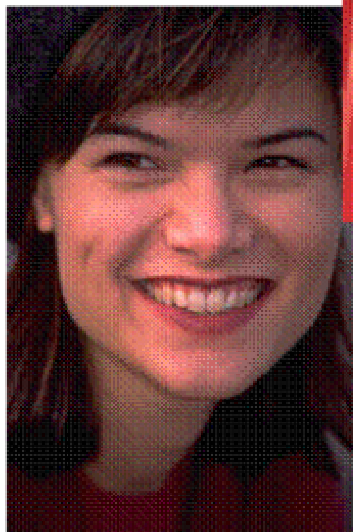
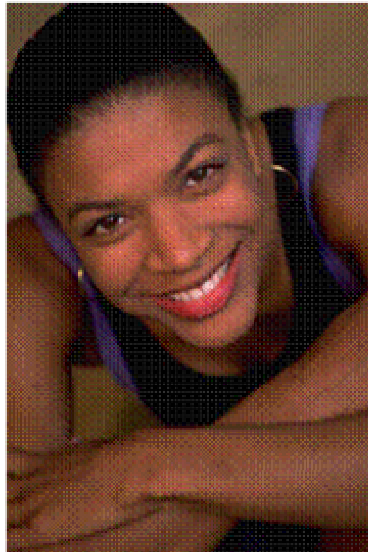
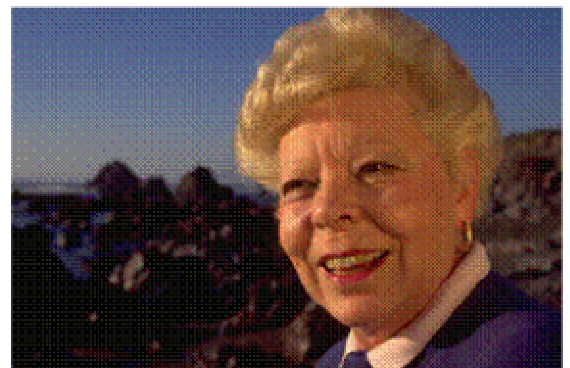


A report on the level of care for sexual assault patients in Texas hospital emergency rooms.



December 2003



Authored by:
Mimi Garcia
B.A. Sociology Candidate
Southwestern University
Research Intern

And

Torie Hilton, M.Ed.
Director of Operations
TAASA



Texas Association Against Sexual Assault

Acknowledgements

This study and report would not have been possible without the expertise of the following individuals:

Rusty Rooms BSN, RN, DABFN
Coordinator of Forensic Nursing Services
Memorial Hermann Healthcare System

Sheri Nevins, RN, CA/CP SANE
Sexual Assault Nurse Examiner Administrator
Sexual Assault Prevention & Crisis Services
Texas Office of the Attorney General

Jennifer Banda, JD
Director of Government Affairs
Texas Hospital Association

Cynthia N. Colbert, MSW
President
Catholic Health Association of Texas

Dr. Ed Kain
Sociology and Anthropology Department
Southwestern University

For additional copies of this report, contact the TAASA office at:

TAASA
7701 N. Lamar Blvd., Suite 200
Austin, TX 78752
Phone: (512) 474-7190
Fax: (512) 474-6490

This report is also available at www.taasa.org

TABLE OF COMMENTS

| | |
|--|----|
| EXECUTIVE SUMMARY | 3 |
| BACKGROUND | 5 |
| PURPOSE | 5 |
| METHODS | 5 |
| RESULTS | 6 |
| SECTION 1: GEOGRAPHIC DATA ON FACILITIES | 7 |
| SECTION 2: BEFORE THE EXAM | 8 |
| SECTION 3: PROVIDING TREATMENT | 10 |
| SECTION 4: HOSPITAL POLICIES AND PROTOCOLS | 14 |
| SECTION 5: SANES AND OTHER TRAINED PROFESSIONALS ... | 16 |
| DISCUSSION | 18 |
| LIMITATIONS | 19 |
| APPENDIX A | 21 |
| APPENDIX B | 24 |
| APPENDIX C | 25 |

EXECUTIVE SUMMARY

Central Focus of Study:

This study was conducted to assess the level of care for sexual assault patients in Texas hospital emergency rooms, specifically pertaining to the patient's care in the hospital before, during, and after a forensic medical examination.

Methods:

All hospitals with emergency rooms¹, including children's hospitals and members of the Catholic Health Association, were asked to participate in a survey that included measures of: geographic data, routines for treating sexual assault patients before, during, and after medical examinations, hospitals policies and protocols, and training of health care providers.

Analysis and Results:

Four hundred twelve surveys were distributed and 107 were returned (26 percent response rate). These data were analyzed with Excel and SPSS applications and analyses included descriptive statistics, one-way analysis of variance tests, post hoc examinations, and regression analyses.

Describing Hospital Participants. The average number of beds in participant hospitals was 147. Fourteen percent of these hospitals describe themselves as public; 26 percent as for-profit; and 60 percent as nonprofit. Additionally, 62 percent of hospitals indicated they were in rural locations and 39 percent in urban locations. Finally, the hospitals see an average of 4.6 sexual assault patients per month.

Before the Exam. Privacy is extremely important to sexual assault patients. Details of the assault are often embarrassing to discuss. Because of this concern TAASA recommends that a private area be provided for sexual assault patients to discuss the assault with law enforcement and medical professionals. Eighty-two percent of hospitals in this survey indicated private area was provided, 19 percent only when possible.

Because the evidence collected through the exam may be used in a trial, it is important to maintain a proper chain-of-custody. This is easier when the exam occurs in a dedicated exam room. Seventy-three percent of hospitals indicate these were provided, 21 percent not provided, and 6 percent provided when possible.

Texas State law allows a support person, including a rape crisis center advocate, in the exam room for support and comfort if the patient desires. Seventy-six percent of hospitals indicate that they gave the patient the option for contacting a rape crisis center advocate, 7 percent said no and 16 percent indicated there was no rape crisis center in their area.

Treatment of Sexual Assault Patients. Some communities have developed a system where one hospital in their area treats sexual assault patients. In this survey, 60 percent of hospitals treat the sexual assault patients and 40 percent stabilize and transfer.

Sexually Transmitted Infections (STI), including HIV, are a common concern of rape survivors. It is standard care to provide information about STIs, including HIV to sexual assault patients. Treatment is dependent on the circumstances of the patient. 89 percent of hospitals provide information and treatment for STI's, 70 percent for HIV.

Pregnancy is another common concern. Eight-four percent of hospitals indicate they provide information on the risks of pregnancy. Emergency contraception (EC) can prevent a pregnancy if taken within 72 hours after the assault. It is the standard of care to inform and offer female sexual assault patients emergency contraception, yet only 23 percent of Texas emergency

¹ Only regular care hospitals were included. This excluded residential and rehabilitation facilities.

rooms meet this standard of care. Seventy percent of emergency rooms provide, at a minimum, information, but a distressing 13 percent do not even inform sexual assault patients of emergency contraception unless the patient asks.

Hospital Policies Regarding the Treatment of Sexual Assault Patients

There should be a minimum level of care for sexual assault patients in Texas emergency rooms. This minimum level may be indicated by the presence of hospital policy and/or the presence of policies/protocols published by outside entities. Seventy-eight percent of hospitals report having a specific policy for the treatment of sexual assault patients. Sixty-five percent report having a copy of the *Texas Evidence Collection Protocol* on file. Thirty-one percent report having a copy of the *American College of Emergency Physicians Guidelines for the Care of Sexual Assault Patients*.

Free, confidential services are provided to all rape survivors through their local rape crisis center. Services include: hospital accompaniment, individual and group counseling, criminal justice accompaniment and advocacy. Survivors should be assisted in contacting their local rape crisis center. Seventy-seven percent of hospitals report referring patients for rape crisis center care, 8 percent do not refer patients and 15 percent indicate that a rape crisis center is not available.

Training Hospital Staff for the Treatment of Sexual Assault Patients

Sexual Assault Nurse Examiners (SANEs) are nurses who are specially trained to conduct sexual assault exams sensitively, accurately and as objectively as possible. The sexual assault exam usually lasts 2-3 hours and consists of a detailed set of collection “steps.” Training is highly recommended since the evidence collected will be scrutinized in a court of law. Thirty-four percent of hospitals report having a SANE program and 66 percent report not having the program.

Although a SANE program is ideal, many hospitals do not have the program and depend on their regular emergency room staff to perform the sexual assault exams. Typically speaking, only one-fourth of emergency room physicians and nurses are reported as receiving specific training regarding the treatment of sexual assault patients with less than 5 percent of respondents indicating that it is a requirement for employment. Findings also indicate that physician assistants and nurse practitioners have seldom receive training on sexual assault examinations.

Discussion and Analysis of Trends:

Hospital Size and Location May Affect the Distribution of Emergency

Contraception. The responses from participating hospitals indicate that: (1) only the largest hospitals provide EC as a part of standard care; (2) mid-sized hospitals tend to transfer sexual assault patients; (3) smaller hospitals tend to only give information regarding EC if it is specifically requested; (4) urban settings are more likely than rural hospitals to give EC.

Information Regarding the Risks of Pregnancy Varies. The responses from participating hospitals indicate that: (1) larger facilities tend to more freely provide information to sexual assault patients regarding pregnancy; (2) the risks of pregnancy are more likely to be discussed in urban rather than rural settings.

Limitations. The two significant limitations identified are: the use of self-report data and potential instrument error.

Conclusions

Findings indicate that care for sexual assault patients in Texas depends on the hospital, setting, size, and training of staff. Understanding these differences is an important feature to improving the care to victims of sexual assault in Texas.

BACKGROUND

This study was completed at the Texas Association Against Sexual Assault under the supervision of Victoria Hilton, Special Projects Director. TAASA is a non-profit educational and advocacy organization. As an agency, TAASA works to promote sexual assault awareness throughout the state of Texas. TAASA provides training to rape crisis personnel, law enforcement, other service agencies, community groups, and schools on topical issues related to sexual assault as well as curriculum information for sexual assault trainings.

The care that sexual assault patients receive in hospital emergency rooms is one of the many areas where sexual assault survivors are vulnerable to re-victimization. Because of the nature of the crime, sexual assault patients have specific needs in the hospital emergency room that are unlike other emergency patients. These needs include forensic evidence collection, prophylaxis treatment for sexually transmitted infection (STI), HIV counseling and pregnancy prevention including emergency contraception (EC).

This study was undertaken to assess the level of care for sexual assault patients in Texas hospital emergency rooms as pertaining to the patient's care in the hospital before, during and after a forensic medical exam.

PURPOSE

The purpose of this study was five-fold:

1. To develop a survey that would evaluate the level of care in hospital emergency rooms for sexual assault patients,
2. To administer the survey to hospital emergency rooms throughout the state of Texas,
3. To analyze the data acquired via the survey,
4. To discuss the implications of the findings, and
5. To generate a written report of the results.

METHODS

In order to provide a comprehensive evaluation of the level of care for sexual assault patients in Texas hospital emergency rooms, all regular hospitals with emergency services throughout the state of Texas were asked to participate in the survey. Regular hospitals were determined as non-residential, non-rehabilitation hospitals. Children's hospitals were included in the study on the grounds that children are also victims of sexual assault and their treatment is of vital importance to the general treatment of sexual assault patients. Children's hospitals, however, were not separated from general care hospitals in this study.

Mimi Garcia and Torie Hilton developed the survey for this study based on anecdotal knowledge, standards of care established in other states and national protocols outlining the needs of sexual assault patients in hospital emergency rooms. The survey was also refined through suggestions from allies at the Texas Office of the Attorney General, Texas Hospital Association, Catholic Health Association, Texas Sexual Assault Nurse Examiners (SANE) and Southwestern University Sociology/Anthropology Department. The final product was a two page, thirty-one item survey including instructions and references for web sites to contact to receive copies of protocols that are addressed in the survey (Appendix A).

Section titles of the survey included:

- Geographic data on your facility
- When sexual assault patients are seen in your emergency department and before an exam is administered
- In providing treatment to sexual assault patients
- Hospital policies and protocols regarding the care and treatment of sexual assault patients
- Sexual Assault Nurse Examiners and other trained professionals

A cover letter (Appendix B) written by the special projects director and researcher, signed by executive director, Annette Burrhus-Clay, included a deadline for completion of the survey and contact information. The survey was also made available via the internet on the free survey service of Zoomerang.com. The cover letter, survey and self-addressed envelope were mailed to 368 non-Catholic hospitals from the TAASA office. The mailing was addressed to the Emergency Department Director/Manager to insure that the survey would reach a staff member who was familiar with hospital protocol and qualified to answer the questions.

Because some Catholic hospitals have been traditionally opposed to some of the treatments discussed in the survey, TAASA partnered with the Catholic Health Association (CHA) to specifically target these hospitals in the state. The CHA contacted the 44 Catholic hospitals via e-mail, including electronic copies of the survey and informing them of the option to complete the survey via the Internet. This email was sent to the CEO of the hospital who then forwarded the survey on to the appropriate staff member. Seven mailings were returned to TAASA due to undeliverable addresses. In total 405 hospital emergency rooms were contacted.

A two-week period from the time the surveys were mailed until the suggested deadline was allotted for participants to receive, complete and return the survey. Participants were offered the option of mailing the completed survey in the self-addressed envelope or completing it online by going to our website, www.taasa.org, and clicking on the link to the Zoomerang survey. As a means to increase the response rate, follow-up reminder post cards (Appendix C) were mailed to all hospitals extending the deadline another two weeks and reposting the original survey online. A copy of the Hospital Licensing Directory for the state of Texas from the Texas Department of Health provided the addresses for both mailings.

Returned surveys were received and checked for completeness and consistency. Telephone calls were made to a few respondents for response clarification and survey completion. The survey was analyzed at TAASA using Microsoft Excel 2000 and SPSS version 10.0.

RESULTS

Of the 412 surveys mailed to hospital emergency rooms, 107 surveys were completed and returned by August 31. Seven of the surveys were returned to sender. Thus the final response rate was 26 percent. Results of the survey will be reported according to the survey section.

SECTION 1: GEOGRAPHIC DATA ON FACILITIES

“How many beds does your facility have?”

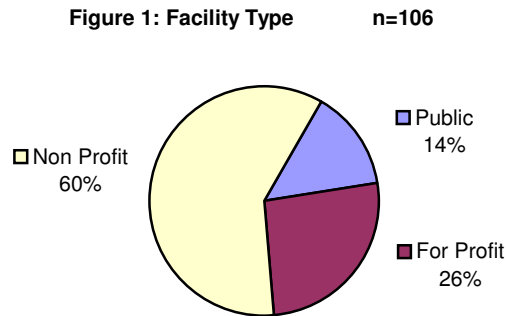
The number of beds throughout the hospital determined the size of the hospitals. This number varied widely and ranged between 2 – 561 beds. The mean (average) number of beds was 147, while the mode (number occurring most often) was 25 (Table 1).

Table 1: Number of beds n=106

| | | | | | |
|---------------|-----|--------------|-----|----------------|-----|
| Mean | 147 | Range | 559 | Minimum | 2 |
| Median | 91 | Mode | 25 | Maximum | 561 |

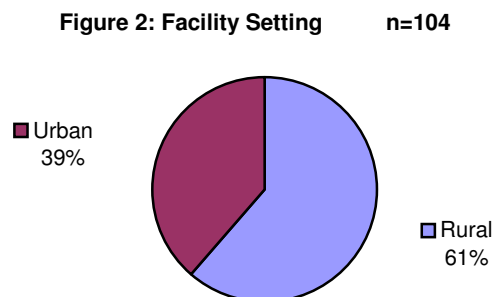
“What type of facility is your hospital?”

Respondents were asked about the type of facility. Fourteen percent (14%) of respondents indicated that they were public hospitals while twenty six percent (26%) indicated they were for-profit hospitals and sixty percent (60%) indicated they were “not-for-profit” (Figure 1).



“What type of setting does your facility serve?”

Respondents were asked what type of population their facility served. Sixty-two percent (62%) of respondents indicated that their facility served a rural population, while thirty-nine percent (39%) served an urban population (Figure 2).

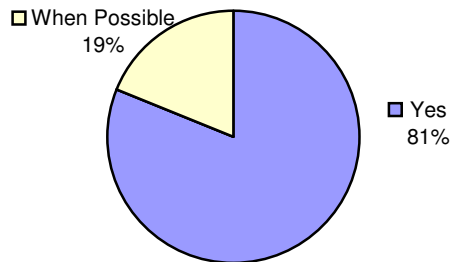


SECTION 2: BEFORE THE EXAM

1. “Does your hospital provide a private area (where conversations may not be overheard) for sexual assault patients to speak with law enforcement, medical professionals, their friends or family?”

One of the areas that has not gained as much attention when it comes to the treatment of sexual assault patients in the emergency room is the issue of privacy before, during and after the exam. Respondents were asked if sexual assault patients were provided with a private area where conversations could not be overheard and where they could speak with law enforcement, medical professionals, family or friends. Eighty-one percent (81%) indicated that they provided a private area, and nineteen percent (19%) of respondents indicated that they did this only when it was possible or space allowed it. No respondent indicated that they did not ever provide a private room for the patient before the exam (Figure 3).

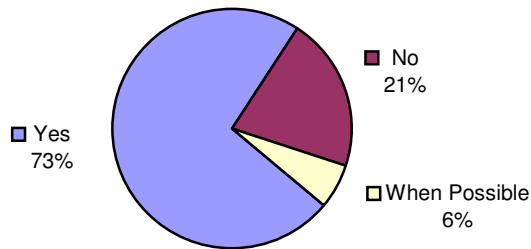
Figure 3: Private Room Before Exam n=103



2. “Are sexual assault patients given a dedicated exam room for a forensic medical exam?”

Hospitals were asked if the medical forensic exam was performed in a “dedicated exam room,” meaning a room that is private and specific for this exam. Seventy-three percent (73%) of respondents indicated that they used a dedicated exam room for the forensic exam while twenty-one percent (21%) indicated that they did not. Six percent (6%) indicated that they used a dedicated exam room only when one was available (Figure 4).

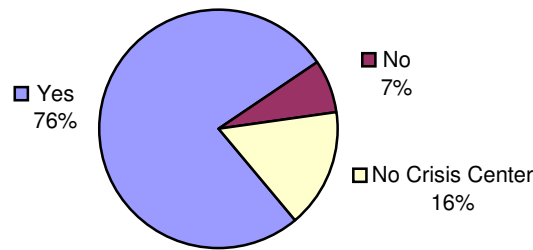
Figure 4: Medical Forensic Exam Done in a Dedicated Exam Room n=102



3. “Are sexual assault patients asked if they would like a rape crisis center advocate to provide information and support?”

Respondents were asked if sexual assault patients were offered the assistance of a rape crisis advocate from a rape crisis center to provide information and support for the patient. Seventy-six percent (76%) indicated that the services of an advocate from a rape crisis center were offered while seven percent (7%) indicated that they did not. Sixteen percent (16%) indicated that there was no rape crisis center available in the area to offer this service (Figure 5).

Figure 5: Rape Crisis Advocate Services Offered n=101



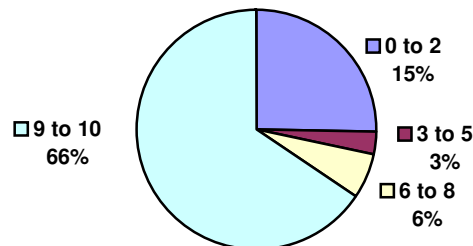
4. “If the rape crisis center advocate is called, how many times out of 10 is the advocate available to come to the hospital for that patient?”

In order to ascertain the response rate from the crisis centers when they were called the respondents were asked to estimate how many times out of ten a crisis center advocate was available to come to the hospital. On the whole, the availability of rape crisis advocates was high and consistent. The mean response was 8.5 (Table 2), indicating that on average advocates are available eighty-five percent of the time. However, fifteen percent (15%) of the respondents indicated that advocates were sent only 0 to 2 times out of 10 when they were requested by the hospital (Figure 6).

Table 2: “How many times out of ten is an advocate available to come to the hospital for the patient?” n=59

| | | | | | |
|---------------|-----|--------------|----|----------------|----|
| Mean | 8.5 | Range | 10 | Minimum | 0 |
| Median | 10 | Mode | 10 | Maximum | 10 |

Figure 6: Times Out of 10 Crisis Center Advocates Come When They are Requested by Hospital, n=59

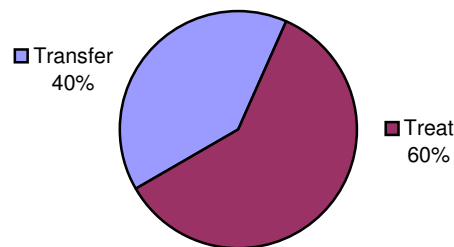


SECTION 3: PROVIDING TREATMENT

5. “Do you treat sexual assault patients or is your policy to stabilize and transfer patients to another facility?”

Respondents were asked a series of questions pertaining to the actual treatment of sexual assault patients as pertaining to the forensic medical examination. Respondents were asked if they treat sexual assault patients or if it is their policy to stabilize these patients and transfer them on to another facility for medical examination. Sixty percent (60%) of respondents indicated that it is their policy to treat sexual assault patients while forty percent (40%) indicated that they transfer patients for the forensic medical exam (Figure 7). Some respondents indicated that they have different policies for adults than for children stating, “Treat - if adult, Transfer if not of child-bearing age, not started menses” or in the case of a children’s hospital, “Treat if < 13 y/o, Transfer if > 13 y/o” (regardless of menarche). Another respondent indicated that it was their policy to treat sexual assault patients only when their Sexual Assault Nurse Examiner (SANE) is available; otherwise the patient is transferred to another hospital with a SANE on duty.

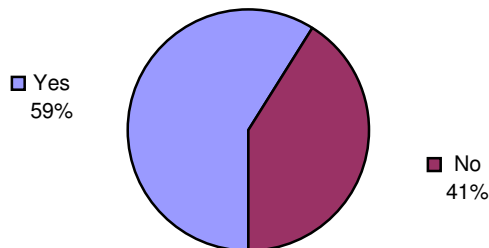
Figure 7: Hospital Policy Transfer for Sexual Assault patients n=105



6. “Do you have an agreement with another hospital for transfer?”

Respondents who indicated that it is their policy to transfer sexual assault patients were asked if they had a specific agreement with another hospital or facility to receive the transferred sexual assault patients. Of the respondents, thirty-five percent indicated they do not transfer sexual assault patients. However, of the remaining respondents who do transfer sexual assault patients, fifty-nine percent (59%) of respondents indicated that they have a specific agreement with another facility, and forty-one percent (41%) indicated that they did not have a specific agreement with another facility for the transfer of sexual assault patients (Figure 8).

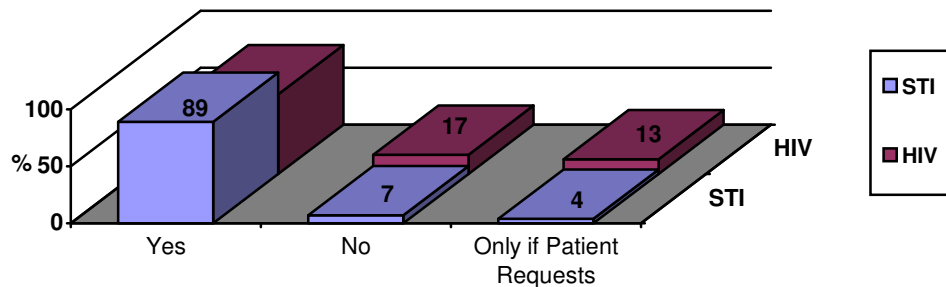
Figure 8: Agreement With Another Facility for Transfer, n=69



7. "Are sexual assault patients offered treatment for sexually transmitted infections?" and
8. "Are sexual assault patients offered HIV testing and treatment choices?"

Respondents were asked if treatment and testing was offered to sexual assault patients for HIV and Sexually Transmitted Infection (STI). Eighty-nine percent (89%) and seventy percent (70%) of respondents indicated that they offer and discuss treatment and testing options for STI and HIV, respectively, with sexual assault patients. Seven percent (7%) indicated that they did not offer treatment for STI and seventeen percent (17%) indicated that they did not offer treatment for HIV. Four percent (4%) indicated they offered treatment and testing for STI only if the patient specifically requested it. Thirteen percent (13%) indicated that they only discuss and provide testing and treatment options for HIV when the patient specifically requests it (Figure 9).

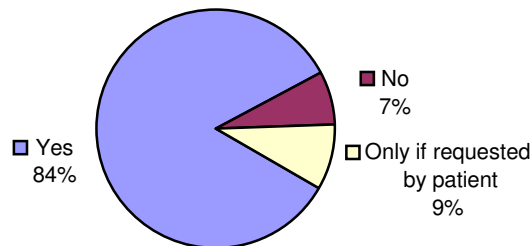
Figure 9: Treatment of STI and HIV n=101



9. "Are female sexual assault patients of child bearing age offered information about the risks of pregnancy associated with sexual assault?"

Respondents were asked if sexual assault patients of childbearing age are offered information about the risks of pregnancy associated with sexual assault. Eighty-four percent (84%) of respondents indicated that patients were offered this information while seven percent (7%) of respondents indicated that sexual assault patients were not offered this information; nine percent (9%) indicated that this information was provided only when requested by the patient (Figure 10).

Figure 10: Risks of pregnancy associated with sexual assault discussed with patient n=99



10. “In which of the following ways is emergency contraception (EC, “morning after pill,” Plan B®, Preven®) available to sexual assault patients?”

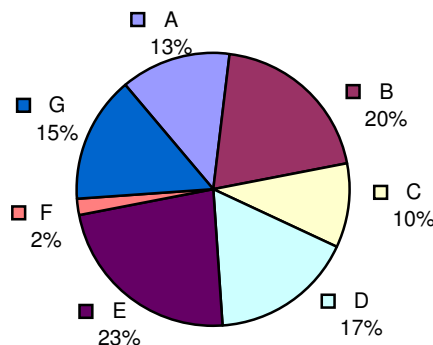
Emergency Contraception (EC) is an important treatment for sexual assault survivors. Respondents were asked, “In which of the following ways is emergency contraception (EC, “morning after pill,” Plan B®, Preven®) available to sexual assault patients?” (Appendix A, item10). They were asked to choose from a list of options (Table 3) that included five different scenarios and an “other” option that requested specification. Thirteen percent (13%) of respondents indicated that only information about EC is provided when the patient specifically requests it. Twenty percent (20%) of respondents indicated that only information about EC was provided as a standard part of care whether or not the patient specifically requests it. Ten percent (10%) of respondents indicated that only information about EC is provided with a referral to a doctor or pharmacy for EC. Seventeen percent (17%) of respondents indicated that information concerning EC and a prescription for the drug to be filled outside of the hospital is provided while twenty-three percent (23%) of respondents indicated that information about EC is provided to the patient and can be administered in the hospital if the patient desires. Two percent (2%) of respondents indicated the “other” response. One clear category emerged from the write-in explanations: patients are transferred to another facility/ services are not available at this facility with fifteen percent (15%) of the respondents indicating this was the case (Figure 11). Write-in explanations on the use of emergency contraception included “not available at the hospital”, “Physician’s choice, we are a faith based hospital,” and that the administration of EC was under the discretion of the SANE performing the exam.

Table 3: Options for the handling of EC in the emergency room for sexual assault patients

| | |
|---|---|
| A | Information about EC is provided when the patient specifically requests it. No EC is administered. |
| B | Information about EC is provided as a part of standard care. No EC is administered. |
| C | Information about EC, including a referral to a doctor or pharmacy is provided as a part of standard care. No EC is administered. |
| D | Information about EC and a prescription to be filled outside the hospital are provided as a part of standard care. No EC is administered. |
| E | Information about EC is provided and EC is administered in the hospital if the patient desires as a part of standard care. |
| F | Other, (please specify) |
| G | Patients are transferred; services are not available at this facility* |

*This category emerged from the specified responses under other as a distinctive category.

Figure 11: Ways in Which EC is Administered in ER n=94



11. "Please estimate the number of sexual assault patients your hospital sees on average per month."

Respondents were asked to estimate the number of sexual assault patients that came into the ER on an average month. While many respondents indicated that they saw less than one sexual assault patient per month or even just one or two a year, several respondents indicated that there were more than twenty (20) sexual assault patients per month for sexual assault. The mean number of sexual assault patients seen in an average month by hospital emergency rooms in this sample was slightly more than four (4.1). (Table 4) However, one respondent, who serves an urban area, indicated that more than fifty-five (55) sexual assault patients were seen in the emergency room on an average month. Sixteen percent (16%) of the urban hospitals surveyed saw more than twenty sexual assault patients per month while only two percent (2%) of the rural hospitals saw more than twenty sexual assault patients per month. Most of these patients in the rural area were children who had been transferred there from other facilities.

Table 4: Number of sexual assault patients seen in ER on an average month n=99

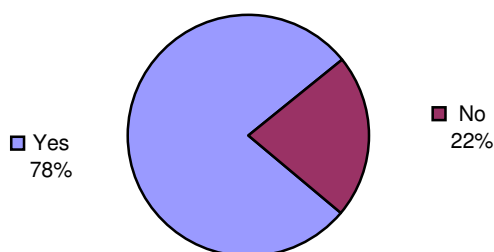
| | | | | | |
|---------------|-----|--------------|----|----------------|----|
| Mean | 4.6 | Range | 55 | Minimum | 0 |
| Median | 1 | Mode | 0 | Maximum | 55 |

SECTION 4: HOSPITAL POLICIES AND PROTOCOLS

12/13. “Does your hospital have a policy or protocol for the treatment of sexual assault patients?”

Respondents were asked whether or not their hospital had its own policy concerning the care and treatment of sexual assault patients. Seventy-eight percent (78%) of respondents indicated that the hospital had such a policy and twenty-two percent (22%) indicated that they had no such policy (Figure 12). Several respondents indicated that their policy was based on the Texas Evidence Collection Protocol developed by the Office of the Attorney General; others indicated that they had a policy that was adapted from another state’s forensic evidence collection policy.

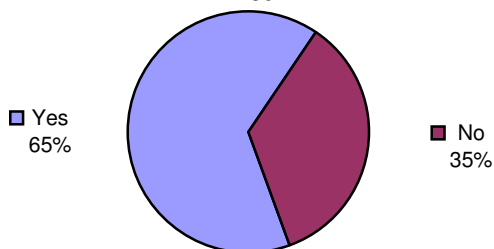
Figure 12: Policy for the Treatment of Sexual Assault Patients n=105



14. “Does your hospital have a copy of the Texas Evidence Collection Protocol developed by the Office of the Attorney General on file?” ⁽¹⁾

While the great majority of respondents indicated that they had their own policy concerning the treatment of sexual assault patients, many fewer indicated that they had copies of certain key protocols on file or available in the emergency room. Sixty-five percent (65%) indicated that they had the Texas Evidence Collection Protocol as developed by the office of the Attorney General on file while thirty-five percent (35%) indicated that they did not have a copy of this protocol (Figure 13).

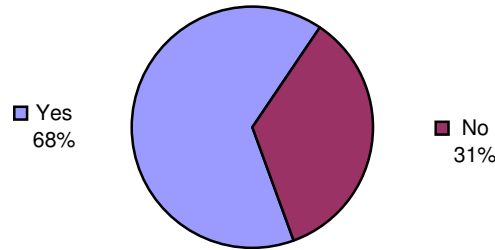
Figure 13: Hospitals with Copies of the Texas Forensic Evidence Collection Protocol n=56



15. “Does your hospital have a copy of the American College of Emergency Physicians Guideline for the care of sexual assault/abuse patient available on file?” (2)

Only thirty-one percent (31%) of respondents indicated that there was a copy of the American College of Emergency Physicians Guideline for the care of sexual assault/abuse patients in the hospital; sixty-eight percent (68%) of respondents indicated that their hospital did not have a copy of these guidelines (Figure 14).

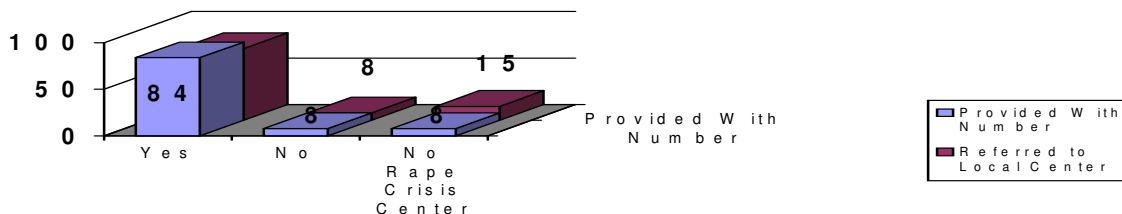
Figure 14: Hospitals with a copy of the American College of Emergency Physicians Guidelines for care of sexual assault survivors n=99



16. “Are sexual assault patients provided with the hotline number to their local rape crisis center?” and 17. “Are sexual assault patients referred to a local rape crisis center for follow-up care?”

It is also very important that sexual assault patients be referred to a rape crisis center for follow up care, resources and advocacy. Respondents were asked if sexual assault patients were given the hotline number of their local rape crisis center and if they were referred to the rape crisis center for follow up care. Eighty-four percent (84%) and seventy-seven percent (77%) of respondents indicated that patients were given a hotline number and referred to a local rape crisis center for follow-up care, respectively. Eight percent (8%) and eight percent (8%) of respondents indicated that these referrals were not made, while eight percent (8%) indicated that there was no hotline number available to give as a referral and fifteen percent (15%) indicated that there was no crisis center in the area for this referral (Figure 15).

Figure 15: Sexual Assault Patients Referred to Rape Crisis Center n = 103



SECTION 5: SANES AND OTHER TRAINED PROFESSIONALS

The Sexual Assault Nurse Examiner (SANE) program was established to provide nurses with training to:

1. Provide comprehensive care to sexual assault survivors
2. Demonstrate competency in conducting a forensic exam to include evaluation for evidence collection
3. To provide effective courtroom testimony
4. Show compassion and sensitivity to survivors of sexual assault. ⁽³⁾

18. “Does your hospital have a Sexual Assault Nurse Examiner (SANE) program?”

19. “If so, how many SANE’s are in the program?”

Respondents were asked if their hospital had a SANE program. Thirty-four percent (34%) indicated that they have a SANE program while sixty-six percent (66%) indicated that they do not. The average number of SANEs in the program was four (4), however some respondents indicated that there were more than twelve (12) trained SANE’s in their program (Table 5). While the majority of respondents indicated that they did not have a SANE program at their own facility, many of them indicated they were part of a coalition in their city that has SANEs on call to serve multiple facilities.

Table 5: Number nurses in SANE program n=35

| | | | | | |
|---------------|---|--------------|----|----------------|----|
| Mean | 4 | Range | 12 | Minimum | 0 |
| Median | 1 | Mode | 1 | Maximum | 12 |

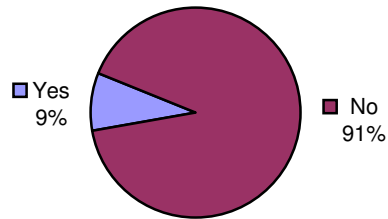
20 – 28. “To your knowledge, has any of the following medical staff at your hospital received specific training on forensic evidence collection? ER Physicians, ER Physician Assistants, ER Nurse Practitioners, ER Nurses”

It is important that doctors and nurses who are performing the medical forensic examination are properly trained on how to perform this exam. The patient’s physical health and their rights as victims can be seriously affected if the exam is not done properly. Respondents were also asked to identify if any members of the staff for different categories of medical personnel had been trained to administer a forensic medical examination. Twenty-five percent (25%) of respondents indicated that there was at least one emergency room physician at their facility who had received specific training to perform these exams and twenty-eight percent (28%) of respondents indicated the same for nurses. Very few respondents indicated that this was an employment requirement for any of the medical personnel (Table 6). In addition to this, only nine percent (9%) of respondents indicated that training was available at the hospital for these medical personnel (Figure 16).

Table 6:
Hospital personal trained in forensic evidence collection and employment requirement.

| Position | Trained | | Employment Requirement | |
|---------------------------------|---------|-----|------------------------|------|
| | YES | NO | YES | NO |
| ER Physicians N=100 | 25% | 75% | 4% | 96% |
| ER Physician Assistants N=82 | 2% | 98% | 0% | 100% |
| ER Nurse Practitioners N= 81 | 4% | 96% | 0% | 100% |
| ER Nurses N=102 | 28% | 72% | 3% | 97% |

Figure 16: Hospitals Providing Training on Forensic Evidence Collection for Sexual Assault to Medical Staff n=99



DISCUSSION

Emergency Contraception:

Emergency contraception (EC) is an important part of treatment for sexual assault patients. About one-fifth (20%) of hospitals surveyed indicated that sexual assault patients were informed of EC and that EC was available at the hospital, as a part of routine care. Seventeen percent (17%) of hospitals surveyed provided patients with a prescription for emergency contraception to be filled outside of the hospital (Figure 11).

These data also provide preliminary support for the conclusion that hospital size and location may affect the distribution of emergency contraception (EC). When comparing the potential ways in which EC could be distributed in a hospital with the size (based on the number of beds in the facility) of the hospitals, a comparison of means, using a one-way ANOVA, found significant differences in the trends ($M = 151.19$; $F(6, 92) = 2.60$; $p < .05$). Only the largest hospitals (i.e., those above the Mean) provided EC as either part of their standard care for sexual assault patients or freely administer it if the patient desires. Midrange hospitals ($M = 140.93$) tend to transfer their sexual assault patients. Finally, there is a tendency for smaller hospitals ($M < 95$) to provide information only if the patient requests, provide referrals to doctors or pharmacies, or given information and a prescription to be filled outside the hospital. While there were no significant differences when comparing the ways in which EC was distributed in rural versus urban settings, this could have been a function of the sample distribution and size because there are trends in the data regarding setting of care. In urban settings the trends in the data indicate that they are more likely (than rural) to transfer their sexual assault patients to another facility or if they treat their sexual assault patients urban hospitals are more likely (than rural) to provide EC as a part of standard care. In rural settings the trend in the data suggests a greater likelihood to provide referrals about EC to doctors and pharmacies (Table 7).

Table 7:
Analysis of the Availability of Emergency Contraception

| EC Option | Number | Size Mean | Size Std. Deviation | Setting Mean | Setting Std. Deviation |
|---|-----------|---------------|---------------------|--------------|------------------------|
| Info. provided only if patient specifically requests | 12 | 92.00 | 105.27 | 1.33 | 0.49 |
| Info. provided as part of standard care | 19 | 238.26 | 150.81 | 1.47 | 0.51 |
| Info. including referral to Dr. or pharm. provided | 9 | 93.22 | 79.10 | 1.11 | 0.33 |
| Info & prescription filled outside hospital provided | 16 | 94.88 | 99.95 | 1.38 | 0.50 |
| Info & administration in hospital provided if patient wants | 21 | 184.00 | 157.77 | 1.38 | 0.50 |
| Sexual assault patients transferred, not available | 14 | 140.93 | 171.40 | 1.43 | 0.51 |
| Other | 2 | 118.00 | 84.85 | 1.50 | 0.71 |
| Totals | 93 | 151.19 | 144.14 | 1.38 | 0.49 |

Overall, when analyzing differences in the likelihood that a sexual assault victim is going to be informed about the risks of pregnancy, on first glance there were no significant differences found. Significant differences that might have existed in the data were affected because an overwhelming majority (82 of 97) of respondents report providing such information as a part of standard care. However, there are some important trends that emerge in the data. First, there is a positive trend in the data to suggest that the larger the facility, the greater the propensity it will freely provide information about the risks of pregnancy (Those providing information, $M = 158$;

those who do not provide information, $M = 120$). Second, when comparing the communication of pregnancy risk with the setting (rural vs. urban, overall Mean = 1.39), the trend shows that of those who do not provide information they are more likely to be in an urban setting than rural. Additionally, controlling for those who do provide information, there is a strongly rural trend to provide information only if the patient requests (compared to urban). Finally, when the data were examined for only ‘yes, information is provided’ or ‘no, information is not provided’ responses, these data show a positive correlation approaching significance ($R = .147$; $p = 0.08$). This suggests that as the setting for a hospital is increasingly urban, medical staffs are more likely to voluntarily discuss the risks of pregnancy with sexual assault patients. These trends in the data, while not statistically significant, are qualitatively significant because they offer more information about what information a sexual assault patient is likely to receive and under what circumstances or settings s/he is likely to receive it.

Physician/Nurse training, SANE programs

The ways in which sexual assault patients are treated in hospital emergency rooms are extremely important in preserving the integrity of evidence collected in the medical forensic examination and in establishing a path to physical and psychological recovery. Sexual assault patients have specific and special needs that directly influence their rights as victims. The forensic medical examination itself can be re-traumatizing to the patient even if it is done under the best possible circumstances, and it is vitally important to the integrity of any criminal investigation that evidence collected maintain a specific chain of custody.

Only twenty-five percent (25%) of respondents indicated that there was at least one ER physician specifically trained in administering a medical forensic exam at their hospital and twenty-eight percent (28%) of respondents indicated the same of ER nurses (Table 6). This means that in approximately seventy percent² of the hospitals surveyed there is no staff member who is a part of the emergency department who is specifically trained to administer these exams. When the average hospital in this study may see five sexual assault patients on average per month in the emergency room, this means that a large majority of sexual assault patients may receive treatment from medical staff that has not been trained to perform vital examinations, therefore endangering the rights of the victim and risking increased trauma to the patient.

LIMITATIONS:

While the findings indicate that there are significant challenges in ensuring the availability of EC, the information given to sexual assault patients, and training of medical staff in sexual assault forensic evidence collection, it is also important to recognize the study’s limitations. First, because these were self-report data, there is the potential for participant bias. Because of ‘social desirability, respondents may choose to view their hospital’s treatment of sexual assault patients in a more positive manner. Additionally, there may be discrepancies between official policy of the hospitals and what actually occurs within the hospital emergency room, especially since many courses of action are up to the discretion of individual physicians and SANE’s.

² A Pearson’s r correlation demonstrated a 0.38 correlation between hospitals having both doctors and nurses trained on forensic evidence collection. Accordingly while the raw percentages would indicate that 53 percent of hospitals have staff trained in forensic evidence collection, the overlap leaves approximately 20 percent fewer hospitals with trained staff in forensic evidence collection.

The second limitation to the study could be instrument (i.e., the questionnaire) error. Response options may not have been exhaustive. For example, when classifying the setting of the hospitals respondents' only choices were 'rural' or 'urban'; there were some respondents who indicated both settings and some who indicated suburban settings. As a result, some of the reporting categories may not have included all response options. Both of the limitations in this study only highlight the need to conduct similar studies in the future clarifying hospital response to sexual assault patients.

Conclusion:

This study sought to evaluate the level of care for sexual assault patients in Texas hospital emergency rooms. There appears to be a widely variable level of care among Texas hospital emergency rooms that is dependent on the size of the facility and the type of population the hospital serves (rural vs. urban). There is a significant absence in the availability of emergency contraception to sexual assault patients and an overall lack of training for medical personals to administer medical forensic examinations. The necessary efforts and resources should be directed toward these areas in order to provide sexual assault patients and survivors with the best comprehensive care possible.

References:

1. Office of the Attorney General (1998). *Texas Evidence Collection Protocol*.
2. American College of Emergency Physicians (2002). Management of patient with the complaint of sexual assault. *ACEP Policy Statements*. Retrieved June 26, 2003, from <http://www.acep.org/1,614,0.html>.
3. Texas Office of the Attorney General (2002). Sexual Assault Nurse Examiners (SANE) info site. Retrieved July 31, 2003. from <http://www.oag.state.tx.us/victims/sane.shtml>

APPENDIX A

Thank you for taking the time to complete this survey regarding services for sexual assault patients. The survey should take no more than 10 minutes of your time.

Please circle the most appropriate answer.

Geographic Data on your Facility

How many beds does your facility have? _____

What type of facility is your hospital?

PUBLIC FOR-PROFIT NOT-FOR-PROFIT

What type of setting does your facility serve?

RURAL URBAN

I. When sexual assault patients are seen in your emergency department and before an exam is administered:

1. Does your hospital provide a private area (where conversations may not be overheard) for sexual assault patients to speak with law enforcement, medical professionals, their friends or family?
YES NO When possible
2. Are sexual assault patients given a dedicated exam room for a forensic medical exam?
YES NO When possible
3. Are sexual assault patients asked if they would like a rape crisis center advocate to provide information and support?
YES NO No rape crisis center available
4. If the rape crisis center advocate is called, how many times out of 10 is the advocate available to come to the hospital for that patient? _____/10

II. In providing treatment to sexual assault patients:

5. Do you treat sexual assault patients or is your policy to stabilize and transfer patients to another facility?
TREAT TRANSFER
6. Do you have an agreement with another hospital for transfer?
YES NO We do not transfer sexual assault patients
7. Are sexual assault patients offered treatment for sexually transmitted infections?
YES NO Only if requested by patient

8. Are sexual assault patients offered HIV testing and treatment choices?

YES NO Only if requested by patient

9. Are female sexual assault patients of child bearing age offered information about the risks of pregnancy associated with sexual assault?

YES NO Only if requested by patient

10. In which of the following ways is emergency contraception (EC, "morning after pill", Plan B, Preven) available to sexual assault patients?

- A. Information about EC is provided only when the patient specifically requests it.
- B. Information about EC is provided as a part of standard care.
- C. Information about EC, including a referral to a doctor or pharmacy is provided.
- D. Information about EC and a prescription to be filled outside the hospital are provided.
- E. Information about EC is provided and EC is administered in the hospital if the patient desires.
- F. Other (please specify) _____

11. Please estimate the number of sexual assault patients your hospital sees on average per month.

_____/month

III. Hospital Policies and Protocols Regarding Care and Treatment of Sexual Assault Patients.

12. Does your hospital have a policy or protocol for the treatment of sexual assault patients?

YES NO

13. If yes, is your hospital willing to share the protocol? If so, please include a copy of your protocol.

YES NO

14. Does your hospital have a copy of the Texas Evidence Collection Protocol developed by the Office of the Attorney General on file?

YES NO

15. Does your hospital have a copy of the American College of Emergency Physicians Guideline for caring for the sexual assault/abuse patient available on file?

YES NO

16. Are sexual assault patients provided with the hotline number to their local rape crisis center?

YES NO No rape crisis center available

17. Are sexual assault patients referred to a local rape crisis center for follow up care?

YES NO No rape crisis center available

IV. Sexual Assault Nurse Examiners and other trained medical professionals

18. Does your hospital have a Sexual Assault Nurse Examiner (SANE) program?

YES NO

19. If so, how many SANEs are in the program? _____

To your knowledge, have any of the following medical staff at your hospital received specific training on forensic evidence collection?

20. ER Physicians YES NO

21. Is this a requirement of employment? YES NO

22. ER Physician Assistants YES NO

23. Is this a requirement of employment? YES NO

24. ER Nurse Practitioners YES NO

25. Is this a requirement of employment? YES NO

26. ER Nurses YES NO

27. Is this a requirement of employment? YES NO

28. Does your hospital provide training on forensic evidence collection for sexual assault patients to its medical staff? YES NO

____ Please do not disclose our identity in your report, we wish to remain anonymous and all identities kept confidential.

____ Please send a copy of the final report to the address below.

Hospital Name _____
Street _____
City _____ State _____ Zip _____
Phone __ (____) _____

____ Please feel free to disclose the hospital's identity in your final report.

Hospital Name _____
Street _____
City _____ State _____ Zip _____
Phone __ (____) _____

If you would like to obtain a copy of the Texas Evidence Collection Protocol contact the Attorney General's Office. Go to www.oag.state.tx.us/AG_Publications/pdfs/evidence_collection.pdf

If you would like to obtain a copy of American College of Emergency Physicians Guideline for caring for the sexual assault/abuse patients call 800-798-1822 x6, or go to www.acep.org

APPENDIX B

June 26, 2003

Dear Emergency Department Administrator,

Every year thousands of Texans are sexually assaulted. The care that sexual assault patients receive in Texas hospitals is something that we both care very deeply about. The Texas Association Against Sexual Assault is currently conducting survey related to the care available to sexual assault patients in the state's hospital emergency rooms. We would appreciate it if you could take a few moments to complete this survey. If possible, we would ask that you attach or describe in writing your hospital's policy concerning the treatment of sexual assault patients. **The survey is also available to take online.** Please go to our website (www.taasa.org) and look under the "Latest News" for the link to the online version of the survey.

TAASA is the statewide organization committed to ending sexual violence in Texas. A non-profit educational and advocacy organization based in Austin, TAASA member agencies comprise a statewide network of more than 79 crisis centers that serve rural as well as metropolitan areas. Founded in 1982, the agency has a strong record of success in community education, legal services, youth outreach, law enforcement training, legislative advocacy, and curricula and materials development.

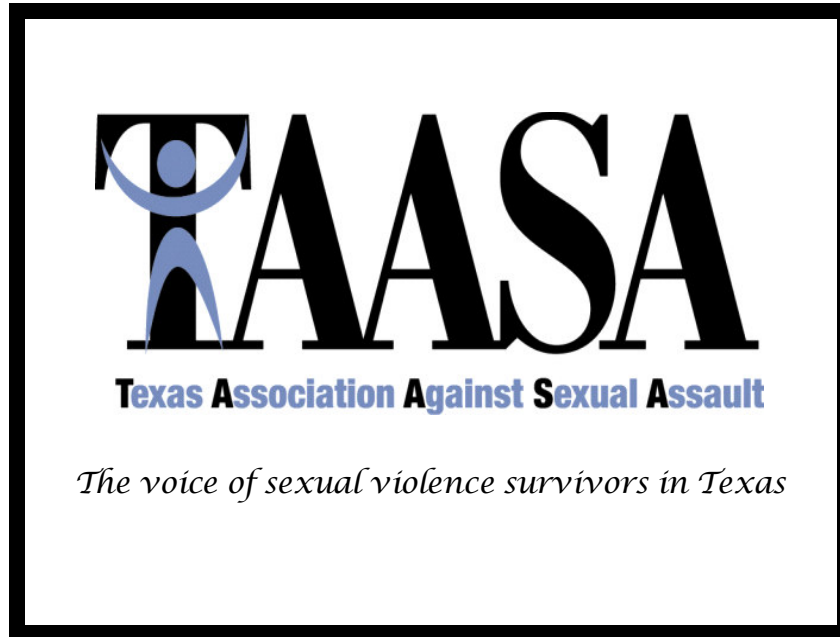
The survey should not take more than 10 minutes to complete. Your response is important. Please take a few minutes to complete the survey and return in the envelope provided or take the online version of the survey by **Friday, July 11, 2003**. We will contact you by phone in the next 2 weeks to answer any questions. In the mean time, please feel free to contact Mimi Garcia at (512) 474-7190 x7013 if you have any questions.

Thank you,

Annette Burrhus-Clay
Executive Director

APPENDIX C

Side 1



Side 2

Texas Association Against Sexual Assault
7701 N. Lamar Blvd. Ste 200
Austin, Texas 78752
1-888-91-TAASA (82272)

By now you should have received our survey about the level of care for sexual assault patients in the emergency room.

The date to return this survey has been extended to July 25th. If you need another copy please call our toll free number and we'll send you one right away. Also know that you can go online to complete the survey via our website www.taasa.org

Thank you!

Mimi Garcia
1-888-91-TAASA (82272)
EX: 7013