First National SANE Coordinator Symposium

Final Report and Recommendations

Portland, Oregon

NSVRC
national sexual violence resource center

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Table of Contents

Introduction

Local Sexual Assault Nurse Examiner (SANE) Programs and the providers working within them have significantly improved the medical-legal care provided to victims of sexual assault in communities across the United States. The purpose of the SANE Coordinator Symposium Project has been to help regional (tribal, state, military branch, and territory) level efforts take the next step towards stronger coordination, program development, and sustainability through face-to-face networking, information sharing, strategizing and the identification of technical assistance and research priorities. This report provides an overview of the SANE Coordinator Symposium Project and information generated at the Symposium in order to increase SANE program development.

Background and Purpose of the National SANE Coordinator's Symposium Project

Every two minutes, someone in America is sexually assaulted (Rand, 2008). Despite this, sexual assault is the most underreported crime in the United States (Rand, 2008). Whether or not they report the crime to police, many victims of sexual assault seek care and support at hospital emergency rooms and clinics, often without receiving appropriate basic health services or adequate forensic evidence collection (Campbell and Wasco, 2004). Specialized training and coordination of victim service professionals, including medical professionals, is required to address this discrepancy.

Sexual Assault Nurse Examiner (SANE) and Sexual Assault Forensic Examiner (SAFE) programs have emerged across the country to address the unique and often complex medical-

legal needs of victims of sexual assault. Where such programs exist they have greatly improved the quality of medical care for victims and the potential for successful prosecution of offenders. In 2004, the Department of Justice published the first National Protocol for Sexual Assault Medical Forensic Examinations and using SANEs has become the standard of care for sexual assault survivors seeking medical-legal assistance. The International Association of Forensic Nurses (IAFN) reports that there are over 500 local SANE programs currently in operation in the United States.

Although there are guides, standards, and helpful resources for SANE programs and SANE practice, every community, territory, tribe, military branch, and state has had to develop and adapt models that respond to local conditions and needs. Strong infrastructures, access to strategic information, and peer networks are needed to maintain programs and provide for further growth in a time when resources are scarce. anti-sexual assault coalitions, offices of attorneys general, and departments of health are working to build this infrastructure by creating statewide or regional SANE programs and coordinator positions.

Using SANEs has become the standard of care for sexual assault survivors seeking medical-legal assistance.

The NSVRC (National Sexual Violence Resource Center) originally identified 35 individuals working on regional, state, territory, military, or tribal-wide SANE coordination. Even though opportunities to share strategies and solutions have grown through support organizations, in-person networking and information-sharing among coordinators has been limited. At the National SART Conference in June of 2005, several coordinators approached staff from the NSVRC and Oregon's Attorney General's Sexual Assault Task Force with a request to facilitate and host a gathering of SANE coordinators from around the country.

The Office for Victims of Crime funded the First National SANE Coordinator Symposium, attended by fifty-three participants, in Portland, Oregon on May 10-12, 2006. The Symposium provided an opportunity for coordinators to discuss critical issues in their communities, to learn about best and promising approaches and practices being used in other programs, to assess the effectiveness of their programs, and to build connections with peers.

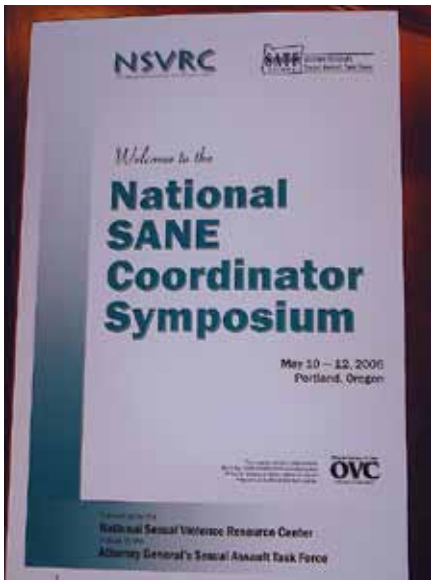
A SANE coordinator database and listserv established by NSVRC staff was the basis for initial outreach. A Steering Committee comprised of national experts and SANE coordinators from around the country was formed in early 2005 and worked together for over a year to identify other potential participants, develop a survey and convene a national symposium. In order to keep the focus on regional-level issues and collaboration, invitations were only sent to SANE coordinators working at a territory, tribal, military-branch, or state level, or to those working to establish a program at one of these levels. Thirty-three participants represented states, three represented territories, four represented tribes and two represented branches of the military.

SANE Coordinator Survey

A thirty-nine question web-based survey was conducted to gather information about the scope, structure, funding, capacity, and status of regional, state, territory, and tribal level SANE coordination, and also to identify promising practices and innovations and technical assistance needs. The survey served as the starting point for prioritizing and addressing each topic area at the Symposium and for identifying additional issues and recommendations found in this report.

The Symposium

The Symposium was organized to enable SANE coordinators to have the highest level of interaction and participation possible. Based on very positive evaluations of the Symposium, participants felt they were able to reduce barriers, find vital support for their efforts, and learn from each other. Over the two-and-a-half day Symposium, participants shared challenges and strategies, practices and policies, innovative solutions, and needs. The process, developed by the Steering Committee and facilitated by skilled staff and volunteers, included: slide show presentations of survey results, short panel presentations by participants, small group work sessions, and reports of session highlights to the full group. All activities were organized around major topic areas identified through the survey.



State of SANE Coordination

Symposium participants were provided with an overview of the thirty years of SANE history since the first U.S. SANE programs were established in Memphis, TN in 1976, in Minneapolis, MN in 1977, and in Amarillo, TX in 1979. The 1980s saw the emergence of 17 additional programs with an exponential growth of programs to over 500 by 2006. Currently, 80% of all SANE programs are hospital-based with another 20% located in a variety of community-based settings. There is a national SANE certification process in place through the International Association of Forensic Nurses (IAFN). The benefits of a national system include a well developed standardized testing process, the establishment of a national standard through a nursing organization, and reciprocity across states and regions. Additionally, some states have developed their own certification process with varying degrees of success. State-level certification can complement IAFN standards by providing local support and oversight to meet the specific needs of a region, including preceptor requirements that foster local networking and helping to develop and maintain clinical competency. State certification bodies are not standardized in that they house or maintain their authority under different structures (state Attorneys General, departments of nursing or health, or sexual assault coalitions). Most states with certification programs have been supportive of SANEs obtaining both IAFN and state-level certification and have developed programs that are in keeping with IAFN standards.

Where it exists, the formal position of the state, territory, tribal, or military level SANE coordinator is relatively well-established. Nineteen (19) survey respondents report that they are in formal positions as state-level coordinators. Of those, 11 (63.2%) said their positions have existed for five years or more. Almost 90% of these positions have a formal written job description

and all have funding for the position. Twelve of the 19 formal coordinators are nurses. The remaining seven are advocates, trainers, administrators, attorneys, community organizers, and therapists. Regional-level programs serve overlapping jurisdictions including states and territories (100%), tribal communities (21.5%), campus communities (36.8%), large metropolitan areas (36.8%), and military bases or installations (36.8%).

Supervisory responsibility for regional-level SANE coordination is most often shared. State Attorneys General share authority with public health departments and heath care facilities share authority with community-based victim advocacy programs. Multi-disciplinary and multi-agency coalitions hold the authority for only one of the regional-level programs surveyed. Most respondents (80%) are satisfied with the supervisory structure for their program. Problems mentioned in both the survey and at the Symposium related to supervision of nurses by non-nurses, power and control issues related to location of the program or supervisory structure, jurisdictional or philosophical complications or differences, isolation and lack of support, and lack of funding.

The benefits of a national certification system include a standardized testing process, the establishment of a national standard through a nursing organization, and reciprocity across states and regions.

Coordinators identified numerous innovative practices and responses to challenges. Several programs have facilitated an expanded role for SANEs. Over 73 % of coordinators who responded to the survey report that local programs in their regions provide exams and care for young child victims of sexual assault. Perpetrator exams, DNA collection from offenders, working in collaborative settings that focus on child abuse, sexual assault and domestic violence, and generalized forensic nursing provide opportunities for increasing and maintaining competency and sustaining programs long-term. Competency is supported in many programs through peer and collaborative case review, certification and recertification processes, consultant support, local/regional SANE coordinators covering multiple local programs, strong collaborations with state boards of nursing and the IAFN, and focused professional development and evaluation efforts.

Emerging Issues

- The need for clinical supervision and technical assistance for nurses when the coordinator is not a nurse.
- The difficulty for coordinators who are not nurses to engage medical professionals, including hospital/clinic-based SANEs.
- The need for more information on how the Crawford[1] decision impacts the practice of SANEs.
- The consideration of power and control issues between and within organizations and how these relate to specific staff roles and the prioritization of sexual assault.
- The need for clarification regarding sexual assaults involving military personnel, including issues of confidentiality, payment for medical exams, and cooperation and collaboration between military and civilian entities.
- The need for clarification regarding jurisdictional issues when a sexual assault involves military personnel or tribal members or occurs on military property or tribal land.
- The need to address issues regarding isolation, disconnection and/or lack of direct support for SANE coordinators and local SANE programs.
- The lack of stable funding for regional-level coordination, local program implementation, and/or the provision of exams.
- The need for developing and newer programs to gain authority and legitimacy.
- The lack of program standards and/or supportive legislative and administrative policies in some regions.
- The lack of established or formal regional-level coordinator positions (some positions are "on the side" or part of another job).
- The concern that when a SANE program is based in a non-profit advocacy center or coalition it may not be perceived as neutral or credible.
- The resistance of professionals, both within and outside of the health care system, to address sexual assault, provide or pay for exams, and/or acknowledge sexual assault as a significant issue.

Promising Practices

- The development of working partnerships between nurses and non-nurses in administering programs.
- The use of a consultancy model for addressing training, program development, and technical assistance needs in local programs.
- The implementation of a state-wide mentorship program between experienced and newly-trained SANEs.

1 In Crawford v. Washington, the U.S. Supreme Court held that when hearsay statements of an unavailable witness are "testimonial," the 6th amendment requires that the accused be afforded a prior opportunity to cross-examine the witness.

- The development of Memoranda of Understanding between local programs, tribes, military installations, and others (e.g., prisons, schools, etc.)
- The creation of expanded roles for SANEs, such as the involvement in general forensics, pediatrics, domestic violence, and perpetrator exams with the benefit of building program capacity and sustainability.
- The formalization of partnerships to support stability and legitimacy (e.g., IAFN, state boards of nursing, academic programs, etc.)
- The recognition of regional-level ability and authority to set and implement standards (e.g., for training, provision of services, maintenance of SANE competency).
- The development of regional and county-level coordination and networking.
- The implementation of state-level certification for local programs and nurses that complements the IAFN certification process.
- The development of 'for profit' program models.
- The development of a multidisciplinary center to provide medical-legal services for victims of domestic violence, sexual assault, child abuse, etc.
- The inclusion of funding for state-level coordinator program as a line-item in state budget.

Technical Assistance and Support Needs

- Organizational capacity-building (including infrastructure and funding).
- Development and dissemination of practice and policy guidelines.
- Development support, "start-up guidelines" and a "tool kit" for new programs.
- Sample Memoranda of Understanding for interagency and cross-jurisdictional efforts.
- Technical assistance regarding how to develop partnerships with nurses and administrators in order to support the work of the regional coordinators who are not nurses.
- Tools and training for program and system evaluation.
- Time and support for multidisciplinary perspectives and networking.
- Time and support for regional-level networking and resource sharing.

SANE Practice

Despite the variation in supervision and the newness of some regional-level coordination, most programs have recognized authority with regards to local SANE programs and practice. The majority of regional-level coordinators surveyed (77.8%) have authority for setting local program and service standards, 44.5% have some recognized responsibility for ensuring compliance, 22% provide supervision for direct service staff, and 22% have direct authority or a role in local staff hiring.

Issues related to SANE scope of practice are often addressed at the regional level. At the Symposium, a presentation was given on the regulation of nursing practice and on understanding states' Nurse Practice Acts. Utah and Nevada were used as examples to show how each state's Nurse Practice Act, state boards of nursing, and nursing administrative rules and regulations impact SANE practice. Needs and issues were addressed with regard to lack of clinical authority of a non-SANE as coordinator of a SANE program and the role of professional nursing organizations in providing services, guidelines, and education to its members.

Nurse Practice Acts vary across the country. Nursing scope of practice with regards to providing care to victims of sexual assault varies both in relation to the differences across regions and also as a result of interpretation at the local level. For example, some nurses practice independently with no supervision, while others may not be allowed to do a complete exam or dispense medication. Other questions, such as how to work with unconscious or incapacitated victims and use and

efficacy of colposcopy[2] and toluidine blue,[3] were discussed at the Symposium as needing further research.

Survivor access (or lack of access) to emergency contraception (EC) and the inadequacy of the national protocol in addressing it is a serious issue identified by SANE coordinators. Many Catholic hospitals, individual providers and pharmacists, and even some national retail pharmacies are refusing to dispense EC. The U.S. Conference of Catholic Bishops created a document on Emergency Contraception and the Treatment of Sexual Assault Victims saying, "victims of sexual assault should be treated with compassion and understanding. Health care providers who treat sexual assault victims should provide medically accurate information and offer spiritual and psychological support. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization".[4]

Hospitals have been sued for not providing EC and there are efforts to create state and federal legislation to require the provision of EC. Though the national statistics on the provision of EC to victims of rape are abysmal (only 20% received EC in 2002), 98% of SANE programs offer it.[5] Not surprisingly, SANEs and SANE programs are also directly involved in providing treatment for sexually transmitted infections (STIs). While nationally only 58% of victims presenting to hospitals are screened or given prophylactic treatment for STIs, 99% of all SANE programs offer treatment and 58% offer testing. In Minnesota, 99% of those offered prophylactic treatment accept, making SANE programs an important partner in efforts to reduce STIs. HIV is also a serious concern in many communities and SANE programs are in the middle of the debate. While 38% of SANE programs surveyed offer HIV meds, many have opted out due to the expense, perceived or real lack of risk, and a known lack of patient compliance with the regimen.

2 A colposcopy is a way healthcare professionals can examine genitals, vagina and cervix closely through the use of an instrument called a colposcope that shines a light on the cervix and magnifies the view.

3 The application of Toluidine Blue Dye (TBD), a nuclear stain, is used to identify microtrauma in the genital area of sexual assault patients.

4 United States Conference of Catholic Bishops. (2001). *Ethical and religious directives for catholic health care services, fourth edition*. Washington, DC: United States Conference of Catholic Bishops.

5 National Sexual Violence Resource Center. (2006). *Sexual Assault Nurse Examiner Coordinator Survey Findings*. Unpublished manuscript.

SANE programs and Sexual Assault Response Teams (SARTs) have had a positive impact on every aspect of the response to sexual assault, and on the way survivors of sexual assault are treated. In communities with an effective SART that includes the active participation of SANEs, reporting rates are higher to start with and survivors who start out not wanting to report often change their minds.[6] When evidence kits are done by trained SANEs, proper chain of evidence is maintained, collection of sperm and blood evidence is done better, and documentation of the incident and of the process of evidence collection is much more accurate and thorough. The change in technology that makes it possible to get DNA from much smaller samples and to hold evidence that might implicate a serial perpetrator through a "cold hit" is impacting SANE practice. Many SANE programs are being asked to do perpetrator as well as victim exams as a way to raise money for their programs.

Emerging Issues

- Some coordinators have no recognized authority with regards to local programs and practices.
- Nurse practice acts vary from state to state regarding numerous issues related to SANE practice (e.g., administration vs. dispensing of meds, conducting a bimanual pelvic exam, or whether or not use of a speculum is allowed).
- Local hospitals and clinics have policies that contradict states' Nurse Practice Acts.
- There may be funding for exams but not for coordination of programs, or vice versa.
- Some regions allow nurses to operate independently and others require MD supervision.
- Different levels of nurses (e.g., RNs versus nurses with advanced practice licenses) may practice and be treated differently.
- SANEs are often involved in providing pediatric exams with or without specialized training.
- Unresolved questions about "incapacitated" patients and consent (unconscious, drunk, drugged, etc.)
- In some regions, VOCA/VAWA funds are used primarily for domestic violence services with little left for providing care to victims of sexual assault.
- Lack of general awareness or support for services for victims of sexual assault.
- Lack of access to or provision of emergency contraception.
- Lack of capacity or support for anonymous reporting and evidence collection and storage.

6 Ledray, L. E. (1999). Sexual assault nurse examiner, SANE: Development and operationg guide. Washington, DC: Office for Victims of Crime.

Promising Practices

- The provision of standing orders for medications for victims of sexual assault.
- Hospitals pay nurses and coalitions to provide training in a supportive partnership that is an effective and efficient use of state-level resources and expertise.
- Nursing unions and others - including health care policy makers, physicians, emergency department managers, etc. - interpreting Nurse Practice Acts in favor of independent SANE practice.
- Regional support of SANE involvement in providing pediatric exams.
- The involvement of public health professionals in promoting SANE practice and in setting the scope of practice for SANEs.
- The establishment of local hospital-program reciprocity so SANEs can practice at multiple sites.
- The enactment of state statutes that require the provision of emergency contraception.
- The development of a system that allows for anonymous reporting and evidence collection.
- The development of co-location options for providing SANE exams (e.g., a special room in a new domestic violence shelter, sharing space with a Child Advocacy Center, etc.)
- The provision of information (e.g., the results of toxicology and STI testing) via phone hotlines to non-reporting victims who wish to remain anonymous.

Technical Assistance and Support Needs

- Clarification and dissemination of information on scope of practice at the regional level.
- Research on the use and efficacy of colposcopy, anogenital photography, and toluidine blue.
- Clarification/consensus regarding unconscious/incapacitated victims.
- Clarification/consensus regarding anogenital photograph storage.
- Development and dissemination of tools and materials for working with special populations.
- Support and guidelines for SANEs conducting pediatric exams.
- Collection and dissemination of sample Memoranda of Understanding or contracts from programs where SANEs practice in multiple locations or work out of a central location.

SANE Training and Competency

Regional-level programs provide training and technical assistance to a wide variety of local programs. All (100%) regional-level programs and coordinators surveyed provide training and technical assistance to local adult and adolescent SANE programs, almost 58% to child-serving, 26.3% to military, and 20.5% to tribal SANE/SAFE programs. Most provide the general training for SANEs in their region though not all meet the national or IAFN standards. Some regions recruit nurses to become SANEs only if they are experienced or have had advanced training while others take any nurse who is interested. Still others have difficulty attracting nurses interested in SANE training and practice. Many programs have developed incentives and support structures to make recruitment and retention more successful. Maintaining competency, especially for isolated or rural programs, can be difficult. Programs pay for training in a variety of ways, from charging a fee to participants to completely subsidizing it with grant or government funding. Training for addressing the special needs of certain types of victims is available in some areas but not in others.

Maintaining competency, especially for isolated or rural programs can be difficult.

Emerging Issues

- Recruitment and retention can be difficult due to inadequate pay, vicarious trauma, and SANE workload in addition to other full-time employment.
- Not all regional-level training meets national standards.
- The provision of training can be expensive and may or may not be supported.
- It is often difficult to ensure and support competency, especially for nurses in rural areas or in teaching hospitals where residents get prioritized for training.
- Securing options for meeting preceptorship/continuing education requirements can be difficult, especially in smaller or rural communities.
- Isolated SANEs have no access to peer review or ongoing/advanced training to ensure and maintain competency.
- Some programs and communities have low volume of patients presenting in need of exams, limiting the opportunities to stay in practice and maintain competence.

- Reciprocity across regions or even local programs can be restricted due to scope of practice, standards, organizational policies, or certification issues.
- There is a lack of training for addressing special needs of certain victims (e.g., victims who are incapacitated, have developmental disabilities or mental illness, children, non-readers, etc.)

Promising Practices

- The provision and use of teleconferencing and distance learning.
- The development of contracts for nurses conducting exams at multiple sites.
- The expansion of roles for SANEs so they can stay current in their practice (e.g., involvement in all forensic exams, caring for victims of domestic violence, conducting pediatric exams, etc.)
- Partnerships among SANE programs and Planned Parenthood clinics and crime labs for continuing education.
- Affiliations/Memoranda of Understanding with schools of nursing, public health, military services, and others.
- The use of experienced SANEs as assistant trainers in order to enlarge the local pool of trainers.
- Frequently asked questions (FAQs) on websites to disseminate basic information and policies.

- The use of other professionals as trainers to provide local buy-in and to support a multidisciplinary approach.
- The use of new technology for training and education.
- The standardization or provision of training at the regional level.
- The development and maintenance of regional-level SANE list serves and discussion boards.
- The involvement of crime labs in supporting quality and competence by completing a Quality Assurance sheet with feedback to SANEs on all kits received.
- The use of a "clinical ladder tool" to encourage continuing education and competency.
- The provision of incentives (e.g., higher pay for more experience, initial training fee refunded for a certain commitment) for continued practice as a SANE and participation at meetings.
- Training in developmentally appropriate history-taking for SANEs.
- The use of peer review/quality assurance processes.
- The development and dissemination of flow charts or algorithms to guide the sexual assault exam process.
- The development and provision of simulated or mock exams and court proceedings.
- SANEs training physician residents to avoid unskilled "practice" on victims of sexual assault.
- 'Currency of Practice' model.[7]
- The requirement of a minimum number of precepted exams for maintaining competency and (in some areas) certification.
- The development of state/regional-level certification processes.
- The development of credentialing processes.

Technical Assistance and Support Needs

- Support for the development of guidelines and a consensus regarding unconscious/incapacitated victims.
- Training on the use of photography for documenting injury.
- Support for the development and dissemination of tools and materials for working with special populations (e.g., diagrams and picture boards to assist non-readers in telling their stories, materials in Braille, etc.)
- Online education/alternative educational capacity and technology support.

7 The Currency of Practice model requires all nurses who complete SANE training to complete a minimum number of exams annually on sexual assault patients in order to maintain their certification. There are additional continuing education requirements regarding sexual assault as well.

- Dissemination of and training on IAFN and other national standards.
- Clarification/guidelines for peer review and quality assurance processes.
- Sample quality assurance process format and guidelines.
- Tools and materials (including case scenarios) for conducting mock exams and mock trials.
- Clarification on regional-level certification and credentialing processes and how they do or do not complement IAFN certification.
- Support and information on creating a resident training program for physicians at teaching hospitals or clinics.

Leadership Development and Policy Issues

With the support of regional and national promotion and leadership there has been an exponential growth in the establishment of local SANE programs across the United States. Organizations such as the Sexual Assault Coalitions, IAFN, the NSVRC, and government entities including the Office for Victims of Crime (OVC), Office on Violence Against Women (OVW), and the Department of Justice (DOJ) have worked to provide guidance and support for SANE practice and programs. More recent efforts such as the SAFE TA Project[8], the emergence of regional-level SANE program coordinators, and this project have generated a growth in leadership as well as an increased need for leadership development and support. In many regions coordinators have come up through the ranks bringing with them a wealth of direct experience in providing care to victims of sexual assault. Though some have experience as program managers, many do not and may be learning "on the job". In some regions, coordinators have not been involved in SANE programs before and some are not nurses. In these programs there are concerns about providing clinical support to local SANEs and SANE programs or clinical expertise to other professionals, and there may be questions about the legitimacy of policies and standards being instituted or promoted that impact clinical practice. Some regions have created organizational structures and work relationships based on partnerships between program management and clinical staff, while others depend on collaborative bodies or workgroups to establish and disseminate standards or protocols. Leadership development is a formal part of some regional programs but is often unsupported or has not been a priority.

8 The SAFE TA Project is funded by the Office on Violence Against Women to disseminate and provide technical assistance for the Sexual Assault Forensic Examination Protocol released as a component of the President's DNA Initiative.

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Emerging Issues

- Some programs are being developed to address local needs without leadership or support (program development is outpacing coordination, training, and support capacity).
- In many areas RN coordinators do not have training or experience as community leaders or as program managers.
- Coordinators are geographically and organizationally isolated or are not supported.
- Due to a lack of funding or support, there is often a focus on program sustainability and survival as opposed to program development or expansion.
- In some areas, local history and philosophy dictates where and if coordination exists and how policies and agreements are developed.

Promising Practices

- The inclusion of leadership development and support into the work.
- The development and implementation of county/area-level SANE program coordination (in addition to regional and local-level coordination).
- The inclusion and involvement of members from vulnerable populations in planning, program implementation, and coordination.
- Support for the networking and involvement of regional coordinators at the national level.
- The development and provision of support for formal leadership positions.
- The development, identification, and dissemination of local, regional, and national resources.
- The identification and development of natural leaders within local programs and in broader collaborative efforts.

Technical Assistance and Support Needs

- Support for communication with allies, national organizations, and tribes.
- Opportunities for coordinators to meet as part of other national and international gatherings (IAFN Conference, National SART Conference, regional meetings, etc.)
- Training and support for lobbying, community organizing, and policy development.
- Identification and development of leaders from underrepresented or marginalized communities.

Program Sustainability

Adequate and stable funding, effective recruitment and retention strategies (including professional development and training and direct support for nurses impacted by repeated exposure to injured and traumatized victims), and accessible and relevant evaluation processes are important factors in sustaining local programs and the state-level coordination efforts that support them.

Funding

Many coordinators have a role in resource development and fundraising and some have responsibility for distributing funding to local programs. Though some emerging coordinator positions and regional efforts are not funded at all, those that are cobble together a mix of federal, regional, local, and private funding. Sexual assault exams are also paid for using a similar mix of funds with the addition of the reimbursements by victims' health insurance policies. Some areas still use law enforcement funds but most have developed some form of regional funds to cover the cost for exams. Federal funds are more likely to be used than any other source to pay for regional-level coordination (47.5%). State funds (57.9%) and victims' health insurance (47.4%) are the most likely to be used to pay for sexual assault exams. The expansion of the role and practice of SANEs not only supports competency and professional development, it creates more legitimacy and opportunities for funding. Several programs are reversing the long-standing trend for subsidization by increasing profitability and becoming self-sustaining through insurance billing, charging fees for services, and creating reimbursement systems that do not depend on billing survivors. Various private foundations, taxes, and government funds are also used to supplement SANE program budgets.

Emerging Issues

- Newer programs do not have the time or capacity to focus on fundraising.
- Some programs cost more than the reimbursements they receive for care and are at risk of being cut.
- The availability of VOCA funding for training is steadily being reduced in some states.
- No single stream of funding is dependable.
- There is a lack of information about and coordination of funds/resources that include sexual assault as a priority.
- Negative media coverage of sexual assault or of particular cases has not been helpful to existing SANE programs.
- SANE program coordinators do not always have skills and experience in fundraising, community organizing, or lobbying.
- A lack or perceived lack of confidentiality for military personnel makes some seek non-military assistance.
- Military victims of sexual assault may be charged for exams if they do not want to report as the have to go offsite to access services.
- Victims of sexual assault are being billed for exams in some local areas and regions.
- SANEs are often not reimbursed for call time and programs may not provide adequate pay for providing exams.
- Many areas and regions have problems with payment for exams for non-reporting or anonymous victims.

Promising Practices

- The inclusion of the cost of SANE programs and sexual assault exams as a line item in state/military/tribal budgets.
- The expansion of the role for SANE to include other money generating services (e.g., charging for suspect exams, DNA collection services, fees for providing general forensic services).
- Payment to SANEs or SANE programs for testifying in court (as expert and as factual witnesses).
- The diversification of funding (e.g., grants, fundraising activities, fees for services, etc.)
- The use of taxes (e.g., "sin tax" on pornography) to pay for programs and exams.
- The creative use of federal and other funding (e.g., using Byrne funds[9] to pay for HIV prophylaxis program).
- The use of VOCA funding to pay nurses' salaries.
- The use of Title X funds to pay for emergency contraception pills, professional

9 The Edward Byrne Memorial Formula Grant program, managed by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, provides sub-grants to local governments and state agencies to support drug control, drug treatment, crime prevention, community-oriented justice, and various criminal justice improvements. For more information see http://www.ojp.usdoj.gov/BJA/grant/byrne.html.

education, and travel and wages for a coordinator to provide training state-wide.
- The use of non-profit status for SART/SANE programs.
- The statutory use of fines for conviction of sexual offense to support SANE programs.
- The development of state mandates for the provision of SANE services.
- The development of tiered reimbursement incentives when SANEs (as opposed to non-SANEs) provide the exam.
- The involvement of nurses in lobbying the legislature.
- The use of nurse registries and traveling nursing programs to provide SANE services in rural and under-funded or under-staffed communities.

Technical Assistance and Support Needs

- Sample Memoranda of Understanding for coordination of services (e.g., military, tribal, local programs, etc.)
- Dissemination of information regarding funding and use of certain funding to support centralized coordination.
- Strategies and examples for positive/proactive use of the media for raising awareness and increasing legitimacy.
- Designated funding streams for regional and local-level SANE coordination, training, and exams.
- Identification and dissemination of examples of partnerships with prosecutors' offices and SANE programs (e.g., payment for expert witness).
- Support for more healthcare-based funding as opposed to criminal justice-based funding.
- Strategies and sample policies/practices for billing insurance for the medical portion of exams (e.g., coding medical records and insurance claims in a way that protects confidentiality).

Recruiting and Keeping Nurses Healthy and Engaged

In regions with more established programs and higher numbers of practicing SANEs, recruitment and retention is less problematic. Where programs are newer and nurses are less supported, recruiting new nurses and sustaining those currently involved can be very challenging. Coordinators and local program staff have been very creative in developing incentives, training programs, sponsorship support, and media campaigns to attract nurses interested in becoming SANEs. Ongoing professional development, formal recognition as experts, higher and on-call pay, good support systems, and opportunities for collaboration with other community partners or to those involved in other aspects of work to address sexual assault are all strategies that keep nurses and coordinators engaged in the work longer-term. For the many who

experience secondary trauma, or who are survivors themselves, the challenges can be more difficult.

Many SANEs and SANE program coordinators are survivors of sexual assault themselves, or have been close to a survivor. Even those who have not experienced sexual assault in their own lives are often deeply impacted by their work with the traumatized individuals they serve. Some survivors are attracted to the potential of "giving back" or of making a difference, while others may see it as a way to find healing and resolution for themselves. This passion and empathy can be the basis of strong leadership and commitment but nurses and coordinators with unresolved trauma may need specialized support to stay effective. Some programs have developed strategies for addressing these concerns, but many are just beginning to recognize their seriousness and impact.

Emerging Issues

- Some local and regional-level programs have only one dedicated and funded position.
- Local SANEs and SANE programs are often isolated without much direct support or connection with other peers.
- Local programs may have only a few trained SANEs taking calls and providing care.
- Nurses without court experience or training often stop working as SANEs after their first (often negative and overwhelming) experience testifying in court.
- In some areas and regions there is a general lack of hospital/clinic/community support for SANEs and for victims of sexual assault.
- Many programs have funding difficulties.
- Lack of quality assessment or evaluation tools or processes.
- Many areas and regions do not have a formal feedback system so that SANEs stay informed about the progress or outcome of cases.
- Problems with survivors who have unresolved issues practicing as SANEs (sometimes using SANE courses for therapy).
- Nurses not prepared or supported to understand or handle the constant exposure to trauma.
- Most programs do not have a formal screening process for identifying nurses with unresolved trauma histories or poor coping skills.
- Most programs do not have a formal process for identifying and/or dismissing nurses who are not able to function appropriately.
- Many programs have little access to "critical incident" or vicarious trauma debriefing.

Promising Practices

- Multidisciplinary collaboration and community involvement that includes SANEs.
- The involvement of SANEs in prevention work as a way to stay encouraged and engaged.
- Ongoing networking and communication with allies and peers.
- Good preceptorship, training, and ongoing professional development opportunities.
- Rewards and incentives for continued involvement.
- Models for debriefing and case-staffing that address triggers and personal history.
- The use of a clinical ladder model of gaining respect, higher pay, and competency for longer-term involvement.
- The development of mock trials and expert witness training and practice.
- The practice of screening nurses prior to and throughout their initial training and preceptorship (not all nurses who apply or go through training become SANEs).
- The practice of shadowing and working in teams/partnership.
- The use of 100% chart-review and quality assurance processes for training and debriefing.
- Opportunities for SANEs to be involved in community leadership and collaboration.

Technical Assistance and Support Needs

- Mentorship models.
- Lobbying and community organizing support and skills.
- A clearinghouse of policies, protocols, tools, and supportive research.
- Models for addressing vicarious trauma (e.g., required debrief system, training, self-care support, etc.)
- Tools/models for pre-screening or interviewing nurses interested in becoming SANEs (e.g., checklist for "red flags", interview questions, processes for evaluating someone's ability to remain professional and unbiased, etc.)
- Models for community collaboration (SARTs, advocate/nurse partnership, etc.)
- Mock trial processes for preparing SANEs to testify.

Evaluation

SANE program evaluations use formative and summative processes to study SANE program outcomes that have been identified in research. One such outcome of a SANE program is the impact on the local and regional community. Many SANE programs were developed following community surveys for need. The symposium participants were provided an overview of one published model for evaluating the effectiveness of SANE practice and programs. The public health model defines community, addresses the

process for determining which data to collect, and provides resources with defined data fields. The public health model was compared with the Precede-Proceed model that focuses on the evaluation of health interventions in programs within a community; both the public health and Precede/Proceed models promote community stakeholder involvement (Green and Kreuter, 2005). Research methodology, data gathering, and trends in SANE research were also discussed.

The national SANE database project, formal processes for documenting and tracking care and outcomes for patients seen by SANEs, peer-based quality and case review, and anecdotal evidence makes it clear that SANE programs and SARTs have greatly improved services to and the outcomes for survivors of sexual assault. However, for many programs, locating funding for medico-legal evaluation, kit collection, and pay for SANE/SAFE services is consuming administrators' time and reducing the time available for standardized program evaluation. While the data elements have been identified in many historical and recent publications, most SANE research continues to be descriptive. The utility of SANE services including outcomes that are cost effective; further injury prevention and intervention, especially the prevention of persistent mental health problems; research on the efficacy and timing of evidence collection; STI/HIV risk and prophylaxis; and SANE practice and programs, are all areas requiring new and enhanced inquiry.

Emerging Issues

- There are not standardized Quality Assurance processes in many programs.
- Only "problem cases" are reviewed by SARTs or SANE teams.
- Lack of funding or support for evaluation and for SANE continuing education.
- Lack of evaluation experience and inability to maintain competence.
- Funding is most often tied to numbers served as opposed to patient or program outcomes.
- There is no consensus on what outcome measures to use.

Promising Practices

- SANE Program Evaluation Questionnaire (SPEQ ©) (Palmer, 2005).
- Quality circle of service, chart audit, and remedial training driven by payment.
- State and local funders setting standards for program outcomes and requiring program evaluations.

Technical Assistance and Support Needs

- Development and dissemination of a useful inter-professional and multidisciplinary biomedical database model.
- A database format to track the program (not just patient care or outcomes) as a whole, where inputs include continuous quality improvement (CQI) information, payer information and sources, and other pertinent program data.

Summary of Promising Practices and Emerging Issues

Participants identified many areas of consensus related to SANE coordination, practice and current needs for support and research. Most acknowledged the benefit of regional-level coordination and authority for SANE practice, especially in the areas of fundraising, training development and provision, competency, and quality assurance, recruitment and retention, legislative and policy work, and the development and dissemination of program and service standards. Many, however, have less than adequate authority, recognition or support, and supervisory relationships may or may not be conducive to regional-level coordination. Some programs are coordinated by nurses while others are not. Everyone agreed there are benefits to partnership relationships that draw on the potential community networking and administrative strengths of non-nurse/SANE coordinators and the clinical expertise and professional legitimacy of those who are SANEs/nurses or nurse practitioners.

Though many regional-level SANE coordination efforts and positions are fairly new, some are very well-established and have a lot to offer in terms of replicable strategies and tools. Most programs are multi-jurisdictional in terms of the geographical regions and populations they serve. Many programs serve military personnel, campus communities, and tribes, and many serve communities beyond defined borders providing regional coordination and training as well as direct services. Most coordinators have had to be flexible and creative on many levels, from how to fund the program, where to focus energy and resources, and how to be a part of a local as well as regional community, to balancing the provision of crisis services with the need to provide technical

assistance and support to increase capacity in order to sustain the effort long-term.

Coordinators and programs have wide-ranging authority and responsibility with regards to local programs. Most set program and service standards, many have some authority for ensuring compliance with quality assurance, and some provide direct supervision to local program staff or have authority or some role in hiring staff. Coordinators provide training and technical assistance to a variety of local programs and providers, as well as clinical support. Clinical competency is supported by SANE program coordinators through initial and ongoing training, peer and case review, chart audits, and certification or other credentialing processes. Programs often work closely with state boards of nursing, accreditation, and academic programs and develop and provide many innovative opportunities for learning and competency development. Program evaluation, or the lack thereof, is a significant concern for many coordinators. At the same time, evaluation models exist and expertise is growing in this area.

SANE coordinators and programs have worked out many of the challenging practice issues related to caring for victims of sexual assault. Examples include: the development of anonymous reporting systems and the creation of storage capacity for evidence not taken by law enforcement; passing laws protecting victims from being billed for

their care and to ensure access to emergency contraception; expanding the scope of practice of SANEs to include care for children and victims of domestic violence and other violent crimes; and, creating consortia of SANEs to provide care at multiple sites regardless of who employs them. Some coordinators have developed protocols, forms, and tools that have been adopted and implemented throughout their regions. Very flexible and creative collaborations have been built among SANEs, their programs, and the military, health care organizations, law enforcement, and advocates with an enormous amount of success and to the benefit of victims of sexual assault. SANE coordinators are making use of and providing support for new technology, including web-based training, teleconferencing, telemedicine, and digital cameras. SANEs and SANE coordinators are often very involved with local and regional-level Sexual Assault Response Team (SART) efforts.

Burn out, power struggles, scope of practice restrictions, isolation, inconsistent standards, and general resistance in many places to acknowledge and address sexual assault challenge many coordinators and programs. Some coordinators do their work "on the side" while others have formal positions and are paid specifically to provide coordination. Some funding for these positions is stable while other funding is temporary or non-

existent. Some programs are contained and sustained within a regional-legal system while others are healthcare or advocacy program-based. Many coordinators are directly involved in fundraising and resource development and some participate in the distribution of funding to local programs. The federal government funds SANE coordination at a higher rate than any other identified funding source, but it is most often state funds that are used to pay for sexual assault exams. Some coordinators are promoting the potential of programs to turn a profit while others are being innovative in raising money to sustain their work through other means.

Recommendations to Address Priority Technical Assistance Needs

Training

SANEs need training and practice for being involved in a trial as a factual or expert witness. There should be dedicated money for training and professional development. SANEs and SANE programs should be promoted in the media, and there is a need for SANEs to be able to access one another for clinical and program support and resource sharing, to debrief and conduct peer case reviews, and to keep growing and learning.

Resources

Policies and protocols have been developed in some areas but there are still unresolved issues at the local, regional, and national levels. Needs include: standards for archiving and releasing digital photos; standards for STI/STD testing; research on the use of toluidine blue and the use of a colposcope; clarification on the legality of peer review and its potential for being "discoverable"; and, help with and support for data collection and evaluation.

Technical assistance is needed to assist SANE coordinators in their fundraising efforts, to provide information and tools for using insurance and billing codes that do not jeopardize confidentiality or interfere with preserving options for the victim, to develop protocols for involving advocates, to develop and conduct program evaluations, and to serve and include underserved and vulnerable populations in program and policy development.

Additionally, there is a need to address vicarious trauma, to raise awareness in the larger community, to support the development of strong and effective local and regional collaborations, and to create opportunities like the Symposium to stay connected and growing.

Research

There are many areas in SANE provision and coordination where more research is needed. These areas include: measuring the immediate and long-term health outcomes of SANE programs; measuring effective ways to encourage patient follow-up counseling at rape crisis centers; research to develop the best practice for SANEs around several controversial treatment topics including treatment as opposed to prophylaxis, pubic hair plucking, and the use of toluidine blue; examining the outcomes of sexual violence screening in the primary care setting; researching best care protocols for adolescent sexual assault patients; and, researching and compiling the SANE models that are used nationally.

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Technical Assistance Resources

Organizations

International Association of Forensic Nurses (IAFN)
1517 Ritchie Hwy, Ste 208
Arnold, MD 21012-2461
Phone: 410-626-7805
Fax: 410-626-7804
Email: info@iafn.org
Website: www.iafn.org

The mission of the IAFN is to provide leadership in forensic nursing practice by developing, promoting, and disseminating information internationally about forensic nursing science.

IAFN SAFE TA Project

www.safeta.org

The SAFE TA Website is a project funded by the Office on Violence Against Women (OVW) and is a national resource for Sexual Assault Nurse Examiners and Sexual Assault Response Team members on the National Protocol for Sexual Assault Medical Forensic Examinations, and the National Training Standards. The website holds valuable information including a library, the national protocol and training standards, a glossary of forensic terms, training programs, frequently asked questions, forms for download, and news pertaining to sexual assault. Technical assistance can be requested via the web site or by calling the toll free helpline number at 877-819-SART.

National Sexual Violence Resource Center (NSVRC)
123 N. Enola Dr.
Enola, PA 17025
Toll free: 877-739-3895
Phone: 717-909-0710
Fax: 717-909-0714
TTY: 717-909-0715
Email: resources@nsvrc.org
Website: www.nsvrc.org

The National Sexual Violence Resource Center (NSVRC), founded by the Pennsylvania Coalition Against Rape and funded by the Centers for Disease Control and Prevention opened in July 2000 as the nation's principle information and resource center regarding all aspects of sexual violence. The NSVRC provides national leadership, consultation, and customized technical assistance by generating and facilitating the development and flow of information on sexual violence intervention and prevention strategies. The NSVRC works to address the causes and impact of sexual violence through collaboration, prevention efforts, and the distribution of resources.

NSVRC SANE Coordinator's Listserv

The purpose of this listserv is to share information on emerging topics, training, challenging issues, promising practices, and the logistics of coordinating a state, territory, tribal, or military SANE/SAFE program.

NSVRC National Sexual Assault Response Team (SART) Toolkit Project

With funding from the Office for Victims of Crime, the NSVRC created a toolkit to promote the development and implementation of a coordinated, multidisciplinary, and victim-centered first response to victims of sexual assault in communities across the United States and U.S. Territories. The NSVRC also offers training and technical assistance on SART development.

NSVRC SANE Sustainability Project

Through a cooperative agreement with the Office on Violence Against Women, NSVRC aims to build sustainable SANE programs by increasing access to information, building local SANE program staff capacity, and enhancing collaborative efforts between victim advocates and forensic nurses.

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810 Seventh Street NW., Eighth Floor
Washington, DC 20531
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Fax: 202-514-6383
Web site: **www.ovc.gov**

Training and Technical Assistance Center (TTAC)

TTAC focuses on strengthening the capacity of victim assistance organizations across the country. The Center's training and TA activities are coordinated through needs assessment, capacity building, and evaluation. OVC TTAC maintains a database of consultants and trainers, an email list, a library of resources and publications, and a calendar of training events across the country.

Sexual Assault Resource Service

Sexual Assault Nurse Examiner/Sexual Assault Response Team Website
www.sane-sart.com

The goal of this website is to provide information and technical assistance to individuals and institutions interested in developing new SANE-SART programs or improving existing ones.

Research/Evaluation

Work is being done to evaluate the efficacy of single versus multiple SART interviews, specifically looking at the impact on victim satisfaction and recovery.

Training Conference

The Sexual Assault Resource Service organizes the biannual National SART Training Conference, with funding from the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice.

Standards and Guidelines

Antiretroviral Post-exposure Prophylaxis After Sexual, Injection-Drug Use, or Other Non-occupational Exposure to HIV in the United States.

Recommendations from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Published in the Morbidity and Mortality Weekly Report, January 21, 2005 / Vol. 54 / RR02; pp1-20.
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm

Ethical and Religious Directives for Catholic Health Care Services
4th Edition, Paragraph 36 (June 2001)
http://www.nccbuscc.org/bishops/directives.shtml

A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/ Adolescents
U.S. Dept. of Justice, Office of Violence Against Women (2004)
http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf

National Training Standards for Sexual Assault Medical Forensic Examiners
U.S. Dept. of Justice, Office of Violence Against Women (2006)
http://www.ncjrs.gov/pdffiles1/ovw/213827.pdf

2006 Sexually Transmitted Disease Treatment Guidelines
Recommendations from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Published in the Morbidity and Mortality Weekly Report, August 4, 2006 / Vol. 55 / No. RR-11.
http://www.cdc.gov/std/treatment/2006/rr5511.pdf

Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements.
National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (2002).
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About the National Sexual Violence Resource Center

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