Testimony on:
"Examining the Availability of SAFE Kits at Hospitals in the United States"

U.S. House of Representatives Energy and Commerce Committee
Subcommittee on Oversight & Investigations

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Good Morning. My name is Kiersten Stewart and I'm the Director of the Washington Public Policy Office for Futures Without Violence (FUTURES).

I'd like to thank you for the opportunity to speak with you today on the need to improve access to forensic exams for sexual assault victims as well as other actions you might consider to reduce sexual assault and improve the health system's response to victims.

For those of you who don't know us, FUTURES is a national non-profit organization dedicated to ending violence against women and children here in the United States and around the world. We design public education campaigns to increase awareness about these issues, help parents and other caring adults prevent and address child trauma, work to improve systems' response to victims and survivors of violence, and provide extensive technical assistance to health systems on how to improve their response to physical and sexual violence. We actually began as an organization about 35 years ago simply with a chair in the emergency room at San Francisco General Hospital.

It is from this experience that we offer the following information and suggestions.

Sexual assault is painfully common and a crime committed largely against the young.

According to the Centers for Disease Control and Prevention, more than 80 percent of rapes are perpetrated against those under the age of 25 and about half of those are committed against those under the age of 18… children.[i] While girls and young women are overwhelmingly the victims of rape and sexual assault, we also know that men and boys are victims, as are individuals who don't fit our traditional definitions of male and female. Gender non-conforming youth are at higher risk for rape and sexual assault, and our health care responses need to catch up to meet their needs.

Others who experience higher rates of sexual assault are American Indian and Alaska Native women and children, people who live in rural areas, as well as individuals with disabilities. As we analyze who has access to forensic exams and how we need to improve the reach of this important law enforcement tool, we need to keep in mind the needs of all victims, particularly the most vulnerable.

Sexual assault has life-long consequences.

The consequences of sexual assault and sexual violence are often severe and long-lasting. While different people respond to sexual assault differently, and I have seen directly how services and support can help victims go on to live full and joyful lives, sexual violence leaves a painful mark that some never fully heal from.

The full extent of the physical and mental health effects of rape and sexual assault are only beginning to be fully understood, but we have new estimates that create a staggering picture.

Using 2014 US dollars, the estimated lifetime cost of rape was $122,461 per victim, or a population economic burden of nearly $3.1 trillion over victims' lifetimes. This is based on data showing that more than 25 million U.S. adults have been raped. This estimate included $1.2 trillion (39% of total) in medical costs; $1.6 trillion (52%) in lost work productivity among victims and perpetrators; $234 billion (8%) in criminal justice activities; and $36 billion (1%) in other costs, including victim property loss or damage. Government sources pay an estimated $1 trillion (32%) of the lifetime economic burden.[ii]

These numbers do not even fully capture the costs given that they don't fully capture the consequences of sexual violence and rape on children, such as costs to the foster care system, as well as the often intergenerational effects of violence we see when survivors who were never treated for their trauma become parents.

Given this, it is essential that we do all we can to prevent sexual violence, help victims heal, and hold perpetrators accountable. This is why this hearing today is so important – forensic exams are a powerful tool in bringing perpetrators to justice. They can help victims by providing additional evidence, should they choose to bring charges, and they can keep rapists off the streets, preventing further harm. When done well they can also be an important first step to helping a victim begin to heal.

Forensic exams help improve prosecutors responses to sexual assault but training is essential.

Given the expertise of my colleagues on the panel from IAFN on what an exam entails and how they improve prosecution, I will keep my remarks in this area brief. Forensic exams are important tools in prosecuting sexual assault crimes, but a good forensic exam requires training. While we believe that others in the health care system can be trained to effectively do exams, we agree that nurses are well-placed within the health care infrastructure to perform them and importantly are often the most trusted health care provider by the patients most likely to be sexually abused.

Hospitals Need to Invest in Hiring and Supporting SAFE

Sadly, we have also seen what happens when exams are not properly done or when rape kits are left to languish untested or even destroyed by law enforcement uninterested in the time or expense required to test them.

Your colleague, Congressman (Judge) Ted Poe, in partnership with Rep. Carolyn Maloney, last year introduced a bill to respond to this issue, the Megan Rondini Act. Megan was a college student who reported being sexually assaulted by a man from a prominent and wealthy family in Tuscaloosa, Alabama. After jumping out of a second-story window and fleeing to escape him, Megan went to the hospital for a rape kit, and contacted the police. The hospital did not have a trained examiner on site, and the evidence from her rape kit was never properly examined. Law enforcement officers also immediately challenged her report, telling her she hadn't been raped because she didn't physically fight

and kick back enough. Deeply traumatized by the assault, dealing with threats from law enforcement to prosecute her for actions she took when escaping her assailant, feeling unbelieved with no way to prove her claims, she later took her own life. This bill, HR. 3415 would require hospitals to have a SAFE – Sexual Assault Forensic Examiner –available 24 hours a day/7 days a week or have a plan in place to get that victim to another nearby hospital with a SAFE.[iii] While I recognize that the "how" we make this happen is important, I would encourage your support for this legislative goal.

Other recommendations include *ongoing* training for forensic examiners, attention to the vicarious trauma often experienced by SAFEs, and to ensure that training engage the entire health entity, from intake to billing to risk management to the frontline care provided by all medical personnel. These exams take time to be done well, and billing rates we are told often do not make doing them profitable for a hospital or clinic. That is not an excuse, but it is why we must strengthen requirements that trained examiners are available, as well as address financial incentives --- or at least remove financial disincentives --- to doing a sexual assault forensic exam.

Use a Patient-Centered, Trauma Informed Approach

We also strongly recommend that as hospitals and clinics bring on more trained SAFEs, that they adopt a patient-centered, trauma –informed model. Brigham and Women's Hospital in Boston serves as a national model for this approach and they have found that by adopting it they are addressing many of the concerns identified by the GAO Report that helped inform this hearing.[iv] This model allows more follow-up care for the clients and better coordinated care, which often goes well-beyond the specific steps of a forensic exam.[v] It involves simple steps like ensuring a client has a phone so they can receive a text message, to follow up on care. This model also reduces costs for things like missed visits and illnesses that develop as a result of not taking medications. Staff also report they are more satisfied by their jobs when they feel like they can treat a whole person. Many sexual assault survivors also show up in emergency rooms for things that aren't the sexual assault, but then when a good patient-centered, trauma-informed interview is done, the person may be far more likely to disclose the assault and in so doing allow a forensic exam to be done in the timeframe necessary.

High Need for Training for Pediatric Providers

Services for pediatric sexual assault victims are particularly lacking. Only a small number of board certified, child abuse pediatricians exist in the country, so we also support the use of specially trained SANES as a means to help fill that gap. Again, though, training is essential. While victim services dollars from the Victims of Crime Act can be used to provide services, their use for training is severely limited.[vi]

Beyond Exams: Promoting Prevention and Early Intervention

As Congress considers its role in responding to sexual assault and improving the response to victims, it is important to understand that most victims never make it to an emergency room, and the cases that do are often the exception rather than the rule.

We need to expand training for health care providers beyond forensic exams. Providers need to be trained to help victims who may be seeking care for the mental, behavioral or physical health effects of sexual violence that happened in the past.

Substance use and mental health providers need to understand the role of sexual abuse and trauma in healing and treatment, particularly for women who may be clients. Adolescent health and OB/GYN providers also, in particular, need training to understand the health impacts of sexual abuse and trauma.

College campuses, including community colleges, need to better address sexual assault prevention and response, moving beyond solely Title IX and Clery Act obligations, to actually reduce rates of sexual violence experienced by their students and staff.

Sexual violence and coercion also are often a part of abusive relationships – in fact about 22 million women have experienced sexual violence by an intimate partner, a little less than 3 million a year according to recent data. [vii]

Importantly, we also have evidence-based clinical interventions that have been shown to both improve health outcomes and actually reduce abusive behavior.[viii]

The "CUES" intervention involves training providers and health staff to provide education about violence and health to all patients regardless of the reason for a visit, to provide health promoting and healing strategies, and for those who ask for more information, provide coordinated referrals to community based programs for ongoing support. Larger clinical trials of this approach are ongoing.

Recommendations for VAWA, Appropriations and Maternal and Child Health/HRSA

Federal lawmakers are uniquely positioned to improve access to sexual assault forensic exams, reduce sexual violence and promote survivor healing.

The following are five specific actions we would encourage you to take in the next year that would have an immediate impact.

Specifically, we would recommend:

1. Increase funding for HRSA's Advanced Nursing Education-Sexual Assault Nurse Examiners (ANE-SANE) Program, out of the Bureau of Health Care Workforce. The most recent RFA was for $8 million to fund approximately 16 programs. While this is an important investment, the need is ongoing. This is a newer program, developed in response to concerns being addressed today.
2. Provide $5 million in dedicated funding for Project Catalyst, out of the Office of Women's Health at HRSA, to improve the response of community health centers to sex trafficking and sexual and intimate partner violence;
3. Increase funding for VAWA programs that support training for sexual assault nurse examiners and services for sexual assault victims, such as the STOP Grants, Rural Grants, Campus Grants and the Sexual Assault Services Program (SASP), and create designated funding for the VAWA Health program to train health care providers on addressing sexual and physical violence and building partnerships with community-based organizations and health and public health agencies;
4. Increase funding for prevention and youth programs, such as the Rape Prevention and Education Program and VAWA Youth Program; and
5. Reauthorize the Violence Against Women Act, including:
    a. Continue to make funding available for sexual assault training and services for victims in core VAWA programs;
    b. Expand the campus grants program to reach more colleges and universities and improve coordination between campus health centers and other campus providers and programs;
    c. Increase authorization levels for sexual assault prevention programs such as the Rape Prevention and Education Program and VAWA Youth program; and

d. Expand tribal programs to include the ability of tribal courts to prosecute non-Tribal members who commit sexual assault and violence against children.

Thank you for the opportunity to provide these comments, and I look forward to answering any questions you may have.

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[i] Smith, S.G., Zhang, X., Basile, K.C., Merrick, M.T., Wang, J., Kresnow, M., Chen, J. (2018). The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief – Updated Release. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[ii] Peterson C, DeGue S, Florence C, Lokey CN. (2017) Lifetime Economic Burden of Rape Among U.S. Adults, American Journal of Preventive Medicine, Jun;52(6):691-701.

[iii] https://poe.house.gov/2017/7/congressman-poe-introduces-the-megan-rondini-act.

[iv] https://www.gao.gov/assets/680/675879.pdf.

[v] Lewis-O'Connor, A. & Chadwick, M. (2015). Voice of the patient: informing research, policy and practice on violence against women. Journal of Forensic Nursing, 11:4, 188-197. In addition, personal correspondence with Professor Lewis-O'Connor.

[vi] Questions and Answers Victims of Crime Act (VOCA) Victim Assistance Program Rule https://www.gpo.gov/fdsys/pkg/FR-2016-07-08/pdf/2016-16085.pdf.

[vii] Smith, et al. , p.20.

[viii] Integrating Intimate Partner Violence Assessment and Intervention into Healthcare in the United States: A Systems Approach, Elizabeth Miller, Brigid McCaw, Betsy L. Humphreys, Connie Mitchell
J Women's Health 2015 Jan 1; 24(1): 92–99.