ARKANSAS COMMISSION ON CHILD ABUSE, RAPE AND DOMESTIC VIOLENCE

University of Arkansas for Medical Sciences

Healthcare Protocol Manual for Sexual Assault

ARKANSAS COMMISSION ON CHILD ABUSE, RAPE AND DOMESTIC VIOLENCE

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

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Chapter

1

1. Introduction

Sexual violence is a significant and prevalent public health problem. According to the "Rape in Arkansas Report" of the more than one million women living in Arkansas, nearly 129,000 or approximately 12.4% have been victims of a completed forcible rape at some point in their lifetime (Ruggiero, K.J., & Kilpatrick, D.G., 2003). However, this is mostly likely a very conservative estimate because it does not include men, children or other forms of sexual violence. Sexual violence means enormous physical and psychological consequences for victims and their families. It can damage one's sense of safety in the world, self-esteem, educational development and later, the ability to be a productive citizen.

There are many myths about sexual violence that contribute to the pain a victim suffers. For instance, many people believe the majority of sexual assaults are perpetrated by strangers. In 2002, law enforcement agencies in Arkansas reported that over 77% of victims said they knew the perpetrator either as a family member or an acquaintance (ACIC, 2002). Another common belief is that there is a great deal of false reporting. According to the FBI, "False reports of rape are rare, occurring only 8 percent of the time" (FBI, 1995).

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

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

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

Definitions

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

A

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

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

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

B

Battery: The unlawful touching of another without their consent.

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

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

C

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

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

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

Child neglect: Failure on the part of a parent, guardian or other adult to provide the necessities of life such as adequate living conditions, nutrition, education, medical care, failure to provide adequate emotional support, stimulation or to adequately supervise or protect the child.

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

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

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

Compassion Fatigue: emotional residue of exposure to working with the suffering, particularly those suffering from the consequences of a traumatic event.

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

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

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

D

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

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

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

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

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

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

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

E

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

Elder abuse: The maltreatment of an elderly person. The maltreatment may include physical injury, restraint, financial exploitation, threats, ridicule, insult or humiliation, forced isolation or change in living arrangements. It might also include neglect or abandonment.

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

Emergency contraception: is used to prevent pregnancy after sexual intercourse by stopping ovulation, fertilization or implantation. Must be taken within 72 hours.

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

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

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

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

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

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

F

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

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

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

G

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

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

H

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

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

I

Incest: Sexual intercourse with a person who is related by blood or marriage.

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

K

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

L

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

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

M

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

Medicolegal: Pertaining to law and medicine.

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

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

N

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

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

P

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

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

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

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

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

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

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

Post-traumatic Stress Disorder (PTSD): a psychiatric disorder that can occur following the experience or witnessing of life-threatening events. Victims with PTSD are unable to function at normal levels or have difficulties in one or more areas. The four major symptoms PTSD are: re-experiencing the trauma; social withdrawal; avoidance behaviors and actions; and increased physiological arousal characteristics. Patients that have been sexually assaulted may experience PTSD related to sexual assault. This is also referred to as Rape Related PTSD.

R

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

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

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

Registered sex offender: Arkansas law states a person is required to register as a sex offender if the person is adjudicated guilty on or after August 1, 1997, of a sex offense; or is serving a sentence of

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

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

S

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

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

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

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

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

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

Sexual Assault Nurse Examiner (SANE): A registered nurse who possesses advanced skills in the evaluation of injuries consistent with forced sexual contact. SANE's perform medico-legal examinations, collect legal evidence, utilize psychosocial skills in aiding the patient and participate in legal proceedings as an expert witness in cases involving sexual assault.

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

Sodomy: Arkansas law states a person commits sodomy if such person performs any act of sexual gratification involving: the penetration, however slight, of the anus or mouth of an animal or a person by the penis of a person of the same sex or an animal; or the penetration, however slight, of the vagina or anus of an animal or a person by any body member of a person of the same sex or an animal.

Stalking: Crime that occurs when someone purposefully engages in a course of conduct that harasses another person and makes terroristic threats while intending to make that person or member of their family fear death or serious physical injury.

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

T

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

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

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

V

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

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

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

W

Woods Lamp: longwave ultraviolet light used during physical exam to help delineate stains/secretions deposited on the body or clothing.

Chapter

2

2. Multi-Disciplinary Response

Effective treatment and intervention for sexual assault or abuse patients requires a team effort. Services will be provided by professionals and/or volunteers from differing disciplines. These team members may include representatives from law enforcement, emergency medical services, hospitals/healthcare facilities, physicians, Sexual Assault Nurse Examiners (SANE) and other healthcare professionals, victim advocates, State Crime Lab, mental health providers, prosecutors and others. The patient is best served when the participating members of these disciplines strive for a coordinated approach. One method of providing a coordinated approach to care is the creation of a sexual assault treatment center. These centers have long been functioning in other states to provide forensic evidence collection exams, prophylactic treatment and act as a gateway to counseling and other care as needed. The first such program opened in Arkansas in Fort Smith, January 2000. Sexual Trauma, Assault & Rape Response Service (STARRS) offers a comprehensive response system for the provision of forensic care to sexual assault patients and works in cooperation with law enforcement and rape crisis advocates. (STARRS, 2000).

Emergency Medical Services (EMS)

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

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

Hospitals/Healthcare Facilities

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

PHYSICIANS

Physicians commonly evaluate sexual assault patients in hospital emergency departments, clinics and offices. They usually are not part of a formal multi-disciplinary team for the evaluation and management of sexual assault, since such teams do not exist in most of Arkansas. Instead, physician examiners in most counties should be considered part of an ad hoc case-specific team. Their responsibilities are to provide medical evaluations and treatment, interpret forensic findings, access existing systems for their patients, provide or refer for subsequent medical and mental health care, communicate effectively with other involved professionals, and testify in court if needed.

SANE-A

A SANE-A is an RN that has completed a didactic training program; demonstrated competence in the performance of sexual assault medical/forensic examinations of adults and adolescents, and the related clinical skills; and has successfully passed the Forensic Nursing Certification Board. For more information go to www.IAFN.org. (International Association of Forensic Nurses, 2002).

Law Enforcement

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

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

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

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

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

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

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

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

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

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

General guidelines for the law enforcement investigative interview:

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

- With the consent of the victim, a support person who may have been present during the medical and evidence collection examination may also be present during this interview.
- The interviewer should be sympathetic and understanding of the victim's trauma while at the same time, effective in collecting all necessary information about the case.
- The interviewer should establish him/herself as an ally of the victim and try to cushion the victim from pressures by family, friends or others, as well as from possible harm or threats made by the assailant.
- The victim should be allowed to tell his/her story without interruption by the interviewer.
- The interviewer should go back over the story and, using the notes taken, ask specific questions covering any areas of the narrative that may have been incomplete or unclear.

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

Victim Advocacy Programs

A sexual assault victim advocate is a person who has received specialized training and is sensitive to the issues surrounding rape and sexual assault. Most frequently, these are rape crisis center representatives. Areas that do not have rape crisis centers often rely on other professionals such as hospital social workers or victim witness coordinators to serve as an advocate. The advocate generally provides information and support to the survivor throughout the medical, investigative, and court process.

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

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

Mental Health Professionals

It is the role of mental health professionals to provide supportive and re-integrative services to patients who have been sexual assaulted. These services may be provided immediately after the report of the assault, at the hospital or other facility, or as follow-up service. Counselors may also provide services such as support groups, crisis intervention, treatment or other forms of assistance.

Prosecutors, Judicial System

The role of the judicial system, represented by members of the prosecutor's office is to represent the plaintiff in legal proceedings. In the case of rape or sexual assault, the plaintiff is generally the state where the assault occurred. The attorney for the prosecution will present the evidence and testimony in an attempt to prove the accused is "guilty" of the named offense. The judicial system's overall function is the search for "truth and justice" and to prevent future crime by the guilty offender(s).

Forensic Laboratory Scientists

The physical evidence (the sexual assault evidence collection kit and the patient's clothing) will be analyzed by the Arkansas State Crime Laboratory. Other items of evidence (such as bed sheets, vehicle seats, fingerprints, weapons, etc.) may be collected by the law enforcement officer. The items will be examined for body fluids, hairs, fibers, debris or any other pertinent information. If body fluids or hairs with roots are found, DNA analysis can be performed. A report will be released to the law enforcement officer who submitted the case and then the analyst will testify in court as to their findings.

Sexual Assault Response Team (SART)

A SART is a coordinated, multidisciplinary team which pursues a collaborative investigation, physical examination, treatment, counseling, and prosecution of sexual assault cases. A SART usually includes:

- Healthcare provider
- Law enforcement
- Prosecutor
- Victim advocates
- Mental healthcare provider
- Forensic scientist

(U.S. Department of Justice, Office of Violence Against Women, 2004)

Chapter

3

3. Comprehensive Treatment

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

General Information

It is recommended that a healthcare provider (physician, nurse practitioner, or Sexual Assault Nurse Examiner) with specialized education & training in the evaluation & treatment of sexual assault patients complete the examination & provide treatment for these patients.

Most examinations should be performed in a Sexual Assault Treatment Center or Hospital Emergency Departments. These facilities are available 24 hours per day and have the appropriate equipment and staff to conduct the forensic evidence collection examination.

Coordinated Team Approach

Recommendations At A Glance:

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

A Coordinated Team Approach among involved disciplines is strongly recommended to simultaneously address the needs of both patients and the justice system. Use of a coordinated, multidisciplinary approach in conducting the medical forensic examination can afford patients access to comprehensive immediate care, help minimize trauma they may be experiencing, and encourage the use of community resources. Raising public awareness about the existence and benefits of a coordinated response to sexual assault may lead more patients to disclose the assault and seek the help they need.

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

- Evaluating and treating injuries;
- Conducting prompt examinations;

- Providing support, crisis intervention, and advocacy;
- Providing prophylaxis against STIs;
- Assessing female patients for pregnancy risk and discussing treatment options, including reproductive health services; and
- Providing follow-up care for medical and emotional needs.

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

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

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

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

Victim-Centered Care

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

Recommendations At A Glance:

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

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

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

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

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

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

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

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

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

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

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

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

Physical comfort needs should be provided. Provide an opportunity to wash in privacy (offering shower facilities if possible), brush their teeth, change clothes (clean and ideally new replacement clothing should be available), get food and/or a beverage, and make needed phone calls. They may also require assistance arranging for transportation to their home or another location.

Sexual Assault Information Packet

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

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

Informed Consent

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

Recommendations At A Glance:

- Seek informed consent, as appropriate, throughout the evaluation in accordance with state law and your hospital policy.
- Verbal and written information given to sexual assault patients to facilitate the consent process should be complete, clear, and concise.
- Make sure policies exist to guide seeking informed consent from special populations.
- Be familiar with statutes and policies governing consent in cases of minor sexual assault patients, vulnerable adult patients, and those who are unconscious or intoxicated.

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

Verbal and written information given to sexual assault patients to facilitate the consent process should be complete, clear, and concise. This information, along with consent forms, should be tailored to the communication skill level/modality and language of sexual assault patients. Encourage patients to ask questions. Make sure all signatures and dates needed are obtained on

written consent forms and document consent or reasons for declining to consent as appropriate (either on the medical record or forensic report forms).

Make sure policies exist to guide seeking informed consent from special populations. It is always important for examiners to assess patients' ability to provide informed consent. In addition, facilities should have internal policies based on applicable jurisdictional statutes governing consent for treatment of vulnerable adult patients. The medical provider will generally need to assess whether the patient has the cognitive capacity to give consent for the examination, and, if not, the provider should follow these internal policies and jurisdictional statutes. Policies should include procedures to determine whether or not patients are their own guardians; if there is a guardian, to determine the extent of the guardianship; to obtain consent from a guardian if needed; and what to do if the guardian is not available or is suspected of abuse or neglect. Exam facilities should also have policies in place to address consent for treatment in cases in which patients are unconscious, intoxicated, or under the influence of drugs, and are therefore temporarily incompetent to give consent.

Be familiar with statutes and policies governing consent in cases of minor sexual assault patients, vulnerable adult patients, and those who are unconscious or intoxicated. In cases of adolescent sexual assault patients, jurisdictional statutes governing consent and access to the exam should be followed. For instance, a State statute may allow minors to receive care for STIs and pregnancy, but not a medical forensic examination without parental or guardian consent. Exceptions to parental consent requirements also exist when the parent or guardian is the suspected offender or where the parent or guardian can't be found and the collection of evidence needs to be done quickly. In such cases, the law generally specifies who may give consent in lieu of the parent or guardian, such as a police officer, representative from the jurisdiction's children's services department, or judge.

In all cases, the medical forensic evaluation should never be done against the will of the patient. Responders should not touch sexual assault patients or otherwise perform exam procedures without their permission.

Confidentiality

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

Recommendations At A Glance:

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

Be sure that jurisdictional policies address the scope and limitations of confidentiality as it relates to the examination process and with whom information can be legally and ethically shared. Members of a SART or other collaborating responders should inform sexual assault

patients of the scope of confidentiality with each responder and be cautious not to exceed the limits of patient consent.

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

Anonymous or Blind Reporting

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

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

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

Sexual assault patients making anonymous or blind reports and going through the medical forensic exam should be informed about jurisdictional policies regarding storage of evidence and exam payment. In some communities, it is a challenge to find adequate space to hold evidence in cases where a report has not been made. If patients have evidence collected, they also should have the option of being notified if DNA evidence from their case is linked to an offender already in the national DNA database or identifies other patients of the same offender.

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

- Encourage patients to consent to the medical forensic history, an examination, and documentation regardless of whether an evidence collection kit is used.
- Explore the myriad reasons why patients are reluctant to report and how the actions or attitudes of agencies may help perpetuate these fears. Help agencies consider how to reduce reluctance and fears.

- Evaluate local trends regarding reporting and patients' involvement in the criminal justice system. Based on feedback, develop and implement a plan to improve multi-disciplinary response to sexual assault.
- Increase victim-sensitivity education for first responders (e.g., educate law enforcement investigators on interviewing versus interrogating skills, educate health care personnel to be compassionate and not blame patients for the assault, and educate prosecutors to be victim-centered in their approaches).
- Encourage criminal justice statistical reports that accurately reflect the frequency and severity of sexual assaults reported in a jurisdiction.
- Initiate community education, outreach, and services targeting groups that may be reluctant to seek assistance after an assault.
- Offer viable options for reimbursement of exam costs for which patients are responsible.
- Encourage the development of a coordinating council and/or SART to facilitate a more coordinated, victim-centered, comprehensive community response to sexual violence.
- Support the formation of specialized examiner programs, investigative and prosecution units, and sexual assault victim advocacy programs to handle these cases. Specialization can potentially increase the knowledge base and commitment of involved responders, increase adherence to jurisdictional protocols for immediate response to sexual assault, encourage a victim-centered response, and positively advertise services offered.
- Develop jurisdiction-wide public information initiatives on mandatory reporting—mandatory reporters need to know applicable statutes regarding reporting sexual assault cases that involve older vulnerable adults, persons with disabilities, and minors. A toll-free hotline number exclusively dedicated to abuse reports may also help simplify reporting and ensure a written report of each case and referrals to appropriate agencies. Such a hotline could be operated at a State, tribal, regional, or local level. To encourage both reporting and follow-through, protective agencies that investigate these cases should work collaboratively with local law enforcement agencies to ensure that each case is dealt with in the best possible manner and that further harm does not occur.
- In institutional settings such as prisons, jails, immigrant detention centers, nursing homes and assisted living programs, in victim treatment centers, and group homes, ensure that patients can report assaults to outside agencies and are offered protection from retaliation for reporting.
- In each case, strive to create an environment in which patients are encouraged to report and are supported throughout the criminal justice process and beyond. Even in those cases that do not develop beyond an initial report to the police, patients should feel that they are respected.
- After steps have been taken to identify and remove barriers to reporting sexual assaults, educate the public about the potential benefits of reporting, how to go about reporting, what happens once a report is filed, and jurisdictional legal advocacy services available (if any) for sexual assault patients. Build upon already existing public awareness efforts of local advocacy programs.

  (Office of Violence Against Women, 2004).

Special Populations

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

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

Cultural Competency

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

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

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

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

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

- Be aware that beliefs about women, men, sexuality, sexual orientation, race, ethnicity, and religion may vary greatly among patients of different cultural backgrounds. Also, understand that what helps one patient deal with a traumatic situation like sexual assault may not be the same for another patient.

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

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

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

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

Sexual Assault Patients with Disabilities

- Understand that patients with disabilities may have physical, sensory, or mental disabilities, or a combination of disabilities.

- Consult with jurisdictional statutes and policies regarding the use of community-based advocates as interpreters—such a dual role may jeopardize their confidentiality with patients. Make every effort to recognize issues that arise for patients with disabilities (both in general and in relation to their specific disability) and provide reasonable accommodations when working with them.

- Be aware that the risk of criminal victimization (including sexual assault) for people with disabilities appears to be much higher than for people without disabilities. People with disabilities are often victimized repeatedly by the same offender. Caretakers, family members, or friends may be responsible for the sexual assault.

- Respect patients' wishes to have or not have caretakers, family members, or friends present during the exam. Although these individuals may be accustomed to speaking on behalf of persons with disabilities, it is critical that they not influence the statements of patients during the exam process. If professional assistance is required (e.g., from a language interpreter or mental health professional) this should be arranged. Ideally those providing assistance should not be associated with patients.

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

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

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

proceeding to help them (or touch them, handle a mobility or communication device, or touch a service animal).

- Note that not all individuals who are Deaf or hard-of-hearing understand sign language or can read lips. Not all blind persons can read Braille. Communication equipment that may be beneficial to patients with sensory disabilities include TTY machines, word boards, speech synthesizers, anatomically correct dolls, materials in alternative formats, and access to interpreter services. Responders should familiarize themselves with the basics of communicating with an individual using such devices. Be aware that some patients with sensory disabilities may prefer communicating through an intermediary who is familiar with their patterns of speech. Ideally, this would be someone not associated with the patient, but in some cases this may be necessary.

- Recognize that individuals may have some degree of cognitive disability: mental retardation, mental illness, developmental disabilities, traumatic brain injury, neurodegenerative conditions such as Alzheimer's disease, or stroke. Note that not all developmental disabilities affect cognitive ability (e.g., cerebral palsy may result in physical rather than mental impairment). Be aware that patients with cognitive disabilities may be easily distracted and have difficulty focusing. Speak to patients in a clear, calm voice and ask very specific, concrete questions. Be exact when explaining what will happen during the exam process and why.

- Keep in mind that patients with disabilities may be reluctant to report the crime or consent to the exam for fear of losing their independence. For example, they may have to enter a long-term care facility if their caretakers assaulted them or may need extended hospitalization to treat and allow injuries to heal.

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

- While a patient's disability may have resulted in them being more vulnerable to an assault, it is important to listen to their concerns about the assault and what the experience was like for them, and not focus on the role of their disability. Assure them that it is not their fault that they were sexually assaulted. If needed, encourage discussion in a counseling/advocacy setting if they are concerned about their safety in the future.

Male Sexual Assault Patients

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

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

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

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

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

Adolescent Sexual Assault Patients

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

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

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

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

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

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

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

Older Sexual Assault Patients

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

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

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

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

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

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

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

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

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

Chapter

4

4. ADULT MEDICAL/FORENSIC EXAM

Recommendations At A Glance

- Overview
- Intake & Triage
- Obtain supplies
- Interview for medical/forensic history
- Collection of clothes
- Assess body (except genitalia) for TEARS and collect evidence
- Assess genitalia for TEARS and collect forensic evidence
- Obtain urine specimen
- Lock down evidence in dryer (if available)
- Administer prophylactic pregnancy & STD medications
- Patient Education/ Discharge
- Chain of custody to law enforcement
- Complete any necessary paperwork

OVERVIEW

The purpose of the medical-forensic (or medical-legal) exam is to properly collect, document, preserve evidence, and maintain the chain of custody. The findings in the exam and collected evidence often provide information to help reconstruct the details about the events. Health care needs and other related concerns of patients presented in the course of the exam are addressed prior to discharge. The patients need to be informed that the exam does not provide routine medical care.

Patients know the suspects in the majority of cases. Many suspects will claim that the patient consented to the sexual contact. Therefore, the evidence and documentation of physical findings

related to whether force or coercion was used against patients are important. However, the absence of physical trauma does not mean that coercion or force was not used or proves that consensual sex occurred. Nor does it mean that the presence of physical trauma is indicative of a sexual assault.

Each examiner develops her own routine. There is more than one approach in completing the exam; as long as all the steps are covered, variation is acceptable. It is important that each examiner follow the same sequence with each exam to ensure consistency and to avoid omissions. The exam needs to follow a logical sequence, ideally from least to most invasive procedure. This helps in the therapeutic process of giving power back to the victim. At any time, the patient has a right to refuse a portion or all of the exam.

Photographing injuries will not be covered in this section. Photographing injuries may hurt a case more than it can help if poor photos are taken. The photographer needs to be trained in forensic photography. Some facilities contact the local police department for a criminal photographer to come to the site and photograph injuries.

A physical examination should be performed in all cases of sexual assault, *regardless of the length of time which may have elapsed between the time of the assault and examination.*

Some patients may ignore symptoms which would ordinarily indicate serious physical trauma, such as internal injuries sustained by blunt trauma or foreign objects inserted into body orifices. Also, there may be areas of tenderness which will later develop into bruises but which are not apparent at the time of initial examination.

If the assault occurred *within 72 hours prior to the examination,* a medical/legal examination utilizing a sexual assault evidence collection kit should be performed with the exception of children, or incidents involving kidnapping or extensive trauma. The Arkansas State Crime Laboratory will provide kits free of charge. Kits may be obtained by sending a written request to: Arkansas State Crime Laboratory, Forensic Biology Section, P.O. Box 8500, Little Rock, AR 72215. Should any questions arise during the utilization of the kit, contact the Crime Laboratory at (501) 227-5747.

If it is determined that the assault took place *more than 72 hours prior to the examination*, an evidence collection kit may not utilized. However, evidence may still be gathered by documenting any findings obtained during the medical examination (such as bruises or lacerations), photographs and bite-mark impressions (if appropriate), and statements about the assault made by the patient.

Health care providers who perform the forensic or evidentiary exams include: Physicians trained in evidence collection and Sexual Assault Nurse Examiners (SANE's). SANE's are registered nurses who have completed a training program and subsequent supervised practice that qualifies them to perform the forensic examination of sexual assault patients. (International Association of Forensic Nurses, 2002) The Arkansas State Board of Nursing has adopted a paper that states forensic examination and evidence collection is within the scope of practice of registered nurses in Arkansas (ASBN, 1997). However, the title SANE-A is a protected and requires successful completion of the IFN Boards. For the purpose of this text, the examiner will be referred to in the female pronoun, though men can perform the exams too. When the patient is a male, he should be asked if he would prefer to have a male perform the exam.

Intake and Triage

The initial examination or triage of sexual assault patients is considered a medical emergency. Although many patients may not have visible signs of physical injury, they will, at the very least be suffering from emotional trauma. A private location and quiet examination area should be utilized if possible. Establishing a sexual assault response center or designating a private area in or near the Emergency Department can accomplish this. It is recommended that the same type of facility be provided for the follow-up law enforcement interview at the conclusion of the examination.

Many hospitals have developed "code" words to describe the care required for a patient of sexual assault. They may use the designation, "code R' or "code SA', when referring to the care being given to a patient of sexual assault. This limits the need for describing the type of care by specifying "rape" or "sexual assault" in a public location where a breach of confidentiality might inadvertently occur.

Other methods can be devised to avoid inappropriate references to sexual assault cases and hospitals are encouraged to develop their own plans to ensure privacy.

The importance of having a support person available to sexual assault patients cannot be overemphasized. Whenever possible, one person should be assigned to stay with the patient throughout the entire examination. The use of trained sexual assault victim advocates is preferred. The patient should be asked for their consent to have an advocate present. The victim advocate can provide crisis intervention support, act as liaison for family or friends of the patient, and provide items such as clothing, referrals, counseling services, etc. A victim advocate can also help with other information such as the availability of victim compensation programs or other types of assistance, emphasize the importance of follow-up medical testing and answer many other questions.

Victim advocates are often available through non-profit organizations such as a sexual assault or rape crisis center, law enforcement, prosecutor's office or through other programs. Most advocacy programs provide services during the initial response after the sexual assault. However, some programs offer follow-up services, including support for the patient throughout the entire criminal justice process.

Adult patients presenting for medical treatment as the result of a sexual assault, shall decide if they wish to report the incident to a law enforcement agency. The adult patient is not required to report the incident in order to receive treatment. However the patient should be told that a police report must be filled out to be eligible for Arkansas Crime Victims Reparations program funds. If a victim chooses to report a crime, when possible, a report should be made to the law enforcement agency where the assault occurred. Forensic evidence will be collected only with permission of the patient. However, permission shall not be required in instances where the patient is unconscious, mentally incapable of consent, or intoxicated. (Arkansas Attorney General, 2004).

Acute medical needs take precedence over forensic needs. Acute injury, trauma care, and safety needs should be addressed before the interview or evidence collection. Patients should not wash, change clothes, urinate, defecate, smoke, drink, or eat until initially evaluated by an examiner; unless necessary for treating acute medical needs.

If the patient must urinate before the evidence collection is complete, collect the tissue paper or have the patient blot him/herself dry using a gauze pad.

Obtain Supplies

It may be advantageous to have a cart available in the examination room with all necessary supplies, including extra collection kits. *Once the collection process begins, the examiner MUST keep all evidence with her at all times.* In the event the examiner has to leave the room, she can wheel the whole cart with her. Having all of the supplies in the room will decrease the chance of needing to leave the room during the exam. Some items to include on the cart:

- Alcohol prep
- Betadine
- Distilled water in spray mister
- Orange sticks
- Unlined index cards
- Clear packing tape
- Tape measure in centimeters
- Envelopes
- Lunch size paper bags
- Grocery size paper bags
- Roll of table paper
- Toluidine blue dye
- 4 X 4's
- Wood's Lamp
- Swab dryer
- Disposable locks for swab dryer
- Evidence log book
- Sexual assault examination kits

Interview for Medical/Forensic History

It is ideal to ask patients to provide a medical/forensic history before the examination and evidence collection. The history entails asking patients' detailed forensic and medical questions relating to the assault. The purpose is to guide the exam, evidence collection, treatment and crime lab analysis findings. If law enforcement is involved, they will collect information from patients to help in the apprehension of suspects and in the case investigation. Examiners should ask only for information related to treatment and collecting/interpreting physical and lab findings. Asking investigative questions is outside their role and scope of practice. One concern is that interview details reported by examiners differ from the law enforcement report and may be used against patients. Patients may feel re-violated and may feel uncomfortable discussing personal matters with involved personal. Communication may be difficult due to their emotional and physical condition. Effort should be made to conduct the interview in a room that is private and secure. Ideally, there should be no interruptions and no time constraints for the interview.
(Ledray, 1999)

The facility should have procedures in place to accommodate patient's communication skill level and preferred mode of communication. This is particularly important for patients with communication-

related disabilities and non-English speaking patients. Try to avoid family members and friends interpreting for the patient.

Prior to the history taking, patients should be informed that the presence of personal support persons (other than trained advocates) may influence or be perceived as influencing their statements. These individuals could be subpoenaed as a witness. If the patient still requests that they be present, instruct these individuals not to actively participate in the process. They should not answer questions for the patient, comment on patient's answers, interrupt patients, or make facial expressions in response to their questions.

Specific questions will vary from one jurisdiction to the next, as do forms for recording the history. However, the following information should be routinely sought from patients:

Date and time of the sexual assault(s): It is essential to know how much time has elapsed between the assault and the collection of the evidence. For example, if over 72 hours have passed a collection kit is not utilized with the exception of minors, kidnapping and extensive trauma.

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

Recent consensual sexual activity: This is due to the sensitivity of DNA analysis. Consensual sex consisting of anal, vaginal, and/or oral, and whether a condom was used needs to be asked. A trace amount of semen or other bodily fluid may be identified that is not associated with the crime. Therefore, once identified as a consensual partner, this can be used for elimination purposes.

Post-assault activities of patient: Quality of evidence is affected both by the actions taken by patients and the passage of time. It is crucial to know what, if any activities were performed prior to the examination. This includes asking patients if they have urinated, defecated, wiped genitals or the body, douched, removed/inserted a tampon/sanitary pad/diaphragm, Nuvaring, used oral rinse/gargled, washed, brushed teeth, took a bath, showered, ate or drank, smoked, used drugs, or changed clothing.

Assault-related patient history: This includes memory loss, lapse of consciousness, vomiting, non-genital injury, pain and/or bleeding. This information directs evidence collection and medical care. Memory loss and lapse of consciousness is a strong indicator that a Drug Facilitated Sexual Assault (DFSA) occurred.

Suspect information (if known): The gender and number of suspects may offer guidance to types and amounts of foreign materials that might be found on patients' bodies and clothing. Suspect information gathered during this interview should be limited to what will guide the exam and forensic evidence collection.

Nature of the assault: Information about the physical surroundings of the assault(s) (e.g., indoors, outdoors, car, alley, room, rug, dirt, mud, or grass) and methods employed by suspects is crucial to the detection, collection, and analysis of physical evidence. Methods may include, but are not limited to, use of weapons (threatened and/or injuries inflicted), physical blows, grabbing, holding,

pinching, biting, using physical restraints, strangulation, burns, threat(s) of harm to patient or loved ones, and involuntary ingestion of alcohol/drugs. Knowing if suspects may have been injured during the assault may be useful when recovering evidence from patients such as fingernail scrapings and in the event of an arrest may provide corroborating support of incident.

Description of the sexual assault: An accurate, but brief description in chronological order is crucial to detecting, collecting, and analyzing physical evidence. The description should include any:

- Penetration of genitalia (vulva and/or vagina of female patient), however slight;
- Penetration of the anal opening, however slight;
- Oral contact with genitals (of patient's by suspect or of suspect's by patient);
- Other contact with genitals (of patient's by suspect or of suspect's by patient);
- Oral contact with the anus (of patient's by suspect or of suspect's by patient);
- Nongenital act(s); licking, kissing, sucking, and biting;
- Other acts (urination, defecation on patient) or use of objects;
- If known, whether ejaculation occurred and location(s) of ejaculation (e.g., mouth, vagina, genitals, anus/rectum, body surface, clothing, bedding or other);
- Use of condoms and lubrication.

Collection of Clothes

As previously stated, collection of clothing and other evidence will be guided by the medical forensic history. Often clothing contains important evidence in a case of sexual assault for the following reasons:

- Clothing provides a surface upon foreign matter may be found, such as the assailant's semen, saliva, blood, hairs and fibers, as well as debris from the crime scene. While foreign matter can be washed off, wiped off or fall off the body of the patient, the same substances can often be found intact on clothing for a considerable length of time following the assault.

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

Prior to the full examination, the health care provider should determine if the patient is wearing the same clothing worn during or immediately following the assault. If so, great care should be taken to see that the clothing is examined for any apparent foreign material, stains or damage. The presence of these items should be documented. If it is determined that the patient is not wearing the same clothing, the health care provider should inquire as to the location of the original clothing. The information about the location of the clothing should be given to the investigating officer so that arrangements to retrieve the clothing can be made and should also be included in the documentation by the health care provider. The most common items of clothing that are collected from patients for analysis are underwear, bras, hosiery, blouses, shirts, pants and diapers. In some cases coats and shoes are collected as well.

To minimize loss of evidence, the patient should disrobe over a white cloth or sheet of paper. A suggested method is to place a clean cloth sheet on the floor and then place a sheet of table paper over the cloth in a bindle. (*See Appendix A)* The cloth sheet prevents transfer of debris from the floor to the piece of paper. The patient would disrobe over the piece of paper and any debris that falls from the clothing should be collected for the crime laboratory. If it is necessary to cut off

items of clothing from the patient, do not cut through existing rips, tears, or stains. Cut close to a seam if possible. Include in the documentation which items of clothing were cut and the location of the cuts.

Any foreign material found should be collected and put into a small paper envelope, labeled with patient's name, date, location the material was removed from and the examiner's initials. Wear gloves and follow Universal Precautions per facility's protocol while collecting clothing. Be sure to change gloves to prevent cross-contamination.

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

- Air-dry any items of clothing that are wet or damp. Any wet stains, such as blood or semen, should be allowed to air dry before being placed into paper bags.

- Place the underwear in the paper bag marked "UNDERWEAR" provided in the sexual assault evidence collection kit. This should include underpants only. The underpants should be collected, even if they are not the pair the patient was wearing at the time of the assault. It is possible that secretions or ejaculate may drain from the patient and be found on the underpants.

- If a bra is present, place it in a separate bag and label it "BRA".

- Other clothing items should be placed in separate paper bags. It is preferable that each piece of clothing be folded inward, placing a piece of paper against any stain so that the stains are not in contact with the bag or other parts of the clothing.

- Label all bags with the patient's name, the date, the name of the item and the collector's name or initials.

- Seal the bags, using tape. Initial and date over the seal of the bags or envelopes.

- If after air drying, moisture is still present on the clothing and might leak through the paper bag during transportation to the crime laboratory, the labeled and sealed paper clothing bags should be placed inside a larger plastic bag. Leave the top of the plastic bag open. A label should be affixed to the outside of the plastic bag, alerting the crime laboratory and law enforcement personnel that wet evidence is present inside the plastic bag. This will enable the laboratory to immediately remove the clothing and avoid potential loss of evidence due to mold or putrefaction.

Assessment of the body for injuries and evidence

<u>Assess body head-to-toe (except genitalia) for TEARS (see definition) and collect evidence:</u> The patient's body is considered the "crime scene". The physical assessment and examination will be guided by the medical forensic history previously provided. It is important to wear powder-free gloves and change them throughout the exam/evidence collection, especially between sites. A systematic head-to-toe approach should be consistently utilized, excluding the genitalia. The rationale for excluding the genitalia at this point is to perform the exam from least to most invasive. Also, it will diminish the risk of cross-contamination in assessment and evidence collection.

Note and record physical appearance, general demeanor (expressive or controlled), and behavior of the patient: Record all physical findings utilizing the acronym TEARS: T (tearing/lacerations), E (ecchymosis/bruising), A (Abrasion), R (Redness), and S (Swelling). Further assess for foreign materials such as grass, sand, stains, dried or moist secretions. Note areas of tenderness and induration. Carefully inspect the body, including the head, hair, and scalp, and work down in a head to toe system for dried or moist secretions and stains (e.g., blood, seminal fluid, sweat and saliva) and other foreign material. Information and/or findings should be noted using body maps or diagrams.

If available, use an alternate light source (ALS) in a darkened room to examine the patient's entire body. Wear recommended eye protection. Also, protect the patient's eyes when using ultraviolet light. Specifically examine the head, face, hair, lips, perioral region, and nares; chest and breasts; inner thighs, skin, and other areas indicated by the medical forensic history. A systematic assessment may help omit errors. Dried semen stains may have a shiny appearance and tend to flake off the skin. Semen may exhibit an off-white fluorescence under UV light. Fluorescent areas may appear as smears, streaks or splash marks. Moist or freshly dried semen may not fluoresce. The appearance of fluorescent areas does not confirm the presence of semen, as other substances such as urine or body lotions may fluoresce. Restraint marks, bite marks, recent contusions, and other subtle injuries may be more visible with the aid of an ALS.

Collection of foreign materials and swabs from the surface of the body: Obtain swabs from any suspicious area that may be a dry secretion or stain, any moist secretion, any area that fluoresces with an ALS, and any area for which patients relate a history or suspicion of bodily fluid transfer (licking, kissing, biting, splashed semen, urine, defecation, or suction injury).

Dried secretions are collected by moistening a swab very slightly with distilled water or normal saline and using the double-swab technique in the indicated area. Swab moist secretions with a dry swab. Separate swabs should be used for every sample area collected. It is optional to smear swabs onto microscope slides. The swabs should be placed in separate envelopes or a plain piece of paper that is folded and labeled. The envelope or paper should be sealed, labeled with the patient's name, date, collector's name and location of the collection site. Use a pencil or specially designed marker when labeling slides with frosted ends to lessen the chance that the labeling information will become smudged. According to facility and protocol, air-dry all specimens, package swabs and slides separately, label, seal, and initial seals. The coding of evidence must allow the crime lab to know which swab was used to prepare which slide. Change gloves in between collection sites.

If dried secretions are on hair (head, facial or pubic) flake off material if possible or cut matted hair only with patient's permission. Place in a separate envelope.

It may be beneficial to label all envelopes and slides prior to collection, with the patient's name, date and health care provider's name. After envelopes are labeled, the health care provider should keep them in view at all times to preserve the appropriate chain of evidence.

When sealing the evidence collection envelopes, use tape, staples, distilled water or normal saline to very slightly moisten the pre-gummed flap, if present on the envelope. DO NOT LICK the flaps of these evidence collection envelopes.

Bite mark evidence: Bite marks may be found on patients as a result of sexual assault and other violent crimes. The collection of saliva and photographs of the affected area are the minimum procedures which should be followed in cases where a bite mark is present. Documentation of the bite mark, size, location and condition is also needed.

Saliva, like semen, demonstrates blood group factors that are characteristic of their donor. Therefore, the collection of saliva from the bite mark should be made prior to cleansing or dressing the wound. If the skin is broken, swabbing of the actual punctures should be avoided when collecting specimens. To collect swab from the bite mark area, moisten the swab very slightly with distilled water or normal saline and gently swab the affected area. Use two swabs and prepare a slide from one of the swabs. Air dry the swabs and slide, label appropriately and seal in envelopes.

If bite photographs are used, it is important that photographs of the bite marks be taken properly. It is recommended that a representative of the law enforcement or a forensic photographer be consulted on the proper instructions for forensic evidence photography. To demonstrate the size of the bite mark, a ruler or standard should be placed adjacent to but not touching or covering the bite mark and then photographed. An additional photograph without the ruler or standard should also be made. The camera should be placed perpendicular to the bite mark. If instamatic camera, the picture should be labeled with patient's name, date, name of photographer and area that is photographed. If this is film to be developed, a photograph should be taken of the wound that includes a label with the above information on it. The film should be labeled, placed in an envelope and sealed.

In some bite mark cases, it may be helpful to have a three-dimensional cast made. Whenever possible, a dentist or a forensic odontologist should be consulted to examine the bite mark and further document their findings. Health care providers should either contact the crime laboratory or law enforcement for a listing of qualified forensic odontologists who can assist in this process. Further information is available from the American Board of Forensic Odontology, Inc.

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

Use two cotton swabs together and swab the mouth. Attention should be paid to those areas of the mouth where seminal material might remain for the longest amount of time, such as junctions of the gum and teeth. Take one of the swabs and prepare a smear on the glass slide provided in the evidence collection kit.

The swabs should be allowed to air dry or be placed in a swab dryer especially designed for this purpose. When the oral swabs have dried, they should be inserted in the paper envelope marked "Oral Swabs". The envelope should be sealed and labeled as described previously.

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

The patient should be asked whether or not they scratched the assailant's face, body or clothing. If fibers or other materials are observed under the patient's fingernails, the under part of the nails should be scraped, one hand at a time, using a wooden stick or "orange" stick made for that purpose. The patients may want to perform this procedure themselves.

The scrapings from each hand should be made over a separate piece of paper. The paper should then be folded and placed in a small envelope, along with the wooden or "orange" stick. The envelope should be labeled with the patient's name, date, collectors name and the hand which the scrapings came from. The envelope should be properly sealed and labeled.

Blood sample: A blood sample is collected from patients for DNA analysis to distinguish their DNA from that of the suspects. This is included in the AR Sexual Assault Evidence Collection kit. This involves using less invasive methods of blood collection:

- Using a Betadine swab, wipe the tip of the left or right ring finger;
- Using a sterile lancet, prick finger;
- While holding the finger over one of 4 circles on the blood collection card, milk the finger, allowing 2 drops of blood to fall in a circle;
- Repeat procedure for the remaining circles;
- Allow blood to air-dry. Fill out the patient's name on the 1st line;
- Package according to policy, then place in envelope, label, seal and initial the seal.

American College of Emergency Physician general rules for forensic evidence collection:

- There is only one chance to collect.
- When in doubt, collect.
- Air dry, no heat
- If once living, such as blood and body fluids, refrigerate.
- Use paper or glass only, no plastic.
- Label, seal, and initial everything.
- Separate items collected.
- Do not touch items that may contain fingerprints; package to preserve prints.
- The 72 hour presumptive guideline of collection may change because it was a function of the sensitivity of forensic test.
- Suspect's DNA from epithelial cells has been found in the vaginal vault of patients for as long as 3 weeks and on clothing for years.
- Buccal swabs are good as known samples in lieu of blood. However, in Arkansas both buccal swaps and patient blood is sampled.
- Collect samples without water if possible-ease off stain and place in bindle; if needed place one drop of tap water (not saline) on a swab to collect.
- Sterile collection is not necessary; however it is necessary to change gloves between sites to avoid cross-contamination.
- Core evidence needed consist of oral, vaginal, and anal samples, as appropriate.
- Collect urine if drug-facilitated sexual assault was a possibility.
- Evidence collection changes as technology changes; keep current.

(American College of American Physicians, 1999)

Assessment of Genitalia

This stage should ideally be done in a consistent, systematic way from least to most invasive. Of course, at times the examiner may do things out of order, but the examiner with experience will find a system that works for them and use it consistently to avoid omissions. Make sure between sites, especially during collection of swabs, to change gloves and avoid cross-contamination.

Assessment of female genitalia: Make sure to wear gloves throughout the exam and to follow facility's Universal Precautions. Examine the external genitalia and perineal area for injury (TEARS), and foreign materials in the following areas: labia majora, labia minora, clitoral hood and surrounding area, perurethral tissue/urethral meatus, hymen, fossa navicularis and posterior fourcette. Further examine the buttocks, perianal skin, and anal folds for injury, foreign materials and other findings. Using swabs collect any foreign material and/or secretions as described earlier in this chapter. Take care to change gloves between sites to avoid cross-contamination of evidence. Document all findings on a body map according to facility's policy. The use of describing position of the noted injury by the hands of a clock is helpful (e.g., 3 cm laceration on labia minora at 3 o'clock).

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

- Apply by cotton swab across the fossa navicularis, posterior fourcette and related areas.
- Wait for 1 minute and blot excess dye away with 1% acetic acid solution.
- Recent lacerations will show up blue.
- Advise patients that small traces of the dye might shed in their clothing for about 2 days.

Assessment of male genitalia: Examine the external and perineal area for injury, foreign materials, and other findings, including the urethral meatus, shaft, scrotum, perineum, glands, tests, buttocks, perianal skin and anal folds. Using swabs collect any foreign material and/or secretions as described earlier in this chapter. Document findings on a body map according to facility's policy.

Collection of pubic hair combing: Pubic hair combing is part of the evidence requested in the AR Sexual Assault Collection Kit. Use the comb, paper sheet, and envelope included in the evidence collection kit. This is to collect hairs from the perpetrator. This is not a known, pulled hair sample. Pubic hairs should not be cut. Place the unfolded paper sheet under patients' buttocks and comb hair toward paper (patients may comb). Fold comb with debris/hair into paper in the envelope marked "PUBIC HAIR COMBINGS". Package, label, seal, and initial the seals.

Some patients may shave their pubic region and have no hair or stubble. In this case, a visual examination for hair may be done. Duoderm or a comparable tape may also be used instead of a comb. The tape then can be affixed to a bland or unlined index card or slide and placed in envelope.

Collection of vaginal/cervical sample: After inserting a speculum examine vagina and cervix for injury, foreign materials, and foreign bodies. When collecting the vaginal specimens, it is important

not to irrigate the vaginal vault or to dilute the secretions. It is prudent to collect swabs from both the vagina and cervix.

- Using two cotton swabs together, swab the vaginal vault.
- Using two additional swabs, repeat the swabbing procedure around the cervix.
- From the additional swabs, prepare one smear on the glass slide provided in the evidence collection kit. This slide should not be fixed or stained.
- After the slide has been air dried, place it in the envelope, marked "VAGINAL" included with the evidence collection kit.

Please note if a speculum is used, it is important to lubricate the speculum with water ***only****. Do not use gel lubricant.*

<u>Collection of penile area sample:</u> For the male patient, the presence of saliva on the penis could indicate that oral-genital contact was made, the presence of vaginal secretions could help corroborate that the penis was introduced into a vaginal orifice and feces or lubricants might be found if rectal penetration occurred. To collect specimens from the surface of the penis:

- Slightly moisten two cotton swabs with distilled water or normal saline and thoroughly swab the external surface of the penile shaft and glans.
- All outer areas of the penis and scrotum where contact is suspected should be swabbed.
- Gently roll the swabs over the microscope slides. Do not chemically fix or stain the slide. A smear should be made on one of the glass slides included in the evidence collection kit.
- The specimen should be air dried, labeled and placed in the envelope included in the kit and marked "PENILE".
- Flaked dried secretions should be placed into the provider container.
- Air-dry swabs and slides. Package them separately. Place in envelope, label, seal, and initial the seal.

If collecting the penile urethral specimens, it is important not to irrigate or dilute the secretions in any way. Using one cotton swab at a time, swab just inside the urethral meatus of the penis. Repeat this procedure with at least one additional swab for evidence collection. From the additional swabs, prepare one smear on the glass slide provided in the evidence collection kit. This slide should not be fixed or stained. Air dry and place it in the envelope included with the evidence collection kit and labeled as "PENILE".

<u>Collection of anal/rectal sample:</u> The patient may be placed in a lateral position to increase comfort during the collection of rectal swabs. To obtain rectal swab:

- Slightly moisten the cotton swabs with distilled water or normal saline. One cotton swab at a time may be used to swab the rectum. Very slight penetration is adequate. Avoid contact with external skin surfaces.
- Repeat the procedure to obtain the second swab.
- Prepare a slide with one of the swabs obtained. After the rectal swabs and slide have air dried, place the labeled slide and swabs in the envelope marked "RECTAL" in the evidence collection kit.

Lock Down Evidence

After obtaining the specimens, it is crucial to place them in a locked, secure place. Ideally, an air dryer that locks can hold the specimens in a secure place, while drying the specimens. Clothing

must be kept in sight or locked as well. *The essential point is that all evidence cannot be out of the examiner's sight, unless it is in a locked, secure location.* Follow facility's policy on locking down evidence.

Obtain Urine Specimen

Ideally, it is best to obtain the urine specimen after the genitalia collection and assessment since evidence can be lost if the patient voids. This is not always possible. Therefore, the examiner will need for the patient to save his/her urine in a collection cup. Approximately 30ML is sufficient and should be refrigerated. Furthermore, instruct the patient to save the toilet paper and/or gauze used for wiping. This needs to be dried before packaging. Do not include urine specimen in evidence collection kit, unless otherwise indicated.

A urine sample needs to be obtained, especially in the case of suspected Drug Facilitated Sexual Assault. A urine specimen can be used to rule out pregnancy, dehydration, ketosis, and other medical conditions. The collection does not need to be a clean catch, unless per protocol for pathogens. Before administration of any prophylactic medication, it is vital to rule out pregnancy.

Drug-facilitated Sexual Assault (DFSA)

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

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

Drugging should be recognized as a separate and distinct act of victimization and is in and of itself a separate crime. In 1996 the Drug-Induced Rape Prevention and Punishment Act was passed and provides up to 20 years in prison and fines (up to $250,000) for anyone who intends to commit a violent crime by covertly distributing a controlled substance to an unknowing individual.

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

The four most common substances used in DFSA are alcohol, Gamma Hydroxy Butyrate (GHB), rohypnol, and ketamine. Alcohol is the number one substance used in DFSA. A brief discussion about the other three substances follows; however, the effects of each substance are dependent upon a number of variables including: dose ingested purity of the drug, and individual factors such as body size, metabolism, concurrent drug and alcohol consumption.

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

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

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

The end metabolite from the drug will be detected for the longest duration in the urine.
30 cc of urine should be obtained and packaged in a leak proof container for transport to the crime lab. Do NOT put urine into the Sexual Assault Evidence Kit. Label, sign, seal and maintain proper chain of custody. Refrigerate the specimen (in a locked refrigerator) until it is released to law enforcement. Some jurisdictions may also require a blood specimen. Use betadine and not alcohol as the prep for venipuncture.

Pregnancy Risk Evaluation & Care

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

Recommendations at a glance:

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

Discuss probability of pregnancy. The risk of pregnancy from sexual assault is estimated to be 2% – 5%. However, pregnancy resulting from sexual assault may be of great concern and considerable additional trauma to the patient. These concerns should be taken seriously.

Conduct a pregnancy test. An exception is if a patient is clearly pregnant. If the patient is pregnant, other prophylaxis medications may need to be re-evaluated. Medical management may be best managed by or in collaboration with the patient's obstetrician.

Discuss intervention options. Because of genuine fear of pregnancy, choices of interventions should be made clear to the patient.

EMERGENCY CONTRACEPTION (EC)

Emergency contraception, the "morning-after" pill, is birth control that women can use to **prevent** pregnancy after unprotected intercourse such as sexual assault. The "abortion pill" Mifeprex, also called RU486, works **after** a woman becomes pregnant. These pills cause the uterus to expel the egg, ending the pregnancy. (National Women's Health Information Cener, 2002) Immediate use of an emergency contraceptive reduces a woman's risk of pregnancy to 1% or 2%.

EC works in several ways: by suppressing ovulation, disrupting endometrial development to prevent implantation, and altering the effectiveness of tubal transport of the ovum. There is no evidence of increased incidence of ectopic pregnancy.

The frequency of nausea and vomiting with the progestin-only method is significantly lower. This difference also is true for dizziness and fatigue. If vomiting occurs within one hour after taking either dose, repeat dosing may be considered. *However, it seems reasonable to infer that if gastrointestinal symptoms are estrogen-mediated secondary to an effect on the central nervous system, absorption of the dose should have occurred by the time of emesis.*

EC is 95% effective when taken within 24 hours, but before 72 hours only 89% effective. Some authorities suggest that EC may effective beyond 72 hours after unprotected intercourse, but that option should be evaluated for each situation. Data do not suggest that use of oral contraceptives can interrupt an established pregnancy. The most common side effects are nausea and vomiting. Dramamine 25-50 mg, other antiemetic taken 30 minutes before the first dose, can decrease these problems.

The Yuzpe regimen consists of oral contraceptive pills for a dose levonorgestrel 0.5 mg and ethinyl estradiol 50 mcg. and repeated in 12 hours.

The Plan B option consists of two tablets, each containing 0.75 mg of levonorgestrel and is generally preferred to the Yuzpe regimen where available because it is more effective and has fewer side effects. In addition, a World Health Organization (WHO) multicenter randomized trial shows that the dose does not have to be split but can be taken as a *single 1.5-mg dose.* One dose simplifies the EC without causing an increase in side effects.

Emergency Contraception EC Methods

EC Method	Regimen
YUZPE REGIMEN *Combination oral contraceptive method*	0.1 mg of ethinyl estradiol + 1.0 mg of DL-norgestrel (equivalent to 0.5 mg of levonorgestrel) in two doses taken 12 hours apart

PREVEN PAC *Combination oral contraceptive method pre- packaged kit*	
PROGESTIN ONLY	0.75 mg of levonorgestrel
PLAN B *Progestin-only method*	0.75 mg of levonorgestrel in two doses taken 12 hours apart

A test for pregnancy should be provided prior to administering emergency contraception. However, treatment must not be delayed if test is not readily available.

Patient Education/ Discharge

After the examination and evidence collection is complete, the patient should be provided with written instructions for care and follow-up. The written information might include the following:

- A file or case number if one has been assigned.
- Instructions about what to expect after a pelvic examination, i.e.: slight bleeding or discharge, cramps.
- Any instructions for medications or follow-up care.
- Where to receive follow-up services and/or testing.
- Referral sources, rape crisis advocates, counselors, therapy groups, etc

Chain of Custody to Law Enforcement

It is important to adequately and accurately label each evidence collection envelope or package. Information required will include the patient's name, date, social security or identifying number and type of specimen (if not already on the envelope or package). It is important to date and initial on the flap after the envelope has been sealed. The date and collector's initials should be written in such a way that it is both on the flap and on the envelope. Extreme care should be taken that writing is accurate and legible.

The purpose of establishing a chain of custody is to guarantee that the items admitted into evidence at trial are authentic, i.e., that they are the same items and in substantially the same condition as those taken from the patient during the forensic examination.

The custody of an evidence collection kit and the specimens it contains must be accounted for from the moment the evidence kit is opened, through the collection process and until it is introduced in court as evidence. Therefore, anyone who handles the evidence should sign the chain of evidence document.

After the examination is complete, law enforcement is responsible for picking up and delivering the Sexual Assault Evidence Collection Kit it to the AR State Crime Lab. A log book at the facility where the exam took place should be utilized. The law enforcement officer who picks up the kit should sign it per jurisdiction and facility protocol. Follow directions on the kit for documentation of the exchange of the collection kit from examiner to law enforcement.

Complete Necessary Documentation

It is vital that the exam documentation be thorough, precise, unbiased, and accurate. Examiners should receive education on the importance of proper documentation.

Forensic examination records should be maintained separately from other records to avoid inadvertent disclosure of unrelated information and to preserve confidentiality. The medical record is stored at the exam site. The exam site should have clear policies about who is allowed access to these records. The medical record is not part of the evidence collection kit and it should not be submitted to the crime lab.

Chapter

5

5. STI Evaluation and Care

Contracting a sexually transmitted infection (STI), also commonly known as a sexually transmitted disease or STD, from assailants is typically a significant concern of sexual assault patients. Because of this concern, it should be addressed as part of the medical forensic exam.

Recommendations at a glance:

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

Offer patients STI [Sexually Transmitted Infection] information. Include information about the risks of STIs, symptoms and the need for immediate examination if symptoms occur, testing and treatment options (and the need for abstinence from sexual intercourse until treatment is completed), follow-up care, and referrals as needed. Referrals should include free and low-cost testing, counseling, and treatment offered in various sections of the community.

Encourage patients to accept prophylaxis against STIs if indicated. If prophylaxis is accepted at the time of the exam, testing is usually not indicated medically. Routine preventive therapy after a sexual assault is often recommended because follow-up with these patients can be difficult. It also may reduce the need for more expensive/extensive treatment if an STI is discovered at a later time.

Testing at the time of the initial exam does **not** typically have forensic value if patients are sexually active and an STI could have been acquired prior to the assault. Also, despite rape shield laws, there

may be a concern that positive test results could be used against patients (e.g., to suggest sexual promiscuity). *Testing for STIs should be considered on a case-by-case basis.* If prophylaxis is declined at the time of the initial exam, encourage a follow-up examination and testing. Document the patient's decision and rationale for declining prophylaxis.

Patients are offered PEP [Post-Exposure Prophylaxis] for STIs at the time of sexual assault examination. Current CDC guidelines are used to determine treatment. Chlamydia and gonorrhea are prevalent STIs that may lead to serious pelvic infections and should be treated promptly. Trichimonas and bacterial vaginosis are common STIs among sexually active females; treatment recommendation is metronidozole which should NOT be used within 72 hours of ETOH intake to avoid a disulfiram reaction. Often patients have used ETOH just prior to the sexual assault examination. Refer to current CDC Sexually Transmitted Diseases Guidelines.

CDC suggests a regimen to protect against Chlamydia, Gonorrhea, Ttrichomonas, Bacterial Vaginosis, and Hepatitis B Virus. However, Gonorrhea & Chlamydia are of particular concern due to possibility of ascending infection.

2005 PEP Recommendations

Gonorrhea PEP	Ciprofloxacin 500 mg PO in single dose
	Ceftriaxone 250 mg IM in single dose
	Ofloxacin 400 mg PO in single dose
Chlamydia PEP	Azithromycin 1 gm PO in single dose
	Doxycycline 100 mg BID x 7 days
	Amoxicillin may be used if patient is pregnant; however, this is best managed with patient's obstetrician

(CDC Sexually Transmitted Diseases Guidelines, 2002).

Encourage follow-up STI exams, testing, immunizations, counseling, and treatment if indicated. The CDC recommends that testing for syphilis and HIV infection should be repeated 6, 12, and 24 weeks **after** the assault if these infections are likely to be present in assailants. It is important that follow-up communication with patients (particularly by advocates) include a reminder to go to follow-up exams and receive STI-related testing, immunizations, and treatment as directed.

Address concerns about HIV infection. Although the risk of human immunodeficiency virus (HIV) infection from a sexual assault appears to be low, it is typically of grave concern for sexual assault patients.

Although HIV-antibody seroconversion has been reported among individuals whose only known risk factor was sexual assault or sexual abuse, the risk for acquiring HIV infection through a single episode of sexual assault is likely low. The overall probability of HIV transmission during a single act of intercourse from a suspect known to be HIV-infected depends on many factors. In specific circumstances, the probability of transmission could be high. These factors may include the type of sexual intercourse (oral, vaginal, or anal), presence of oral, vaginal, or anal trauma (including bleeding), site of exposure to ejaculate, viral load in ejaculate, and presence of a STI or genital lesions in assailants or patients. (CDC, 2002)

The use of antiretroviral agents after possible exposure through sexual assault must balance potential benefits of treatment with its possible adverse side effects. Health care personnel must evaluate patients' risk of exposure to HIV and consider whether to offer treatment based on their perceived risk. See CDC Guidelines @ http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00054952.htm

HIV Status of Source

Sexual assault patients who have had sexual or other non-occupational exposures to potentially infectious fluids of persons **known** to be HIV infected are at risk for acquiring HIV infection and should be considered for non-occupational post exposure prophylaxis [PEP] if they seek treatment within 72 hours of exposure. If possible, source persons should be interviewed to determine his or her history of antiretroviral use and most recent viral load because this information might provide information for the choice of PEP medications.

Persons with exposures to potentially infectious fluids of persons of **unknown** HIV status might or might not be at risk for acquiring HIV infection. When the source is known to be from a group with a high prevalence of HIV infection (e.g., a homosexual or bisexual man, an IV drug user, or a commercial sex worker), the risk for transmission might be increased. The risk for transmission might be especially great if the source person has been infected recently, when viral burden in blood and semen might be particularly high. However, ascertaining this in the short time available for PEP evaluation is rarely possible. When the HIV status of the source is unknown, it should be determined whether the source is available for HIV testing. If the risk associated with the exposure is considered substantial, PEP can be started pending determination of the HIV status of the source and then stopped if the source is determined to be noninfected.

Transmission Risk from the Exposure

The estimated per-act transmission risk from unprotected exposure to a partner known to be HIV infected is relatively low for different types of exposure. *(See Appendix B)* The highest levels of estimated per-act risk for HIV transmission are associated with blood transfusion, needle sharing by injection-drug users, receptive anal intercourse, and percutaneous needlestick injuries. Insertive anal intercourse, penile-vaginal exposures, and oral sex represent substantially less per-act risk.

Bite Injuries represent another potential means of transmitting HIV. However, HIV transmission by this route has been reported **rarely**. Transmission might theoretically occur either though biting or receiving a bite from an HIV-infected person. Biting an HIV-infected person, resulting in a break in

the skin, exposes the oral mucous membranes to infected blood; being bitten by an HIV-infected person exposes non-intact skin to saliva. Saliva that is contaminated with infected blood poses a substantial exposure risk. Saliva that is not contaminated with blood contains HIV in much lower titers and constitutes a negligible exposure risk.

Discuss HIV testing options. Baseline HIV testing is NOT typically an exam component. If the assault is considered a HIGH RISK for HIV exposure, patients could establish their baseline HIV status within 72 hours post assault then be tested periodically as directed by healthcare personnel. Some patients may wish to be tested even if the assault is NOT considered a high risk for HIV transmission. *HIV testing should be done in a setting where counseling can be offered to explain results and make appropriate treatment referrals as necessary.*
(Office of Violence Against Women, 2004).

Chapter

6

6. SEXUALLY ABUSED/ASSAULTED CHILDREN AND ADOLESCENTS

INTRODUCTION

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

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

Child sexual abuse has little in common with a forensic sexual assault (rape) examination of an adult. They are compared in the following table:

	Child Sexual Abuse	**Sexual Assault (Rape)**
Age of Victim	Early childhood into teens	Usually postmenarchal
Engagement	Threats, bribes, manipulation	Fear, intimidation, force
Sexual Activity	Touching, rubbing, grooming to sexual intercourse and sodomy	Attempted or actual sexual intercourse and sodomy
Perpetrator	▪ Known to child and family; family member ▪ Has an abnormal attraction to children	▪ Stranger or acquaintance ▪ Power motive
Duration	Often many years	1 to 2 times
Presentation	Disclosure occurs days or years after event	Disclosure occurs soon after event
Physical Findings	▪ Usually acute findings are absent ▪ Older, healed findings are generally absent due to the non-violent nature of the acts, delayed disclosure, and rapid healing of tissues	▪ May have acute injuries ▪ Healed injuries may be present due to delayed disclosure rather than past sexual activity
Laboratory	▪ Presentation usually too late for rape kit collection ▪ Cultures (not PCR) for GC and Chlamydia ▪ Blood drawn at presentation or 3 months after last event	▪ Rape kit collection commonly indicated ▪ Cultures for GC and Chlamydia ▪ Blood for RPR, HIV and Hepatitis B & C to be drawn initially and 3 months after event ▪ Pregnancy prophylaxis may be appropriate
Report	Child Abuse Hotline	Law Enforcement

Much remains to be learned about child sexual abuse. However, we can dispel the following myths:

MYTH	FACT
Children are abused by strangers.	About 80% of abusers are known to the child
All abusers are male.	The majority of cases involve males. The number of reported female abusers is increasing.
Victims are always female.	About 18% of suspected cases at ACH are boys.
Children fantasize about sex with adults.	Children fantasize about those things that are in their experiences. They may fantasize about romance, not sex.
Children never lie.	Children lie to stay out of trouble, not to get into trouble. More commonly they will lie to deny abuse.
Children feel negatively about the abuse.	Sometimes they have a close, warm relationship with an abusive adult. They may feel protective of that adult. The sexual touching may feel good.
Children usually tell.	Children seldom tell. When disclosure does occur, it is usually delayed and tentative.
There are usually physical findings of abuse.	In the majority of cases, especially those involving the very young child, there will be NO findings. This is compounded by the delayed reporting on the part of the child.
Emergent medical examination is needed.	Except in acute rape cases, a poorly done examination by a disinterested healthcare professional is worse than no exam.

(Arkansas Commission on Child Abuse, Rape and Domestic Violence, 2004)

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

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

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

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

Reporting

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

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

History

The initial health care provider needs information from the parent and child to determine safety and the importance of a prompt examination. Disclosure interviews of children can require patience, time, skill and experience. The interview should be performed by or in conjunction with an investigating agency, which may be local law enforcement, Arkansas State Police or the Arkansas Department of Human Services. If a health care provider alone interviews, the child will be re-interviewed by an investigator, and multiple interviews are undesirable.

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

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

Sites of Evaluation

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

- Alleged sexual abuse occurred less than 72 hours previously
- Child has urinary, genital, or rectal complaints

- Child discloses pain or bleeding associated with the sexual abuse
- Child has bruises or other signs of trauma
- Alleged perpetrator is known or believed to have a sexually transmitted disease
- Child will be exposed to the alleged perpetrator

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

- Support pediatric forensic medical issues through demonstrated leadership, quality assurance, and continuing education in child abuse issues
- Designate and support one or more physicians to be a "child abuse specialist"
- Provide a timely forensic medical response to child sexual abuse
- Administer an ongoing multidisciplinary peer review program of cases for quality improvement purposes
- Referral by appointment to a specialized center for the evaluation is best for the child and family if the history meets the criteria for delayed examination.

OVERVIEW OF PHYSICAL EVALUATION

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

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

- Diagnosis and treatment of medical conditions resulting from sexual abuse;
- Identification and documentation of evidence of abuse;
- Assessment of the child's safety;
- Differentiation of variants of normal anatomy commonly mistaken for injury;

- Diagnosis and treatment of other medical problems which may mimic abuse;
- Reassurance of the child and family when the exam is normal (since the examinations of most sexually abused girls and boys are normal);
- Referral for counseling if indicated;
- Provision of expert witness testimony.

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

- Penile Contact: disclosure of penile contact with the genitalia, anus, or mouth of a possible victim (This contact poses a risk of sexually transmitted diseases, whether or not penetration clearly occurred.)
- Painful Contact: disclosure of painful contact of a finger or object with the genital or anal areas of a possible victim (This history suggests signs of fresh or healed injury may be present.)
- Penetration Attempted: disclosure of an attempt to put a finger or object inside the genital or anal areas, whether described as successful or not (Attempt versus actual penetration is not reliably described by children.)
- Physical Symptoms: presence of such symptoms as genital or anal pain, discharge, sores, bleeding, or painful urination (These are consistent with an injury or sexually transmitted disease.)
- Perpetrator-Exposed Children: siblings or step-siblings of a patient of sexual assault who were exposed to an alleged perpetrator. (They commonly have been sexually abused in spite of denials.) They include:
  - Siblings of a child with a sexually transmitted disease (They are often infected.)
  - Children of a suspected perpetrator (They also commonly have been sexually abused and have their own reasons for denial.)
- Predisposition of Child to Deny: denial of sexual abuse when circumstances suggest it may have occurred, especially when a child:
  - Is a relative or close associate of the suspected perpetrator, one the child (or family)may wish to protect would be likely to bond with the alleged perpetrator: low self-esteem, trusting, naïve, little self confidence, affection or approval-seeking; tends to obey others;
  - Has cause for fear and anxiety: history of physical abuse, spousal violence, or significant family dysfunction;
  - Models the suspected perpetrator by displaying sexualized behavior is less than age five.

These are only guidelines, however, and not an inclusive listing.

(Kellogg, N. and the Committee on Child Abuse and Neglect, 2005)

LEVELS OF HEALTH CARE PROVIDERS

Examiners of children suspected of having been sexually abused can be considered in three categories based on training, experience, continuing education, and professional dedication to the field.

Primary (Level I) Examiners

Examinations of sexually abused children are usually performed by primary examiners because of necessity, when an examination is needed without delay for availability of a more experienced examiner. Primary examiners often are community hospital emergency department physicians. They commonly:

- Evaluate children and adolescents for evidence of acute injuries.
- Test for sexually transmitted diseases (STDs) and provide appropriate initial management.
- Address potential pregnancy issues in post-pubertal female patients.
- Refer most children to a more experienced examiner to assess for non-acute, healed injuries and make appropriate referrals and follow-up appointments.

Secondary (Level 2) Examiners

The expertise of these medical professionals is in recognition of acute injuries and examinations that are very clearly normal. They perform the following:

- Obtain a screening medical history to determine whether an examination needs to be performed immediately, or can be scheduled at a later time.
- Obtain a complete medical history, including past medical history, current symptoms, and recent treatment, if any.
- Understand the concept of differential diagnosis, and the signs and symptoms which can be caused by conditions other than abuse.
- Perform genital exams of 35 to 50 females less than age 18 per year, whether or not they are suspected victims of sexual abuse.
- Evaluate children and adolescents for evidence of acute (fresh) injuries of sexual assault/abuse utilizing photodocumentation (or drawings of findings as a less desirable alternative); recognize genital and anal findings that are clearly normal or normal variants; utilize peer review; may defer final assessment pending review of photographs or videotapes.
- Test for STDs and provide appropriate initial management.
- Address potential pregnancy issues in post-pubertal female patients.

- Collect forensic evidence as appropriate, depending on time since last incident and other factors.

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

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

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

Tertiary (Level 3) Examiners

- Have sufficient subspecialty training in pediatric medicine, emergency medicine, pediatric gynecology, family practice, or obstetrics and gynecology.

- Have had specialized training in the evaluation of child sexual abuse cases.

- Evaluate a minimum of 35 to 50 prepubescent children per year who are suspected victims of sexual abuse or have cumulative clinical experience exceeding 150 such cases.

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

- Meet at least three of the following four criteria:

  - Hold a teaching or faculty position and/or provide training and workshops on child sexual abuse related issues;

  - Have published articles or research on child abuse and neglect topics;

  - Hold membership in hospital or professional organizations on child abuse and neglect related issues;

  - Work for, or are affiliated with, a regional center for the evaluation of sexually abused children

  - Are regularly available to testify on child sexual abuse cases

  - Demonstrate ongoing continuing medical education hours or continuing education units on child abuse related issues and are current on the medical literature on child sexual abuse.

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

- Interpreting a minority of examinations (10-15%) as abnormal;

- Readily permitting review of photographic or videotape documentation of exam findings by outside experts;

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

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

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

- Using the prone knee-chest position to confirm a possible hymenal injury;

- Limiting the diagnosis or "proof" of sexual abuse from the medical exam alone to:

  - Presence of sperm;

  - Identification of perpetrator DNA in the patient;

  - Complete transaction (tear) of the hymen in the absence of a history of accidental penetrating trauma;

  - Certain sexually transmitted diseases;

  - Pregnancy.

- Adherence to an evidence-based documentation scheme in reporting the results of the physical exam. Common "findings" which are not evidence-based indicators of sexual abuse include:

  - Absence of the hymen;

  - Apparently large hymenal opening without other findings;

  - Generalized redness in genital area without bruising, bleeding, or petechiae;

  - Anal dilatation without specific measurement in different planes (directions) and notation of absence of visible stool;

  - Anal "scars" in midline.

  (Jones, J.G., 2005)

PHYSICIAN, ADVANCED PRACTICE NURSE, AND REGISTERED NURSE EXAMINERS

Each health care professional who wishes to examine sexually abused children must have the training and experience to perform at one of the three levels. Physicians, advanced practice nurses, and registered nurses are all unlikely to have had degree-specific training to be secondary or tertiary examiners, and some training regarding genital anatomy is needed to perform adequately as a primary examiner.

Some controversy, whether unfair or not, has surrounded the more non-traditional role of registered nurses who are not nurse practitioners or advanced practice nurses in the examination of children suspected of having been sexually abused. They provide examinations, identify and interpret the significance of physical findings, and testify in juvenile and criminal court proceedings under Arkansas State Board of Nursing Position Statement 98.6, which states the following:

The licensed nurse is responsible and accountable, both professionally and legally, for determining his/her personal scope of nursing practice. Since the role and responsibilities of nurses, and consequently the scope of nursing practice, is ever changing and increasing in complexity, it is important that the nurse makes decisions regarding his/her own scope of practice.

Position Statement 95-1 describes the personal decision making process regarding scope of practice.

The nursing decision to carry out a health care act should always include consideration of:

- Degree of immediate risk to the client if the action is not carried out when appropriate professional personnel are absent;
- The overall complexity of the client's healthcare problem;
- The degree of invasiveness of the act. The more invasive into the anatomical or physiological integrity of a client a task or activity is, the greater the liability of the nurse and the greater the risk to the public;
- The reversibility of the action;
- Prompt access to medical support;
- The nurse's ability to prove by documentation and appropriate knowledge and skill base that the nurse is competent to perform the act.

(Arkansas State Board of Nursing, 1998)

Some registered nurses use the designation SANE-P (Sexual Abuse Nurse Examiner – Pediatric), although the International Association of Forensic Nurses has not developed course work, standards, procedures or certification for this designation at the time of this writing (IAFN, 2006). *If an RN who is not a nurse practitioner/advanced practice nurse chooses to become a secondary level examiner, the following may be appropriate guidelines.*

- Has successfully completed the didactic and clinical component of a Sexual Assault Nurse Examiner (adult/adolescent) training in accordance with International Association of Forensic Nurse's Training Guidelines prior to taking a Pediatric Forensic Nurse Training Seminar;

- Has successfully completed the didactic and clinical components of a Pediatric Forensic Nurse Training Seminar in accordance with International Association of Forensic Nurse's Training Guidelines;

- Evaluates a minimum of 35 - 50 prepubescent children per year who are suspected victims of sexual abuse or has cumulative clinical experience exceeding 150 such cases;

- Employs diagnostic quality photodocumentation;

- Is supervised by a local medical director who is:

  - Licensed and board eligible or certified in pediatrics, family practice, gynecology, or emergency medicine

  - Participates in yearly CME on child abuse issues;

  - Peer reviews any exams with findings indicating child sexual abuse;

  - A tertiary examiner or participates in peer review with one.

- Is regularly available to testify on child sexual abuse cases;

- Demonstrates ongoing continuing medical education hours or continuing education units relevant to child sexual abuse related issues and is current on the medical literature on child sexual abuse;

- Releases photographs or videotapes of examinations on subpoena for review by other professionals designated by officers of the court, whether prosecution or defense.

SUMMARY

All healthcare professionals should understand the procedures to follow when presented with a child suspected of having been sexually abused. Medical evaluations of sexually abused children should be offered to all suspected victims. They must be performed and documented by professionals who have appropriate knowledge and clinical experience. Otherwise, children, families, community agencies, courts, and society may be harmed.

Chapter

7

7. Arkansas Law

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

The Arkansas Legislature meets every other year, in odd numbered years (2005, 2007, etc.). Should you notice that the laws as presented here are inconsistent with current laws, please contact the Arkansas Commission on Child Abuse, Rape and Domestic Violence at (501)661-7975 for an updated version.

Reporting

Reporting Sexual Assault- Adult Patients

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

The adult patient should not be required to report the incident in order to receive medical treatment. However, the patient should be told that eligibility for Arkansas Crime Victims Reparations Program Funds requires that a report to law enforcement must be filled out. This information should be shared in a non-threatening, non-biased manner.

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

Reporting Sexual Assault or Abuse- Child Patients

Reporting the sexual assault or abuse of a minor is mandatory for many professionals. Arkansas Code § 12-12-507 and §12-12-509. Reports of child abuse, sexual abuse, and neglect made pursuant to § 12-12-507 can be made to the child abuse hotline at 1-800-482-5964. All investigations shall begin within seventy-two (72) hours, however; if the notice contains and allegation of severe maltreatment, then the investigation shall begin within twenty-four (24) hours. Investigations of sexual abuse, physical abuse and neglect are conducted by the Department of Human Services Division of Children & Family Services; the Arkansas State Police Crimes Against Children Division and local law enforcement personnel pursuant to existing contracts, written or verbal agreements.

Medical Legal Examinations

Definitions

As used in this subchapter:
(A) "Appropriate emergency medical-legal examinations" means health care delivered with emphasis on the collection of evidence for the purpose of prosecution.

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

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

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

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

Procedures governing medical treatment

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

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

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

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

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

(2)(A) Should an adult victim wish to report the incident to a law enforcement agency, the appropriate law enforcement agencies shall be contacted by the medical facility or licensed health care provider or the victim's designee.

(B)(i) The victim shall be given a medical screening examination by a qualified medical person as provided under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, as in effect on January 1, 2001, if the victim arrives at the emergency department of a hospital, and the person shall be examined and treated and any injuries requiring medical attention will be treated in the standard manner.

(ii) A medical-legal examination shall be conducted and specimens shall be collected for evidence.

(C) If a law enforcement agency has been contacted and with the permission of the victim, the evidence shall be turned over to the law enforcement officers when they arrive to assume responsibility for investigation of the incident.

(c)(1) Any victim under eighteen (18) years of age shall be examined and treated, and any injuries requiring medical attention will be treated in the standard manner.

(2) A medical-legal examination shall be performed, and specimens shall be collected for evidence.

(3) The reporting medical facility or licensed health care provider shall follow the procedures set forth in § 12-12-507 regarding the reporting of injuries to victims under eighteen (18) years of age.

(4) The evidence shall be turned over to the law enforcement officers when they arrive to assume responsibility for investigation of the incident.

(d) Reimbursement for the medical-legal examinations shall be available to the medical facility or licensed health care provider pursuant to the procedures set forth in § 12-12-403.

(e) The victim shall not be transferred to another medical facility unless:

(1)(A) The victim or a parent or guardian of a victim under the age of eighteen (18) requests the transfer; or

(B) A physician, or other qualified medical personnel when a physician is not available, has signed a certification that the benefits to the patient's health would outweigh the risks to the patient's health as a result of the transfer; and

(2) The transferring medical facility or licensed health care provider provides all necessary medical records and ensures that appropriate transportation is available.

Examinations and treatment - Payment

(a) All licensed emergency departments shall provide prompt, appropriate emergency medical-legal examinations for sexual assault victims.
(b) All victims shall be exempted from the payment of expenses incurred as a result of receiving a medical-legal examination provided the following conditions are met:

(1) The assault must be reported to a law enforcement agency; and

(2)(A) The victim must receive the medical-legal examination within seventy-two (72) hours of the attack.

(B) However, the seventy-two-hour time limitation may be waived if the victim is a minor or if the Crime Victims Reparations Board finds that good cause exists for the failure to provide the exam within the required time.

(c)(1) A medical facility or licensed health care provider that performs a medical-legal examination shall submit a sexual assault reimbursement form, an itemized statement which meets the requirements of 45 C.F.R. 164.512(d), as it existed on January 2, 2001, directly to the board for payment.

(2) The medical facility or licensed health care provider shall not submit any remaining balance after reimbursement by the board to the victim.

(3) Acceptance of payment of the expenses of the medical-legal examination by the board shall be considered payment in full and bars any legal action for collection.

Reimbursement of medical facility- Rules and regulations

(a) The Crime Victims Reparations Board may reimburse any medical facility or licensed health care provider that provides the services outlined in this subchapter for the reasonable cost for such services.

(b) The board is empowered to prescribe minimum standards, rules, and regulations necessary to implement this subchapter. These shall include, but not be limited to, a cost ceiling for each claim and the determination of reasonable cost.

License suspension or revocation

Non-compliance with the provisions of this subchapter is grounds for licensure suspension or revocation pursuant to the provisions of § 20-9-215 or any other provisions governing the licensure of medical facilities or health care providers.

Sexual Offenses

Sexual Assault Definitions

(1) "Deviate sexual activity" means any act of sexual gratification involving:

(A) The penetration, however slight, of the anus or mouth of one person by the penis of another person; or

(B) The penetration, however slight, of the labia majora or anus of one person by any body member or foreign instrument manipulated by another person;

(2) "Forcible compulsion" means physical force or a threat, express or implied, of death or physical injury to or kidnapping of any person;

(3) "Mentally defective" means that a person suffers from a mental disease or defect which renders the person incapable of understanding the nature and consequences of sexual acts or unaware the sexual act is occurring. A determination that a person is mentally defective shall not be based solely on his intelligence quotient;

(4) "Mentally incapacitated" means that a person is temporarily incapable of appreciating or controlling the person's conduct as a result of the influence of a controlled or intoxicating substance:

(A) Administered to the person without the person's consent; or

(B) Which renders the person unaware the sexual act is occurring;

(5) "Physically helpless" means that a person is:

(A) Unconscious or is physically unable to communicate lack of consent; or

(B) Is rendered unaware the sexual act is occurring;

(6) "Public place" means a publicly or privately owned place to which the public or substantial numbers of people have access;

(7) "Public view" means observable or likely to be observed by a person in a public place;

(8) "Sexual contact" means any act of sexual gratification involving the touching, directly or through clothing, of the sex organs, or buttocks, or anus of a person or the breast of a female;

(9) "Sexual intercourse" means penetration, however slight, of the labia majora by a penis; and

(10) "Guardian" means a parent, stepparent, legal guardian, legal custodian, foster parent, or anyone who, by virtue of a living arrangement, is placed in an apparent position of power or authority over a minor.

Rape

(A) A person commits rape if he engages in sexual intercourse or deviate sexual activity with another person:

(1) By forcible compulsion; or

(2) Who is incapable of consent because he is physically helpless, mentally defective or mentally incapacitated; or
(3) Who is less than fourteen (14) years of age; or
(4) Who is less than eighteen (18) years of age, and the actor:
(a) The victim's guardian;
(b) Uncle, aunt, grandparent or step-grandparent, grandparent by adoption;
(c) Brother, sister or the whole or half-blood or by adoption;
(d) Nephew, niece or first cousin.
(e) It is an affirmative defense to prosecution under this subdivision (D) that the actor was not more than three (3) years older than the victim.

(B) It is not a defense to prosecution under (3) or (4) of this section that the victim consented to the conduct.

(C) It is an affirmative defense to prosecution under (3) of this section that the actor was not more than three (3) years older than the victim.

(D) Rape is a Class Y felony.

(1) A court may issue a permanent no contact order when:
(a) A defendant pleads guilty or nolo contendere; or
(b) All the defendant's appeals have been exhausted and the defendant remains convicted.
(2) If a judicial officer has reason to believe that mental disease or defect of the defendant will or has become an issue in the case, the judicial officer shall enter such orders as are consistent with Arkansas Code 5-2-305.

Sexual Assault First Degree

(A) A person commits sexual assault in the first degree if the actor engages in sexual intercourse or deviate sexual activity with another person, not the person's spouse, who is less than eighteen (18) years of age and the actor:

(1) Is employed with the Department of Correction, Department of Community Punishment, Department of Human Services, any city or county jail or juvenile detention facility, and the victim is in the custody of the Department of Correction, Department of Community Punishment, Department of Human Services, any city or county jail, or juvenile detention facility, or their contractors or agents; or
(2) Is a professional under Arkansas Code 12-12-507(b) and is in a position of trust or authority over the victim and uses the position to engage in sexual intercourse or deviate sexual activity; or
(3) Is an employee in the victim's school or school district, a temporary caretaker, or a person in a position of trust or authority over the victim. It is an affirmative defense to prosecution under this subdivision that the actor was not more than three (3) years older than the victim.

(B) Is it no defense to prosecution that the victim consented to the conduct.

(C) Sexual assault in the first degree is a Class A felony.

Sexual Assault Second Degree

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

(1) Engages in sexual contact with another person by forcible compulsion; or
(2) Engages in sexual contact with another person who is incapable of consent because the person is physically helpless, mentally defective, or mentally incapacitated; or
(3) Being eighteen (18) years of age or older, engages in sexual contact with the sex organs of another person, not the person's spouse, who is less than fourteen (14) years of age.
(4) Engages in sexual contact with another person who is less than eighteen (18) years of age and the person:
(a) Is employed with the Department of Correction, Department of Community Punishment, any city or county jail or any juvenile detention facility, and the minor is in custody at one of the facilities operated by the agency or contractor employing the person; or
(b) Is a professional under Arkansas Code 12-12-507(b) or is in a position of trust or authority over the minor; or
(c) Is the minor's guardian, an employee in the minor's school or school district, a temporary caretaker, or a person in a position of trust over the minor.

(B) It is not a defense to prosecution under (4) of this section that the minor consented.

(5) Is a teacher in a public school in grades kindergarten through twelve (K-12) and engages in sexual contact with another person who is a student enrolled in the school and who is less than twenty-one (21) years of age; or
(6) Being less than eighteen (18) years old, the person engages in sexual contact with a person not the person's spouse who is less than fourteen (14) years old.
(1) It is an affirmative defense to prosecution under this section that the person was not more than three (3) years older than the victim if the victim is less than twelve (12) years of age.
(2) It is an affirmative defense to prosecution under this section that the person was not more than four (4) years older than the victim if the victim is twelve (12) years of age or older.

(C) Sexual assault in the second degree is a Class B felony.

(D) Sexual assault in the second degree is a Class D felony if committed by a person less than eighteen (18) years of age with a person, not the person's spouse, who is less than fourteen (14) years of age.

Sexual Assault Third Degree

(A) A person commits sexual assault in the third degree if the person engages in sexual intercourse or deviate sexual activity with another person, not the person's spouse, and the person:

(1) Is employed with the Department of Correction, Department of Community Punishment, Department of Human Services, any city or county jail, and the victim is in the custody of the Department of Correction, Department of Community Punishment, Department of Human Services, or any city or county jail; or

(2) Is a professional under Arkansas Code 12-12-507(b) or a member of the clergy, and is in a position of trust or authority over the victim and uses the position to engage in sexual intercourse or deviate sexual activity.

(B) Is it no defense to prosecution under (A) of this section that the victim consented to the conduct.

(C) A person commits sexual assault in the third degree if the person being under eighteen (18) years of age, engages in sexual intercourse or deviate sexual activity with another person not the person's spouse, who is less than fourteen (14) years of age.

(D) It is an affirmative defense under (C) of this section that the person was not more than three (3) years older than the victim.

(E) Sexual assault in the third degree is a Class C felony.

Sexual Assault in the Fourth Degree

(A) A person commits sexual assault in the fourth degree if, being twenty (20) years of age or older, the person engages in sexual intercourse, deviate sexual activity, or sexual contact with another person, not the person's spouse, who is less than sixteen (16) years of age; or

(B) The person engages in sexual contact with another person, not the person's spouse, who is less than sixteen (16) years of age.

(C) Sexual assault in the fourth degree under (A) of this section is a Class D felony.

(D) Sexual assault in the fourth degree under (B) of this section is a Class A misdemeanor.

The Impact of HIPAA on Disclosure Of Patient Health Information

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

Adults

AR Code Arm 12-12-402 states that "any adult victim who presents for medical treatment for rape, sexual assault, or incest shall make the decision of whether or not the incident will be reported to a law enforcement agency." Since health professionals are not required to report, *no HIPAA exception to disclosure of protected health information for adult rape victims exists*. The patient's written permission must be

obtained utilizing a form that meets HIPAA standards. The form utilized in the Arkansas Children's House of the University of Arkansas College of Medicine is Appendix C.

Persons Less Than Age 18 or Mentally Incompetent

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

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

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

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

Accounting Versus Obtaining Authorization for Disclosure

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

- A disclosure required by law;
- A disclosure to a law enforcement official;
- A disclosure pursuant to a subpoena, court order, warrant or during testimony given in court;
- A disclosure to a coroner, medical examiner, funeral director or to an organ procurement organization such as ARORA;
- A disclosure to a health oversight agency responsible for overseeing the health care system.

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

Forms

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

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

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

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

Penalty for Violation of HIPAA

HIPAA violations carry fines and penalties that would be assessed against a covered entity or an individual. A staff member who caused the privacy breach could be held accountable for any financial penalties the covered entity incurs – either by way of HIPAA violations or private actions. (American Academy of Pediatrics, 2004).

Disclaimer

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

Chapter

8

8. Testifying in Court

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

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

When preparing to testify the following guidelines may be useful:

- Meet with the prosecuting attorney in advance, if possible.

- Some prosecutors, if asked, may agree to let the medical witness be on call for the hearing with 30 minutes notice.

- Refresh your memory about the case. Do not rely on your memory alone. Some cases may not come to trial for months or years after the event. Review written charts or records of the examination.

- Be prepared as an expert witness to educate the court, particularly the jurors. Consider in advance the terminology and descriptions that will most clearly advise the lay members of the court about the procedures, symptoms, etc. that are involved in the case.

- Remember that anything that you write about the case is potentially 'discoverable'. This means that it could be brought before the court as part of your testimony or to refute your testimony. You may be asked about any notes you have written or files you have concerning this case. If you have made notes or files about a case, you might discuss these with the prosecuting attorney.

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

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

During the testimony, it may be helpful to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Listen to the questions fully and carefully.

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

ARKANSAS SYSTEM FOR JUVENILE SEXUAL ASSAULT PATIENTS

Reporting to the Child Abuse Hotline

Arkansas law requires that professionals must report all sex crimes involving children less than age 18 to the Arkansas State Police Child Abuse Hotline. Civil and criminal penalties for failure to report may apply. The requirement includes reporting of teenage victims in the following situations:

- Indecent Exposure
- Sexual Contact
- Oral Sex
- Sexual Penetration

Your report initiates an investigation and assessment of safety. The telephone number of the Hotline is 800-482-5964.

Investigations

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

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

Court Proceedings

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

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

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

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

Sharing of Protected Health Information

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

- Consent of a legal guardian to provide information to relatives of the sexual assault patients;
- A subpoena for a medical affidavit unless the patient is in DHS custody;
- Consent of the sexual assault patient's guardian to provide information to a defense attorney, unless a prosecuting attorney is present. (This applies even when one has a subpoena from a defense attorney);
- A subpoena in order to testify in court.

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

Chapter

9

9. Reimbursement

Crime Victims Reparation Fund

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

It is the intent of Act 817 to provide compensation for expenses incurred as a direct result of the criminal acts of other persons. Examples of economic loss covered under the law are: medical care, rehabilitation, funeral expense, work loss and mental health treatment. The maximum award is $10,000; however, for victims receiving catastrophic injuries resulting in total and permanent disability on or after August 1, 1999, the maximum award is $25,000. The law does not cover property loss or pain and suffering.

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

- The crime/victimization must have been reported to the proper authorities within 72 hours.
- An application for help must be submitted to the Crime Victims Reparations Board within one-year of the date of the crime/victimization.
- The victim must cooperate with the investigation/prosecution.
- The victim must not have contributed to the crime/victimization.
- The victim must not have been convicted of a criminally injurious felony.

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

SEXUAL ASSAULT REIMBURSEMENT PROGRAM

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

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

In order for a medical facility to seek reimbursement for the expenses incurred while performing the medical-legal examination, the victim must seek treatment within seventy-two (72) hours, except in the case of a minor. A request form for reimbursement must be completed and signed by a physician or sexual assault nurse examiner who performs the examination. In addition, law enforcement or a victim assistance coordinator must sign the reimbursement form verifying that a report was made to law enforcement of the alleged assault. The reimbursement form and an itemized statement should then be submitted to the Attorney General's Office.

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

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

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

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

Medical facilities that transfer or receive a transferred patient alleging to have been sexually assaulted must complete the area on the sexual assault reimbursement form. In these instances, the Sexual Assault Reimbursement Program will not disburse any payments for eligible expenses to either medical facility until the necessary documentation and itemized billing statements are submitted from both the

transferring and receiving facility. This documentation includes justification of the decision to transfer the alleged victim. In these instances, the medical facilities must share the allowable award ceilings outlined in the Sexual Assault Reimbursement Program's Policies and Procedures. The Arkansas Crime Victims Reparations Board will determine the appropriate portion of the ceiling for each medical facility on a case-by-case basis.

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

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

For additional information or an application, please contact:

Arkansas Crime Victims Reparations Board
Office of Attorney General Mike Beebe
Catlett-Prien Tower Building
323 Center Street, Suite 1100
Little Rock, Arkansas 72201
(501) 682-1020 or 800-448-3014 (outside Pulaski County)

Office of the
Arkansas Attorney General
Mike Beebe

ARKANSAS CRIME VICTIMS
REPARATIONS BOARD

SEXUAL ASSAULT REIMBURSEMENT
PROGRAM

Reimbursement will be made ONLY on the following conditions:

1. Treatment is sought and rendered within 72 hours of the assault. (This will be waived if the victim is a minor or if good cause is shown);
2. The incident was reported to a law enforcement agency;
3. Treatment was not for a pre-existing injury, a physical injury directly relating to the assault, or any other condition; and
4. The victim is not covered by a federally financed benefits program, such as Medicaid, Medicare, Champus or VA.

This stipulation has been made pursuant to a VOCA amendment adopted as a part of the Crime Bill.

SEXUAL ASSAULT VICTIM INFORMATION

Victim's name

____

Victim's date of birth ____________________ Social Security No. ______________

Victim's full address

____

____

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

____

Date and time of assault

____

Date and time treatment sought

____

Name and address of law enforcement agency notified

____

____

Name and address of medical facility rendering treatment

____

____

Telephone number ________________________ Contact person ________________

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

____

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

____

Transferred victims:

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

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

____

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

ATTENDING PHYSICIAN'S OR SANE CERTIFICATION

Brief description of examination, treatment and tests

____

____

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

Physician's or SANE signature____________________________________ Date ______

LAW ENFORCEMENT OR VICTIM ASSISTANCE COORDINATOR

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

____

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

Title/Agency

____

Date ______________________________ Badge Number ____________________

Pursuant to Arkansas Code Annotated 12-12-404, the Crime Victims Reparations Board will reimburse a medical facility for costs incurred in performing a medical-legal examination and tests for venereal disease on sexual assault victims. The medical facility must complete all sections and obtain the physician's certification and the law enforcement/victim witness coordinator/verified victim advocate's certification. A copy of the *itemized* bill (including current procedural terminology (CPT) codes), along with any other relevant information to substantiate the claim must be attached to this form to ensure payment. *NOTE: In compliance with Arkansas Code Annotated 12-12-403, the medical facility or licensed health care provider shall not submit any remaining balance after reimbursement by the Arkansas Crime Victims Reparations Board to the victim. Additionally, acceptance of payment of the expenses of the medical-legal examination by the Arkansas Crime Victims Reparations Board shall be considered payment in full and bars any legal action for collection.* Information should be forwarded to:

Arkansas Crime Victims Reparations Board
323 Center Street, 1100 Catlett-Prien Tower Building
Little Rock, AR 72201
Phone Numbers: 1-800-448-3014 or (501) 682-1020
Fax: (501) 683-5569 or (501) 682-5313

Chapter

10

10. Follow-up Services and Referrals

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

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

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

Sexual Assault State and Nationwide Resources

1-800 helpline telephone numbers, national and statewide

AGENCY	**PHONE**
Adult Protective Services	1-800-482-8049 or 501-682-8491
Arkansas Crime Victims Reparation Board	1-800-482-8982 or 501-682-1323
National Victims Resources Center	1-800-627-6872
Suicide Crisis Hotline	1-800-784-2433
V.D. National Hotline	1-800-227-8922
R.A.I.N. (Rape, Abuse and Incest National Network)	1-800-656-HOPE

LOCAL RESOURCES

Program Name	Address	Phone	Hotline	Email	Area Served
Benton County Women's Shelter and Rape Crisis Center	P.O. Box 572 Bentonville, AR 72712	479-273-5702	479-273-0730	bcws@cox-internet.com	Benton, Madison, Washington and Carol
Child Advocacy Center	530 Jefferson Camden, AR 71701	870-837-1940		cac13jd@arkansas.net	Quachita, Calhoun, Columbia, Union, Cleveland and Dallas
Courage House	P.O. Box 924 Arkadelphia AR 71923	870-246-3122	870-246-2587	AWAC1@sbcglobal.ne	Clark, Nevada and Hot Springs
Covenant Ministries	P.O. Box 719 Mena AR 71953	479-394-7745	479-394-2999	edith@voltage.net	Polk, Montgomery, Sevier, Howard and Pike
Crisis Center for Women	401 Lexington Avenue Fort Smith AR 72901	479-782-1821	800-359-0056	jcanada@crisiscenterforwomen.org www.crisiscenterforwomen.org	Crawford, Franklin, Sebastian, Logan, Scott and Polk
Domestic Violence Prevention, Inc.	P.O. Box 712 Texarkana, AR 75504	903-794-4000	800-876-4808	gpmdvp@aol.com	Miller, Little River, Hempstead, Lafayette and Sevier
Family Service Agency- Rape Crisis	628 W. Broadway North Little Rock, AR 72118	501-801-2700	877-432-5368	hmcnamer@fsainc.org www.helpingfamilies.org	Pulaski, Faulkner and Jefferson
Family Violence Prevention-S.A.I.L.	P.O. Box 2943 Batesville, AR 72503	870-698-0006	800-894-8821	Sail112002@yahoo.com	Independence and Izard
Northwest Arkansas Rape Crisis	614 E. Emma Suite 247 Springdale AR 72765	479-927-1025	800-794-4175	randolph@jtlshop.jonesnet.org www.nwrapecrisis.com	Benton, Madison and Washington
Options	P.O. Box 554 Monticello, AR 71657	870-367-7450	877-977-3488	noble@seark.net	Ashley, Bradley, Chicot, Desha and Drew

Ozark Family Development Center, Inc.	P.O.Box 683 124 Woodland Hills Rd., Ste E (Hardy 72542) Cherokee Village AR 72525	870-856-4119	888-659-RAPE	donnaofdc@pokeynet.com	Sharp
Ozark Rape Crisis	715 W. Main, Suite A Clarksville AR 72830	479-754-6869	800-818-1189	orcc@mail.cswnet.com www.ozarkrapecrisis.com	Boone, Carroll, Newton, Marion, Searcy and Johnson
Prosecuting Attorney's Rape Crisis Program	101 W. Barraquet Pine Bluff, AR 71601	870-541-5387		cmenotti@jeffpa.com	Jefferson and Lincoln
Serenity, Inc.	P.O. Box 1111 Mountain Home AR 72654	870-424-7576	870-424-SAFE	Serenity@mtnhome.com	Baxter, Fulton, Stone, Sharp, Marion and Izard
Southwest Arkansas Domestic Violence Center	P.O. Box 87 DeQueen, AR 71832	870-584-3441		Thehouse1@alltel.net	Howard, Sevier, Pike and Polk
Stone County Abuse Prevention	P.O. Box 689 Mountain View, AR 72560	870-269-9941	870-269-4888	Scap_outreach@excite.com	Stone and Searcy
The Family Center, Inc.	406 Pecan Street Helena, AR 72342	870-338-8447		ggiles@ipa.net	Cross, Phillips, Lee, Monroe, St. Francis, and Woodruff
Union County Family Violence Center (Turning Point)	Simmons First Plaza 100W. Grove, Suite 301 El Dorado, AR 71730	870-862-3672		Turningpoint2vip@sbcglobal.net	Union, Columbia, Ouachita and Bradley
UCA-Counseling Center	201 Donaghey Conway, AR 72033	501-450-3138		reesar@mail.uca.edu	Faulkner
U of A-Fayetteville-University Health Center	120 Ozark Hall Fayetteville AR 72701	479-575-3845		mwyandt@comp.uark.com	Washington
Victim Services	844 Faulkner Conway, AR 72032	501-450-3051		khudson@faulkner.org	Faulkner
Women's Crisis Center of Northeast Arkansas	P.O. Box 721 Jonesboro, AR 72403	870-972-9575	866-982-9575	wccnea@sbcglobal.net	Craighead, Greene, Lawrence, Clay, Mississippi, Poinsett, and Randolph

Information You Should Have as a Sexual Assault Survivor

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

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

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

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

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

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

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

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

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

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

Sexual Assault Exam

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

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

Legal Issues

In Arkansas, rape and sexual assault are criminal offenses. The hospital staff is required by Arkansas law to call law enforcement (police or sheriff). You have the right to decide if you want to talk with the police/ sheriff. **Talking to the police/ sheriff does not mean that you have to press charges.** We encourage you to talk with the police/ sheriff so there will be a record of this crime.

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

Who will pay for this?

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

Follow-up Medical Care

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

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

Support Services

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

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

Things You Can Do

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

Resources

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

Arkansas Commission on Child Abuse, Rape and Domestic Violence
501-661-7975
www.accardv.uams.edu
Arkansas Coalition Against Sexual Assault
1-866-63ACASA
www.acasa.ws
Rape, Abuse, & Incest National Network (RAINN)
1-800-656-HOPE.
www.rainn.org.

Always remember that you are a survivor.

Helping Your Son or Daughter After Sexual Assault

Common Reactions

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

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

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

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

Things You Can Do

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

Thing you can say

- Tell your child you believe him/her and thank them for trusting you enough to tell you about the abuse.
- Let your child know you will do everything in your power to keep them safe.

- Let your child know that his/ her feelings and reactions are normal.
- Tell your child the sexual assault is not his/ her fault.
- Tell your child not to worry about you- it is your job to worry about him/ her.
- Be honest with your child about specific things that are happening.

What is Next?

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

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

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

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

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

Arkansas Commission on Child Abuse, Rape and Domestic Violence
501-661-7975
www.accardv.uams.edu
Arkansas Coalition Against Sexual Assault
1-866-63ACASA
www.acasa.ws
Rape, Abuse, & Incest National Network (RAINN)
1-800-656-HOPE.
www.rainn.org.

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

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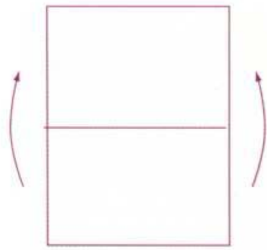
APPENDIX A

Folding a Bindle



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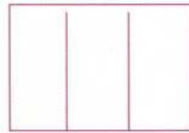
Fold the paper in half.



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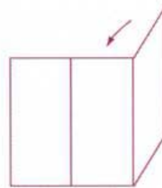
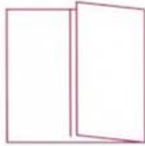
Fold the half-sized paper into thirds.



3
Fold over the right flap.



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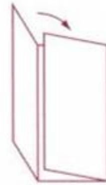

5
Fold over the left flap.

6

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

APPENDIX B

STI's Information for Sexual Assault Patients

FROM: *MMWR* January 21, 2005.

The most effective means of preventing human immunodeficiency virus (HIV) infection is preventing exposure. The provision of antiretroviral drugs to prevent HIV infection after unanticipated sexual or injection-drug--use exposure might be beneficial. The U.S. Department of Health and Human Services (DHHS) Working Group on Nonoccupational Postexposure Prophylaxis (nPEP) made the following recommendations for the United States. For persons seeking care <72 hours after nonoccupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person known to be HIV infected, when that exposure represents a substantial risk for transmission, a 28-day course of highly active antiretroviral therapy (HAART) is recommended. Antiretroviral medications should be initiated as soon as possible after exposure. For persons seeking care <72 hours after nonoccupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person of unknown HIV status, when such exposure would represent a substantial risk for transmission if the source were HIV infected, no recommendations are made for the use of nPEP. Clinicians should evaluate risks and benefits of nPEP on a case-by-case basis. For persons with exposure histories that represent no substantial risk for HIV transmission or who seek care >72 hours after exposure, DHHS does not recommend the use of nPEP. Clinicians might consider prescribing nPEP for exposures conferring a serious risk for transmission, even if the person seeks care >72 hours after exposure if, in their judgment, the diminished potential benefit of nPEP outweighs the risks for transmission and adverse events. For all exposures, other health risks resulting from the exposure should be considered and prophylaxis administered when indicated. Risk-reduction counseling and indicated intervention services should be provided to reduce the risk for recurrent exposures

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STIs	Symptoms	PEP
GONORRHEA	Usual sites of infection include the urethra, inside the mouth of the uterus, anus, and throat. The bacteria may also cause infection of the Fallopian tubes in women, sometimes resulting in abscesses, and in the male may cause abscess formation in the urethra area as well as infection of the duct where sperm is stored. Symptoms in the **female** include vaginal discharge, dysuria, polyuria, abnormal menstrual bleeding, anal discomfort, and sore throat. Infection may extend into the pelvis causing Pelvic Inflammatory Disease [PID] which can lead to infertility. Symptoms in the **male** include a purulent urethral discharge, dysuria, and polyuria. Those symptoms usually begin two to six days after exposure to the bacteria. Infection of the anal canal and throat are common as a result of oral and anal sex with infected partner. Symptoms of anal infection include anal burning, itching, pain or discharge. Infection of the throat may result in soreness with purulent material visible on the tonsils, or back of the throat.	RECOMMENDED
CHLAMYDIA	In **women**, the bacteria initially attack the cervix and the urethra. The few women with symptoms might have an abnormal vaginal discharge or a burning sensation when urinating. Lower abdominal pain, low back pain, nausea, fever, painful intercourse, bleeding between menstrual periods, and may be asymptomatic. When infection spreads to the upper reproductive system, permanent	RECOMMENDED

	damage can occur. **Men** have a penile discharge, burning sensation when urinating, swelling in the testicles, or may be asymptomatic.	
Trichomonasis	**Women** report foul smelling or frothy green vaginal discharge, vaginal itching & redness, painful intercourse, lower abdominal discomfort, urge to urinate, and may be asymptomatic. Most men are asymptomatic. The most common symptoms are urethra discharge, urinary urgency & burning.	NOT RECOMMENDED MAY USE PEP (Metronidaxole 2 gm PO in single dose)
Bacterial Vaginosis [BV]	Women with BV may have a vaginal discharge with an unpleasant odor. Often it is a strong fish-like odor, especially after intercourse. Discharge may be white or gray. Women with BV may also have dysuria and itching around the outside of the vagina. Some women are asymptomatic.	NOT RECOMMENDED MAY USE PEP (Metronidaxole 2 gm PO in single dose)
Hepatitis B [HBV]	Signs & symptoms include: jaundice, fatigue, abdominal pain, loss of appetite, nausea, vomiting, & joint pain. May be asymptomatic.	MAY USE PEP (begin HBV immunizations) Protected if completed full HBV vaccinations prior to assault. Unless suspects are known to have acute hepatitis B, HBIG (hepatitis B immune globulin) is not required. (When HBIG is needed, use CDC recommended doses.)
Genital Herpes [HSV-2]	Sores (blisters) around the vagina, on the penis, or near the anus. Sometimes sores appear on the scrotum, buttocks, or thighs. The sores usually begin as a rash of red bumps that turn into blisters. It is common for the blisters to open up, sometimes causing severe pain. In time, the sores will scab over and heal. The first outbreak, symptoms: Swollen glands in the groin, vaginal or penile discharge, dysuria or difficult urination, fever, headache, and muscle aches.	NOT AVAILABLE
Syphilis	Infected people may not have symptoms for years, yet remain at risk for late complications if untreated. Presents in 3 stages: **Primary Stage** is marked by a single sore (chancre) about 21 days after infection. The chancre is usually firm, round, small, and painless. It appears at the spot where syphilis entered the body. The chancre heals in 3 to 6 weeks, but without treatment the infection progresses. **Secondary Stage** is characterized by a skin rash. This stage typically starts with the development of a non-pruritic rash that is rough, red, or reddish brown spots on the palms of the hands and the bottoms of the feet. Also, symptoms may include fever, lymphadenopathy, sore throat, patchy hair loss, headaches, weight loss, muscle aches, and fatigue. Secondary stage symptoms will resolve, but without treatment the infection will progresses. **Latent Stage** (hidden phase) begins when secondary	NOT RECOMMENDED

	symptoms disappear. Without treatment, the infection remains in the body. Over time, it may damage the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints. Signs and symptoms of the late stage of syphilis include difficulty coordinating muscle movements, paralysis, numbness, gradual blindness, and dementia.	
Genital Warts [HPV]	Genital warts (condylomata acuminata) are soft, moist, or flesh colored lesions in the genital area. They may appear in clusters that resemble cauliflower-like bumps, and are either raised or flat, small or large. In **women**, lesions are on the vulva, cervix, inside and surrounding the vagina, and anus. In men, lesions are on the scrotum, penis, and anus. High-risk HPV may cause abnormal Pap smear results, and could lead to cancers of the cervix, vulva, vagina, anus, or penis.	NOT AVAILABLE
HIV	Flu-like symptoms, unexplained weight loss, fever, extreme fatigue, diarrhea, & lymphadenopathy. May be asymptomatic.	MAY USE PEP (Case-by-case basis)

APPENDIX C

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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

____
Patient Name/Date of Birth``

2. I authorize disclosure of the information indicated below **to all of the persons/entities listed below unless noted otherwise:**

AR State Police
Juvenile court of ___________County(s) & its agents
Police Department of the city(s) of _______________
Prosecuting attorney of ________________County(s)
Sheriff's Office of _____________________ County(s)
Child Maltreatment Multidisciplinary Team of
AR Dept of Human Services of ___________County(s)
___________________________________County.
Circuit court of ____________County(s) & its agents
Other:_____________________________________

(Note: We are required by law to provide information to certain state agencies when child maltreatment has been suspected.)

3. Information to be released
   _____Discharge Summary _____Operative Report _____Clinic Report _____Medical Abstract
   _____Social History _____Psychiatric Evaluation _____X-Ray & Lab _____Substance Abuse
   _____Psychological Evaluations _____Education Information _____ER Report _____History/Physical
   _____Diagnosis _____Treatment Plan _____Progress Notes
   _____Other : ____

4. Released information is needed for:
   _____ Continuity of Care _____ Legal Reasons _____ School
   _____ Disability _____ Insurance

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

6. I release __________________________and its staff from responsibility or liability for the release of the above information to the extent indicated and authorized herein.

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

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

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

____
Patient Name

____
Signature of Parent/Guardian

____
Legal Relationship To Child

____
Witness

____
Date

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

ADDITIONAL RESOURCES