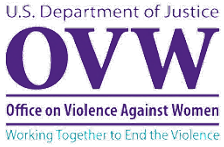
U.S. Department of Justice

Office on Violence Against Women

National Training Standards for Sexual Assault Medical Forensic Examiners

U.S. Department of Justice Office on Violence Against Women

Second Edition – August 2018



This document is intended to be a voluntary blueprint for training medical forensic examiners to provide specialized care to patients who have been sexually assaulted or abused. It is a tool to assist in the development or revision of training programs. The document itself has no force or effect of law and does not create any legally binding rights or obligations binding on persons or entities. To the extent that this document uses terms such as "should," or "may," OVW is making nonbinding recommendations, not issuing requirements. Alignment of training programs with these standards is voluntary and deviation from the standards will not, in itself, result in any enforcement action.

Acknowledgments

Many individuals contributed their skills and expertise to the development and update of this *National Training Standards for Sexual Assault Medical Forensic Examiners*. Special appreciation goes to the International Association of Forensic Nurses for its leadership in developing updated training standards. We are grateful to the many experts—reflecting the work of a variety of federal, state, tribal and community entities—who took the time to review and comment on these standards.

Foreword

A National Protocol for Sexual Assault Medical Forensic Examinations: Adolescents/Adults (SAFE Protocol) was initially released in September 2004 and updated with revisions in 2013. It provides details on the roles of responders to sexual assault and abuse as one aspect of a coordinated community response. In 2006, the *National Training Standards for Sexual Assault Medical Forensic Examiners (Training Standards)* was released as a companion to the *Protocol* with recommendations for training objectives and topics for examiners who provide care to adolescent/adult patients of sexual assault and abuse. Then in 2016, *A National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatric (Pediatric SAFE Protocol)* was released, offering long-awaited guidance on responding to the sexual abuse of prepubescent children. As a result, the *National Training Standards*, a companion to the protocols, has been updated to include recommendations for training objectives and topics that will provide a blueprint for training examiners to provide specialized care to patients who have experienced sexual violence and abuse using the recommendations of both protocols. The *Protocols* and *Training Standards* take a victim-centered, trauma-informed approach to sexual assault medical forensic examinations. We hope the updated standards will be useful for communities that plan to establish or enhance training programs for forensic examiners.

Contents

Intended Audience

The intended audience for the *National Training Standards* are clinicians (registered nurses, advanced practice nurses, physician assistants and physicians) who have been specially trained to provide comprehensive, specialized care to patients[1] who present with known or suspected sexual assault or abuse, including the medical forensic examination, evidence collection and testimony. Patients who have experienced sexual assault and abuse have a variety of complex concerns at the time of the examination, such as safety; injury; pregnancy and disease risk; legal reporting and evidence collection options and requirements; and both short- and long-term health sequelae. For these reasons it is critically important that healthcare facilities provide specially trained examiners to properly provide care for this patient population. For communities unable to provide specially trained examiners, Appendix C outlines the training **all providers** should have prior to performing an examination on a patient who has been sexually assault or abused.

[1] The term *patient* is commonly used in this document to denote a person who presents for medical forensic care following disclosure of sexually abuse, sexual assault or a suspicion of such. At times, however, the term *victim* is used rather than *patien*t. The use of the term *victim* and/or *survivor* is simply meant to acknowledge a person who has disclosed having been sexually assaulted/abused and who should have access to certain services and interventions designed to help them be safe, recover and seek justice. Suspects are not addressed in these training standards. Clinicians are encouraged to refer to community/organizational protocols for guidance on completing suspect exams. See also, SANE Program Development and Operation Guide, Resource List (Suspect Exams).

Introduction

This second edition of the *National Training Standards for Sexual Assault Medical Forensic Examiners (Revised Training Standards)* offers a framework for the specialized education of healthcare providers who wish to practice as sexual assault medical forensic examiners. A growing trend across the United States is the use of sexual assault nurse examiners (SANEs) to conduct the examination. SANEs are registered and advanced practice nurses who receive specialized education and fulfill clinical requirements to perform these examinations. To identify a broader array of clinicians providing sexual assault medical forensic examinations, communities may use the terms *sexual assault forensic examiner* (SAFE), *sexual assault medical forensic examiner* (SAMFE) and *sexual assault examiner* (SAE) rather than SANE (these alternate terms are inclusive of physicians and physician assistants, as well as registered nurses and advanced practice nurses, such as nurse practitioners and certified nurse midwives). All sexual assault medical forensic examiners (SANEs, SAMFEs, SAFEs and SAEs) have received specialized education and completed clinical requirements to perform the medical forensic sexual assault and sexual abuse examination.[2] These clinicians manage the entire patient encounter—from the beginning of the medical forensic examination to discharge and referral planning. For the purposes of this document, the acronym SAFE[3] will be used, except when referring to specific disciplines within the field.

Clinicians who may be involved in assisting with a portion of the examination or specimen collection process may benefit from many aspects of SAFE training without necessarily needing training to the extent set forth in the *Revised Training Standards*.

The standards recommend **minimum** guidelines for didactic and clinical preparation of pediatric and adolescent/adult SAFEs. The use of these standards across all U.S. jurisdictions[4] will improve uniformity of SAFEs' knowledge and skills. The goal is that every person who reports or discloses sexual assault, or in the case of children where sexual abuse is suspected, will have access to a specially educated and clinically prepared SAFE. The SAFE can validate and address the patient's health concerns; minimize their trauma; promote their healing, agency and autonomy; and maximize the detection, collection, preservation and documentation of evidence for potential use by the legal system. Uniformity in SAFE education can improve consistency of service provision and aid in evaluating the effectiveness of examiner response. In addition, the use of these standards is meant to support a coordinated community response to sexual assault and abuse, promote responses that recognize and address the unique needs and circumstances of each patient and support the caregivers in all cases. Consistent with both protocols, the *Revised Training Standards* emphasize the healthcare focus of SAFEs, while also attending to issues, such as evidence collection and collaboration, inherent to the profession.

Some SANE-trained nurses have become board certified in the adolescent/adult or pediatric/adolescent populations (referred to as SANE-A® or SANE-P®) through the International Association of Forensic Nurses (IAFN).[5] Additionally,

[2] *National SAFE Protocol,* p. 16.

[3] Some clinicians, such as board-certified child abuse pediatricians, may not use the SAFE acronym. No requirement exists that clinicians do so. Ultimately, this document focuses more on the role clinicians fill, and less on the label they use to describe that role. The use of SAFE in this document simply allows for a single term to identify a variety of clinicians providing medical forensic care to patients who have experienced sexual assault and sexual abuse.

[4] The term *jurisdiction* may be used in two ways in this document. One is to broadly describe a community that has the authority to govern or legislate for itself. For example, a jurisdiction may be a locality, state, territory, tribal land or federal land. The term also includes the authority to interpret and apply laws, and is used in this context primarily when identifying the entity that has "jurisdiction" over a particular case.

[5] A handful of states require separate SANE credentialing, generally applicable only to registered nurses (exempting advanced practice nurses, physician assistants and physicians). A link to the state-specific credentialing programs can be found at https://www.ovcttac.gov/saneguide/management-of-sane-programs/sexual-assault-nurse-examiners/. However, this credentialing is not simply a state version of the IAFN board certification; state credentialing

several states have adopted their own specific SANE credentialing processes. Pediatricians can seek board certification as child abuse pediatricians through the American Board of Pediatrics; an equivalent board certification does not exist for physicians who provide care to adult abuse patients. Currently, no similar board certification is available for physician assistants.

Board-Certified Child Abuse Pediatricians

Pediatricians can seek board certification in the specialty field of child abuse pediatrics through the American Board of Pediatrics (ABP). Requirements for specialty board certification include holding current board certification in general pediatrics by the ABP, completion of an accredited three-year fellowship training in child abuse pediatrics or approved practice-path training and passage of a knowledge assessment board examination. The ABP provides Maintenance of Certification requirements for pediatricians to maintain certification (including continuing education, knowledge assessment and participation in quality improvement projects). A child abuse pediatrician has advanced training for pediatric patients from birth up to age 18 years in the evaluation and management of all forms of child maltreatment (sexual abuse, physical abuse, neglect, etc.) which exceeds the standards outlined in the *National Training Standards for Sexual Assault Forensic Medical Examiners*.

No equivalent board certification currently exists for physician assistants, advanced practice nurses or physicians in other fields of medicine (such as family medicine or emergency medicine) who may care for pediatric patients. There is also no equivalent board certification program for those physicians, physician assistants or advanced practice nurses who provide care to adult patients who have experienced abuse. However, without holding the designation of Child Abuse Pediatrician, physicians and advanced practice providers trained in the overall assessment of pediatric health conditions can seek additional training and work as specialty providers in the care of pediatric patients who have been abused.

The *Revised Training Standards* provide guidelines to prepare SAFE candidates to work in coordination with other responders to meet the healthcare, forensic and resource needs of patients across the lifespan who have been sexually assaulted or abused. These standards are intended to guide those who develop, revise, coordinate and/or conduct SAFE training regarding the minimum levels of instruction necessary to prepare candidates for their role.

The *Revised Training Standards* differs from the original document, most notably with the addition of targeted content based on the recently published *Pediatric SAFE Protocol*. Updates to the *Training Standards* also reflect the progress the healthcare field has made in attending to the comprehensive care of patients of all ages who have been sexually assaulted or abused. In addition to the two protocols, the *Training Standards* incorporate other national guidance, including the *SANE Education Guidelines*, published by the International Association of Forensic Nurses; the *National Children's Alliance Standards for Accredited Members;* the *SANE Program Development and Operation Guide*, published by the

requirements focus on entry into practice, and are mandatory in certain states. IAFN board certification demonstrates that an individual "has demonstrated the highest standards of forensic nursing" and is optional, although encouraged, for practice.

Office for Victims of Crime; and the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*.

This document is meant to be a tool to assist in the development or revision of SAFE training programs across the country. Because the standards are minimum recommendations, they enable those who create and provide basic SAFE education to customize training programs that address a diverse range of practice settings and community-specific needs. When planning trainings, trainers should familiarize themselves with federal, state, tribal or agency requirements (military, Indian Health Service) to ensure all existing guidance and regulations are met, where applicable.

Diversity considerations, including cultural and accessibility considerations, are an integral component of this document and the training of sexual assault forensic examiners. A wide range of patient populations seek care, and an individual's identity may impact how they perceive and receive care. In addition to cultural adaptations, it is essential that the SAFE be knowledgeable about high-risk populations that are vulnerable to sexual victimization—such as those who have intellectual, physical and/or developmental disabilities—and be prepared to provide care with any necessary accommodations for the examination.[6]

[6] Generally speaking, *culture* is a body of learned beliefs, traditions and guides for behaving and interpreting behavior that is shared among members of a particular group (Blue, n.d.). In the protocols and this accompanying training standards document, a *cultural group* refers not only to ethnic or racial groups, but also other groups with distinct cultures. Examples include faith communities; deaf and hard-of-hearing communities; lesbian, gay, bi-sexual and transgender individuals; immigrants; refugees; individuals at risk of or experiencing homelessness; military personnel and their dependents; and individuals in detention settings, foster care systems, boarding schools and other residential settings. One culture may be closely connected to another (e.g., an ethnic group may be rooted in religious and/or spiritual beliefs of a particular faith community). Individuals often belong to multiple cultural groups. Note that cultural beliefs may or may not affect a child's experience of sexual abuse, the related reactions of the child and caregiver and preferred approaches to emotional support, healing and justice (adapted from DeBoard-Lucas et al., 2013). If culture is influential in this regard, responders can offer to help children and caregivers to access cultural resources during the examination process and beyond.

Background

The Office on Violence Against Women (OVW) developed the original *Training Standards* under the direction of the Attorney General, pursuant to the Violence Against Women Act (VAWA) of 2000.[7] The standards were based on recommendations in the *SAFE Protocol*, which describes the examination process and associated responsibilities of healthcare personnel, as well as the responses of other professionals related to this process.[8] In creating the *Revised Training Standards*, OVW collaborated with the International Association of Forensic Nurses (IAFN) to gather input from veteran SAFE trainers and SAFEs (both nurses and physicians), survivors of sexual assault and sexual abuse, advocates for victims of sexual assault and sexual abuse, law enforcement representatives, prosecutors and forensic scientists. Since the development of the original *Training Standards*, the following recently developed education and accreditation standards have helped inform the recommendations in the second edition:

- *International Association of Forensic Nurses (IAFN) Sexual Assault Nurse Examiner Education Guidelines*
- *National Children Alliance (NCA) 2017 Standards for Accredited Members*
- *U.S. Indian Health Service Policy, Indian Health Manual Part 3-Professional Services, Chapter 29: Sexual Assault*[9]
- *IAFN SANE-A® and SANE-P® Certification Eligibility Requirements*
- *Department of Defense and Service-Specific Criteria for Sexual Assault Medical Forensic Examiner (SAMFE) Eligibility*

Purpose of the *Revised Training Standards*

The purpose of the *Revised Training Standards* is to:

> Identify the minimum standard of evidence-based scientific and practical education that a healthcare provider should receive to function in the role of a sexual assault forensic examiner (SAFE).

[7] The statutory requirement to develop a national recommended standard for training healthcare professionals who perform these examinations can be found in Section 1405 of the Violence Against Women Act of 2000, Public Law Number 106–386. The statutory requirement also mandates the development of a national protocol for these examinations and related recommended training for all healthcare students.

[8] Refer to the protocols for an explanation of terms, as well as recommendations specific to each component of the examination process.

[9] https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p3c29

Defining Patient Populations

To align the content of the two protocols for which this document provides support, the adolescent/adult SAFE didactic and clinical training standards target healthcare professionals who will provide care for postpubertal patients. The pediatric didactic and clinical training standards provide recommendations for education for those caring for prepubertal patients.[10] Many clinicians provide care for postpubertal as well as prepubertal patients, so the *Revised Training Standards* contains information for both, in tandem, with certain topics highlighted for one population versus the other, as indicated in the respective protocols.

Overall Recommendations

A number of broad-based recommendations are offered below to help those involved in the development, revision, coordination and/or delivery of training programs for SAFEs.

1. Create a foundation for training that supports a coordinated multidisciplinary approach.
2. Find ways to incorporate the voices of survivors into training.
3. Establish instructor qualifications along with methods to ensure comprehensive, quality training.
4. Establish participant qualifications. Consider how to recruit and screen SAFE candidates, identify those who reflect the diversity of the community for whom they will provide care; assess learning needs prior to training; provide opportunities to apply skills learned; and maintain competency after the initial training.
5. Build the capacity of SAFE candidates to provide culturally competent care.
6. Incorporate evidence-based information[11] into the training program as much as possible.
7. Instruct SAFE candidates to use language that fits their role and is unbiased.
8. Incorporate into training discussions those issues involving a lack of consensus regarding clinical practices, where they exist.

1. Create a foundation for training that supports a coordinated multidisciplinary approach.

The training team should be multidisciplinary, although the primary trainer should always be a SAFE with experience in delivering didactic instruction, as well as having extensive experience delivering sexual assault- and sexual abuse-specific patient care. Education for SAFE candidates should also include training and information from the following disciplines, depending upon the defined victim population and the available resources in a given community (pediatric vs. adult):

[10] *Postpubertal* is defined as development of secondary sex characteristics at Tanner Stage 3 and above. Prepubertal is defined as Tanner Stage 1 or 2 of sexual maturation. See the *Pediatric Protocol*, Appendix 1: Tanner Stages of Sexual Maturation for additional information.

[11] *Evidence-based information* refers to a combination of the research evidence published in peer-reviewed journals; clinical expertise and anecdotal knowledge gleaned from practice; and patient values and preferences (Melnyk & Fineout-Overholt, 2011).

- Healthcare providers who are experienced, specially educated and clinically prepared SAFEs[12]
- In courses specific to sexual assault nurse examiners (SANEs), a minimum of one core faculty member holding current board certification for adult courses (SANE-A), and a minimum of one core faculty member holding current board certification for pediatric courses (SANE-P)[13]
- Nonprofit, nongovernmental, community or tribal-based advocates for victims of sexual assault and abuse (from local programs and state, territorial and tribal sexual assault and sexual abuse coalitions)[14]
- Systems-based victim assistance personnel and sexual abuse advocates (from Child Advocacy Centers [CACs]; state, federal and tribal prosecutor's offices; and law enforcement agencies)
- State, federal and tribal law enforcement investigators and prosecutors involved in the investigation and response to sexual assault and sexual abuse (specific to the age group on which the training is focused)
- Forensic scientists
- Child and/or adult protective services' staff
- Prison Rape Elimination Act (PREA) coordinators or other corrections practitioners coordinating responses to sexual assault inside correctional settings
- Civil attorneys who bring an understanding of victims' privacy and other legal rights

Others may be involved in the training program, depending on the topical area discussed (e.g., emergency medical services [EMS] providers, hospital emergency department clinical staff, forensic photographers, toxicologists, infectious

[12] Currently, no national standard is accepted across healthcare disciplines quantifying a minimum level of education and clinical experience required for SAFE trainers, except that they should have completed the necessary basic education and clinical practice to become a SAFE. However, those who contributed to the development of this document expressed concern about the quality of education provided and subsequent competency of SAFE candidates if trainers do not have sufficient expertise. The IAFN *SANE Education Guidelines* recommend that at least one core faculty member have five years of clinical experience caring for the specific patient population related to the educational content (IAFN *SANE Education Guidelines*, p. 10).

[13] The requirement for certified SANEs as core faculty is outlined in the IAFN *SANE Education Guidelines*, specifically for nurses who want to be eligible to sit for the corresponding board certification examinations offered by IAFN (p. 9). Child abuse pediatricians may also be included as core faculty in SANE-P courses, but they are not required—nor should they replace the SANE-P core faculty if the program is to be consistent with the *SANE Education Guidelines*.

[14] Jurisdictions developing a SAFE training program that do not have a nonprofit, nongovernmental community or tribal-based sexual assault and abuse victim advocacy program (e.g., rape crisis center or child advocacy center) may question the appropriateness of using trainers who represent other victim service entities (e.g., those based in the criminal justice system, examination facility, social services or other agency). Although including them on the training team may be helpful, it is recommended that they not replace trainers who are community-based nonprofit, nongovernmental sexual assault victim advocates. It is critical that SAFE candidates understand what victim advocacy fully entails for patients who have been sexually assaulted and its importance and relevance to a victim-centered examination process. Due to their training, trainers who are community-based nonprofit, nongovernmental sexual assault victim advocates are typically best positioned to help candidates meet this objective by articulating their primary mission of supporting victims' needs and wishes; discussing the range of services they are accustomed to providing to victims and their significant others before, during and after the examination process; and addressing their capacity to talk with patients with some degree of confidentiality. (See the *SAFE Protocol* and *Pediatric SAFE Protocol* for a discussion of the roles of victim service providers/advocates.) If a local community-based advocacy program does not exist, the state, tribal or territorial sexual assault coalition that serves the jurisdiction may be willing to be involved in the training. Alternately, a community-based advocate trainer from another jurisdiction might be considered. It is recommended that any involved advocates/victim service providers coordinate their presentations so that SAFE candidates appreciate the scope and limitations of the roles of each, and how the two disciplines can work together to provide optimal services to patients.

disease specialists, pharmacologists, interpreters, forensic interviewers, sex offender management professionals[15] and responders who can address the needs of specific populations in the community, such as military personnel and their dependents, disability service providers, culturally specific and tribal community service providers, college students and staff, faith-based leaders, traditional healers or any other community service providers that serve the local jurisdiction). Mental health/behavioral health providers—including programs serving community members with intellectual and developmental disabilities—are essential participants of the multidisciplinary team (MDT) response, and may offer valuable educational content in the training program.

The involvement of these practitioners in training should be more than an introduction of their agencies and roles. Just as all responders should learn how to work collaboratively throughout the examination process to assist patients and facilitate their care, these collaborative working relationships can be demonstrated through the role modeling of trainers during the course. Involving trainers from other disciplines who have a role in the examination process or are responders to victims of sexual assault and abuse also helps SAFE candidates understand that they have partners in this work, additional support networks and other referral resources for their patients.

The use of a facilitator or course director who is an experienced, specially educated, and clinically prepared SAFE to oversee the entire training process helps ensure cohesion and current practice, and highlights the connections between topical areas.[16]

Training should stress the importance of SAFEs understanding their roles as licensed healthcare providers first and foremost, as well as understanding the roles of other members of the sexual assault and sexual abuse response team.[17] This information can build SAFEs' knowledge of how to maintain professional boundaries and preserve objectivity throughout the examination process and beyond. In addition, this information can help avoid problems that sometimes occur when disciplines need to work collaboratively wherein roles can become blurred or conflicts may arise among responders (rather than each working in the best interests of patients). This is particularly important if the SAFE will need to be prepared to work collaboratively across tribal, state and federal jurisdictions when inadequate resources may exist to comprehensively address sexual assault.

[15] http://www.csom.org/pubs/OVW-Collaboration-Resource-Package-Sept-2016.pdf

[16] States with non-nurse statewide coordinators are encouraged to partner with an experienced clinician to provide the clinical content and ground the multidisciplinary content in SAFE practice.

[17] A sexual assault response team (SART) provides a multidisciplinary, specialized, and at times immediate response to persons who disclose they recently have been sexually assaulted/abused. The team typically includes healthcare personnel, law enforcement representatives, community-based victim advocates, prosecutors and forensic scientists (although prosecutors and forensic scientists are usually available for consultation rather than actively involved at this stage). Where they exist, these types of teams vary in what they are called, how they operate, the extent of their activities and the composition of their members. Jurisdictions that do not have a SART may have a more informal network of professionals who work together to respond to these cases. In pediatric sexual abuse cases, a separate team may meet (many of the same professionals are included in the MDT or Coordinated Community Response (CCR) to coordinate the response to child sexual abuse. In some jurisdictions these child response systems may be statutorily mandated.

2. Find ways to incorporate the voices of survivors into training.

Incorporating survivor input into the training program can help SAFE candidates learn about patients' experiences during the examination process. This information also allows the candidates to hear directly from patients what was—and was not—helpful, and what could be improved to help future patients. There are numerous ways to involve survivors in training. They may be willing to serve as panelists or individual speakers (either in person or through video or audio conferencing) or they may prefer to provide input without being physically present at the training (e.g., by providing a letter about their experiences that could be read aloud to SAFE candidates or by providing a videotape or audiotape recording that could be aired). In addition, survivor video interviews are available for viewing and use in training at http://www.safeta.org/?page=survivorinterviews.

Some survivors may want to offer input but remain anonymous. Community-based advocacy programs may assist in soliciting survivor involvement—advocates may be able to help identify survivors who are willing and able to provide input, help them prepare, and provide them with emotional support if needed.

Regardless of the manner in which one incorporates survivors into the training, care should be taken to avoid an approach that is or appears to be in any way exploitive of their experience. The goal of their involvement is to better inform examiners while avoiding any re-traumatization of survivors. Because child survivors are among the most vulnerable, children who have experienced victimization should not be used in trainings. A trauma-informed approach may include adult victims of childhood sexual abuse or non-offending parents of children who have experienced sexual abuse.

It is important to be mindful that survivors inevitably will comprise some course participants. To help mitigate the challenges some may experience, a brief statement at the beginning of the course may be beneficial with reminders throughout the training that some of the content can be triggering for some people, and that the students should practice self-care throughout, including taking breaks when needed, or reaching out to local rape crisis advocates.

3. Establish instructor qualifications and identify methods that ensure comprehensive, quality training.

Instructor qualifications should be developed and regularly assessed for currency. It is essential that SAFE instructors, as well as those involved in the development, planning, revision and coordination of training programs:

- Recognize that SAFE trainers can come from a variety of healthcare disciplines. [18]
- Understand that medical forensic examinations of patients who have been sexually assaulted/abused are performed within a healthcare framework governed by professional standards of care, privacy principles and scope of practice.

[18] SAFEs and SAFE trainers might be registered and advanced practice nurses, physicians and physician assistants.

- Embrace a holistic approach to restoring and promoting the physical, psychological and social health of patients throughout the examination process.
- Understand the crucial role that SAFE training programs play in educating SAFEs to provide objective[19] health care and forensic evaluation in a trauma-informed, competent, compassionate, culturally/linguistically appropriate and victim-centered manner.
- Recognize the importance of using multiple teaching methods in a variety of combinations and formats, including PowerPoint presentations, videos, discussion, case studies, lecture and role play. Engaging students through multiple methods will meet different learning styles of SAFE candidates in the didactic sessions.
- Recognize that simulation may be used as a component of the clinical coursework to teach and reinforce skills associated with the medical forensic examination, such as anogenital inspection, speculum insertion, evidence packaging, et cetera. The medical forensic examination may be simulated with either live models or mechanical simulators.[20] Care should be given to develop and evaluate appropriate scenario content and objectives. Ideally, simulation should not replace the precepted examination.

SIMULATION AS AN EDUCATIONAL TOOL

Simulation has become an increasingly popular tool in nursing and medical education (Sanford, 2010). The use of simulation includes mechanical simulators ("sim-man"), role playing with standardized patients, scenario setting and case studies. This type of learning has shown to increase patient safety and decrease errors, improve clinical judgment, and is useful for evaluating specific skills (Harder, 2010). Disadvantages to using simulation include the amount of time required to set up a simulation laboratory, create scenarios and plan for role plays (Sanford, 2010). When mechanical simulators are used, patient reactions to procedures are lost (Lasater, 2007). The use of simulation to teach and evaluate skills associated with conducting the medical forensic sexual assault and sexual abuse examination may be incorporated into the curriculum.[21] However, the simulation should be structured. Clear objectives with set scenarios and methods for evaluating student performance based upon the established objectives are essential. A process for providing feedback to the student should be developed and consistently used (International Nursing Association for Clinical Simulation & Learning, 2011). To address the student's action or inaction in the simulation environment, the instructors should be thoroughly familiar with the scenarios. Successful simulation sessions require much preparation and cannot be loosely organized. Consultation with educators who use various methods of simulation is highly recommended.

[19] The terms *objectivity*/*objective* and *neutrality*/*neutra*l are used interchangeably in the *National Training Standards*, but it is important to recognize that some difference of opinion exists in the field about whether these terms have the same meaning when referring to SAFE activities.

[20] Schools of medicine and university-affiliated hospitals are often resources for both gynecological/urological teaching associates (live models) and medical simulation labs (mechanical models). For an example of the use of live models in medical forensic education, see Rutgers New Jersey Medical School: http://njms.rutgers.edu/departments/ob_gyn/test.cfm. To identify an accredited healthcare simulation center in the United States, see the Society for Simulation in Healthcare's Directory: http://www.ssih.org/Home/SIM-Center-Directory/Area/US

[21] For those who wish to be eligible for SANE-A or SANE-P certification, the IAFN requires simulation training to be in addition to the 40-hour content, and not completed as a part of the didactic coursework. "Clinical components, including simulated clinical experiences, are completed in addition to the coursework and are not calculated as part of the 40 hours" (IAFN *SANE Education Guidelines*, p. 7).

In particular, instructors should:

- Have significant experience in the topical areas in which they are providing instruction (e.g., instructors who are SAFEs should have considerable experience in all aspects of care for patients who have been sexually assaulted/abused, including performing examinations, evaluating and managing patients, coordinating responses with other professionals and preparing for and testifying in court).
- Provide instruction appropriate to their expertise and discipline-specific role (e.g., training that addresses legal issues and the impact of evidentiary findings on a legal case should be done primarily by a prosecutor, although a SAFE may assist with this discussion).
- Be familiar with pertinent medical, scientific, and forensic literature (including the ability to understand the scientific methods described and to critically evaluate the literature).
- Recognize the importance of using a trauma-informed foundation for the training and be able to articulate the importance of this approach in the care of the patient who has been sexually assaulted or abused.
- Be aware of variations in practices and policies related to the examination process across jurisdictions.
- Be skilled in how to sensitively and appropriately respond to cultural and linguistic concerns that arise for patients during the examination process, knowledgeable about how to teach SAFE candidates these skills, and able to address SAFE candidates' cultural needs and concerns during training.
- Be knowledgeable about high-risk populations that are especially vulnerable to sexual victimization, such as those with intellectual and developmental disabilities and other cognitive disabilities.
- Incorporate how to address requirements for access to language assistance or other accommodations needed to clearly communicate and meet the needs of the patient and/or family.
- Evaluate, on an ongoing basis, any biases and deeply held beliefs they personally hold related to sexual violence that could hinder their ability to train SAFE candidates.
- Use instructional techniques that support adult learning and develop content that is effective with different styles of learning (e.g., seeing, doing, hearing and reading).
- Have experience in facilitating and guiding group discussions, knowledge of/experience with adult learning theory and the capacity to help trainees evolve in attitude, knowledge and ability.[22]
- Be cognizant that the didactic content may trigger a traumatic response based on the trainee's personal history and be able to offer support, referral and intervention.[23]

[22] See, for example, Knowles, M., Holton, E., & Swanson, R. (2015). *The adult learner (8th ed.).* London, UK: Routledge; Post, H. (n.d.). *Teaching adults: What every trainer needs to know about adult learning styles.* Bloomington, MN: Pacer Center.

[23] A history of sexual violence victimization should not prevent a clinician from participating in SAFE training and practice. However, clinicians need to consider how their own victimization impacts their ability to provide this care, ensuring that they are able to provide objective, evidence-based patient care without jeopardizing their own well-being. SAFE trainers should be prepared to sensitively address concerns with clinicians who appear to be struggling with the content or unable to objectively view the issues.

- Employ analytical and critical thinking skills in many aspects of the clinical care of the patient following sexual assault and abuse.

(See Appendix A for a complete outline of qualifications for clinician faculty in both adolescent/adult and pediatric SAFE courses.)

Methods to ensure the quality of training and the instructors should be developed. It is imperative to evaluate the quality of education provided through each training program and the instructors used. Programs are urged to develop measurable and observable learning outcomes that specify the desired knowledge, skills and/or practices that SAFE candidates are to gain through each training module.[24] Evaluation can help ensure that these training objectives are being met and facilitate continuous improvement of the program. Examples of some evaluative tools include pretests of SAFE candidates, post-training evaluations of SAFE candidates that focus on their level of knowledge of the examination process and their level of satisfaction with the training and instructors, and longitudinal evaluation of the effectiveness of the training program in preparing SAFE candidates for their role. A systematic approach will help ensure that feedback from participants, advancements in clinical knowledge and best practices, and advances in forensic science and the law are incorporated into the training program on a regular basis.

INSTRUCTIONAL METHODOLOGIES

Clinicians learn in a variety of ways. Knowles's theory informs the process of adult learners. This theory states that active involvement is key to the learning process. The active learner retains more information, more readily sees the applicability of that information and learns more quickly. Knowles assumes that the learner is self-directed, knows the reason that he or she needs to know the information, and brings a different type and quality of experience (Amerson, 2001; Atherton, 2011). Because not all adults learn in the same manner, instructors may use a variety of mediums to design and deliver a curriculum to the students.

4. Establish participant qualifications. Consider how to recruit and screen SAFE candidates, identify those who reflect the diversity of the community for whom they will provide care; assess learning needs prior to training; provide opportunities to apply skills learned; and establish and maintain competency after the initial training.

When identifying potential candidates to **participate** in SAFE training, instructors should recognize that:

- Healthcare providers (including physicians, advanced practice nurses and physician assistants) from a variety of specialty areas in health care can be specially educated and clinically prepared to be SAFEs (noting that the examination should be done with equal competence regardless of the healthcare area, baseline education or degree of the examiner).

[24] For guidance on crafting effective learning objectives, see International Training and Education Center for Health (2010). Writing sound learning objectives; University of North Carolina, Charlotte. (n.d.). Writing objectives using Bloom's Taxonomy.

- For nurses taking the course, the minimum level of education should be that of a registered nurse.
- Due to the autonomous nature of SAFE clinical care, some fundamental clinical assessment and critical thinking skills need to be demonstrated prior to practicing as a SAFE. New graduates of either nursing or medical schools may not be appropriate candidates until they have more clinical experience in their respective roles.

Create a plan to identify, recruit and screen healthcare providers interested in becoming SAFEs. Some initial questions to answer when creating a plan include who will conduct the recruitment and screening (e.g., individual examiner programs and/or those coordinating trainings) and what selection criteria will be used. Jurisdictions should strive to recruit SAFEs who collectively represent the diversity of the community they serve. Planners should ensure that recruitment and screening approaches do not perpetuate biases against particular groups. Through the recruitment and screening process, potential candidates should be fully informed of what being a SAFE involves (e.g., initial and ongoing education and clinical practice needed, the work itself and the time commitment). Recognize that multiple areas of clinical practice may yield SAFE candidates. For example, not all SAFE candidates need to come from the emergency department (ED); consider recruiting from maternal child health, pediatrics, intensive care units/pediatric intensive care units, women's health, gynecology, psychiatric/mental health and other clinical practice areas within the hospital or community clinic setting. Planners should make efforts to include nurses from marginalized communities.

In preparation for each training program, instructors should assess the needs of attending SAFE candidates. The assessment might entail understanding the level of the candidates' experiences and competency; becoming familiar with local, state, territorial, tribal and federal laws and statutes and protocols that affect examination procedures; local practices, including those that address minors' consent, privacy and privilege, kits and forms related to the examination; and considering the needs of specific populations in the community.

Opportunities to practice skills learned during the didactic training should be provided. A great deal of information is presented to SAFE candidates during classroom education. To increase their capacity to absorb and apply this information, candidates should have sufficient and varied opportunities to translate knowledge into action. Opportunities can be provided during classroom education through mechanisms that include, but are not limited to, role play, use of case studies, demonstrations using models, mock court testimony and periodic assessment testing. In addition, the clinical practicum component of SAFE training (completed in addition to the didactic course) should include extensive hands-on opportunities (see Clinical Content). Those developing training curriculums should carefully consider which training tools are best suited to maximize absorption and application of information for each topic area.

Jurisdictions and examiner programs should consider how to enhance competencies of SAFEs after the initial didactic training and clinical practicum.[25] Supporting advanced education, continuing education, supervised clinical practice and

[25] *Clinical practicum* refers to the experiences completed as a part of the Clinical Practice Content—Recommendations. These can be accomplished through precepted experiences in a clinician's own community, precepted experiences in communities with greater resources or patient volume or by attending a formalized clinical practicum, such as those offered by IAFN (http://www.forensicnurses.org/?page=ClinicalSkillsTrn) or the Tribal Forensic Healthcare project (http://www.tribalforensichealthcare.org/?page=Clinical), or a combination thereof.

certification for healthcare providers who conduct the medical forensic examination is recommended.[26] This approach will build upon SAFEs' knowledge; keep them current with changes in technology, current science, documentation and promising practices; and offer them opportunities to refresh skills that were gained in basic training. One-on-one supervision and mentoring is critical to allow experienced examiners to evaluate the individual performance of newer SAFEs, answer case-specific questions that arise and consider how to promote their professional development. Quality assurance and peer review processes should be implemented in some form to help maintain the highest quality care for patients.[27]

5. Build the capacity of SAFE candidates to provide culturally and linguistically competent care.

A culturally competent SAFE sensitively and appropriately addresses patients' cultural needs and concerns. To build SAFE candidates' capacity to be culturally competent, instructors are encouraged to incorporate cultural issues throughout the training, rather than highlight these issues in a single, discreet section of the course. In addition, "Victim-Centered Care" from the *SAFE Protocol* and "Principles of Care" and "Adapting Care for Each Child" from the *Pediatric SAFE Protocol* both look more broadly at cultural and other individual considerations that may affect how the examination is conducted.[28] Instructors also should discuss with SAFE candidates approaches to rectifying situations in which sensitive and culturally appropriate responses may have been lacking.

Those developing training programs are urged to seek out the expertise of service providers who can discuss cultural and accessibility issues facing the jurisdictions to be served by the SAFE candidates. Not only can they provide information, resources and referral sources that can be used by the SAFE candidates, they also may be willing to serve as presenters. To be most effective, this self-exploration should be ongoing and supported by local MDTs—such as sexual assault response teams (SARTs)—and represent the community being served.

6. Incorporate evidence-based information into the training program as much as possible.

SAFE candidates should be educated about cutting-edge research and evidence-based information on best practices (to the extent it is available) that can guide care of patients who have been sexually assaulted and abused, and allow for more

[26] *Pediatric SAFE Protocol*, p. 58.

[27] For resources to help implement or refine quality assurance and quality improvement processes, see the *SANE Sustainability Information* from the National Sexual Violence Resource Center.

[28] For information on adapting the *SAFE Protocol* as a resource for those conducting examinations and/or responding to incarcerated victims: https://www.justice.gov/sites/default/files/ovw/legacy/2013/08/12/confinement-safe-protocol.pdf

effective courtroom testimony.[29] Modeling the use of evidence-based information in the education process can also be used to address victim-blaming attitudes that SAFE candidates may hold (or inevitably encounter in others).

7. Instruct SAFE candidates to use language that fits their role and is unbiased.

Careful selection of words is critical throughout the examination process, including on the examination documentation and in communication with colleagues, not only to ensure accuracy, but also to reflect objectivity.[30] Instructors should ensure SAFE candidates understand the importance of being able to articulate the role of the SAFE in accordance with nursing scope and standards of practice and other current published guidance, and encourage SAFE candidates to use language that precisely reflects the patient history, behavior, medical forensic findings and evidence-based conclusions within the scope of the SAFE role. When assisting patients with disabilities, the use of "people-first language" is important to emphasize the person and not their abilities or disability.[31]

8. Incorporate into training discussions those issues involving a lack of consensus regarding clinical practices, where they exist.

Although much agreement exists across the country regarding acceptable and best practices in the examination process, SAFE candidates should understand that areas of disagreement also exist among practitioners (many of which are recorded in the protocols). Instructors should be able to identify areas for which there is no consensus about best practices[32] and help SAFE candidates understand the importance of following the best available clinical guidance and jurisdictional laws and policies to respond appropriately to meet the needs of the individual patient.

[29] Because the discipline is relatively young, the research base is still developing; and there is much information that has not yet been published in peer-reviewed journals. Clinicians should strive for "evidence-informed" care where the research base has not yet been established.

[30] https://www.americanbar.org/groups/women/publications/perspectives/2015/winter/how_language_reflects_our_response_sexual_violence.html and National Judicial Education Program/Legal Momentum, "Raped or 'Seduced:' How Language Helps Shape Our Response to Sexual Violence." https://www.legalmomentum.org/raped-or-seduced-how-language-helps-shape-our-response-sexual-violence

[31] https://www.thearc.org/who-we-are/media-center/people-first-language

[32] For example, care of the unconscious patient: The field has not been able to reach consensus regarding whether medical forensic exams should be conducted on patients who are unresponsive. See *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, p. 108; Pierce-Weeks, J., & Campbell, P. (2008). The challenges forensic nurses face when their patient is comatose: Addressing the needs of our most vulnerable patient population. *Journal of Forensic Nursing*, *4*(3), 104–110.

Training Content: Didactic

Physicians, advanced practice nurses, physician assistants and registered nurses without advanced practice nursing education may all engage in the medical forensic evaluation of sexual assault and/or child sexual abuse. Due to differences in foundational training in assessment, and variances in scope of practice, clinicians should refer to their individual organizations (e.g., IAFN, National Children's Alliance) or for some registered nurses, their state regulatory agency, to ensure compliance with required didactic hours.

Regardless of provider type, all providers should be licensed to practice and in current good standing by their corresponding state board of practice regulation. All providers are required to practice within the scope of their applicable state practice acts.

A medical director[33] who has received the equivalent specialized training is recommended (and depending on local laws and agency requirements, may be required) to assist with development of protocols and treatment plans—including those for follow-up and referral recommendations for specialized services, such as ongoing medical or mental health care—as well as to participate in quality assurance and quality improvement processes.[34]

Because the following issues are not specific to any single category within the training content, faculty should ensure that these are discussed during the didactic course in a manner that allows for robust debate and application at the local level:

1. **Ethical practice**: SAFE practice necessitates that a foundation is created upon which all SAFEs have the capacity to make clinical practice decisions consistent with their professional codes of ethics. This means ensuring that all clinicians are practicing within their scope, supported by policies and procedures that minimize potential conflicts, and place the patient at the center of the healthcare encounter. Faculty are encouraged to include relevant codes of ethics (e.g., ANA's *Code of Ethics for Nurses with Interpretive Statements*, ACEP's *Code of Ethics for Emergency Physicians*) in training for discussion as applied to the patient who has been sexually assaulted and sexually abused.

2. **Screening for and addressing co-occurring abuse**: Although these training standards specifically address sexual assault and sexual abuse across the lifespan, many patients experience polyvictimization.[35] Clinicians should be prepared to address the multiple forms of violence, abuse, and exploitation that can potentially arise within any

[33] A program director/coordinator in some cases may not be a licensed healthcare provider (see footnote 37). A medical director is expected to be a licensed advanced practice provider.

[34] The medical director does not have to be a physician; some communities and organizations may use physicians, physician's assistants or advanced practice nurses to fill this role.

[35] *Polyvictimization* refers to the experience of multiple types of victimization, including intimate partner violence, sexual exploitation and trafficking. Although more frequently discussed in reference to children, polyvictimization can happen across the lifespan.

given patient encounter. Therefore, discussion about available resources—including screening tools, treatment protocols and targeted referral agencies—should be part of every SAFE course.[36]

3. **Evidence-based practice**: Forensic health care is a relatively young profession. Although the evidence base that guides clinical decision making is limited compared to many other healthcare fields, it is constantly evolving. Beyond simply providing training informed by the current evidence base, faculty should encourage discussion of the gaps in the current body of evidence and how new research can be integrated into SAFE practice. Emphasis should be placed on maintaining currency with the available scientific literature and the importance of sharing that literature with other members of the MDT, in particular prosecutors and other attorneys who may need to address the science in court. Consider including resources for participants on issues such as reading and understanding research, conducting literature searches and evaluating the quality of scientific articles.

4. **Telemedicine**: The use of telemedicine has great potential in providing care to patients who have experienced sexual assault and sexual abuse. Some communities have already instituted this type of programming, but the literature related to its efficacy and the availability of specific protocols for implementing a telemedicine program with this patient population remains limited. In communities where telemedicine is employed, SAFE faculty will need to discuss how its use impacts every component of the didactic content—from the necessary regulations impacting programs (such as the Health Information Technology for Economic and Clinical Health (HITECH) Act), to cross-state licensure issues, adaptations in documentation and the consequences of its use on the investigative and judicial response.

[36] The toolkit at http://ipvhealthpartners.org/ is available to build a comprehensive and sustainable response to screening and responding to intimate partner violence (IPV) in your health center, in partnership with local domestic violence and sexual assault service providers.

Training Content: Clinical

Clinical education is designed to complement the classroom educational experience and allow the healthcare provider to apply the knowledge obtained during the didactic coursework. Clinical experiences should be completed *in addition to* the didactic training (and for registered nurses seeking the SANE-A or SANE-P certification, is a requirement). Preceptorships, internships and residencies combined with ongoing training will assist the clinician in developing a solid foundation for competent and current practice in this field.

Clinical educational experiences should be completed in a time frame that ensures competency and maximum retention of knowledge and skills, typically within six months of completion of the didactic training. Required clinical skills should be performed until competency is demonstrated. Competency is individualized, and should be determined by the professional who is assessing the clinician's skills.

Given the diversity of communities and the different challenges facing rural, tribal, low-volume versus urban, high-volume communities, multiple options for clinical skills attainment should be recognized. Clinical skills may be obtained using any of the following approaches:

- Medical internship, residency, fellowship or preceptorship in a program providing care to sexual assault and sexual abuse patients' medical forensic needs.
- Preceptorship in a simulation setting using medical simulation models and/or standardized patients, ideally in combination with one of the aforementioned clinical education experiences.

Critical components to consider in the development of the above modalities are development of clearly defined competencies that should be achieved during the clinical training, and ensuring the experience of the instructor.

Accredited continuing education hours (contact hours in nursing or Category 1 or 2 CME in medicine) or academic credit should be awarded to the candidate who demonstrates proof of hours and course content.[37]

[37] Note: For nurses who wish to be eligible for SANE-A® or SANE-P® certification, the IAFN required that each course provide nursing contact hours, nursing academic credits or a national equivalent that demonstrates proof of hours and course content. Additionally, the IAFN requires clinical preceptorships to be completed as outlined in the most current edition of the IAFN *SANE Education Guidelines*.

WEB-BASED EDUCATION:

A growing trend in education has been the development of web-based programs or courses that are available on the internet. Evidence has shown the effectiveness of internet learning as documented in nursing and medical education, particularly as an adjunct to in-person education (Fang, Chang, Chang, Erdley, & Chang, 2013; Wong, Greenhalgh, & Pawson, 2010). Message boards, teleconferencing, and chats make collaborative learning more readily available. Studies in collaborative learning have shown higher levels of learning satisfaction, improvements in knowledge and self-awareness and an enhanced understanding of concepts, course objectives and changes in practice (Ruiz, 2006). In a 2013 review of e-learning research in medicine and nursing, the authors found that situated e-learning programs significantly improved novice learners' knowledge and performance (Fang, et al. 2013). This type of curriculum delivery allows large numbers of participants to benefit from the learning opportunity. Students complete course requirements at their own pace within a given time frame. The major disadvantage is that the face-to-face interaction with instructors and peers is lost because of a separation of time and space (University of Connecticut, n.d.). Effective time management skills are required for this type of learning, which may discourage some from excelling.

Recommendations for Instructors

SAFE instructors should include both core faculty members and multidisciplinary content experts. Core faculty are defined as those individuals who are primarily responsible for structuring, delivering and evaluating the content associated with the training. At a minimum, core faculty should hold an active, unrestricted professional healthcare provider license, have successfully completed both didactic and clinical training in the area of expertise they are teaching, hold national board certification in the specialty (if certification exists) and demonstrate expertise in teaching adult learners.[38]

Core faculty should include someone who is:

- SAFE-trained and clinically practicing specific to the patient population—for non-nursing programs (MDs and PAs),
- A SANE-A® (SANE-P® for pediatric courses) or a nurse with equivalent training/clinical and forensic experience—for programs training nurses.[39]

Multidisciplinary content experts are individuals who provide specific educational content in their respective area of expertise. At a minimum, multidisciplinary content experts should demonstrate expertise in teaching adult learners, and demonstrate content expertise through recent experience in the specialty area. Listed below are the recommended core

[38] For those organizations bringing in professionals to serve as core faculty, Appendix B: SAFE Core Faculty Assessment provides some suggestions for areas to consider when looking for a trainer that can provide education consistent with the *Revised Training Standards.*

[39] In SANE-P courses, child abuse pediatricians are welcome as members of the core faculty, but in addition to, and not in place of, the SANE-P core faculty member.

faculty member(s) and the multidisciplinary content expert(s), although others may be included depending on the needs of the community (e.g., spiritual/faith-based support programs, culturally specific resources, correctional facility personnel, sex offender management professionals, Indian Child Welfare personnel, survivor-centered civil attorneys or victim's rights attorneys, campus representatives, corrections or military-specific personnel, etc.):

- Adult protective services (adolescent/adult course only)
- Child protective services
- Community-based advocacy (where available)
- Crime laboratory personnel
- Criminal prosecutors
- Law enforcement investigators (local, state, federal and/or tribal)
- Systems-based victim assistance personnel (e.g. child advocacy center, victim witness or victim assistance program, etc.)

Didactic Content

The didactic content establishes the foundational knowledge base of the SAFE. It is meant to introduce new concepts, further develop known concepts (such as anogenital assessment or sexually transmitted disease[40] evaluation and treatment) and apply them to a specific patient population (adolescent/adult and/or pediatric). The following education content outlines the framework for the specially educated and clinically prepared SAFEs who care for the sexual abuse/assault patient population. These target areas identify the minimum content required during the didactic training experience, including training outcomes, critical topics and cultural considerations (which should be integrated throughout the training rather than presented as a separate topic). Note: Some topics and resources are listed separately for adolescent/adult and pediatric populations. This organization is based on the respective protocols for each of these populations, and is provided here as a guide rather than as a mandate. Clinicians are encouraged to include and adapt information and resources applicable to both populations as they deem appropriate.

I. *SEXUAL VIOLENCE OVERVIEW*	
KEY CONCEPTS	*All populations:* • Definition of sexual violence • Definition and identification of the types of assault/abuse that may occur concurrent with sexual assault and sexual abuse • The global and jurisdictional incidence and prevalence rates for sexual assault and sexual abuse in the pediatric, adolescent and adult populations • Risk factors for vulnerability to sexual assault and sexual abuse • Health consequences of sexual assault and sexual abuse and co-occurring violence • Unique healthcare challenges to underserved sexual assault and sexual abuse patient populations • Factors that make victims more vulnerable to being targeted for sexual assault and abuse (i.e., adverse childhood experiences [ACEs], generational violence) • Biases and deeply held beliefs regarding sexual assault and sexual abuse • Key concepts of offender behavior and the effect on sexual assault and sexual abuse patient populations • Delayed disclosures and recantation as a common presentation

[40] In this document the terms *sexually transmitted disease* (STD) and *sexually transmitted infection* (STI) are used interchangeably.

	• Capacity to consent to services • Cost of violence and sexual violence *Adolescent/adult:* • Underserved sexual assault and sexual abuse populations and associated prevalence rates • Differences between the minor and adult patient populations as related to adult and adolescent sexual assault and sexual abuse *Pediatric:* • Sexual abuse of children as a distinct issue from that of adolescents and adults • Assent[41] and related legal status considerations in children
PROTOCOL CONTENT	*All populations:* • Types • Co-occurrences • Health consequences
TRAINING OBJECTIVES	*All populations:* • Define and identify the continuum of sexual assault and sexual abuse that patients experience and the variety of co-occurring violence that may be identified in patients who have been sexually assaulted/abused • Outline incidence and prevalence rates for sexual assault and sexual abuse across populations • Identify sources for local incidence and prevalence data • Discuss the health consequences of sexual assault and sexual abuse to include physical, psychosocial, cultural and socioeconomic sequelae • Identify characteristics of sexually abusive behaviors • Describe the interplay between vulnerability and sexual assault and sexual abuse

[41] Assent is the expressed willingness of an individual to participate in an activity (*National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatric*, p. 99). Although a minor may not be legally permitted to consent to the exam, the examiner should obtain assent.

I. *SEXUAL VIOLENCE OVERVIEW*	
CULTURAL AND ACCESSIBILITY CONSIDERATIONS	*All populations:* • The diversity and strengths of the community the SAFE will be serving • Patients' and providers' biases and experience of privilege and oppression, and how this may impact sexual assault and sexual abuse care • Gender-based violence as a healthcare issue globally, nationally, regionally and locally • The impact of historical trauma, intergenerational trauma and sexual assault and sexual abuse on communities • Understanding the impact that sexual assault and sexual abuse can have on the patient, the family and the community • The impact of culture on the caregiver's/other family member's response and support of the child
ADDITIONAL GUIDANCE	*All populations:* • Adverse Childhood Experiences Study (CDC) including state- or location-specific statistics when available • Sexual Violence: Definitions (CDC) *Adolescent/adult:* • SANE Program Development and Operation Guide: Understanding the Problem of Sexual Assault • SANE Education Guidelines (IAFN, pp. 11–12, 13–14) • National Intimate Partner and Sexual Violence Survey (CDC) • Recognizing and Responding to Human Trafficking in a Healthcare Context (National Human Trafficking Resource Center) • Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States (IOM). • Impact of Sexual Violence on Health (National Sexual Violence Resource Center) • People Who Commit Sexual Violence (National Sexual Violence Resource Center) • Crawford-Jakubiak, J. E., Alderman, E. M., Leventhal, J. M., & the Committee on Child Abuse and Neglect, Committee on Adolescence. (2017). Care of the adolescent after an acute sexual assault. *Pediatrics,139*(3), e20164243.

I. *SEXUAL VIOLENCE OVERVIEW*

	Pediatric: • American Professional Society on the Abuse of Children • Child Abuse Library Online (CALiO), Polyvictimization • SANE Education Guidelines (IAFN, pp. 35–38) • Child Sex Trafficking and Commercial Sexual Exploitation: Health Care Needs of Victims (AAP) • National Child Traumatic Stress Network • Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States (IOM)

II. *PRACTICE CONSIDERATIONS*

KEY CONCEPTS	*All populations:* • Scope of practice issues in sexual assault and sexual abuse care • The importance of a healthcare focus in the SAFE response • The role of the SAFE in the care of the patient who has been sexually assaulted and sexually abused • The role of the SAFE in sexual assault and sexual abuse education and prevention[42] • Professional and ethical conduct in sexual assault and sexual abuse care including: autonomy, informed consent, beneficence, non-malfeasance, veracity, confidentiality, justice • Resources, locally and globally, that contribute to current and competent SAFE practice • Vicarious trauma • Mandatory reporting

[42] Within this context, the use of *prevention* includes what have been historically considered components of prevention in health care, such as secondary prevention (where detection of healthcare issues occurs before they become evident) and tertiary prevention (where healthcare issues are actively addressed so as to avoid exacerbation or development of additional clinical sequelae).

	• Consent for the examination
	• Evidence-based practice in the care of sexual assault and sexual abuse patient populations
	• Importance of collaborative relationships on quality of SAFE practice
	• Promoting resilience
	
	Pediatric:
	
	• Assent of the child
	• Need for ongoing education and access to experts (such as board-certified child abuse pediatricians) for pediatric examiners, with an established system for peer review and consultation
	• Recognition that the holistic examination offers an opportunity to consider unique needs of each child and family
	  o Importance of caregiver support of the child/family-centered care
	  o Recognition that patient and caregiver needs may not always align, and process for victim-centered care in such instances

PROTOCOL CONTENT	*Adolescent/adult:* • Licensure • Program type • Regulations • Patient-centered care • Cultural awareness • Trauma-informed care • Informed consent • Quality assurance • Confidentiality

II. *PRACTICE CONSIDERATIONS*

	See also: • Facilities *Pediatric:* • Licensure • Program type • Regulations • Patient centered care • Cultural awareness • Trauma-informed care • Consent and assent • Quality assurance
TRAINING OUTCOMES	*All populations:* • Describe the role and scope of practice of the SAFE • Discuss professional and ethical conduct as they relate to SAFE practice • Discuss key concepts associated with the use of evidence-based practice in the care of patients who have been sexually assaulted/abused • Identify ways in which collaboration positively impacts SAFE practice • Define vicarious trauma, methods for prevention and treatment options in SAFE practice
CULTURAL AND ACCESSIBILITY CONSIDERATIONS	*All populations:* • Language differences, limited English proficiency, accommodations and barriers, literacy issues, non-binary gender identity and disability issues with regard to consent and documentation forms

	• The use of plain language to explain the examination process and patient options for the examination for both the patient and support persons • Patient and family verbal and nonverbal behaviors that may indicate discomfort with procedures or care • Culturally and developmentally appropriate explanations of options and the examination to patients with adaptations as needed to meet individual needs • Respect for traditional practices and rituals for the patient • Respect for the patient's request for an examiner of a particular gender and other accommodations • Materials and resources for the patient and family in languages that are most common in the geographic area • Identification and recognition of actual and perceived barriers to service, based on immigration/legal status • Clinician education that addresses the unique cultural needs of patients and families served in the community • Clinician education that addresses the healthcare and safety needs of the patient, including specific concerns of patients who are detained or incarcerated • Education on vicarious trauma for agency and program staff, service providers, patients and their families and caregivers for healing, including cultural/traditional practices, support, counseling and debriefing • Importance of partnering with agencies that have expertise in working with diverse cultures and assuring that patient confidentiality, privacy is maintained *Pediatric:* • Integration of familial, social and community response to child sexual abuse into a cultural framework
ADDITIONAL GUIDANCE	*Adolescent/adult:* • SANE Program Development and Operation Guide • Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient: Quality Assurance for Sexual Assault Service (ACEP, pp. 95–98) • SANE Education Guidelines (IAFN, pp. 18–19, 24–26)

This document provides voluntary recommendations for training of sexual assault medical forensic examiners and does not create any rights or obligations binding on any persons or entities.

II. *PRACTICE CONSIDERATIONS*

	• Building Cultures of Care (NSVRC) • Fostering Collaboration Between SANE Program Coordinators and Medical Directors (NSVRC) *Pediatric:* • National Children's Alliance Standards for Accredited Members, Cultural Competency and Diversity (pp. 17–18); Medical Evaluation (pp. 30–32); Appendix 3 Continuous Quality Improvement (p. 60) • SANE Education Guidelines (IAFN, pp. 37–38, 51–53) • Building Cultures of Care (NSVRC)

III. *VICTIM RESPONSE AND CRISIS INTERVENTION*

KEY CONCEPTS	*All populations:* • Impact of trauma on memory, cognitive functioning and communications • Diverse reactions to trauma • Delayed disclosures and recantation • Importance of a trauma-informed approach that uses victim centered practices • Safety issues, including self-harm and suicidal ideation • Impact of historical trauma, generational trauma and/or familial abuse

III. *VICTIM RESPONSE AND CRISIS INTERVENTION*	
	Pediatric: • Support of adult caregivers to positively impact a child's resilience • Developmental age of the child as consideration for reactions to and coping with trauma
PROTOCOL CONTENT	*All populations:* • Neurobiology of trauma • Psychosocial factors • Developmental factors • Diverse populations
TRAINING OUTCOMES	*All populations:* • Describe the emotional and psychological responses and sequelae following sexual assault and sexual abuse • Discuss the acute and long-term biopsychosocial effects associated with sexual assault and sexual abuse • Define components of culturally informed and trauma-informed care in the context of sexual assault and sexual abuse • Describe methods for assessing and addressing patient safety and using a collaborative approach with team members to develop safety plans, follow up and access to post-exam services *Pediatric:* • Discuss methods for assessing caregiver and other support systems for the child
CULTURAL AND ACCESIBILITY CONSIDERATIONS	*All populations:* • Identification of and respect for patients' individual/cultural differences • Provision of cultural and developmentally appropriate explanations to patients

	• Recognition of the importance of using a common language • Availability of certified or trained interpreters (who are not members of the patient's family or immediate community) for the examination • Alternative communication methods that are culturally and developmentally appropriate • Identification and recognition of potential concerns about immigration/legal status • Impact of gender identity and sexual orientation on patient responses to trauma, access to support o Identification of preferred name and pronouns • Impact of historical trauma on patient responses • Impact of generational trauma • Confidential and appropriate responses for patients who are incarcerated and detained *Pediatric:* • Importance and impact of cultural identity on the family in coping with adversity and providing support
ADDITIONAL GUIDANCE	*Adolescent/adult:* • SANE Program Development and Operation Guide, Building a Patient-Centered, Trauma-Informed SANE Program • Understanding the Neurobiology of Trauma and Implications for Interviewing (EVAWI) • SANE Education Guidelines (IAFN, pp. 14–15) • Building Cultures of Care (NSVRC) *Pediatric:* • National Children's Alliance Standards for Accredited Members, Mental Health (pp. 36–37) • SANE Education Guidelines (IAFN, pp. 38–39) • Harvard University Center on the Developing Child, Toxic Stress • Understanding the Effects of Maltreatment on Brain Development (Child Welfare Information Gateway)

III. *VICTIM RESPONSE AND CRISIS INTERVENTION*

	• Understanding Child Maltreatment (CDC) • Defending Childhood, Defining Childhood Traumatic Stress • Developmental Milestones (CDC)

IV. *COLLABORATION WITH MULTIDISCIPLINARY TEAM MEMBERS*

KEY CONCEPTS	*All populations:* • Roles of all members of the sexual assault and sexual abuse response team • Scope of confidentiality of individual SART members during the medical forensic examination • Confidentiality and community-based advocates vs. system-based victim assistance personnel/providers • Confidential vs. privileged communications and related legal issues • Case review • Mandatory reporting for healthcare providers and other MDT members, and the impact on collaboration • The scope of the examination addressing the needs of the patient and the justice system • Related jurisdictional laws and policies; if applicable, related cross-jurisdictional issues • The role of the SAFE in education and prevention efforts • Development, implementation and sustainability of a MDT, including any jurisdictional mandates • Goals, ethics, boundaries and legal issues for multidisciplinary teams of the team • Collaboration without compromising the SAFE's legal and ethical practice requirements • Multidisciplinary communication procedures during the initial response[43] • Expanded SARTs based on needs and availability of local resources

[43] Because some MDTs respond as a team, communication procedures should be established to address role delineation to avoid team interviews, interruption of the medical forensic examination, etc.

IV. *COLLABORATION WITH MULTIDISCIPLINARY TEAM MEMBERS*	
	• Expansion of traditional MDT partners to address varied needs and experiences of children and caregivers, including mental health agencies, patients in the custody of the state and tribal/guardian agencies responsible for care, drug endangerment professionals • The medical forensic examination as a component of a comprehensive community response to sexual assault and sexual abuse • Development, implementation and sustainability of the MDT • Evaluating the coordinated response • Collaboration between local agencies and larger entities, including military installations, colleges/universities and tribal organizations/governments • Importance of ongoing intra- and interdisciplinary education • Conflict management and ethical communication • Addressing cold cases, including DNA hits and victim notification after a delay in identifying a suspect
PROTOCOL CONTENT	*All populations:* • Collaborative models (SART, CAC, Family Justice Center [FJC], etc.) • Role of the sexual assault forensic examiner • Individual member roles • Role of the team *Adolescent/adult:* • Sexual assault forensic examiners • Facilities • Initial contact • Appendix B: Creation of Sexual Assault Response and Resource Teams

IV. *COLLABORATION WITH MULTIDISCIPLINARY TEAM MEMBERS*	
	Pediatric: • Appendix 6: Initial Response Algorithm
TRAINING OUTCOMES	*All populations:* • Describe the roles and responsibilities of key multidisciplinary team members • Discuss key strategies for maintaining effective communication and collaboration between multidisciplinary team members while maintaining patient privacy and confidentiality • Describe how mandatory reporting obligations of the healthcare provider can impact collaborative work • Identify differences between community-based advocacy and systems-based victim assistance response, both in theory and as operationalized at the local level • Describe the breadth of potential collaborators with which SAFEs may interact
CULTURAL AND ACCESSILIBITY CONSIDERATIONS	*All populations:* • SARTs and MDTs representing the diversity of the community being served, with an understanding that diversity is more than simply ethnicity, race and religion • Identification of diverse needs of the community and adjusting operations, practices and MDT partners as appropriate • Identification of the scope and diversity of the community being served, including recognition of differences within populations • Inclusion of culturally specific support personnel, such as religious/spiritual leaders and tribally specific healing practices, where appropriate • MDT continuing education that focuses on cultural issues specific to patients served in the community

IV. *COLLABORATION WITH MULTIDISCIPLINARY TEAM MEMBERS*

	Pediatric: • Expansion of traditional MDT partners to address varied needs and experiences of children and caregivers, including mental health agencies, patients in the custody of the state and tribal/guardian agencies responsible for care
ADDITIONAL GUIDANCE	*Adolescent/adult:* • SANE Program Development and Operation Guide, Management of SANE Programs; Multidisciplinary Response • Position Paper: Collaboration with Victim Advocates (IAFN) • SANE Education Guidelines (IAFN, pp. 12–13, 15) • Sexual Assault Response Team Development (NSVRC) *Pediatric:* • National Children's Alliance Standards for Accredited Members, Multi-disciplinary Team (pp. 12–15); Victim Support and Advocacy (pp. 25–28) • SANE Education Guidelines (IAFN, pp. 37, 40)

V. *HISTORY TAKING*

KEY CONCEPTS	*All populations:* • Understanding the difference between medical forensic history taking and investigative interviewing • Roles, responsibilities and potential legal impact of having support persons present during the medical forensic history • Using the medical forensic history to guide physical assessment and evidence collection • Using medical forensic history to identify polyvictimization, including strangulation

V. *HISTORY TAKING*	
	• The importance of an accurate and unbiased documentation of the history • Boundary issues for SAFEs • Obtaining a comprehensive, developmentally appropriate patient history, including a focused review of systems • Coordination between law enforcement representatives and SAFEs regarding the logistics and boundaries of medical forensic history taking and investigative interviewing *Pediatric:* • Role of forensic interviewers and collaboration with SAFEs
PROTOCOL CONTENT	*All populations:* • Developmental levels and implications • Medical/surgical/sexual history • Psychosocial history • History of the assault • Documentation by healthcare personnel *Pediatric:* • Entry into the healthcare system
TRAINING OUTCOMES	*All populations:* • Identify techniques for establishing rapport and facilitating communication about the sexual assault and sexual abuse

V. *HISTORY TAKING*	
	• Demonstrate a thorough understanding of the key components of history taking following sexual assault and sexual abuse • Distinguish between the medical forensic history and investigative interviews *Pediatric:* • Demonstrate a thorough understanding of the key components of developmentally appropriate history taking following child sexual abuse
CULTURAL AND ACCESSIBILITY CONSIDERATIONS	*All populations:* • Cultural and physical safety for patients throughout the history taking process • Process for asking questions in culturally and developmentally appropriate ways • Unbiased history taking and documentation that is free of insensitive or inappropriate language • Use of communication aids or language assistance during history taking • Collaboration with qualified confidential interpreters to include their education on sexual assault and sexual abuse • Awareness of the patient's non-verbal behavior (body language), responses or non-responsiveness may be a sign of distrust
ADDITIONAL GUIDANCE	*Adolescent/adult:* • SANE Education Guidelines (IAFN, pp. 15–16, 18–19) • SANE Program Development and Operation Guide, Medical Forensic History Taking and Documentation of the Medical Forensic Examination • Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient, Overview (pp. 8–9); Documentation (pp. 39–42); Adolescent/Adult Sexual Assault Forensic Medical Report (pp. 45–50) (ACEP)

V. *HISTORY TAKING*

	Pediatric: • National Children's Alliance Standards for Accredited Members, Appendix 1 Medical History for Child Sexual Abuse; Forensic Interview (pp. 20–23) • SANE Education Guidelines (IAFN, pp. 40–41)

VI. *PHYSICAL EXAMINATION*

KEY CONCEPTS	*All populations:* • Circumstances that require referral/consultation • Importance of ongoing consent and assent • Caring for patients unable to give consent or assent (e.g., nonverbal, unconscious) • Importance of clinical judgment in determining course of care • The physical assessment of the patient for injury identification and treatment as needed • Differentiating between normal and abnormal anatomy; differentiating between injury and disease processes • Understanding the variations in physical findings related to sexual maturity and the aging process • Use of chaperones[44] during the medical forensic examination, including issues of confidentiality • Holistic examination process

[44] A chaperone is necessary during the medical forensic examination as a safeguard for patients. The chaperone may be an advocate, a healthcare provider other than the examiner or another supportive person not suspected of the abuse. Law enforcement or child protective service representatives should not be present during the exam. For more information on the presence of chaperones: http://www.kidsta.org/?page=SectionB7

VI. *PHYSICAL EXAMINATION*	
	Adolescent/adult: • Specialized assessment techniques to enhance visualization of anatomical structures *Pediatric:* • Identification of the genital structures in the child • Establishing rapport with the child • Normal anogenital variants that may be mistaken as sexual abuse • Developmental/sexual maturation changes in male and female anatomy • Patient positioning and assessment techniques to improve visualization of the anogenital anatomy • Review of the examination process for child and caregiver, including importance of freely given participation in the process • Presence of law enforcement or child protection service personnel during the examination
PROTOCOL CONTENT	*All populations:* • Head-to-toe • Anogenital • Injury identification • Assessment/visualization techniques • Research *Pediatric:* • Tanner stages of sexual maturation • Illustration of examination positions and techniques • Labeled diagrams of genital anatomy • Appendix 7 Care Algorithm

VI. *PHYSICAL EXAMINATION*	
TRAINING OUTCOMES	*All populations:* • Define terminology associated with physical trauma findings • Identify normal anogenital anatomy and physiology • Identify current evidence-based references regarding physical findings following sexual assault and sexual abuse
CULTURAL AND ACCESSIBILITY CONSIDERATIONS	*All populations:* • Recognition of patient concerns related to examiner gender and other preferences[45] • Recognition of how drug and/or alcohol use may be viewed in different communities by adults as well as minors • Recognition of the significance that "virginity" can have for different cultures • Development of culturally and developmentally appropriate explanations for the examination and findings from the examination in a sensitive manner, with awareness of the impact that positive findings may have culturally • Verbal and nonverbal behaviors that indicate the patient is uncomfortable with procedures or care • Cultural practices related to the genitalia • Use of communication aids or language assistance during the examination • Identification of the types of female genital mutilation (FGM) that may be prevalent in specific cultures • Modification of the examination to meet the unique developmental, physical and communicative needs of the patient (and, as appropriate, the caregiver) • Identification of the impact that gender identity and potential associated transition-related care (such as hormone therapy and gender confirmation surgeries) can make on the examination process and findings
ADDITIONAL GUIDANCE	*All populations:* • Female Genital Mutilation (WomensHealth.gov) • WHO Guidelines on the Management of Health Complications from Female Genital Mutilation

[45] When possible, efforts should be made to accommodate the patient's requests for responders of a specific gender (and other patient preferences). http://www.safeta.org/?page=VictimCenteredCare

- Reading, Understanding and Evaluating Research (NSVRC)

Adolescent/adult:

- SANE Education Guidelines (IAFN, pp. 16–18)
- SANE Program Development and Operation Guide, Medical Forensic History Taking and Documentation of the Medical Forensic Examination; Suicide Assessment
- Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient, Overview (pp. 9–10); Adolescent/Adult Sexual Assault Forensic Medical Report (pp. 45–50); Male Patient Sexual Assault Exams (pp. 51–54) (ACEP)
- Care of the Adolescent After Sexual Assault (AAP)
- Non-Fatal Strangulation Toolkit (IAFN)

Pediatric:

- National Children's Alliance Standards for Accredited Members, Medical Evaluation (pp. 30–34)
- SANE Education Guidelines (IAFN, pp. 42–44)
- Adams, J., Kellogg, N., Farst, K., et al. (2016). Updated guidelines for the medical assessment and care of children who may have been sexually abused. *Journal of Pediatric and Adolescent Gynecology*, *29*(2), 81–87

VII. *EVIDENTIARY SPECIMEN COLLECTION*	
KEY CONCEPTS	*All populations:* • Using the medical forensic history to guide evidence identification and collection • Sexual assault and sexual abuse evidence collection kit components • Evidence collection when there is no history • Integration of evidence collection into the examination • Evidence samples and collection techniques, including documentation of site/source of all collected evidence • Special evidence sample identification, collection, packaging and preservation • Other sources of evidence that can be affected by patient reporting options • Legal implications of kit handling • Transfer of evidence • Storage and preservation of evidence • Chain of custody • Follow-up examinations • Effective collaboration with forensic laboratory professionals
PROTOCOL CONTENT	*All populations:* • Types • Time frames for evidence collection • Collection procedures and handling • Sexual assault evidence collection kit and forms • Evidence integrity • Alcohol- and drug-facilitated sexual assault and sexual abuse • Discharge and follow up
TRAINING OUTCOMES	*All populations:* • Define time limits of collection of biological evidence following a sexual assault and sexual abuse

	• Identify and describe the types of evidence that can be collected following a sexual assault and sexual abuse, based on the event history • Define the chain of custody and explain procedures for maintaining it properly • Describe criteria associated with drug-facilitated sexual assault and sexual abuse (DFSA)
CULTURAL AND ACCESSIBILITY CONSIDERATIONS	*All populations:* • Culturally and developmentally appropriate explanations of the examination process, timing issues, etc. • Identification of cultural issues that can influence a patient's choice of what should be collected (e.g., a patient may believe that hair is sacred and therefore be reluctant to provide a hair sample), how it is collected (e.g., cultural beliefs may preclude a member of the opposite sex from being present when a patient disrobes) or how comfortable a patient is with having certain evidence collected • Potential body image issues and building patients' comfort in having evidence collected for the kit • Adaptation of and/or modification to the evidence collection process, to address patients' individual needs • Use of communication aids or language assistance during specimen collection
ADDITIONAL GUIDANCE	*All populations:* • The Biological Evidence Preservation Handbook: Best Practices for Evidence Handlers (NIST) • National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach (NIJ) • SANE Program Development and Operation Guide, Evidence Collection *Adolescent/adult:* • SANE Education Guidelines (IAFN, pp. 18–19) • Position Paper, DNA Evidence Collection from the Oral Cavity (IAFN) • SANE Programs and Evidence Storage (SAFEta)

VII. *EVIDENTIARY SPECIMEN COLLECTION*

	Pediatric: • National Children's Alliance Standards for Accredited Members, Appendix 4 Examination Referral and Timing • SANE Education Guidelines (IAFN, pp. 44–46)

VIII. *PHOTOGRAPHY*

KEY CONCEPTS	*All populations:* • Informed consent and assent for photographs • Who should take photographs • Equipment/resources • Special techniques/skills • Follow-up photographs • Quality assurance for photos • Abuse involving images • Integrity of images • Maintenance and release of photographs • Legal issues in photography *Pediatric:* • Photography or video as a standard of care with prepubescent child sexual abuse

VIII. *PHOTOGRAPHY*	
PROTOCOL CONTENT	*All populations:* • Procedure • Confidentiality issues • Storage and release *Adolescent/adult:* • Informed consent • Confidentiality • Photography *Pediatric:* • Consent and assent • Photodocumentation • Confidentiality and release of information
TRAINING OUTCOMES	*All populations:* • Demonstrate an understanding of consent, storage, confidentiality and the appropriate release and use of photographs taken during the medical forensic examination • Recognize the need for consistent peer review of photographs to ensure quality and accurate interpretation of photographic findings • Demonstrate an understanding of the impact of abuse involving photography/images on a patient's experience with photodocumentation • Understand potential legal issues related to photography (e.g., use of filters, alterations to images, use of unauthorized camera equipment such as personal cell phones or law enforcement's camera)

VIII. *PHOTOGRAPHY*	
CULTURAL AND ACCESSIBILITY CONSIDERATIONS	*All populations:* • Explanation of photography in a culturally and developmentally appropriate manner • Ways in which culture may influence patients' decisions regarding photography • Impact of use of photos in abuse/assault history (current or past) and its impact on patient's willingness to participate in photodocumentation • Informed consent and assent for photographs using culturally and developmentally appropriate processes • Use of communication aids or language assistance during photography to ensure informed consent is obtained prior to photographs
ADDITIONAL GUIDANCE	*Adolescent/adult:* • SANE Education Guidelines (IAFN, p. 20) • SANE Program Development and Operation Guide, Photo Documentation *Pediatric:* • SANE Education Guidelines (IAFN, pp. 46–47)

IX. *STDs*	
KEY CONCEPTS	*All populations:* • Prevalence/incidence and morbidity related to: o Specific communities o Age o Gender o Ethnicity o Drug resistance

IX. *STDs*	

	• Transmission
	• Follow-up
	  o Assessment and treatment
	  o Testing recommendations
	• HIV
	  o Risk assessment
	  o Post-exposure prophylaxis
	  o Treatment and follow-up medical care
	• Financial assistance resources (e.g., crime victim compensation) for costs related to testing for and care of STDs and HIV
	
	Adolescent/adult:
	• Potential legal implications of testing and results
	• Community resources
	• Regulations concerning confidential testing and mandatory reporting
	• Expedited Partner Therapy (EPT), where appropriate
	
	Pediatric:
	• Diagnostic significance of STDs in a prepubescent patient

PROTOCOL CONTENT	*All populations:* • Types of STDs • Prevalence and incidence

IX. *STDs*	
	• Signs and symptoms • Testing procedures *Adolescent/adult:* • STD evaluation prophylaxis and treatment • Payment for the examination under VAWA • Discharge and follow-up *Pediatric:* • STD evaluation and care • Appendix 8. Prepubescent STD Testing Algorithm • Appendix 9. HIV Testing nPEP Algorithm
TRAINING OUTCOMES	*All populations:* • Outline prevalence rates and risk factors for acquiring select sexually transmitted diseases • Recognize symptoms associated with select sexually transmitted diseases • Recognize that STDs are commonly asymptomatic • Identify current evidence-based national guidelines for the testing and prophylaxis/treatment of sexually transmitted diseases • Describe the appropriate approach to HIV risk assessment and prophylaxis decision making, based on current guidance, local epidemiology and available resources
CULTURAL AND ACCESSIBILITY CONSIDERATIONS	*All populations:* • Potential beliefs related to STDs and HIV • Discussion of STDs and HIV with patients in a culturally and developmentally appropriate manner

IX. *STDs*	
	• Approaches for articulating to patients the prevalence of STDs in their community and their risk, their partners' risk, testing, prophylaxis, treatment options, follow-up medical screening and care, financial assistance and referrals in a culturally and developmentally appropriate manner • Use of communication aids or language assistance for testing, risk analysis, consent for treatment and discussion of medication issues
ADDITIONAL GUIDANCE	*All populations:* • STD Treatment Guidelines (CDC) • Updated Guidelines for Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV (CDC) *Adolescent/adult:* • SANE Education Guidelines (IAFN, pp. 20–21) • SANE Program Development and Operation Guide, Prevention of Sexually Transmitted Diseases • Legal Status of Expedited Partner Therapy (CDC) • Guidance on the Use of Expedited Partner Therapy in the Treatment of Gonorrhea (CDC) *Pediatric:* • SANE Education Guidelines (IAFN, pp. 47–48) • Red Book: 2015 Report of the AAP Committee on Infectious Diseases, Sexual Victimization and STDs

X. *PREGNANCY, RISK, EVALUATION AND CARE*

KEY CONCEPTS	*Adolescent/adult:* • Understanding the probability of pregnancy after sexual assault • Testing for pregnancy with appropriate consent • Minors, consent and confidentiality for pregnancy risk, evaluation and care • Treatment options available to patients • Current treatment guidelines • Follow-up care and resources
PROTOCOL CONTENT	*Adolescent/adult:* • Risk and prevalence • Testing procedures • Available current medical treatment See also: • Pregnancy risk, evaluation and care • Discharge and follow up
TRAINING OUTCOMES	*Adolescent/adult:* • Understand how to convey to patients the science behind reproduction • Understand how to assess examiner, patient and parent/guardian belief systems related to reproduction • Understand how to recognize patients' level of understanding related to pregnancy and how to articulate medical definitions of terms that may be confusing • Identify ways to discuss with patients the full range of treatment options and potential outcomes for each option • Identify local resources

X. *PREGNANCY, RISK, EVALUATION AND CARE*	
CULTURAL AND ACCESSILIBITY CONSIDERATIONS	*Adolescent/adult only:* • Review of pregnancy risk and treatment options in a culturally and developmentally appropriate manner • Impact of cultural/religious beliefs related to pregnancy • Identification of patients' individual beliefs related to pregnancy • Use of communication aids or language assistance to ensure appropriate discussion about treatment options and consent
ADDITIONAL GUIDANCE	*Adolescent/adult:* • SANE Education Guidelines (IAFN, p. 22) • Indian Health Services Manual, Part 1. Chapter 15 • SANE Program Development and Operation Guide • Position paper (IAFN) • Position paper (ACOG) • Position paper: Sexual Assault (ACOG) • Policy statement: Management of the Patient with the Complaint of Sexual Assault (ACEP)

XI. *DOCUMENTATION*

KEY CONCEPTS	*All populations:*
	
	• Types of documentation
	  o Written
	  o Photographic
	  o Body maps/anatomic diagrams
	  o Forms
	• Informed consent documentation
	• Mandatory reporting
	• Medical forensic history documentation
	• Documentation of examination findings
	• Documentation of sources/sites of evidence collection
	• Documenting in an unbiased and accurate manner assuring consistency between written, diagrammatic and photodocumentation
	• Limitations of medical forensic documentation
	• Confidentiality
	• Quality assurance/peer review
	• Release, distribution and duplication of medical records, forensic documentation, forensic photographic and video images and forensic evidence
	  o Written
	  o Any potential cross-jurisdictional issues
	  o Procedures for seeking authorization to release information/evidence
	  o Explanation of adequate release
	  o Applicable facility/examiner program policies (e.g., restricted access to medical records related to the examination, response to subpoenas and procedures for image release)
	• Applicable facility/examiner program policies (e.g., restricted access to medical records related to the examination, response to subpoenas and procedures for image release)
	• Storage and retention policies for medical forensic records (including the importance of adhering to criminal justice standards for maintaining records)

	• Sharing medical forensic documentation with other treatment providers • Patient access to the medical forensic record • Documenting outcry statements made during the examination
PROTOCOL CONTENT	*All populations:* • Confidentiality • Regulatory and legal issues • Release of the medical forensic record • Storage of and access to the medical forensic record • Photodocumentation • Documentation by healthcare personnel • Confidentiality and release of information *Adolescent/adult:* • Informed consent *Pediatric:* • Medical history
TRAINING OUTCOMES	*All populations:* • Identify and describe key principles of medical forensic documentation, including access, storage, archiving and retention • Describe the purpose of medical forensic documentation • Define the boundaries of medical forensic documentation

XI. *DOCUMENTATION*	
CULTURAL AND ACCESSILIBITY CONSIDERATIONS	*All populations:* • Documentation that avoids insensitive or inappropriate language and biases • Use of gender neutral body maps for documentation • Communication and documentation techniques that avoid personal biases
ADDITIONAL GUIDANCE	*Adolescent/adult:* • SANE Education Guidelines (IAFN, pp. 20–23) • SANE Program Development and Operation Guide, Medical Forensic History Taking and Documentation of the Medical Forensic Examination; Medical Records Maintenance • Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient, Documentation (ACEP, pp. 39–42) • SANE Programs and Evidence Storage (SAFEta) *Pediatric:* • National Children's Alliance Standards for Accredited Members, Medical Evaluation (pp. 33–34); Appendix 5 Disclosure Log for Protected Health Information • SANE Education Guidelines (IAFN, pp. 49–50)

XII. *DISCHARGE AND FOLLOW-UP*

KEY CONCEPTS	*All populations:*
	
	• Additional follow up:
	  o Healthcare follow up (e.g., healing/resolution of injuries, confirmation of normal variants vs. injury, development of new symptoms, STI/HIV testing, tolerance of HIV nPEP)
	  o Mental health/crisis intervention
	  o Advocacy to assist with comprehensive services
	  o Criminal justice (including information on law enforcement reporting if the patient was undecided about reporting at the time of the examination)
	  o Medical (e.g., infectious disease [where available] when HIV nPEP has been initiated, other specialty care when needed)
	• Multidisciplinary coordination needed during the discharge process
	• If applicable, related cross-jurisdictional issues and information sharing between jurisdictions
	• Appropriate and confidential billing processes, consistent with applicable legislation, that address a broad spectrum of examination scenarios (including delayed disclosures and exams without completion of evidence collection kits)
	
	Adolescent/adult:
	
	• Payment for the examination
	• Jurisdictional and/or facility/examiner program policies addressing coverage of examination costs
	• Applicable provisions and definitions relating to payment for the examination under VAWA and other relevant legislation
	• Payment options for the various components of the examination, including HIV nPEP
	  o Impact of reporting/not reporting on payments
	  o Specifics for billing each entity
	  o If applicable, related cross-jurisdictional issues
	  o Crime victim compensation process: applicability, eligibility, access and who can assist patients with navigating this process
	  o Other financial assistance resources

XII. *DISCHARGE AND FOLLOW-UP*	
	○ Issues and concerns related to payment: patient and provider perspectives • Discharge planning that is done in a collaborative manner to ensure that patients' needs are met (i.e., transportation, clothing replacement for those taken during the exam, housing) and written discharge instructions • Safety planning • Other agency and community referrals, including adult or child protective services, as indicated *Pediatric:* • Additional follow up ○ Child protection/social services • Crime Victim Compensation fund access and other resources for financial assistance for families concerned about examination costs • Coordination with the family, child protection/social services and law enforcement to assure the immediate safety of the child
PROTOCOL CONTENT	*All populations:* • Safety • MDT considerations • Medical follow up • Crime victim compensation • Coordinated team approach • Discharge and follow up • Reporting to law enforcement • Payment issues
TRAINING OUTCOMES	*All populations:* • Identify patient-specific resources that address safety following a sexual assault and sexual abuse

	• Facilitate access to appropriate multidisciplinary agencies, recognizing that limitations in access may exist in rural and tribal communities • Demonstrate awareness of differences in discharge and follow-up concerns related to age, developmental level, cultural diversity and geographic differences • Describe applicable regulations and guidance for medical forensic examination payment, and reimbursement for additional medical care
CULTURAL AND ACCESSIBILITY CONSIDERATIONS	*All populations:* • Use of culturally and developmentally appropriate language in both verbal and written discharge instructions • Use of communication aids or language assistance to craft discharge and follow-up plans • Use of certified or qualified interpreters to convey discharge and follow-up plan • Creation of discharge instructions in community-specific languages • Spiritual health, including identification and provision of referrals for culturally specific healers, faith-based organizations and agencies providing services in the community
ADDITIONAL GUIDANCE	*All populations:* • The Centers for Disease Control Sexual Violence Prevention Package *Adolescent/adult:* • SANE Education Guidelines (IAFN, pp. 23–24) • SANE Program Development and Operation Guide, Discharge and Followup Care • National Association of Crime Victim Compensation Boards (for state listings)

XII. *DISCHARGE AND FOLLOW-UP*

	Pediatric: • National Children's Alliance Standards for Accredited Members, Case Review (pp. 33–35) • SANE Education Guidelines (IAFN, pp. 50–51)

XIII. *LEGAL CONSIDERATIONS AND TESTIMONY*

KEY CONCEPTS	*All populations:* • Investigation o Components of a criminal investigation, and differences between the investigation and the medical forensic examination encounter o Differences between a criminal investigation or prosecution o Circumstances where concurrent jurisdiction and concurrent investigations may exist • Confidentiality o In difficult/complex situations (e.g., communities that are isolated or have small populations, residents tend to know one another and word of a crime may travel quickly) o When providing follow-up care and sharing medical forensic documentation with other care providers o When debriefing about cases o Related to data used during trainings or quality assurance/quality improvement/peer review processes Circumstances where concurrent jurisdiction and concurrent investigations may exist • Reporting o Laws and regulations o Mandatory reporting laws for sexual assault and sexual abuse incidents and other related laws and regulations o Patient options for reporting including: • Anonymous and unreported examinations

XIII. *LEGAL CONSIDERATIONS AND TESTIMONY*

- Restricted and unrestricted reporting in the military patient
  - Delayed reporting and related issues
  - Potential consequences of reporting options and assisting patients with informed decision making
  - Issues and fears that patients who disclose sexual assault and sexual abuse incidents may have about reporting
  - Scope of confidentiality/policies related to self-harm or harm of others
  - The impact of reporting and examination payment

- Informed consent/assent
  - Determining capacity to consent, and identifying alternative processes for patients who are unable to provide consent
  - Assent
  - Consent when the patient is intoxicated or under the influence of alcohol and/or drugs
  - Withdrawal of consent and withdrawal of assent, and their associated potential consequences
  - HIPAA-compliant patient consent
  - Coordination with other providers to support patient choices for examination and consent
  - Procedures to obtain consent when the patient is unable to consent
  - The importance of never performing an examination against the will of the patient
  - When the parent/caregiver is the suspected perpetrator
  - Patient consent for trainee participation in the examination process (including medical/nursing students, licensed healthcare providers in formal training and examiners in training)

- Regulatory
  - The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- Review of VAWA as it impacts patient choices and payment for the medical forensic examination
- Role of SAFEs in judicial and administrative proceedings
- Fact vs. expert witnesses
- Judicial proceedings arising from sexual assault or abuse (e.g., proceedings in criminal, civil, tribal courts and military courts)

	• Related administrative and family court proceedings (e.g., university/administrative hearings, Title IX hearings, matrimonial/divorce proceedings and family law matters, such as child custody hearings)
	• Preparing and testifying for the prosecution and the defense
	• Legal privilege and waiver of privilege
	• Conflicts of interest
	• Responding to subpoenas
	• Access to the patient records (court, investigative, child protection, patient, parent/guardian)
	
	Adolescent/adult only:
	
	• Investigation
	  o Potential impact on a case if a patient has outstanding warrants or if the patient is under arrest or may be arrested for criminal activity that occurred within or around the sexual assault
	
	Pediatric only:
	
	• Informed consent/assent
	  o Determining who can provide consent for the examination of the child
	  o Differentiating consent from assent and the importance of both
	  o Accessing the medical forensic examination records of the child
	• Differentiation between criminal response to child sexual abuse and child protection response

PROTOCOL CONTENT	*All populations:* • Reporting • Legal requirements (i.e., HIPAA, Emergency Medical Treatment and Labor Act [EMTALA])

XIII. *LEGAL CONSIDERATIONS AND TESTIMONY*	
	• Judicial proceedings *Adolescent/adult:* • Victim-centered care • Confidentiality • Informed consent • Reporting to law enforcement • Examiner court appearances • Appendix C: Impact of Crawford v. Washington, Davis v. Washington, & Giles v. California • Payment for the examination under VAWA *Pediatric:* • Consent for care • Appendix 5: Impact of Crawford v. Washington and the Confrontation Clause
TRAINING OUTCOMES	*All populations:* • Define the concepts of informed consent and assent • Identify appropriate methodology for obtaining consent to perform a medical forensic examination • Describe Crime Victim Compensation options associated with the provision of a medical forensic examination • Demonstrate the necessary knowledge to explain patient confidentiality and its limitations • Describe legal requirements associated with mandated reporting requirements in specific patient populations • Identify necessary skills for providing effective, objective trial testimony • Identify the different types of proceedings in which a SAFE may testify

XIII. *LEGAL CONSIDERATIONS AND TESTIMONY*	
CULTURAL AND ACCESSIBILITY CONSIDERATIONS	*All populations:* • Potential barriers, including, but not limited to, language differences, literacy issues and disability issues with regard to consent forms and communicating information to patients (and caregivers) • Provision of culturally and developmentally appropriate explanations to patients • Potential concerns about and impact of immigration/legal status on investigation and judicial proceedings • Fear and/or distrust of law enforcement by some patients and differing views of the criminal justice system • Potential concerns over the financial impact of participation in criminal/civil justice systems and continuing follow-up care • Privacy concerns about participation in criminal/civil justice systems • Methods for ensuring patients are not billed for core services • Resources to assist patients with financial issues that are language appropriate
ADDITIONAL GUIDANCE	*All populations:* • Indian Health Services Manual Part 5 Management Services, Chapter 27 *Adolescent/adult:* • SANE Education Guidelines (IAFN, pp. 23-24) • SANE Program Development and Operation Guide, Options for Reporting; Informed Consent and Patient Confidentiality; Legal and Ethical Foundations for SANE Practice; SANE Testimony • Medical Evidence and the Role of Sexual Assault Nurse Examiners in Cases Involving Adult Victims (AEquitas) • Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient, Testimony (ACEP, pp. 113–116) • Anonymous Reporting in Sexual Assault Cases (Aequitas) *Pediatric:* • SANE Education Guidelines (IAFN, pp. 51—54)

Clinical Content

Didactic training is only one component of SAFE education. Applying that content in the clinical setting is critical to achieving competency for any clinician. The following clinical education content identifies the framework for the specially educated and clinically prepared SAFE who cares for the sexual assault and sexual abuse patient population, including training objectives, critical topics and cultural considerations. Students should ***demonstrate*** each of the following competencies applicable to the specific patient population (e.g., adult/adolescent or pediatric). The competencies are not mandatory, but rather, are intended to serve as guidance to be adapted as appropriate or established in the community where the clinician practices.

Adolescent/Adult SAFE **Clinical Training Objectives**	**Pediatric SAFE** **Clinical Training Objectives**
The SAFE in clinical training and under supervision will demonstrate the following: 1. Preparing the adolescent/adult for the examination. 2. Documentation of physical examination findings. 3. Differentiation and documentation of normal anogenital anatomy and normal variants from abnormal findings. 4. Proper collection and documentation of specimens for testing for sexually transmitted diseases. 5. Proper collection, documentation, packaging and transfer of evidentiary materials. 6. Appropriate discharge and follow-up practices as they relate to patient safety and MDT response. 7. Participation in quality assurance documentation review processes.	The SAFE in clinical training and under supervision will demonstrate the following: 1. Preparing the prepubescent child and the caregiver for the examination. 2. Documentation of physical examination findings. 3. Differentiation and documentation of normal anogenital anatomy and normal variants from abnormal findings. 4. Proper collection and documentation of specimens for testing for sexually transmitted diseases. 5. Proper collection, documentation, packaging and transfer of evidentiary materials. 6. Appropriate discharge and follow-up practices as they relate to patient safety and MDT response. 7. Participation in quality assurance documentation review processes.

Adolescent/Adult SAFE **Competencies**	**Pediatric SAFE** **Competencies**
Informed consent—preparing the adolescent and adult patient for the medical forensic examination • Explaining examination options to the patient in a developmentally appropriate manner • Recognizing and initiating mandatory reporting where applicable • Assessing capacity to consent • Mandatory reporting requirements and the limitations of confidentiality	Informed consent and assent—preparing the child and caregiver for the medical forensic examination • Explaining the examination options to the child and parent/guardian in a developmentally appropriate manner • Explaining the examination to the child's caregiver • Mandatory reporting requirements and the limitations of confidentiality • Navigating differences between desires of patients and their parent(s) or guardian(s)
History taking • From patient or others if the patient is unable • Recognizing the critical elements to include in the medical forensic history, including review of systems • Understanding the impact of issues such as trauma and substance use/abuse on the patient's ability to recall and sequence details • Using information from the history to establish the plan of care	History taking • From caregiver and/or child • Recognizing the critical elements to include in the medical forensic history, including review of systems • Understanding the impact of trauma on the patient's ability to recall details • Using information from the history to establish the plan of care • Formulating the plan of care when there is no disclosure from the child
The sexual assault and sexual abuse evidence collection kit • Documentation of the medical forensic history • The kit contents • Using the contents of the kit for collection of samples • Timing considerations for evidentiary samples	The sexual assault and sexual abuse evidence collection kit • Documentation of the medical forensic history • The kit contents • Using the contents of the kit for collection of samples • Timing considerations for evidentiary samples
Head-to-toe physical assessment	Head-to-toe physical assessment

Adolescent/Adult SAFE **Competencies**	**Pediatric SAFE** **Competencies**
• Demonstrating appropriate physical assessment techniques • Demonstrating positions for the examination to allow optimal visualization of anogenital structures • Optional positioning in cases where mobility restrictions exist • Integrating the collection of specimens into the physical assessment process based on the history, if available, and the assessment findings • When the history is not available, formulating a plan for collection of potential evidentiary materials	• Demonstrating appropriate physical assessment techniques • Demonstrating positions for the examination to allow optimal visualization of anogenital structures • Integrating the collection of specimens into the physical assessment process based on the history, if available, and the assessment findings • When the history is not available, formulating a plan for collection of potential evidentiary materials
Detailed anogenital examination • In the female patient (including the impact of female genital mutilation [FGM] on assessment) • In the male patient (including the circumcised vs. uncircumcised penis) Examination techniques for visualization • Examination positions • Labial separation • Labial traction • Toluidine blue dye, including appropriate parameters for use and techniques for application and removal • Hymenal assessment, including urinary catheter use • Use of the speculum	Detailed anogenital examination • In the female patient (including the impact of FGM/C on assessment) • In the male patient (including the circumcised vs. uncircumcised penis) Examination techniques for visualization • Examination positions • Labial separation • Labial traction • Hymenal assessment
Injury identification • Body surface	Injury identification • Body surface

Adolescent/Adult SAFE **Competencies**	**Pediatric SAFE** **Competencies**
• Anogenital • Oral cavity • Strangulation injury • Developing differential diagnoses	• Anogenital • Oral cavity • Strangulation injury • Developing differential diagnoses

Documentation
 	
• Written/electronic
• Photography
  o Colposcope or other magnification tool used for photodocumentation
	Documentation
	
	• Written/electronic
	• Photography
	  o Colposcope or other magnification tool used for photodocumentation

Sexually transmitted diseases • Collection techniques[46] • Prophylaxis administration and explaining the use of medications to prevent STD • Implements expedited partner therapy (EPT) when/where applicable • HIV risk assessment, evaluation and prophylaxis	Sexually transmitted diseases • Collection techniques • Prophylaxis administration and explaining the use of medications to prevent STD • HIV risk assessment, evaluation and prophylaxis
Pregnancy risk, evaluation and care • Explains pregnancy risk to the patient and offers appropriate treatment	N/A
Identification, collection and preservation of forensic evidence	Identification, collection and preservation of forensic evidence

[46] Routine STD testing in adolescent/adult patients is not recommended, rather an approach assessing each individual patient for the need for testing is recommended (SAFE Protocol, pp. 119–124).

Adolescent/Adult SAFE **Competencies**	**Pediatric SAFE** **Competencies**

• Buccal swabs
• Oral swabs
• Bite mark swabbing
• Other body surface swabbing
• Fingernail clippings/swabbing
• Genital swabs
• Anal/rectal swabs
• Vaginal swabs
• Cervical swabs
• Head hair combing/collection[47]
• Pubic hair combing/collection
• Clothing
• Toxicology, including indications, consent and different purposes for obtaining samples
• Debris
• Other special specimen collection options such as:
  o Products of conception
  o Tampons
  o Foreign bodies, including condoms
	• Buccal swabs
	• Oral swabs
	• Bite mark swabbing
	• Other body surface swabbing
	• Fingernail clippings/swabbing
	• Genital swabs (pubic area, labia major and minor)[48]
	• Anal swabs
	• Head hair combing/collection[49]
	• Clothing
	• Toxicology
	• Debris
	• Other special specimen collection options such as:
	  o Diapers

Evidence integrity • Proper packaging and sealing of evidentiary materials	Evidence integrity • Proper packaging and sealing of evidentiary materials

[47] Jurisdictions should evaluate the necessity of routinely collecting hair samples based on discussions of how often such evidence is actually useful or used in the jurisdiction (SAFE Protocol, p. 71 footnote 147).

[48] Hymenal and vaginal swabs should not be performed on prepubertal children unless the child has required sedation or anesthesia to conduct the exam due to anogenital trauma.

[49] Jurisdictions should evaluate the necessity of routinely collecting hair samples based on discussions of how often such evidence is actually useful or used in the jurisdiction (SAFE Protocol, p. 71 footnote 147).

Adolescent/Adult SAFE Competencies	Pediatric SAFE Competencies
• Proper maintenance of chain of custody	• Proper maintenance of chain of custody

Additional Content for Clinical T[50]	
Adolescent/Adult SAFE	**Pediatric SAFE**
Working with collaborative partners from the sexual assault and sexual abuse response team or MDT • Community based advocacy agency • Systems-based victim assistance agency/personnel • Law enforcement agency • Prosecutor • Forensic laboratory • Adult/child protection/welfare agencies • Victims' rights attorneys/civil attorneys Understanding patient referral resources for discharge and follow up • Medical/mental health providers and agencies • Shelter/housing services • Social service agencies	Working with collaborative partners from the MDT • Community based advocacy agency • Systems-based victim assistance agency/personnel • Law enforcement agency • Prosecutor • Forensic laboratory • Child protection/welfare agencies • CACs • Child abuse pediatricians Understanding patient referral resources for discharge and follow up • Medical/mental health providers and agencies • Shelter/housing services • Social service agencies

[50] By observing and or meeting with professionals in the disciplines listed in the additional options for clinical training, the SAFE may benefit by recognizing the resources available for referral after sexual assault. These additional options for training should not substitute for the clinical skills recommended in the prior sections of this chart.

Additional Content for Clinical T[50]	
• Faith-based community support services • Culturally specific community support service providers and resources • Military resources and service providers • Tribal resources and service providers • Civil legal services	• Faith-based community support services • Culturally specific community support service providers and resources • Military resources and service providers • Tribal resources and service providers
Demonstrate use of the microscope in clinical practice[51]	Demonstrate use of the microscope in clinical practice[52]
Demonstrate the appropriate use of the anoscope if within the clinical practice of the trainee[53]	
Observation of court proceedings and SAFE/expert witness testimony • Criminal • Civil[54] • Administrative • School disciplinary hearings • Military (if applicable) • Tribal (if applicable)	Observation of court proceedings and SAFE/expert witness testimony • Criminal • Civil • Military (if applicable) • Tribal (if applicable)

[51] If a microscope is used by the clinician, policies and procedures should be in place that establish and maintain ongoing competency in the practice for which the microscope is being used.

[52] See footnote 43.

[53] Certain circumstances make anoscopic evaluation more urgent, including bleeding, pain, penetration with a foreign body and previous anal/rectal trauma. Programs should establish a policy that outlines when evaluation for anoscopy is medically necessary, and not simply as an ancillary tool for potential injury documentation. Clinicians should ensure that anoscopy falls within their scope of practice.

[54] For minors, the SAFE could provide testimony in the context of a juvenile dependency, delinquency and/or termination of parental rights' hearing. SAFEs can also provide testimony for orders of protection.

References

Melnyk, B. M., & Fineout-Overholt, E. (2011). *Evidence-based practice in nursing and healthcare. A guide to best practice*. Philadelphia, PA: Lippincott, Williams, & Wilkins.

Appendix A: SAFE Core Faculty Considerations

Not every organization will conduct its own SAFE training. Many rely on outside faculty to provide the core content. Because many professionals offer this service, this tool suggests some areas to consider when identifying an educator who can provide comprehensive training consistent with the *Revised Training Standards*.

Core Faculty	Adolescent/Adult Course	Pediatric Course
Non-Nursing (MDs and PAs)		
SAFE-trained and clinically practicing specific to the patient population served	X	X
Nursing		
In programs training nurses, one SANE-A®-certified nurse or nurse with equivalent training/clinical and forensic experience[55]	X	
In programs training nurses, one SANE-P®-certified nurse or nurse with equivalent training/clinical and forensic experience[56]		X

[55] Note: For nurses who wish to be eligible for SANE-A® or SANE-P® certification, at least one core faculty member is required to hold current SANE-A certification.

[56] Note: For nurses who wish to be eligible for SANE-A® or SANE-P® certification, at least one core faculty member is required to hold current SANE-P certification.

Multidisciplinary Content Experts	Adolescent/Adult Course	Pediatric Course
Adult protective services	X	
Child protective services	X	X
Community-based advocacy (where available)	X	X
Criminalist (crime laboratory personnel)	X	X
Criminal prosecution	X	X
Law enforcement investigation	X	X
Systems-based victim assistance personnel (Child Advocacy Center, victim witness, offender management professionals, etc.)	X	X

Appendix B: Guidance Around the Use of Standardized Patients

For centuries, healthcare education has included the use of simulation for clinical learning.[57] The use of live subjects in medical and nursing education has burgeoned since the early 1960s. Skills that need to be acquired during the clinical component of SAFE training can be accomplished with the use of adult standardized patients. Standardized patients provide students the ability to practice history taking, pelvic examinations, evidence collection and specialized examination adjuncts used in the course of the medical forensic examination, while simultaneously receiving guidance and feedback from the standardized patient. Using standardized patients to teach medical students to perform the pelvic examination and male genital examination has been shown to be an effective method of education.[58] Currently, the Association of Standardized Patient Educators (ASPE) is drafting a set of Standards of Practice for the use of simulation training. Other organizations have drafted standardized patient guidelines for use in their institutions,[59] outlining issues such as payment, requesting standardized patients for training, photography and videotaping of standardized patients.

For programs that intend on using federal grant funds to support the use of standardized patients, the Department of Justice (DOJ) has released guidance on the research and protection of human subjects, which, although not specifically addressing the use of standardized patients, may help to clarify that the "Research and Protection of Human Subjects" regulations do not apply in this situation. Employing the OJP Decision Tree for determining whether an activity constitutes research involving human subjects will help ensure that the intended activity is for the skills acquisition of the individual learner and not for systemic investigation or generalizable knowledge.

Recommendations for the use of standardized patients for clinical training of registered nurses, advanced practice nurses, physicians and physician assistants include:

Educate the standardized patients about the skills that SAFE candidates will need to obtain during the clinical skills labs. These skills may include:

1. Explaining the medical forensic examination, patient options and obtaining informed consent for the procedures planned
2. Incorporating an understanding of sexual assault and sexual abuse response and the neurobiology of trauma into patient scenarios

[57] Bradley, P. (2006). The history of simulation in medical education and possible future directions. *Medical Education*, *40*(3), 254–262.

[58] McBain, L., Pullon, S., Garrett, S., & Hoare, K. (2016). Genital examination training: Assessing the effectiveness of an integrated female and male teaching programme. *BMC Medical Education, 16*(1),299. DOI 10.1186/s12909-016-0822-y

[59] Standardized patient guidelines and request form, Stanford University.

3. History taking, to include the patient's medical and surgical history, as well as the history of the sexual assault and sexual abuse for the purposes of organizing the medical forensic examination
4. Evaluating HIV and STD risk and explaining treatment options
5. Conducting the female and male anogenital assessment and examination, including speculum insertion to visualize the internal structures of the female patient, and the bimanual examination
6. Evidence collection techniques
7. Medical forensic examination techniques to include: examination/inspection of the hymenal tissue using the urinary catheter and/or swab, toluidine blue dye to visualize/highlight injury, labial separation and traction techniques

Work collaboratively with the standardized patient(s) to establish:

1. The number of speculum/anoscope insertions that will be permitted during a clinical skills day.
2. The length of sessions, including history taking, non-invasive physical evidence collection, victim counseling role play, assessment and feedback, teaching and application of any moulage materials.
3. The maximum hours of work, breaks and rotation through different skills areas.
4. Photography parameters (include privacy considerations).

Appendix C: Minimum Training Recommendations
(for all providers who care for patients who have been sexually assaulted and sexually abused)

Basic Elements:

1. Neurobiology of trauma
2. The role and importance of multidisciplinary collaboration in sexual assault including:
    a. healthcare providers
    b. sexual assault and sexual abuse advocacy
    c. law enforcement
    d. adult/child protective services
3. The pediatric, adolescent and adult sexual assault and sexual abuse medical forensic examination
    a. Informed consent and assent
    b. Language
        i. Behavioral descriptors
        ii. Terminology, anatomy and definitions
        iii. Avoiding use of legal terminology (vs. medical terminology)
        iv. Using factual terms rather than value judgements in language use
        v. Avoiding coercion and/or judgment
    c. Mandatory reporting
    d. Patient options for reporting to law enforcement
    e. History taking in sexual assault and abuse
    f. Sexual assault and sexual abuse evidence collection
        i. The evidence collection kit
        ii. Evidence identification
        iii. Specimen collection and basic forensic principles
            1. Changing gloves between body areas
            2. Drying specimens
            3. Handling, labeling and packaging samples
            4. Toxicology specimens
            5. Other specialized specimen handling
        iv. Specimen handling, chain of custody
    g. Documentation of the examination
        i. Forms
        ii. Body maps
    h. Medical management
        i. STD treatment standards and recommendations for prophylaxis
        ii. HIV risk evaluation, screening and recommendations for prophylaxis
        iii. Pregnancy risk, evaluation and care
        iv. Injury evaluation, treatment and documentation

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        1. Basic mechanisms of injury
        2. Strangulation evaluation
    v. Other medical management issues (tetanus)

i. Discharge planning, safety planning, suicide risk assessment and referrals for post-assault care and follow-up needs
j. Management of documentation/records
    i. Storage of examination records
    ii. Release of records
    iii. Retention of records
k. Court testimony
    i. Subpoena responses
    ii. Testimony basics