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The Efficacy of Illinois' Sexual Assault Nurse Examiner (SANE) Pilot Program

A Report to the Illinois General Assembly

by the Illinois Criminal Justice Information Authority

Pursuant to Public Act 91-0529

December 2003

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Authority staff express much gratitude to the Sexual Assault Response Team (SART) Coordinators in each of the three counties where the Sexual Assault Nurse Examiner (SANE) Pilot Program was implemented: Patty Metzler, RN, SANE, Carle Foundation Hospital; Nancy Salamie, RN, SANE, Edwards Hospital; and Wendy Ivy, Program Coordinator of Advocacy Services, Lake County Coalition Against Sexual Assault (LaCASA). Without their willful cooperation and invaluable assistance, this report could not have been completed. Although we cannot release their names as all subjects of this study will remain confidential, staff would also like to thank the sixteen respondents who agreed to complete the telephone interviews required for this evaluation. These individuals were willing to spend time out of their busy schedules to share their experiences and knowledge about the SANE program. Their honest, informative responses provided the insight needed to answer the research questions posed. Finally, staff would like to thank all the participants of the SART meetings, who shall again remain nameless for confidentiality reasons. These professionals allowed research staff to sit in, observe, and take notes during their meetings. Their willingness to openly discuss ideas and opinions, activities, and successes and challenges helped research staff understand how multidisciplinary SARTs are so essential to the operation of the SANE programs.

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EXECUTIVE SUMMARY

A sexual assault nurse examiner (SANE) is a registered nurse (R.N.) who has advanced education in conducting medical and forensic examinations of patients who are sexually victimized. SANE programs consist of SANEs as well as other professionals from community agencies that respond to sex crimes such as police departments, state's attorney's offices, and victim service agencies. Together, these professionals work to achieve two primary objectives: 1) improve treatment of sexually assaulted victims who are admitted to hospital emergency departments; and 2) improve the quality of evidence collection and presentation to increase successful prosecution outcomes.

In 1999, the Illinois General Assembly enacted Public Act 91-0529. This legislation charged the Illinois Criminal Justice Information Authority with administering the SANE Pilot Program. This entailed establishing four SANE programs in different counties throughout the state, and then reporting to the General Assembly regarding the efficacy of these programs. This study reports on the efficacy of the SANE Pilot Program and provides recommendations based on the study's findings.

Evaluations of existing SANE programs outside Illinois have been mostly positive. This is the first study to report on the efficacy of Illinois' SANE programs. The two salient findings of this study were:

1. Illinois' SANE Pilot Program substantially improves community responses to victims of sex crimes.

2. Illinois' SANE Pilot Program improves the quality of evidence collection and presentation for sex crimes; however, we could not determine whether it also increases the percentage of successful prosecution outcomes for sex crimes.

Community responses to victims of sex crimes are improved in several ways. First, victims receive prompt attention by a multidisciplinary team of professionals. Then, victims receive essential services designed to alleviate victims' suffering. Furthermore, victims are provided important information about their legal options, so they are better informed to make decisions about the criminal justice system in their own best interests. Finally, victims receive improved treatment at hospitals. Victims spend less time and experience less discomfort in emergency rooms. SANEs provide compassionate, objective care, while also maintaining respect for a victim's dignity throughout every step of the examination.

We could not determine whether Illinois' SANE Pilot Program results in a greater percentage of successful prosecution outcomes for SANE cases because data collected were inconsistent. Some data supported that successful prosecution outcomes increase, while other data did not support this premise. However, we did conclude that the SANE program improves the quality of evidence collected and presented for sex crime cases. Findings indicated that SANEs completed procedures essential toward effective collection and presentation of evidence. Also, several subjects from the phone interviews conducted for this study commented about how evidence collected by SANEs is of higher quality and documented with fewer or no mistakes.

The following steps are recommended based on this study's findings:

1. Identify funding sources to help programs participating in the Illinois SANE Pilot Program to continue their efforts, as well as to create opportunities for new programs to be established in other jurisidictions.

2. Ensure that every county in Illinois has 24-hour access to a SANE.

3. Hospital staff should always contact a sexual assault advocacy center upon admission of a patient who is a sex crime victim. Hospital staff should always offer patients the opportunity to speak with a victim advocate during their stay at the hospital.

4. Educate criminal justice personnel about improved collection and presentation of evidence by SANEs.

5. Communities should establish Sexual Assault Response Teams (or SARTs) that include local professionals from police departments, state's attorney's offices, sexual assault advocacy centers, hospitals, forensic laboratories, and other interested agencies.

6. Increase community awareness about the effects of sexual victimization on victims and the value of SANE Programs.

7. Conduct additional research that measures differences in court outcomes between SANE sexual assault cases and non-SANE sexual assault cases.

Illinois' SANE Pilot Program is making substantial differences in victims' lives, and improved evidence collection offers greater potential for successful prosecution outcomes. Counties participating in Illinois' SANE Pilot Program should continue their efforts to expand coverage throughout their jurisdictions. In the majority of Illinois counties where SANE programs do not exist, agencies that respond to sexual assault should establish similar models in their communities.

I. Purpose of Report

This report is pursuant to Public Act 91-0529, which requires the Illinois Criminal Justice Information Authority (ICJIA) to report on the efficacy of the Sexual Assault Nurse Examiner (SANE) Pilot Program. A SANE is a registered nurse (R.N.) who has been trained and certified to conduct medical and forensic examinations of victims of sex crimes.[1] Since the early 1990's, hundreds of SANE programs have been established across the country to improve traditional medical evidentiary responses to sexual assault. Today, SANE programs have demonstrated much success in alleviating the suffering of sexual assault victims as well as improving evidence collection procedures.

The Illinois General Assembly enacted Public Act 91-0529 to establish four pilot SANE projects. The amendment to the Illinois Criminal Justice Information Act, enacted January 1, 2000, states:

CRIMINAL PROCEDURE – SEXUAL ASSAULT
NURSE EXAMINER PILOT PROGRAM

Public Act 91-0529

SB673

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Criminal Justice Information Act is amended by adding Section 7.1 as follows:

(20 ILCS 3930/7.1 new)

Sec. 7.1. Sexual assault nurse examiner pilot program.

(a) Legislative findings and intent. The General Assembly finds that the compassionate treatment of sexual assault victims in hospital emergency rooms is necessary to help alleviate the suffering of sexual assault victims. The General Assembly also finds that the effective collection and presentation of forensic evidence in sexual assault cases is necessary to increase the success rate of prosecutions for sex crimes in Illinois.

The General Assembly intends to create a pilot program to establish 4 sexual assault nurse examiner (SANE) projects in the State of Illinois. For each project, specially trained sexual assault nurse examiners or specially trained sexual assault physician examiners will provide health assessments and collect forensic evidence from sexual assault victims in the emergency

[1] The terms "victims of sex crimes" and "sexual assault victims" are used interchangeably throughout this report. Both terms refer to all victims of sexual assault and other sex crimes.

room. The sexual assault nurse examiners or sexual assault physician examiners will also testify to victims' injuries during criminal prosecutions.

(b) Definitions. In this Section:

(1) "Sexual assault nurse examiner" means a registered nurse who has completed a sexual assault nurse examiner (SANE) training program that meets the Forensic Sexual Assault Nurse Examiner Education Guidelines established by the International Association of Forensic Nurses.

(2) "Sexual assault physician examiner" means a physician licensed to practice medicine in all its branches who has completed a sexual assault nurse examiner (SANE) training program that meets the Forensic Sexual Assault Nurse Examiner Education Guidelines established by the International Association of Forensic Nurses.

(3) "Hospital" means a facility licensed by the Department of Public Health under the Hospital Licensing Act or that meets both the definition of hospital and the exemption provisions of that Act.

(4) "Hospital emergency services" means the health care delivered to outpatients within or under the care and supervision of personnel working in a designated emergency department or emergency room of a hospital.

(c) SANE pilot program. The Authority shall, subject to appropriation, establish a SANE pilot program to operate 4 pilot projects in Illinois. The projects shall be established in the emergency rooms of hospitals in 4 counties geographically distributed throughout the State. Hospitals located throughout the State may apply to the Authority to participate in the program. Each project must provide the following services:

(1) Compassionate health assessment and effective forensic evidence collection for sexual assault victims by a trained sexual assault nurse examiner or sexual assault physician examiner in a hospital emergency room as part of the provision of hospital emergency services.

(2) Presentation of testimony regarding victims' injuries during criminal prosecutions for sex offenses.

(d) Each of the SANE projects established under this pilot program must, at a minimum, meet the Sexual Assault Nurse Examiner Standards of Practice established by the International Association of Forensic Nurses.

(e) Each of the 4 pilot projects established by the Authority under this Section shall be in existence for a minimum of 3 years.

(f) Report. No later than 2 years after the establishment of pilot projects under this Section, the Authority must report to the General Assembly on the efficacy of SANE programs.

(g) Rules. The Authority shall adopt rules to implement this Section.

Approved: August 13, 1999

Effective: January 1, 2000

This legislation charged the Illinois Criminal Justice Information Authority (ICJIA) with administering State General Revenue funds to establish four SANE projects in different counties

throughout the state. Additionally, ICJIA must report to the General Assembly on the efficacy of SANE programs no later than two years after the establishment of pilot projects. Three of the four funding recipients have successfully established SANE programs. These programs operate in Champaign, DuPage, and Lake Counties. The fourth funding recipient attempted to establish their program for nearly two years after being selected for funding. Staff delayed completion of the report during this period to ensure activity from the fourth project was incorporated into the report's findings. Changes within the fourth recipient's administration resulted in fiscal and programmatic difficulties that eventually caused them to decline funds in March 2002. At this time, ICJIA received first notification that the fourth pilot project would not be formally established, and we began our evaluation of the other projects. This report serves to meet this requirement.

II. How did ICJIA administer the appropriated funds for the SANE Pilot Program?

An amount of $240,000 was appropriated to implement the SANE Pilot Program as specified by Public Act 91-0529. Hospitals throughout the state were to apply to ICJIA to participate in the SANE Pilot Program. In October 1999, ICJIA distributed a Request for Proposals (RFP) to 228 hospitals and sexual assault advocacy centers statewide. Seven proposals were received, and a panel of five experts reviewed them. Four applicants were recommended for funding. Each of the recommended sites was given $20,000 per year for three years to support the costs of establishing and operating a SANE program.

Additionally, ICJIA earmarked Victims of Crime Act (VOCA) funds for the purchase of colposcopes for each hospital that intended to participate in the SANE Pilot Program. A colposcope is an instrument that enhances visualization of injuries resulting from sexual assault. Every hospital that participated as a pilot site includes the colposcopic examination as part of their evidentiary exam

protocol for treating sexual assault victims. A total of six colposcopes were purchased for the participating hospitals.[2]

III. What is a SANE program?

Those who work with sexual assault victims have long recognized that victims often experience further trauma while receiving medical treatment for the assault at hospital emergency departments. If many patients are waiting in an emergency department, sexual assault victims are usually assessed at lower priority because they typically have no visible injuries. They are frequently asked to wait several hours for treatment, often in busy, public areas. During this time, they are not allowed to eat or drink, shower or brush their teeth, or use the restroom so that evidence is not destroyed. Furthermore, most medical staff are not trained to conduct forensic examinations of sexual assault victims, nor do they perform these exams frequently enough to maintain proficiency. Staff may fail to gather and/or document all available evidence, especially in cases between intimate partners, as they tend to be seen as less serious. Because some medical personnel do not understand the dynamics of sexual victimization, they may overlook the need to provide sensitive, compassionate, and informative care to patients who have experienced this form of violence. Lastly, medical staff who are not specialists in forensic evidence collection are seldom qualified to provide expert witness testimony in court, which is critical to the prosecution and conviction of sex offenders.[3] As research became more prevalent on the complex needs of sexual assault victims, and the importance of efficient

[2] Two of the four pilot programs each had two participating hospitals, while the other two pilot programs had one participating hospital. Thus, although only four counties were selected to implement a pilot site program, a total of six hospitals intended to participate in the SANE Pilot Program.

[3] Littel, Kristin, *Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims*, Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice, Washington, DC, April, 2001.

collection and presentation of evidence toward prosecution; victim service, medical, and legal professionals recognized the need for an improved medical-legal response to victims of sex crimes.

SANE programs aim to correct the inadequacies of traditional sexual assault medical evidentiary exams. A SANE has advanced education and clinical preparation in forensic examination of sexual assault victims. SANEs are educated in rape trauma syndrome, injury and evidence identification, collection and preservation of evidence, courtroom testimony, photography, and colposcopic procedure.[4]

SANE programs have two primary goals: (1) to provide compassionate, objective, informative, and comprehensive care to all patients who report sexual victimization; and (2) to improve identification, collection, preservation, documentation, and presentation of forensic evidence. It is hoped that these goals result in improved medical treatment for patients with more compassionate, timely, victim-centered care from a professional educated in rape trauma syndrome and knowledgeable about common reactions and concerns of victims. Additionally, they aim to increase victims' options for legal action with more efficient evidence collection by trained forensic examiners with expertise in injuries resulting from sexual victimization.

SANE programs not only benefit victims of sexual assault, but also entities such as hospitals, sexual assault advocacy centers, police departments, and state's attorney's offices. For hospitals, benefits include the opportunity for improved patient care, more efficient use of hospital staff, and an improved relationship with the community due to the hospital's higher standard of care. Sexual assault advocacy centers are better able to serve their clients by acting as a liaison between the victim and medical and criminal justice personnel. Law enforcement and prosecution agencies benefit from improved evidence collection, which helps substantiate arrests and yield convictions.

[4] The colposcope is a photographic instrument used by medical staff to identify microscopic trauma such as tears, abrasions, swelling, or bruises.

For all agencies that respond to sexual assault, forming productive partnerships with one another has substantial advantages. This is why SANEs are essential components of a collaborative effort most commonly known as a Sexual Assault Response Team or SART. SANE programs often include a multidisciplinary SART of community agencies dedicated to working together to develop policies, standardize care, and improve community responses to sexual assault. The primary members of SARTs include SANEs, sexual assault victim advocates, law enforcement personnel, forensic scientists from crime labs, and prosecutors.

More than 25 years ago, the first SANE programs were launched in Minneapolis, Minnesota; Memphis, Tennessee; and Amarillo, Texas.[5] By 1991, 20 SANE programs were known throughout the nation. This number grew to 86 by 1996.[6] Today, there are an estimated 330 programs and about 300 more programs in their early stages that are run by counties, cities or hospitals.[7] Still, with 3,066 counties and nearly 6,000 hospitals in the United States, it is likely that many victims of sex crimes are not treated by SANEs.

IV. What have other evaluation studies revealed about SANE programs?

Most information about whether the traditional SANE program model meets the objectives of improved care for victims, evidence collection, and prosecution and conviction rates is anecdotal. However, some SANE programs have been able to collect data that reveal the impact of their efforts. Although some SANE programs have struggled with finding cost-efficient operating methods, particularly in rural areas where few sexual assault victims are seen, findings from past evaluations have been overwhelmingly positive.

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[5] Alexander, Brian, "After rape," *Self for Women Magazine*, July, 2002.
[6] Ledray, Linda E., *SANE Development and Operation Guide,* Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice, Washington, DC, 1999.
[7] Alexander, Brian, "After rape," *Self for Women Magazine*, July, 2002.

A Minneapolis-based SANE program, Sexual Assault Resource Service (SARS), conducts periodic satisfaction surveys with sexual assault victims who were treated in emergency rooms. Of 34 survey respondents that completed the survey, 29 or 85 percent responded by ranking their satisfaction level on a five-point Likert Scale,[8] with five indicating the highest level of satisfaction and one indicating the lowest. On average, respondents rated treatment they received by police at 3.4, by hospital staff at 4.0, and by SANEs at 4.4.[9]

Additionally, SARS worked with the State Bureau of Criminal Apprehension to complete an audit of rape kits submitted to crime laboratories from different jurisdictions in the state. Of the 97 kits analyzed, 24 were submitted by SANEs while the remaining 73 were completed by non-SANEs. Kits completed by SANEs were all admissible in court, more complete, and better documented. SANEs made no major errors that threatened the integrity of the evidence, and the chain of evidence was maintained with more consistency when compared to kits completed by non-SANEs. Of the 73 non-SANE kits submitted, nearly 18 percent were not admissible in court because no one could identify the staff person who collected the evidence.[10]

Another study of more than 1,000 sexual assault victims in Albequerque, New Mexico, indicated that sexual assault victims were better informed about potential health impacts of their victimizations after a SANE Program was implemented. Findings reported that 20 to 25 percent more women were provided information regarding sexually transmitted diseases and pregnancy after the SANE Program was established.[11]

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[8] A Likert Scale, developed by Rensis Likert, is a questionnaire format in which respondents are asked to strongly agree, agree, disagree, or strongly disagree, or perhaps strongly approve, approve, and so forth.
[9] Ledray and Simmelink, "Sexual Assault: Clinical Issues, Efficacy of SANE Evidence Collection, A Minnesota Study," *Journal of Emergency Nursing*, 23 (1), 1997.
[10] Ibid.
[11] Alexander, Brian, "After rape," *Self for Women Magazine*, July, 2002.

The same study also supported the argument that the Albuquerque SANE Program improved rates of victim reporting to law enforcement as well as offender convictions. Statistics were compiled both before and after the program was implemented that revealed numbers of sexual assault victims who filed police reports, as well as outcomes for subsequent stages during the criminal justice process. After the SANE Program was implemented, the percentage of sexual assault victims filing police reports increased from 50 to 72 percent, and many more rape kits were completed. Police made more arrests that resulted in charges being filed, and more defendants pleaded guilty when evidence was collected by a SANE. Before the SANE program was established in Albuquerque, 32 percent of charges filed against defendants of sex crimes resulted in conviction. After the SANE program, this figure rose to 51 percent.[12]

Further support that SANE programs have an impact on conviction rates comes from a director of a Wisconsin SANE program. She reported that during a 3½ year period, 100 percent of cases where a SANE testified at trial resulted in convictions.[13] Although no data for court outcomes were available for non-SANE cases, the director reported that conviction rates were very high when SANEs testify in court.

Although studies lacking any positive findings about SANE programs are virtually nonexistent, anecdotal information has revealed some of the challenges to implementing and maintaining successful programs.[14] First, some confusion regarding the specific roles of each SART member can result in power struggles if they are not discussed and clarified among the group. For example, advocates may feel the need to monitor SANEs during examinations because of their deep sense of

[12] Ibid.
[13] Ledray and Simmelink, "Sexual Assault: Clinical Issues, Efficacy of SANE Evidence Collection, A Minnesota Study," *Journal of Emergency Nursing*, 23 (1), 1997.
[14] Littel, Kristin, *Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims*, Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice, Washington, DC, April, 2001.

protectiveness for victims and past experience with their clients being retraumatized by medical and criminal justice institutions. Advocates need to learn to trust that SANEs will provide sensitive, competent care and forensic evaluation so they can concentrate on providing such needed services such as crisis intervention and information. Similarly, victim support provided by SANEs is no substitute for services offered by advocates. Police may also need to modify their traditional roles in investigation of crimes, because sexual assault is just about the only crime where someone outside law enforcement handles the evidence.[15]

Second, it is common for professionals who are uneducated about rape trauma syndrome to hold the same biases and social stigmas toward sexual assualt victims that have been long recognized by victim service professionals and feminist groups.[16] Hospital personnel as well as staff from public agencies that address sexual assault can have misperceptions of who is a "real" rape victim, as well as the level of trauma and humiliation experienced by sexual assault victims who typically do not "look" as though they have been violently victimized.[17] These preconceived notions present real challenges to convincing local professionals that establishing SANE programs should be a priority.

Finally, financial planning for SANE programs is difficult without careful estimation of the number of SANEs needed to ensure prompt response to sexual assault victims on a 24-hour basis. This can be especially hard in rural areas where hospitals may encounter few victims of sexual assault.[18]

Although empirical studies and anecdotal information can help us better understand the efficacy of the traditional SANE model operating throughout the country, none of them provide

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[15] Ibid.
[16] Campbell, R., "The community response to rape: Victims' experiences with the legal, medical, and mental health systems." *American Journal of Community Psychology*, 26, 355-379, 1998.; Koss, M.P., et. al., *No safe haven: Male violence against women at home, at work, and in the community*, American Psychological Association, Washington, DC, 1994.; Ullman, S., "Do social reactions to sexual assault victims vary by support provider?" *Violence and Victims*, 11, 143-157, 1996.
[17] Ibid.
[18] Littel, Kristin, *Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims*, Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice, Washington, DC, April, 2001.

findings specific to the performance of Illinois' SANE Pilot Program. This report describes the performance of the pilot sites in Champaign, DuPage, and Lake Counties—who they serve, what services are provided, and how the SARTs operate. Moreover, this report lends insight about the efficacy of Illinois' SANE programs in meeting the objectives specified in the legislation enacted to establish pilot SANE programs: (1) to provide compassionate treatment of sexual assault victims in hospital emergency rooms, as this is necessary to help alleviate the suffering of sexual assault victims; and (2) to improve effective collection and presentation of forensic evidence in sexual assault cases, as this is necessary to increase the success rate of prosecutions for sexual assault in Illinois.

V. Research Questions and Methods Used to Address Them

The objectives of the Illinois SANE Pilot Program specified in Public Act 91-0529 lead us to two research questions this report aims to address: (1) Is Illinois' SANE Pilot Program helping to alleviate suffering of sexual assault victims in the counties where the program is implemented?; and (2) Does Illinois' SANE Pilot Program help increase successful prosecution rates for sex crimes in the counties where the program is implemented? The combination of three methods were used to address these research questions.

First, ICJIA required that each of the three programs complete and submit quarterly data reports. Data obtained from these quarterly reports[19] were analyzed. They contained quantitative performance indicators that revealed several aspects of program implementation in each of the sites, including the population served and the services that were provided. Quarterly reports also included anecdotal information about program activity. These anecdotal questions asked grantees about court

[19] Quarterly data reports covered three months of program activity and were submitted to ICJIA every April 15 (January through March), July 15 (April through June), October 15 (July through September), and January 15 (October through December).

outcome information for recent SANE cases, problems and successes that occurred during the quarter, and any other information grantees thought was substantial.

During the entire period of performance between March 2000 and December 2002, data from quarterly reports represent about 70 percent of total program activity during the the entire period of performance. Missing or incomplete data during the period exist for two reasons. First, two of the three pilot sites began in March 2000, while the third started in June 2000. However, ICJIA did not distribute uniform quarterly reports for the SANE pilot sites to begin completing until January 2001. Developing a data report that collected information about clients served, services provided, and performance measures relevant to the programs' objectives took several months. Additionally, we also needed to ensure that grantees had the capacity to provide the information requested, and that the reports were not too time-consuming for them to complete. Therefore, data submitted prior to January 2001 are incomplete.[20] Additionally, one of the three pilot sites did not receive funding from ICJIA for a one-year period between July 2001 and June 2002 due to a change in the hospital within the county that administered the SANE Pilot Program. Although the program was still operating, they were not receiving funds from ICJIA, so data reports do not exist for this program during that 12-month period.

The second method entailed conducting phone interviews with members of the SART in each of the three counties. We attempted to complete interviews with two SANEs, two sexual assault advocates, and two prosecutors in each of the three counties, thus aiming for a total of 18 interviews. After a maximum of four contact attempts with each potential respondent, sixteen interviews were completed: six SANEs, five victim advocates, and five prosecutors. To be eligible for the phone interviews, each respondent must have had experience working with cases in which victims were treated by SANEs, as well as experience working with cases in which victims were *not* treated by

[20] Although the pilot sites were submitting data during these months as required, data from all three sites were not consistent until ICJIA developed the data report in January 2001.

SANEs. The rationale was that respondents who have both experiences would be better able to speak to differences that may have resulted from the SANE program.

The interview instruments were similar for all three groups of subjects, yet tailored to each profession. Questions aimed to capture these professionals' opinions about the extent to which the SANE program had improved care for victims and had increased successful outcomes for prosecution and conviction of sex crimes. Most of the questions were open ended, so respondents were not limited to a predetermined selection of responses. Respondents were encouraged to describe relevant examples from their experiences to support their answers. Questions specific to program implementation were included that aimed to determine what type of training, if any, they had undergone specifically for the SANE program, and their level of participation in their community's SART.

Respondents for the phone interviews were recruited using what is known as the snowball sampling method. The contact person for each pilot site, who was also the SART coordinator in each county, was asked to provide referrals of colleagues whom they believed had experience with both SANE and non-SANE cases (or victims treated by SANEs and non-SANEs). These professionals were contacted, informed of the study and its purpose, and asked for their consent to participate in the study. Occassionally, we ran out of referrals for potential respondents. In such incidents, we asked respondents who had completed phone interviews to refer colleagues whom they believed also had experience with SANE and non-SANE cases. We later pursued those individuals and asked them to complete a phone interview.

The third method employed was non-participant observation of a SART meeting in each of the three counties. The aim was to better understand how the SARTs operate in each county, which community agencies are represented and what their roles are, what types of information are shared,

and what collective strategies are discussed for responding to sexual assault in their communities. One week prior to each SART meeting observed, a letter was sent to each team member to announce the researcher's attendance, explain the purpose of the study, request permission to be observed during the meeting, and provide contact information for questions or comments. On the day of each meeting, team members were orally briefed on the study's purpose and method, and asked for consent as a group for the researcher to observe and take notes for the duration of the meeting.

VI. Findings

Findings revealed by quarterly data reports

Between March 2000,[21] and the end of calendar year 2002, quarterly reports indicate that the three pilot sites served 520 patients who reported sexual victimizatation. Between March 1 and December 31, 2000, 139 patients were treated. This number grew to 198 in calendar year 2001, and then decreased slightly to 183 in 2002 (Figure 1). Staff from SANE programs not only treated and/or provided services to patients, but also provided services to many patients' "significant others"[22] as well. When someone's child, spouse, parent, or other family member or partner is sexually victimized, that person may also need crime victim services. Data from the quarterly reports show that at least 245 significant others of patients received services from the SANE program staff.

These figures can be compared with county level indicators for prevalence of sex crimes to shed light on the proportion of sex crime victims that are treated by SANEs. Between the years 2000 and 2002, the total number of reported Index criminal sexual assault offenses reported in Champaign, DuPage, and Lake counties was 1,321.[23] Between state fiscal years 2000 and 2002,[24] the Illinois

[21] Remember that just two of the pilot sites were established in March 2000, while the third was established in June 2000.
[22] A significant other is a person very close to the patient (spouse, parent, child, or other family member or partner) who is in need of victim services due to the victimization of the patient.
[23] Data source: Illinois State Police

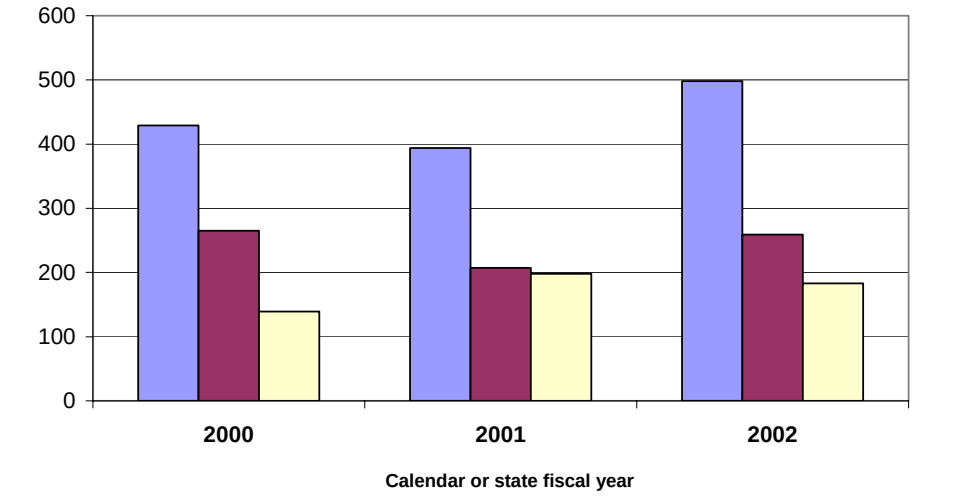
Department of Children and Family Services verified a total of 731 cases of child sexual abuse in Champaign, DuPage, and Lake counties. Thus, a combined total of 2,052 sex crimes were identfied in official statistics representing the three participating counties during the most recent three-year period (Figure 1). When these 2,052 reported sex crimes are compared to the 520 patients served between March 2000 and December 2002,[25] and we consider that many sex crimes are never reported to police,[26] it is likely that many victims of sexual assault in Champaign, DuPage, and Lake counties are not treated by SANEs.

Victims of sex crimes may not have been treated by SANEs in the participating counties for two reasons. First, victims may have been treated at a hospital that did not use SANEs;[27] or second, victims did not seek medical treatment at all. SART members in one pilot site concluded that, county-wide, just 30 percent of sexual assault victims who sought medical treatment were treated by a SANE. On a more positive note, they also concluded that 100 percent of patients who sought treatment at one of the hospitals that utilize SANEs were treated by a SANE. This was so even for a hospital that had not yet established around-the-clock SANE coverage, because SANEs were willing to volunteer their personal time to treat a sexual assault victim.

[24] Reflects time period between July 1, 2000 and June 30, 2002.
[25] It is important to consider that these 520 patients were treated by SANEs during a period of 2.8 years, while the official crime statistics represent a three-year period. Furthermore, this number of patients does not include the number of patients treated by SANEs during the one-year period in which one of the three counties was not receiving funding from ICJIA.
[26] The 2001 National Crime Victimization Survey conducted annually by the U.S. Department of Justice, Bureau of Justice Statistics indicates that 60 percent of sexual assault offenses are never reported to police.
[27] Not all hospitals from each county participated in the SANE Pilot Program.

Figure 1

Number of patients treated by SANEs and other sex crime indicators in Champaign, DuPage, and Lake counties



Number of reported Index criminal sexual assault offenses (by calendar year)

Number of children verified for child sexual abuse (by state fiscal year)

Number of patients treated by SANEs (by calendar year, except for 2000 which reflects March to December)

Sources: Illinois State Police, Illinois Department of Children and Family Services, and the three SANE pilot sites

The most common demographic population treated by SANEs during the period of performance (March 1, 2000 to December 31, 2002) were white females aged 18 or younger. Of all patients treated by SANEs in the three counties, 90 percent where female. More than 25 percent were children 12 or younger. A greater percentage (32 percent) were teenagers aged 13 to 18.[28] Thus, more than half of patients treated by SANEs during the performance period were age 18 or younger. Another 30 percent were young adults between the ages of 18 and 30.[29] The remaining 13 percent of

[28] This figure may be slightly underestimated because some data reports submitted to ICJIA (about 30 percent) contained age categories that differed from those of the quarterly reports. These data reports included an age category of 13 to 17, and then 18 to 29. Patients from the 18 to 29 category who were 18 years of age would not be included in the figure provided.
[29] Quarterly reports reflected age category 19 to 30, while a few data reports reflected a category of patients age 18 to 29.

patients treated by SANEs were in their thirties and forties. Six patients, all female, were age 60 or older.

For SANE patients whose race/ethnicity was reported (470 of 520), 77 percent were white, 15 percent were black, five percent were Hispanic, and one percent was Asian or Pacific Islander. Differences were noted when this distribution was compared to census data by race/ethnicity in Champaign, DuPage, and Lake counties. The 2000 Census indicated that of residents in the three counties combined, 77 percent were white, five percent were black, 10 percent were Hispanic, and six percent were Asian or Pacific Islander.[30] Thus, black patients were treated by SANEs more than three times their representation in the population of the area served. Conversely, Hispanics and Asian/Pacific Islanders were underrepresented among patients treated by SANEs. Hispanics were underrepresented by half, and Asian/Pacific Islanders were underrepresented by 85 percent. The percentage of white patients treated by SANEs was equal to their represenation in the general population for the three counties.

Finally, it should be noted that nine percent of the patients treated by SANEs during the period of performance were reported to have a physical or mental disability.[31] According to the 2000 Census, this is similar to the 10 percent of the population between ages 5 and 64 that reportedly have a disability in Champaign, DuPage, and Lake Counties.

Some findings from the analysis of data reports are based on only those quarterly reports that included performance indicators about the number of victims who received specific services. These reports included data on 188 victims and 245 significant others who were treated by SANEs. Although the pilot sites served more than twice this number of victims during the period of performance, data

[30] 2000 Census, U.S. Census Bureau

[31] Grantees were asked to self-report the number of patients treated with disabilities using their own judgment of what constituted a physical or mental disability.

for some victims did not include information about direct services. Either this information was not included in the data reports, or it was reported inconsistently so we could not analyze the information.

One of the essential practices of the SANE protocol for treating sexual assault victims is conducting a forensic exam. This exam should include photography of injuries with the colposcope as often as possible. Of 188 patients treated by SANEs, 90 percent received a forensic exam; 71 percent received forensic exams that included a colposcopy. Only six percent of patients refused to have a forensic exam completed.

Table 1 describes types of services patients and their significant others received from SANEs or sexual assault victim advocates participating in the SANE program. It also illustrates the percentages of patients and significant others that received different types of services. The overwhelming majority of patients received crisis counseling, medical advocacy, information and referral services, and personal advocacy, while more than half also received follow-up services from SANEs. Most significant others (more than 80 percent) received crisis counseling, medical advocacy, and information and referral services. Two-thirds of significant others received personal advocacy, and just under one-third received follow-up services. Finally, 89 percent of patients and 80 percent of significant others also received direct services from victim advocates of the local sexual assault center.

Table 1

Direct services reported by SANE programs

Direct service	**Definition**	**Percent of patients who received this service *(n=188)***	**Percent of significant others who received this service *(n=245)***
Crisis counseling	Providing in-person crisis intervention, emotional support, guidance, and counseling.	93%	83%
Medical advocacy	Assisting in understanding the physical examination and the forensic evidence collection process; explaining the purposes of each medical procedure; helping to alleviate further trauma during examinations.	93%	85%
Follow up contact	Following initial contact, contacting by telephone or written communication to offer emotional support, provide empathetic listening, or check on a patient's progress or recovery.	54%	30%
Information and referral	Providing information about services and support resources that are available.	93%	85%
Personal advocacy	Assisting in securing rights and services from other agencies; locating emergency financial assistance, intervening with employers, and others on their behalf; assisting in filing for losses covered by public and private insurance.	93%	66%
Direct services provided by sexual assault victim advocate	Refers to any of the above mentioned services or any other direct service provided to patients or significant others at the hospital by an advocate from the local sexual assault center.	89%	80%

Quarterly data reports also included performance indicators to reveal more about how different SART agencies were involved in the pilot site, as well as how often SANEs are involved in the prosecution of sex crimes. Again, however, these data were only available for the 188 patients who were reported using the quarterly data report form created by ICJIA.

Pilot sites were asked to report the number of patients who were accompanied to the emergency department by two other SART members, law enforcement personnel and sexual assault victim advocates. Of 188 patients, 13 percent were brought to the hospital by police. Another two percent were brought by staff from the local sexual assault center (Table 2). This means that the majority of these patients had likely sought medical treatment without being accompanied by a SART

member. However, the number of significant others who also received services from the SANE programs indicates that most, if not all, patients were accompanied to the hospital by a significant other.

Although most patients were not accompanied by a police officer or a sexual assault victim advocate, SANEs (or other emergency department personnel) often contacted these professionals and asked them to respond to patients while they were at the hospital. Police were contacted for 90 percent of patients, and victim advocates from the local sexual assault center were contacted for 73 percent of patients. More than 80 percent of patients received referrals for the local sexual assault center (Table 2). Furthermore, anecdotal information suggests that in most cases where police officers or advocates were not contacted, this occurred because the patient had requested that they not be contacted.

Data reports also indicated that for 25 percent of patients, the Illinois Department of Children and Family Services (DCFS) was contacted by the SANE program (Table 2). Of the 188 patients for which this information was submitted, 18 percent were age 12 or younger and another 40 percent were between the ages of 13 and 18.

Data reports did not indicate that SANEs are supoenaed by the court or testify in court often. Of the 188 patients for which these data were obtained, SANEs were supoenaed a total of 15 times, and had testified in a case four times (Table 2).

Table 2

Performance indicators submitted by SANE programs

Performance indicator	Percent of patients (n=188)
Patients who received a forensic examination:	90%
Patients who received a forensic exam including a colposcopy:	71%
Patients who did NOT receive a forensic examination because it was found unnecessary or the patient refused:	6%
Patients accompanied to the hospital by police:	13%
Patients for whom police were contacted to respond to the patient at the hospital:	90%
Patients accompanied to the hospital by a staff person from a sexual assault center:	2%
Patients for whom a sexual assault center was contacted for a staff person to respond to the patient at the hospital:	73%
Patients who were referred to a sexual assault center for follow-up services:	80%
Patients for whom DCFS was contacted:	25%
Patients for whom SANE staff were subpoenaed to testify in court about their case:	8%
Patients for whom SANE staff testified in court about their case:	2%

Phone interviews

In general, the phone interviews support the finding that SANE programs do improve treatment and care for sexual assault victims. However, opinions about whether or not SANE programs result in more successful court outcomes were mixed. Slighty more than half of respondents reported that court outcomes were improved. Most respondents who did not say that the SANE program had improved prosecution or conviction rates responded so because they simply did not know.

The first question in the phone interview asked all three groups of respondents whether or not they had been trained about the SANE protocol; and, if they had, what their opinion was of the training. Although this question does not directly address one of our research questions, the legislation

specified that, “pilot projects must have completed a sexual assault nurse examiner (SANE) training program that meets the Forensic Sexual Assault Nurse Examiner Education Guidelines established by the International Association of Forensic Nurses.” Thus, it was important to determine that program staff had fulfilled this requirement. Furthermore, it is always important to determine training levels of staff when assessing impact of staff-provided treatment and services.

All SANE respondents to the phone interviews (six of six) reportedly received formal training to become certified SANEs. Of the five sexual assault victim advocate respondents, all five received formal training; and two of the five prosecutors said they received formal training. Although no formal SANE certification process exists for sexual assault victim advocates or state’s attorneys who prosecute sex crimes, the International Association of Forensic Nurses encourages such professionals to attend formal SANE training. Of those that did not receive formal training, one advocate and three prosecutors reported that they were trained informally by reading materials about the SANE protocol and speaking with others who had formal training. Thus, of all 16 respondents, 12 were trained formally. Of the three professions interviewed, prosecutors were the least likely to attend a formal SANE training course.

Every respondent who received formal training (12 of 16) made positive comments about the quality of instruction. Overall assessments ranged from good to outstanding, and several respondents reported how impressed they were with the detailed instruction about the medical and evidentiary procedures conducted by SANEs. Another common response referred to the value of training in understanding the roles of each member of the SART, including SANEs, police, advocates, forensic scientists, prosecutors, judges, and even defense attorneys. Five of the 16 respondents commented specifically on the high quality instruction they received from a nationally known SANE, Jamie Ferrell. Only two criticisms were expressed. One respondent stated that a particular training “could

have been a little more organized," while another thought that some of the curriculum should have been more applicable for sexual assault victim advocates.

All three groups of respondents reported that treatment of sexual assault victims improves substantially with a SANE program. In fact, every respondent agreed that victims receive an improved response from SANE program staff. Repeated comments included how SANEs provide one-to-one contact; spend more time with patients; establish a more positive rapport with patients; are objective, sympathetic, and compassionate; and explain the forensic exam process to the victim as it is occurring. Respondents' comments about victim responses to the SANE program included: victims treated by SANEs are more comfortable with the medical and criminal justice processes, they report more positive interactions with SANEs, they have more knowledge of the processes and are better informed to make decisions, they feel more in control, and they are much less frightened and more at ease during the examination.

When respondents were asked if they believed victims treated by SANEs are more likely to report their victimization to police, just over half (9 of 16) answered "yes." SANEs were most likely to respond affirmatively with five of six responding "yes." For both the advocates and the prosecutors, two in each group of five answered, "yes."

Respondents who believed victims were more likely to report their victimization to police supported their statement with three primary reasons. First, SANEs provide more objective, sensitive care that helps victims feel supported and believed, thereby removing a common barrier to reporting sex crimes (victims *not* feeling supported or believed). Second, SANEs and victim advocates educate the victim about their options regarding the criminal justice system, thereby alleviating fears of the unknown. Third, SANEs explain to victims that police are part of their sexual assault response *team*,

which increases the likelihood that victims will trust that law enforcement personnel will treat them respectfully and without judgment.

Six of the seven respondents that did not affirmatively answer the question of whether SANE programs increased victims' likelihood of reporting to police provided neutral responses. In other words, they stated that they just do not know the answer to that question, even after the interviewer explained that their response could be based on experience and knowledge rather than actual statistics. One respondent stated that the likelihood of victims' reporting to police does *not* increase with a SANE program. However, all seven of these respondents relayed that SANE programs do help victims become better informed so that they can make decisions about the criminal justice system in their own best interests.

On the question of whether victims treated by SANEs are more likely to follow through with their cases into the prosecution stage, just over half (9 of 16) of the respondents answered affirmatively. SANE respondents answered this question "yes" most often (4 of 6), followed by advocates (3 of 5), and then prosecutors (2 of 5). Reasons cited for supporting this statement were similar to those cited for why victims are more likely to report their victimization to police. The two primary justifications were that SANEs, advocates, and police officers each provide information to victims that help alleviate fears of the criminal justice system, and that victims feel more justified and supported by a team of professionals who provide objective and compassionate treatment.

Most of the remaining seven respondents reported that they were unsure, or that their experience was insufficient to support the argument that the SANE program increases the percentage of sexual assault victims who support prosecution. Again, however, they reported that victims treated by SANEs are much better informed to make educated decisions. Although they believed that

providing more information is a great benefit to victims, they did not believe that this increases a victim's desire to participate in prosecution.

Respondents were also asked for their opinions about whether the SANE program increases the likelihood of successful criminal justice outcomes against sex offenders. Specifically, respondents were asked if they believed that offenders who victimized persons who were treated by SANEs are more likely to be arrested, prosecuted, and convicted. Overall, 10 of 16 respondents accepted that offenders whose victims were treated by SANEs are more likely to be convicted. Five of six SANEs answered this question affirmatively, while one did not know. Of the five advocate respondents, two responded, "yes," while the other three were not sure. Of the five prosecutors, three stated that they "definitely" believe such offenders are more likely to be convicted, one was not sure, and one stated that the likelihood of conviction does not increase when compared to non-SANE cases. However, this respondent also reported that SANEs are more consistent in their documentation and evidence collection, and that victims have more positive interactions with SANEs. Two prosecutors who claimed to have experience with more than ten cases involving examination and evidence collection by a SANE stated that they had not lost a SANE case yet.

Another question asked SANE and advocate respondents about court experience with their patients/clients to better understand their involvement with the criminal justice system. SANE respondents were asked if they had ever testified in court for their patients; while advocate respondents were asked if they had ever accompanied their clients (who were treated by SANEs) to court. However, not all respondents reported having court experience with their patients/clients. Of the six SANEs who were interviewed, three had never testified. However, those who had not testified stated that they had been supoenaed several times. Two SANEs stated that they never testified because most

cases were settled through a plea bargain and never reached the trial phase. Of the five advocates that responded, two reported that they had accompanied a victim who was treated by a SANE to court.

The last question of the phone interview asked respondents about their involvement in the SART and their opinions about how helpful they felt the team response was with performing their professional duties. Of the six SANE respondents, all reportedly attended at least one SART meeting, and most attended regularly. Of the five advocates interviewed, three attended SART meetings regularly. Prosecutors attended least often as only two of five attended SART meetings regularly. Thus, nine of the 16 respondents reported attending SART meetings regularly, and one respondent had attended one but was not in regular attendance.

All respondents who attended SART meetings specifically relayed three benefits of the SART. First, they emphasized the importance of understanding the different perspectives of other SART members. Several reported that this helped them improve their individual responses to victims as well as their relationships with other SART members. Second, SART meetings allowed members to exchange information about issues at the community, organizational, and individual levels. Such exhange increases awareness of all the SART members about matters such as outreach efforts, organizational protocol or policy changes, and outcomes and follow-up information about individual cases.[32] Many respondents emphasized how valuable they found information shared by different members of the SART, and that this was information they would not have been privy to otherwise. Finally, and most often expressed by respondents, was that the SART approach allowed members to make informed, collective decisions on how to respond to sexual assault in their communities.

[32] Information shared at SART meetings about individuals or individual cases was always done in accordance with effective confidentiality rules for each profession.

Observations of SART meetings

Findings revealed from observations of one SART meeting in each of the three pilot sites provided insight about how collaborative efforts helped the pilot sites improve their collective response to sexual assault.

All three sites had representation from four primary community stakeholders[33] on the days the meetings were observed: law enforcement, prosecution, sexual assault victim services, and hospital emergency department personnel (including SANEs). One challenge for all three SARTs was gaining representation from more law enforcement agencies and hospitals in the area served by each pilot site. None of the sites had attained full representation at the time of the observations, but the aim of increasing this was discussed at all meetings observed.

Additionally, each SART had representation by forensic scientists from the local crime laboratory. Crime lab staff contributed information regarding the evidence analyzed from the examinations, and were highly regarded by other SART members. For example, one forensic scientist reported that an offender's DNA was identified on a victim's article of clothing even after the article of clothing was washed. The scientist explained that although this is a rare occurrence, it can happen, especially if the clothing was washed with a mild detergent or in a gentle cycle. Other SART members gained knowledge that could potentially result in arrest and conviction of a sex offender.

Second, rapport among the SART members was evident at each of the meetings observed. Each member displayed respect for one another, even in situations of disagreement. Appreciation for others' efforts was frequently expressed, concerns and criticisms were presented with tact and respect, and recipients of such criticisms demonstrated a sincere interest in recognizing potential problems and working with other members to clarify misinterpretations and/or respond to challenges. At one

[33] The SANE Development and Operation Guide by the U.S. Department of Justice, Office for Victims of Crime, states that the typical agencies represented on a SART include law enforcement, prosecution, sexual assault services, SANEs, and emergency department personnel (SANEs often are also emergency department personnel).

meeting, an advocate expressed concern that some police officers were not aware of, or were not upholding, the rights of teenagers to withhold information regarding their victimization from their parents. A law enforcement member acknowledged this concern and explained that those police officers who have children of their own are challenged by these rights because they would want to know if their child had experienced such trauma. SART members empathized with the difficulty of this situation, especially for a police officer who is also a parent. The officer recognized this as an important clarification to address with his colleagues and agreed to do so.

Third, agenda items that addressed challenges for the SARTs comprised the greatest portion of time during the meetings. Participants of all three SART meetings spent considerable time discussing the same challenge—the low percentage of sexual assault patients that are seen by SANEs within their respective counties. Although exact percentages were not revealed at each meeting, members brainstormed for ways of increasing the number of SANEs, promoting hospital buy-in to utilize SANEs, and marketing the SANE program to police departments. Barriers to ensuring that all sexual assault victims are treated by SANEs in a county include the following:

- Securing funding for SANE training;
- Convincing registered nurses (R.N.s) to become trained SANEs;
- Preventing potential recruits from deciding not to be a SANE after training;
- Promoting the SANE program in their counties;
- Addressing organizational and public attitudes such as “rape doesn’t occur here so we don’t need it;”
- Addressing hospital reluctance to prioritize SANE training when there may be low incidence of sexual assault; and
- Addressing turf issues, for example, whether or not police can transport victims outside their jurisdictions to receive treatment by a SANE.

Progress on the SART’s goals and objectives was the next most frequent topic discussed at meetings. All three SARTs discussed training goals for SANEs, law enforcement personnel, and prosecutors. Members viewed training as a method for attaining multiple objectives of increased victim sensitivity, expanding SANE program awareness (and wider coverage), and improving their

collaborative response to sexual assault. Other goals discussed were educating themselves by inviting guest speakers who are experts in specific sexual assault issues, e.g. pornography or child sexual abuse; revising protocols; developing and maintaining a database to better track progress; and developing methods of evaluating court outcomes of SANE cases.

One SART meeting included discussion of an analysis that tracked sexual assault patients from admission to the emergency department through conviction and even sentencing of the offender whenever possible. Data were presented that revealed the number of sexual assault patients admitted to emergency departments, the number of patients treated by SANEs, the number of patients that reported to police, and statistics on later stages of the criminal justice process including prosecution and sentencing. Although the figures were lower than SART members had hoped, presentation of the data allowed them to identify where potential barriers exist and provided insight about ways to address them. Knowing where barriers exist among each of the stages in the process allowed this team to more effectively target their efforts.

VII. Discussion of How Findings Address Research Questions

In discussion of this study's findings, we should restate the two research questions posed by the objectives in Public Act 91-0529. Following are discussions about how our findings address each research question.

Research Question 1: Is Illinois' SANE Pilot Program helping to alleviate suffering of sexual assault victims in the counties where the program is implemented?

Findings support that Illinois' SANE Pilot Program is helping to alleviate the suffering of sexual assault victims that are served. Data report analyses revealed that victims treated by SANEs are receiving services designed to assist crime victims, and that victims are receiving prompt responses by

multidisciplinary teams of professionals. The phone interviews supported that SANE services are helpful to victims of sexual assault. All methods supported that victims are better informed, which also helps alleviate suffering because most victims who are educated about their options can make better decisions in their own best interests.

Table 1 (page 20) demonstrates that nearly all patients treated by SANEs received some type of service designed to alleviate suffering of sexual assault victims. More than 90 percent of patients treated by SANEs in the Pilot Program received crisis counseling, medical advocacy, information and referral services, and personal advocacy. More than half of these patients received follow-up services from SANEs. More than two-thirds of patients' "significant others" also received these services. Furthermore, nearly 90 percent of patients treated by SANEs in the Pilot Program also received services from victim advocates from the local sexual assault advocacy center. Because of SANEs' advanced education on conducting medical evidentiary exams in a way that preserves a patient's dignity, their familiarity with community resources available to victims, and their partnerships with the criminal justice system and other community agencies, these findings support that victims treated by SANEs are more likely to receive these services compared to victims who are not treated by SANEs.

Findings also support that sexual assault victims treated by SANEs in the Pilot Program receive a multidiscplinary team response while they are at the hospital. This is important toward alleviating the suffering of victims, because prompt responses from professionals of different agencies that work together as a team help victims become more informed of their options with the criminal justice system and community resources that are available to them. Data in Table 2 (page 22) show that police were contacted to respond to patients while they were at the hospital for 90 percent of patients treated by SANEs. SANEs or other emergency department personnel contacted staff from a sexual assault advocacy center to respond at the hospital for 73 percent of patients. Finally, referrals

for a sexual assault advocacy center were provided to more than 80 percent of patients treated by SANEs. Although it is impossible to confirm that these contacts actually resulted in face-to-face contacts between agency professionals and victims, this finding does show that other SART members were contacted and requested to respond at the hospital for most patients treated by SANEs in the Pilot Program. The prompt multidisciplinary team response while a victim is in the hospital helps ensure that victims will be more informed about their options with the criminal justice system as well as resources available to help alleviate suffering.

Responses to the phone interviews also support that suffering is alleviated for sexual assault victims who are treated by SANEs in the Pilot Program. All 16 respondents, several of whom interact with victims daily, agreed that services provided by the SANE program are helpful to sexual assault victims. Furthermore, when respondents were asked how victims treated by SANEs benefit compared to those who are not treated by SANEs, some characteristics were repeated often enough to support that victims' suffering is alleviated: victims are more comfortable; they feel more in control; they are less traumatized; they are less humiliated; and they are treated more compassionately. All of these comments suggest that the Illinois' Pilot SANE Program is doing much to alleviate the suffering of sexual assault victims.

Finally, all three study methods support that the SANE Program helps sexual assault victims become better informed to make decisions. One of the most consistent responses of the phone interviews was that victims receive care that is non-judgmental; and that victims receive more information about their own care, the evidence collection process, and their options with the criminal justice system. More than half of respondents emphasized the importance educating victims about their options with criminal procedures, rather than persuading them to make a specific decision. The

rationale is that victims make the best decisions for themselves with compassionate treatment and accurate information from SART members.

Research Question 2: Does Illinois' SANE Pilot Program help increase successful prosecution rates for sex crimes in the counties where the program is implemented?

The second research question is not as easily answered from our findings. Confirmation of an increased prosecution rate, and the extent of such a rate, requires further examination that includes involvement of additional personnel from law enforcement, prosecution, courts, and crime laboratories, as well as quantitative data that reveal court outcomes for SANE and non-SANE cases.

Data from the quarterly reports do not directly support that SANE cases are more likely to result in successful prosecution outcomes. However, they did support that SANEs in the Pilot Program completed procedures that are important for effective collection and presentation of evidence, which is necessary to increase the success rate of prosecutions. First, forensic examinations were completed on 90 percent of patients treated by a SANE. Additionally, more than 70 percent of these examinations included a colposcopy, which can detect microscopic injuries resulting from sexual assault that could otherwise be missed (Table 2).

Some support for increased prosecution rates was found in prosecutors' responses to the phone interviews. Each prosecutor was asked whether they felt SANE cases were more likely to result in successful prosecution and conviction than non-SANE cases. Of the five prosecutors interviewed, three answered this question affirmatively. One of these prosecutors stated that it was "so much easier to obtain a conviction with a SANE." One of the prosecutors that did not answer affirmatively indicated that he was not sure, but commented that SANEs are more consistent in their documentation and collection of evidence than non-SANEs. The remaining prosecutor stated that the likelihood of prosecution and/or conviction does *not* increase due to the SANE program, but that it does increase if

a sexual assault victim receives any kind of medical treatment. The most compelling support for more successful prosecution outcomes for SANE cases came from two of the prosecutor respondents, who each reported to have prosecuted more than 10 SANE cases. Both of them stated that they had yet to lose a SANE case.

The findings that SANEs are not supoenaed to appear in court often and rarely testify in court do not help directly answer the question of whether the Illinois' SANE Pilot Program results in more successful prosecution outcomes. Additional data should be collected regarding court outcomes for a greater number of sexual assault cases in which SANEs do testify in court, as well as SANE cases where SANEs do not testify. Some could argue that if SANEs are not required to testify in court often, that means cases are too weak to justify prosecution. However, data obtained during the phone interviews suggest otherwise. Several respondents referred to SANE cases as "so airtight," that defendants are more likely to plead guilty, thereby avoiding a trial. When a defendant pleads guilty before a trial, this will often result in the defendant being convicted of less serious charges or receiving a more lenient sentence.

Respondents were asked whether sexual assault victims treated by SANEs are more likely to report their victimization to police. Their responses did not directly answer our second research question, but they did provide insight about *potential* for increased prosecution rates. This is because when more incidents are reported to police, this results in more cases that *could* be prosecuted. Although this does not necessarily increase *rates* of successful prosecution or conviction, it would increase the actual number of sexual assault cases prosecuted, and thus more sex offenders being convicted.[34] When interview respondents were asked if victims treated by SANEs are more likely to report the crime to police, responses were mixed. Recall that nine of 16 respondents responded

[34] This statement is made with the assumption that the percent of arrests resulting in prosecution, and the percent of prosecutions resulting in convictions does not decrease.

affirmatively (that victims treated by SANEs are more likely to report), while the other seven respondents were not sure. So again, although more than half of respondents believed that Ilinois' SANE Pilot Program helps increase the number of of sexual assault victims that report the crime to police, our findings do not help determine whether prosecution rates are increased in the pilot sites.

Findings were also inconclusive when respondents were asked whether victims treated by SANEs are more likely to cooperate with criminal justice personnel into the prosecution stage. With increased victim cooperation during the prosecution stage, the likelihood of prosecution and conviction is also increased because prosecuting cases without a victim's testimony is usually difficult and often not pursued by prosecutors. However, again, because just nine of 16 respondents answered this question affirmatively, the question remains unanswered.

In summary, although data from all three research methods used in this study support more than reject that prosecution rates are increased in the counties where the SANE Pilot Program is implemented, they do not provide strong enough support to accept this is an impact of the SANE Pilot Program. However, data do support that the Pilot Program does result in improved collection and presentation of forensic evidence, which is necessary to increase the success rate of prosecutions for sex crimes. Although our findings cannot directly answer the second research question, they do suggest that when sexual assault victims are treated by SANEs, and especially when they also receive services from advocates and police support, victims are better educated to make more informed decisions about the criminal justice system.

VIII. Recommendations

1. Identify funding sources to help programs participating in the Illinois SANE Pilot Program continue their efforts, as well as to create opportunities for new programs to be established in other jurisidictions.

Illinois' SANE Pilot Program is making substantial differences in victims' lives, and thorough evidence collection offers improved opportunities for increased success rates with prosecution and conviction. Counties currently participating in Illinois' SANE Pilot Program should continue their efforts to expand coverage throughout their jurisdictions. In the vast majority of Illinois counties where SANE programs do not exist, community agencies that respond to sexual assault should be encouraged to establish similar models in their communities.

2. Ensure that every county in Illinois has 24-hour access to a SANE.

Successes of Illinois' SANE Pilot Program are evident in the improved health systems response to victims of sexual assault. Data support that victims spend less time and experience less discomfort in the emergency room, they have greater access to support services, and they receive more compassionate, objective care. The overwhelming majority of patients treated by SANEs also received victim services in addition to medical treatment, and patients were informed of resources available to help alleviate their suffering. Lastly, patients treated by SANEs are better informed about their options with the criminal justice system, so that they are better able to make decisions in their best interests. All victims of sexual assault should receive the kind of treatment and thorough evidence collection that SANEs provide.

At least one hospital in every county should have 24-hour access to a SANE on staff or on call. Larger or more populated counties should have more than one hospital with access to SANEs, depending on the number of sexual assault victims encountered. For counties with fewer sexual assault victims, a "traveling" SANE could be on-call for more than one hospital or county.

Communities need to identify funding sources to meet this objective. Sexual assault victims should not be billed for forensic examinations, just as victims of other crimes are not charged fees for collecting evidence from crime scenes.

3. Hospital staff should always contact a sexual assault advocacy center upon admission of a patient who is a sex crime victim. Hospital staff should always offer patients the opportunity to speak with a victim advocate during their time at the hospital.

During the phone interviews, victim advocates expressed concern that emergency department personnel from some hospitals do not always contact their agency when a sexual assault victim is admitted to the emergency department. Regardless of whether or not a SANE is available to conduct a forensic examination, the advocacy center should be contacted so that patients have the option of speaking with an advocate during their time at the hospital. Victim advocates provide compassionate, objective support; offer services designed to help alleviate suffering of victims; and can also inform victims about their options with the criminal justice system. This study has shown that prompt response to sexual assault victims by an advocate is a critical component to the SANE programs, and essential to helping alleviate suffering of sexual assault victims.

4. Educate criminal justice personnel about improved collection and presentation of evidence by SANEs.

Although our findings did not support that SANE programs increase success rates for prosecution, they do support that SANEs are more efficient at collecting and presenting evidence compared to other medical personnel. Police officers need to know which hospitals in their communities utilize SANEs, so that they can escort victims to these hospitals. This could help police officers arrest more sex offenders and increase the percentage of arrests that result in prosecution. Prosecutors should also be educated about SANEs' advanced forensic training so that they can fully utilize SANEs' expertise and the evidence collected by SANEs. This would improve the quality of sexual assault cases presented, which is necessary to increase successful prosecution rates.

5. Communities should establish SARTs that include local professionals from police departments, state's attorney's offices, sexual assault advocacy centers, hospitals, forensic laboratories, and other interested parties.

The multidisciplinary team approach is working effectively toward helping community stakeholders work together to respond to sex crimes in their communities. This team approach is especially helpful because several team members have conflicting purposes. For example, victim advocates aim to alleviate suffering of victims, while prosecutors work to convict sex offenders. Working together in a team setting provides each member with different perspectives necessary to effectively respond to sex crimes in their communities. Team members learn to respect and accommodate each others' objectives, while they also work to develop and accomplish collective team objectives. An environment that encourages, and even relies upon, the understanding of multidisciplinary perspectives provides the essential foundation for developing an effective community response to sexual assault.

6. Increase community awareness about the effects of sexual victimization on victims and the value of SANE Programs.

Findings suggest that the primary barrier to expanding coverage of SANE programs stems from a lack of buy-in for SANE programs among community agencies and the public. Convincing others of the value of SANE programs requires the greater challenge of affecting attitudes and stereotypes in the community. Public attitudes often do not acknowledge the prevalence of sexual assault, and they also include distorted perceptions of who is a "legitimate" sexual assault victim. These stigmas often permeate into the same agencies that respond to sexual assault, thereby resulting in agency personnel who hold similar perspectives. Increased awareness about the effects of sexual victimization and the improved response from SANE programs will empower communities to hold agencies more accountable. For example, increased community awareness would result in more people

recognizing that if they, or any of their loved ones, are ever sexually victimized, they would demand to be treated by a SANE.

SART members in Illinois spend a considerable amount of time working to change community perspectives as well as those of agency personnel who respond to sexual assault victims. With continued persistence, patience, and dedication, these professionals will affect change in their communities.

7. Conduct additional research that measures differences in court outcomes between SANE sexual assault cases and non-SANE sexual assault cases.

Although findings from this study strongly support implementation of more SANE programs in Illinois; tracking cases from initial reporting to final court disposition and sentence would provide a better understanding of the extent to which SANE programs result in increased success rates for prosecution and conviction. If findings reveal that SANE cases are prosecuted more successfully than non-SANE cases, promoting buy-in for SANE programs will prove easier, particularly among criminal justice professionals.

APPENDICES

I. References

II. Background on the Illinois Criminal Justice Information Authority

III. Data report used by SANE programs to report program activity

IV. Phone interview instrument for Sexual Assault Nurse Examiners (SANEs)

V. Phone interview instrument for sexual assault victim advocates

VI. Phone interview instrument for prosecutors

APPENDIX I

REFERENCES

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APPENDIX II

BACKGROUND ON THE ILLINOIS CRIMINAL JUSTICE INFORMATION AUTHORITY

The Illinois Criminal Justice Information Authority was created in 1983 to coordinate the use of information in the criminal justice system; to promulgate effective criminal justice information policy; to encourage the improvement of criminal justice agency procedures and practices with respect to information; to provide new information technologies; to permit the evaluation of information practices and programs; to stimulate research and development of new methods and uses of criminal justice information for the improvement of the criminal justice system and the reduction of crime; and to protect the integrity of criminal history record information, while protecting the citizen's right to privacy (see 20 ILCS 3930 *et seq.*).

Composition & Membership

The Authority is governed by an 18-member board of state and local leaders in the criminal justice community, plus experts from the private sector. The Authority is supported by a full-time professional staff working out of the agency's office in Chicago. The Authority is led by a chairman, who is appointed by the governor from among the board's members. By law, the Authority meets at least four times a year in public meetings. Authority members are responsible for setting agency priorities, tracking the progress of ongoing programs, and monitoring the agency's budget.

By law, the Authority includes:

- Two police chiefs (Chicago and another municipality)
- Two sheriffs (Cook and another county)
- Two state's attorneys (Cook and another county)
- Two circuit court clerks (Cook and another county)
- Illinois attorney general (or designee)
- Director, Illinois State Police
- Director, Illinois Department of Corrections
- Director, Office of the State’s Attorney’s Appellate Prosecutor
- Director, Office of the State’s Attorney’s Appellate Defender
- Executive Director, Illinois Law Enforcement Training and Standards Board
- Six members of the public

The Authority accomplishes its goals through efforts in four areas: 1) information systems, technology and data quality; 2) research and analysis; 3) policy and planning; and 4) grants administration.

1. Information systems, technology, and data quality

The Authority: (1) Develops, operates, and maintains computerized information systems for police agencies; (2) Serves as the sole administrative appeal body for determining citizen challenges to the

accuracy of their criminal history records; and (3) Monitors the operation of existing criminal justice information systems to protect the constitutional rights and privacy of citizens.

2. Research and analysis

The Authority: (1) Publishes research studies that analyze a variety of crime trends and criminal justice issues; (2) Acts as a clearinghouse for information and research on crime and the criminal justice system; (3) Audits the state central repositories of criminal history record information for data accuracy and completeness; and (4) Develops and tests statistical methodologies and provides statistical advice and interpretation to support criminal justice decision making.

3. Policy and planning

The Authority: (1) Develops and implements comprehensive strategies for drug and violent crime law enforcement, crime control, and assistance to crime victims, using federal funds awarded to Illinois; (2) Advises the governor and the General Assembly on criminal justice policies and legislation; and (3) Develops and evaluates state and local programs for improving law enforcement and the administration of criminal justice.

4. Grants administration

The Authority: (1) Implements and funds victim assistance and violent crime and drug law enforcement programs under the federal Anti-Drug Abuse Act, Victims of Crime Act, Violence Against Women Act, and other grant programs as they become available; (2) Monitors program activity and provides technical assistance to grantees; (3) Coordinates policy-making groups to learn about ongoing concerns of criminal justice officials; and (4) Provides staff support to the Illinois Motor Vehicle Theft Prevention Council, an 11-member board working to curb motor vehicle theft.

APPENDIX III

DATA REPORT USED BY SANE PROGRAMS TO REPORT PROGRAM ACTIVITY

Illinois Criminal Justice Information Authority

Sexual Assault Nurse Examiner (SANE) Programs
Quarterly Data Report

QUARTER (Circle one): **Jan-Mar** **Apr-June** **July-Sept** **Oct-Dec**

Year: _____

IMPLEMENTING AGENCY: _____

AGREEMENT #: _____

NOTE: This quarterly data report form is designed to collect information on direct services provided by the SANE programs. When completing this report, include only SANE services and persons served that are funded under this agreement. The only other services to be included on this report are those persons served by sexual assault crisis center advocates or counselors while patients are at the hospital (see instructions in Section D). Do not include other services provided by non-SANE staff or persons not from a sexual assault center.

Information collected in Sections A-L below is compiled for all Authority funded SANE programs.

PATIENTS Persons that come to the hospital for treatment due to an alleged sexual assault and receive services from a SANE staff person at the hospital during the quarter.

SIGNIFICANT OTHERS Persons with the patient (e.g. spouse, child, or other family member or friend) who receive services from a SANE staff person due to the alleged victimization of the patient.

A. **PATIENTS** served by the SANE project this quarter: _____

B. **SIGNIFICANT OTHERS** served by the SANE program this quarter: _____

TOTAL: _____

C. DEMOGRAPHIC INFORMATION (REPORT THE FOLLOWING INFORMATION FOR <u>PATIENTS</u>): Report age, race, and ethnicity for each patient served by SANE staff during the quarter by their gender, in addition to the number of disabled patients served. The totals for sections one (1) and two (2) should equal the total number of male and female patients served during the entire quarter.

(1) AGE OF PATIENTS:

	Males	Females
0-4		
5-8		
9-12		
13-18		
19-20		
21-30		
31-40		
41-50		
51-60		
61-65		
66 years and up		
Unknown		
TOTAL		

(2) RACE/ETHNICITY OF PATIENTS (See attached definitions for each category)

(2a) RACE

	Males	Females
Black		
White		
Asian		
American Indian or Alaska Native		
Native Hawaiian or Pacific Islander		
Bi-racial		
Other		
Unknown		
TOTAL		

(2b) ETHNICITY (Regardless of race)

	Males	Females
Hispanic		
Non-Hispanic		
Unknown		
TOTAL		

(3) PATIENTS WITH DISABILITIES: Males _____ Females _____

D. DIRECT SERVICES PROVIDED TO PATIENTS AND SIGNIFICANT OTHERS: This section reports direct services provided to patients and significant others by SANE staff **and** by sexual assault center staff (if known) during the quarter. In rows 1 through 6, please indicate the number of patients and significant others who received each given service from **SANE** staff only. Refer to the definitions provided below for each type of direct service. In row 7, please indicate the known number of patients and significant others that received services from sexual assault center staff while the patient was at the hospital. Each patient/significant other may receive more than one type of service.

Type of Direct Service	**Number of Patients Who Received Services**	**Number of Significant Others Who Received Services**
(1) Crisis Counseling – SANE staff *Refers to in-person crisis intervention, emotional support, and guidance and counseling provided to patients and significant others.*		
(2) Medical Advocacy – SANE staff *Refers to assisting patients and significant others in understanding the physical examination and the forensic evidence collection process; explaining the purposes of each medical procedure; helping to alleviate further trauma during examinations, etc.*		
(3) Follow Up Contact – SANE staff *Refers to in-person and telephone contacts and written communications with patients or significant others to offer emotional support, provide empathetic listening, checking on a patient's progress or recovery, etc.*		
(4) Information & Referral – SANE staff *Refers to in-person contacts with patients or significant others during which time services and available support are identified.*		
(5) Personal Advocacy – SANE staff *Refers to assisting patients or significant others in securing rights and services from other agencies; locating emergency financial assistance, intervening with employers, and others on their behalf; assisting in filing for losses covered by public and private insurance programs.*		
(6) Other (Specify) – SANE staff		
(7) Direct services provided by sexual assault center staff *Refers to any of the above mentioned services or any other direct service. Please indicate the known number of patients and significant others who were provided direct services by sexual assault center staff at the hospital.*		

E. STAFF INFORMATION:

Number of hours devoted this quarter to the SANE program by paid staff:	
Number of days during quarter in which SANE staff were available 24 hours:	
Number of certified SANEs on staff at each participating hospital (please list by hospital): _____ _____ _____	 _____ _____ _____

F. OTHER PERFORMANCE INDICATORS:

1. Of patients mentioned in Item 1 above, number that were examined with a colposcope: _____

2. Number of patients that did NOT receive a forensic examination because it was found unnecessary or the patient refused: _____

3. Number of patients accompanied to the hospital by police: _____

5. Excluding those who were accompanied by police, number of patients for which police were contacted to respond to the patient at the hospital: _____

6. Number of patients accompanied to the hospital by a staff person from a sexual assault center: _____

7. Excluding those who were accompanied by sexual assault center staff, number of patients for which a sexual assault center was contacted for a staff person to respond to the patient at the hospital: _____

8. Excluding those that were accompanied to the hospital by or seen by sexual assault center staff at the hospital, number of patients that were referred to a sexual assault center for follow-up services: _____

9. Number of cases in which DCFS was contacted: _____

10. Number of cases for which SANE staff were subpoenaed to testify in court: _____

11. Number of cases for which SANE staff testified in court: _____

G. ANECDOTAL FOLLOW-UP INFORMATION: Describe any new follow-up information obtained on patients or significant others provided SANE services in the past. For example, were any patients successful in having alleged perpetrators arrested, prosecuted, or convicted in court? Are any patients or significant others following up with referrals to sexual assault counseling or advocacy services?

H. TRAININGS HELD DURING QUARTER:

Description	Date	Number Attending

I. MEETINGS HELD DURING QUARTER:

Description	Date	Number Attending

J. PRESENTATIONS MADE DURING QUARTER:

Description	Date	Number Attending

K. COMMENTS AND OTHER INFORMATION: A summary of other activities undertaken during this quarter or other information you feel is relevant.

L. PROBLEMS ENCOUNTERED DURING THE QUARTER: Describe any problems encountered during the quarter that are affecting achievement of the goals and objectives of this project.

U.S. Census Bureau

Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity

This classification provides a minimum standard for maintaining, collecting, and presenting data on race and ethnicity for all Federal reporting purposes. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature. They are not to be used as determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies. The standards have five categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. There are two categories for data on ethnicity: "Hispanic or Latino," and "Not Hispanic or Latino."

Race/Ethnicity Categories and Definitions

The minimum categories for data on race and ethnicity for Federal statistics, program administrative reporting, and civil rights compliance reporting are defined as follows:

-- American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

-- Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

-- Black or African American. A person having origins in any of the black racial groups of Africa.

-- Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

-- White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

-- Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

APPENDIX IV

PHONE INTERVIEW INSTRUMENT FOR SEXUAL ASSAULT NURSE EXAMINERS (SANEs)

Screening

1. Are you currently a trained and certified, practicing SANE? *(Must respond "yes")*

2. Can you tell me about how many evidentiary exams you completed on sexual assault victims BEFORE you became a certified SANE? *(Must be at least 2)*

3. Can you also tell me about how many evidentiary exams you completed on sexual assault victims AFTER you received SANE training? *(Must be at least 2)*

If respondent provides the required answers, the principal investigator will proceed. If he/she does not meet these requirements, the principal investigator will attempt to get a referral from this respondent to someone who is more likely to provide the required answers.

Instrument

1. When did you receive training necessary to become a certified SANE?

   - What was your opinion of this training?

   - Did this training increase your knowledge about treating sexual assault victims? If so, to what extent?

2. Do you receive continued training as a SANE on treating sexual assault victims?

   - What was your opinion of these trainings?

3. Do you think that SANE services have been helpful to victims of sexual assault?

   - In what ways do you feel victims have been helped (or not helped)?

4. Can you tell me any differences you have noticed between working with sexual assault victims BEFORE you were a certified SANE versus AFTER you became a certified SANE?

   Probe for answers to the following if respondent is not answering them already.

   - Do you think that victims who were treated by a SANE are more likely to report their victimization to police?

   - Do you think that victims who were treated by a SANE are more likely to follow through with carrying the case through the criminal justice system?

- Do you think that victims that were treated by a SANE are more likely to seek advocacy services from the local sexual assault center?

5. Do you think offenders that have sexually assaulted victims that have received SANE services are more likely to be arrested, and subsequently convicted?

   - What has been your experience?

   - Have you ever testified in court for a victim that received SANE services? (If this hasn't already been mentioned)

     If YES, how many times, and what was your experience?

6. Do you attend SART meetings?

   If YES, about how often?

   - Have you been attending these meetings since you have been a SANE?

   - In your opinion, how helpful are these meetings with providing care to sexual assault victims?

   - In your opinion, how helpful are these meetings with working with sexual assault victims in the criminal justice system?

This now concludes the survey. Thank you for your time. Remember, you may contact me at any time if you have any questions, concerns, or would like additional information about this research. You may reach me directly at 312-793-8405. I am generally in the office between 8:30 and 5:00. Thanks again for your participation.

APPENDIX V

PHONE INTERVIEW INSTRUMENT FOR SEXUAL ASSAULT VICTIM ADVOCATES

Screening

1. Are you currently a sexual assault victim advocate at (name of sexual assault center)? *(Must respond "yes")*

2. Can you tell me the approximate number of sexual assault victims you've provided services to that were NOT been treated by a SANE at (name of hospital) Hospital *(Must be at least 2)*

3. Can you also tell me the approximate number of sexual assault victims you've provided services to that WERE treated by a SANE at (name of hospital) Hospital? *(Must be at least 2)*

If respondent provides the required answers, the principal investigator will proceed. If he/she does not meet these requirements, the principal investigator will attempt to get a referral from this respondent to someone who is more likely to provide the required answers.

Instrument

1. Did you receive special training or instruction on the SANE/SART program and working with sexual assault victims that were treated by SANEs?

    - If YES, when did you receive this?

    - What was your opinion of this instruction/training?

    - Did this instruction/training increase your knowledge about providing services to sexual assault victims? If so, to what extent?

2. Have you received continued instruction/training on working with sexual assault victims that have been treated by SANEs?

    - What has been your opinion of this instruction/training?

3. Do you think SANE services have been helpful to victims of sexual assault?

    - In what ways do you feel victims have been helped (or not helped)?

4. Can you tell me any differences you have noticed between working with sexual assault victims who HAVE NOT been treated by a SANE versus those who HAVE been treated by a SANE?

Probe for answers to the following if respondent is not answering them already.

- Do you think that victims who HAVE been treated by a SANE are more likely to report their victimization to police?

- Do you think that victims who HAVE been treated by a SANE are more likely to follow through with carrying the case through the criminal justice system?

- Do you think that victims who HAVE been treated by a SANE that have received services from a SANE are more likely to seek advocacy services your center?

5. Do you think offenders that have sexually assaulted victims who have been treated by a SANE are more likely to be arrested, and subsequently convicted?

    - Have you ever accompanied a victim that was treated by a SANE to court*? (If this hasn't already been mentioned)*

    - If YES, how many times, and what was your experience?

6. Do you attend SART meetings?

    - If yes, about how often?

    - In your opinion, how helpful are these meetings with providing care to sexual assault victims?

    - In your opinion, how helpful are these meetings with working with sexual assault victims in the criminal justice system?

This now concludes the survey. Thank you for your time. Remember, you may contact me at any time if you have any questions, concerns, or would like additional information about this research. You may reach me directly at 312-793-8405. I am generally in the office between 8:30 and 5:00. Thanks again for your participation.

APPENDIX VI

PHONE INTERVIEW INSTRUMENT FOR PROSECUTORS

Screening

1. Are you currently a practicing prosecutor for (name of state's attorney's office)? *(Must respond "yes")*

2. Can you tell me the approximate number of sexual assault cases you've prosecuted with victims who were NOT treated by a SANE at (name of hospital) Hospital? *(Must be at least 1)*

3. Can you also tell me the approximate number of sexual assault cases you've prosecuted with victims who WERE treated by a SANE at (name of hospital) Hospital? *(Must be at least 1)*

If respondent provides the required answers, the principal investigator will proceed. If he/she does not meet these requirements, the principal investigator will attempt to get a referral from this respondent to someone who is more likely to provide the required answers.

Instrument

1. Did you receive special training or instruction on the SANE/SART program and working with sexual assault cases with victims that were treated by SANEs?

    - If YES, when did you receive this?

    - What was your opinion of this instruction/training?

    - Did this instruction/training increase your knowledge about prosecuting sexual assault cases? If so, to what extent?

2. Have you received continued instruction/training on prosecuting sexual assault cases with victims that have been treated by SANEs?

    - What is your opinion of this instruction/training?

3. Do you think SANE services have been helpful to victims of sexual assault?

    - In what ways do you feel victims have been helped (or not helped)?

4. Can you tell me any differences you have noticed between prosecuting sexual assault cases with victims who HAVE NOT been treated by a SANE versus those with victims who HAVE been treated by a SANE?

Probe for answers to the following if respondent is not answering them already.

- Do you think that victims who HAVE been treated by a SANE are more likely to report their victimization to police?

- Do you think that victims who HAVE been treated by a SANE are more likely to follow through with carrying the case through the criminal justice system?

- Do you think that victims who HAVE been treated by a SANE that have received services from a SANE are more likely to seek advocacy services your center?

5. Do you think offenders that have sexually assaulted victims who have been treated by a SANE are more likely to be arrested, and subsequently convicted?

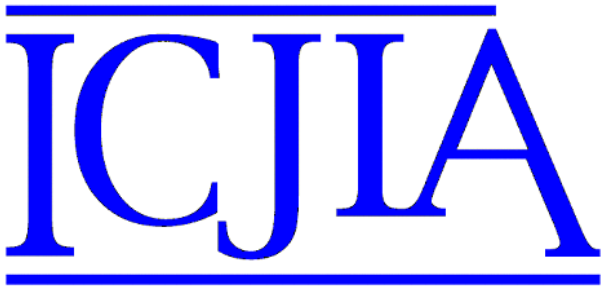
    - If YES, how many times, and what was your experience?

6. Do you attend SART meetings?

    - If yes, about how often?

    - In your opinion, how helpful are these meetings with prosecuting sexual assault cases?

This now concludes the survey. Thank you for your time. Remember, you may contact me at any time if you have any questions, concerns, or would like additional information about this research. You may reach me directly at 312-793-8405. I am generally in the office between 8:30 and 5:00. Thanks again for your participation.



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