintain proper chain of custody. Refrigerate the specimen (in a locked refrigerator) until it is released to law enforcement. Some jurisdictions may also require a blood specimen. If DFSA is suspected a blood sample in two full tubes (any color top) should also be drawn. If a blood sample is collected for toxicology screening, it should be accompanied by a urine sample (since the end metabolite from the drug will be detected for a longer duration in urine).

If blood alcohol determination is needed, collect blood within 24 hours of alcohol ingestion and use betadine (not alcohol) as the prep for venipuncture.

Establish policies and follow them for collection, packaging, labeling, storage of samples, and handling when patients are undecided about reporting or awaiting transfer of specimens to the crime lab. As with any forensic evidence, the chain of custody must be maintained.

It is not in the scope of this manual to educate health care providers about all aspects of DFSA and it is recommended that those persons performing medical forensic exams obtain additional and specific training.

Patient Education and Discharge

After the examination and evidence collection is complete, the patient should be provided with clear and concise oral and written instructions for care and follow-up. Information should include the following:

- A file or case number if one has been assigned.
- Instructions about what to expect after a pelvic examination (i.e. slight bleeding, etc.).
- Instructions for medications (including name, dose, possible side effects)
- Signs and symptoms that require immediate follow up.
- Instructions not to engage in unprotected intercourse until after completing all medications, follow-up testing, and return of menses.
- If EC was administered and there is no menses within 3 weeks, follow up care is warranted.
- Make sure patient's medical and mental health needs related to the assault have been addressed.
- Recommend follow-up appointments for patients. Make it clear that patients do not have to disclose the assault to receive follow-up medical care (although it is advised to allow a thorough evaluation).
- For patients with evidence of acute trauma, a short-term follow-up appointment is needed 2 to 3 days after initial exam to re-examine and document the development of visible findings and photography of the areas of injury. An exam 2 to 4 weeks later is then needed to document resolution of findings or healing of injuries.
- Primary health care providers or other nonacute care providers (such as public health departments) can provide longer term care as needed (e.g., for HIV testing, STD testing, and administering doses of Hepatitis B vaccine).
- Information on advocacy and counseling services including rape crisis advocates, counselors, and therapy groups.
- For patients who have not made a law enforcement report, they should be given information on who to contact and how to make a report if they change their mind. They should also be given information concerning the length of time kits will be kept in storage prior to destruction (See Guidelines for Jane Doe Rape Kit on page 22)

Chain of Custody

It is important to adequately and accurately label each evidence collection envelope, package, vial and specimen container. Information required includes the patient's name, date, identifying/case number, type of specimen (if not already on the envelope or package) and examiner's name. It is important to date and initial the flap after the envelope has been sealed. The date and examiner's initials should be written in such a way that it is both on the flap and on the envelope. Another way to seal envelopes and packages is by placing a pre-printed patient label across the flap and dating and initialing over seal.

The custody of an evidence collection kit and the specimens it contains must be accounted for from the moment the evidence kit is opened, through the collection process and until it is introduced in

court as evidence. Therefore, anyone who handles the evidence should sign the chain of evidence document. The purpose of establishing a chain of custody is to guarantee that the items admitted into evidence at trial are authentic (i.e., that they are the same items and in substantially the same condition as those taken from the patient during the forensic examination).

After the examination is complete, law enforcement is responsible for picking up and delivering the Sexual Assault Evidence Collection Kit to the Arkansas State Crime Lab. For chain of custody and tracking purposes, healthcare personnel and law enforcement should follow the instructions and protocol set forth in the Arkansas Crime Lab's secure online Sexual Assault Kit Tracking System. In addition, follow the directions on the kit for documentation of the exchange of the collection kit from the examiner to law enforcement.

Sexual Assault Kit Tracking System

The tracking of sexual assault evidence kits in the state of Arkansas in compliance with Arkansas Act 1168 of the 2015, 90th General Assembly is now available through a secure online tracking system. Authorized medical, law enforcement, and lab personnel shall manage the status of sexual assault evidence kits under the jurisdiction of their agency. Also, victims of sexual assault can view the history and current status of their sexual assault evidence kit. Healthcare providers will log into the system to accept sexual assault kits that have been sent to their facility.

Chapter

5

5. Evaluation and Care of Sexually Transmitted Diseases and Human Immunodeficiency Virus

Contracting a sexually transmitted disease (STD) and/or Human Immunodeficiency Virus (HIV) from an assailant is typically a significant concern for sexual assault patients. STD and HIV should be addressed as part of the medical forensic exam.

Recommendations at a glance:

- Offer patients information about the risks of STDs and HIV including symptoms, what to do if symptoms occur, testing and treatment options, follow-up care, and referrals.
- Encourage patients to accept post-exposure prophylaxis (PEP) against STDs at the time of the initial exam. If accepted, provide care that meets or exceeds Centers for Disease Control and Prevention (CDC) guidelines.
- Encourage follow-up STD examinations, testing, immunizations, and treatment if indicated.
- Offer post-exposure prophylaxis (PEP) for HIV to patients at high risk for exposure, particularly when it is known that suspects have HIV/AIDS. Follow current CDC guidelines. Discuss risks and benefits of the prophylaxis with patients prior to their decision to accept/decline treatment. Careful monitoring and follow-up by a health care provider or agency experienced in HIV issues is required.
- Consider the need for testing patients for STDs during the initial exam on a case-by-case basis. If testing is done, follow the guidelines of the most current CDC guidelines.

STD Evaluation and Care

The medical forensic exam presents an opportunity to identify preexisting STDs, regardless of when they were acquired, and for examiners to make recommendations for specific treatment.

Trichomoniasis, Bacterial Vaginosis, gonorrhea, and chlamydial infection are the most frequently diagnosed infections among women who have been sexually assaulted. Chlamydial and gonococcal infections in women are of particular concern because of the possibility of ascending infection and risk of infertility if untreated. However, the presence of an STD after an assault in a sexually active woman does not necessarily imply acquisition during the assault. In addition, Hepatitis B Viral infection can be prevented by post-exposure administration of hepatitis B vaccine (CDC, 2010).

The decision to obtain genital or other specimens for STD diagnosis should be made on an individual basis. Care systems for survivors should be designed to ensure continuity (including timely review of test results), support adherence, and monitor for adverse reactions to any therapeutic or prophylactic regimens prescribed. Testing for STDs at the time of the exam gives examiners and patients the option to defer empiric prophylactic antimicrobial treatment if it is not needed. However, testing at the time of the initial exam does not typically have forensic value if patients are sexually active. Since the identification of an STI in a previously sexually active adult might represent an infection acquired prior to the assault, it may prove to be more important for the psychological and medical for public health management of the patient than for legal purposes (CDC, 20105). However, since compliance with follow-up visits is historically poor among sexual assault patients, a routine preventive therapy after a sexual assault should be encouraged for post-pubertal girls and adult women who would be at risk for ascending pelvic infection if exposed from the assault. Current CDC guidelines are used to determine PEP treatment and include a regimen to protect against Chlamydia, Gonorrhea, Trichomonas, and the Hepatitis B Virus. PEP treatment can also reduce the need for more expensive/extensive treatment if an STI is discovered at a later time.

Testing for STD's in young children or adolescents who are not yet sexually active can yield results with potential forensic significance. It is imperative that providers understand the need for confirmatory testing in such cases prior to providing treatment.

Laws in all 50 states strictly limit the evidentiary use of a survivor's previous sexual history, including evidence of previously acquired STDs, as part of an effort to undermine the credibility of the survivor's testimony. Evidentiary privilege against revealing any aspect of the examination or treatment also is enforced in most states. However, despite rape shield laws, there may be a concern that positive test results could be used against patients (e.g., to suggest sexual promiscuity). There may, however, be situations in which testing has legal purposes, as in cases where the threat of transmission or actual transmission of an STD was an element of the crime. Or, for non-sexually active patients, a baseline negative test followed by an STD diagnosis could be used as evidence, if the suspect also had an STD.

STD PEP Treatment

Adolescent and Adult Females:
The following prophylactic regimen is suggested as preventive therapy:

- Post-exposure Hepatitis B vaccination, without HBIG. This vaccine should be administered to sexual assault patients at the time of the initial examination if they have not been previously vaccinated. Follow-up doses of vaccine should be administered 1–2 and 4–6 months after the first dose.
- An empiric antimicrobial regimen for chlamydia, gonorrhea, and trichomoniasis.

If prophylaxis is declined at the time of the initial exam, it is medically prudent to obtain cultures and arrange for a follow-up examination. Document the patient's consent for prophylaxis or their decisions and rationales for declining prophylaxis in their medical records.

Recommended Regimens:

Ceftriaxone 250 mg IM in a single dose or Cefixime 400 mg orally in a single dose

PLUS

Metronidazole 2 g orally in a single dose

PLUS

Azithromycin 1 g orally in a single dose or Doxycycline 100 mg orally twice a day for 7 days

Refer to the most current CDC Sexually Transmitted Diseases Guidelines. At time of publication these guidelines can be found at: http://www.cdc.gov/std/treatment/2015/sexual-assault.htm.

Note that metronidazole should NOT be used within 72 hours of alcohol intake to avoid a disulfiram reaction. Inquire if the patient consumed alcohol within 72 hours pre-assault or post assault. Caution patients to abstain from alcohol for 72 hours if metronidazole is given.

Provide the patient with written and verbal information about the risks of STDs, symptoms and the need for immediate examination if symptoms occur, testing and treatment options, the need for abstinence from sexual intercourse until treatment is completed, follow-up care, and referrals as needed. Referrals should include free and low-cost testing, counseling, and treatment offered in various sections of the community.

If patient's clinical presentation suggests a pre-existing ascending STD, they should be evaluated and treated for the ascending infection.

Refer to the CDC recommendations (https://www.cdc.gov/std/tg2015/default.htm) related to HBV diagnosis, treatment and prevention including: pre-vaccination antibody screening; post-exposure prophylaxis; and special considerations.

The CDC recommends initial testing for syphilis and HIV (within 72 hours post assault) and then repeated at 6, 12 and 24 weeks after the assault if initial test results were negative.

Males and Children:
The following prophylactic regimen is suggested as preventive therapy:

- Post-exposure Hepatitis B vaccination, without HBIG. This vaccine should be administered to sexual assault patients at the time of the initial examination if they have not been previously vaccinated. Follow-up doses of vaccine should be administered 1–2 and 4–6 months after the first dose.

Refer to the CDC recommendations (https://www.cdc.gov/std/tg2015/default.htm) related to HBV diagnosis, treatment and prevention including: pre-vaccination antibody screening; post-exposure prophylaxis; and special considerations.

The CDC recommends initial testing for syphilis and HIV (within 72 hours post assault) and then repeated at 6, 12 and 24 weeks after the assault if initial test results were negative.

HIV Evaluation and Care

Always address concerns about HIV infection thoroughly and remember contracting HIV is typically of grave concern for sexual assault patients. Although HIV-antibody seroconversion has been reported among individuals whose only known risk factor was sexual assault or sexual abuse the risk for acquiring HIV infection through a single episode of sexual assault is low. As with other STDs, offer patients information about HIV risks, symptoms and the need for immediate examination if symptoms occur, testing and treatment options, and the need for abstinence or condoms during sexual intercourse until treatment and testing are completed. Include local referrals for testing/counseling and comprehensive HIV services.

In discussing testing options it should be explained that baseline HIV testing is not typically an exam component. However, if the assault is considered a high risk for HIV exposure, patients should establish their baseline HIV status within 72 hours after the assault and then be tested periodically as directed by health care personnel. Even if the assault is not considered a high risk for HIV exposure, some patients may still wish to be tested. HIV testing should be done in settings where follow up appointments and counseling can be offered to explain results, implications, treatment and referrals. (Office of Violence Against Women, 2004).

HIV Status of Source

Several factors impact the medical recommendation for HIV PEP and affect the assault patient's acceptance of the recommendations, including:

- the likelihood of the assailant having HIV,
- any exposure characteristics that might increase the risk for HIV transmission,
- the time elapsed since the event, and
- the potential benefits and risks associated with the PEP.

Determination of the assailant's HIV status at the time of the sexual assault examination is usually not possible. Therefore, the health-care provider should assess any available information concerning:

- characteristics and HIV risk behaviors of the assailant(s) (e.g., a homosexual or bisexual man, an IV drug user, or a commercial sex worker),
- local epidemiology of HIV/AIDS, and
- exposure characteristics of the assault (e.g., anal penetration; ejaculation on mucous membranes; multiple assailants; mucosal lesions on the assailant or patient; presence of oral, vaginal, or anal trauma (including bleeding), site of exposure to ejaculate, and presence of a STD or genital lesions in assailant or patient (CDC, 2015).

Persons with exposures to potentially infectious fluids of persons of unknown HIV status may or may not be at risk for acquiring HIV infection. When the source is known to be from a group with a high prevalence of HIV infection, the risk for transmission is generally increased. The risk for transmission may be higher if the source person has been infected recently, when the viral load in blood and semen

are higher. However, ascertaining this information in the short time available for PEP evaluation and treatment is rarely possible. When the HIV status of the source is unknown, it should be determined whether the source is available for HIV testing. If the risk associated with the exposure is considered substantial, PEP can be started until there is a determination of the HIV status of the source and then stopped if the source is non-infected.

Transmission Risk from the Exposure

The estimated per-act transmission risk from unprotected exposure to a partner known to be HIV infected is variable, depending on the type of exposure (see Appendix B). The highest levels of estimated per-act risk for HIV transmission are associated with blood transfusion, needle sharing by injection-drug users, receptive anal intercourse, and percutaneous needle stick injuries. Insertive anal intercourse, penile-vaginal exposures, and oral sex represent substantially less per-act risk.

Bite Injuries represent another potential means of transmitting HIV. However, HIV transmission by this route has rarely been reported. Transmission might theoretically occur either though biting or receiving a bite from an HIV-infected person. Biting an HIV-infected person, resulting in a break in the skin, exposes the oral mucous membranes to infected blood; being bitten by an HIV-infected person exposes non-intact skin to saliva. Saliva that is contaminated with infected blood poses a substantial exposure risk. Saliva that is not contaminated with blood constitutes a negligible exposure risk.

HIV PEP Treatment

In considering the use of antiretroviral agents after possible exposure through sexual assault, the provider must:

- evaluate the patient's risk of contracting HIV;
- balance the potential benefits of treatment against possible adverse side effects;
- and take into consideration the patient's desires.

Refer to CDC Guidelines @ http://www.cdc.gov/std/treatment/2015/sexual-assault.htm

Chapter

6

6. Sexually Abused/Assaulted Children and Adolescents

Introduction

In the United States, more than 100,000 cases of reported sexual abuse are found to be true each year. This figure does not tell the whole story, however, because almost one-fourth of surveyed adults have reported they were sexually abused as children. Many of them were less than 6 years of age when the abuse occurred, and most perpetrators were relatives or people well-known to the children and families.

Sexual abuse can be defined for healthcare purposes as the involvement of children and adolescents less than 18 years of age in sexual activities they do not understand, are unable to give informed consent, or that violate the social taboos of family or society roles. Sexual abuse may involve attempted intercourse. However, other sexual activities, such as fondling and exhibitionism, also constitute sexual abuse.

Child sexual abuse may present following an acute assault, but often presents after it has been occurring over time. It is also true that while adolescent/adult sexual assault (rape) often presents acutely, these cases can also be occurring over time in abusive relationships. The 2 categories are compared in the following table:

	Child Sexual Abuse	**Sexual Assault (Rape)**
Age of Victim	Early childhood into teens	Usually postmenarchal
Engagement	Threats, bribes, manipulation	Fear, intimidation, force
Sexual Activity	Touching, rubbing, grooming to sexual intercourse and sodomy	Attempted or actual sexual intercourse and sodomy
Perpetrator	▪ Known to child and family; family member ▪ Has an abnormal attraction to children	▪ Stranger or acquaintance ▪ Power motive
Duration	Often many years	1 to 2 times
Presentation	Disclosure usually occurs days or years after event	Disclosure usually occurs soon after event
Physical Findings	▪ Usually acute findings are absent ▪ Older, healed findings are generally absent due to the non-violent nature of the acts, delayed disclosure, and rapid	▪ May have acute injuries ▪ Healed injuries be cannot be differentiated from prior consensual events

	healing of tissues	
Laboratory	▪ Presentation usually too late for rape kit collection ▪ Testing for GC, Chlamydia Chlamydia and Trichomoniasis if indicated by history ▪ Blood drawn at presentation and 3 months after last event for events that could have involved STD transmission	▪ Rape kit collection commonly indicated ▪ Testing for GC, Chlamydia and Trichomoniasis ▪ Blood for RPR, HIV and Hepatitis B to be drawn initially and 3 months after event ▪ Pregnancy and prophylaxis may be appropriate
Report	Child Abuse Hotline, Law Enforcement	Law Enforcement

Myths about child sexual abuse are common. The following is a list of some of the more common myths:

MYTH	FACT
Children are abused by strangers.	Typical for a child's abuser to be known to the child and family
All abusers are male.	The majority of cases involve males. The number of reported female abusers is increasing.
Victims are always female.	Incidence is higher in girls, but under-reporting is even more common in boys than in girls.
Children fantasize about sex with adults.	Children fantasize about those things that are in their experiences. They may fantasize about romance, not sex.
Children never lie.	Children lie to stay out of trouble, not to get into trouble. More commonly they will lie to deny abuse.
Children feel negatively about the abuse.	Sometimes they have a close, warm relationship with an abusive adult. They may feel protective of that adult. The sexual touching may feel good.
Children usually tell.	It is difficult for children to disclose. When disclosure does occur, it is usually delayed and tentative. Recantation can occur if the child is not supported.
There are usually physical findings of abuse.	In the majority of cases, especially those involving the very young child, there will be NO findings. This is compounded by the delayed reporting on the part of the child.
Emergent medical examination is needed.	Except in acute rape cases, a poorly done examination by a disinterested healthcare professional is worse than no exam.
Exams are painful with the use of a speculum.	Exams performed by experienced examiners are usually not painful and a speculum is rarely required.

Child sexual abuse examinations usually require interpretation of physical findings that may be healed injuries, rather than the fresh trauma more commonly seen in sexual assault patients. The examiner must be able to distinguish normal genital variations and changes as children grow from evidence of healed injuries of sexual abuse. The medical evaluations must be performed with sensitivity and low stress for the child and family, and the examiner must have knowledge, skill, and experience. Although most health care providers will not want to examine sexually abused children, all should know when to suspect and report it and make appropriate referrals to an experienced examiner.

The objective of this section is not to make readers into child sexual abuse examiners. One does not actually learn to perform the examinations from print material, lectures, or electronic programs, but rather by performing them under an experienced examiner. The *objectives of this section* are to enable the reader who encounters a child suspected of having been sexually abused to do the following:

- Report suspicions to the Arkansas State Police (ASP) Child Abuse Hotline
- Document available history, especially in regard to immediate safety of the child
- Make referrals to qualified examiners at appropriate times
- Understand the qualifications, levels, and types of examiners
- Judge the performance of examiners to whom one refers
- Determine the skills the reader may wish to develop

The knowledge acquired will help the health care professional protect and facilitate the recovery of children and families in a team-like approach with community agencies and courts.

Reporting

Almost everyone who works with children in a professional capacity, including physicians and nurses, is required to report a suspicion of child abuse to the Arkansas State Police Child Abuse Hotline. The telephone number is (800) 482-5964. The reporting of a suspicion (not necessarily a certainty) is legally required of health care providers, who frequently will not be certain that abuse occurred. Good faith reporting is considered to provide immunity from suit.

Disclosure of relevant information to the Hotline is not a violation of HIPAA. If an investigator needs to quickly interview the child and determine safety of discharge from your office or emergency department, this information should be provided clearly to the Hotline intake personnel.

History

The initial healthcare provider needs information to plan the type of examination and testing needed as well to assess for immediate safety concerns. This can be accomplished with a focused medical history. A more in-depth, disclosure interview requires specific training and should be performed in conjunction with an investigating agency, which may be local law enforcement, Arkansas State Police or the Arkansas Department of Human Services. If a health care provider alone interviews, the child will be re-interviewed by an investigator, and multiple interviews of children are undesirable.

Unfortunately, sexually abused children might not disclose in an interview. The perpetrator may have ensured their past silence for days, weeks or months by intimidation or bribery, causing them to remain cautious about repeating the disclosure to a stranger. Since the offender commonly is a family member, the non-offending parent often is conflicted as to whether to believe the child's disclosure or the adult's denial, and the safety of the child becomes a concern.

If the child is clearly safe, the clinician does not need to maintain the presence of the child and family for an immediate interview by an investigator. If the safety of the child from an alleged perpetrator is uncertain, however, prompt interview and assessment of the child and family by an investigator *before they leave the health care provider's office or emergency room* is essential. This assessment is obtained by reporting the suspected abuse to the Child Abuse Hotline and clearly and directly describing the imminent concern for the child's safety.

Arkansas now has a statewide hospital protocol decision tree flowchart posted in emergency departments. Healthcare providers should refer to this chart for procedures to follow for a child victim. After making a report to the Child Abuse Hotline, wait for contact by Arkansas State Police Crimes Against Children Division before discharging the patient.

Sites of Evaluation

Immediate examinations are sometimes needed for timely medical intervention or when biologic material from an alleged perpetrator is likely to be recovered. They are commonly performed in hospital emergency rooms. Emergency exams are indicated in the following situations:

- Alleged sexual abuse occurred less than 96 hours previously and biological material may have been exchanged.
    - Collection of Collection of biologic material out to 96 hours is indicated in post-menarchal females with a history of vaginal penetration with ejaculation.
- Child has current urinary, genital, or rectal complaints
- Child discloses current pain or bleeding
- Child has bruises or other signs of trauma
- Alleged perpetrator is known or believed to have a sexually transmitted disease
- Child will be exposed to the alleged perpetrator
- Suspicion of DFSA

Hospital emergency rooms are highly stressful environments for sexually abused children and their families and sometimes lack the appropriate equipment and expertise. Fortunately, most evaluations of sexually abused children can be postponed to an appointment time in a regional center or children's advocacy center for the medical evaluation of sexually abused children. In order to be considered such a center, a facility should:

- Support pediatric forensic medical issues through demonstrated leadership, quality assurance, and continuing education in child abuse issues
- Provide a timely forensic medical response to child sexual abuse
- Participate in ongoing review of examinations with abnormal or unclear findings with an experienced child sexual abuse provider.
- Accept appointments by referral to a specialized center for the medical evaluation if the history meets the criteria for delayed examination or if there is an examiner available to perform an acute examination. Children's advocacy centers and the Arkansas Children's Hospital Rice Medical Clinic meet these criteria.

Overview of Physical Evaluation

Scientifically based, appropriate, and minimally invasive examination techniques are required, usually with magnification. The science is evolving rapidly; accurate diagnosis and treatment is dependent upon the clinician's understanding of the current state of the art. *A skillful examination must be conducted, physical findings documented, forensic materials preserved, and tests for infection obtained. A poorly performed examination can result in added stress to the child, loss of evidence, and failure to diagnose a sexually transmitted disease. An incorrectly interpreted exam can result in failure to protect a child, unnecessary disruption of a family, and false accusation of an alleged perpetrator.* Diagnostic quality photographic still and/or video documentation of examination findings enables peer review and expert or second opinions.

The potential benefits of a pediatric physical evaluation are more than forensic. The purposes include the following:

- Diagnosis and treatment of medical conditions resulting from sexual abuse;
- Identification and documentation of evidence of abuse;
- Assessment of the child's safety;
- Differentiation of variants of normal anatomy commonly mistaken for injury;
- Diagnosis and treatment of other medical problems which may mimic abuse;
- Reassurance of the child and family when the exam is normal (since the examinations of most sexually abused girls and boys are normal);
- Referral for counseling if indicated;
- Provision of expert witness testimony.

All children who are suspected victims of child sexual abuse should be offered physical evaluations. *Situations in which immediate or delayed examinations are likely to be the most critical are listed in the following:*

The SIX "Ps"

1. PENILE CONTACT or PENETRATION by any object

- Penile contact with the genitalia, anus or mouth of a possible victim poses a risk of an STD, whether or not penetration clearly occurred.
- Insertion of a finger or object inside the genital or anal area

2. PAINFUL CONTACT

- Any contact that caused pain in the anal or genital area of the victim.

3. PHYSICAL SIGNS

- Genital or anal pain, discharge, sores, bleeding, or painful urination could indicate an injury or STD.

4. PROBLEMATIC SEXUAL BEHAVIORS

- Young children (10 years and younger) who force or coerce other children into sexual contact and children who are displaying sexual acting out behaviors beyond normal developmentally appropriate ranges (child resists being distracted from sexual behaviors/viewing sexual material, self-touching that causes pain, imitating sexual acts with others or with dolls, sexual contact with animals). These problems are not diagnostic that sexual abuse has occurred but warrant evaluation.

5. PERPETRATOR EXPOSED CHILDREN

- A victim's siblings or step-siblings that were exposed to the alleged perpetrator often have been sexually abused in spite of denials.
- Siblings of a child with an STD may also be infected.
- Children of a suspected perpetrator often have been sexually abused and have their own reasons for denial.

6. PREDISPOSITION OF A CHILD TO DENY

Denial of sexual abuse when circumstances suggest it may have occurred, especially when a child:

- Is related to or has close attachment to the suspected perpetrator
- Perceives being blamed by family for causing problems
- Has low self-esteem, low self-confidence
- Seeks approval, tends to obey anything asked of them
- Has cause for fear/anxiety due to prior abuse/violence in the home or has been threatened that harm would occur with disclosure
- Is less that age 5 and/or has cognitive delays making verbalization of abuse more difficult.

Levels of Sexual Abuse Examiners of Premenerchal/Prepubertal Children

In Arkansas, examiners of premenarchal/prepubertal children suspected of having been sexually abused can be divided into three current functional levels based on training, experience and continuing education. All providers should be licensed to practice in their respective field by the state of Arkansas.

Urgent Care (Level I) Examiners

Examinations of sexually abused children are often performed by Level 1 examiners. They perform preliminary assessments because of necessity when an examination is needed without delay for availability of a more experienced examiner. Level 1 examiners often are community hospital emergency department or

primary care physicians that have training in the overall care of emergent medical needs of children, but are not specifically trained in child sexual abuse. They commonly:

- Document presence of injuries by verbal description or drawings in the medical record.
- Test for sexually transmitted diseases (STDs) and provide appropriate initial management.
- Address potential pregnancy issues in post-pubertal female patients.
- Refer most children to a more experienced examiner to assess for non-acute, healed injuries and make appropriate referrals and follow-up appointments.

Ideally, all sexual abuse examinations would be performed by Level 2 or Level 3 examiner so that follow-up exams would not be needed. However, in a rural state such as Arkansas, that is not always possible.

Skilled (Level 2) Examiners

These medical providers have had specific training in the recognition of acute injuries, normal findings, healed injuries, and STD's. They perform the following:

- Obtain a screening medical history to determine whether an examination needs to be performed immediately, or can be scheduled at a later time.
- Obtain a complete medical history, including past medical history, current symptoms, and recent treatment, if any.
- Understand the concept of differential diagnosis, and the signs and symptoms which can be caused by conditions other than abuse.
- Have completed both didactic and clinical training specifically in the field of child sexual abuse, participate in ongoing continuing education in the field and participate in review with a Level 3 provider or child abuse expert of all examination findings thought to be abnormal or indicative of trauma from sexual abuse.
- Evaluate children and adolescents for evidence of acute (fresh) injuries of sexual assault/abuse utilizing photo documentation (or drawings of findings if the child objects to use of photo-documentation device); recognize genital and anal findings that are clearly normal or normal variants; utilize peer review for findings thought to indicate physical evidence of sexual abuse or unclear findings; deferment of final assessments pending review of photographs if concerning findings are present.
- Test for STDs and provide appropriate initial management. Understand the need to perform confirmatory testing of certain types of STD's prior to treatment.
- Address potential pregnancy issues in post-pubertal female patients.
- Collect forensic evidence as appropriate, depending on time since last incident and other factors.

- If needed, refer to a Level 3 examiner for confirmation that a healed injury may be present; otherwise, arrange other appropriate referrals (including mental health) and follow-up tests for STDs and pregnancy.

- Understand and accept responsibility for providing court testimony if needed.

- Participate in ongoing continuing medical education on child abuse issues.

Most pediatric SANE nurses evaluating children in Arkansas' children's advocacy centers are Level 2 examiners.

Tertiary (Level 3) Examiners

- Perform the items listed for a Level 2 provider.

- Have advanced training as a nurse practitioner or physician in the overall assessment of the health and developmental status of children.

- Have had specialized post graduate/post residency training in the evaluation of child sexual abuse cases.

- Participate in ongoing professional continuing education specific to the field of child sexual abuse.

- Commonly provide initial evaluations of children and adolescents, perform second opinion examinations for less experienced examiners, and review photographs for other examiners.

How is the quality of the evaluations of secondary and tertiary examiners assessed? In addition to utilizing the preceding qualifications, an examiner should provide care at current nationally recognized standards. These standards include:

- Utilize a photo-documentation system that allows for magnification and capture of diagnostic quality still or video images of the ano-genital findings. The "colposcope" was traditionally used to accomplish this, but other options are available to provide the needed light source, magnification and capture/storage functions of a colposcope.

- Avoids overcalling insignificant findings as significant. Experienced providers will typically have significant findings in no more than 10 % of their overall cases.

- Routinely participates in review of examination findings that are abnormal or unclear with other expert or Level 3 providers.

- Documenting the location of injuries in an anatomically correct manner (labia, vestibule, hymen, urethral orifice, intra-vaginal, anal verge, anus or rectum);

- Documenting the location of injuries as if a clock was superimposed over the genital or anal area, such as "at 4 o'clock";

- Never using outdated or slang terms for the status of the hymen such as "intact", "marital", or "virginal";

- Limiting the diagnosis or "proof" of sexual abuse from the medical exam alone to:
    - Identification of perpetrator DNA in the patient;
    - Acute or healed complete transection (tear) of the hymen in the absence of a history of accidental penetrating trauma;
    - Acute injuries to the anal or genital structures in the absence of a history of accidental trauma;
    - Certain sexually transmitted diseases;
    - Pregnancy in the absence of a legal, consensual relationship.
- Adherence to an evidence-based documentation scheme in reporting the results of the physical exam. Common "findings" which are not evidence-based indicators of sexual abuse include:
    - Absence of the hymen;
    - Apparently large hymenal opening without other findings;
    - Generalized redness in genital area without bruising, bleeding, or petechiae;
    - Anal dilatation without specific measurement in different planes (directions) and notation of absence of visible stool;
    - Anal "scars" in midline.

    (Jones, J.G., 2005)

Arkansas Children's Advocacy Centers

A Child Advocacy/Safety Center (CAC/CSC) is a not-for-profit child friendly facility that provides a location for forensic interviews, advocacy services and access to specialized medical examinations and trauma focused mental health services during the course of a child maltreatment investigation. It provides a coordinated, collaborative and culturally competent Multi-Disciplinary Team (MDT) response to allegations of child abuse. To the greatest extent possible, components of the team response are provided at the CSC.

Currently Arkansas has 15 functional CAC's, with other communities in varying stages of interest and center development. (http://cacarkansas.org/find_a_cac.php) CAC's offer access to specialized medical evaluations for alleged sexual abuse and many have access to these services on-site. Typically, centers utilize pediatric-Sexual Assault Nurse Examiners (P-SANEs), physicians or advance practice nurses who have received specific training in pediatric sexual assault examinations and are physician supported (if not an advanced practice nurse), to complete the exams.

Arkansas' centers also offer access to specialized trauma focused mental health services, either on site or through linkage agreements with local providers. The CAC's advocate will help the child and non-offending caregiver access the appropriate treatment to meet their individual mental health needs. Mental health services provided on site at the CAC are provided free of charge.

Trauma-Focused Mental Health Services

Children who have been sexually abused may suffer from a variety of symptoms related to their trauma. It is recommended that these children are referred for assessment to determine if they are suffering from trauma-related symptoms to assist in treatment planning. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based approach that has been shown to be helpful for children dealing with trauma. Children treated with TF-CBT have shown improvement in PTSD, depression, anxiety, shame, and behavior problems when compared to supportive therapy. These improvements have been maintained when followed up after two years. TF-CBT also focuses on the parents' needs. Improvement in parental distress, parental support, and parental depression has also been maintained in two-year follow-ups. The treatment is successful with diverse ethnic and racial populations. It is recommended that children who have trauma-related symptoms receive TF-CBT or other evidence-based therapies. Support and education for parents is crucial as parent support for victims is the most critical factor in positive outcomes for children.

Many children who have experienced traumatic events go without treatment or receive treatment that has not proven to be effective in treating traumatic stress symptoms. There is a tremendous need for mental health professionals to be trained in evidence-based models for treating trauma. Mental health professionals may access resources in Arkansas for TF-CBT training or to find TF-CBT-trained therapists listed at www.uams.edu/arbest.

Family Treatment Program

The Family Treatment Program (FTP) is a specialized mental health treatment program within the UAMS Department of Pediatrics that provides assessment and treatment for victims of sexual abuse, youth who have offended, and the parents of both. A team approach is used for victims of child sexual abuse and their families, including secondary victims such as non-offending parents, siblings, and grandparents. Specialized services in the FTP include individual, family, and group therapies. Therapists also work with community agencies to coordinate services for children and minimize system trauma for the child and family. FTP provides TF-CBT and treatment to address family reunification issues. Referrals are made by community agencies, CACs, the Arkansas Division of Children and Family Services, courts, and the families themselves.

The Adolescent Sexual Adjustment Project (ASAP) is a specialized program within the Family Treatment Program that has provided assessment and victim-centered treatment of children and adolescents with sexual behavior problems since 1995. A specially trained and experienced staff assists families and community agencies in safety and treatment planning. Services include psychosexual assessments, specialized individual, group, and family treatment for young children and adolescents with sexual behavior problems, and educational groups for their parents. Referrals are made by Juvenile Courts and the Division of Youth Services and the Division of Children and Family Services.

Chapter

7

7. Arkansas Law

The following is a composition of statutes from **Arkansas Code Annotated** that may be relevant to your work as a medical professional conducting sexual assault exams. For more information: http://www.arkleg.state.ar.us

The Arkansas Legislature meets every other year, in odd numbered years (2011, 2013, etc.) to address substantive law issues and it meets every year to address fiscal issues. Should you notice that the laws as presented here are inconsistent with current laws, please contact the Arkansas Commission on Child Abuse, Rape and Domestic Violence at (501)661-7975 for an updated version.

Reporting

Reporting Sexual Assault - Adult Patients

The decision to report a sexual assault to law enforcement or not is made by the adult patient. Should the patient decide to report the incident to a law enforcement agency, the appropriate law enforcement agency shall be contacted. Generally, this will be the law enforcement agency in the area where the assault occurred, if known. Arkansas Code §12-12-402.

Also, the victim of sexual assault is not required to participate in the criminal justice system or to cooperate with law enforcement in order to be provided with a forensic medical exam or reimbursement for charges incurred on account of a forensic medical exam, or both.

Forensic evidence will be collected only with informed consent of the patient. However, permission shall not be required in instances where the patient is unconscious, mentally incapable of consent or intoxicated.

Reporting Sexual Assault or Abuse - Child Patients

Reporting the sexual assault or abuse of a minor is mandatory for many professionals. Arkansas Code Annotated Section 12-18-402. Reports of child abuse, sexual abuse, and neglect made pursuant to § 12-18-402 can be made to the child abuse hotline at 1-800-482-5964. All investigations shall begin within seventy-two (72) hours, however; if the notice contains an allegation of severe maltreatment, or of neglect, then the investigation shall begin within twenty-four (24) hours. Investigations of sexual abuse, physical abuse and neglect are conducted by the Department of Human Services Division of Children & Family Services; the Arkansas State Police Crimes Against Children Division and local law enforcement personnel pursuant to existing contracts, written, or verbal agreements.

Medical Legal Examinations

§ 12-12-401. Definitions

As used in this subchapter, unless the context otherwise requires:

(1) **(A)** "Appropriate emergency medical-legal examinations" means health care delivered with emphasis on the collection of evidence for the purpose of prosecution.

(B) It shall include, but not be limited to, the appropriate components contained in an evidence collection kit for sexual assault examination distributed by the Forensic Biology Section of the State Crime Laboratory;

(2) "Licensed health care provider" means a person licensed in a health care field who conducts medical-legal examinations;

(3) "Medical facility" means any health care provider that is currently licensed by the Department of Health and providing emergency services; and

(4) "Victim" means any person who has been a victim of any alleged sexual assault or incest as defined by § 5-14-101 et seq. and § 5-26-202.

HISTORY: Acts 1983, No. 403, §§ 1-3; A.S.A. 1947, §§ 41-1820 -- 41-1822; Acts 1991, No. 612, § 1; 2001, No. 993, § 1; 2003, No. 1390, § 3.

12-12-402. Procedures Governing Medical Treatment

(a) All medical facilities or licensed health care providers conducting medical-legal examinations in Arkansas shall adhere to the procedures set forth in this section in the event that a person presents himself or herself or is presented for treatment as a victim of rape, attempted rape, any other type of sexual assault, or incest.

(b)(1)(A) Any adult victim presented for medical treatment shall make the decision of whether or not the incident will be reported to a law enforcement agency.

(B) No medical facility or licensed health care provider may require an adult victim to report the incident in order to receive medical treatment.

(C)(i) Evidence will be collected only with the permission of the victim.

(ii) However, permission shall not be required when the victim is unconscious, mentally incapable of consent, or intoxicated.

(2)(A) Should an adult victim wish to report the incident to a law enforcement agency, the appropriate law enforcement agencies shall be contacted by the medical facility or licensed health care provider or the victim's designee.
(B)(i) The victim shall be given a medical screening examination by a qualified medical person as provided under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, as in effect on January 1, 2001, if the victim arrives at the emergency department of a hospital, and the person shall be examined and treated and any injuries requiring medical attention will be treated in the standard manner.
(ii) A medical-legal examination shall be conducted and specimens shall be collected for evidence.
(C) If a law enforcement agency has been contacted and with the permission of the victim, the evidence shall be turned over to the law enforcement officers when they arrive to assume responsibility for investigation of the incident.
(c)(1) Any victim under eighteen (18) years of age shall be examined and treated, and any injuries requiring medical attention shall be treated in the standard manner.
(2) A medical-legal examination shall be performed, and specimens shall be collected for evidence.
(3) The reporting medical facility or licensed health care provider shall follow the procedures set forth in Subchapter 4 of the Child Maltreatment Act, § 12-18-101 et seq., regarding the reporting of injuries to victims under eighteen (18) years of age.
(4) The evidence shall be turned over to the law enforcement officers when they arrive to assume responsibility for investigation of the incident.
(d) Reimbursement for the medical-legal examinations shall be available to the medical facility or licensed health care provider pursuant to the procedures set forth in § 12-12-403.
(e) A medical facility or licensed healthcare provider shall not transfer the victim to another medical facility unless:
(1) The victim or a parent or guardian of a victim under eighteen (18) years of age requests the transfer, or a physician or other qualified medical personnel when a physician is not available has signed a certification that the benefits to the victim's health would outweigh the risks to the victim's health as a result of the transfer; and
(2) The transferring medical facility or licensed healthcare provider provides all necessary medical records and ensures that appropriate transportation is available.
Credits
Acts of 1985, Act 400, §§ 1, 2; Acts of 1985, Act 838, §§ 1, 2; Acts of 1991, Act 612, § 2; Acts of 2001, Act 993, § 2, eff. Aug. 13, 2001; Acts of 2009, Act 758, § 23, eff. July 31, 2009; Acts of 2017, Act 250, § 4, eff. Aug. 1, 2017; Acts of 2017, Act 845, § 3, eff. Aug. 1, 2017.

12-12-403. Examinations and Treatment - Payment

(a) All licensed emergency departments shall provide prompt, appropriate emergency medical-legal examinations for sexual assault victims.
(b)(1)(A) All victims shall be exempted from the payment of expenses incurred as a result of receiving a medical-legal examination if the victim receives the medical-legal examination within ninety-six (96) hours of the attack.
(B) However, the time limitation of ninety-six (96) hours may be waived if the victim is a minor or if the Crime Victims Reparations Board finds that good cause exists for the failure to provide the medical-legal examination within the required time.

(2)(A) This subsection does not require a victim of sexual assault to participate in the criminal justice system or to cooperate with law enforcement in order to be provided with a forensic medical exam or reimbursement for charges incurred on account of a forensic medical exam, or both.
(B) Subdivision (b)(2)(A) of this section does not preclude a report of suspected abuse or neglect as permitted or required by the Child Maltreatment Act, § 12-18-101 et seq.
(c)(1) A medical facility or licensed health care provider that performs a medical-legal examination shall submit a sexual assault reimbursement form, an itemized statement that meets the requirements of 45 C.F.R. § 164.512(d), as it existed on January 2, 2001, directly to the board for payment.
(2) The medical facility or licensed health care provider shall not submit any remaining balance after reimbursement by the board to the victim.
(3) Acceptance of payment of the expenses of the medical-legal examination by the board shall be considered payment in full and bars any legal action for collection.

Credits
Acts of 1983, Act 403, §§ 4, 5; Acts of 1991, Act 396, § 8; Acts of 2001, Act 993, § 3, eff. Aug. 13, 2001; Acts of 2007, Act 676, § 4, eff. July 31, 2007; Acts of 2009, Act 758, § 24, eff. July 31, 2009; Acts of 2017, Act 920, § 1, eff. Aug. 1, 2017.

§ 12-12-404. Reimbursement of Medical Facility – Rules and Regulations

(a) The Crime Victims Reparations Board may reimburse any medical facility or licensed health care provider that provides the services outlined in this subchapter for the reasonable cost for such services.
(b) The board is empowered to prescribe minimum standards, rules, and regulations necessary to implement this subchapter. These shall include, but not be limited to, a cost ceiling for each claim and the determination of reasonable cost.

HISTORY: Acts 1983, No. 403, § 6; A.S.A. 1947, § 41-1825; Acts 1991, No. 396, § 1; 2001, No. 993, § 4.

§ 12-12-405. License Suspension or Revocation

Noncompliance with the provisions of this subchapter is grounds for licensure suspension or revocation pursuant to the provisions of § 20-9-215 or any other provisions governing the licensure of medical facilities or health care providers.
HISTORY: Acts 1991, No. 612, § 3; 2001, No. 993, § 5.

Sexual Offenses

5-14-101. Definitions

As used in this chapter:

(1) "Deviate sexual activity" means any act of sexual gratification involving:
(A) The penetration, however slight, of the anus or mouth of a person by the penis of another person; or
(B) The penetration, however slight, of the labia majora or anus of a person by any body member or foreign instrument manipulated by another person;
(2) "Forcible compulsion" means physical force or a threat, express or implied, of death or physical injury to or kidnapping of any person;
(3) "Guardian" means a parent, stepparent, legal guardian, legal custodian, foster parent, or any person who by virtue of a living arrangement is placed in an apparent position of power or authority over a minor;
(4)(A) "Mentally defective" means that a person suffers from a mental disease or defect that renders the person:
(i) Incapable of understanding the nature and consequences of a sexual act; or
(ii) Unaware a sexual act is occurring.
(B) A determination that a person is mentally defective shall not be based solely on the person's intelligence quotient;
(5) "Mentally incapacitated" means that a person is temporarily incapable of appreciating or controlling the person's conduct as a result of the influence of a controlled or intoxicating substance:
(A) Administered to the person without the person's consent; or
(B) That renders the person unaware a sexual act is occurring;
(6) "Minor" means a person who is less than eighteen (18) years of age;
(7) "Physically helpless" means that a person is:
(A) Unconscious;
(B) Physically unable to communicate a lack of consent; or
(C) Rendered unaware a sexual act is occurring;
(8) "Public place" means a publicly or privately owned place to which the public or a substantial number of people have access;
(9) "Public view" means observable or likely to be observed by a person in a public place;
(10) "Recording" includes without limitation an image or video;
(11) "Sexual contact" means any act of sexual gratification involving the touching, directly or through clothing, of the sex organs, buttocks, or anus of a person or the breast of a female;
(12) "Sexual intercourse" means penetration, however slight, of the labia majora by a penis;
(13) "Sexually explicit conduct" means the same as defined in § 5-27-302; and
(14) "State of nudity" means the same as defined in § 5-26-302.

Credits
Acts of 1975, Act 280, § 1801; Acts of 1985, Act 327, § 1; Acts of 1985, Act 563, § 1; Acts of 1995, Act 525, § 1; Acts of 2001, Act 1724, § 1, eff. Aug. 13, 2001; Acts of 2009, Act 748, § 7, eff. July 31, 2009; Acts of 2017, Act 664, § 1, eff. Aug. 1, 2017.

5-14-103. Rape

(a) A person commits rape if he or she engages in sexual intercourse or deviate sexual activity with another person:
(1) By forcible compulsion;
(2) Who is incapable of consent because he or she is:
(A) Physically helpless;
(B) Mentally defective; or

(C) Mentally incapacitated;
(3)(A) Who is less than fourteen (14) years of age.
(B) It is an affirmative defense to a prosecution under subdivision (a)(3)(A) of this section that the actor was not more than three (3) years older than the victim; or
(4)(A) Who is a minor and the actor is the victim's:
(i) Guardian;
(ii) Uncle, aunt, grandparent, step-grandparent, or grandparent by adoption;
(iii) Brother or sister of the whole or half blood or by adoption; or
(iv) Nephew, niece, or first cousin.
(B) It is an affirmative defense to a prosecution under subdivision (a)(4)(A) of this section that the actor was not more than three (3) years older than the victim.
(b) It is no defense to a prosecution under subdivision (a)(3) or subdivision (a)(4) of this section that the victim consented to the conduct.
(c)(1) Rape is a Class Y felony.
(2) Any person who pleads guilty or nolo contendere to or is found guilty of rape involving a victim who is less than fourteen (14) years of age shall be sentenced to a minimum term of imprisonment of twenty-five (25) years.
(d)(1) A court may issue a permanent no contact order when:
(A) A defendant pleads guilty or nolo contendere; or
(B) All of the defendant's appeals have been exhausted and the defendant remains convicted.
(2) If a judicial officer has reason to believe that mental disease or defect of the defendant will or has become an issue in the case, the judicial officer shall enter orders consistent with § 5-2-327 or § 5-2-328, or both.
(e) A person convicted of rape is subject to § 9-10-121.

Credits
Acts of 1975, Act 280, § 1803; Acts of 1981, Act 620, § 12; Acts of 1985, Act 281, § 2; Acts of 1985, Act 919, § 2; Acts of 1993, Act 935, § 1; Acts of 1997, Act 831, § 1, eff. March 26, 1997; Acts of 2001, Act 299, § 1, eff. Aug. 13, 2001; Acts of 2001, Act 1738, § 1, eff. Aug. 13, 2001; Acts of 2003, Act 1469, § 3, eff. July 16, 2003; Acts of 2006 (1st Ex. Sess.), Act 5, § 2, eff. July 21, 2006; Acts of 2009, Act 748, § 8, eff. July 31, 2009; Acts of 2013, Act 210, § 2, eff. March 1, 2013; Acts of 2017, Act 472, § 19, eff. Aug. 1, 2017.

5-14-124. Sexual Assault in the First Degree

(a) A person commits sexual assault in the first degree if:
(1) The person engages in sexual intercourse or deviate sexual activity with a minor who is not the actor's spouse and the actor is:
(A) Employed with the Department of Correction, the Department of Community Correction, the Department of Human Services, or any city or county jail or a juvenile detention facility, and the victim is in the custody of the Department of Correction, the Department of Community Correction, the Department of Human Services, any city or county jail or juvenile detention facility, or their contractors or agents;
(B) Employed by or contracted with the Department of Community Correction, a local law enforcement agency, a court, or a local government and the actor is supervising the minor while the minor is on probation or parole or for any other court-ordered reason;

(C) A mandated reporter under § 12-18-402(b) and is in a position of trust or authority over the victim and uses the position of trust or authority to engage in sexual intercourse or deviate sexual activity; or
(D) An employee in the victim's school or school district, a temporary caretaker, or a person in a position of trust or authority over the victim; or
(2) The person is a teacher, principal, athletic coach, or counselor in a public or private school in kindergarten through grade twelve (K-12) and the actor:
(A) Engages in sexual intercourse or deviate sexual activity with a person who is not the actor's spouse and the victim is:
(i) Less than twenty-one (21) years of age; and
(ii) A student enrolled in the public or private school employing the actor; and
(B) Is in a position of trust or authority over the victim and uses his or her position of trust or authority over the victim to engage in sexual intercourse or deviate sexual activity.
(b) It is no defense to a prosecution under this section that the victim consented to the conduct.
(c) It is an affirmative defense to a prosecution under subdivision (a)(1)(D) of this section that the actor was not more than three (3) years older than the victim.
(d) Sexual assault in the first degree is a Class A felony.

Credits
Acts of 2001, Act 1738, § 2, eff. Aug. 13, 2001; Acts of 2003, Act 1391, § 1, eff. July 16, 2003; Acts of 2003, Act 1469, § 2, eff. July 16, 2003; Acts of 2009, Act 748, § 10, eff. July 31, 2009; Acts of 2009, Act 758, § 2, eff. July 31, 2009; Acts of 2013, Act 1044, § 1, eff. Aug. 16, 2013; Acts of 2017, Act 418, § 2, eff. Aug. 1, 2017.

5-14-125. Sexual Assault in the Second Degree

(a) A person commits sexual assault in the second degree if the person:
(1) Engages in sexual contact with another person by forcible compulsion;
(2) Engages in sexual contact with another person who is incapable of consent because he or she is:
(A) Physically helpless;
(B) Mentally defective; or
(C) Mentally incapacitated;
(3) Being eighteen (18) years of age or older, engages in sexual contact with another person who is:
(A) Less than fourteen (14) years of age; and
(B) Not the person's spouse;
(4)(A) Engages in sexual contact with a minor and the actor is:
(i) Employed with the Department of Correction, the Department of Community Correction, any city or county jail, or any juvenile detention facility, and the minor is in custody at a facility operated by the agency or contractor employing the actor;
(ii) Employed by or contracted with the Department of Community Correction, a local law enforcement agency, a court, or a local government and the actor is supervising the minor while the minor is on probation or parole or for any other court-ordered reason;
(iii) A mandated reporter under § 12-18-402(b) and is in a position of trust or authority over the minor; or
(iv) The minor's guardian, an employee in the minor's school or school district, a temporary caretaker, or a person in a position of trust or authority over the minor.
(B) For purposes of subdivision (a)(4)(A) of this section, consent of the minor is not a defense to a prosecution;

(5)(A) Being a minor, engages in sexual contact with another person who is:
(i) Less than fourteen (14) years of age; and
(ii) Not the person's spouse.
(B) It is an affirmative defense to a prosecution under this subdivision (a)(5) that the actor was not more than:
(i) Three (3) years older than the victim if the victim is less than twelve (12) years of age; or
(ii) Four (4) years older than the victim if the victim is twelve (12) years of age or older; or
(6) Is a teacher, principal, athletic coach, or counselor in a public or private school in a grade kindergarten through twelve (K-12), in a position of trust or authority, and uses his or her position of trust or authority over the victim to engage in sexual contact with a victim who is:
(A) A student enrolled in the public or private school; and
(B) Less than twenty-one (21) years of age.
(b)(1) Sexual assault in the second degree is a Class B felony.
(2) Sexual assault in the second degree is a Class D felony if committed by a minor with another person who is:
(A) Less than fourteen (14) years of age; and
(B) Not the person's spouse.

Credits
Acts of 2001, Act 1738, § 3, eff. Aug. 13, 2001; Acts of 2003, Act 1323, § 1, eff. July 16, 2003; Acts of 2003, Act 1720, § 2, eff. July 16, 2003; Acts of 2009, Act 748, §§ 11 to 13, eff. July 31, 2009; Acts of 2009, Act 758, § 3, eff. July 31, 2009; Acts of 2011, Act 1129, § 1, eff. July 27, 2011; Acts of 2013, Act 1086, § 2, eff. Aug. 16, 2013; Acts of 2017, Act 418, § 3, eff. Aug. 1, 2017.

5-14-126. Sexual Assault in the Third Degree

(a) A person commits sexual assault in the third degree if the person:
(1) Engages in sexual intercourse or deviate sexual activity with another person who is not the actor's spouse, and the actor is:
(A) Employed with the Department of Correction, Department of Community Correction, Department of Human Services, or any city or county jail, the victim is in the custody of the Department of Correction, Department of Community Correction, Department of Human Services, or any city or county jail, and the actor is in a position of trust or authority over the victim and uses the position of trust or authority to engage in sexual intercourse or deviate sexual activity;
(B) Employed by or contracted with the Department of Community Correction, a local law enforcement agency, a court, or a local government and the actor is supervising the person while the person is on probation or parole or for any other court-ordered reason;
(C) Employed or contracted with or otherwise providing services, supplies, or supervision to an agency maintaining custody of inmates, detainees, or juveniles, the victim is in the custody of the Department of Correction, Department of Community Correction, Department of Human Services, or any city or county jail, and the actor is in a position of trust or authority over the victim and uses the position of trust or authority to engage in sexual intercourse or deviate sexual activity; or
(D) A mandated reporter under § 12-18-402(b) or a member of the clergy and is in a position of trust or authority over the victim and uses the position of trust or authority to engage in sexual intercourse or deviate sexual activity; or
(2)(A) Being a minor, engages in sexual intercourse or deviate sexual activity with another person who is:

(i) Less than fourteen (14) years of age; and
(ii) Not the person's spouse.
(B) It is an affirmative defense under this subdivision (a)(2) that the actor was not more than three (3) years older than the victim.
(b) It is no defense to a prosecution under this section that the victim consented to the conduct.
(c) Sexual assault in the third degree is a Class C felony.

Credits
Acts of 2001, Act 1738, § 4, eff. Aug. 13, 2001; Acts of 2003, Act 1324, § 1, eff. July 16, 2003; Acts of 2007, Act 363, § 1, eff. July 31, 2007; Acts of 2009, Act 748, § 14, eff. July 31, 2009; Acts of 2009, Act 758, § 4, eff. July 31, 2009; Acts of 2017, Act 418, § 4, eff. Aug. 1, 2017; Acts of 2017, Act 660, § 1, eff. Aug. 1, 2017.

5-14-127. Sexual Assault in the Fourth Degree

(a) A person commits sexual assault in the fourth degree if the person:

(1) Being twenty (20) years of age or older:

(A) Engages in sexual intercourse or deviate sexual activity with another person who is:

(i) Less than sixteen (16) years of age; and

(ii) Not the person's spouse; or

(B) Engages in sexual contact with another person who is:

(i) Less than sixteen (16) years of age; and

(ii) Not the person's spouse; or

(2) Engages in sexual contact with another person who is not the actor's spouse, and the actor is employed with the Department of Correction, Department of Community Correction, Department of Human Services, or any city or county jail, and the victim is in the custody of the Department of Correction, Department of Community Correction, Department of Human Services, or a city or county jail.

(b) (1) Sexual assault in the fourth degree under subdivisions (a)(1)(A) and (a)(2) of this section is a Class D felony.

(2) Sexual assault in the fourth degree under subdivision (a)(1)(B) of this section is a Class A misdemeanor if the person engages only in sexual contact with another person as described in subdivision (a)(1)(B) of this section.
HISTORY: Acts 2001, No. 1738, § 5; 2003, No. 1325, § 1; 2009, No. 630, § 1.

The Impact of HIPAA on Disclosure of Patient Health Information

HIPAA is an acronym referring to the federal Health Insurance Portability and Accountability Act of 1996. HIPAA has two key purposes. The first (Title I) is intended to protect health insurance coverage for workers and their families when they change or lose their jobs. The second (Title II) addresses, through new protections, the security and privacy of patient health data. This latter area has different requirements regarding the protection of health information for adult and child victims of sex crimes.

Adults

AR Code Arm 12-12-402 states that "any adult victim who presents for medical treatment for rape, sexual assault, or incest shall make the decision of whether or not the incident will be reported to a law enforcement agency." Since health professionals are not required to report, *no HIPAA exception to disclosure of protected health information for adult rape victims exists*. The patient's written permission must be obtained utilizing a form that meets HIPAA standards. The form utilized in the Arkansas Children's House of the University Of Arkansas College Of Medicine is Appendix C.

Persons Less Than Age 18 or Mentally Incompetent

Child abuse/neglect are specifically addressed in two separate sections of the HIPAA regulations. *Section 160.203* makes it clear that HIPAA preempts state laws where they are contrary to HIPAA.

Section 164.512 addresses situations where the subject's consent may not be required. A covered entity may disclose information (beyond mere reporting) about victims of child maltreatment or domestic violence, even if otherwise "protected health information," to appropriate government authorities only if:

- Such disclosure would be authorized or required by law or regulations; and
- Disclosure of information on the victim is considered necessary to prevent serious harm to them or to other potential victims; or
- The victim consents to the disclosure.

When information is sought about child victims of crimes, provisions for disclosure to police are similar to those in Section 164.512(c). There are further exceptions for providing information to coroners or medical examiners.

Accounting Versus Obtaining Authorization for Disclosure

Any disclosure for purposes of treatment, payment or healthcare operations, or for which there is patient authorization to make the disclosure, is permissible under HIPAA and does NOT have to be accounted for in a log maintained by the health care facility. *Any disclosure for the following purposes MUST be accounted for in a log maintained by the health care facility, unless written consent is provided:*

- A disclosure required by law;
- A disclosure to a law enforcement official;
- A disclosure pursuant to a subpoena, court order, warrant or during testimony given in court;
- A disclosure to a coroner, medical examiner, funeral director or to an organ procurement organization such as ARORA;

- A disclosure to a health oversight agency responsible for overseeing the health care system.

Disclosure of protected health information for any purpose other than treatment, payment or healthcare operations, even if required by law to report, must be recorded in the log unless the legal guardian has signed an authorization for disclosure of the information. Thus, the most expedient approach may be to request everyone to sign an authorization for disclosure of protected health information.

Forms

Each patient must be given a *Notice of Privacy Practices*. HIPAA requires covered entities to make "good faith efforts" to obtain written verification that patients have received a copy of a Notice of Privacy Practices. Covered entities should have patients sign an *acknowledgement form* when they receive a copy of the Notice of Privacy Practices. Medical practices should also keep a copy of this written acknowledgement in patient's medical records.

The following materials and forms must be available upon patient request:

1) Patient Authorization for Use and Disclosure of Protected Health Information to Third Parties
2) Request for Limitations and Restrictions of Protected Health Information
3) Request to Inspect and Copy Protected Health Information
4) Request for Correction/Amendment of Protected Health Information
5) Request for an Accounting or Certain Disclosures of Protected Health Information
6) Patient Complaint Form

Use of a consent form for examination and treatment of a patient is optional. It does not take the place of an authorization for disclosure of protected health information. Practices that decide to obtain signed consent forms from its patients must still make a good faith effort to obtain written acknowledgement from them of receipt of the Notice of Privacy Practices in order to be in compliance with the Privacy Rule.

Penalty for Violation of HIPAA

HIPAA violations carry fines and penalties that would be assessed against a covered entity or an individual. A staff member who caused the privacy breach could be held accountable for any financial penalties the covered entity incurs – either by way of HIPAA violations or private actions. (American Academy of Pediatrics, 2004). It is not a HIPAA violations for place a call to an advocate upon the victim's request.

Disclaimer

The above information is provided for informational purposes and should serve only as suggested starting points in your practice's compliance with HIPAA. Additional information is needed for compliance. This section is not intended to substitute for technical or legal advice. Reliance on information presented is at your own risk.

Chapter

8

8. Testifying in Court

A patient examination after sexual assault is a medical as well as a legal examination. It should be the expectation that the healthcare provider conducting the examination will be called on to testify in court as either a fact and/or expert witness. Court testimony will not always be needed, an arrest may not be made, a plea bargain may be agreed upon or the prosecuting attorney may decide not to try the case. Despite those possibilities, the healthcare provider should conduct and document each exam with the thought that legal testimony may occur. Most prosecutors are willing to work with the healthcare provider's busy schedule, and will allow them to be on call rather than sitting in the courthouse all day.

To prepare for potential testimony, the healthcare provider should first assure that documentation at the time of the exam is legible, objective, concise, and complete and includes diagrams when appropriate.

When preparing to testify the following guidelines may be useful:

- Meet with the prosecuting attorney in advance, if possible.
- It is reasonable to request if the attorney or victim witness coordinator could contact you with an appropriate lead time to avoid waiting at the courthouse for several hours.
- Refresh your memory about the case. Do not rely on your memory alone. Some cases may not come to trial for months or years after the event. Review written charts or records of the examination.
- Be prepared as an expert witness to educate the court, particularly the jurors. Consider in advance the terminology and descriptions that will most clearly advise the lay members of the court about the procedures, symptoms, etc. that are involved in the case.
- Remember that anything that you write about the case is potentially "discoverable". This means that it could be brought before the court as part of your testimony or to refute your testimony. You may be asked about any notes you have written or files you have concerning this case. If you have made notes or files about a case, you might discuss these with the prosecuting attorney.

- Keep a log of any material that you review for the case. For instance if you reviewed the medical record of John Doe's emergency department visit, your log entry might state: "Medical record of emergency department visit 1/2/00 reviewed on 6/29/00." To be even more specific, you might state: "Emergency department visit 1/2/00, reviewed results of CBC, chest x-ray, chlamydia screen, physician notes, nursing progress note and physician orders."

- Be prepared to "prove" your qualifications as an "expert". You may be asked about your education, clinical experience and prior experience as an expert witness. If you are testifying to facts in a case, you may be asked to explain how you are qualified to testify as to those facts. It is helpful to keep a portfolio that lists your education, experience and previous appearances as a witness.

During the testimony, it may be helpful to:

- Dress appropriately. Most of the lawyers and others in the courtroom will be dressed in business attire. Some studies say that people form an opinion about an individual in the first few seconds after meeting them. To this end, it is important to dress professionally.

- Be sincere, polite and appear in control. Being nervous is normal, even for those who have testified previously. Make eye contact with those who are questioning you. Avoid behaviors that display nervousness, such as: slouching in the chair, whispering, excessive hand movements or giggling.

- If you are unable to answer a question, be honest. If you need to refresh your memory, ask the judge or questioning attorney if you can refer to your report or to the record. If you do not know the answer to a question, say so. It is not necessary to defend yourself or provide an explanation for why you don't know the answer.

- Answer only the questions that are asked of you. Be concise and correct in your responses.

- If you do not understand a question that is asked of you, do not assume. Ask the questioning attorney for clarification or to restate the question.

- Avoid medical jargon if possible. It may be necessary to use medical terminology; however, its usage will need to be defined.

Our legal system is an adversarial system. This means there are two opposing sides that will both have the opportunity to question you. Be as sincere, polite and in control with the defense attorney as you were with the prosecutor. You do not have a side in the case. You are there to present the facts. If you have been called as a witness by the prosecutor's office, then you will be cross examined by the defendant's attorney. If you have been called by the defense attorney, you will be cross-examined by the prosecutor. In order to help you during cross- examination, remember to:

- Be sincere, polite and appear in control. Remain calm. Your credibility will be harmed if you appear angry, rude or out of control.

- You may disagree when appropriate, but do so calmly. Avoid arguing or interrupting during your disagreement.

- Look for "tricks" or "hidden meanings" designed to place doubt on your testimony. For instance, if a compound question is asked, the answer to one part may be "yes" and answer to the other part may be "no". Be sure to divide your answers instead of simply responding "Yes" or "No".

- When referring to the individuals involved in the case, use their names rather than calling them the patient and the suspect.

- Listen to the question and only answer what is asked of you. Don't elaborate unless you are asked to do so.

- Be sure your answers are concise and correct. You may be asked the same question several times, using different wording. Be sure your answers match each time.

- Be precise in your speech. Avoid terms such as "I believe" or "I think". And remember, if you don't know, say so.

- If an error or omission occurs in your testimony, acknowledge it politely. Do not make excuses, argue or take it personally.

- Always think before you answer a question. Allow time to consider your answers and clearly compose them before speaking.

- Listen to the questions fully and carefully.

After the legal proceedings are over, try to meet with the attorney to evaluate your testimony. Seek input concerning suggestions for improvement. Watch other experts testify when possible (Arndt, S., 1998).

Arkansas System for Juvenile Sexual Assault Patients

Reporting to the Child Abuse Hotline

Arkansas law requires that professionals (mandated reporters) must report to the Child Abuse Hotline if he or she has reasonable cause to suspect that a child has been subjected to child maltreatment which is defined to include sexual abuse.

(20) "Sexual abuse" means:
(A) By a person fourteen (14) years of age or older to a person younger than eighteen (18) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion;
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion;
(iii) Indecent exposure; or
(iv) Forcing the watching of pornography or live sexual activity;

(B) By a person eighteen (18) years of age or older to a person not his or her spouse who is younger than fifteen (15) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact;
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact; or
(iii) Solicitation of sexual intercourse, deviate sexual activity, or sexual contact;
(C) By a person twenty (20) years of age or older to a person not his or her spouse who is younger than sixteen (16) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact;
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact; or
(iii) Solicitation of sexual intercourse, deviate sexual activity, or sexual contact;
(D) By a caretaker to a person younger than eighteen (18) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact;
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact;
(iii) Forcing or encouraging the watching of pornography;
(iv) Forcing, permitting, or encouraging the watching of live sexual activity;
(v) Forcing the listening to a phone sex line;
(vi) An act of voyeurism; or
(vii) Solicitation of sexual intercourse, deviate sexual activity, or sexual contact;
(E) By a person younger than fourteen (14) years of age to a person younger than eighteen (18) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion; or
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion; or
(F) By a person eighteen (18) years of age or older to a person who is younger than eighteen (18) years of age, the recruiting, harboring, transporting, obtaining, patronizing, or soliciting of a child for the purpose of a commercial sex act

Failure to report by a mandated reporter in the first degree is a Class A misdemeanor and failure to report in the second degree is a Class C misdemeanor. Making a false report is a Class D felony. Your report initiates an investigation and assessment of safety. The telephone number of the Hotline is 800-482-5964.

Investigations

Your report will be transmitted, by the Hotline to the State Police area in which the incident is alleged to have occurred or the DHS/DCFS County where the family resides, which may give the local law enforcement office (police or sheriff) the opportunity to investigate. Once initiated, a safety assessment will be conducted and if the patient is not safe in the current environment, the Division of Children and Family Services will be notified and their involvement requested. Thus, investigations are conducted by agencies to determine whether civil or criminal proceedings should be initiated, or whether DHS will need to apply safety measures.

In some situations, the Hotline may not accept your report based on specific criteria. However, it is legally and ethically safer to have made the report.

Court Proceedings

Both criminal and civil laws may apply to sexual abuse and rape of teenagers. Investigators are often subpoenaed to appear in different court proceedings involving the same sexual event.

Civil proceedings are typically initiated by the Arkansas Department of Human Services (DHS) to either remove a child from a dangerous environment or to ensure that the child is properly protected from future harm or neglect. Although the identity of persons who caused harm to a child is often relevant in civil proceedings, those cases typically focus on the abuse and the parent or custodian who should have protected the child. In many instances, DHS attorneys must obtain an immediate order (sometimes referred to as a temporary or emergency order) to protect a child from a potentially dangerous situation until the investigation can be completed. Medical information relating to the child's injuries must be presented to a judge, but at this stage, testimony can sometimes be presented by medical affidavit. If the matter is not resolved, further court proceedings will be scheduled, and it will be necessary for medical personnel to testify in court. DHS cases are decided by a judge, not a jury.

DHS also conducts administrative proceedings for which subpoenas may be issued. These proceedings are conducted before an administrative law judge who is an employee of DHS, and the hearings are held in DHS offices throughout the state. If requested in advance of the hearing, the administrative law judges may allow medical testimony by telephone.

Criminal cases are assigned to prosecuting attorneys or their deputies, who file charges against persons suspected of causing the injuries. These two types of cases often involve the same facts and witnesses. However, the legal proceedings are in different courts, presented by different attorneys, and utilize different rules of evidence. Criminal proceedings also involve proof of injury or abuse, but they usually focus on the person(s) who allegedly harmed the patient. Defendants in criminal cases are entitled to a trial by jury unless waived by both the defendant and the prosecuting attorney. A non-jury trial is often referred to as a bench trial.

Sharing of Protected Health Information

Examiners are often unclear with whom they can provide protected health information. Even when a parent or guardian has signed the HIPAA Authorization, examiners still will need to exercise care in providing this information regarding any teenager less than age 18. In the following situations, you must have the following:

- Consent of a legal guardian to provide information to relatives of the sexual assault patients;
- A subpoena for a medical affidavit unless the patient is in DHS custody;
- Consent of the sexual assault patient's guardian or court order to provide information to a defense attorney
- HIPAA order for disclosure to share information to an attorney ad litem or CASA worker.
- A subpoena in order to testify in court.

If in doubt regarding the legality of providing health information, talk with your program's legal advisor.

Chapter

9

9. Reimbursement

Sexual Assault Reimbursement Program

In an effort to consolidate services offered by the Arkansas Crime Victims Reparations Board and the Sexual Assault Reimbursement Program, responsibility for the administration of the sexual assault program was transferred from the Office of the Prosecutor Coordinator to the Office of the Attorney General through Act 396 of 1991.

It is the objective of this legislation to ensure that in the instance of an alleged sexual assault, evidence can be collected without the burden of the expense falling on the shoulders of the alleged victim. The Sexual Assault Reimbursement Program simply pays for the collection of evidence and in no way attempts to prove or disprove the allegation of sexual assault.

In order for a medical facility to seek reimbursement for the expenses incurred while performing the medical-legal examination, the victim must seek treatment within seventy-two (72) hours, except in the case of a minor. A request form for reimbursement must be completed and signed by a physician or sexual assault nurse examiner who performs the examination. On July 31, 2007 Act 676 of 2007 changed the law that required sexual assault victims to report and cooperate with law enforcement for reimbursement of the medical-legal examination. This law now states that a sexual assault victim does not have to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam and to be reimbursed for charges incurred. The reimbursement form and an itemized statement should then be submitted to the Attorney General's Office.

The Sexual Assault Reimbursement Program will not cover expenses that are eligible to be paid by a federally financed benefits program, such as Medicaid, Medicare, TriCare or VA. In addition, this program will not cover expenses related to treatment of physical injuries that are directly related to the alleged assault or for a pre-existing injury.

Eligible expenses consist of the emergency room or facility fee, the physician or SANE fee, the ambulance fee, lab fees and colposcopy fee. In addition, medications for preventive measures are eligible.

The Arkansas Crime Victims Reparations Board instituted policies and procedures for the Sexual Assault Reimbursement Program that provides for the following maximum limits on the eligible expenses:

- Facility fee (includes medications) $350.00
- Physician or SANE fee $350.00
- Ambulance fee $350.00
- Lab fees $200.00
  (outside lab facilities will be given priority)
- Colposcopy fee $160.88

Medical facilities that transfer or receive a transferred patient alleging to have been sexually assaulted must complete the area on the sexual assault reimbursement form. In these instances, the Sexual Assault Reimbursement Program will not disburse any payments for eligible expenses to either medical facility until the necessary documentation and itemized billing statements are submitted from both the transferring and receiving facility. This documentation includes justification of the decision to transfer the alleged victim. In these instances, the medical facilities must share the allowable award ceilings outlined in the Sexual Assault Reimbursement Program's Policies and Procedures. The Arkansas Crime Victims Reparations Board will determine the appropriate portion of the ceiling for each medical facility on a case-by-case basis.

In compliance with Arkansas Code Annotated 12-12-403, the medical facility or licensed health care provider shall not submit any remaining balance after reimbursement by the Arkansas Crime Victims Reparations Board to the victim. Additionally, acceptance of payment of the expenses of the medical-legal examination by the Arkansas Crime Victims Reparations Board shall be considered payment in full and bars any legal action for collection.

The Sexual Assault Reimbursement Program covers only the expenses involved in performing the medical-legal examination. The victim or authorized claimant would need to submit any expenses pertaining to other treatment to the Crime Victims Reparations Board for consideration of payment. For additional information or an application, please contact:

Arkansas Crime Victims Reparations Board
Office of Attorney General Dustin McDaniel
323 Center Street, Suite 200
Little Rock, Arkansas 72201
(501) 682-1020 or 800-448-3014 (outside Pulaski County)

Crime Victims Reparation Fund

The Arkansas Legislature created the Arkansas Crime Victims Reparations Act when it passed Act 817 of 1987. The legislation provides a method of compensating and assisting victims and their dependents who have suffered personal injury or death as the result of a violent crime, including DWI. The program is funded primarily by the assessment of court costs and fees; however, the program also receives court-ordered restitution and federal funding through the Victims of Crime Act.

It is the intent of Act 817 to provide compensation for expenses incurred as a direct result of the criminal acts of other persons. Examples of economic loss covered under the law are: medical care,

counseling, lost wages, replacement services, funeral expenses, loss of support and crime scene clean-up. The maximum award is $10,000; however, for victims receiving catastrophic injuries resulting in total and permanent disability on or after August 1, 1999, the maximum award is $25,000. The law does not cover property loss or pain and suffering.

Eligible claimants are: a victim, a dependent of a deceased victim, or a person authorized to act on behalf of a victim or a dependent. Also, claimants must meet certain other eligibility criteria, including the following:

- Incident occurred in Arkansas on or after July 1, 1988
- Application is filed within one year of incident
- Incident must be reported to proper authorities within 72 hours (minors excluded)
- Victim must suffer personal injury or death as a result of a criminal act
- Victim or claimant must cooperate with the investigation and/or prosecution
- Victim's expenses must not be covered by a collateral source
- Victim or claimant must not have a criminally injurious felony conviction
- Victim's conduct did not contribute to the incident
- Victim was not engaged in illegal activity at the time of the incident
- Victim was not incarcerated at the time of the incident
- If injuries result from the use of a motor vehicle, the incident must involve intent to inflict harm, be a hit and run, or be in violation of the Omnibus DWI Act.

Many local offices may have applications to the Crime Victims Reparations Board, including law enforcement agencies, hospitals, prosecuting attorneys and victim advocacy organizations. Applications and further information can also be obtained by contacting the Crime Victims Reparations Board within the Attorney General's Office by calling 501-682-1020 or toll free at 1-800-448-3014 (outside Pulaski County).

Office of the
Arkansas Attorney General
Leslie Rutledge

ARKANSAS CRIME VICTIMS
REPARATIONS BOARD

SEXUAL ASSAULT REIMBURSEMENT
PROGRAM

REIMBURSEMENT FORM
(for medical facilities only)

Reimbursement will be made ONLY on the following conditions:

1. Treatment is sought and rendered within 96 hours of the assault. (This will be waived if the victim is a minor or if good cause is shown);

2. Treatment was not for a pre-existing injury, a physical injury directly relating to the assault, or any other condition; and

3. The victim is <u>not</u> covered by a federally financed benefits program, such as Medicaid, Medicare, Champus or VA. This stipulation has been made pursuant to a VOCA amendment adopted as a part of the Crime Bill.

SEXUAL ASSAULT VICTIM INFORMATION

Victim's name
_____

Victim's date of birth _____ Social Security No.
_____

Victim's full address
_____

_____

Is victim covered by a federally financed benefits program (if yes, please state which program and the victim's identification number)?
_____

Date and time of assault
_____

Date and time treatment sought
_____

Name and address of law enforcement agency notified
_____

_____

Name and address of medical facility rendering treatment
_____

_____

Telephone number _____ Contact person _____

Was the victim transported by ambulance? _____ If so, please give the name of the ambulance service.

_____

Was an outside lab facility used to perform or analyze specimens? _____ If so, please give the name of the facility.

_____

Transferred victims

Was the victim transferred from your facility? _____ If so, please attach documentation justifying the decision to transfer and the name of the facility to whom the victim was sent.

Was the victim transferred to your facility? _____ If so, please give the name of the facility that transferred the victim.

_____

In the case of transferred victims, please be advised that the Sexual Assault Reimbursement Program will not disburse any payments for eligible expenses to either medical facility until the necessary documentation and itemized billing statements are submitted from both the transferring and receiving facility. In addition, these medical facilities must share the allowable award ceilings outlined in the Sexual Assault Reimbursement Program's Policies and Procedures. The Arkansas Crime Victims Reparations Board will determine the appropriate portion of the ceiling for each medical facility on a case-by-case basis.

Do you have knowledge of the victim incurring expenses with another facility that are related to the sexual assault examination? _____ If so, please give the name of the facility.

_____

ATTENDING PHYSICIAN'S OR SANE CERTIFICATION

Brief description of examination, treatment and tests

_____

_____

I hereby certify that this patient received a medical-legal examination, which included laboratory tests needed by the State to collect evidence for prosecution.

Physician's or SANE signature_____ Date_____

LAW ENFORCEMENT OR VICTIM ASSISTANCE COORDINATOR

If law enforcement was notified, please complete the following section:

I hereby certify that the named law enforcement agency received a report that the victim had been sexually assaulted. The information contained in the application is true and correct to the best of my knowledge or belief.

_____

(Law enforcement/victim witness coordinator/verified victim advocate signature)

Title/Agency

_____

Date _____ Badge Number_____

Pursuant to Arkansas Code Annotated 12-12-404, the Crime Victims Reparations Board will reimburse a medical facility for costs incurred in performing a medical-legal examination and tests for venereal disease on sexual assault victims. The medical facility must complete all relevant sections, including the necessary signatures. A copy of the *itemized* bill (including current procedural terminology (CPT) codes), along with any other relevant information to substantiate the claim must be attached to this form to ensure payment. NOTE: In compliance with Arkansas Code Annotated 12-12-403, the medical facility or licensed health care provider shall not submit any remaining balance after reimbursement by the Arkansas Crime Victims Reparations Board to the victim. Additionally, acceptance of payment of the expenses of the medical-legal examination by the Arkansas Crime Victims Reparations Board shall be considered payment in full and bars any legal action for collection. Information should be forwarded to the **Arkansas Crime Victims Reparations Board, 323 Center Street, 200 Catlett-Prien Tower Building, Little Rock, AR 72201. You may fax the form and itemized statement to (501) 682-5313 or (501) 683-5569. Questions may be directed to 1-800-448-3014 or (501) 682-1020**.

Chapter

10

10. Follow-up Services and Referrals

It is important that sexual assault patients are fully informed about follow-up services and provided with the appropriate referrals. Referrals may include follow-up for medical or mental health needs. Sexual assault advocates usually offer a variety of services in addition to those offered during the sexual assault examination. Often these services include support groups as well as providing referrals for services such as counseling.

Patients may need to follow-up with law enforcement for an interview or information on their case. Examiners should coordinate with law enforcement or victim advocates to discuss safety planning, the investigative and judicial process, as well as follow-up contact procedures.

It is helpful to offer clear and concise verbal and written information about such services at the skill level/ modality and language that is appropriate for the patient. The following pages are handouts that may be helpful for sexual assault patients and their families to understand the healing process and locate needed services in their area. They may be photocopied and distributed.

Sexual Assault State and Nationwide Resources

1-800 helpline telephone numbers, national and statewide

AGENCY	PHONE
Arkansas Coalition Against Sexual Assault	1-800-632-2272
Adult Protective Services	1-800-482-8049 or 501-682-8491
Arkansas Crime Victims Reparation Board	1-800-448-3014 or 501-682-1020
Office for Victims of Crime Resources Center	1-800-851-3420
Suicide Crisis Hotline	1-800-784-2433
CDC National STD Line	1-800-227-8922
R.A.I.N. (Rape, Abuse and Incest National Network)	1-800-656-HOPE
Children's Advocacy Centers of Arkansas	501-615-8633

LOCAL RESOURCES

Program Name	Address	Phone	Hotline	Email	Area Served
Angels of Grace	406 Pecan St. Helena, AR 72342	870-338-8447	877-572-9530	ggonner0614@yahoo.com	Phillips, Lee, Woodruff
Anna's Place	406 Pecan St. Helena, AR 72342	870-338-8447	877-572-9530	rosieburton96@yahoo.com	St. Francis, Lee Monroe, Cross
Center for Healing Hearts and Spirits	2416 South Chester Street Little Rock, AR 72206	501-372-3800	501-372-3800	joyce.raynor@sbcglobal.net	Pulaski, Saline, Lonoke, Garland
Crisis Intervention Center	5603 South 14th Street Fort Smith, AR 72901	479-782-1821	800-359-0056	allison@fscic.org candace@fscic.org	Crawford, Franklin, Logan, Polk, Scott, Sebastian
Delta Crisis Center	1393 Highway 243 South Helena/West Helena, AR 72390		870-816-8022	deltacrisiscenter@gmail.com	Phillips
Family Crisis Center	P.O. Box 721 Jonesboro, AR 72403	870-253-9611	870-933-9449	vgestring@neafamilycrisiscenter.org brogers@neafamilycrisiscenter.org	Craighead, Greene, Poinsett, Lawrence, Clay, Mississippi, Randolph
Family Violence Prevention	P.O. Box 2943 Batesville, AR 72503	870-698-0006	800-798-8111	fvp2943@gmail.com	Independence, Izard, Stone
Northwest Arkansas Rape Crisis	2367 N. Green Acres Road, Suite 1 Fayetteville, AR 72703	479-445-6448	800-794-4175	www.nwarapecrisis.org	Benton, Madison and Washington
Options, Inc. Rape Crisis	P.O. Box 554 Monticello, AR 71657	870-460-0684	870-367-3488	watchman59@yahoo.com	Ashely, Bradley, Desha Chicot, Drew
Ozark Rape Crisis	715 W. Main, Suite A Clarksville AR 72830	479-754-6869	800-818-1189	Dorinda.Edmisten@gmail.com orcc.advocate@gmail.com	Boone, Carroll, Newton, Marion, Searcy and Johnson

Rape Crisis Services (RCS)	P.O. Box 9090 Pine Bluff, AR 71611	870-541-5386	870-541-7100	howard_denice@rocketmail.com	Jefferson and Lincoln
Safe Passage	P.O. Box 755 Melbourne, AR 72556	870-368-3236	870-368-3222	safepassage72556@yahoo.com	Izard, Fulton
Serenity, Inc.	P.O. Box 1111 Mountain Home, AR 72654	870-424-7576 Yellville 870-449-7576	870-424-7233	paulette@serenityinc.org	Baxter, Marion, Fulton
Southwest Arkansas Crisis and Resource Center Inc.	116 South 4th De Queen, AR 71832	(870) 642-2141	1-800-338-9844	debbielynnmc@gmail.com	Sevier, Howard, Pike, Polk, Montgomery, Little River, Garland, and Hot Spring
Union County Family Violence Center (Turning Point)	900 E. First El Dorado, AR 71730	870-862-3672	800-980-0929	turningpointvip@suddenlinkmail.com	Union, Columbia Calhoun
UCA- Counseling Center	201 Donaghey Conway, AR 72033	501-450-3138		reesar@mail.uca.edu	Faulkner
U of A-Fayetteville- STAR Central	Pat Walker Health Center 525 N Garland, Fayetteville, AR 72701	479-575-7252		survivor@uark.edu mwyandt@uark.edu	Washington
Women's Crisis Center of South Arkansas	P.O. Box 1149 Camden, AR 71701	870-836-0375	888-836-0325	acadv6@sbcglobal.net	Calhoun, Cleveland, Columbia, Dallas, Ouachita
Women's Shelter of Central Arkansas (Sexual Assault Crisis Response of Central Arkansas	P.O. Box 2557 Conway, AR 72033	501-730-9864	866-358-2265	wsca@conwaycorp.net wsca1@conwaycorp.net	Faulkner
Women and Children First	P.O. Box 1954 Little Rock, AR 72203	501-376-3219	1-800-332-4443	amcgraw@wcfarkansas.org	Pulaski

CHILDREN'S ADVOCACY CENTERS OF ARKANSAS

Member Centers	Physical Address	Telephone	Executive Director	Email Address	Satellite Location
Central Arkansas Children's Advocacy Center	574 Locust St., Conway, AR 501.328.3347	501.328.3347	Tess Fletcher	tfletcher@hopeandjustice.org	
Children's Advocacy Center of Benton County	2113 Little Flock Dr., Little Flock, AR 72756 479.621.0385	479.621.0385	Natalie Tibbs	natalie@cacbentonco.com	
Children's Advocacy Center of Eastern Arkansas	905 N Seventh, West Memphis, AR 72301 870.702.5933	870.702.5933	Lori Wilson	l1wilson@mshs.org	Forrest City

Children's Advocacy Center of Pine Bluff	211 W Third, Ste. 130, Pine Bluff, AR 71601 870.850.7105	870.850.7105	Christa Menotti	cacdirector@pbreynoldscenter.org;	
Children's Advocacy Center of South Arkansas	1130 East Main St., El Dorado, AR 71730	870.862.2272	Robin Krneta	director@13southcasa.com	
Children's Protection Center - Little Rock	1210 Wolfe St., Little Rock, AR 72202	501.364.5490	Jennifer Long	jlong@childrensprotectioncenter.org	
Children's Safety Center - Springdale	614 E. Emma, Ste. 200, Springdale, AR 72764	479.872.6183	Elizabeth Shackelford	elizabeth@childrenssafetycenter.org	
Cooper-Anthony Mercy Child Advocacy Center	216 McAuley Court, Hot Springs, AR 71913	501.622.2531	Karen Wright	Karen.Wright@Mercy.Net	Mena
Grandma's House Children's Advocacy Center	501 W Stephenson, Harrison, AR 72601	870.391.2224	Michelle Steiner	msteiner@grandmashousecac.com	Green Forest
Hamilton House Child Safety Center	Mercy Medical Tower	479.783.1002	Jackie Hamilton	calljackie@aol.com	
Northeast Arkansas Children's Advocacy Center	1302 Stone St., Jonesboro, AR 72401	870.275.7902	Kaye Beall (Interim)	kaye.beall@yahoo.com	
Percy and Donna Malone CSC	442 Mt. Zion Rd., Arkadelphia, AR 71923	870.403.6879	Christa Neal	christaneal86@gmail.com	
River Valley Children's Advocacy Center	2206 Red Hill Lane	479-498-4747	Marilyn Sanders	msanders.paris@gmail.com	
Texarkana Children's Advocacy Center	1201 Main St, Texarkana, TX 75503	903.792.2215	Brandy Eldridge	brandyeldridge@casatexarkana.org	Nashville
Wade Knox Children's Advocacy Center	1835 SW Front St., Lonoke, AR 72086	501.676.2552	Karen James	kjames.wadecac@sbcglobal.net	Brinkley
White County Children's Safety Center	414 Rodgers Dr., Searcy, AR 72143	501.268.4748	Robin Connell	robinconnell@yahoo.com	

Information You Should Have as a Sexual Assault Survivor

What is sexual assault?
Sexual assault occurs when there is an unwanted sexual behavior without your consent or if you are unable to consent. Some examples of sexual assault include: rape, attempted rape, fondling, voyeurism and sexual harassment.

Perpetrators of sexual assault can be anyone. They can be an acquaintance, date, stranger, or even a spouse. Sexual assault is a crime of power, not lust. It is done to hurt or humiliate and it is a crime.

Common Reactions
Sexual assault can be one of the most painful and upsetting things that can happen to a person. You shouldn't be surprised if you experience a wide variety of emotions following an assault. Here is a list of common feelings and reactions that survivors have reported:

- Reluctance to go to work/ school
- Fear
- Loss of control
- Guilt
- Panic
- Inability to concentrate
- Anger
- Stomach or headache
- Wondering "why"
- Betrayal
- Numbness or Emptiness
- Rage
- Difficulty Sleeping
- Withdrawal
- Sense of loss

You may find yourself constantly thinking about the sexual assault or refusing to think about it. All of these feelings, thoughts and reactions are normal. It is important for you to have support to help you express and deal with these reactions. Don't be afraid to talk with someone about your reactions, particularly someone trained in issues relating to sexual assault.

Your options: What do you do if you have been sexually assaulted?
Making decisions after a sexual assault is often confusing and overwhelming. In addition to making decisions about who to tell, you may be struggling with your medical and legal decisions. If you decide to report the sexual assault to law enforcement, you have a right to have someone of your choosing remain with you at all times during the law enforcement questioning and the sexual assault exam.

Medical treatment: What to expect
If they are available in your area and if you desire, a sexual assault advocate or a social worker can be called to talk with you and stay with you through the sexual assault exam for support. This person can also explain procedures and options available to you.

Paperwork
A nurse or physician will ask you some difficult and possibly painful questions. They may include:

- Have you had sexual activity in the last five days?
- Have you been drinking alcohol or using drugs?
- Do you know the person who raped or sexually assaulted you?
- Have you ever had consensual sex with this person?
- Are you currently using any method of birth control?

These questions are not meant to imply that you are at fault. **You are not to blame for this assault.** These questions simply help document the circumstances and event that are relevant to the assault. They also help us provide the best medical care for you.

Sexual Assault Exam

Once the paperwork is completed, a doctor, emergency room nurse or a sexual assault nurse examiner will begin the sexual assault examination. This may include:

- Asking you to undress. Your clothes will be kept as part of the evidence collection. If you did not bring any clothes with you to wear home, additional clothing may be available from an advocate or the hospital or you may call a family member or friend to bring you additional clothing.
- Check for injuries. Depending on you injuries, X-rays or photographs may be taken.
- Taking specimens from various areas of your body including your fingernails, samples of pubic hair, swabbing the inside of your mouth, your vagina for a woman or your penis for a man and anal area. This type of collection occurs with every sexual assault examination.
- Given medicine to prevent infection from sexually transmitted diseases and being screened for emergency contraception.
- Drawing blood.
- Being given referrals to various support services.

Legal Issues

In Arkansas, rape and sexual assault are criminal offenses. However, you have the right to decide whether or not you want to report the sexual assault to the police/ sheriff. **Making a report to the police/ sheriff does not mean that you have to press charges.** We encourage you to talk with the police/ sheriff so there will be a record of this crime.

The police/ sheriff may ask you some of the same questions as the hospital staff as well as additional, possibly difficult, questions. This information could help catch the perpetrator. They will want to know the time, date, and location of where the sexual assault occurred. **None of these questions are meant to blame you for the sexual assault.** They are simply part of a thorough investigation. If you do choose to report the sexual assault, the evidence that is collected will be turned over to the police/ sheriff.

Who will pay for this?

Neither you nor your private health insurance should be billed for any costs associated with the sexual assault examination. There may be additional charges if you have any physical injuries. If your health insurance plan does not cover these charges, you may be eligible for the Arkansas Crime Victim's Reparation Board. If you are billed for the sexual assault examination or would like to know more about the Crime Victim's Reparation Board, please call the Attorney General's Office at (501) 682-1020 or 800-448-3014.

Follow-up Medical Care

Because not all injuries show up right away, do not be surprised if you discover additional bruising over the next day or two. If this happens, call the police officer who is assigned to your case. They may want to take additional photographs.

Also, you will need to follow-up for Sexually Transmitted Diseases as recommended by your healthcare provider.

Support Services

Allow yourself enough time to heal. Don't be afraid to talk with someone about your feelings and reactions, especially someone trained in issues relating to sexual assault. They may be able to help you with medical and legal questions. **No one should go through this alone.**

Follow your inner feelings about the people you trust with sharing your emotions. Do not be afraid to question what they say or how they act toward you. Choose someone who will understand your experience and feelings. This person will allow you to take as much time as you need.

Things You Can Do

- Address immediate concerns such as medical and legal issues. Identify your options.
- Breathe. Try to relax and take deep breaths.
- Be patient with your self. It takes time to heal.
- Honor your experiences. Appreciate yourself and your strength for having survived!
- Reassure yourself. Many people who suffer from a sexual assault feel this way.
- Find help. Look for people such as counselors, clergy or friends that can help.
- Go to a support groups for survivors. Other survivors are wonderful support. Contact your local rape crisis center for a support group near you.
- Educate yourself. Read books or contact your local rape crisis center to get information about the common myths and misconceptions about sexual assault.
- Be familiar with people and places that make you feel unsafe. Find help creating a safety plan that addresses your needs and concerns.

Resources

You may need additional resources to help in your recovery. Other local support services may provide you with additional information. Below are some state and national resources.

Arkansas Commission on Child Abuse, Rape and Domestic Violence
501-661-7975
www.accardv.uams.edu

Arkansas Coalition Against Sexual Assault
1-866-63ACASA
www.acasa.us

Rape, Abuse, & Incest National Network (RAINN)
1-800-656-HOPE.
www.rainn.org.

Office of Victims of Crime (Victim Rights)
http://www.ovc.gove/rights/compliance.html

Always remember that you are a survivor.

Helping Your Son or Daughter after Sexual Assault

Common Reactions

Learning your child has been a victim of sexual assault can be one of the most painful and upsetting things that can happen to a parent. Often learning who assaulted your child can also be overwhelming. Conflicting loyalties can be an issue if the perpetrator is someone close to you or your child. You shouldn't be surprised if you and your child experience a wide variety of emotions following an assault. Here is a list of common feelings and reactions that survivors of sexual assault have reported:

- Fear
- Numbness or emptiness
- Guilt
- Reluctance to go to school/ work
- Sense of loss
- Disbelief
- Regression
- Anger
- Stomach or headache
- Nightmares
- Difficulty concentrating
- Agitation
- Shame
- Withdrawal
- Rage
- Difficulty sleeping
- Panic
- Wondering "why me?"
- Replay the event
- Betrayal

All of these feelings and reactions are normal. It is important you and your child have the support you need to express and deal with these feelings and reactions. Looking out for your child and the rest of your family can be exhausting and overwhelming. You would not expect your child to handle this alone so don't expect that of yourself. Don't be afraid to talk with someone about your reactions, particularly someone trained in issues relating to sexual assault.

Your child and your family need you more than ever. Don't be afraid to reach out and comfort them. Remember to always respect their feelings and reactions. Give them and yourself space when needed.

Things You Can Do

- Address immediate concerns such as medical and legal issues. Identify your options.
- Take steps to ensure your child's safety and explain to him/her what you are doing.
- Be patient. This is a difficult thing for your child to share with you.
- Allow your child to talk about his/ her fears and come up with a plan to address them.
- Let you child know you are proud of him/ her for disclosing the sexual assault.
- Create situations that allow your child to feel in control and empowered.
- Find help. Look for people such as counselors, clergy or friends that can help guide and support you and your family.
- Educate yourself. Read books or contact your local rape crisis center to get information about the common myths and misconceptions about sexual assault.

Thing you can say

- Tell your child you believe him/her and thank them for trusting you enough to tell you about the abuse.
- Let your child know you will do everything in your power to keep them safe.
- Let your child know that his/ her feelings and reactions are normal.
- Tell your child the sexual assault is not his/ her fault.

- Tell your child not to worry about you- it is your job to worry about him/ her.
- Be honest with your child about specific things that are happening.

What is Next?

Law Enforcement Investigation
Whether or not the perpetrator of this crime is prosecuted, a law enforcement office may get in touch with you for a follow-up interview. You and/or your child will have to talk about the assault again. If at any time you feel uncomfortable as to why a certain question is being asked, you have a right to ask why it is being asked.

Follow-up Medical Care
Because not all injuries show up right away, do not be surprised if you discover additional bruising over the next day or two. If this happens, call the police officer who is assigned to your case. They may want to take additional photographs.

Support Services
Allow yourself and your child enough time to heal. Don't be afraid to talk with someone about your feelings and reactions, especially someone trained in issues relating to sexual assault. They may be able to help you with medical and legal questions. **No one should go through this alone.** Crisis counseling can make all the difference in your recovery.

Follow your inner feelings about the people you trust with sharing your emotions. Do not be afraid to question what they say or how they act toward you. Choose someone who will understand your child's experience and feelings. This person will allow as much time as needed for recovery.

Resources
We recognize you and your child may need help in your recovery from this traumatic experience. Below are some state and national resources that may provide additional information:

Arkansas Commission on Child Abuse, Rape and Domestic Violence
501-661-7975
www.accardv.uams.edu

Arkansas Coalition Against Sexual Assault
1-866-63ACASA
www.acasa.ws

Rape, Abuse, & Incest National Network (RAINN)
1-800-656-HOPE.
www.rainn.org.

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Non-referenced material was taken from the original edition of this manual.

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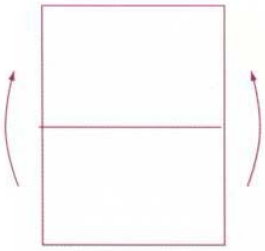
APPENDIX A

Folding a Bindle



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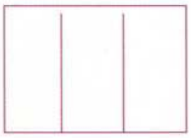
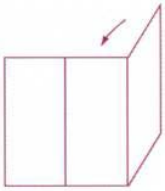
Fold the paper in half.



2
Fold the half-sized paper into thirds.



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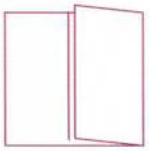

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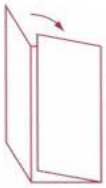

5
Fold over the left flap.

6

7
Fold in half. Seal the open end of the bindle, not the folded end. Initial the tape before sealing.

APPENDIX B

ARKANSAS CHILDREN'S HOSPITAL
SOCIAL WORK DEPARTMENT

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1. I authorize Arkansas Children's Hospital to disclose **protected health information** to the persons or entities indicated below, including the release of any information contained in the medical records of

Patient Name: _____ **Date of Birth** _____

2. I authorize disclosure of the information indicated below **to all of the persons/entities listed below unless noted otherwise. These agencies have a right to this information according to the Child Maltreatment Law.**
Please place your initials in each blank:

____AR State Police
____Police Department of the city (s) of_____
____Sheriff's Office of _____County(s)
____AR Dept of Human Services of _____County (s)
____Child Maltreatment Multidisciplinary Team of _____County

3. I authorize disclosure of the information indicated below to all person/entities listed below that I have initialed.

____Circuit Court of _____County(s) & its agents
____Juvenile court of _____County(s) & its agents
____Prosecuting attorney of _____County(s)
____Other:_____

4. Information to be released

❑Discharge Summary	❑Operative Report	❑Clinic Report	❑Medical Abstract	❑Social History
❑Psychiatric Evaluation	❑X-Ray & Lab	❑Tx Plan	❑Substance Abuse	❑Progress Notes
❑Psychological Evaluations	❑Education Information	❑ER Report	❑History & Physical	❑Diagnosis

5. The information is need for:
❑Continuity of Care ❑Legal Reasons ❑School ❑Disability ❑Insurance

6. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by the Federal privacy laws and regulations.

7. Arkansas Children's Hospital, employees, and attending physicians are released from responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

9. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to AR Children's Hospital except to the extent that action has been taken in reliance on this authorization. This authorization expires two (2) years from the date signed below, or until the investigation and legal proceedings involving the patient(s) are completed, whichever is later.

10. **Purpose of request to release records/protected health information**: Support of investigation, management, treatment, and/or legal action in cases of possible child maltreatment.

NOTE: An ACH social worker may call in the next few days.

_____
Patient Name

_____ _____
Signature of Parent/Guardian Legal Relationship to Patient

_____ _____
Witness Date

PROVIDE A COPY TO PARENT or OTHER LEGAL REPRESENTATIVE SIGNING THIS FORM

AUTH. ROI

ADDITIONAL RESOURCES

Patient's Medical History and Sexual Assault Information

1. Patient's Name: _____

2. Date of Birth: _____ **3.** Race: _____

4. Male: ☐ Female: ☐

5. Date and time of alleged assault: Date: ___/___/___ Time: _____

6. Date and time of hospital examination: Date: ___/___/___ Time: _____

7. Examining physician: _____ **8.** Examining nurse: _____

9. Between the assault and now, has the patient:

☐ Douched ☐ Defecated ☐ Brushed Teeth ☐ Urinated ☐ Drank
☐ Vomited ☐ Mouthwash ☐ Bathed/ Showered ☐ Changed Clothes

10. Was there penetration of (if known):

	Attempted	*Successful*		*Yes*	*No*	*Not Sure*
Vagina:	☐	☐	Ejaculation:	☐	☐	☐
Anus:	☐	☐	Ejaculation:	☐	☐	☐
Mouth:	☐	☐	Ejaculation:	☐	☐	☐

11. Oral/ Genital Sexual Contact (if known): ☐ Fellatio ☐ Cunnilingus

12. Did assailant use (if known): ☐ Lubricant ☐ Condom ☐ Insert foreign object/s

13. Was patient menstruating at time of assault? ☐ Yes ☐ No

14. Any consensual intercourse in the last 96 hours? ☐ Yes ☐ No

If yes Date: Time: If yes, was condom used? ☐ Yes ☐ No

15. Is patient pregnant? ☐ Yes ☐ No

16. Any injuries to patient resulting in bleeding? ☐ Yes ☐ No

If yes, describe: _____

17. Number of assailants: _____ **18.** Race of assailant/s if known: _____

19. Assailant/s relationship to patient:

☐ Stranger ☐ Acquaintance ☐ Intimate partner ☐ Relative (specify)

_____

20. Was any medication taken by patient prior to or after assault? ☐ Yes ☐ No

If yes, describe: _____

21. Is patient still wearing same clothes from the assault:

_____

_____

_____

22. Patient's description of alleged assault:

_____

_____

_____

_____ _____

Signature of Medical Provider Date

It is recognized that not all information may be known by the patient or may not be suitable to ask children. Any additional information or evidence that can be provided will be of great assistance. Information provided is used by the crime lab to facilitate processing of the evidence.