

**GUIDELINES FOR THE MEDICAL
FORENSIC EXAMINATION
OF ADULT AND ADOLESCENT
SEXUAL ASSAULT PATIENTS**

Indiana Emergency Nurses Association
www.indianaena.org

Indiana Chapter, International Association of Forensic Nurses
<http://community.iafn.org/indianastate/home>

The Indiana Coalition to End Sexual Assault
www.indianacesa.org

These guidelines are intended as recommendations. They should not invalidate protocols or policies already in place at hospitals or sexual assault treatment centers. Nor should the guidelines supersede law.

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CONTENTS

2019 Indiana Guidelines for the Medical Forensic Examination of Adult and Adolescent Sexual Assault Patients

Preface	6
Purpose of the Sexual Assault Medical Forensic Examination	7
Section A. Overarching Issues	
1. Role of the Healthcare Provider	8
2. Sensitivity to Patients' Needs	8
a. Patient-centered Care	8
b. Trauma-informed Care and the Neurobiological Response to Trauma.....	9
c. Culturally Sensitive Care/Special Populations	10
i. LGBTQ+ patients	10
ii. Male Patients	11
iii. Patients who have been trafficked	11
iv. Incarcerated Patients.....	12
v. Patients who are immigrants, refugees, and/or migrant workers.....	12
vi. Older Adult Patients	13
vii. Adolescent Patients	13
viii. Children.....	14
ix. Patients with Disabilities.....	14
x. Endangered Adults.....	14
xi. Deceased Patients	15
xii. Incapacitated Patients	15
xiii. Patients with limited English proficiency.....	15
3. Contacting Advocacy	15
4. Informed Consent	16
5. Confidentiality	16
6. Reporting to Law Enforcement	17
a. Anonymous Kits	18
b. Mandatory Reporting	18
7. Payment for the Medical Forensic Examination	18
Section B. Operational Issues	
1. Sexual Assault Nurse Examiners/Forensic Examiners ...	20
a. Advanced Practice Providers	20
2. Facilities	20
a. Transfers.....	21
3. Equipment and Supplies	21
4. Sexual Assault Evidence Collection Kit (SAEK)	22
5. Timing Considerations for Collecting Evidence	22
6. Evidence Integrity	23

CONTENTS (CONTINUED)

Section C. The Examination Process

1. Initial Contact	25
2. Triage and Intake	25
3. Documentation by Healthcare Personnel	26
4. The Medical Forensic History	26
a. General Principles	27
b. Essential Components of the History of Assault.....	28
c. Essential Components of the History of Post Assault Activities	29
d. Essential Components of the Medical History.....	29
5. Photography	30
6. Exam and Evidence Collection	31
a. Clothing Collection.....	32
b. Oral Exam and Collection	32
i. Patient Standard	32
c. Head Hair Combing Collection	32
d. Pubic Hair Combing Collection.....	32
e. Fingernail Exam and Collection.....	33
f. The Anogenital Exam	33
i. External Genital Collection.....	34
ii. Internal Genital Collection	34
iii. Vaginal Collection	34
iv. Collection of Tampon, Sanitary Pad and/or Condom.	34
v. Anal Collection	34
g. Foreign Material, Dried Secretion, and Debris Collection...	34
h. Bite Mark Collection	34
i. Not Recommended.....	35
j. Collection Recommendations for Patients Unable to Provide a History	35
k. Evidence Collection and Handling	35
7. Alcohol and Drug Facilitated Sexual Assault	35
8. Strangulation	36
9. STI Evaluation and Care	37
a. PEP/nPEP.....	38
10. Pregnancy Risk Evaluation and Care	40
11. Discharge and Follow-up	41
12. SANE/SAFE Testimony	42
Definitions	43
Additional Resources	44
References	45
History and Acknowledgments	47
Appendices	48

PREFACE

In August of 2017, representatives from the Indiana Chapter of the International Association of Forensic Nurses and the Indiana Emergency Nurses Association Forensic Committee met with the Indiana Coalition to End Sexual Assault and were tasked with updating the Indiana Guidelines for the Medical Forensic Examination of Adult and Adolescent Sexual Assault Patients with a goal of assuring a solid framework for the medical forensic exam based on current science and national best practice. These guidelines should provide guidance for high quality patient care and evidence collection that can both begin a victim's healing journey and serve the needs of the legal system. They should assist in optimizing care and reduce unnecessary variations in the practice of the medical forensic exam in the state of Indiana.

Sexual assault is a form of interpersonal violence that is prevalent throughout the United States and the state of Indiana. For the purposes of this document, sexual assault is defined as any type of sexual contact or behavior that occurs without mutual, un-coerced, freely given consent. The Indiana code defines sexual assault in [IC 35-42-4-1](#). It is a crime that can occur regardless of a victim's socioeconomic status, race, ethnicity, religion, gender, sexual orientation, age, physical ability, or cognitive development. The perpetrator may be a stranger to the victim but far more often is someone the victim knows and trusts such as an acquaintance, partner, or family member. Sexual assault is an act of power and control that can result in acute physical injury, emotional and psychological distress, risk of infection and/or unwanted pregnancy, long term physical and mental health concerns, and acute and ongoing safety concerns. Victims may be reluctant to seek medical attention or report to law enforcement for a variety of reasons including minimizing or normalizing abusive behavior, self-blame, embarrassment, fear, trauma, lack of faith in the medical or judicial systems, or lack of knowledge of available resources and services.

Individuals who have experienced sexual assault require and deserve specialized, patient or victim-centered, trauma-informed, culturally sensitive care. This model of care is essential to appropriately meet their medical, psychological, and emotional needs while also addressing the forensic requirements of the criminal justice system. The role of providing this care and collecting evidence for sexual assault patients/victims is typically performed by nurses, advanced practice providers, and physicians in hospital emergency departments and sexual assault treatment centers (SATC). Throughout these guidelines, the term Sexual Assault Treatment Center will refer to medical facilities that provide evidence-based, trauma-informed and victim-centered medical forensic services and that use Sexual Assault Forensic Examiners (SAFE) to perform medical forensic exams. They can be hospital or community based. A SAFE is a registered nurse, nurse practitioner, physician, or physician assistant, most often a registered nurse (Sexual Assault Nurse Examiner, or SANE), who has specialty training to provide comprehensive care to patients who have been sexually assaulted, conduct a medical forensic examination, collect forensic samples that are turned over to law enforcement as evidence, and testify as both a fact and expert witness. Care of those who have been sexually assaulted is best provided by SANE/SAFEs. Receiving this high quality care may assist the healing process, minimize trauma, increase the quality of documentation and evidence collected, and ultimately increase cooperation with law enforcement and the criminal justice system (Campbell, Patterson, Bybee, & Dworkin, 2009; Greenson & Campbell, 2013). Research has shown that utilizing SANE/SAFEs to perform medical forensic examinations is associated with higher rates of prosecution and convictions (NIJ National Best Practices, 2017). As such, recommendations within these guidelines are based upon research and best practice regarding the physical and emotional needs of the sexual assault victim, reasonably balanced with the requirements of the legal system.

It is known that a coordinated, multidisciplinary community response, often through a Sexual Assault Response Team (SART) including healthcare professionals, law enforcement, prosecutors, advocates, and other disciplines, can improve treatment of victims, promote healing and recovery, facilitate criminal investigation, hold offenders accountable, and ultimately contribute to efforts to end sexual assault. For more information on SARTs please

see the National Sexual Violence Resource Center SART Toolkit (<https://www.nsvrc.org/sarts/toolkit>) and/or the Indiana Coalition to End Sexual Assault (ICESA) Indiana SART Guide (<https://indianacesa.org/wp-content/uploads/2018/03/IndianaSARTsGuideE2018.pdf>).

While the role of each SART member is vital, these guidelines focus on the role of the healthcare professional in performing the medical forensic exam. This document should assist the healthcare professional to:

- Reduce the physical and psychological trauma experienced by a patient and promote the acute and long term health, well-being, and healing of the patient;
- Maximize the probability of collecting and preserving physical evidence for potential use in the legal system;
- Standardize the quality of care for sexual assault patients and base this care on the latest scientific evidence; and,
- Address important issues surrounding the medical forensic examination.

Please note that these guidelines focus on the evaluation and care of the adult and adolescent sexual assault patient, which differs significantly from the approach to the pediatric sexual assault patient. Of note, sexual assault patients are also referred to as victims or survivors depending on the type of responder. The term “victim” is not used in a strictly criminal justice context but can also simply acknowledge that persons who have disclosed history of sexual assault should have access to certain services (*OWW National Protocol, 2013*). The term “patient” is typically most appropriate for the healthcare provider. The guidelines are intended as recommendations not mandates. They do not invalidate protocols, policies or practices in place within a hospital, sexual assault treatment center, or community, or supersede law (*NIJ National Best Practices, 2017*).

Purpose of the Sexual Assault Medical Forensic Examination

1. To recognize the sexual assault patient as a high-acuity patient with urgent needs.
2. To identify and treat injuries to the patient.
3. To follow standardized procedures for documentation of pertinent history, physical findings, and collection of forensic evidence from patients who present following sexual assault.
4. To assess risk and offer prophylactic treatment for sexually transmitted infections (STIs) including HIV.
5. To assess risk and offer treatment for pregnancy prevention.
6. To provide support, crisis intervention, and access to patient/victim advocacy services.
7. To develop discharge and aftercare plans for the patient including assessment and provision for safety planning.
8. To facilitate the beginning of the healing process and minimize short and long-term health sequelae of sexual violence for the patient.

NIJ National Best Practices, 2017

OVERARCHING ISSUES

1. ROLE OF THE HEALTHCARE PROVIDER

The healthcare provider assesses patients for acute medical needs and provides stabilization, treatment, and/or consultation. Ideally, sexual assault nurse examiners perform the medical forensic exam, obtain a medical forensic history, collect and document forensic evidence, and document pertinent physical findings from the exam. SANE/SAFEs offer information, treatment, and referrals and/or follow-up for sexually transmitted infections or diseases (STIs/STDs) including HIV and other acute and non-acute medical concerns; assess pregnancy risk and discuss emergency contraceptive options with the patient; and may follow up with patients for medical and forensic purposes.

Healthcare providers report to law enforcement and Department of Child Services (DCS) or Adult Protective Services (APS) as mandated reporters as required by law. They also help facilitate the patient's contact with law enforcement if a patient wishes to report the assault and has not done so prior to presenting for examination. The provider testifies in court as needed. They should also coordinate with advocates to ensure that patients are offered crisis intervention, support, and advocacy before, during, and after the exam process and encourage the use of other victim services (OVW National Protocol, 2013).

2. SENSITIVITY TO PATIENT'S NEEDS

Patient-centered, trauma-informed, culturally sensitive care is paramount to the success of the examination process. Response to sexual assault patients should be timely, appropriate, competent, sensitive, and respectful (OVW National Protocol, 2013). "Ultimately, it is the [patient] and not the sexual assault kit that should drive the medical-forensic encounter" (NIJ National Best Practices, 2017, p. 13).

Patient-Centered Care

The Institute of Medicine defines patient-centered care as "providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions (www.oneviewhealthcare.com/the-eight-principles-of-patient-centered-care).

Recommendations to facilitate patient-centered care include:

- Give sexual assault patients priority as emergency cases;
- Provide patient privacy;
- Adapt the exam process to address the individual needs and circumstances of each patient;
- Explain, in language that the patient understands, each procedure and component of the exam and its purpose, and confirm ongoing consent prior to proceeding;
- Address and respect patients' priorities;
- Integrate medical and evidentiary procedures where possible;
- Provide written information in language that the patient understands that can be reviewed at the patient's convenience; and
- Address patients' safety and physical comfort needs throughout the exam.

Trauma-informed Care and the Neurobiological Response to Trauma

The Substance Abuse and Mental Health Services Association's (SAMHSA's) *Concept of Trauma and Guidance for a Trauma-Informed Approach* (2014, p. 9) conceptualizes a Trauma-Informed approach as one that:

- 1) Realizes the widespread impact of trauma and understands potential paths for recovery;
- 2) Recognizes the signs and symptoms of trauma...;
- 3) Responds by fully integrating knowledge about trauma into policies, procedures and practices; and
- 4) Seeks to actively resist re-traumatization.

Several concepts are especially salient to maintaining a trauma-informed approach to care with patients who have been sexually assaulted. While most do not, some sexual assault patients suffer severe physical injuries, contract a sexually transmitted infection or other communicable disease, or become pregnant as a result of the assault; however, nearly every patient will experience some degree of psychological trauma from the assault. The effects of this type of trauma may be more difficult to recognize than overt physical trauma or infection. It is important to understand that following trauma, a person may not react or behave in an expected way. Each person has an individual way of processing and responding to stress and trauma. Patients can appear to be calm, indifferent, matter-of-fact, dismissive, flippant, good-humored, angry, sad, tearful, uncooperative, and/or hostile towards those who are trying to help them. There is a wide range of normal response, and these methods of coping do not reflect on one's credibility. Additionally, to provide trauma-informed care, it is helpful to keep in mind that many patients have experienced other instances of trauma before this presenting event. A provider must understand "the connection between presenting symptoms and behaviors, on the one hand, and the individual's past trauma history, on the other" (Bush, 2016, p. 1).

The medical forensic examiner should have a working knowledge of the neurobiological response to trauma. When a trauma occurs, the hypothalamic pituitary adrenal (HPA) axis is activated by the amygdala. The hypothalamus communicates with the pituitary gland, which signals the adrenal glands to release hormones to help the body respond to the trauma. The catecholamines, epinephrine (adrenaline) and cortisol are released, priming the body for the "fight, flight, or freeze" response. The adrenals may also release opiates and oxytocin helping to mitigate pain (physical and/or emotional) resulting from the trauma. These major hormonal changes can contribute to flat affect, high/positive affect that seem at odds with a rational response to a negative experience, low/negative affect or aggression that seems misplaced towards someone offering help, and/or mood swings. As discussed above, this wide range of responses to trauma is normal, and has a scientific, neurobiological foundation (Campbell, 2012).

Hormonal action alters the functioning of the brain structures including the prefrontal cortex, hippocampus, and amygdala. The hippocampus is responsible for consolidating information and encoding memories while the amygdala dominates the processing of stress and fear-based information. While catecholamines, opiates, and oxytocin are released to help the victim survive and cope with a traumatic event, they also create complications especially regarding memory. They can cause difficulty with orderly recall of memories. Some details may be lost entirely while others are extremely vivid. Sequencing of events may be stored out of order. While this may create challenges in obtaining a patient's history, it is a normal trauma reaction and should not be viewed as a reason to doubt the patient. Keep in mind that getting sleep (two sleep cycles is often recommended) helps to consolidate memory following trauma (Campbell, 2012).

Additionally, catecholamines blunt the ability of the prefrontal cortex to facilitate rational, logical thought processes and execution of action, explaining why victims' actions surrounding an assault may be difficult to understand. The high level of catecholamines released can also induce a state of tonic immobility, sometimes referred to as "rape-induced paralysis." This autonomic response is the "freeze" component of fight, flight, or freeze, and occurs as a protective mechanism and is essentially fear-induced muscular paralysis (Campbell, 2012).

Trauma-informed care also involves working collaboratively with patients to create goals for care that meet and honor their needs. Finally, it is vital to be cognizant of the elements of health care that can be triggering for patients with trauma histories including but not limited to: power differentials, being asked to remove clothing, examination of the body, blood draws, speculum exams, closed doors, gender of caregivers, and more. Examiners must strive to minimize potential for re-traumatization at every opportunity. Members of sexual assault treatment center/medical staff may be the first contact a victim has after the assault. As such, it is imperative that the response and care the patient receives be supportive, non-judgmental, and informed to minimize further trauma and promote healing and long-term recovery.

Culturally Sensitive Care/Special Populations

For some patients, minority status, poverty, and experiences of discrimination contribute to limited access to healthcare and/or fear of the healthcare and criminal justice systems. People belonging to these and other marginalized groups may experience high rates of victimization. They may have had previous poor experiences within these systems that lead to significant distrust. It is recommended that SATCs serving specific populations seek assistance with reliable community consultants to help develop procedures and resources that will reflect the needs of special populations and facilitate culturally sensitive care.

Culture “refers to a body of learned beliefs, traditions, and guides for behaving and interpreting behavior that may be shared among members of a particular group. Aspects of a culture include its values, beliefs, customs, communication styles, behaviors, practices and institutions...” (OVW National Protocol, 2013, p. 15). Many groups can have a distinct culture, including but not limited to: racial, ethnic, and religious groups, deaf or hard-of-hearing communities, the LGBTQ+ community, refugees, military personnel, those who are incarcerated, victims of human trafficking, and more. Remember that variance within groups is often greater than variance between groups. Each individual will belong to multiple cultural groups and have a worldview informed by this intersectional identity.

The way patients experience assault, as well as their needs and wishes after an assault, may be influenced by multiple factors such as age, gender, language barriers, sexual orientation, gender identity, disability, cultural or religious beliefs, and/or immigration status. There is no need to ask questions about such information beyond what is needed to provide appropriate care.

It is important to avoid making assumptions about patients, offenders, or the assault itself. Forms used during the exam process and discussions with patients should be framed in a way that does not assume they are of a specific background, gender identity, or gender expression (OVW National Protocol, 2013). Multiple religious and cultural groups may have objections to being touched or exposing certain body parts to healthcare providers. Every effort should be made to accommodate these preferences, while still providing information on rationale for each step of the exam, and any benefits or risks of declining or accepting each step. Culturally sensitive care includes attention to both verbal and nonverbal communication. Be mindful of body language and that a sigh or raised eyebrows may be interpreted as judgment rather than acceptance.

While a SANE or SAFE may not be able to anticipate and meet every need of every patient, providers and programs should be constantly working to develop resources and best care practices for these and other identifiable special populations within the community.

LGBTQ+ Patients

Avoid taking a binary approach to gender (male/female) by including transgender, gender non-binary, and intersex options on forms, or by simply leaving questions open-ended. Always refer to patients by their chosen name and pronouns, in speaking to the patient directly, when speaking to others, and in written communication. Please confirm that it is safe for the patient to be referred to in this way when speaking to others. (<https://www.lgbthealtheducation.org/wp-content/uploads/2018/03/Ready-Set-Go-publication-Updated-April-2018.pdf>). One strategy to obtain this information is for providers to include their own pronouns when introducing themselves to patients, and then ask how the patient

would prefer to be addressed. This opens the door for conversation and allows patients to disclose as much as they feel comfortable. Transgender and gender non-binary patients may use nonstandard labels for body parts. Providers should mirror the language used by the patient as much as possible. It is important to conduct an organ inventory to assess what testing, treatments, and medications are appropriate for each patient. Individuals who have a vagina and take testosterone, or individuals who have had a vaginoplasty may have vaginas that are more fragile. Transgender men who still have ovaries and a uterus can become pregnant even when on testosterone and/or not menstruating. Address emergency contraception as appropriate. Transgender individuals may decline to give up prostheses, chest binders, or other similar items to turn over as evidence due to cost or safety concerns. The process of coming out or self-disclosure of one's sexual orientation or gender identity can be complex. Patients who are not out in every facet of their lives may have fears that reporting or receiving care could out them. Lesbian, gay, bisexual, and transgender victims may be especially hesitant to seek care or report, fearing inappropriate questions and prejudice or having had previous negative experiences within the healthcare and/or judicial system. For more information on caring for transgender people, see Appendix A. For more information on gathering sexual orientation and gender identity (SOGI) information, see Appendix B. For a sample organ inventory, see Appendix C.

Male Patients

Male victims may be reluctant to report sexual assault, seek medical care, or to disclose to and seek support from family members, friends, or advocacy and counseling services. All patients' ability to seek care and support will vary based upon the stigma they may feel, the sensitivity of initial responders, and the appropriateness of referrals provided. Stigma and/or shame around sexual assault of males by male perpetrators may be intensified by homophobia. Male patients may have questions or concerns regarding physical responses to the assault such as erection or ejaculation. Medical providers should familiarize themselves with the concept of arousal non-concordance, and can review and reassure that these are involuntary physiological responses to stimulation and do not make the patient at fault in any way.

Patients who have been trafficked

Patients who are victims of human trafficking will rarely self-identify as such; therefore, it is important to assess for signs of trafficking, including but not limited to: 1) being denied access to basic necessities (i.e. food, water, sleep, health care, etc.), 2) lack of control of finances, 3) various wounds in different stages of healing, 4) lack of control of one's identifying documents (i.e. visa, driver's license, etc.), 5) limited personal possessions, 6) not being allowed to speak for themselves (someone else insisting on being present with the patient or insisting on translating), 7) claims of just visiting or inability to clarify where they are staying, and/or 8) being especially fearful of law enforcement. As a common part of the coercive tactics utilized to keep victims of human trafficking feeling trapped and/or bonded to their traffickers, victims may be compelled to engage in illegal activities. As such, trafficking victims are commonly distrustful of systems including law enforcement and health care, and more often than not, display deep loyalty to their trafficker. It is imperative to speak with patients alone. The provider may need to use creative methods to separate the patient from the person who brought them in. Providers must work to examine their own prejudices regarding sex industry work, irregular or undocumented status, drug use and abuse, and more to adequately serve this population. Remember that those who have been trafficked have typically been sexually assaulted on multiple occasions and by different perpetrators, which may require adjusting language and approach throughout the exam. Providers are encouraged to mirror the language utilized by the patient rather than using assumed labels (e.g. boyfriend vs. pimp, employer vs. trafficker, cousin vs. exploiter, etc.). Be aware of mandatory reporting laws as well as hospital/facility protocols, working to give patients choice and promote safety. See Section A6, page 18 for more on mandatory reporting. [IC 25-1-9-4.5](#) requires that health care providers must provide patients who may have been victims of human trafficking with information concerning available services and resources including the telephone number for the National Human Trafficking Hotline, 1 (888) 373-7888. If the patient who has been trafficked is age 17 or younger this must be reported to the Department of Child Services and/or local law enforcement ([IC 31-33-5-1](#), [IC 31-33-5-4](#)). A human trafficking indicator tool can be found in Appendix D.

Incarcerated Patients

Patients who suffer sexual assault while incarcerated or immediately prior to arrest face barriers to reporting and seeking care due to fear they will not be believed, fear of retaliation, and lack of knowledge regarding how to report within the system or resources available to them. Perpetrators can be other inmates, those in positions of authority, or individuals with whom the patient had contact immediately prior to arrest. Incarcerated victims experience the same range of emotional, physical, psychological, and health-related effects of sexual violence as non-incarcerated victims. Some of these effects may be further complicated because these patients cannot control many aspects of their environment, have substantially limited privacy, and may be sharing living space with the perpetrator. Possible reactions or behavior changes may include: withdrawing, depression, anxiety, nightmares, self-harm, uncharacteristic acting out in an effort to be placed in isolation or facilitate transfer; refusal to shower, eat, or be in less supervised or communal areas, and increased medical concerns. The prevalence of STIs is high among incarcerated populations. Offer prophylaxis for STIs including HIV as appropriate.

According to the Prison Rape Elimination Act (PREA), which applies to all local jails as well as state and federal prisons, those who are victims of sexual assault while incarcerated shall have access to medical forensic examinations, whether on-site or at an off-site medical facility, without incurring financial cost, when medically or evidentiarily appropriate. The safety of SANEs, staff, and other patients must be a top priority. Local law enforcement policies and procedures may require that the patient be handcuffed and/or an agent is present throughout the medical forensic exam. This can create challenges for positioning throughout the exam. Agents who accompany the patient to the SATC typically stay in the exam room throughout the process. While maintaining the safety of all involved, strive to provide a level of privacy and dignity with draping, etc. as appropriate. The correctional facility may collect clothing for evidentiary purposes prior to transferring the patient for the examination. These patients may arrive in clean correctional facility approved clothing and leave in these same clothes. It is helpful to have an understanding of the medical follow-up plan in place at the corrections facility to which the patient will return to ensure that medication such as Post-exposure Prophylaxis (PEP) can be appropriately initiated and maintained, and that STI results can be communicated and responded to as needed. Additional information can be found at <https://www.prearesourcecenter.org/training-and-technical-assistance>.

Costs related to the medical forensic examination should be paid by the correctional facility. See Section A7, "Payment for the Medical Forensic Examination," page 18 regarding reimbursement for care of incarcerated patients.

Patients who are Immigrants, Refugees, and/or Migrant Workers

People who immigrate to the United States may present with unique challenges based on a variety of factors including the length of time they have lived in the U.S., their understanding of English and the availability of quality interpretation services, the healthcare norms of their country of origin, and their legal status as non-citizens.

Immigration status is a hugely complex issue. Many non-citizens are lawfully present in the United States, either on a temporary visa (i.e. tourist visa, employment visa, student visa, etc.) or in a more permanent status (legal permanent resident, asylee, refugee, etc.). Other non-citizens are not lawfully present in the United States, either because they entered the country without inspection (usually by crossing a land border with the help of a smuggler) or they stayed beyond the period authorized by their visa — these immigrants are generally referred to as "undocumented" immigrants.

Many immigrants, regardless of method of entry, have often witnessed violence against a loved one or have directly experienced violence themselves. For example, many have been victims of domestic violence, rape, and/or trafficking, prior to their arrival in the United States. These individuals, when undocumented, may be eligible for asylum or other humanitarian immigration remedies that could legalize their presence in the United States. Providers should keep in mind this risk for previous trauma and how it may affect a patient's experience of the assault for which they present as well as the patient's healing process.

If an undocumented immigrant or individual present on a non-immigrant visa becomes the victim of a crime during their time in the United States, they may be eligible to pursue options to legalize or extend their legal presence in the U.S., including T Visas, U Visas, and VAWA self-petitions, each of which has its own qualification requirements. The following resources can help patients assess whether or not they qualify for these forms of relief for immigrant victims of crime:

The Center for Victim and Human Rights: <http://www.cvhr.org>

Neighborhood Christian Legal Clinic: <http://www.nclegalclinic.org>

Indiana Coalition Against Domestic Violence: <http://www.icadvinc.org>

Indiana Legal Services: <http://www.indianalegalservices.org>

and/or <https://www.dhs.gov/immigration-options-victims-crimes>

Undocumented immigrants may try to avoid situations where their status might be scrutinized or that could increase risk of being identified to immigration authorities for deportation. This can include use of public services (such as Medicaid), and contact with healthcare and law enforcement. There may also be a distrust of law enforcement based on the structure and norms of the justice system in their country of origin. There is no medical need or requirement to ask about a patient's immigration status before or during treatment. It may therefore be beneficial to provide information about rights, Visas, and immigration resources to all patients to eliminate the need for disclosure.

Older Adult Patients

Older adults may be more at risk for tissue or skeletal damage from an assault for multiple reasons including lack of estrogen and medications such as blood thinners, as well as exacerbation of existing illnesses and vulnerabilities. The physical recovery process for older adult patients may also be lengthier. Consider appropriate adjustments to account for possible hearing impairment, physical challenges, communication barriers, and cognitive disease that may be present with advancing age. Do not mistake altered abilities (e.g. hearing impairment or aphasia), acute stress reactions, or confusion following the assault for senility. Many social changes that occur in this life stage can impact a patient's experience of the assault as well as overall healing and wellness such as a weakened support system or isolation due to mobility limitations or death of loved ones, fear of being burdensome to family members, loss of independence, depression, and more. Consider the possibility of re-victimization and the potential history of past trauma. Safety planning and decisions around reporting may be complicated if the assailant is in a caregiving role or the patient is somehow dependent on the perpetrator. Follow jurisdictional policy on obtaining consent and mandated reporting regarding endangered adults as appropriate. See Section A6, page 18 for more regarding mandatory reporting.

Adolescent Patients

The sexual assault of anyone age 17 or younger must be reported to the Department of Child Services and/or local law enforcement ([IC 31-33-5-1](#), [IC 31-33-5-4](#)). See Section 6, page 17 for more information. Reports can be made by calling the Indiana Child Abuse and Neglect Hotline (1-800-800-5556). Additional information on the hotline is available at <https://www.in.gov/dcs/2971.htm>. Examiners should follow jurisdictional laws and hospital/facility protocols regarding obtaining consent, providing medical treatment, and reporting for minors. ([English, Bass, Boyle, & Eshragh, 2010](#); [IC 16-36-1-3](#); [IC 16-36-1-5](#); [IC 16-21-8-1](#); [IC 16-21-8-1.1](#); [IC 16-21-8-3](#)). There is variation in interpretation of the Indiana Code regarding the need to obtain parental consent for a medical forensic examination. It is prudent for SATCs to develop policies and procedures regarding this issue with their institutional legal counsel. For additional legal and ethical analysis, see Appendix E.

Often adolescents are brought to the exam site by a parent or guardian. Keep in mind that parents or guardians may also be traumatized by their child's victimization and/or may blame their child for the assault if the child disobeyed them or engaged in behaviors perceived as increasing risk for victimization. Advocates can be invaluable in mitigating these

situations. Adolescent patients may not feel able to be forthcoming with details of the assault or questions and concerns in the presence of parents or guardians; therefore, it is imperative to create opportunity to speak with the patient alone. An exam should not be performed without the patient's assent even if parents request it and/or have given consent. The SANE/SAFE can help to facilitate communication between adolescent patients and their families. Healthcare providers must assess physical and emotional development of adolescent patients and take this into consideration in determining methods of examination and evidence collection. Keep in mind that the sexual assault medical forensic exam may be a patient's first experience with a speculum or internal exam and take appropriate care and time in explaining the process (OVW National Protocol, 2013).

In the state of Indiana, no one under the age of 14 can legally consent to sexual activity ([IC 35-42-4-3](#)). Adolescents who are 16 and 17 years old can consent to sexual activities with most adults, but not with people in a position of power or authority over them such as stepparents, school employees, counselors, and military recruiters ([IC 35-42-4-7](#); [ICESA SART Guide 2018](#)). The Indiana Code is complex regarding adolescents ages 14-17 ([IC 35-42-4-9\(e\)](#)), consult as necessary with law enforcement, DCS, and institutional legal representation.

Children

These guidelines are indicated for the adult and adolescent patient. Prepubescent patients require different care than those who have gone through puberty. While patients are considered children based on developmental stage rather than chronological age, in Indiana, it is generally preferred that children 13 years and younger are cared for by a trained pediatric SANE, SANE-P, or appropriately trained advanced practice provider or physician. In some circumstances, if the patient is post-menarche, it may be appropriate to have the exam performed by an adolescent/adult trained SANE. Please seek additional guidance from sources intended for the child patient such as the Office on Violence Against Women's "A National Protocol for Sexual Abuse Medical Forensic Examinations Pediatric" available online at <https://www.justice.gov/ovw/file/846856/download/>, Dr. Joyce Adams' 2016 "Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused," and Dr. Joyce Adams' "Interpretation of Medical Findings in Suspected Child Sexual Abuse: An Update for 2018."

Patients with Disabilities

People with disabilities are at a much greater risk of sexual assault than those without disabilities. They may have physical, sensory, cognitive, developmental, or mental health disabilities, or a combination of disabilities, some of which are apparent and others that are not. Safety planning and decisions around reporting may be complicated as assailants are often family members, caretakers, or friends. This population is at risk for repeated abuse because the victims may not be able to report the crime or feel the risk of loss of care or resources may be too great. Follow jurisdictional policy on consent and reporting regarding endangered adults as appropriate. For more information on mandated reporting, see A6, page 18.

Endangered Adults

Indiana defines endangered adults as persons 18 years or older who are incapable of managing their own property or self-care due to mental illness, intellectual disability, dementia, or other incapacity ([IC 12-10-3-2](#)). Cases of suspected abuse, neglect, or exploitation of endangered adults must be reported to Adult Protective Services (APS) and/or to law enforcement ([IC 12-10-3-9](#); [IC 35-46-1-13](#)). Reports may be made online at <https://ddrsprovider.fssa.in.gov/APSONlineReporting> or by calling the state hotline (1-800-992-6978).

Deceased Patients

Death investigations may indicate the possibility of associated sexual assault. SANE/SAFEs may collect specimens and standards from the decedent's body during a postmortem exam/autopsy. All obtainable samples should be collected remembering that the autopsy is the last opportunity to obtain samples from the deceased patient. This can include swabs of the neck, breasts, mouth, external genitalia, vagina, cervix, anus and rectum, pulled scalp hair, pulled pubic hair, swabbing and/or scraping under fingernails, and dental floss (NIJ National Best Practices, 2017). It is recommended to establish good working relationships with local county coroners and forensic pathologists to facilitate appropriate collaboration and ensure these colleagues are aware of the potential benefits of working with a SANE/SAFE in these situations. Note that coroners are exempt from HIPAA when investigating a death. [IC 36-2-14-21](#) outlines this exemption and provides for unrestricted access to blood and tissues of deceased patient. Be aware of and follow institutional policies.

Incapacitated Patients

Indiana law ([IC 16-21-8-1.1](#)) allows healthcare providers to complete a medical forensic examination on adults who are incapacitated and unable to give consent if the following criteria are met: 1) based on the medical opinion of the healthcare provider, the patient will be incapable of providing consent within the timeframe for evidence collection, 2) the provider has a reasonable suspicion the patient may be a victim of a sex crime, and 3) others who could provide consent (e.g. next of kin, power of attorney) are not reasonably available or are the suspected perpetrator of the sex crime. The provider is immune from civil liability in these cases. For clarity, this does not apply to someone unable to consent due to being temporarily under the influence of substances or other states reasonably assumed to resolve within the timeframe for evidence collection.

Patients with Limited English Proficiency

It is important to be aware of the languages spoken in the community and make every attempt to provide same language services and professional medical interpreters. Family and friends may know the perpetrator as well as the patient, may not maintain confidentiality, and while one may be conversationally fluent, they may not have the ability to translate medical language. It is also helpful to have forms, discharge materials, and other materials translated in advance and available.

3. CONTACTING ADVOCACY

Advocates are specially trained to provide emotional support, information, and resources/referrals to victims during the initial crisis and throughout the healing and criminal justice process. Advocates seek to ensure the ongoing safety of victims, answer their questions, help to provide a more victim-centered, trauma-informed response, and can provide long-term support to both patients and their loved ones or “co-survivors” throughout their lives. At an SATC the advocate supports the patient during the medical forensic exam, helps patients understand the process and options available to them, and helps to provide and explain follow-up resources.

Ideally, exam facility personnel should call a victim services/advocacy program and ask that an advocate be sent to the exam site (unless an advocate has already been called). This should be done without providing patient identifying information to comply with HIPAA (OVW National Protocol, 2013). The role and services of the advocate should be explained to the patient and the patient given the opportunity to accept or decline to meet, speak with, and receive services from the onsite advocate prior to the advocate being introduced to the patient. While the great benefit of advocates is well established, this is an instance where power and control must be returned to victims, enabling the patient to make their own choices about when and whether to use an advocate. Some communities may have a protocol in which patients are asked whether or not they want to speak with an advocate before the advocate is contacted. This may be problematic as patients may not wish to burden an advocate to come in, wake up, etc., and given this, making the offer once the advocate is already on-site may be a more patient-centered approach. Advocates may be present for all or part of the medical forensic exam, based on the patient's preferences.

Indiana statute ([IC 35-37-6-9](#)) provides for confidential communication privileges between an advocate and victim. It is important to clarify that this privilege does not apply to victim assistance specialists or advocates employed by law enforcement or prosecution. Indiana currently has sexual assault victim advocates available 24/7 to support victims in some counties, but not most ([ICESA SART Guide, 2018](#)).

Be aware of and follow institutional policies regarding outside agency engagement with patients as appropriate. Creating a memorandum of understanding with area advocacy agencies may be advantageous.

4. INFORMED CONSENT

It is standard hospital/medical practice to obtain a patient's written consent before conducting a medical exam or administering any treatment. This is expanded in the case of the medical forensic exam to also address consent for evidence collection, photography, and release of evidence and photos.

Informed consent is a further expanded and ongoing process, well beyond obtaining a signature on a form. Procedures in a medical forensic exam can be unfamiliar and potentially embarrassing, intimidating, or difficult to understand for the patient. All procedures should be explained as much as possible, in language the patient understands, as many times as necessary to ensure that the patient understands what the examiner is doing and why. While an advocate can assist in explaining procedures and processes, the ultimate responsibility of informed consent belongs to the healthcare provider.

Patients have the right to consent to or decline any individual part of the exam at any time during the process. If at any time a patient expresses resistance, confusion, or non-cooperation, the examiner should immediately discontinue that portion of the process, discuss any questions or concerns the patient has and together determine whether or not they can continue. If the patient agrees, they may return to that portion at a later time in the exam process. Patients have the right to decline any portion of the exam, offered testing, or to answer any question without negatively impacting the remainder of the exam or care provided. If a patient chooses to stop the exam before its completion, a partial kit may be turned over to law enforcement with appropriate documentation (e.g. "patient declines further examination"). Follow institutional protocols.

It is important to help patients understand the impact of the decision to decline a procedure or portion of the exam. This includes a discussion of available alternatives to, benefits of, and possible negative effects of proceeding with or foregoing a component of the exam. Benefits and risks may relate to the quality and completeness of medical care or of evidence collection. Declining portions of the exam may have negative impact on criminal investigation and/or prosecution. This information should be presented without judgment or intent to sway a decision but rather to empower patients to make an informed decision that is best for them. Giving the patient power and control over decision making throughout the exam can facilitate initiation of healing. Examiners' language in documentation should be nonjudgmental (e.g. declines vs. refuses or noncompliant).

Follow institutional and legal guidelines for consent from special populations such as minors, endangered adults, those with altered mental status, and incapacitated patients. In all cases, a medical forensic exam should never be done against the will of the patient.

5. CONFIDENTIALITY

Mechanisms should be in place to protect patient privacy and confidentiality. Patients have a right to understand the scope and limits of confidentiality related to laws, mandated reporting, and roles of various providers as it relates to communications, records, forensic evidence, and photographs.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule established national standards for protection of individually identifying health information. The Violence Against Women Act (VAWA) also contains

confidentiality provisions requiring that a victim's personally identifying information not be released without a victim's written, time-limited, informed consent or a court or statutory mandate (OVW National Protocol, 2013).

If the assault is reported to law enforcement, healthcare providers provide information collected during the medical forensic exam that is related to forensic evidence to the criminal justice system; however, most adult patients have the right to a medical forensic exam and all of its associated care whether or not they choose to report to law enforcement. If the patient chooses not to make a police report, an anonymous or "J. Doe" kit can be completed and the patient's identity and information should not be revealed to law enforcement. Indiana Code requires that each Sexual Assault Response Team (SART) develop a plan for maintaining confidentiality of the nonreporting victim (IC 16-21-8-2(b)). See additional information on anonymous kits on page 18 (in Reporting to Law Enforcement section below). For additional information on when protected health information (PHI) can be released to law enforcement see <https://www.hhs.gov/hipaa/for-professionals/faq/505/what-does-the-privacy-rule-allow-covered-entities-to-disclose-to-law-enforcement-officials/index.html>.

The NIJ National Best Practices (2017) document recommends that all kits have a unique identifier to increase efficiency of proper storage, tracking, and retrieval as well as discreet labeling to protect patient privacy.

6. REPORTING TO LAW ENFORCEMENT

As discussed above, most patients who are 18 years of age or older may choose whether or not to report the assault to law enforcement. Reporting provides the criminal justice system with the opportunity to offer immediate protection to the victim, collect evidence from all crime scenes, investigate and prosecute the case, and hold offenders accountable for crimes committed. Healthcare providers should discuss all reporting options with patients and the pros and cons of each, including the fact that delayed reporting may be detrimental to the prosecution of the offender. Patients should be informed that even if they are not ready to report at the time of the exam, the best way to preserve the option to report later is to have the exam performed and evidence collected.

Some patients are unable to decide whether they want to report or be involved in the criminal justice system in the immediate aftermath of an assault, or simply do not feel ready for any number of reasons. The SANE/SAFE should ensure that patients understand the potential advantages and disadvantages of remaining anonymous including that kits will not be tested while they remain anonymous, kits will be held for at least one year and after that time, may be destroyed (IC 16-21-8-10). Additionally patients should know that they could be contacted by the Indiana Criminal Justice Institute (ICJI) prior to destruction of the kit, patients are responsible for retaining the numbers or code to identify their kits, and that potential sources of additional evidence, such as items from the scene of the assault, will not be collected without law enforcement involvement. For sample anonymous patient information sheet, see Appendix F.

Healthcare providers should trust that, given adequate information about options, patients are best able to make the right decision for themselves. Pressuring victims to report may discourage future involvement. These patients will still benefit from support, advocacy, medical assessment and treatment, and information focused on their health and well-being. Recognizing that traumatic injuries heal and evidence is lost as time passes and that they may choose to report at a later date, victims can still be encouraged to have the medical forensic exam completed. Victims who receive compassionate and appropriate care at the time of the exam are more likely to cooperate with law enforcement and prosecution in the future. To be clear, except in situations covered by mandatory reporting laws, patients, not health care workers, make the decision to report a sexual assault to law enforcement. The sexual assault of anyone age 17 or younger must be reported to the Department of Child Services and/or local law enforcement (IC 31-33-5-1, IC 31-33-5-4).

Anonymous Kits

Adult patients have the right to a medical forensic exam and all of its associated care whether or not they choose to report to law enforcement. If the patient chooses not to make a police report, an anonymous, “Jane Doe,” or “J. Doe” kit can be completed and the patient’s identity and information should not be revealed to law enforcement. In the state of Indiana, law enforcement is charged with storing anonymous kits for at least one year ([IC 16-21-8-10](#)) or until the statute of limitations has run ([IC 16-21-8-2\(b\)\(7\)](#)). At this time, in Indiana, each county is responsible for determining how to correctly identify a “J. Doe” evidence collection kit (e.g. “J. Doe,” Hospital Name, Medical Record Number, Date of Service, Date of Birth) should the victim later choose to report the crime to law enforcement within the allowable timeframe; however, a standard method across the state is strongly recommended. The forthcoming statewide tracking system should clarify and standardize this process upon its implementation. A patient’s decision to remain anonymous must be respected such that the determined method of identification must maintain the patient’s privacy from law enforcement or associated personnel who may come in contact with the kit following the medical forensic exam until the time the patient may reverse the stated desire for anonymity. If the patient later chooses to report, it is the patient’s responsibility to notify law enforcement of that decision.

Mandatory Reporting

Healthcare providers must follow mandatory reporting laws regarding minors and endangered adults. In Indiana, anyone who has a suspicion that a minor (age 17 or under) is a victim of abuse or neglect is considered a mandated reporter with a duty to report to the Department of Child Services and/or local law enforcement ([IC 25-1-9-4 \(a\) 14](#); [IC 31-33-5-1](#)). Reports can be made by calling the Indiana Child Abuse and Neglect Hotline (1-800-800-5556), additional information on the hotline is available at <https://www.in.gov/dcs/2971.htm>. Similarly, cases of suspected abuse, neglect, or exploitation of endangered adults must be reported to Adult Protective Services (APS) and/or to law enforcement ([IC 12-10-3-9](#)). Reports may be made by calling the state hotline (1-800-992-6978) or online at <https://ddrsprovider.fssa.in.gov/APSOnlineReporting>.

SANE/SAFEs should be familiar with additional duties to report such as the requirement to report all wounds or injury caused by the discharge of a firearm, injury that may result in death that was inflicted by a knife or other sharp or pointed instrument ([IC 35-47-7-1](#)), and certain burn injuries ([IC 35-47-7-3](#)).

7. PAYMENT FOR THE MEDICAL FORENSIC EXAMINATION

In order to comply with the requirements of the Violence Against Women Act (VAWA), the state must certify that it or another government entity incurs the full out-of-pocket cost of the medical forensic exam for sexual assault victims and that they do not require victims to participate with law enforcement in order to be provided with an exam. In addition, the state may not require victims to seek reimbursement from their insurance carriers.

In the state of Indiana, the Victim Compensation Fund, established under the Victims of Crime Act (VOCA), is administered through the Indiana Criminal Justice Institute (ICJI). The provider or SATC who performs the medical forensic exam submits the application for the Sexual Assault Compensation Fund and will receive reimbursement from ICJI if approved. This fund is available regardless of patients’ decisions around reporting. See [IC 16-21-8](#) for more information. Of note, the sexual assault must have occurred in the state of Indiana to be eligible for this fund. Services provided that are associated with the sexual assault may not be billed to patients even if a charge is denied by ICJI. Billing a patient’s insurance is not expressly prohibited by VAWA 2013; however, great administrative care would be required to remain in compliance as victims may not be charged any co-pays, deductibles, or other out-of-pocket costs. In light of these complications, as well as concerns around possible loss of confidentiality, the Office on Violence Against Women strongly discourages this practice (Lonsway & Archambault, 2016).

The Indiana Code requires that hospitals provide medical forensic exams and additional forensic services to patients seeking services related to injury or trauma resulting from a sexual assault ([IC 16-21-8-1](#)). Additional forensic services include: initial pregnancy testing and sexually transmitted disease testing, prophylactic medication related to a pregnancy or sexually transmitted disease testing (including HIV prophylaxis medications), alcohol and drug testing, some longer term follow-up testing, and up to \$3,000 of mental health counseling ([IC 16-18-2-1.8](#)). All of the above must be provided without charge to the patient and the Victim Services Division of the Indiana Criminal Justice Institute (ICJI) shall provide compensation or reimbursement for medical forensic exams and additional forensic services ([IC 16-21-8-6](#)), assuming the victim is at least 18 years of age, or if less than 18 years of age, a report has been made to child protective services or law enforcement, and the sex crime occurred in Indiana ([IC 16-21-8-5](#)).

The Indiana Administrative Code ([203 IAC 1-2-3](#)) also discusses suturing, wound care, and imaging secondary to the assault as covered services. Documentation regarding services that fall outside of the standard medical forensic exam should clearly state the basis for their necessity and how labs or diagnostics ordered are directly related to the assault. Services provided must be necessary secondary to the assault or have forensic value for ICJI to cover their costs. If this is not the case, institutions are not prohibited from billing patients or their insurance for these additional services if they are rejected by ICJI. Thorough, high quality documentation is imperative.

There is an additional fund for Violent Crime Compensation, the application for which must be submitted by victims themselves. Access to this fund does require cooperation with law enforcement. In this case, ICJI is the payer of last resort. Patients and/or insurance will be billed and then the patient submits to ICJI for reimbursement. For more information, see the ICJI Victim Compensation website, <https://www.in.gov/cji/2333.htm>. It is helpful for the sexual assault forensic examiner to have an understanding of the statutes governing payment so that patients can understand what services are covered by Victim Compensation Funds and when cooperation with law enforcement is required.

The Indiana Criminal Justice Institute application for benefits from the Sex Crime Victim Services Fund does require the consent of a parent or guardian for patients age 17 or under. ICJI will accept the form absent parental consent as long as there is documentation supporting the circumstances. Release from anyone authorized to sign the form or who represents the best interests of the child can be accepted.

For patients who are incarcerated at the time of an assault, reimbursement for the SAEK would be provided by the Department of Corrections, the jail, or other detention facilities where the patient is detained rather than ICJI. Each facility's protocols may vary. The patient should not incur costs.

OPERATIONAL ISSUES

1. SEXUAL ASSAULT NURSE EXAMINERS/FORENSIC EXAMINERS

These guidelines seek to promote consistent care throughout the state of Indiana that prioritizes the physical, psychological, and emotional needs of the sexually assaulted patient while collecting the best possible medical forensic evidence (OVW National Protocol, 2013). In support of this goal, wherever possible, specialized providers should perform these exams.

Nationally, and within the state of Indiana, Sexual Assault Nurse Examiners (SANEs) are the professionals who typically provide this high quality, specialty care. SANEs are registered nurses (RNs) who have been specially trained to provide comprehensive care to patients who have experienced sexual assault. SANE-trained nurses attend a 40-hour didactic course and fulfill additional clinical requirements to meet institutional competency requirements. They demonstrate competency in conducting a medical forensic exam and can testify in court when necessary. Some nurses have been certified as SANE – Adult and Adolescent (SANE-A) or SANE – Pediatric (SANE-P) through the International Association of Forensic Nurses (IAFN). The American Nurses Association has recognized Forensic Nursing, which encompasses sexual assault nursing, as a specialty since 1997. For additional information on guidelines for SANE education, see https://cdn.ymaws.com/www.forensicnurses.org/resource/resmgr/education/2018_sane_edguidelines.pdf.

All communities in Indiana should strive to have all medical forensic exams performed by a SANE or in some cases, a Sexual Assault Forensic Examiner (SAFE) (NIJ National Best Practices, 2017). SAFE more broadly denotes a healthcare provider, including physicians, nurse practitioners, and physician assistants who have undergone SANE training or its equivalent. In communities or circumstances where access to a SANE or SAFE is not possible, appropriate training of emergency department personnel must be a priority.

Advanced Practice Providers

Advanced practice providers should be aware of institutional credentialing requirements depending on role. In the SAFE role, the advanced practice provider (APP) (nurse practitioner, nurse midwife, clinical nurse specialist, nurse anesthetist, or physician assistant) can offer an additional component to the forensic team. The APP, in their full scope of practice, can admit, assess, diagnose and medically treat forensic patients independently according to their licensure and practice arrangements. The APP may be able to prescribe medications, order labs and radiographs, provide follow-up treatment, and manage sequelae of an assault or traumatic injury. Adherence to the scope of practice parameters such as those established by certification, licensure, and the Nurse Practice Act, is imperative. There may be situations where the APP functions in a role more typical of an RN; however, they may be held accountable to their highest level of education and competency. "Standard of care... is defined as that of what a reasonable and prudent [provider] would do when caring for a same or similar patient in the same or similar circumstances" (<https://www.nursingcenter.com/upload/static/403753/ch03.html>).

2. FACILITIES

Exams should be conducted at medical facilities that provide evidence-based, trauma-informed and victim-centered medical forensic services by SANE/SAFEs (i.e. hospital or community-based Sexual Assault Treatment Centers (SATCs) whenever possible. This helps to ensure that exams are conducted at sites with the necessary space, equipment, supplies, and policies to facilitate the exam process and where victims are served by examiners with advanced education and clinical experience in the field of sexual assault.

SATCs can exist in many forms including hospital and community-based programs. Jurisdictions may rely on examiner programs to serve multiple exam sites within a specific area. For more on program models, see

<https://www.ovcttac.gov/saneguide/building-a-sustainable-sane-program/program-models/>. SATCs should strive to have SANE/SAFEs available 24/7, though this may not be possible in all communities.

The majority of SATCs in Indiana and nationally are currently located within hospital emergency departments. This location typically allows for access to and collaboration with other medical and supportive disciplines, is open 24/7, provides some type of security, and has access to lab services and medications. In cases where it is necessary, they also have the ability to provide continued care beyond the basic medical forensic exam such as radiology, treatment of injury, and extended observation. SATCs within hospitals must have policies in place to treat sexual assault victims as high acuity patients, minimizing time spent waiting in public areas and facilitating the privacy, safety, and comfort of these patients. As medical forensic exams are often lengthy, every effort should be made to avoid taking a nurse from normal floor or emergency department staffing. This could cause the patient and/or SANE to feel rushed and risk providing a decreased quality of care. Facilities should familiarize themselves with the federal Emergency Medical Treatment and Active Labor Act (EMTALA). For more information, see <http://www.emtala.com>.

Community-based, or “free-standing,” programs typically provide a more private environment and may reduce costs of care. Community based SATCs should have plans in place to address access to lab services and pharmacy/medications as needed, as well as the safety and security of patients, staff, and providers. They must also have protocols with area hospitals and/or access to an emergency department when higher levels of evaluation and care are needed. As of 2018, there are two community-based or freestanding SATCs in Indiana, one in Allen County and one in Madison County.

Transfers

If a sexual assault patient arrives at a hospital or medical facility that is not equipped to provide a sexual assault examination, a medical screening examination should be completed in accordance with the Emergency Medical Treatment and Labor Act (EMTALA), and then arrangements should be made to transfer the patient to the nearest SATC. Protocols should minimize time delays and loss of evidence, and continue to prioritize the patient's needs, comfort, and well-being. If acute medical or psychological concerns exist that must be treated immediately, this should be done at the initial receiving facility. Additionally, keep in mind in cases where a report is necessary (e.g. minors, endangered adults) the initial facility has the same duty to report as if they had provided the full scope of care, even when the patient is planning to transfer. A copy of all records, including any imaging, should be transported with the patient to the designated SATC to facilitate the continuum of care/services.

Some patients may be hesitant to transfer to another facility. Advantages and disadvantages of available options should be explained. To accommodate circumstances in which transfer is not possible or is declined, providing emergency department personnel with basic training in sexual assault and forensic care must be a priority.

Ideally patients should be directed to a fully staffed SATC first to minimize stress and confusion for patients and eliminate unnecessary delays in care resulting from transfer. This should also reduce the need for the patient to disclose to multiple providers, reduce the potential loss of evidence, increase potential for cooperation with law enforcement, and increase cooperation with exam procedures given the length of the exam process. Sexual Assault Response Team (SART) members should be aware of area SATCs and direct patients to appropriate facilities for care. Information about locations of SATCs should also be available to the public.

3. EQUIPMENT AND SUPPLIES

Certain additional materials and equipment outside of what comes in the State of Indiana Sexual Assault Evidence Collection Kit (SAEK) are needed to conduct a medical forensic examination. These are typically supplied by the facility performing the exam. Each exam may not require all equipment listed. Examinations should be individualized and adapted based on patients' needs and history.

Equipment and supplies may include:

- Standard exam room equipment for physical assessment, speculum exam, and basic medical care including GYN bed, speculum, appropriate emergency equipment, sharps container, gauze, etc.;
- Non-powdered, non-latex gloves;
- Supplies for testing (e.g. STI testing including HIV, wet mount for infection, pregnancy test, toxicology);
- Medications (e.g. STI prophylaxis, HIV prophylaxis, pregnancy prophylaxis, pain management, anti-emetics, etc.);
- Comfort items (e.g. replacement clothing, toiletries, food and drink, blanket, etc.);
- Method or device to dry evidence;
- Camera and/or colposcope and related supplies, including extra batteries;
- Cloth and disposable drape sheets;
- Additional supplies for use with kit (e.g. sterile water, water-based lubricant, extra swabs, tape, envelopes, ruler or device for measuring, pens, etc.);
- Venipuncture equipment;
- Foley catheters, OB swabs;
- Toluidine blue dye;
- An alternative light source; and an
- Anoscope.

4. SEXUAL ASSAULT EVIDENCE COLLECTION KIT (SAEK)

In Indiana, the Sexual Assault Evidence Collection Kit or Sexual Assault Examination Kit, as it is referred to in [IC 16-21-8-0.2](#), means the standard medical forensic examination kit for victims of sexual assault developed by the Indiana State Police. The kit is a box containing materials that a medical professional, ideally a SANE or SAFE, uses in the collection of evidentiary samples from a victim's or suspect's body. The kit includes swabs and envelopes to collect and package biological samples and/or debris, and bags to package clothing items. The type of evidence collected will vary based on the history of events related to the assault as well as the physical exam (NIJ National Best Practices, 2017). It is best practice to use a standardized kit across the state, involve facilities and persons who conduct sexual assault medical forensic exams in the development and revision of the kit, ensure that facilities that perform sexual assault medical forensic exams are supplied with kits, and to work with relevant agencies to keep abreast of scientific advances and changes in standards of care and practice to periodically review and adjust the kit as necessary (OVW National Protocol, 2013).

5. TIMING CONSIDERATIONS FOR COLLECTING EVIDENCE

Prompt examination of the patient is essential both to minimize loss of evidence and identify and address medical concerns.

The National Protocol for Sexual Assault Medical Forensic Examinations Adult/Adolescent stresses that "health care providers and other individuals responding to sexual assault victims to optimize evidence collection [should] recognize the importance of gathering information for the medical forensic history, examining patients, and documenting exam findings, separate from collecting evidence. Examiners should obtain the medical forensic history as appropriate, examine patients, and document findings when patients are willing, whether or not evidence is gathered for the sexual assault evidence collection kit" (p. 73, 2013).

All patients who present for a medical forensic exam within an appropriate time frame should be offered the opportunity to have a sexual assault kit completed regardless of whether or not they choose to report (or have a mandated report

made) to law enforcement or remain anonymous. Evidentiary sample collection should be guided by the patient history and, because of deterioration or other loss of forensic evidence, be completed as soon as possible and up to five days (120 hours) or longer after the assault (NIJ National Best Practices, 2017). For further information see <https://nij.gov/topics/law-enforcement/investigations/sexual-assault/Pages/national-best-practices-for-sexual-assault-kits.aspx>. The Department of Defense uses a collection window of seven (7) days (168 hours). Decisions regarding timing of evidence collection should be made on a case-by-case basis, guided by an understanding that types of samples collected, location of evidence, type of assault, and activities engaged after the assault may alter likelihood of obtaining evidence. Timeframes should serve as a benchmark, recognizing that specific circumstances may call for a different or expanded window for evidence collection based on clinician judgment and should never be used to deny care or services to a patient. DNA technology continues to improve and as the science evolves, time frames for evidence collection will likely continue to expand. “Emerging research indicates there may be potential to extend the time frame to nine (9) days post-assault in the living patient” (NIJ National Best Practices, 2017, p. 17). Reimbursement for the medical forensic exam should be provided regardless of the time frame (NIJ National Best Practices, 2017).

Patients who present outside of the typical window for evidence collection should still receive trauma-informed, patient-centered care. Care should include a forensic history and may include a physical assessment and STI treatment/prophylaxis based on institutional protocol. Referral to local advocacy/counseling agencies and other relevant community resources should be provided.

6. EVIDENCE INTEGRITY

Examiners must be educated regarding jurisdictional policies regarding drying, packaging, labeling, and sealing evidence. The State of Indiana Sexual Assault Evidence Kit contains two types of swabs — capped and uncapped. Wet uncapped swabs must be air-dried at room temperature, quickly, and in a clean environment, such as a drying box (OVW National Protocol, 2013). “With the ever-increasing sensitivity of DNA analysis, there is a greater chance that accidental contamination and dilution by foreign DNA can be detected. Every precaution should be taken to reduce outside contamination and dilution of evidence” (OVW National Protocol, 2013, p 75). When using capped swabs, the swab may be packaged prior to thorough drying as the cap allows continued air movement and drying to take place after packaging. There is no standardization regarding which samples should be collected with capped versus uncapped swabs, leaving it to the examiner’s discretion or guidance of a given program. Programs and jurisdictions should have policies for handling evidence that takes excessive time to thoroughly dry (e.g. tampons, menstrual pads, diapers, wet clothing).

All containers for packaging evidence should be made of paper. Plastic bags or containers should never be used as plastic retains moisture and promotes degradation of biological samples. The Indiana SAEK contains a white paper bag for packaging of underwear that should be returned inside the kit itself as well as multiple brown paper bags for other articles of clothing, which should be returned with but outside of the kit itself. Package only one item per bag. All clothing bags must be sealed, labeled with description of contents, initialed and dated by the examiner, and include patient identification unless presenting anonymously. Chain of custody must be documented and maintained.

Careful and proper drying and packaging of samples is imperative to maintain quality evidence, avoid contamination, and prevent growth of mold and bacteria. Follow jurisdictional policies regarding refrigeration of drawn blood samples, urine samples, or other wet evidence. Of note, liquid blood and urine, such as that taken for drug facilitated sexual assault kits/toxicology must be securely refrigerated. These samples may be kept at room temperature for no longer than 24 hours (OVW National Protocol, 2013). Urine and blood should not be placed into the standard Indiana Sexual Assault Evidence Kit.

Additional practices to decrease risk of contamination include:

- Examiners should wear powder free gloves and change gloves frequently throughout the exam and when packaging evidence. Change gloves when changing areas on the body and/or at any time when cross-contamination could occur;
- Envelopes should never be sealed with the examiner's saliva;
- Single use instruments and products (e.g. lubricants) are preferred; and
- Position any support persons away from sample collection.

Attention must also be paid to the integrity of exam documentation including the medical forensic history and exam findings. The kit and all samples must be labeled and sealed properly and chain of custody must be maintained and documented. The examiner should not leave a kit unattended/unsecured at any time from the time it is opened until it is signed off to law enforcement or security. Patients, advocates, family members and other support persons should not handle the evidence.

Evidence should be transferred from the exam site to the appropriate crime lab or designated storage site by a law enforcement or crime lab official. Keep in mind that in the case of anonymous, or non-reporting kits, transfer and storage must occur without revealing the patient's identity to law enforcement. The National Institute of Justice National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach (2017) emphasizes that law enforcement or laboratories rather than SATCs or other healthcare facilities should be responsible for storage of all SAEKs. They recommend that kits should be transferred from the SATC as soon as possible and specifies not later than three business days from when the kit was collected. They further recommend that kits that are not anonymous be submitted to the crime lab for analysis as soon as possible and specifies no later than seven business days from when the kit was collected.

THE EXAMINATION PROCESS

The **Medical Forensic Examination** is a comprehensive examination provided to a sexual assault victim by health care personnel trained to provide trauma-informed, patient-centered medical care and to gather evidence of sexual assault in a manner suitable for use in a court of law. The examination includes at a minimum*:

- Patient medical history;
- History of present illness/assault for diagnosis and treatment;
- Medical examination for physical trauma/injuries;
- Collection of evidence;
- Photographic documentation and body mapping;
- Prophylaxis for exposure to STIs, including HIV, and/or possible pregnancy; and
- Safety planning and discharge planning.

**Patients have the right to decline any portion of the Medical Forensic Examination.*

A medical evaluation should be offered to all patients reporting sexual assault regardless of the length of time that may have elapsed between the time of the assault and the examination. Some patients under these circumstances may ignore symptoms that could indicate serious physical and/or psychological trauma (New Hampshire Protocol, 2015). For additional information on considerations regarding timeframe for evidence collection, see section B5 "Timing Considerations for Collecting Evidence," page 22.

The Indiana Code requires that hospitals provide medical forensic exams and additional forensic services to patients seeking services related to injury or trauma resulting from a sexual assault ([IC 16-21-8-1](#)). All of the above must be provided without charge, and the victim services division of the Indiana Criminal Justice Institute (ICJI) shall provide compensation or reimbursement for medical forensic exams and additional forensic services ([IC 16-21-8-6](#), for additional information see Section A7, page 18).

1. INITIAL CONTACT

While some patients will present directly to a Sexual Assault Treatment Center (SATC), most victims will initially contact law enforcement, an advocacy organization, or 911. Creating a coordinated response through a multidisciplinary Sexual Assault Response Team (SART) supports the needs of the victim as well as the needs of the criminal justice system. Please see the ICESA Indiana SART Guide <https://indianacesa.org/wp-content/uploads/2018/03/IndianaSARTsGuideE2018.pdf> for more information.

2. TRIAGE AND INTAKE

It is imperative that sexual assault patients be treated as a priority. Triage must include both medical and forensic emergencies. While most sexual assault patients do not have severe or life threatening physical injuries, the psychological trauma is significant. Prompt, competent, patient-centered care facilitates healing and minimizes further traumatization. Prompt consideration must also be given to preserving forensic evidence.

Intakes should be performed in a private location. Additionally, private space should be available for family members or friends who have accompanied the patient as well as for any law enforcement interviews taking place during this time. The patient should be asked their preferred name during intake, and should be addressed by their pronouns and preferred name throughout their visit. For more information on gathering sexual orientation and gender identity (SOGI)

data, see Appendix B. The SANE/SAFE should be contacted immediately if not present at the exam site or already notified. Advocacy services should also be notified immediately, if not already involved, according to institutional policies. For more information, see Contacting Advocacy Section A3, page 15. Safety concerns should also be assessed and addressed, as risk may exist for the patient, support persons, staff, and others in the facility.

A competent medical screening exam should be performed promptly. Acute medical concerns supersede evidentiary concerns and immediate medical and psychological needs must be addressed. A secondary benefit to prompt care is the minimization of loss of evidence through time and activities of daily living. Counsel patients to avoid washing, toileting, smoking, drinking, eating, or changing clothes unless necessary to address acute medical concerns until initial appropriate steps have been taken by the SANE/SAFE. If the patient needs to urinate prior to the arrival of the SANE/SAFE and drug facilitated sexual assault is suspected, that urine should be collected and chain of custody must be maintained. Additionally, any time that a patient needs to void prior to completion of the anogenital exam and evidence collection, the patient should be encouraged to blot rather than wipe and may be encouraged to save that toilet paper. When collected, the examiner should maintain chain of custody of the toilet paper, dry, package, document appropriately, and send with the kit. When possible, in cases of significant injury or impairment, the SANE/SAFE can operate alongside of the rest of the medical team to complete forensic components of the exam during stabilization or treatment of a patient.

3. DOCUMENTATION BY HEALTH CARE PERSONNEL

SANEs/SAFEs must document details of the medical forensic exam and care provided as well as information required for the evidence collection kit. Documentation should be thorough, precise, and accurate (OVW National Protocol, 2013). Healthcare providers should maintain focus on the assessment, diagnosis, treatment and promotion of the health and well-being of the patient. They should not ask for details beyond those necessary for the medical forensic care of the patient and high-quality evidence collection.

Confidentiality must be a priority and when possible the complete medical forensic record should be maintained separately from the rest of the patient's medical record. To protect patients' rights to privacy, portions of the medical record that are not relevant to the evidence collection kit and/or case prosecution may not be released to law enforcement or to the crime lab. Law enforcement may obtain their own release from patients for any additional medical records needed for their investigation, and parts of the medical record may ultimately be subpoenaed by any party if found to be pertinent to a pending case. Examiners should be familiar with their facility's privacy and confidentiality policies.

4. THE MEDICAL FORENSIC HISTORY

A thorough and well-documented history is vital to establish the details of the assault needed to guide the patient's medical exam, diagnosis and treatment, as well as to inform the appropriate collection of forensic evidence.

Multiple SART disciplines (medical, law enforcement, advocacy, DCS, etc.) have information gathering needs in response to a sexual assault, therefore several models may be employed to obtain information and may vary depending on jurisdiction, SATC protocol, SART protocol, and specifics of each patient's situation, needs, and preferences. Ultimately the medical forensic history is the responsibility of the SANE/SAFE alone and must not be confused with law enforcement's interview or investigation.

With the exception of the examination of incarcerated patients, law enforcement should not be present during any part of the medical forensic examination itself. Law enforcement and medical respondents may work jointly to respect the time of all involved and minimize repetition of questions to and history by the victim, but patients may be uncomfortable or unwilling to discuss certain health information such as contraception, menses, sexual orientation, mental health or other diagnoses with law enforcement. There may also be details of the assault that they are not ready to disclose to

law enforcement at that time such as types of penetration (OVW National Protocol, 2013). Questioners must remain focused on asking that which is relevant to their disciplines. The investigative interview should be conducted separately from the medical history and there is *no medical or legal reason* for the presence of law enforcement during the medical forensic history taking or examination.

Each discipline may gather information separately while maintaining communication and coordination as appropriate. Advantages to this approach may include one-on-one rapport building and minimizing the opportunity to conflate medical and investigative roles. Disadvantages include potential for delays in medical care and evidence collection or investigation/steps that can be taken for public safety, lost information between disciplines, and the need for patients to repeat history and answers to questions, which may be inconsistent with the most trauma-informed, patient-centered approach to care.

The preferred approach allows for the SANE/SAFE to be present while law enforcement asks basic questions similar to the “minimal facts interview” commonly discussed in the interview of children (<https://cacnc.org/wp-content/uploads/2016/06/minimal-facts-interview.pdf>) such as what happened, where, when, etc. This information should allow law enforcement to serve public safety interests and preserve relevant crime scenes as necessary while waiting for a more thorough, trauma-informed interview at a later time. This also gives the SANE/SAFE a base level of information from which to ask more directed questions during the medical history portion of the medical forensic exam.

When a patient chooses to complete an anonymous kit and does not want to involve law enforcement at the time, law enforcement should not be contacted until after the medical forensic exam is completed and should only be notified that there is an anonymous kit from an assault that occurred within the jurisdiction that must be picked up within 48 hours and stored for at least one year ([IC 16-21-8-10](#)). For more information on anonymous kits, see Section A5 “Confidentiality”, page 16 and Section A6 “Reporting to Law Enforcement”, page 17. For information about patients who cannot choose to remain anonymous, see Section A6, page 18 for more on mandatory reporting.

General Principles

- Patients should provide as much history as possible in their own words;
- Use open-ended questions (e.g. tell me what you are able to remember about what happened to you, tell me more about that);
- Avoid leading questions;
- Use language that the patient understands, use a professional medical interpreter or communication assistive devices when needed. Family/friends should never be used to interpret;
- Ask “what was going through your mind” and “what were you feeling” rather than “why”;
- Clarify vague or unknown terms/idioms (e.g. “had sex,” “put it in,” slang for body parts);
- Be aware of and responsive to both verbal and nonverbal messages from patients; and
- Take breaks as needed.

The SANE/SAFE should consider patients’ needs before and throughout the information gathering process. As previously discussed, acute medical concerns should be addressed first. Consider other salient patient concerns such as childcare needs during the process. Complete the history and exam in as private and quiet an environment as possible. Avoid interruptions and situations where there is pressure to rush the history taking and/or exam such as shift changes, competing staffing needs, or competition for the room/setting of the medical forensic history and exam.

Ideally, only the examiner and an advocate (if desired by the patient) should be present during the history taking. If patients desire the presence of a personal support person such as a friend, family member, or partner, their wishes should ultimately be honored; however, it is appropriate to discuss potential drawbacks. These can include the patient feeling less able to speak freely regarding medical history, concerns, or details of the assault with a loved one present,

the possibility of the support person being called as a witness if the case goes to trial, and concerns with maintaining the integrity of evidence with additional persons in the room. Regardless, the history must come from the patient rather than through a support person.

Utilize knowledge of the neurobiological response to trauma to craft an effective approach to history taking. Memory is often stored in fragments, sensory based, and not chronological. Open-ended questions and simply stating, “tell me more about_____” (feeling scared, not being able to breathe, what happened to your shirt, etc.) are often beneficial in obtaining a trauma-informed history. Asking questions based on senses (i.e. what did the patient smell, hear, taste, feel, and/or see) can be helpful. If patients cannot remember, consider asking what, if anything, they cannot forget. Help to normalize the disorganization of memories of trauma and do not push for chronological or detailed information that the patient cannot readily provide (<https://www.strandsquared.com/what-does-it-mean-to-be-trauma-informed/>).

Essential Components of the History of Assault

- **Date and time of assault(s) and examination:** The time interval between the assault and the medical forensic exam affects evidence collection and assists in the interpretation of the physical exam. It can also inform safety planning, follow-up needs, and approach to prophylaxis.
- **Location of assault:** This must be considered in safety planning and is essential to determine which law enforcement agency will be involved if a report is being filed and which law enforcement agency will take custody of the evidence in the case of a non-reporting adult.
- **Recent consensual sexual activity:** Due to sensitivity of DNA analysis, it is important to know about recent consensual sexual activity (within the last 5 days). It should be specified if it was oral, vaginal, and/or anal and whether or not a condom or dental dam was used. Elimination samples from consensual partners may be needed for interpretation of DNA findings. There may also be genital findings not associated with the assault.
- **Assault-related injury history:** The location of non-genital and anogenital injury, pain, and/or bleeding should be documented and will direct care as well as photography and evidence collection. Patients should also be directly asked about strangulation, as it is a common feature of sexual assault (Zilkens, Phillips, Kelly, Mukhtar, Semmens, & Smith, 2016). For more information about strangulation, see page 36, Section C8.
- **Suspect information (if known):** Suspect information should be limited to that which may guide the medical forensic exam or directly affect the health and safety of the patient upon discharge. This includes the number and sex of the assailant(s) as this will inform potential health risks to the patient as well as guide the examiner regarding types and amounts of foreign substances that may be found on the patient's body and clothing. While information regarding “distinguishing characteristics” is the purview of an investigatory interview and outside the scope of the medical forensic examiner, factors such as known history of IV drug use, known HIV or other infection status, noted jaundice, tattoos, etc. have implications regarding blood borne pathogens. If the patient spontaneously discloses additional details related to the assailant, this information should be documented. If the suspect is an intimate partner or otherwise has physical access to the patient at home, work or school, suspect identity and relationship is important for patient health and safety and is a vital part of providing appropriate medical and psychological treatment, discharge safety planning, and service referrals.
- **Circumstances of the assault(s):** Information regarding potential mechanisms of injury such as physical blows (with hands, feet, and/or object), holding, grabbing, biting, using physical restraints, strangulation, burns, use of weapons, forcing use of substances, etc. directs the examination, patient care, and collection of evidence. Use of threats (towards patients, loved ones, property, etc.) should be documented and considered in safety planning. Information

regarding physical surroundings (e.g. inside, outside, car, room, rug, dirt, mud, grass, etc.) directs assessment of trauma and injury as well as collection of debris or other forensic samples. Knowing whether suspects may have been injured during the assault may also be useful in planning evidence collection from patients (e.g. blood or skin under nails).

- **Detection of alcohol- or drug-facilitated sexual assault:** Information regarding loss of consciousness and/or memory loss is critical. Assess for significant accompanying trauma such as head injury or strangulation and obtain information regarding voluntary or involuntary consumption of alcohol or drugs. With history of loss of consciousness or memory loss, collecting toxicology samples is recommended, according to institutional and jurisdictional policy. For more information about Drug Facilitated Sexual Assault, see Section C7, page 35.
- **Description of sexual assault(s):** An accurate, but brief description is essential to guide the physical exam, assess health risks, form treatment and follow-up plan, and direct evidence collection. This includes presence or absence of:
 - Penetration, however slight, of external genitalia (e.g. labia majora or vulva);
 - Penetration of the vagina;
 - What was used for penetration (e.g. finger(s), penis, object);
 - Penetration of anal opening, however slight, by an object, penis, or finger(s);
 - Penetration or any act involving the genitalia of one person and the anus of another person;
 - Oral contact with genitals and/or anus (of patient by suspect or of suspect by patient);
 - Other contact with genitals (of patient by suspect or of suspect by patient);
 - Non-genital acts (e.g. licking, kissing, suction injury, biting);
 - Whether ejaculation occurred and in what location(s), if known;
 - Use of lubricants, if known; and
 - Use of condom or other contraceptives such as spermicide, if known.

Essential Components of History of Post Assault Activities

The quality and quantity of evidence is affected by not only the amount of time passed but also by actions taken by patients since the assault. While this information is important, post-assault activities should not be used as a justification to decline to offer evidence collection. Post-assault activity history should address whether the patient has:

- Urinated;
- Defecated;
- Vomited;
- Eaten/Drank;
- Brushed teeth/gargled/used mouth wash/flossed;
- Douched/washed/wiped genitals;
- Showered/bathed/washed;
- Inserted or removed a tampon, menstrual cup, sanitary pad, diaphragm, “female”/internal condom, etc.; and
- Changed clothes.

Essential Components of Medical History

As with any patient, medical history provides the foundation to direct medical care and interpret physical findings. Medical history should include:

- SOGI (sexual orientation, gender identity) data (Appendix B);
- Menstrual history, including last menstrual period;
- Known or possible current pregnancy;
- Current and/or recent use of contraceptives including emergency contraception;

- Tetanus, Hepatitis B, and Human Papilloma Virus (HPV) immunization status;
- Current medications (including over-the-counter medications);
- Known drug or latex allergies;
- Acute or chronic illnesses;
- Recent/preexisting anogenital injuries or discomfort (unrelated to the assault), including recent history of constipation, diarrhea, vaginal or rectal bleeding prior to the assault;
- Other recent/preexisting injuries or discomfort (unrelated to the assault);
- Past medical history such as surgeries, hospitalizations, diagnostic procedures, bleeding/clotting disorders, blood transfusions, obstetric history (including vaginal deliveries), other pertinent medical conditions or treatment;
- Organ/Anatomical Inventory (Appendix C); and
- Post assault symptoms/review of systems (e.g. pain, bleeding, loss of consciousness, nausea, vomiting, diarrhea, headache).

OVW National Protocol, 2013

5. PHOTOGRAPHY

Photography is an important tool to supplement the medical forensic history and document physical findings and, with the patient's informed consent, should be a routine part of the medical forensic examination process. Photographs should be an adjunct to written descriptions of exam findings, diagrams, and/or body maps, not a replacement. Examiners should be familiar with equipment operation and trained in techniques for best capturing accurate images, striving for undistorted photographs with good perspective and sharp focus.

Taking photographs in the aftermath of an assault can increase or exacerbate the patient's traumatic experience. To help minimize traumatization or re-victimization, examiners should obtain informed consent including an explanation of the purpose of photography in the medical forensic exam, potential uses of photographs during investigation and prosecution (especially anogenital images, if taken), the possible need to obtain additional photographs following the exam, and the patient's right to rescind consent and/or take breaks. Photography should be integrated into the medical forensic examination, but should be taken prior to evidence collection. The examiner should work to minimize patient discomfort and respect patients' modesty and privacy as much as possible. In cases where a full body photograph is warranted to show state of clothing or scope of injury, the patient should be draped to the extent possible to preserve privacy. If photos are taken for the purpose of identification, they should be done with the patient gowned or fully clothed. Examiners can consider photographing clothing or other items from the patient, prior to packaging. If examiners have the ability to photograph areas of positive fluorescence on the body and clothing these should be included. Additionally, if a patient declines providing the clothing for the evidence kit, the examiner is encouraged to examine those clothing with the use of an alternative light source, noting and photographing areas of positive fluorescence. The examiner may also swab the clothing, in high yield areas or areas of positive fluorescence, when a patient declines to provide the clothing into the evidence kit.

Link the patient's identity and the date of service to photographs according to institutional and/or jurisdictional policy. Mechanisms should be in place to protect patients' privacy and confidentiality related to photographs. All photographs should be clearly labeled and chain of custody maintained. Follow institutional and jurisdictional policy for storage, transfer, and duplication of images. Photographs should not be included in the sexual assault evidence kit (SAEK) sent to crime lab. Photographs taken by examiners may be medical and/or forensic and should not be automatically turned over to law enforcement. Consent forms should include a clause for patients to sign allowing photographs to be provided to law enforcement on request. Law enforcement should be guided by the body diagrams used in documentation and/or consultation with the SANE/SAFE in deciding what photographs to request (OVW National Protocol, 2013).

Except where emergent medical needs take precedence and do not allow, photograph evidence before moving or collecting it. Minimize background distraction in photographs, focus on the area of interest, and avoid distortion of the image. Use a forensic scale or ruler as a size reference. If a scale/ruler is unavailable, a coin or other standard object could be substituted. Measurement objects need not be included in the kit. Any area photographed with scale must also be photographed without scale to document that the scale did not obscure findings. Use a method that promotes thorough coverage such as working from top to bottom and side to side.

All identified injury should have at least three types of images taken:

- 1) Medium-long range orienting the viewer to the area of the body being photographed using easily identifiable anatomical structures and/or region of the body.
- 2) Close up of the injury using a macro lens or setting.
- 3) Close up of the injury with scale.

6. EXAM AND EVIDENCE COLLECTION

The SANE/SAFE should work to integrate the medical and forensic components of the exam as much as possible. Maintain a focus on empowering patients to have as much control as possible throughout the exam. This can include offering them the opportunity to assist with components of the exam and collection and must include ongoing consent throughout the process. Starting with less invasive portions of the examination and moving to more invasive may increase comfort for the patient. Maintaining flexibility and prioritizing patients' needs and comfort is imperative (e.g. collecting oral swabs before obtaining the history so that patients can eat, drink, or take pain medication). "Ultimately, it is the victim and not the sexual assault kit that should drive the medical-forensic encounter" (NIJ National Best Practices, 2017, p 13).

The medical forensic exam should include a thorough, competent "head-to-toe" examination such that injury identification and documentation is completed along with forensic evidence collection. Forensic samples should be collected and/or photographed prior to any physical assessment that might alter or disturb potential evidence. The examiner should "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" (OVW National Protocol, 2013, p 95). The exam should include vital signs, observation and palpation of the body for potential injuries and tenderness, external anogenital exam, vaginal exam with speculum as appropriate, and in some cases anoscopy. It may also include assessment of the body with an alternative light source (ALS). Bimanual exam is not a part of the medical forensic examination. In cases where this is clinically warranted a physician, advanced practice nurse, or physician assistant should complete this portion of the exam. Patient and situational specifics should further guide the exam. All physical findings should be documented using body diagrams.

Keep medical specimens separate from evidentiary specimens. Those collected for medical purposes should be processed at the medical facility and do not require chain of custody. Follow exam facility policies for documentation of medical care and storage of medical records. Specimens collected for forensic analysis should be transferred to a crime laboratory or other contracted laboratory (such as those required for suspected drug facilitated sexual assault samples) with patients' consent and appropriate chain of custody.

Use the fewest swabs needed for collection from a given site to concentrate foreign material (>2 swabs may result in a diluted sample). If multiple swabs are used, they should be collected concurrently. If this is not possible, note the order in which swabs were collected. If more than one swab is collected, it is preferred that they be collected in the same manner (e.g. using moistened swabs rather than wet to dry technique) (NIJ National Best Practices, 2017). Swabs should be moistened with sterile water.

Clothing Collection

If the patient is wearing the clothing worn during or immediately following the assault, clothing should be collected. In cases where the patient has changed clothing, underwear or whatever clothing item is next to the patient's skin should be collected. If the patient is not wearing the clothes worn at the time of the assault and the patient is reporting to law enforcement, notify the investigating officer that evidence may need to be secured from an alternative location. While no longer a standard part of the Indiana SAEK, in cases where the patient presents immediately following the assault, in the same clothing, or other circumstances where debris or other trace evidence may be present, the SANE/SAFE may consider having the patient disrobe over a paper drape sheet placed over a cloth or paper sheet and submitting the paper drape sheet for possible analysis. Consider photography if clothing is damaged, torn, and/or stained and use care to not disturb or alter the condition of items in disrobing and packaging clothing. Any wet stains should be allowed to air dry before clothing is packaged. Clothing items should be packaged in paper bags, never plastic. Each clothing item should be packaged separately to avoid cross contamination. Underwear should be placed in the designated white paper bag from the SAEK and placed back in the kit. Sanitary pads may be left in place on the underwear and dried, packaged and sent as such so that orientation of the pad remains clear to laboratory personnel. Confirm preferences with local crime labs. Other items should be packaged in paper bags separately from the kit itself. Examination of clothing should occur in the forensic laboratory (NIJ National Best Practices, 2017).

Patients must understand that it is highly unlikely that clothing will be returned to them. As such, there may be certain items that patients decline to give up. The examiner should explain potential drawbacks of this but respect the patient's decision. If the patient declines to provide clothing for the SAEK, the SANE/SAFE may examine the clothing with the use of an alternative light source, if available, documenting and photographing areas of damage and/or positive fluorescence. Consider swabbing areas of fluorescence or potential high yield areas such as the crotch of pants.

A change of clothing should be provided to the patient for home going.

Oral Exam and Collection

Carefully inspect the inner aspects of the patient's lips, tongue, cheeks, and throat for signs of injury. Attention should be paid to the frenula attaching the upper and lower lips to the gums and junction of the hard and soft palates.

To collect oral swabs, swab the gum line, teeth, under tongue, and cheeks using two dry swabs. Dentures can be removed and swabbed. After these swabs are collected, the patient may eat and/or drink as desired.

Patient Standard

The patient standard should be collected with buccal swabs *after* the collection of the oral swabs. Ask the patient to rinse the mouth with water, wait approximately 15 minutes (during which the patient should have no food or drink other than water), and then collect by firmly pressing two swabs simultaneously onto the inside of the cheek and rubbing for 10-15 seconds. With the same set of swabs, repeat this process on the inner aspect of the other cheek.

Head Hair Combing Collection

Collect head hair using the comb and paper provided in the SAEK. The purpose of this procedure is to collect hair shed by suspects that may have been transferred to patient's hair as well as other potential foreign materials. Matted hair may be clipped or swabbed with lightly moistened swabs. Fold the paper around any evidence present as well as around the comb. If the patient does not have head hair, document this.

Pubic Hair Combing Collection

Place the provided paper under the patient's buttocks. Using the comb provided, comb the pubic area allowing any loose hair or debris to fall onto the paper. Consider allowing patients to complete this step themselves. Matted hair may be clipped or swabbed with lightly moistened swabs. Fold the paper around any evidence present as well as around the comb. If there is no pubic hair present, document this and omit this step.

Fingernail Exam and Collection

Swab the underside of fingernails with a lightly moistened swab. One swab should be used for each hand and these should be packaged separately as “right” and “left.” The National Institute of Justice Best Practice (2017) document discourages the use of tools to scrape underneath fingernails, as this may be a source of injury or infection for patients.

Nail clippings may be appropriate per history (e.g. reports of scratching) and/or with nails broken during the assault. Photograph injury to the hands and/or broken fingernails as appropriate prior to clipping.

Consider swabbing the palmer surface of each hand separately using one lightly moistened swab and packaging in separate “left palm” and “right palm” envelopes (NIJ National Best Practices, 2017).

The Anogenital Exam

It is important to note that the majority of sexual assaults do not involve genital trauma, however, careful examination of the genitals for trauma and/or foreign bodies or substances is important. The absence of trauma does not imply that no assault occurred, nor does the presence of trauma confirm that an assault did occur.

During a vulvar examination, the external genitalia including the labia majora, labia minora, interlabial sulci, clitoral hood and periclitoral areas, periurethral tissues and urethral meatus, hymen, posterior forchette, fossa navicularis, and perineum should be examined, looking for injury, debris, or other findings. Similarly, evaluate the abdomen, thighs and perineum for injury, debris, or other findings.

Gentle but firm downward and outward traction on the labia may assist with visualization of the vestibule and hymenal tissue. For examiners who have been trained in the following techniques, toluidine blue dye and/or the “Foley technique” may enhance the exam. Toluidine blue dye may be used to highlight areas of trauma. If used, dye should be applied after the collection of swabs but before the insertion of a speculum. The Foley catheter technique, or use of a large tip cotton swab, can aid visualization of the hymen and should be performed after evidence collection. Photograph examination utilizing these techniques as appropriate.

During a vaginal exam, use a speculum to examine the vagina and cervix for injury and foreign bodies or materials. Any medically indicated cultures, wet mount, or other samples should be collected while the speculum is in place after evidence has been collected. If patients have not yet had a routine gynecological exam they may need additional explanation and/or support. Patient comfort throughout the exam is a priority. Using a small amount of water-soluble non-spermicidal lubricant or water is acceptable to promote comfort during the anogenital exam and evidence collection. The use of any foreign substance such as lubricating jelly must be documented. Be thoughtful in selecting the appropriate sized speculum for the patient.

During a penile examination, evaluate the abdomen, thighs, foreskin, glans, urethral meatus, penile shaft, perineum, scrotum, and testes for injury, debris, or other findings. Any medically indicated cultures should be collected after evidentiary swabs have been collected.

Evaluate the buttocks, perianal skin and anal folds for injury, debris, foreign material, and other findings. This can be done in lithotomy, prone, supine knee chest, or side lying position. Gentle bilateral pressure from the examiner’s hands to the patient’s buttocks may assist with allowing anal dilation to occur. This exam and collection may be appropriate even in the absence of reported anal assault as there may be drainage of fluids to this area even without rectal penetration. Depending on history and program guidelines, consider use of an anoscope to further identify and evaluate trauma. Informed consent is needed for anoscopy. Potential for discomfort of this procedure should be weighed against potential medical and/or forensic benefit.

A colposcope or other method of magnification can facilitate the anogenital exam, providing better evaluation of microscopic trauma and aiding in photography.

If patients must use the bathroom prior to this part of the examination and evidence collection, encourage them to avoid as much as possible washing or wiping the genital area. If possible, consider collecting, drying, packaging and sending the toilet paper used with the SAEK, maintaining chain of custody, and documenting that the patient voided prior to exam.

External Genital Collection

For patients with vulvas, without spreading the labia, using two lightly moistened swabs, collect from the mons pubis, labia majora, and perineum. For patients with penises, using two lightly moistened swabs, collect from the scrotum and penis. Assess for areas of tenderness and document as appropriate.

Internal Genital Collection

Although not medically accurate, for the purposes of SAEK collection, multiple vulvar structures are considered internal. Complete this step prior to placing a speculum or using toluidine blue dye. Separate the labia and swab the labia minora, fossa navicularis, posterior forchette, clitoral hood/clitoris, and vestibule with two lightly moistened swabs. Use one set of swabs only for this entire collection rather than a separate set of swabs for each specific anatomical structure, as this practice would dilute the sample.

Vaginal Collection

Using two dry swabs simultaneously, swab the vaginal walls, cervical os, and posterior fornix. With the patient's consent, blind swabs may be obtained from a patient past menarche if a speculum exam is declined or not possible.

Speculum exams should only be performed on patients past menarche. If a speculum exam is deemed medically necessary in a prepubertal child, conscious sedation or exam under anesthesia should be employed.

Collection of Tampon, Sanitary Pad and/or Condom

Collect condoms, tampons, pads, and/or panty liners as appropriate. Confirm preferences with local crime lab, but it may be advisable to leave pads in place in underwear such that orientation of the pad is known. This may also change the analysis necessary on the underwear itself. Dry items as much as possible and place in paper collection bag. Notify law enforcement and/or lab personnel if any evidence is not completely dried and follow jurisdictional policy for handling and transporting partially dried evidence.

Anal Collection

Consider swabs of the anal folds for all patients with a history of vaginal and/or anal assaults, as well as those with memory loss/loss of consciousness. If anal penetration is indicated, also collect swabs from the anal canal. These should be lightly moistened for patient comfort.

Foreign Material, Dried Secretion, and Debris Collection

An alternative light source may be helpful in visualizing dried secretions through fluorescence; however, sample collection should primarily be guided by history as not all biological substances will fluoresce and other substances such as detergents and lint may fluoresce. Consider areas with history of licking, kissing, biting, splashed semen, or suction injury. The neck, breasts, inner thighs and external genitals are potentially high-yield areas. Collect using two lightly moistened swabs.

Any debris such as threads, grass, leaves, fibers, hair, etc. noted throughout the exam should be photographed, documented, and collected.

Bite Mark Collection

Describe, document, and photograph any noted bite marks. Swab the area using two lightly moistened swabs for possible dried saliva. The photography of and sample collection from a bite mark should be completed prior to cleansing or dressing any wound. Consider collaboration with or referral to a forensic odontologist as appropriate.

Not Recommended

The following samples are not recommended for collection: emesis (though may be collected for toxicological analysis), dental floss, nasal cavity swabs or washes, pulled or plucked hair, vaginal washes/aspirates (NIJ National Best Practices, 2017).

Collection Recommendations for Patients Unable to Provide a History

- Perioral area, lips, and oral cavity;
- Vaginal collection including posterior fornix and cervix;
- Perianal area and anus;
- External anogenital structures including the vulva and vestibule or penis and scrotum;
- Neck;
- Breasts;
- Palms of hands;
- Fingernails;
- Buccal swabs;
- Any areas that fluoresce with use of an alternative light source;
- Debris or foreign material; and
- Blood and/or urine for toxicology.

NIJ National Best Practices, 2017

Evidence Collection and Handling

Samples should be air-dried or collected with capped swabs (see Section B6, page 23) and then sealed in paper bags or paper envelopes provided within the SAEK. Items should never be packaged in plastic. Each item should be labeled with examiner's initials, the date and time of collection, source of specimen, and patient's name. Each envelope should be labeled and sealed with patient labels or tape. Do not lick envelopes or use tap water to seal. (State of IN SAEK; NIJ National Best Practices, 2017; OVW National Protocol, 2013).

7. ALCOHOL AND DRUG FACILITATED SEXUAL ASSAULT

Urine and blood samples for drug testing should only be collected when indicated. Indications include history of loss of consciousness, loss of motor control, memory lapse, circumstances where patients report a level of intoxication differing from their normal response to similar amounts and types of substances, or any other condition that raises suspicion of a drug facilitated sexual assault (DFSA).

Toxicology samples are not a part of the standard SAEK and analysis of these samples is different from that of other evidence analysis. Typically, DFSA samples may be tested and costs submitted to ICJI regardless of decision to report. DFSA analysis should be completed through specialized laboratories rather than hospital or other exam facility labs. These specialized labs have capacity to test for very small quantities of drugs. Toxicology labs ordered exclusively for medical evaluation may be completed at exam facility labs. Work with laboratories and any other involved partners regarding protocols for maintaining chain of custody on these send outs. It is prudent to develop a memorandum of understanding between the SATC and laboratory.

It is important to note that as blood samples have been eliminated from the Indiana SAEK, any toxicology testing requires samples be collected *in addition* to the kit. These samples are not to be placed into kit and must be sent separately for appropriate toxicology testing.

Substances used in DFSA are typically eliminated from the body quickly. Toxicology samples should be collected as soon as possible after a suspected DFSA is identified and informed consent is obtained, even if the patient is

undecided about reporting to law enforcement. If possible, develop procedures with adjacent SART disciplines such as law enforcement/first responders for collection and maintenance of chain of custody for cases where the patient must urinate before arriving at the place of examination.

Substances are detectable in the body for varying lengths of time depending on factors such as type and volume of drug ingested and patient metabolism. The detection window is longer for urine than for blood. A urine specimen should be collected if ingestion of the substance may have occurred within the previous 96 hours. The specimen does not need to be clean catch. While ideally, a patient would not urinate prior to evidence collection, collection for DFSA should not be delayed. Urine should be refrigerated or frozen for storage. Blood may be collected for the DFSA kit if ingestion of the substance may have occurred within the previous 24 hours. Use a gray top tube with sodium fluoride and potassium oxalate preservatives. Blood should be refrigerated for storage. Collecting blood does not negate the need to collect urine: in this case they should be sent together with appropriate chain of custody documentation (OVW National Protocol, 2013).

Testing for DFSA may also report legal and illegal drugs or alcohol in the patient's system that had been taken voluntarily. Informing patients of this is an important part of the informed consent process regarding DFSA testing. Keep in mind that patients may "self-medicate" following an assault and that patients may have chemical dependencies. Provide resources and referrals as appropriate. Voluntary substance use in no way diminishes the seriousness of the assault or makes the patient at fault. Follow institutional and jurisdictional policy regarding assessment of substance use and testing of drugs and alcohol when medically necessary or otherwise.

For additional resources and information on exam payment, please see <https://www.safeta.org/page/MFEPayment>.

8. STRANGULATION

Strangulation is a highly lethal form of violence, power and control, and frequently co-occurs with sexual assault, especially in cases of sexual assault by an intimate partner. With strangulation, blood vessels and/or air passages are cut off by external pressure to the throat or neck, or normal breathing is impeded by obstructing the nose or mouth by applying pressure to the torso ([IC 35-42-2-9](#)). Patients often refer to this as "being choked" or "not being able to breathe." Keep in mind that the clinical picture may vary and range from no visible injury to significant physical trauma such as petechiae above the level of constriction, self-inflicted injury to the neck from trying to remove an assailant's hands and many other signs and symptoms. All patients should be asked directly about strangulation history and any positive response deserves a thorough medical evaluation and discharge instructions. (<https://www.strangulationtraininginstitute.com>). Consider having separate documentation forms for strangulation specifically, outside of standard sexual assault and/or intimate partner violence documentation.

For more information about strangulation, see:

- The Adult Non-Fatal Strangulation PhotoDocumentation Protocol https://static1.squarespace.com/static/53e530a1e4b021a99e4dc012/t/5a318fa171c10b1b9546a701/1513197478293/SDFI_Adult_Non-Fatal_Strangulation_Protocol.pdf;
- The Non-fatal Strangulation Documentation Toolkit <https://www.forensicnurses.org/page/STOverview>;
- Recommendations for the Medical/Radiographic Evaluation of Acute Adult, Non-fatal Strangulation <https://www.familyjusticecenter.org/wp-content/uploads/2017/11/Recommendations-for-Medical-Radiographic-Evaluation-of-Acute-Adult-Non-Fatal-Strangulation-2017.pdf>;
- Recommendations for the Medical/Radiographic Evaluation of the Pregnant Adult Patient with Non-fatal Strangulation https://gallery.mailchimp.com/b4caaa77b9fc5057a0f989305/files/007c52f2-e887-4da9-9512-5b71d378807a/Recommendations_for_Pregnant_Strangled_Patient_July_2018_1_.pdf;
- Emergency Nurses Association Topic Brief: An Overview of Strangulation Injuries and Nursing Implications <https://www.evawintl.org/Library/DocumentLibraryHandler.ashx?id=898>.

9. STI EVALUATION AND CARE

The possibility of contracting a sexually transmitted infection (STI), sometimes also called sexually transmitted disease (STD), from a sexual assault is often a major concern for sexual assault patients. In some cases this may be the concern that drives a patient to present for care.

STI testing during the medical forensic exam should be considered on an individual basis (<https://www.cdc.gov/std/tg2015/sexual-assault.htm>). STI testing done within 120 hours of an assault is unlikely to show an infection acquired from the assault. Patients should be encouraged to accept STI prophylaxis (preventive therapy) as appropriate. If prophylaxis is completed, testing during the medical forensic exam may not be indicated. Testing may be medically indicated if there are public health concerns such as need for recommendation of treatment for ongoing consensual partners with pre-existing infection to decrease risk of reinfection or if symptoms of an existing infection are present. Keep in mind that STIs are often asymptomatic. In cases where testing is done, laws exist in all states to limit evidentiary use of a patient's prior sexual history (CDC 2015 Sexual Assault and Abuse and STDs). Prophylaxis is recommended because many sexual assault patients are lost to follow-up (OVW National Protocol, 2013).

The medication regimen for STI prophylaxis should be based on the most recent CDC Sexually Transmitted Disease Treatment Guidelines <https://www.cdc.gov/std/tg2015/sexual-assault.htm>. The 2015 Guidelines include:

- Ceftriaxone 250mg IM single dose PLUS Azithromycin 1g PO single dose (Gonorrhea and Chlamydia prophylaxis);
- Metronidazole 2g PO single dose OR Tinidazole 2g PO single dose (Trichomoniasis prophylaxis, *consider recent alcohol use and/or plans to drink in the 48 hours following treatment and defer as appropriate);
- Post exposure hepatitis B vaccination, if not previously vaccinated. See CDC Guidelines for further details;
- HPV vaccination as indicated. See CDC Guidelines for further details; and
- HIV post exposure prophylaxis (see below or page 38).

Consider offering an antiemetic, as nausea and vomiting are common side effects from multiple drugs in this regimen. While all of the above medications are safe to take during pregnancy, possible alternative medications such as doxycycline are not and one might consider other modifications such as deferring the HPV vaccine if a patient were pregnant. As such, a pregnancy test is prudent. SANE/SAFEs who are neither physicians nor advanced practice providers (e.g. NP, PA) should work with medical directors to develop and utilize protocols around treatment and testing and all SANE/SAFEs should have access to medical supervision and/or consultation as needed.

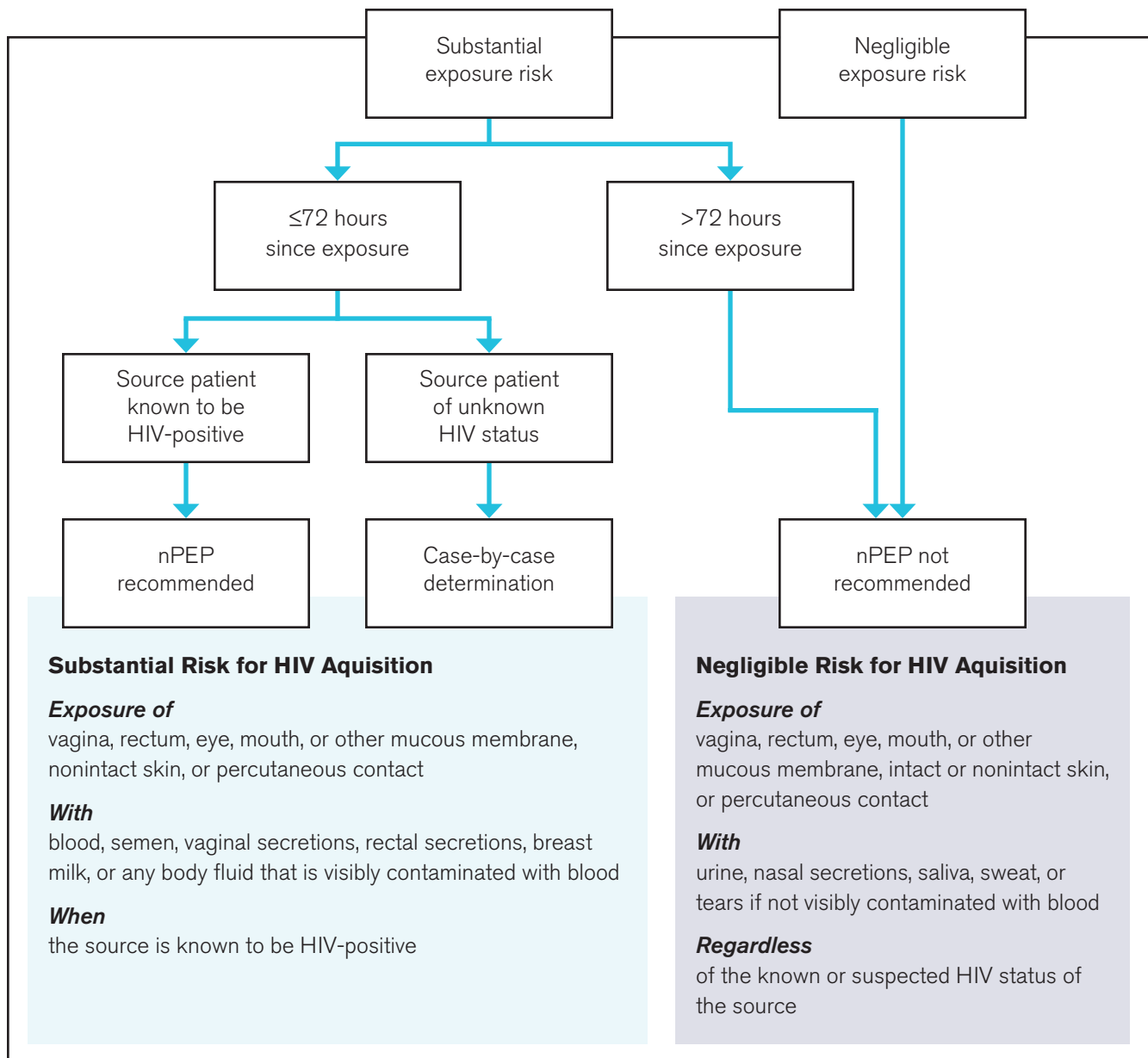
Discharge instructions should include information regarding risks, testing and treatment options, details of what tests and treatment were administered during the medical forensic exam, symptoms to look for and the need for care and testing if symptoms occur, need for abstinence with consensual partners until treatment is completed and testing confirmed negative as appropriate, follow-up recommendations and referrals as needed. These instructions should be given in language the patient can understand and should be provided verbally as well as in writing for patients to continue to reference. SANE/SAFEs should work to develop a referral list of local providers who are trauma-informed and knowledgeable about provision of care following sexual assault.

A 1-2 week follow-up exam is recommended, and provides the opportunity to assess for development of symptoms as well as for adherence to or side effects resulting from prophylactic regimens. If a patient declined prophylaxis, testing for gonorrhea, chlamydia, and trichomoniasis should be completed at this follow-up appointment. For those who received prophylaxis and do not have symptoms, follow-up testing is not necessary, though many patients may desire testing to provide reassurance and closure for these concerns and this may certainly be appropriate for the situation. Syphilis testing should be completed at 6 weeks and 3 months, and HIV testing at 6 weeks, 3 months, and 6 months as indicated. Follow-up appointments also provide opportunity to address ongoing vaccine series needs (i.e. Hepatitis B and Human Papilloma Virus). Additionally, this follow-up provides an opportunity to address other healthcare related sequelae of violence and explore/encourage advocacy, counseling and other appropriate referrals (CDC 2015 Sexually Transmitted Diseases Treatment Guidelines; OVW National Protocol, 2013), as well as an opportunity to provide reassurance regarding healing and normalcy of the body.

PEP

Post-exposure Prophylaxis for Human Immunodeficiency Virus (HIV), sometimes called Nonoccupational Post-exposure Prophylaxis, is referred to as PEP or nPEP. Although the overall risk of contracting HIV from a sexual assault is low, risk varies by circumstances of the assault and is often a significant fear for patients. See the table below from the “CDC 2016 Updated Guidelines for Antiretroviral Postexposure Prophylaxis After Sexual Assault, Injection Drug Use, or Other Nonoccupational Exposure to HIV” regarding evaluation of risk.

Exposure risk is increased in cases of anal penetration (with or without injury), vaginal penetration with injury, and when the assailant is known to be HIV positive or at higher risk of infection (e.g. injection drug users or men who have sex with men). Exposure risk decreases with the use of a condom, absence of ejaculation from the assailant, absence of injury, absence of anal or vaginal penetration, oral penetration only, and when the assailant is known to be HIV negative.



In situations where the assault poses an elevated risk of HIV exposure and/or the patient is extremely fearful of infection, PEP should be offered.

If PEP is to be started, it must be initiated within 72 hours. As such, when a patient presents within 72 hours of assault, the evaluation and decision regarding PEP should be made rapidly. The sooner it is initiated, the more efficacious; therefore, even within the 72 hour window, delays should be avoided. PEP is not recommended if initiation will occur beyond 72 hours after the assault.

Before initiating PEP, a baseline HIV test should be completed. This is important as PEP would not be appropriate and could in fact be harmful for someone who is already HIV positive due to concern for developing drug resistant strains. A rapid 4th generation antigen/antibody test is preferred; however, if this is unavailable, non-rapid testing is acceptable. In this case, or if baseline testing is unavailable, it is acceptable to proceed with the assumption the patient is not infected. Testing and results should be obtained as quickly as possible thereafter and the regimen stopped if the patient were in fact positive. Also obtain a pregnancy test and consider obtaining blood work to assess hematologic status, liver function and renal function (serum creatinine, ALT, AST, estimated creatinine clearance, CBC, serum chemistry/CMP), evaluation of Hepatitis status, and/or other tests per institutional policy and/or based on drug specific recommendations. If the baseline test is positive, provide referrals to an infectious disease or HIV savvy primary care provider and provide supportive counseling (aidsetc.org; CDC.gov; OVW National Protocol, 2013), and do not start PEP. An initial positive should have a blood sample sent for confirmatory testing. Programs should have a mechanism in place for follow up on confirmatory testing results.

PEP should consist of a 28-day course of a 3-drug antiretroviral regimen. The CDC recommends providing a 3-7 day starter kit to bridge patients until they can follow up with an infectious disease specialist or HIV savvy primary care provider. At this follow-up appointment they can assess tolerance to medications and provide the remainder of the 28-day prescription.

The medication regimen for PEP should be based on the most recent CDC PEP Guidelines <https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf>.

The 2016 Guidelines suggest a 3-drug regimen of:

- Tenofovir DF 300mg AND fixed dose combination emtricitabine 200mg once daily.

WITH raltegravir 400mg twice daily OR dolutegravir 50mg once daily:

- Alternative regimen recommended for those with decreased renal function.

Emerging data suggests that dolutegravir is associated with neural tube defects when taken at time of conception through the first trimester of pregnancy. It continues to be recommended for patients who are effectively contracepting or in the second and third trimester. When caring for patients in the first trimester who are appropriate candidates for PEP, raltegravir may be the better option. Consider calling the National Clinician's Consultation Center for assistance in weighing risks and benefits. Note that the PEP line (1-888-448-4911) is available 7 days/week 9am-9pm EST. For these specific patients (or other pregnancy related HIV concerns), the Perinatal HIV line (1-888-448-8765) is available 24/7 (<https://aidsetc.org/consultation>).

Cost of and access to medications can be barriers. See information on Patient Assistance Programs on page 40 and in Appendix G. In addition, the Indiana Criminal Justice Institute (ICJI) will reimburse patients, pharmacies, and hospitals for costs of these medications (see [IC 16-18-2-1.8](#)) and plans to utilize a voucher program for pharmacies to eliminate the need for patients to be reimbursed. Patients should not be responsible for the cost of PEP. For questions about payment process, contact ICJI directly at (317) 232-0157.

Counseling must include the importance of adherence to the full regimen for 28 days without interruption, review of possible side effects, abstinence or protected sex with consensual partners, the importance of follow-up, and recommendation for ongoing HIV testing at 6 weeks, 3 months, and 6 months.

Programs/institutions are strongly encouraged to have a system in place for patients who are eligible to start PEP medications. This should be a collaborative effort between team members and may include a program's medical director, forensic nurse coordinator, pharmacy, social work, case management, and infectious disease.

For additional PEP information and resources see/contact:

- National Clinician's Consultation Center 888-448-4911 or <http://nccc.ucsf.edu/>
- CDC's National HIV/AIDS Information Hotline 800-342-AIDS:
 - For Spanish speakers 800-344-SIDA
 - For Deaf and people with hearing impairment 800-AIDS-TTY
- For uninsured or underinsured patients:
 - Common Patient Assistant Programs Form:
https://www.nastad.org/sites/default/files/PAP_form_interactive.pdf
 - Medication Assistance:
 - 1-800-226-2056 or www.gilead.com/responsibility/us-patient-access (Truvada)
 - 1-844-588-3288 or www.viivconnect.com (Tivicay)

Additional information available in Appendix G.

10. PREGNANCY RISK EVALUATION AND CARE

The possibility of a pregnancy resulting from a sexual assault is often a serious fear for patients who have been sexually assaulted and their loved ones. The risk of pregnancy after an assault is the same as the risk from any other single sexual encounter. Multiple factors influence likelihood of conception including timing in menstrual cycle, use/correct use of contraception, type of assault, presence or absence of ejaculation, condom use, etc. In a typical menstrual cycle, ovulation occurs on day 14 (counting from the first day of the last menstrual period). Sperm live for approximately five days. Therefore, days 9-15 of the menstrual cycle are typically the most fertile time; however, because of the variability in length of menstrual cycle, timing within a cycle should never be used as a reason to not offer pregnancy prophylaxis.

Emergency contraception should be offered to all patients with reproductive capabilities that are not consistently using a reliable method of contraception as appropriate based on history. This includes young women Tanner Stage 3 or above who have not yet begun menstruating, perimenopausal women, those with a history of infertility, transgender men or non-binary persons who have a uterus (even if on testosterone and not menstruating), and women who are breastfeeding.

A pregnancy test should be administered prior to making the decision to use emergency contraception, as it is unnecessary or, depending on method, may be harmful in the presence of an existing pregnancy.

The decision surrounding using emergency contraception (EC) is a personal one that is influenced by social, cultural, religious and spiritual considerations. The examiner must use caution not to influence patients' choices one way or the other. If the examiner feels unable to provide this component of care, there must be a plan in place for the patient to access emergency contraception in a timely manner. These can include over the counter access to levonorgestrel based EC, Planned Parenthood or other family planning clinics, or other colleagues within one's institution. Additional resources include:

- <http://not-2-late.com>;
- <https://www.prjktruby.com/about/products/ella/>;
- <https://afterpill.com/>.

Options for emergency contraception include levonorgestrel-based pills, ulipristal acetate, and the copper intrauterine device (IUD). All must be administered within 120 hours of the assault/unprotected sexual activity. The examiner should discuss mechanism of action, efficacy, side effects, and follow-up needs for each option. There are advantages and disadvantages to each option and different programs may have access to different options. Note that being overweight or obese may decrease the effectiveness of oral emergency contraceptive options. The examiner should follow institutional policies and protocols regarding options available to them while being versed in all available methods so patients can make informed choices. Regardless of method used, patients should be encouraged to take a pregnancy test if they do not have a menses within 2-4 weeks, or when menses would normally be expected.

Additional information on emergency contraception can be found at:

<https://www.acog.org/Patients/FAQs/Emergency-Contraception>;

<https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Emergency-Contraception>;

http://americansocietyforec.org/uploads/3/4/5/6/34568220/asec_ec_efficacy_and_weight_statement.pdf;

<https://ec.princeton.edu/questions/eceffect.html>.

11. DISCHARGE AND FOLLOW-UP

When possible, patients should be offered the opportunity to perform personal hygiene including showering and should be provided clean clothing on completion of the exam.

Discharge instructions should be provided verbally and in writing in language the patient can understand. Written information is imperative as processing of information and memory can be limited. Acute medical and mental health concerns should have been managed and a summary of care provided. If concerns remain unaddressed, appropriate referrals should be given. The summary of care should include a summary of the exam, medications provided or prescribed, tests pending and results if available, follow-up appointments scheduled and/or recommended, referrals, and contact information for local advocacy centers. It may be helpful to develop specific discharge instructions for certain situations such as those taking nPEP or what to monitor following strangulation.

A 1-2 week follow-up appointment with a primary care or OB/GYN services is encouraged (see Part C, Section 9, page 37 for more details). SATCs should work to develop a list of trauma-informed providers in their area. Some programs may provide follow-up to document healing or developing injury or to monitor and reevaluate nonspecific findings where normal variants would remain unchanged but injury would evolve or resolve. Programs may offer a follow-up contact such as a phone call with the SATC to check on medical status, answer questions, and review follow-up recommendations and resources/referrals. Patients must give permission for this type of follow-up contact and careful attention must be paid to safety and privacy concerns.

Safety planning should be an integral part of SANE/SAFE care and should address both physical safety and emotional/psychological needs. This includes evaluating for: a safe place to go to immediately on discharge (helping to facilitate shelter or alternative options if needed as well as safe transportation to determined location), possible need for protection orders or other additional security needs (facilitating this process as much as possible), level of social support (providing phone numbers for additional support as appropriate), and suicidal ideation/risk of self-harm (responding to concerns as appropriate and following institutional policies). When available, a facility's social worker and/or case manager may be able to assist with these items.

Ideally, when present, advocates would explain their services and law enforcement would explain next steps in the investigative process. However, the SANE/SAFE should be able to provide basic information on behalf of these other SART disciplines if either is not involved or not present at the time of exam. The patient should have information on how to contact and follow up with appropriate members of the SART.

12. SANE/SAFE TESTIMONY

SANE/SAFEs should be aware that by nature of the medical forensic exam and their education and expertise, they may be called to testify as a fact and/or expert witness at trial, at a hearing, or in a deposition. It is recommended that SANE/SAFEs maintain a current curriculum vitae (CV) detailing their education, training, and experience, including the number of examinations they have observed and performed, and the number of times they have testified. Health records should be subpoenaed before an examiner can talk with a civil or defense attorney about information in a patient's medical record. In cases where the victim has reported the sexual assault, SANE/SAFEs may speak with law enforcement and/or prosecutors to assist them in understanding exam findings while they are evaluating the case for charging purposes. When called as a witness, examiners should meet with the attorney calling them to prepare for testimony. Examiners may be called by the prosecution or the defense in a criminal case or any party in a civil case, including Child in Need of Services (CHINs) cases, and should give objective, professional testimony in all cases. (OVW National Protocol, 2013). For more information please see the "ICESA Indiana SART Guide" (2018).

DEFINITIONS

Medical Forensic Examination:

A comprehensive examination provided to a sexual assault victim by health care personnel trained to provide trauma-informed, patient-centered medical care and to gather evidence of sexual assault in a manner suitable for use in a court of law. The examination includes at a minimum*:

- Patient medical history;
- History of present illness/assault for diagnosis and treatment;
- Medical examination for physical trauma/injuries;
- Collection of evidence;
- Photographic documentation and body mapping;
- Prophylaxis for exposure to STIs, including HIV, and/or possible pregnancy
- Safety planning and discharge planning.

**Patients have the right to decline any portion of the Medical Forensic Examination.*

Sexual Assault:

Any type of sexual contact or behavior that occurs without mutual, un-coerced, freely given consent.

Sexual Assault Evidence Collection Kit (SAEK):

The standard medical forensic examination kit for victims of sexual assault developed by the state police department.

Sexual Assault Nurse/Forensic Examiner (SANE/SAFE):

A registered nurse, nurse practitioner, physician, or physician assistant, most often a registered nurse (Sexual Assault Nurse Examiner, or SANE), who has specialty training to provide comprehensive care to patients who have been sexually assaulted, conduct a medical forensic examination, collect forensic samples that are turned over to law enforcement as evidence, and testify as both a fact and expert witness. Care of those who have been sexually assaulted is best provided by SANE/SAFEs. In Indiana and nationally, nearly all SAFEs are SANEs.

Sexual Assault Response Team (SART):

A multidisciplinary partnership to provide a consistent, coordinated, competent and compassionate response to sexual assault that makes victim needs a priority, promotes public safety, and holds offenders accountable. Core members include advocates, law enforcement, SANE/SAFEs, and prosecutors. The team may also include crime labs and anyone from the community who provides services in response to sexual assault.

Sexual Assault Treatment Center (SATC):

A medical facility that provides evidence-based, trauma-informed and victim-centered medical forensic services and that uses Sexual Assault Nurse/Forensic Examiners (SANE/SAFEs) to perform medical forensic exams. SATCs can be hospital or community based.

ADDITIONAL RESOURCES

Forensic Technology Center of Excellence

<https://forensiccoe.org/>

“Providing evidence-based resources about forensic technologies and emerging challenges”

Indiana Emergency Nurses Association (ENA) Forensic Nursing

<https://www.indianaena.org/forensic-home>

Includes: updates, education, resources, links to partner organizations

Sexual Assault Forensic Examination Technical Assistance

<https://www.safeta.org>

“Technical assistance and essential knowledge about sexual assault medical-forensic examinations and related topics”

Includes: protocols, form library, training, resources, and other technical assistance

Sexual Assault Nurse Examiner (SANE) Education Guidelines

https://cdn.ymaws.com/www.forensicnurses.org/resource/resmgr/education/2018_sane_edguidelines.pdf

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HISTORY AND ACKNOWLEDGMENTS

This manual represents years of hard work by many individuals throughout Indiana who recognize the importance of addressing the medical, emotional, and evidentiary needs of the victims of sexual assault/abuse in Indiana. Under Governor Orr, a task force was formed to develop statewide guidelines for the medical and forensic examination of sex crime patients. Governor Orr's Task Force for Indiana Sex Crime Victim Guidelines disbanded in 1990 having produced a complete manual, but without funding for implementation or distribution.

In 1994, the former sexual assault coalition, the Indiana Coalition Against Sexual Assault (INCASA), and the Indiana Criminal Justice Institute convened another task force to update, revise, and complete the manual developed by Governor Orr's Task Force. This group was similar to the first task force in that its members represented the medical, legal, law enforcement, forensic science, and victim advocacy professions. Members had extensive experience in working with sexually assaulted/abused adults and children. The members of both original task forces and the organizations they represented at the time are listed below.

Similar groups have met throughout the years to update and revise these guidelines to ensure on going best practice to provide quality care to victims of sexual assault. Thanks are due to individuals from other states who shared their protocols as the initial Indiana Guidelines and further revisions were developed. Special thanks for consultation and contributions to this edition are due to the 2018-2019 Guidelines Work Group, the Center for Victim and Human Rights, the Eskenazi Health Transgender Health & Wellness Program, Leslie Cook, RN, MDI, SANE-A, SANE-P, Diane Daiber, RN, SANE-A, SANE-P, Laurie Gray, JD, the Indiana State Police Laboratory, Indiana Trafficking Victims Assistance Program (ITVAP), Pamella Jahnke, MSN, RN, FNE, Skye Ashton Kantola, Kate Kimmer, Tracey Horth Krueger, Emma Mahern, JD, Devon McDonald, Paul Misner, Mary Ott, MD, MA, Kris Posthuma, MSW, Kristen Pulice, LCSW, Christian Ross, MD, FACEP, and Shaunette Terrell, JD. The Indiana Coalition to End Sexual Assault and Guidelines Work Group thank all of the individuals who contributed hours of discussion and research to the development of these guidelines.

APPENDIX A. Caring for Transgender People

Eskenazi Health Transgender Health & Wellness Program

Glossary of Terms

Sex:

Biological differences, genetics, anatomy either present at birth or that develop secondarily during puberty

Gender Identity:

Internal, individual sense of self/one's gender. Often relates to social and cultural distinctions. Can be multidimensional and has psychological, behavioral, expression, and roles associated with it. Gender is not binary.

- **Transgender:** Umbrella term that describes people whose gender identity differs from the gender and gender roles that are traditionally associated with their sex assigned at birth. Some transgender people may have binary concepts of their gender and others may have nonbinary experiences.
 - **Transgender woman, trans woman, male-to-female (MTF), trans feminine:** A person assigned male at birth (AMAB) who identifies as a woman.
 - **Transgender man, trans man, female-to-male (FTM), trans masculine:** A person assigned female at birth (AFAB) who identifies as a man.
- **Important note:** transgender is an adjective, not a noun. It is one trait of a person and not their whole. It is important to model language that is mindful of this as it can help decrease stigma.
- **Cisgender:** a person whose gender identity is congruent to the gender traditionally associated with their sex assigned at birth.
- **Nonbinary:** a person whose gender identity falls outside the traditional gender binary. Nonbinary experiences are all unique and there is no one-size-fits-all way that nonbinary persons experience themselves or express their gender identity.
- **Other terms:** Gender fluid, gender expansive, gender non-conforming, gender queer, pangender, agender.
- **TGNC:** transgender and gender non-conforming.

Gender/Sexual Minority (GSM):

Usually refers to those who identify as LGBTQ+

Sexual Orientation:

How a person characterizes their sexual, emotional, and romantic attraction to others.

- **Heterosexual (straight):** emotionally and sexually attracted to those of the binary opposite sex/gender.
- **Gay/Lesbian:** emotionally and sexually attracted to people of the same sex/gender.
- **Bisexual:** emotionally and sexually attracted to people from their own sex/gender and people from other sex/genders.
- **Pansexual:** Similar to bisexual but sometimes preferred as term to include attraction to transgender people.
- **Asexual:** lack of sexual attraction to anyone.
- **Queer:** umbrella term, often synonymous to LGBTQ+. May be used by individuals who feel that other sexual/gender identity labels do not adequately describe their experience. This term is most often used by those in the LGBTQ+ community as it has had negative connotation in the past and has been re-appropriated by the community. Some may not feel comfortable using the term given past negative connotations.

Gender Pronouns:

- she/her/hers
 - he/him/his
 - they/them/theirs
 - ze, hir/zir, hirs/zirs
-

Acceptable Terminology

Use these terms:

- **Intersex or Disorders of Sex Development (DSD)**
- **Gay or lesbian**
- **Sexual orientation**
- **Transgender or a transgender person**
- **Gender affirmation or gender confirmation surgery**

Do NOT use these terms:

- Hermaphrodite
 - Homosexual
 - Sexual preference, lifestyle
 - Transgendered, a transgender, tranny, transvestite
 - Sex change, sex reassignment surgery
-

Transgender Rights: Service providers receiving VAWA funding must serve transgender survivors (<http://forge-forward.org/wp-content/docs/know-your-rights-VAWA-fact-sheet.pdf>).

Transitioning is not a singular, linear experience. The process is individual for everyone. Some people have an “end” while others do not. An important note: Not everyone has surgery. Surgery(ies) is/are not essential to transition; in fact, many people do not choose to have genital reconstruction or do not perceive it as essential to validate their gender experience. There are many ways that individuals can affirm their gender including:

- **Social:** hair, clothing, using different name and pronouns, coming out to others;
- **Legal:** changing name and/or gender marker on identity documents (ID, birth certificate, passport, social security card);
- **Medical:** hormones, surgery, hair removal, speech therapy.

Exam and Evidence Considerations:

- Most transgender people, who have access and means, will use hormones to affirm their gender identity.
- The effects of feminizing and masculinizing hormones impact body shape/size (WPATH Standards of Care v 7 at wpath.org).
- Only some people will have surgery due to the cost and lack of insurance coverage.
- Proceed slowly with evidence collection to maintain patient emotional safety. There is a very high rate of physical, sexual and emotional trauma in this patient population. Trauma-informed care always includes discussion before physical touch and to help the patient stay in control.
- Document SOGI (sexual orientation and gender identification) data and an organ inventory. An organ inventory includes an assessment of current, at-birth/expected, and surgically modified secondary sex characteristics. It is important to conduct an organ inventory to assess what testing, treatments, and medications are appropriate for each patient.
- Use gender-neutral body maps. Make sure documentation system allows documentation of all possible body parts, and does not assign a “male” or “female” chart.
- Ask about language. Language is easy to ask about and vitally important to trans people. For example, “I’m going to use medical terms to talk about body parts. Just tell me if there are different words you want me to use.”

- Communicate clearly with the crime lab to correctly label and preserve specimens.
 - “Victim is a transgender male. Legal name is Jennifer Smith. Victim goes by James Smith and uses he/him pronouns. Victim was assigned female at birth and pelvic exam was completed.”
 - “Victim is a transgender female. Legal name is Stephanie, pronouns are she/her, and gender marker has been legally changed to female. Victim was assigned male at birth and does not have anatomy requiring a pelvic exam (see organ inventory).”
- Removal of wig, binder, prosthetics, clothing, etc. is exposing a body that may not match a person’s gender identity. For trans people, having their identity/presentation “removed” can be traumatic even if it’s indicated for specimen collection.

Transmasculine People:

- Dysphoria about genitalia combined with high incidence of trauma among transgender people may cause additional triggers during a pelvic exam. Ask the patient’s preferred terms for body parts beforehand.
- Make clear to the lab/other team members that the patient is assigned female at birth (AFAB), especially if gender marker has been legally changed to male.
- Organ inventory is very important. If the person has a uterus and ovaries, assess for risk of pregnancy.
- Most transmasculine people want to use hormones.
 - Testosterone is the masculinizing hormone. Testosterone is NOT birth control. Just because many transmasculine patients taking testosterone may stop having periods does not mean they cannot become pregnant.
 - Many transmasculine patients opt for long-acting reversible contraception (LARC) like an IUD or Nexplanon. Daily birth control pills can be emasculating and remind people they don’t have the body that makes sense to them. Transmasculine people may also be resistant to taking anything with estradiol in it.
 - Vaginal atrophy begins 3-6 months after starting testosterone therapy. Atrophy may result in more damage during a sexual assault and a more difficult evidence collection process. Pelvic pain is very common.
- The most common surgeries for transmasculine people are “top surgery” (mastectomy and chest reconstruction) and hysterectomy +/- oophorectomy.
- “Binders” are used to minimize breasts.
- “Packers” can be used to imitate the look and feel of a penis.

Transfeminine People:

- Trans women of color and those who engage in survival sex are two groups who experience some of the highest rates of physical and sexual violence.
 - Often, these groups cannot afford feminizing “bottom surgery.” “Tucking” or using a gaff are common ways to feminize the appearance of genitals under clothing. There is a black market for hormones and silicone.
 - Many people buy feminizing hormones from the internet. Injecting non-medical grade silicone, is sometimes the most affordable way to change body shape (cheeks, hips, buttocks, breasts).
- Vaginoplasty surgery is extremely expensive and not accessible for many people. Cost of vaginoplasty surgery ranges drastically from around \$7,000 in Thailand to over \$30,000 in the U.S.
- Usually, the skin from the penis is inverted to create a neovagina between the bladder and rectum. The scrotal skin is used to create the deepest part of the neovagina. In almost all cases, the prostate is retained and is anterior to the neovagina. Neovaginas require a great deal of maintenance. They are not self-lubricating. Size and elasticity are directly related to how often a patient dilates and what size dilator is used. Patients are instructed to dilate, often five times daily in the weeks after surgery, to maintain the size and shape of the neovagina. If patients do not have penetrative sex or continue dilating, they are likely to have a decrease in the depth of the neovagina.

- Considerations for the medical forensic exam.
 - Damage to the colon and bladder are common in cases of sexual assault.
 - The penile skin used to make a neovagina is thinner and not as pliable as that of a natal vagina and is much more likely to tear during a sexual assault. The lining of a neovagina is squamous epithelium rather than natal vaginal mucosa.
 - A healthy part of neovagina maintenance is douching. It is important to document the time the patient last douched for the medical forensic exam.

Tips for providing the best possible care to transgender people who have experienced violence

- Understand the historical context of trans discrimination.
- Recognize your unconscious bias (Fix your Face!).
- Name, Pronouns, and Language: Introduce yourself using name and pronouns. (“If I have to fight over my own pronouns, there is no chance they are going to be able to hear and meet my other needs.”)
 - Ask for, and use, a person’s affirming name and pronouns.
 - Determine with your client when it may not be safe to use their language.
 - Hold yourself and others accountable.
 - Use inclusive, gender-neutral language when possible.
 - Avoid gendered honorifics like Mr., Miss, Mrs. and Sir/Ma’am.
 - Use last names to call patients.
 - Mirror the language your clients use to describe themselves and their bodies.
 - Use a gender-neutral body map to identify injuries/evidence.
 - Do not attempt to “correct” a person’s word choices.
- Educate yourself. Many organizations have great resources including: FORGE, GLAAD, National Center of Transgender Equality, WPATH, Office for Victims of Crime, National LGBT Health Education Center, Center for Excellence for Transgender Health.
- Assess your workplace environment.
 - Is the name of your organization specific to women?
 - Are there visible symbols of the LGBTQ+ community (stickers, flags, pronoun buttons)?
 - How are LGBTQ+ people represented in office media (brochures, magazines, advertising)?
 - Are there single occupancy bathrooms? Is it clear that people may use the bathroom that aligns with their gender identity?
 - How do your electronic medical record and/or forms ask for sex, gender, parents, or partners?

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APPENDIX B. Sexual Orientation and Gender Identity (SOGI) Data

SOGI (sexual orientation and gender identity) Data: Evaluate your documentation system for methods to document SOGI data either on paper or electronically. Staff members should be trained to collect SOGI data in a sensitive manner. All patients should be asked the following three questions:

1. What is your current gender identity? (Check ALL that apply)

Male

Female

Transgender Male/Trans Man/FTM

Transgender Female/Trans Female/MTF

Gender Queer

Additional Category (please specify) _____

2. What sex were you assigned at birth (what was on your original birth certificate)? (please check one)

Male

Female

Decline to Answer

3. What name do you go by or have you chosen and what pronouns do you use (ex: he/him, she/her, they/theirs)

APPENDIX C. Sample Organ Inventory

It is important to document an organ inventory and gender affirming treatments and surgeries during the medical history for transgender patients.

Organs for inventory

- Penis
- Testes
- Prostate
- Breasts
- Vagina
- Cervix
- Uterus
- Ovaries

Common gender affirming treatments and surgeries

- Cross-sex hormone therapy, current or past user
- Vaginoplasty (penile inversion or colon graft)
- Phalloplasty (abdominal flap or free flap)
- Metoidioplasty
- Scrotoplasty
- Urethroplasty
- Bilateral total reduction mammoplasty
- Other gender affirming surgical procedure

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APPENDIX D. Human Trafficking Quick Indicator Health Care Tool

Indiana Trafficking Victims Assistance Program (ITVAP)

If youth:

- Is listed on social media/internet;
- Was brought in unconscious;
- Was recovered from a hotel;
- Admits exchanging sex/sex acts for money/goods, or;
- Has had a prolonged absence from home without explanation/consistently runs away from for >24 hours call DCS immediately. Indiana DCS: 1-800-800-5556.

Other Red Flags

The factors below may also indicate human trafficking. You must use your professional judgment based on the individual circumstances to determine if DCS should be notified. If you report the youth to DCS, DCS will screen and assess for human trafficking.

- Evidence of implantation of chip (raised area) on neck behind earlobe, web area between thumb and forefinger, or inside of lower forearm
- Branding/tattoos (names, numbers, dollar signs, emblems @neck, chest, wrist, fingers, lower back)
- Adult is speaking for youth and is controlling the conversation
- Youth has no ID, or doesn't have control of ID or other important documents, or has fake ID
- Youth is fearful or submissive (looks at ground, not speaking, doesn't know location, looks at adult before answering questions)
- Past or current homelessness
- Genital injuries
- STIs
- Prior pregnancies and/or abortions
- Urinary tract infections/difficulties
- Hypervigilant, angry, or displays unwarranted paranoia/fear
- Bruises in various stages of healing
- Scars, mutilations, or infections
- Signs of drug abuse or symptoms of drug withdrawal
- Malnutrition/dehydration

Indiana DCS: 1-800-800-5556

APPENDIX E. Legal and Ethical Analysis of Minor Consent

This section discusses the legal and ethical issues of determining minor's ability to assent and consent. These are guidelines that assist the provider in assessing a minor's capacity to consent and each situation should be carefully thought through and discussed with each SATC institution's risk management, ethics, and legal departments as appropriate. These are recommendations only and should not be construed as legal advice.

Health care providers involved in the care of the adolescent patient who has experienced sexual violence must consider several factors when caring for this population. Providers face a challenge when balancing the adolescent's right to bodily integrity and confidentiality while simultaneously recognizing and respecting parental rights. As discussed previously, the provider must attain the assent of the adolescent patient before performing a medical forensic exam (MFE). Assent is obtained after the provider explains informed consent, which includes the benefits, risks, and alternatives to the MFE. The more difficult question is who can provide written consent for the adolescent, as Indiana laws do not specifically state who can actually provide the written consent for the medical forensic exam. A review of legal and ethical concerns regarding adolescent consent for providers may provide guidance on how to decide what is in the best interest of the adolescent when determining consent for a medical forensic exam.

- a. There are several Indiana laws that address consent but do not specifically state that a minor may provide written consent to a medical forensic exam. The following is the [Indiana Code 16-21-8-3](#) discussing consent of the medical forensic exams.

"A physician or sexual assault nurse examiner who provides forensic medical exams and additional forensic services shall provide the forensic medical exams and additional forensic services to an alleged sex crime victim under this chapter with the consent of the alleged sex crime victim."

This section of the code does not specifically address the minor's ability to consent. The Indiana minor health consent statute ([IC 16-36-1-3](#)) outlines when it is legal for a minor to consent to care. The statute outlines the criteria for consenting to one's own health care as it relates to specific circumstances, none of which specifically allow for a minor to consent to a medical forensic exam. The provider must balance the law, parental rights, minor confidentiality, and the best interest of the minor patient. Health care providers need to consider the cognitive development of the adolescent to ensure they have the capacity to make health care decisions without being coerced into making a decision. Adolescence is a time during which executive functioning skills have not fully developed and the youth may not understand the consequences of not involving a non-abusive parent(s) in their care. The decision to exclude the parent/caregiver, may have negative consequences regarding future care and well-being of the minor.

- b. The Indiana Minor consent statute ([IC 16-36-1-3](#)) does provide the minor to consent to some aspects of their health care without parental, custodian, or guardian consent. These situations are outlined in the statute. The instances where a minor may consent without parental consent are medical concerns relating to STI exposure, blood donation under certain circumstances for those over 16 years of age, elements of prenatal, intrapartum and postpartum care under certain circumstances for those over age 16 years of age, and when authorized to consent to the health care by other statute, such as consent to treatment for drug and alcohol abuse ([IC 12-23-12-1](#)). Medical Forensic Examination is not included.

Knowing the law is not explicit regarding consent of a medical forensic exam by a minor; a provider should be concerned about the confidentiality of the minor if they do not wish for their parents to know of the sexual assault. Knowing what information to treat as confidential and how to maintain that confidentiality can be a challenge. This can create a dilemma for the provider. Research has shown that confidentiality leads to improved quality of care, access and outcomes for the adolescent. Adolescents provided with confidentiality assurances are more likely to disclose sensitive information to providers. [Reference: Ford CA, Millstein SG. Delivery of Confidentiality Assurances to Adolescents by Primary Care Physicians. Arch Pediatr Adolesc Med. 1997;151:505-9.]

Confidentiality and privacy rights are paramount to health care of adolescents, and essential in establishing trust between the minor patient and the provider, but it is not absolute. There are times when a provider should break confidentiality and notify the adolescent's parents in times of an emergency. The home situation of the adolescent will dictate whether to notify the parents, in addition to the authorities, in the situation of sexual assault. Identifying the assailant in the situation will help guide the provider regarding which individuals may need to be consulted. Certainly, in a scenario where it is unsafe to notify the parents (i.e. if the parent is the abuser or the adolescent will experience additional physical harm if the parent(s) are notified) the provider must act with ethical responsibility that prioritizes the safety of the patient. These are sensitive situations and may require further consultation with the health care team, Department of Child Services, ethics team, and the institution's legal counsel or risk management department. Multidisciplinary collaboration can create a sound plan of care that will benefit the minor patient. Whether or not parents are notified at the time a minor presents for a medical forensic examination, in no way negates the responsibility of the provider to contact law enforcement and/or DCS.

APPENDIX F. Patient Information for Anonymous Reporting

Dear Patient,

Indiana Law gives you the right to have a medical-forensic exam (specimens and clothing) collected even if you chose not to report to law enforcement at this time. Payment for services under this section shall be processed in accordance with rules adopted by the victim services division of the Indiana Criminal Justice Institute. You will not incur a cost for the medical-forensic exam or additional forensic services in relation to injuries or trauma resulting from the sex crime.

By law, the sample kit and clothing collected will be held for one year (365 days). If you decide not to report the crime to law enforcement within 365 days of your exam, the Sample Kit and clothing may be destroyed. Your identifying information will be released with your signed "Application for Benefits" to the Indiana State Sex Crime Victims Services Fund in order to pay for today's forensic-medical exam. No criminal investigation will occur unless you choose to report to law enforcement.

Please initial each statement below.

___ I have chosen not to report to law enforcement (LE) at this time.

___ I understand I have the right to a medical-forensic exam and additional forensic services in relation to injuries or trauma resulting from the sex crime without reporting to LE.

___ I understand I may report the crime to LE within one year (365 days) of my medical-forensic exam.

___ If I report to LE, I will need to inform them that the Sample Kit and/or clothing were collected at _____ hospital/sexual assault treatment center.

___ I understand that the Sample Kit/clothing of forensic specimens collected today will be held for one year and may be destroyed after one year if I do not report to LE. Police Jurisdiction # _____. I will call this number if I wish to report.

___ I understand that the Sample Kit will have serial number under the kit bar code as my individual identifier. My Sample Kit Identification # is _____.

___ I understand I will not be informed of the destruction of my sample kit.

___ I understand that no criminal investigation will occur unless I choose to report to law enforcement.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

APPENDIX G. PEP Resources

Alternative means to obtain antiviral medications for PEP

There are several ways that patients can obtain and pay for antiviral medications other than using the ICJI voucher.

1. Patients with Medicaid

Patients with Medicaid should be able to fill prescriptions for PEP medications without difficulty. Most pharmacies will waive the \$3 co pay per prescription if a patient is unable to pay. There may be instances where a certain Medicaid will not cover the cost of prescriptions such as antivirals. These cases should be referred to social work or case management to assist the patient in obtaining the medications.

2. Patients with Private Insurance

If PEP medications are approved through private insurance, patients may or may not have co-pays. Those on a spouse's or other type of family insurance plan such as college students who are unwilling to notify parents of the assault, could have their privacy impacted if they utilize this insurance coverage. Using the ICJI voucher to obtain the antivirals may be the better option in these cases. Co-pay coupons can be obtained off the pharmaceutical websites to ensure the patient is not paying for the medication that insurance does not cover. More information can be found below.

3. Patients without Insurance

Patient Assistance Programs may be available through drug manufacturers for patients without insurance. Social Work or Case Management in medical facilities can work to obtain medications for patients free of cost if they financially qualify. To facilitate the process, a letter should be sent from the provider explaining the clinical situation, along with the application for free medication, to the drug company for approval. Typically, the antivirals can be sent to the patient's home within 24-48 hours. It is recommended that the patient receive a 3-7 day supply of the antivirals to ensure that the patient does not run out of medication before they receive the additional medication.

SATCs that provide antivirals for PEP may provide a 30-day supply of the medications and submit the medication cost on an itemized bill along with the cost of the medical forensic exam to ICJI. This may not be possible for institutions that do not have an outpatient pharmacy available. For some, it may only be possible to provide the first dose, or a 3-7 day supply of medication and discharge the patient with a prescription for the additional days of medication and a plan to follow one of the above paths. These patients should be also be given the voucher from ICJI.

Information regarding the patient assistance program for antivirals

1. TRUVADA (made by Gilead): Gilead's assistance program for Truvada is relatively easy to navigate and the medication can typically be obtained quickly. The company requires a letter from a provider confirming that an assault occurred, the date it occurred, the date medications were started if they have been, and any other medications the patient is currently prescribed. Once this letter is faxed to Gilead, wait approximately 15 minutes and then call the company to discuss medication assistance. Though Gilead only requires a provider letter for sexual assault victims and does not require that a copy of their application be sent in, the process may be aided by having the patient review and sign the application so that the SANE/SAFE or other staff has all required information to facilitate the conversation with the company. Gilead will provide billing ID, BIN, and GROUP numbers for pharmacy billing once they approve the patient. The patient can then take the prescription and billing codes to the pharmacy.
2. ISENTRESS (made by Merck): This assistance program requires the full patient assistance application be completed, signed by the patient and provider and faxed to Merck. The provider then should call to confirm with Merck that they received the application. Once they confirm that the patient is a sexual assault victim and approve assistance, Merck will ship the medication to the patient within 24-48 hours. A starter pack of Isentress will be necessary to bridge the

patient until the shipment is received. It is imperative the patient have an available address for shipping. If this is not possible or safe for the patient, medication could be shipped to the hospital pharmacy, SATC, or other agreed upon alternative for pick up by the patient.

Other antivirals follow essentially the same process, but shipping times may vary. It is important to note that assistance programs through drug manufacturers may not be accessible on nights, weekends, or holidays. It is strongly encouraged that SATCs have a system in place to support patients through this process. This should be a collaborative effort between team members potentially including the medical director, the forensic nurse coordinator, the pharmacy, the social work, and case management.

Truvada (Gilead)

1. Co Pay Support — <https://www.gileadadvancingaccess.com/hcp/financial-assistance/copay-support>
2. Co Pay Coupon Card — <https://www.gileadadvancingaccess.com/copay-coupon-card>
3. Gilead Advancing Access Free 30-day supply 800-226-2056 *will need letter from provider confirming urgent need
Co-pay assistance — 877-505-6986 or www.gileadadvancingaccess.com/copay-coupon-card
Up to \$4800
4. 24/7 Support for patients without insurance — <https://www.gileadadvancingaccess.com/hcp/financial-assistance/uninsured-support>

Tivicay

1. Co Pay Support — https://tivicayhcp.com/?utm_source=google&utm_medium=cpc&utm_term=tivicay&utm_campaign=GS%20-%20Branded_Tivicay%20PH
2. Co Pay Coupon Card — <https://www.internetdrugcoupons.com/tivicay-coupon>
3. ViV Healthcare — Free 30-day supply 844-588-3288
Co-pay assistance — 844-588-3288 or <https://www.myviivcard.com/>
Up to \$7,500.00
4. Patient Savings — <https://www.viivconnect.com/>

Isentress (Merck)

1. Co Pay Card — <https://www.rxpharmacycoupons.com/isentress-manufacturer-coupon.html>
2. Merck Patient Assistance Program — Free 30-day supply will be shipped overnight.
Call 800-727-5400 for the application.
Co-pay coupon — <https://www.activatecard.com/7726/#> Up to \$6,800.00.

Combivir

1. COMBIVIR: ViV Healthcare — <https://www.viivconnect.com/patient-assistance-program/>
2. Free 30-day supply 844-588-3288
Co-pay assistance — 844-588-3288 or <https://www.myviivcard.com/>
Up to \$4,800.00



SAK Serial Number: IN	__ - ____ - ____
ICJI Claim Number: S	__ - ____ - ____
PIN:	____



Sexual Assault Compensation Information Sheet

Part of State Form 241 (R11 / 5-19)

The Indiana Criminal Justice Institute (ICJI), in accordance with Indiana Code 5-2-6.1-39, administers payment for certain costs associated with a forensic medical exam. These costs include, but may not be limited to, the cost of the forensic medical exam, mental health counseling, certain diagnostic testing, initial pregnancy and follow-up pregnancy testing, certain laboratory testing for STDs, alcohol, drugs, suturing and care of wounds, STD prophylaxis to include HIV prophylaxis, and other limited outpatient services. The approved costs will be paid by ICJI to the provider if the following conditions are met:

1. The patient must be the victim of a sex crime that occurred in Indiana.
2. The patient is treated by a provider that provides general medical, surgical and emergency services for sex crimes that occur in Indiana.
3. The patient must consent, in writing, to allow the release of their medical records to ICJI.
 - a. The consent is authorized when the patient signs their name on the ICJI application while at the hospital.
 - b. If the patient is under eighteen (18) years old, a parent or guardian must give consent in writing as the responsible party. In addition, law enforcement and/or the Indiana Department of Child Services must be notified.
4. The provider is responsible for applying to ICJI for payment of services. ICJI remits payment directly to the service provider on the patient's behalf.

Forensic medical exams must be provided free of charge to the patient.

ICJI may also provide payment for: One follow-up pregnancy test, sexually transmitted disease testing up to thirty (30) days following the initial treatment; one syphilis test up to ninety (90) days following the initial visit. ICJI will also provide payment for mental health treatment up to \$3000. Services must be provided by a licensed mental health provider.

Additional information may be found at www.in.gov/cji/2333.htm or by calling 317-232-1233. You may also track the status of your sexual assault kit (SAK) by logging in to the Victim Compensation Claims System (VCCS) by visiting vcc.cji.in.gov/Public/Home.aspx selecting the SAK tracking module and entering your SAK serial number and assigned PIN.

You may refuse to allow the service provider to apply to the fund on your behalf.

This has no bearing on whether the case may be referred for prosecution. However, the hospital or sexual assault treatment center may bill you or your insurance provider for care received beyond the scope of the forensic medical exam.

HIV medication(s) should be taken as prescribed and should be started within **seventy-two (72) hours** following the incident. Please present the prescription processing information below to the pharmacy of your choice. If you have any questions, please contact Member Services toll free at **(866)-921-4047**.

RXBIN: 020958 RX PCN: 07960000 RXGRP: TRUES000 ID: ID Key: DOB: LASTNAME: FIRSTNAME:	
Pharmacy Help Desk: (844) 544-3228 Member Services: (866) 921-4047	

ICJI is not responsible for the distribution of HIV medication.

Receipt of the medication may take up to twenty-four (24) hours.

For copies of this manual or more information contact:

**The Indiana Coalition to End Sexual Assault
317-624-2370 or www.indianacesa.org**

The 2019 Guidelines for the Medical Forensic Exam of Adult and Adolescent Sexual Assault Patients
has been published by the Indiana Coalition to End Sexual Assault.