The SANE-SART Response To Sexual Assault Of Immigrant Women

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CHAPTER 8

Offenders generally target victims who are the most vulnerable and unlikely to report to law enforcement. Immigrant women clearly fit into this category. Many immigrant women are here without their usual family support, and they are often not familiar with our social service systems, may speak limited English, and may not trust our police force. They also may not be aware of the rights Americans expect women of all social economic levels to have in this country, whether citizens or visitors, documented or undocumented.

"It is hard to admit to myself that my supervisor forced himself on me sexually. I don't like to think about it. It makes me cry...I'm very embarrassed and ashamed of what happened. I know that it wasn't my fault, but I keep wondering if there is something that I could have done. I just don't want my daughters to find out until they're older, if ever."

Sexual assault is rarely the result of a stranger attacking an unknown victim. The victim of rape is far more likely to be assaulted by someone he/she knows and may even trust, someone with whom he/she feels comfortable and perhaps even safe, and in many cases by his/her significant other, employer, co-worker, or a friend. Even though today more than 70% of the reported rape is by a non-stranger,[2] we still recognize that the better the victim knows her assailant, the less likely she is to report the rape, suggesting that non-stranger rape, especially spousal rape, continues to be significantly under-reported.[3]

In the case of migrant farmworker women, while no hard data exists to reflect who is committing the sexual assault in the workplace, anecdotal evidence reveals that supervisors, crewleaders, and other individuals in positions of power in the workplace tend to perpetrate the sexual violence, which for farmworker women often escalates to rape. In these cases, the women know their assailant, but they are not likely to report the sexual offense to anyone for many reasons, including their financial situation, fear of deportation, and unfamiliarity with their rights.

What Do Sexual Assault Victims Need?

First and foremost, victims of sexual assault need to feel safe in disclosing the assault. They also need to know there are systems in place to meet their needs. These systems include the Sexual Assault Nurse Examiner (SANE) program and the Sexual Assault Response Team (SART).

Beginning in the mid-seventies, in an attempt to better meet the needs of sexual assault victims, the first Sexual Assault Nurse Examiner (SANE) programs were developed in Memphis, Tennessee (1976), Minneapolis, Minnesota (1977), and

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2 www.sane-sart.com (last viewed May 8, 2007).

3 Barbara Moynihan, *Domestic Violence, in* Forensic Nursing 260-270 (Elsevier Mosby ed. 2006).

Amarillo, Texas (1979).[4] Every state now has at least one SANE program. The SANE works cooperatively with rape crisis center advocates, law enforcement officers, and the prosecutor. This cooperative inter-agency response is referred to as the Sexual Assault Response Team (SART). The development of SANE-SART programs has significantly improved both the forensic evidence collection and the clinical care of victims of rape.

What Is A SANE Nurse?

The SANE is a specially trained nurse who is usually available on call to a medical facility. Whenever a victim of rape comes to that facility, the SANE is paged and comes in to provide complete care to the victim. This involves the following:

- Medical evaluation, documentation, and care of injuries
- Evaluation of risk of sexually transmitted disease and discussion of prevention with the victim
- Evaluation of risk of pregnancy and discussion of options with the victim
- Forensic evidence collection
- Crisis intervention, support, and information on follow-up

When Should The Victim Be Seen By A SANE?

Most national, state, and institutional protocols recommend an evidentiary exam be completed by a trained forensic examiner/SANE for up to 72 hours after a sexual assault.[5] It is important to know your local standard, as some states recommend completing an evidentiary exam within 96 hours or longer. Even in the areas limiting the initial exam to the first 72 hours, post 72 hour exams are usually recommended in cases when there are injuries that can be documented or when the survivor has not changed clothes or showered and evidence may still be available for collection.

What Should We Tell The Victim?

- Go to a hospital (with a SANE-SART if possible) ASAP. In the case of a migrant farmworker, advocates must have a plan for helping the victim get to the doctor. Many times they do not have transportation. Therefore, advocates should make a plan to help the victim get the necessary treatment.
- Don't change clothes, shower, brush your teeth or eat.

4 Linda E. Ledray, US Department of Justice, Office of Victims of Crime, Sexual Assault Nurse Examiner (SANE) Development & Operation Guide (1999).
5 American College of Emergency Physicians, Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient (June 1999); Linda E. Ledray, USDOJ (1999); US Department of Justice Office on Violence Against Women, A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents (September 2004).

- Take a change of clothes with you to wear home.
- If you have changed clothes, take the clothes you were wearing right after the assault with you in a paper bag.

It is important to remember that there are two distinct yet interconnected overall focuses of the medical care of the sexual assault victim: (1) clinical/medical evaluation and care and (2) medical-legal evidence collection. To best meet the needs of the victim, both of these overall areas must be addressed when responding to a sexual assault. Ledray found that victims who made the decision to report a rape to law enforcement experienced less depression, anxiety, hostility, and symptoms of post-traumatic stress disorder, and were able to return to work or school sooner than victims who did not report.[6] The researcher concluded that this result was likely due to many factors, including that the victim who decided to report the rape had accepted it was not her fault but a crime committed against her; she was more likely to get help from social service agencies; and her friends and family were more likely to believe and support her.

With just over 500 SANE programs identified across the U.S., the vast majority of sexual assault exams are, unfortunately, still completed by untrained medical personnel.[7] An examiner should not simply read the directions on the sexual assault evidentiary exam kits and collect all the evidence available on the victim's body. These untrained examiners are likely missing valuable evidence. This evidence is especially important today with the advances in DNA recovery and with the Combined DNA Index System (CODIS) established by the FBI to identify repeat offenders throughout the U.S. using recovered biological samples.

What Is A SART?

When a SANE works collaboratively with the rape crisis center advocate, law enforcement officer, and prosecutor to better meet the needs of the sexual assault survivor, we refer to this collaborative relationship as a Sexual Assault Response Team (SART). Often other agencies, such as social services, domestic violence programs, or mental health services are often involved in the SART. Some of the team members (usually the SANE, the advocate, and the law enforcement officers) may report collectively to the medical facility when the victim comes in for an evidentiary exam. More often, however, they work independently but collaborate closely to see that all the victim's needs are adequately addressed.

SANE-SART Program Impact

While we are only beginning to evaluate scientifically the effectiveness of SANE-SART programs, initial studies indicate that SANE programs do a significantly better job of collecting the proper evidence and maintaining chain of custody of the evidence

6 Linda E. Ledray, Recovering from Rape (Henry Holt and Co. 2d ed. 1994).
7 www.sane-sart.com (last viewed November 3, 2008).

once it is collected.[8] They are more likely to provide immediate crisis intervention and support for the victim. This increases reporting to the police and thus increases the rate of guilty pleas and community prosecution rates.[9]

SANE-SART programs have improved both the clinical care of the victim and the forensic evidence collection. Despite initial concern, both efforts have worked in tandem quite effectively. By working together as a team, the advocate, SART members, SANE, law enforcement officers, prosecutor, and crime laboratory specialists have better met both the forensic and clinical needs of the victim and the system.

What Will The SANE Do And Why Is It Important?

The SANE will complete an evidentiary examination of the sexual assault survivor. The evidence will be collected for four purposes useful in prosecution of the case:[10]

- to confirm recent sexual contact
- to show force, coercion or lack of consent
- to identify the assailant
- to corroborate (or not) the survivor's experience of the assault

Evidence to identify the assailant. In addition to the statements or description of the assailant provided by the victim, the primary evidence for identification of the assailant is DNA (deoxyribonucleic acid) evidence. The typing of DNA from biological specimens is likely the most important advance in forensic science in recent history. DNA evidence is used to identify an unknown assailant, to corroborate the identity of a suspect, to link serial cases, to identify offenders of multiple assaults, and to exonerate the falsely accused.[11] In 1987, the first man was convicted of sexual assault with the help of DNA evidence. The case was sustained on appeal the following year.[12] In 1991, the Minnesota Bureau of Criminal Apprehension (BCA) Laboratory became the first state crime laboratory to identify a suspect on the basis of DNA evidence alone. As a result of this valuable investigative resource, an otherwise unidentified rapist was found and convicted.[13]

8 Linda E. Ledray & K. Simmelink, *Sexual assault: Clinical issues: Efficacy of SANE evidence collection. A Minnesota study*, 23(1) Journal of Emergency Nursing 75-77 (February 1997).
9 P. Speck & M. Aiken, *Twenty Years of Community Nursing Service*, Tennessee Nurse 15-18 (1995); K. Little, Office for Victims of Crime, Sexual Assault Nurse Examiner Programs: Improving the Community Response to Sexual Assault Victims, Bulletin #4 1-19 (2001); L. Ledray, *The Sexual Assault Nurse Clinician: Minneapolis' 15 Years Experience*, 18(3) Journal of Emergency Nursing (1992); C. Crandall & D. Helitzer, Nat'l Inst. for Justice, Impact Evaluation of a Sexual Assault Nurse Examiner (SANE) Program, NCJ 203276 (2003).
10 Linda E. Ledray, US Department of Justice, Office of Victims of Crime, Sexual Assault Nurse Examiner (SANE) Development & Operation Guide (1999).
11 Linda E. Ledray & Linda Netzel, *Forensic Nursing: DNA Evidence Collection*, 23(3) Journal of Emergency Nursing 156-158 (April 1997).
12 Ricki Lewis, *DNA Fingerprints: Witness for the Prosecution*, Discover, June 1988.
13 Ledray & Netzel (1997).

The recognition of DNA as a valuable investigative tool, and the knowledge that many rapists are repeat offenders, led to the development of the FBI Combined DNA Index System (CODIS), a national DNA database used to identify assailants, even if they move from state to state.[14] The federal DNA Identification Act, included in the 1994 Crime Bill, allocated $40 million to expand DNA testing capabilities on a national basis. Since that time millions of additional dollars have been allocated to assist crime laboratories with DNA analysis of backlogged cases. These databases are used for "DNA fingerprinting" in much the same way as conventional fingerprint databases were used but with much greater specificity.[15]

DNA may be obtained from any body fluids of the assailant containing cells with a nucleus that remain on the survivor's body or clothing. These include: hair, blood, saliva, perspiration, and semen. The newer PCR-based technology can test much smaller samples. Today every state participates in the CODIS system. As of January 2004, CODIS has matched 3,004 forensic biological specimens from victims to offender profiles, referred to as "forensic hits".[16]

Evidence to confirm recent sexual contact. Trauma to the orifice(s) of the victim indicates she was involved in the assault. Semen obtained from that orifice or from the skin or clothing of the victim is important evidence to corroborate that recent sexual contact occurred. Semen can also be useful to prove there was recent sexual contact. It is important, however, to remember that the absence of positive sperm or seminal fluid findings does not prove there was no recent sexual intercourse.[17] Evidence suggests that at least 34% of rapists are sexually dysfunctional,[18] and 40% or more wear condoms.[19] In one study of 1,007 examined rape survivors, sperm was found in only 1% (N=3) of the 369 cases involving oral rape. All of the positive oral specimens were collected within three hours of the rape. Of the 210 cases with rectal involvement, only 2% (N=4) were positive for sperm. These exams were all completed within five hours of the rape. In the 111 skin specimens collected, 19% (N=12) were positive. All but two of the positive specimens were collected within five hours of the rape. Of the 919 vaginal specimens, 37% (N=317) were positive. Of these vaginal specimens, 263 were examined within five hours and 317 were examined within 12 hours of the rape. Only 7 of the positive specimens were collected more than 20 hours after the rape.[20]

Seminal fluid evidence may be analyzed for sperm, motile (alive and moving when observed under the microscope) or non-motile, and for prostatic acid phosphatase (PAP). This enzyme, acid phosphatase, is present in large quantities in seminal fluid and minimal concentrations in vaginal fluids. Thus, if a high level of acid phosphatase is collected in a sexual assault survivor, this is indicative that recent sexual contact occurred. Cases are typically negative for sperm and positive for acid phosphatase when the assailant had a vasectomy, but this is also possible in cases of chronic

14 Miller (1996).
15 Ledray & Netzal (1997).
16 P. Loftus, S. Niezgoda, & J. Behun, *DNA and the CODIS Project in Forensic Nursing,* 117-122 (Elsevier Mosby ed. 2006).
17 S. Tucker, L. Ledray, & Stehle Werner, *Sexual Assault Evidence Collection*, Wisconsin Medical Journal 407-411 (July 1990).
18 Nicholas A. Groth & Ann W. Burgess, *Sexual Dysfunction During Rape*, New England Journal of Medicine 764-766 (October 6, 1977).
19 H. Larkin & L. Paolinetti, IAFN Sixth Annual Scientific Assembly: Pattern of Anal/Rectal Injury in Sexual Assault Victims Who Complain of Rectal Penetration (October 1998).
20 Tucker, Ledray & Werner (1990).

alcoholism.[21] Unfortunately, there has been little study of the results of sexual assault exams and the likelihood of getting specimens positive for sperm or acid phosphatase. Today, the presence of PAP is used to suggest there is sufficient biological evidence to determine the DNA of the assailant.

Evidence to show force, coercion or lack of consent. In non-stranger sexual assaults, the primary defense is likely to be consent. If so, the most important evidence to disprove this allegation will be proof of force, coercion, or lack of consent. The victim's statements, especially her statements to the SANE that indicate she was afraid and feared for her safety would help disprove the consent defense. So would statements as to why she did not fight back, if she did not do so. It may also include urine and blood evidence to show that she was too intoxicated to consent, or that she was given a drug to facilitate the sexual assault, whenever drug-facilitated sexual assault (DFSA) is suspected.

While alcohol has long been used to facilitate sexual assaults, today newer, memory-erasing drugs such as flunitrazepam (Rohypnol), other benzodiadepines, Ketamine, Gamma Hydroxybutyrate (GHB), Gamma Butyrolactone (GBL) and many others are being used to facilitate sexual assault. The victim may have had only a couple of alcoholic beverages but quickly became extremely intoxicated. The survivor can often remember very little of the incident other than flashes, sometimes referred to as "cameo appearances," until she awakens. She may then find herself undressed, or partially dressed, with vaginal or rectal soreness making her believe she has been raped.[22] Even though there is little memory and perhaps no certainty of a sexual assault, whenever the survivor's story is consistent with a DFSA, or suspicious of one, the forensic examiner should collect blood and urine specimens for DFSA analysis as a part of the sexual assault evidentiary examination. If the survivor calls prior to coming to the hospital or clinic, she should be told not to void unless necessary. If she must void, she should collect her first voided urine in a clean container and bring it with her.[23]

While most studies indicate that significant physical injury is extremely rare in a sexual assault (3% to 5% across studies), both genital and non-genital physical injuries are probably the best proof of force and need to always be photographed, documented on body drawings, and described in writing on the Sexual Assault Exam Report.[24]

Evidence to corroborate (or not) the survivor's history of the assault. The forensic examiner should be aware of the likely pattern of injuries from violence, so that she knows the appropriate questions to ask, where to look for injuries on the basis of the history given, and what injuries are or are not consistent with the history of the assault provided by the victim. Intentional injuries tend to be more central and accidental injuries more toward the extremities. Especially if domestic violence is involved, injuries are most often inflicted where the survivor is expected by her attacker to hide them.[25]

21 W.F. Enos & J.C. Beyer, *Prostatic Acid Phosphatase, Aspermia, and Alcoholism in Rape Cases*, 25(2) Journal of Forensic Sciences 353-356 (April 1980).
22 Ledray (1999).
23 Ledray (1999); ACEP (1999).
24 L. Ledray, *Sexual Assault*, *in* Forensic Nursing 279-291 (Elsevier Mosby ed. 2006).
25 Daniel J. Sheridan, *The Role of the Battered Woman Specialist*, 31(11) Journal of Psychosocial Nursing (1993).

Documentation. Proper documentation of the victim's narrative of the assault is often one of the most important components of the sexual assault exam, as the SANE can testify as a medical exception to the hearsay rule since she is completing a medical-legal exam. Necessary documentation is needed to guide the exam and treat the survivor.[26] The term "alleged sexual assault" should never be used in documentation of a sexual assault as the term has negative connotations and may be interpreted by judges and juries as indicating the survivor exaggerated or lied or that the examiner is subtly opining about the victim's credibility.[27]

Additional Victim Needs

Treatment to prevent sexually transmitted infections (STI). In the past, forensic examiners tested for STIs in the Emergency Department and then again at follow up. The rationale was that if a survivor was negative initially, and positive on follow up, the assailant, if apprehended, could be tested as well. If he were positive for the same STI, this fact could then link him to the crime. Because so many variables could account for a positive STI test, its use as forensic evidence is doubtful. STI testing is no longer recommended practice for adult or adolescent examinations. In addition, while the Rape Shield Laws in all 50 states were designed to limit the ability of defense attorneys to use information about previously acquired STIs to discredit a rape victim, all too often this information is still used against the victim in court. For this reason, the clinician should defer testing and treat adult and adolescent victims prophylactically at the initial visit as recommended in the *National Protocol for Sexual Assault Medical Forensic Examinations*.[28]

The fear of contracting an STI is a common concern for survivors from a clinical perspective and must always be addressed as a part of the initial examination. STI testing is expensive and time-consuming for the survivor, who must return two or three times and unfortunately, most survivors do not return.[29]

Prophylaxis recommended includes coverage for chlamydia, gonorrhea, trichomoniasis, and Hepatitis B (for individuals who have not already been vaccinated for Hepatitis B, the first dose of the Hepatitis B vaccine should be given, without HBIG). Chlamydia and gonococcal infections in women are of particular concern because of the possibility of ascending infections leading to pelvic inflammatory disease.[30] The benefits and side effects of these medications should, of course, be discussed with the survivor so they can make an educated decision.

As discussed in the previous chapter, HIV is a concern for rape victims. Today SANE programs recommend discussing the risk and options of HIV infections with all sexual assault survivors so they can make an educated decision, but they do not recommend

26 Ledray (1999).
27 Sheridan (1993).
28 US Department of Justice Office on Violence Against Women, A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents (September 2004); ACEP (1999); Center for Disease Control and Prevention, Sexually Transmitted Diseases Guidelines 2006: Sexual Assault and STD, at www.cdc.gov/mmwr/preview/mmwrhtml/rr5511al.htm (2006).
29 T. Blair & C. Warner, *Sexual Assault*, *in* 14 Topics in Emergency Medicine 4 (1994).
30 Center for Disease Control and Prevention, Sexually Transmitted Diseases Guidelines 2002: Sexual Assault and STD, at www.cdc.gov/std/treatment/8-2002TG.htm (2002).

routine prophylaxis except in high-risk cases.[31] The following factors should be considered when determining if a sexual assault could be considered high-risk:

- anal penetration occurred
- ejaculation occurred on mucous membranes
- multiple assailants were involved
- mucosal lesions were present
- the assailant is a suspected/known IV drug user
- the assailant is suspected/known to be HIV positive

Pregnancy prevention. As discussed in Chapter 7, the risk of pregnancy from a rape is minimal. However, pregnancy is a concern of most sexual assault survivors and must be addressed at the time of the initial examination, even if the treating medical personnel or the medical facility does not support termination of an existing pregnancy. The National Conference of Catholic Bishops has agreed that "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 medication that would prevent ovulation, or fertilization."[32]

The importance of offering complete care to a sexual assault survivor includes care to prevent pregnancy when the survivor wants this care. A monetary fine was imposed against a New York City hospital, which did not ensure the victim received a full birth-control prescription to prevent pregnancy.[33]

In recent years, many states have tried to require that victims of sexual assault are informed about the option of emergency contraception (EC) and provided with EC if they decide it is the best option for them. To date, only four states have passed legislation requiring sexual assault victims be informed about EC or given the medications when they request. The first state to do so was Washington State. Other states to follow their example include California, Illinois, and New York State. Even though EC after a sexual assault is still not legislated in most states, and is noticeably absent from the *National Protocol for Sexual Assault Medical Forensic Examinations*,[34] the majority of SANE programs recognize that the best medical practice is to inform the rape victim about the option of EC. If she is at risk of becoming pregnant, is being seen within five days of the rape, and has a negative pregnancy test in the ER, it is then up to the victim to decide if she wants to take EC to prevent a pregnancy.

31 Ledray (1999); CDC (2006).
32 National Conference of Catholic Bishops, Ethical & Religious Directives for Catholic Health Care Services 16 (1995).
33 C.J. Chivers, *In Sex Crimes, Evidence Depends On Game of Chance in Hospitals*, N.Y. TIMES, August 6, 2000.
34 US Department of Justice Office on Violence Against Women, A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents (September 2004).

Oral contraceptives such as Ovral or Lovral (Yuzpe method) have been used for emergency contraception for many years.[35] However, more recently, clinicians have begun to use a progestin-only contraceptive, Levonorgestrel 0.75 mg (Plan B). Plan B is slightly, but non-significantly, more effective in reducing the risk of pregnancy. When started within 72 hours of unprotected intercourse, 85% of pregnancies were prevented in one study, compared to 57% using the Yuzpe regimen.[36] While Plan B is usually offered for up to five days after a sexual assault, the effectiveness of both methods decreases as the time between the assault and the first dose increases. When given within the first 24 hours Plan B reduced the risk of pregnancy by 95%, but only by 61% when given between 48 and 72 hours after unprotected intercourse. The significant difference is in the only side effects, nausea and vomiting, which were significantly reduced with the use of Plan B to 23.1%, from 50% with the Yuzpe method.[37]

Crisis intervention and counseling. The basic components of the evidentiary exam are crisis intervention, mental health assessment, and referral for follow-up counseling. While these are the primary roles of the rape crisis center advocate, when one is present, the SANE, or forensic examiner is also responsible for providing crisis intervention and ensuring that follow-up counseling services are available.[38]

In Summary

When a woman discloses she has been sexually assaulted within 72 hours (or longer depending upon local guidelines), she should be encouraged to be seen by a trained forensic examiner, a SANE, as soon as possible. The SANE will ensure that her medical-legal needs are properly met and will work cooperatively with the advocate, law enforcement officer, and the prosecutor's office as a Sexual Assault Response Team (SART). As an advocate, you should be familiar with the hospitals and clinics in your area that employ SANE nurses, have SART teams, and perform forensic medical exams. Also be aware of any costs involved in accessing these services. If you encounter a client who has been sexually assaulted, be prepared to help him/her access these clinics and be prepared for what will then occur.

35 American College of Obstetricians & Gynecologists, Evidence-Based Guidelines for Clinical Issues in Obstetrics and Gynecology, Practice Patterns (1996).
36 Task Force on Post Ovulatory Methods of Fertility Regulation (1998).
37 *Id.*
38 Linda E. Ledray, Diana Faugno, & Pat Speck, *Sexual Assault: Clinical Issues. SANE: Advocate, Forensic Technician, Nurse?*, 27(1) Journal of Emergency Nursing, 91-93 (February 2001); USDOJ (2004).

"The pain and shame gave me the strength I needed to get through the case and the court experience."

— FARMWORKER SURVIVOR