Tennessee Best Practice Guidelines
For
Sexual Assault Response Services
Adult Victims

Tennessee Domestic Violence State Coordinating Council

tennessee coalition to end domestic & sexual violence

Tennessee Office of Criminal Justice Programs

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These Best Practice Guidelines would not have been possible without the steadfast commitment and support of the Tennessee Sexual Assault Guidelines Committee. This committee was formed in an effort to create a best practice framework for communities in Tennessee to develop their own unique community response to sexual assault. As a sub-committee of the Domestic Violence Statewide Coordinating Council, this group consisted of service providers from diverse disciplines and jurisdictions across the state. Members of the Tennessee Sexual Assault Guidelines Committee include:

Kathy Walsh, Chair
Executive Director
TN Coalition to End Domestic and Sexual Violence
Nashville, TN

Angie Slack
Executive Director
Hope House
Columbia, TN

Debbie Curtis
Sexual Assault Nurse Examiner
Middle Tennessee Medical Center
Murfreesboro, TN

Ginger Evans
Sexual Assault Nurse Examiner
University of Tennessee, Knoxville
Knoxville, TN

Jeanne Broadwell
General Counsel
Tennessee Bureau of Investigation
Nashville, TN

Justine Bass
Program Manager
Office of Criminal Justice Programs
Nashville, TN

Lanette Mumford
Assistant Director, Victim Services
Office of Criminal Justice Programs
Nashville, TN

Margaret Cole
Executive Director
W.R.A.P.
Jackson, TN

Rachel Freeman
Vice President of Programs
Sexual Assault Center
Nashville, TN

Sarah Davis
Assistant District Attorney General
Office of the District Attorney
Nashville, TN

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Introduction

Background

The Tennessee Best Practice Guidelines for Sexual Assault Response Services are the result of a collaboration between the Tennessee Coalition to End Domestic and Sexual Violence, the Domestic Violence State Coordinating Council, and the Office of Criminal Justice Programs. The guidelines are part of the Community Defined Solutions to Violence Against Women in Tennessee Project, a joint effort of the Tennessee Coalition to End Domestic and Sexual Violence and the Office of Criminal Justice Programs, which was funded by the Office on Violence Against Women in 2010. This project has as one of its primary objectives the development of statewide policies and protocols for forensic rape exams, sexual assault reporting, and evidence collection and retention in sexual assault cases that hold perpetrators accountable and protect survivor safety, self-determination, and confidentiality.

Established in 1983, the Tennessee Coalition to End Domestic and Sexual Violence is a statewide non-profit coalition of diverse community leaders and program members committed to our mission of ending domestic and sexual violence in the lives of Tennesseans and changing societal attitudes and institutions which promote and condone violence through public policy advocacy, education, and activities which increase the capacity of programs and communities to address such violence. The Coalition provides a wide variety of training and technical assistance on domestic and sexual violence to communities throughout Tennessee, including an annual conference. The Tennessee Coalition to End Domestic and Sexual Violence web site – http://www.tncoalition.org – provides information on technical assistance, public policy, criminal justice agencies, allied professionals, community and statewide resources, as well as training and webinar opportunities.

Pursuant to its authorizing legislation, Tenn. Code Ann. § 38-12-102 (2008), the goal of the Domestic Violence State Coordinating Council is to increase the awareness and understanding of domestic and family violence and its consequences and to reduce the incidence of domestic and family violence within the state. The Council is a collaboration between agencies and organizations in Tennessee working together to increase awareness of domestic violence and to reduce the incidence of domestic violence in Tennessee.

Pursuant to Tenn. Code Ann. § 38-12-103, the membership of the Council consists of the following members or their designee: Commissioner of Labor and Workforce Development; Attorney General and Reporter; Director of the Administrative Office of the Courts; Executive Director of the District Public Defenders Conference; Executive Director of the Tennessee Association of Criminal Defense Lawyers; Executive Director of the District Attorneys General Conference; President of the Tennessee Sheriffs' Association; President of the State Court Clerks Conference; President of the Tennessee Chiefs of Police Association; Executive Director of the Tennessee Coalition to End Domestic and Sexual Violence; Executive Director of the Peace Officers Standards and Training Commission; Chair of the Board of Probation and Parole; four judges; two members of the General Assembly; four members appointed by the Coalition; one legal services attorney; one victim witness coordinator; and one Probation and Parole Officer. The Council can also appoint additional members to ensure representation from Tennessee's nine Congressional districts. Appointed members serve three-year terms.

The Tennessee Department of Finance and Administration, Office of Criminal Justice Programs (OCJP) is committed to a safer Tennessee for all of its citizens. OCJP functions as a strategic planning agency that secures, distributes, and manages federal and state grant funds for Tennessee. While collaborating with other public and non-profit agencies, OCJP utilizes these grant monies to support innovative projects statewide in efforts to reduce criminal activity, provide services for victims of crime and promote overall enhancement of the criminal justice system in Tennessee. The OCJP office is the State administering agency of STOP and Sexual Assault Service Program (SASP) funding.

VAWA 2005 Forensic Compliance Provisions

The federal Violence Against Women Act of 2005 requires states and territories that receive STOP (Services Training Officers Prosecutors) formula grant funds to certify that they are in compliance with certain rules concerning the forensic medical examination provided to victims of sexual assault and other rules outlining the appropriate response to sexual assault victims. These forensic compliance mandates require that victims need not participate in the criminal justice system or cooperate with law enforcement in order to receive a forensic medical examination, or receive reimbursement for charges incurred on account of the examination. As such, in order to be considered compliant, all states receiving VAWA STOP monies must certify that they meet two requirements:

1) Ensure victims are offered and provided forensic medical examinations without requiring the victim to cooperate with law enforcement or participate in the criminal justice system; and
2) Ensure that victims do not have any out-of-pocket expenses associated with the forensic medical examination.

The purpose of these mandates is to increase victim access to justice and case outcomes in the criminal justice system, as well as to improve victim access to healthcare and physical and psychological outcomes.

Tennessee Statutes on Forensic Compliance

VAWA 2005 provided all states receiving STOP monies from the Office on Violence Against Women (OVW) four years to comply with these mandates, and states were required to certify compliance prior to January 5, 2009. The state of Tennessee certified that Tennessee is in compliance with these rules by the deadline. Tennessee receives approximately $7,000,000 in OVW funds annually. Tennessee is in compliance with these mandates through two state statutes, T.C.A. § 29-13-118 and T.C.A. § 38-3-123.

T.C.A. § 29-13-118. Forensic medical examinations; sexually oriented crimes; claims for compensation.

> (a) *For purposes of this section, unless the context otherwise requires, "forensic medical examination" means an examination provided to a victim of a sexually-oriented crime by*

any health care provider who gathers evidence of a sexual assault in a manner suitable for use in a court of law.
(b)(1) A victim of a sexually-oriented crime, defined as a violation of § 39-13-502, 39-13-506, 39-13-522, 39-13-527, 39-13-531, and 396-13-532, shall be entitled to forensic medical examinations without charge to the victim. No bill for the examination shall be submitted to the victim, nor shall the medical facility hold the victim responsible for payment. All claims for forensic medical examinations are eligible for payment from the criminal injuries compensation fund, created under § 40-24-107.
(2) Notwithstanding any provision of this part to the contrary, the victims shall not be required to report the incident to law enforcement officers or to cooperate in the prosecution of the crime in order to be eligible for payment of forensic medical examinations.

T.C.A. § 38-3-123. Polygraph examination; victims of sexual offenses; penalty.

a) No law enforcement officer shall require any victim of a sexual offense, as defined in § 40-39-202, or violent sexual offense, as defined in § 40-39-202, to submit to a polygraph examination or any other test designed to detect deception or verify the truth of statements through instrumentation or by means of a mechanical device, as a condition of the officer proceeding with the investigation of the offense.
(b) A violation of this section shall subject the officer to appropriate departmental disciplinary action.

Purpose of this Document

The purpose of this document is to provide communities across the state of Tennessee with important information, considerations, and best practices when responding to adult sexual assault victims.

These guidelines are also designed to help communities assess whether policies presently in place throughout the state of Tennessee are victim-centered and honor the spirit behind forensic compliance mandates. There are numerous stakeholders who play a role in serving sexual assault victims. It is the responsibility of those first responders to sexual assault including health care professionals, law enforcement officers, victim advocates, prosecutors, and other community agencies engaged in the response to and support of victims to maintain high service standards of care and confidentiality.

VAWA 2005 and the Tennessee statutes noted above recognize that many sexual assault victims need some “breathing room” in the aftermath of a sexual assault to learn about and weigh their options. In the past, victims were asked to make a decision about whether to report to law enforcement and receive a forensic medical exam in the midst of many competing pressures and concerns. When confronted with the reality that they must report the assault in order to receive a forensic exam, many victims chose not to report or seek any medical care at all.

In addition, research has shown that between sixty and eighty four percent of sexual assaults are never reported to law enforcement.[1] There are many reasons why victims may hesitate to report the assault to law enforcement, such as fear of not being believed, fear of retaliation by the assailant, self-blame, or not recognizing what has happened as a crime. Numerous research studies have shown how trauma can impact the brain and complicate a victim's ability to recall, organize, and communicate memories, thereby making it difficult for victims to report in the days or months post-assault.[2] Research also shows that victim disclosure is more of a process than a one-time event.

When victims take the courageous step to disclose the sexual assault to a health care professional or advocate, meeting such disclosure with compassion and concern for their immediate physical and emotional needs may increase a victim's desire to participate in the law enforcement process in the long run.[3]

In contrast to the all or nothing reporting approach, a disclosure process that allows victims the opportunity to rally their support system, gather information and resources, and establish a relationship with first responders may "create an environment that encourages reporting, even for those victims who initially feel unable, unwilling, or unsure about doing so."[4]

While Tennessee is compliant with the letter of the law concerning VAWA 2005 forensic compliance mandates, jurisdictions across the state vary in their approach to sexual assault response services for competent, adult victims and, specifically, the forensic medical exam process. These guidelines are designed to assist Tennessee jurisdictions with the creation and implementation of written policies on forensic compliance topics.

How to Use This Document

As a "living document," these guidelines reflect current best practices in responding to adult sexual assault. Readers are encouraged to contact the Tennessee Coalition to End Domestic and Sexual Violence to share information about emerging best practices that may strengthen and support the continued development of these guidelines.

These Best Practice Guidelines are written to address sexual assault response in the case of competent adult victims, 18 years of age and older. While many of the response procedures focused on victim-centered care will be the same for adolescent victims, the reporting requirements for child and adolescent victims (0 – 17 years of age) of sexual assault in Tennessee are different.

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[1] U.S. Department of Justice, 2005 National Crime Victim Survey.

[2] Kaarin Long, Carolyn Palmer and Sara G. Thome, A Distinction Without A Difference: Why the Minnesota Supreme Court Should Overrule its Precedent Precluding the Admission of Helpful Expert Testimony in Adult-Victim Sexual Assault Cases, 31 *Hamline J. Pub. L & Pol'y* 569, 592-607 (August 2010), available at http://www.mncasa.org/Documents/index_175_2534215409.pdf.

[3] Information in this section primarily pulled from the *Minnesota Model Policies for Forensic Compliance*, April 2011.

[4] End Violence Against Women International, *Template Memorandum of Understanding*, available at http://www.evawintl.org/.

All individuals with knowledge or who have reasonable cause to suspect sexual abuse of a child (0 - 17 years of age) must report such abuse to either local law enforcement or the department assigned to investigate such cases.

For technical assistance regarding this issue and/or forensic medical exams for children or adolescents, please contact the Tennessee Coalition to End Domestic and Sexual Violence at 615-386-9406 or 800-289-9018.

37-1-403. Reporting of brutality, abuse, neglect or child sexual abuse Notification to parents of abuse on school grounds or under school supervision - - Confidentiality of records.

(a)(1) Any person who has knowledge of or is called upon to render aid to any child who is suffering from or has sustained any wound, injury, disability, or physical or mental condition shall report such harm immediately if the harm is of such a nature as to reasonably indicate that it has been caused by brutality, abuse or neglect or that, on the basis of available information, reasonably appears to have been caused by brutality, abuse or neglect.

(2) Any such person with knowledge of the type of harm described in this subsection (a) shall report it, by telephone or otherwise, to the:

A. Judge having juvenile jurisdiction over the child;

B. Department, in a manner specified by the department, either by contacting a local representative of the department or by utilizing the department's centralized intake procedure, where applicable;

C. Sheriff of the county where the child resides; or

D. Chief law enforcement official of the municipality where the child resides.

(3) If any such person knows or has reasonable cause to suspect that a child has been sexually abused, the person shall report such information in accordance with § 37-1-605, relative to the sexual abuse of children, regardless of whether such person knows or believes that the child has sustained any apparent injury as a result of such abuse.

(b) The report shall include, to the extent known by the reporter, the name, address, telephone number and age of the child, the name, address, and telephone number of the person responsible for the care of the child, and the facts requiring the report. The report may include any other pertinent information.

(c)(1) If a law enforcement official or judge becomes aware of known or suspected child abuse, through personal knowledge, receipt of a report, or otherwise, such information shall be reported to the department immediately upon the receipt of such information, and, where appropriate, the child protective team shall be notified to investigate the report for the protection of the child in accordance with the provisions of this part. Further criminal investigation by such official shall be appropriately conducted in coordination with the team or department to the maximum extent possible.

(2) A law enforcement official or judge who knows or becomes aware of a person who is convicted of a violation of § 55-10-401 and sentenced under the provisions of § 55-10-403(a)(1)(B), because such person was at the time of the offense accompanied by a child under eighteen (18) years of age, shall report such information, as provided in subdivision (c)(1), and the department shall consider such information to be appropriate for investigation in the same manner as other reports of suspected child abuse or neglect.

(3)(A) If the department receives information containing references to alleged human trafficking or child pornography, which does or does not result in an investigation by the department, the department shall notify the appropriate law enforcement agency immediately upon receipt of such information.

(B) If the department initiates an investigation of severe child abuse, including, but not limited to, child sexual abuse, the department shall notify the appropriate local law enforcement agency immediately upon assignment of such case to a department child protective services worker.

(C) Both the department and law enforcement shall maintain a log of all such reports of such information received and confirmation that the information was sent to the appropriate party, pursuant to this subdivision (c)(3).

(d) Any person required to report or investigate cases of suspected child abuse who has reasonable cause to suspect that a child died as a result of child abuse shall report such suspicion to the appropriate medical examiner. The medical examiner shall accept the report for investigation and shall report the medical examiner's findings, in writing, to the local law enforcement agency, the appropriate district attorney general, and the department. Autopsy reports maintained by the medical examiner shall not be subject to the confidentiality requirements provided for in § 37-1-409.

(e) Reports involving known or suspected institutional child sexual abuse shall be made and received in the same manner as all other reports made pursuant to Acts 1985, ch. 478, relative to the sexual abuse of children. Investigations of institutional child sexual abuse shall be conducted in accordance with the provisions of § 37-1-606.

(f) Every physician or other person who makes a diagnosis of, or treats, or prescribes for any sexually transmitted disease set out in § 68-10-112, or venereal herpes and chlamydia, in children thirteen (13) years of age or younger, and every superintendent or manager of a clinic, dispensary or charitable or penal institution, in which there is a case of any of the diseases, as set out in this subsection (f), in children thirteen (13) years of age or younger shall report the case immediately, in writing on a form supplied by the department of health to that department. If the reported cases are confirmed and if sexual abuse is suspected, the department of health will report the case to the department of children's services. The department of children's services will be responsible for any necessary follow-up.

(g) Every physician or other person who makes an initial diagnosis of pregnancy to an unemancipated minor, and every superintendent or manager of a clinic, dispensary or charitable or penal institution in which there is a case of an unemancipated minor who is determined to be pregnant, shall provide to the minor's parent, if the parent is present, and the minor consents, any readily available written information on how to report to the department of children's services an occurrence of sex abuse that may have resulted in the minor's pregnancy, unless disclosure to the parent would violate the federal Health Insurance Portability

and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 1320d et seq., or the regulations promulgated pursuant to the act.

(1) Failure to provide the written information shall not subject a person to the penalty provided by § 37-1-412.

(2) The department of children's services shall provide to the department of health the relevant written information. The department of health shall distribute copies of the written information to all licensees of the appropriate health-related boards through the boards' routinely issued newsletters. At the time of initial licensure, these boards shall also provide new licensees a copy of the relevant written information for distribution pursuant to this subsection.

(h) Nothing in this section shall be construed to prohibit any hospital, clinic, school, or other organization responsible for the care of children, from developing a specific procedure for internally tracking, reporting, or otherwise monitoring a report made by a member of the organization's staff pursuant to this section, including requiring a member of the organization's staff who makes a report to provide a copy of or notice concerning the report to the organization, so long as the procedure does not inhibit, interfere with, or otherwise affect the duty of a person to make a report as required by subsection (a). Nothing in this section shall prevent staff of a hospital or clinic from gathering sufficient information, as determined by the hospital or clinic, in order to make an appropriate medical diagnosis or to provide and document care that is medically indicated, and is needed to determine whether to report an incident as defined in this part. Those activities shall not interfere with nor serve as a substitute for any investigation by law enforcement officials or the department; provided, that, if any hospital, clinic, school or other organization responsible for the care of children develops a procedure for internally tracking, reporting or otherwise monitoring a report pursuant to this section, the identity of the person who made a report of harm pursuant to this section or § 37-1-605 shall be kept confidential.

(i)(1) Any school official, personnel, employee or member of the board of education who is aware of a report or investigation of employee misconduct on the part of any employee of the school system that in any way involves known or alleged child abuse, including, but not limited to, child physical or sexual abuse or neglect, shall immediately upon knowledge of such information notify the department of children's services or anyone listed in subdivision (a)(2) of the abuse or alleged abuse.

(2) Notwithstanding § 37-5-107 or § 37-1-612 or any other law to the contrary, if a school teacher, school official or any other school personnel has knowledge or reasonable cause to suspect that a child who attends such school may be a victim of child abuse or child sexual abuse sufficient to require reporting pursuant to this section and that the abuse occurred on school grounds or while the child was under the supervision or care of the school, then the principal or other person designated by the school shall verbally notify the parent or legal guardian of the child that a report pursuant to this section has been made and shall provide other information

relevant to the future wellbeing of the child while under the supervision or care of the school. The verbal notice shall be made in coordination with the department of children's services to the parent or legal guardian within twenty-four (24) hours from the time the school, school teacher, school official or other school personnel reports the abuse to the department of children's services, judge or law enforcement; provided, that in no event may the notice be later than twenty-four (24) hours from the time the report was made. The notice shall not be given to any parent or legal guardian if there is reasonable cause to believe that the parent or legal guardian may be the perpetrator or in any way responsible for the child abuse or child sexual abuse.

(3) Once notice is given pursuant to subdivision (i)(2), the principal or other designated person shall provide to the parent or legal guardian all school information and records relevant to the alleged abuse or sexual abuse, if requested by the parent or legal guardian; provided, that the information is edited to protect the confidentiality of the identity of the person who made the report, any other person whose life or safety may be endangered by the disclosure and any information made confidential pursuant to federal law or § 10-7-504(a)(4). The information and records described in this subdivision (i)(3) shall not include records of other agencies or departments.

(4) For purposes of this subsection (i), "school" means any public or privately operated childcare agency, as defined in § 71-3-501, preschool, nursery school, kindergarten, elementary school or secondary school.

For more information on the Tennessee Coalition to End Domestic and Sexual Violence please visit www.tncoalition.org. To contact the Coalition please call 1-800-289-9018 or 615-386-9406.

Glossary: Speaking the Same Language

The purpose of this section is to standardize some of the frequently used terms in this document, allowing for more ease in discussing these terms within multidisciplinary teams, across jurisdictions, and within this document.

Definitions in this section are drawn from various sexual assault publications including: the OVC SART Toolkit, the Minnesota Model Policies for Forensic Compliance, April 2011, the Wisconsin Adult Sexual Assault Response Team Protocol, May 2011, and the National Protocol for Sexual Assault Medical Forensic Examinations, September 2004.

Community-based Advocate: Trained employees or volunteers of local non-profit organizations whose primary purpose is to provide services for victims of sexual assault regardless of whether or not the victim is involved with the criminal justice process.

Coordinated Community Response Team (CCR Team): The purpose of a coordinated community response team is to provide a multidisciplinary approach and response to issues around sexual assault. The CCR team can assist service providers and system members in communication, networking, and collaboration, and bring to light gaps in protocols and other services needed to support victims.

Forensic Compliance: The term used to discuss whether certain laws about the forensic medical exam are being followed. There are both federal and Tennessee laws that dictate how the forensic medical exam must be offered to sexual assault victims and how that exam must be managed. (Minnesota Model).

Forensic Medical Exam: According to T.C.A. § 29-13-118, a forensic medical examination is an examination provided to a victim of a sexually-oriented crime by any health care provider who gathers evidence of a sexual assault in a manner suitable for use in a court of law. The exam has several components. The examiner obtains a verbal history of the assault from the patient. A physical examination of the patient is also conducted in order to document and treat any injury and collect and preserve biological and physical findings that may serve as evidence in a criminal matter, if the case is reported to law enforcement. Therefore, as its name implies, the forensic medical exam has a dual role: 1) provide medical treatment to the patient and 2) collect and preserve any forensic evidence of the assault that might be present on the patient's body and/or through the patient's verbal statements.

Non-Reporting Kit: The term used to describe a sexual assault evidence collection kit that is collected with the victim's consent but without sharing her/his identity with law enforcement or without making a standard report to law enforcement.

Rape: According to T.C.A. § 39-13-501, rape is unlawful sexual penetration of a victim by the defendant or of the defendant by a victim accompanied by any of the following circumstances: force or coercion; without the consent of the victim and the defendant knows or should have known that the victim did not consent; the defendant knows that the victim is mentally defective, mentally incapacitated or physically helpless; or the sexual penetration is accomplished by fraud.

Sexual Assault Nurse Examiner (Certified SANE-A): The term to describe a professional registered nurse who has completed a forty-hour adolescent/adult Sexual Assault Nurse Examiner training and the required additional clinical component and has successfully completed the SANE certification examination.

Sexual Assault Nurse Examiner (SANE-trained): The term used to describe a registered nurse or another health care professional that has completed a forty-hour adolescent/adult Sexual Assault Nurse Examiner training and the required additional clinical component, but who has not yet taken or successfully completed the SANE certification examination**.**

Sexual Assault: Best defined as any unwanted, non-consensual sexual contact with any individual made by another using manipulation, pressure, tricks, coercion, or physical force. The legal definition of sexual assault is outlined in Tennessee Statute T.C.A. § 39-13-501 (8) and includes rape, sodomy, and penetrating, touching, or oral sex where the victim is unwilling or unable to give consent, for reasons that include mental defect, mental incapacitation, or physical helplessness.

Sexual Assault Evidence Collection Kits: Sexual Assault Evidence Collection Kits are created and distributed by the Tennessee Bureau of Investigations. The purpose of the kit is to standardize, as much as possible, the collection of potential biologic evidence from the victim's body during the forensic medical exam. The kit contains envelopes, swabs, basic instructions for health care professionals on the collection of forensic evidence, and a list of Tennessee Sexual Assault Centers for counseling. It also contains a request for Crime Lab exam.

Sexual Assault Evidence Collection Medical Facility/ Program: Any hospital or program that offers a sexual assault forensic medical examination by specifically trained personnel.

Sexual Assault Response Teams (SART): These teams refer to multidisciplinary groups that respond to individual sexual assault cases and/or develop and monitor protocols for the response to sexual assault cases within a county or another jurisdictional boundary.

System-based Advocate: An advocate who provides support and communication to victims involved in the criminal justice system.

Toxicology Evidence Collection Kit: A kit used in suspected Drug Facilitated Sexual Assaults and suspected Incapacitated Sexual Assaults. Blood is drawn on reported cases up to 24 hours. Urine is collected up to 5 days, according to Society of Forensic Toxicologists (SOFT). Blood and Urine are not placed in the Sexual Assault Evidence Kit. They are packaged and sent separately from the evidence kit. www.softKtox.org .

Trauma Informed Care: A response perspective that involves having a basic understanding of trauma and how trauma impacts survivors and designing services to acknowledge the impact of violence and trauma on survivors' lives. A trauma-informed approach is sensitive and respectful: Sexual Assault Response Teams seek to respond to traumatized individuals with supportive intent and consciously avoid re-traumatization.

Victim-Centered: Prioritizing victims' needs, honoring their rights, considering their perspectives, and supporting their decisions. A victim-centered response customizes the

response to meet victims' specific needs and promotes the compassionate and sensitive delivery of services in a nonjudgmental manner.

Recommended Best Practice Guidelines

Sexual Assault Response Teams (SART)

All communities in Tennessee should have a Sexual Assault Response Team (SART). A SART serves as a vehicle for collaboration, relationship building, training, education, and accountability among and between professionals responding to sexual assault. SARTs have a number of primary objectives that are essential to providing victim-centered care to sexual assault victims:

- Educate the criminal justice system and the community to raise awareness of sexual assault, decrease victim blaming, and increase offender accountability
- Build relationships with individual responders to sexual assault
- Identify valuable community resources and avoid duplication of services
- Share information, knowledge, and expertise among team members
- Reduce further trauma to sexual assault victims and mitigate the effect of sexual assault on victims and their family and/or loved ones.

SARTs may include district attorneys, SANE nurses/medical personnel, sexual assault/domestic violence community based advocates, law enforcement personnel, survivors, and other individuals or agencies directly involved in or committed to victim-centered response services for sexual assault victims. SARTs should meet at least quarterly, and four or five adult cases should be reviewed every year. In addition, it is important for SARTs to review sexual assault data to assess the effectiveness of the team and its response services.

A coordinated community response is an essential factor in providing victim-centered services to sexual assault victims. SARTs allow for a comprehensive response to sexual assault victims, addressing medical, mental/emotional, and legal needs in the aftermath of such an intimate crime.

For more information on creating/maintaining a SART, please visit the Office of Justice Programs web site: http://ovc.ncjrs.gov/sartkit/index.html .

Coordinated Community Response to Sexual Assault

The coordinated community response required by health care professionals, law enforcement, and sexual assault victim advocates is paramount to the victims' recovery process. This section outlines the best practices for first responders providing services to a victim seeking medical treatment after a sexual assault.

I. Health care Professionals

The role of the Sexual Assault Nurse Examiner (SANE) or designated medical personnel in the response to sexual assault is to provide for the immediate medical care of the victim in a compassionate, sensitive, and non-judgmental manner.

Sexual assault patients have acute and long-term medical and emotional needs, including:

- Competent and comprehensive medical treatment, regardless of their legal choices;
- Continuity of care and access to appropriate follow-up services; and
- Feeling safe, respected, and in control.

The physical and psychological well-being of the sexual assault victim should always be given precedence over forensic needs. It is best practice that the assessment, examination, and evidence collection should only be done by those health care providers trained as SANEs. If a SANE is not available, it is acceptable to have registered nurses or physicians perform the forensic medical examination.

The coordination of advocacy and support services for the sexual assault victim is an essential component of a comprehensive medical response, and health care professionals are encouraged to facilitate cooperative agreements between the medical facility/program and the local sexual assault advocacy program or center.

Health care providers in Tennessee are **NOT** required to report injuries of adult victims of sexual assault to law enforcement, if the victim objects to the release of this information. This exception to reporting does not apply if the victim's injuries are life threatening or the victim is being treated for injuries inflicted by strangulation, a knife, pistol, gun, or other deadly weapon. Upon arrival at the medical facility, a victim should be informed of these reporting requirements.

Sexual assault victims presenting to a medical facility/program should be given information and resources that are tailored to patients' communication skill level/modality of language. Such information may include:

- Normal reactions to sexual assault (stressing that it is never the victim's fault), and signs and symptoms of traumatic response;
- The examination—what happened and how evidence/findings will be used;
- Victim's rights;
- Victim support and advocacy services;
- Mental health counseling options and referrals;
- Civil remedies that may be available to sexual assault victims, including information on victim's compensation; and
- Medical discharge and follow up instructions.

II. Law Enforcement

Law enforcement is often the first point of contact for a victim of sexual assault and, as such, plays a critical role in initiating the collaborative response by (with the victim's consent) informing the appropriate medical personnel and facilitating advocacy/support services.

Law enforcement's role in responding to a sexual assault includes:

- Responding to the assault call;
- Protecting the safety and well-being of the victim;
- Initiating the collaborative response;
- Assessing the need for emergency medical care for the victim;
- Interviewing the victim to determine whether a crime has occurred;
- Collecting and preserving evidence and documents;
- Conducting an investigation; and
- Submitting a written report per departmental policy.

Law enforcement can be present and participate with the SANE during the taking of the assault and forensic history. However, the victim should always be allowed to determine who is present during the forensic exam.

When collecting information through an initial victim interview or a more comprehensive interview/assault history, trauma, cultural differences, cognitive ability, fear, self-blame and other factors can influence the victim's ability to provide concise details about the assault. Trauma can affect a victim's affect, memory, and ability to give detailed information. Common reactions to trauma include:

- Anxiety;
- Fear for personal safety or safety of loved ones;
- Preoccupation with the stressful event;
- Flashbacks in which the individual mentally re-experiences the event;
- Physical symptoms; muscle aches, headaches, fatigue;
- Disbelief at what has happened; numbness;
- Problems with concentration or memory (especially aspects of the traumatic event);
- A misperception of time;
- Increased startle response; and
- Feelings of guilt and/or self-doubt related to the traumatic event.

The effects of trauma may be seen in a victim's interaction with law enforcement. Each individual responds to the psychological impact of trauma differently. When coping with traumatic stress, some victims may appear to be calm, indifferent, submissive, angry, emotionally distraught, emotionally numb, or even uncooperative or hostile towards those who are trying to provide aid. In the aftermath of sexual assault, victims may struggle to put the traumatic experience into a linear, narrative form. Victims may also recall details of the traumatic event over time, rather than during the course of one interview.

When interviewing a sexual assault victim, it is recommended that law enforcement work with a sexual assault victim from a trauma-informed perspective. This includes:

- Establishing a rapport before beginning the interview;
- Explaining how the investigative process works and why certain questions are necessary;
- Avoiding victim blaming questions—such as "why did you" or "why didn't you"—unless the context and purpose of such a question is clearly explained to the victim;

- Being patient with the victim and allowing ample time for her to tell her/his story with few interruptions; and
- Acknowledging the impact of trauma on the victim during the interview.

III. Advocates

The role of an advocate is to assist the victim by offering a tangible and personal connection to a long-term source of support and advocacy. It is recommended that an advocate be notified and involved in the response process as early as possible once a sexual assault is disclosed. Advocates do not encourage or discourage victims from reporting or participating in the criminal justice system but instead assist victims in making informed choices. As such, the victims' choices and needs determine an advocate's course of action. It is important to remember that advocates may be responding to a victim, even if other systems of support are activated. Best practice indicates that advocates should be available 24 hours a day/365 days a year both on a crisis/help line and in person.

There are two basic types of advocates that respond to sexual assault victims: (1) Community-based advocates and (2) System-based advocates. Communities may have access to one or both types of advocates.

Community-based advocate is the term used to refer to those advocates who work for a private, autonomous, often non-profit agency within the community. Such advocates respond to all self-identified victims of sexual assault, even if the sexual assault happened a long time ago or was not reported to law enforcement. The primary function of the community-based advocate is to listen and respond to the interests and wants of the victim.

Services offered by community-based advocates during the sexual assault response process include:[5]

- Advocating for victims self-articulated needs to be identified and their choices to be respected, as well as advocating for appropriate and coordinated response by all involved professionals;
- Providing victims with crisis intervention and support to help cope with the trauma of the assault and begin the healing process;
- Accompanying the victims through each component (advocates may accompany victims from the initial contact and the actual exam through to discharge and follow up care);
- Assisting in coordination of victim transportation to and from the exam site;
- Providing information about the criminal justice process, including explanation of her/his right to report the crime;
- Acting as an encouraging connector between the victim and law enforcement;
- Serving as an information resource for victims;
- Providing information about Victims Compensation; and
- Assisting victims in planning for their safety and well-being.

[5] This bulleted section was drawn primarily from the National Protocol, 2004 p. 34.

System-based advocate is the term used to describe an advocate who is employed by a public agency, such as a law enforcement agency, office of the prosecuting attorney, or some entity within the city, county, state, or federal government.

System-based advocates' roles and responsibilities will vary based on their host or governing agency but such roles may include:

- Assisting the victim in navigating the criminal justice process;
- Helping the victim navigate interviews with law enforcement or the prosecutor's office;
- Accessing information and other resources within the criminal justice or medical process;
- Acting as an encouraging connector between the victim and government entities;
- Assisting in coordination of services with law enforcement, the prosecutor's office, and/or victim's compensation; and
- Providing support and encouragement to victims who choose to work with law enforcement and/or the prosecutor's office.

Sexual assault victims should have access to both advocates as soon as possible following a disclosure. However, sexual assault victims should be made aware that system-based advocates cannot typically offer confidential communication because they are employees of the government. Community-based advocates have varying levels of confidentiality but in most cases can maintain confidential communication.

Sexual assault victims should have access to as much support and encouragement as possible in aftermath of an assault. Both system-based and community-based advocates can offer meaningful support to victims of sexual assault and can provide an important connection to a variety of agencies and programs that may assist a victim in seeking justice and/or support both physical and emotional healing.

- *Sexual Assault Nurse Examiners (Certified SANE-A)*

It is best practice that all communities in Tennessee strive to ensure that victims of sexual assault have access to specifically educated and clinically prepared examiners to perform the forensic medical exam. These examiners, or SANEs, receive specialized education and fulfill clinical requirements to perform forensic medical exams.

The role of the SANE-A in the immediate response to sexual assault is to provide for the medical care of patients/victims and to collect and document forensic evidence when requested through a forensic medical examination. SANEs should provide compassionate and sensitive medical services and care to a victim, including informing the victim that she/he has the right to medical care and a forensic medical examination without reporting to law enforcement. *Note: Injuries deemed to be life threatening or inflicted by strangulation, a knife, pistol, gun, or other deadly weapon must be reported to law enforcement but even in these cases, a victim does not have to speak directly with law enforcement and health care providers are not required to report the sexual assault itself.*

Eligibility criteria for certified SANEs, as determined by the International Association of Forensic Nursing include:

- Registered license as an R.N. in the United States or its Territories, or a license as a first-level general nurse in the jurisdiction of current practice;
- A minimum of 2 years practice as an R.N. in the United States or as a first-level general nurse in the country of licensure;
- Successful completion of an adult/adolescent SANE education program that includes either
  (a) A minimum of 40 continuing education contact hours of classroom instruction, or
  (b) 3 semester hours (or the equivalent) of academic credit in an accredited school of nursing, and sufficient supervised clinical practice until determined competent in SANE practice.
- An appropriate clinical authority, as outlined in the adult section of the IAFN SANE Education Guidelines (2008) must validate current SANE competency.[6]

A patient must consent to a SANE performing a forensic medical exam and patients should be informed that they have the right to withdraw such consent at any time during the exam process.

As stated above, the best practice is to have a SANE provide the forensic medical exam but this may not be an option at certain times or in communities where a SANE is not available. Best practice in this situation is that one or two professionally licensed health care providers conduct the entire exam and associated paper work and will be available for court testimony as needed.

To inquire about SANE training in your area or for questions regarding SANE certification or SANE programs/hospitals, please contact the Tennessee Coalition to End Domestic and Sexual Violence at 615-386-9406.

V. Remaining Victim-Centered During Service Delivery

Throughout service delivery, across all disciplines, it important to remember:

- The forensic medical exam is an interactive process that must be adapted to the needs and circumstances of each patient.
- Patient/Victim's fears and concerns can affect their initial reactions to the assault, their post-assault needs, and decisions before, during, and after the exam process.
- Recognize that patients/victims control the extent of the personal information they share. There is no reason for responders to question victims about certain data, such as sexual orientation and gender identity, religious or spiritual beliefs, or previous victimization.

[6] Drawn from IAFN SANE Certification Brochure available at http://www.iafn.org and the National Protocol for Sexual Assault Medical Forensic Examinations available at http://www.ncjrs.gov.

- Recognize the importance of victim services within the exam process. Ideally, advocates should begin interacting with victims prior to the exam, as soon after disclosure of the assault as possible.[7]

Medical Care/Forensic Medical Exam Process for Sexual Assault Victims

I. Victim Centered/Priority Response

It is critical to respond to individuals disclosing sexual assault in a timely, appropriate, sensitive, and respectful way. When a sexual assault victim presents to a medical facility/program, she/he should be treated as a priority emergency case, recognizing that every minute victims spend waiting to be examined may cause a loss of evidence and/or undue trauma. Best practice indicates that the SART should be activated within one hour of a sexual assault disclosure.

A coordinated community response in the immediate aftermath of sexual assault is an essential factor in assisting a victim in navigating a number of systems. It is recommended that for cases in which a sexual assault victim is seeking medical treatment, the SANE or designated health care provider perform the forensic medical exam and maintain chain of custody, while an advocate is available to provide support to the victim.

II. Informed Consent

Upon arrival at a medical facility/program, victims should be presented with all relevant information related to her/his medical care options. This is critical to a victim's ability to make informed decisions about whether to allow a procedure. In addition, victims should be informed of any statutes and/or policies governing consent. Specifically, adult victims in Tennessee should be informed of the following:

- A victim of a sexually oriented crime is entitled to a forensic medical examination free of charge (T.C.A. § 29-13-118(b)(1);
- A victim of sexual assault is not required to cooperate with law enforcement in order to receive a forensic medical examination free of charge (T.C.A. § 29-13-118(b)(2); and
- A victim of sexual assault is not required to make a report to law enforcement in order to receive a forensic medical examination, unless she/he is being treated for injuries that are deemed to be life-threatening or are inflicted by strangulation, a knife, pistol, gun, or other deadly weapon. In those cases, such injuries must be reported to law enforcement but health care providers are not required to report the sexual assault (T.C.A. § 38-1-101(d)(1).

The informed consent process includes making victims aware of the impact of declining a procedure, as it relates to quality of care or evidence collection. However, this and all other options should be presented to victims in a compassionate and nonjudgmental manner.

[7] Information from Nat'l Protocol, 2004, p. 46

III. Medical Care Options for Sexual Assault Survivors

The opportunity to receive medical care and a forensic medical examination should be offered to all adult victims of sexual assault in the state of Tennessee. All patients presenting with a report of sexual assault should be offered a forensic medical examination, STI testing and/or treatment per 2010 CDC guidelines. The complete guidelines can be found at http://www.cdc.gov/std/treatment/2010/.

Examiners should obtain a forensic medical history as appropriate, examine patients, and document findings (when patients are willing), regardless of whether or not evidence is gathered for a sexual assault evidence collection kit. The history and documentation of the medical exam findings could be helpful in addressing patients' medical needs and in determining both if and where potential evidence may exist. In addition, such history and evidence may prove invaluable to an investigation and prosecution if a law enforcement report is made in the future. Documentation of a victim's demeanor and statements made relevant to the assault should also occur during the medical exam process. This should be undertaken to ensure that victims have access to as much post-assault documentation as possible, should they choose to make a full report to law enforcement in the future.

In the event the victim declines evidence collection and seeks only medical trauma examination and treatment to prevent STI's and/or pregnancy, the victim will also receive support services and information as requested. Victims should be informed that medical treatment and/or a medical examination, in the absence of a forensic medical examination, may be billed directly to a victim or to a victim's insurance.

A. Forensic Medical Examination with a Report to Law Enforcement

A victim of sexual assault may receive a forensic medical examination with or without a report to law enforcement and should be informed of this right when she/ he presents to a medical facility/program post-assault. Victims of sexual assault should also be informed that a report to law enforcement is required for injuries deemed life threatening or inflicted by strangulation, a knife, pistol, gun, or other deadly weapon. As noted before, healthcare providers must report such injuries listed above but are still not required to report the sexual assault.

The opportunity to undergo a forensic medical examination should be offered to all adult victims of sexual assault who present for treatment between 72 – 96 hours post assault. Many communities have extended the standard cutoff time to 5 days or 1 week and such extensions are supported by empirical evidence regarding the stability of DNA and sensitivity of testing. Therefore, it is critical that each victim be evaluated on a case-by-case basis, as evidence collection beyond the 72 – 96 hour window is conceivable and may be warranted in particular cases.

Best Practice standards indicate that sexual assault evidence collection kits should be stored at the designated medical facility/program prior to use in order to streamline the forensic exam process and provide the most efficient care to victims. Sexual assault evidence collection kits are available statewide through the Tennessee Bureau of Investigation, www.tbi.tn.gov. It is recommended that all sexual assault forensic exams be conducted in accordance with the Sexual Assault Medical Forensic Examinations regardless of a patient/victim's decision to immediately report the crime to law enforcement.

It is preferable that forensic medical exams be provided at medical facilities/programs with a specialized forensic medical exam program. These programs are able to call upon SANEs to provide exams to victims.

All victims have the right to consent or decline any or all parts of a sexual assault forensic medical examination and should be informed of their rights prior to a forensic medical examination. Victims may also withdraw consent at any time during the forensic medical exam process.

If a victim decides that she/he would like to make a full report to law enforcement, the SANE or appropriate health care provider should call and inform the local law enforcement agency. At such time, a law enforcement officer will most likely be dispatched to the medical facility/ program to conduct initial interviews and transport the sexual assault evidence collection kit after the examination is completed.

The SANE, or other health care professional who collected the evidence, should maintain chain of custody in accordance with other evidentiary procedures until the sexual assault evidence collection kit and other evidence are turned over to the designated law enforcement agency. Should law enforcement not be able to retrieve the sexual assault evidence collection kit immediately, the medical facility/ program should maintain the kit and other evidence temporarily in a secure, locked storage area.

Law enforcement should provide a receipt for any evidence collected which should indicate the date, time, and manner of pick-up. Law enforcement is responsible for the pick-up, transport, and storage of sexual assault evidence collection kits and other evidence at a secure, locked storage facility.

B. *Forensic Medical Examination without a Report to Law Enforcement*

There is presently no Tennessee or federal law that dictates where non-reporting sexual assault evidence collection kits or other evidence collected in a non-reporting case must be stored. However, non-reporting kits must be stored in a location that preserves both the integrity and the viability of the evidence, as such evidence may be a victim's only opportunity to seek justice if s/he chooses to involve law enforcement at a later date.

While Tennessee does not presently have a number tracking system for non-reporting evidence collection kits, it is recommended that communities work with their local Sexual Assault Response Teams (SARTs) to implement a tracking system of some kind for non-reporting kits that maintains chain of custody and protects a victim's privacy.

It is imperative that chain of custody be maintained for non-reporting kits. Best practice indicates that non-reporting kits should be stored with law enforcement but if such storage is not available, kits should be stored at the medical facility/ program where the examination is performed.

Evidence in non-reporting sexual assault cases should be stored indefinitely, as long as storage space allows. If storage space is limited, sexual assault evidence collection kits should be stored for a minimum of 18 months.

If the victim takes no further action after the evidence holding period has expired, the law enforcement agency should address the final disposition of the evidence according to standard departmental procedures.

IV. Timing Considerations for Collecting Evidence

A forensic medical examination is recommended for sexual assault victims presenting to a medical facility/program before 72-96 hours post assault. While many communities choose to limit a forensic medical exam to 72-96 hours post assault, it is recommended that 96 hours be used as a guideline rather than a strict rule and cases beyond 96 hours and up to 5 days or even 1 week should be evaluated on a case-by-case basis. Viable forensic evidence can exist up to and beyond 120 hours, and cases should be evaluated on an individual basis to consider each victim's unique needs and situation.

V. General Guidelines for Storage of Sexual Assault Evidence Collection Kits

Secure storage sites should be designated and storage procedures should be consistent within communities and jurisdictions. Storage requirements will depend on a number of variables, including but not limited to, evidence collected, whether or not a report is made to law enforcement, and storage space. Best practice recommends the following conditions be in place for ideal evidence storage:

- Limited Access/Security: It is best practice for Sexual Assault Evidence Collection kits and related evidence to be stored with law enforcement. A secure location not only prevents public access, but also limits access to only one or two specifically trained agency employees. Secure storage locations must have locked entries, an electronic card-access entry system, or other systems that have the ability to restrict access to designated employees.
- Climate Control: An appropriate storage location must be protected from the elements, and have climate control mechanisms in place.[8]
- Refrigeration: Tennessee Sexual Assault Evidence Collection kits do not require refrigeration, as they do not contain blood samples. They do require climate control. The Toxicology kits (blood and urine) will require refrigeration.

VI. Evidence in Cases with a Report to Law Enforcement

Best practice indicates that all sexual assault evidence collection kits that include a report to law enforcement should be stored at room temperature in a climate-controlled environment and should be submitted to the Tennessee Bureau of Investigation (TBI) within one week of collection. In order to maintain chain of custody, law enforcement should pick up kits from the participating medical facility/program in their jurisdiction and deliver the kits to TBI for processing. Once a kit has been processed, law enforcement should return to TBI to pick up the processed kit and transport it to a secure storage facility.

TBI recommends that as much information as possible be obtained from the victim as to the details of the assault and that in cases where a victim is incapacitated, swabs from vaginal, anal,

oral, and breast areas should be taken in order that all potential evidence is recovered.

[8] Information primarily drawn from Minnesota Model Policies for Forensic Compliance, April 2011

VII. Transferring Sexual Assault Victims between Medical Facilities/Programs

Transferring sexual assault patients should be avoided, if possible. Medical facilities/ programs are encouraged to develop the competency needed to provide the forensic medical exam, no matter how few patients may present for this reason. If this is not possible or if quality of care would be enhanced with a transfer to another medical facility/program, the best course of action is to establish a responsible referral policy that includes:

- Advocacy services for the victims;
- An understanding of distance between the referring and receiving facilities;
- Attempts to minimize the transportation burden for victims; and
- Knowledge as to how to maintain evidence during the referral process.

VIII. Sexual Assault Forensic Exam Compensation

Tennessee Code Annotated, Section 29-13-118 provides that victims of certain sexually-oriented crimes shall be entitled to forensic medical examinations without charge. No bill shall be submitted to a victim. All claims for forensic medical examinations are eligible for payment from the Criminal Injuries Compensation Fund. This may include services provided for a sexually-oriented crime by any medical facility, Sexual Assault Nurse Examiner (SANE) program, child advocacy center, or rape crisis center. Services may include those directly related to the collection of forensic materials for evidentiary purposes. Examination expenses may include emergency department, SANE, or physician fee; collection of specimens; lab work; medical examination for sexual trauma; or other necessary forensic-related treatment.

In accordance with Tennessee Code Annotated, Section 29-13-118, the amount reimbursed by the Division/Fund must be accepted as payment in full. The facility cannot bill the patient a balance, for any reason. The maximum available for all such examination-related expenses is $750.

Although the victim may choose to report the crime, a report to law enforcement or cooperation with the prosecution is NOT required for payment of the exam.

The documents must be submitted to the Division of Claims Administration within one (1) year of the date of the exam. Payment shall be rendered within ninety (90) days of receipt of request.

The Criminal Injuries Compensation Program was established to assist victims of crimes in the state of Tennessee. Payments made under this program are intended to defray costs of medical services, loss of earnings, and other financial losses incurred as a direct result of personal injuries sustained by a criminal offense. Sexual assault is a crime deemed eligible for this program. As such, victims of sexual assault in the state of Tennessee can apply for financial assistance from this program.

For more information on the Sexual Assault Forensic Exam Program or the Criminal Injuries Compensation Program, please visit: http://treasury.tn.gov/injury/ or call (615) 741-2734.

IX. Prison Rape Elimination Act (PREA) Summary and Standards

PREA—Prison Rape Elimination Act was signed into law September 2003 to address the problem of sexual assault of people in the custody of U.S. correctional agencies.

Provisions of this act include:

- Development of standards for detection, prevention, reduction, and punishment of prison rape;
- Establishment of a zero tolerance standard for the incidence of inmate sexual assault and rape;
- Collection and dissemination of information on the incidence of prison rape; and
- Award of grant funds to help state and local governments implement the purposes of the act.

The act addresses both inmate on inmate sexual assaults and staff on inmate sexual contact, which includes rape and "consensual acts."

Sexual assault in correctional institutions is a widespread problem across the United States and accurate research on the number of sexual assaults occurring in prisons is difficult to find. In a 2007 survey of prisoners across the country, the Bureau of Justice Statistics (BJS) found that 4.5 percent (or 60,500) of the more than 1.3 million inmates held in federal and state prisons had been sexually assaulted in the previous year alone.[9] Unfortunately, this data reflects only a small fraction of sexual assaults in correctional institutions.

Survivors of sexual assault in prisons experience the same emotional and physical pain as other rape victims and while there are services available to survivors in some institutions, access to coordinated and comprehensive social support and counseling services is severely limited.

In May 2012 the Department of Justice released a final rule to prevent, detect, and respond to sexual abuse in confinement facilities, in accordance with the Prison Rape Elimination Act of 2003. These standards focus on policies and procedures for best practice in preventing and responding to prison rape for facilities operated by or on behalf of state and local governments and the Department of Justice. These standards address detection, prevention, reduction, and punishment of prison rape. For more information on PREA and an executive summary of the rule signed by the Attorney General on May 16, 2012 please visit www.ojp.usdoj.gov/programs/pdfs/prea_executive_summary.pdf. For more information on the National Resource Center for the Elimination of Prison Rape, please visit http://www.prearesourcecenter.org.

[9] Bureau of Justice Statistics, *Sexual Victimization in State and Federal Prisons Reported by Inmates* (2007).

Special Populations

Certain populations may be targeted for their limitations and potential vulnerabilities. Some of these special populations may include individuals with disabilities, Limited English Proficiency, deaf and hard of hearing, elder abuse, homeless population, sexual assault involving incarcerated victims, and many other unique populations that deserve special attention to their individual service needs.

It is important for SARTs to be aware of the available resources to reach out to some of the following special populations:

Tennessee Cultural Competency Resource Manual, http://tncoalition.org/media/pdf/manuals_curricula/Final_Manual.pdf, created by the Tennessee Coalition to End Domestic and Sexual Violence.

Vera Institute of Justice, http://www.vera.org/centers/victimizationKandKsafety, Vera's Center on Victimization and Safety (CVS) works with government and nonprofit organizations to enhance efforts to prevent and address interpersonal violence and related crimes, including domestic violence and sexual assault. The center specializes in fostering cross-disciplinary collaboration and promoting policies and practices that hold abusers accountable, prioritize safety, and also help survivors heal. By combining staff expertise and skills with the practical knowledge of professionals in the field, it provides technical assistance and guidance that is timely, relevant, and reflective of current best practices.

National Center on Elder Abuse (NCEA), http://www.ncea.aoa.gov, the NCEA serves as a national resource center dedicated to the prevention of elder mistreatment.

Just Detention International, http://justdetention.org/, JDI has three core goals for its work: to ensure government accountability for prisoner rape; to transform ill-informed public attitudes about sexual violence in detention; and to promote access to resources for those who have survived this form of abuse.

National Alliance to End Homelessness, www.endhomelessness.org/section/issues/domestic_violence, the National Alliance to End Homelessness is a leading voice on the issue of homelessness.

Resources for Technical Assistance

Tennessee Coalition to End Domestic & Sexual Violence	http://www.tncoalition.org
AEQUITAS Prosecutor's Resource	http://www.aequitasresource.org
ACHA Campus Violence Resources	http://www.acha.org/Topics/violence.cfm
End Violence Against Women International	http://www.evawintl.org
Faith Trust Institute	http://www.faithtrustinstitute.org
Men Can Stop Rape	http://www.mencanstoprape.org
National Alliance to End Sexual Violence	http://www.endsexualviolence.org
National Institute of Justice	http://www.nij.gov
National Online Resource Center on Violence Against Women	http://www.vawnet.org
National Sexual Violence Resource Center	http://www.nsvrc.org
Office on Violence Against Women	http://www.ovw.usdoj.gov/sexassault.htm
Oregon Sexual Assault Task Force	http://www.oregonsatf.org
Pennsylvania Coalition Against Rape	http://www.pcar.org
Rape Abuse and Incest National Network (RAINN)	http://www.rainn.org
Resource Sharing Project	http://www.resourcesharingproject.org
SART Tool Kit	http://ovc.ncjrs.gov/sartkit/index.html