



# **Wisconsin Hospital Toolkit 2006**

## Acknowledgements

This toolkit is the product of collaborative work of the Wisconsin Compassionate Care for Rape Victims Coalition (CCRV) which is a diverse group of organizations dedicated to ensuring comprehensive health care for rape victims. Members of the CCRV Coalition include:

- |  |   |
|--|---|
| American College of Nurse Midwives - WI Chapter        | Reach Counseling Services, Menasha                          |
| Brown County Coalition for Women's Health              | Religious Coalition for Reproductive Choice WI              |
| Chippewa Valley Citizens for Women's Health            | Republicans for Choice                                      |
| Citizens for Women's Health, Winnebago County          | Sexual Assault Treatment Center                             |
| Community Advocates                                    | Task Force on Family Violence                               |
| Eau Claire County Coordinated Community Response Team  | The Healing Center  |
| Family Planning Health Services                        | United Council of UW Students                               |
| Friends of Abused Families, Inc. of Washington County  | Wisconsin Alliance for Women's Health                       |
| League of Women Voters of Wisconsin                    | Wisconsin Association for Perinatal Care                    |
| Medical Students for Choice                            | Wisconsin Coalition Against Domestic Violence               |
| NARAL Pro-Choice Wisconsin                             | Wisconsin Coalition Against Sexual Assault                  |
| National Association of Social Workers, WI Chapter     | Wisconsin Family Planning & Reproductive Health Association |
| Options Fund, Inc                                      | Wisconsin NOW   |
| PAVE: People Against a Violent Environment, Beaver Dam | Wisconsin Women's Network Reproductive Rights Task Force    |
| PAVE: Promoting Awareness, Victim Empowerment, Madison | Women's Medical Fund  |
| Planned Parenthood of Wisconsin                        |   |

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## Introduction

Each year, an estimated 25,000 American women become pregnant following an act of sexual violence. As many as 22,000 of those pregnancies could be prevented through the prompt use of emergency contraception (often referred to as “the morning after pill”.) Emergency contraception (EC) is a high dosage of regular birth control pills and should not be confused with RU-486, also known as medication abortion. It is a safe and effective FDA-approved method of preventing pregnancy after unprotected sex.

Yet, a recent survey conducted by the CCRV Coalition demonstrates that only 1/3 of Wisconsin Hospitals are unconditionally providing EC to rape victims when they are receiving treatment at hospital emergency departments. This survey has identified wide variations in hospital policies on providing EC to rape victims.

Leading national medical organizations such as the American Medical Association, the American College of Emergency Physicians and the American College of Obstetricians and Gynecologists, recognize EC as part of standard rape treatment in hospital emergency departments.

The Compassionate Care for Rape Victims Coalition has produced this toolkit to help Wisconsin hospital emergency departments ensure that every sexual assault victim is offered the means to prevent pregnancy when she receives treatment at a hospital.

To download a copy of this toolkit, please visit [www.wiawh.org](http://www.wiawh.org).

## Stories of Victims of Sexual Assault

The following two stories are powerful testimonies about victims of sexual assault. The first story is written by a direct services provider who supervised a case of a 14-year-old girl, while the second story is provided by a brave sexual assault victim. Each story illustrates the importance of receiving EC during emergency department treatment; one by showing the harm of not receiving EC, the other by showing the positive impact receiving EC had on the victim. (The following stories are presented in the authors' own words.)

### Failure to Receive EC

*I am a Direct Services Supervisor for a sexual assault services center in southeastern Pennsylvania. In the summer of 2002, I supervised a case involving a 14-year-old girl who was sexually assaulted by an acquaintance. The teen's mother took her to the local emergency room where a physician in the children's medical department interviewed and examined her. At the conclusion of the examination, the doctor wrote a prescription for emergency contraception and instructed the mother to have it filled right away. The mother was Hispanic and spoke very little English, but she understood that she needed to have the prescription filled immediately.*

*Approximately 10 days later, the teen came in for a follow-up appointment with the doctor. It was at that time that we learned about their difficulties in getting the prescription filled. The girl said that after leaving the hospital between 3 and 4 a.m., both went to a 24-hour CVS pharmacy. It was the 14-year-old who had to do most of the talking and translating for her mother. When the mother presented the prescription, the pharmacist refused to fill the prescription because it was "too strong for her age." The pharmacist did not offer to help them by calling the physician or referring them elsewhere. The first thing in the morning, the mother and daughter went to a privately-owned pharmacy. Again, the pharmacist there would not fill the prescription or offer any help. In the end, they were not able to obtain any emergency contraception.*

*This Hispanic mother did not have a lot of money, so even if she had found someone to fill the prescription, it would have been a financial burden. One of the saddest things about this whole situation was putting the 14-year-old girl through the added trauma of being the one to ask the pharmacists for the emergency contraception and being denied their help.*

*In my view, we need to have a system that is more compassionate to young victims of sexual assault. If she had received emergency contraception in the hospital, she would have been spared a lot of unnecessary trauma.*

- Direct Services Supervisor Pennsylvania

## **Successful Provision of EC**

*After midnight on July 8, 2002, while asleep in bed next to my 4-year-old son, I was accosted by an unknown man who handcuffed, blindfolded and kidnapped me from my home at gunpoint, threatening to kill me if I did not cooperate. I was driven to an unknown location, raped and - miraculously – returned to my front porch unharmed within a few hours' time. I was warned not to call the police or the man would return to kill both me and my son.*

*Because I was more afraid of not calling the police and having the stranger return to assault me again, I called the police department immediately. They arrived at my home shortly, and after a few brief questions, I was instructed to allow the paramedics who had accompanied the police to take me to the Sexual Assault Nurse Examiners (SANE) unit located at St. Joseph's Hospital in Albuquerque, so that they could examine and treat me for any harm that may have been inflicted during the assault.*

*At the SANE unit, I was provided emotional counseling, was physically examined, and questioned by the detective in charge of my case. I was given various antibiotics and preventive treatments for the possibility that I may have contracted a sexually transmitted disease during the assault. I was also given Plan B – an emergency contraception that, as I understand it, is 89% effective if taken within 72 hours after having unprotected sex.*

*I feel very fortunate to have been taken to a place like the SANE unit after going through what was easily the most terrifying experience of my life. And I feel equally fortunate to have received the anti-STD treatments and emergency contraception that were provided. Knowing the emotional difficulties that I have had to surmount since the attack, I cannot imagine how much worse it could have been if I had to deal with an unwanted pregnancy.*

*I can say from personal experience that dealing with an unplanned pregnancy is difficult enough, much less in a situation where sexual assault is involved. One thing that has made my recovery from the attack much easier is that I have not had to deal with any residual effects – in other words, I have not had to deal with the trauma of recovering from serious injury, contracting a disease, or pregnancy.*

*Based on my experience, I urge legislators at any level to support emergency contraception legislation, making this crucial birth control available to all women who survive sexual assault.*

- Sexual Assault Victim New Mexico

# Facts About Emergency Contraception for Rape Victims

## Rape and Pregnancy

- An estimated 25,000 U.S. women become pregnant as a result of sexual assault each year. EC could be used to prevent as many as 22,000 of these pregnancies.<sup>1</sup>
- 12% of all women experience sexual assault in a lifetime and 4.7% of those assaults result in pregnancy.<sup>2</sup>
- An estimated 3 million unintended pregnancies occur in the U.S. each year. EC could prevent as many as 1.5 million, including as many as 800,000 pregnancies that result in abortion.<sup>3</sup>

## Safe and Effective Pregnancy Prevention

- Emergency contraception is a safe and effective, FDA-approved method of preventing pregnancy after unprotected intercourse.<sup>4</sup>
- EC is time-sensitive. The sooner it is given, the better it works.<sup>5</sup> When taken within 12 hours of a sexual assault, EC is 99.5% effective.
- EC pills can be given in different ways. One approach requires giving a first dose within 72 to 120 HRS of unprotected intercourse and a second dose 12 HRS later. The second approach, which applies uniquely to progestin-only medications, entails giving the entire course of medication at one time within 72 to 120 HRS after unprotected intercourse.<sup>6</sup>
- The side effects of EC are temporary and may include nausea, vomiting and breast tenderness. Plan B® appears to be associated with the fewest side effects.<sup>7</sup>
- According to the World Health Organization, EC will have no effect on an established pregnancy.<sup>8</sup> It is not the same thing as RU-486, also known as medication abortion.

## EC in the ER: Care for Rape Victims

- The American Medical Association, the American College of Emergency Physicians and the American College of Obstetricians and Gynecologists all recognize EC as part of standard rape treatment.
- Yet only 20% of rape victims receiving treatment at hospital ERs actually received EC over a seven-year time period in the 1990's, according to a national study.<sup>9</sup>
- The recent Wisconsin survey found wide variation in hospital policies on provision on EC to rape victims.

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<sup>1</sup> Stewart, F. and Trussell, J. "Prevention of Pregnancy Resulting from Rape," *American Journal of Preventive Medicine*. 2000. (19):228-229. An earlier estimate by Holmes (1996) is 32,000 pregnancies result from sexual assault.

<sup>2</sup> Holmes, M.M., Resnick, H.S., Kilpatrick, D.G., and Best, C.L. "Rape-related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women," *American Journal of Obstetrics and Gynecology*. 1996. 175:320-325.

<sup>3</sup> Trussell, J., et al. "Emergency Contraception Pills: A Simple Proposal to Reduce Unintended Pregnancies," *Family Planning Perspectives*. 1992. 14:269-273.

<sup>4</sup> Food and Drug Administration approval announcement. "Prescription Drug Products: Certain combined oral contraceptives for use as postcoital emergency contraception," *Federal Register*. Vol. 62, No. 27. February 25, 1997.

<sup>5</sup> Ellertson, C., Evans, M., Ferden, S., Leadbetter, C., Spears, A., Johnstone, K., et al. "Extending the time limit for starting the Yuzpe Regimen of emergency contraception to 120 HRS," *Obstetrics and Gynecology*. 2003. 101(6):1168-71.

<sup>6</sup> Von Hertzen, H., "Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomized trial," *The Lancet*. 2002. 360:1803-09.

<sup>7</sup> American College of Obstetricians and Gynecologists. "Emergency oral contraception," *ACOG Practice Bulletin*. 2001. Washington, D.C.:ACOG.

<sup>8</sup> World Health Organization. *Emergency Contraception: A guide to the provision of services*, *Reproductive Health and Research*. 1998.

<sup>9</sup> Amey, A., and Bishai, D. "Measuring Quality of Medical Care for Women Who Experience Sexual Assault with Data from the National Hospital Ambulatory Medical Care Survey," *Annals of Emergency Medicine*. June 2002. 39:6.

# Emergency Contraception Pills and Regimens

Source: <http://ec.princeton.edu/>

## Dedicated Products / Progestin Only

*Take 2 pills within 120 HRS after unprotected sex:*

Plan B

## Oral Contraceptives used for EC / Progestin Only

*Take 40 pills within 120 HRS after unprotected sex:*

Ovrette

## Oral Contraceptives used for EC / Progestin-Estrogen Combined

*Note: in 28-day packs, only the first 21 pills can be used*

*Take 2 pills within 120 HRS after unprotected sex and take 2 more pills 12 HRS later:*

Ogestrel

Ovral

*Take 4 pills within 120 HRS after unprotected sex and take 4 more pills 12 HRS later:*

Cryselle

Levlen

Levora

Lo/Ovral

Low-Ogestrel

Nordette

Portia

Seasonale

Seasonique

*Take 5 pills within 120 HRS after unprotected sex and take 5 more pills 12 HRS later:*

Alesse

Aviane

Lessina

Levlite

Lutera

# Frequently Asked Questions about Hormonal Approaches to EC

*From the American College of Obstetricians and Gynecologists*

## 1. What is emergency contraception?

Emergency contraception (EC) is a term that describes the use of contraceptive methods to prevent pregnancy after unprotected or incompletely protected intercourse. The approach most often used is the ingestion of combined oral contraceptives (COC) or progestin-only pills (POP) within 72 hours of unprotected intercourse. Several regimens of different formulations can be used for EC:

Yuzpe regimen: Two tablets of Ovral (50 mcg ethinyl estradiol plus 0.5 mg norgestrel) followed in 12 hours by 2 additional tablets.

Formulations of sub-50 mcg COCs.

"Preven": The equivalent of the 2 Ovral doses of 2 tablets each).

"Plan B": One tablet of 0.75 mg levonorgestrel followed in 12 hours by 1 additional tablet.

As an alternative to the hormonal approach, an intrauterine device can be very effective for EC when it is inserted within 5 days of unprotected intercourse. IUDs must be inserted and removed by a physician. This method may be appropriate for women seeking long-term contraception; however, it is not advisable for women at high risk for sexually transmitted diseases or for adolescents. Furthermore, insertion of an IUD is not recommended for EC in cases of rape.

## 2. What is meant by "incompletely protected" intercourse?

Approximately half of unintended pregnancies in the U.S. result from a contraceptive method failure. Commonly experienced examples of such failure are condom slippage or breakage or multiple missed pills in a cycle of pill use.

## 3. What is the mechanism of action of COCs or POPs in providing emergency contraception?

Before ovulation, treatment with EC is believed to disrupt follicular maturation and consequently inhibit or delay of ovulation. After ovulation, treatment appears to have no effect on ovarian hormone levels. Thus, prevention of implantation may be a secondary mechanism of action. In addition, POPs alter tubal motility.

## 4. Does this mean that emergency contraception can cause an abortion?

Emergency contraception will not disrupt an established pregnancy. Women often are exposed to exogenous hormones in early pregnancy without adverse outcome. Some women undergoing assisted reproductive technology procedures to achieve pregnancy are routinely prescribed progesterone to support the pregnancy. It is also a common occurrence to interview patients in early pregnancy who were not aware that their missed pills had resulted in contraceptive failure and who thus had continued taking their pills.

## 5. How effective is emergency contraception?

Effectiveness is determined by comparing the number of pregnancies observed with treatment to the number that would have been expected without treatment. Women who utilize emergency contraception in the most fertile segment of the menstrual cycle (6 days preceding ovulation to the day after ovulation) will have a higher failure rate than women who utilize the method during another part of the cycle. The proportion of pregnancies prevented with the Yuzpe regimen has been calculated to be between 57-75%. The effectiveness of the levonorgestrel regimen is reported to be 85%. The effectiveness of all regimens decreases after the first 12-24 hours after unprotected or incompletely protected intercourse.

## **6. Is there any point in using EC after 24 hours?**

Although the reduction in the risk of pregnancy is most striking in the first 12-24 hours, EC can be effective for up to 72 hours. Based on combined COC and POP method use, the World Health Organization (WHO) has reported pregnancy rates of 0.5%-1.5% in the first 12-24 hours compared to approximately 2.6% at 48 hours and 4.1% at 72 hours. To reduce unintended pregnancies it is critical to find ways to make EC as readily available as possible to women as soon as the need is recognized.

## **7. What about having emergency contraception available in advance?**

The correlation of low pregnancy rates with early utilization of emergency contraception supports advance prescribing of the dedicated products along with detailed instructions for their use. In addition, it is well known that users of barrier methods and OCPs would benefit from this kind of intervention. Users of OCPs are routinely advised to take a missed pill along with the current pill. Studies have shown that women can identify their risks and needs quickly, will utilize the regimen appropriately when it is provided in advance, and are not inclined toward repetitive use patterns for EC.

## **8. What are the side effects associated with EC use?**

The most common side effects of EC use are nausea and vomiting. At least 50% of the COC regimen users will experience nausea and 18-20% will have vomiting. The Plan B (levonorgestrel) regimen is associated with less than 25% frequency of nausea and about 5% vomiting. An antiemetic should be offered in conjunction with the EC prescription. Products such as those used for motion sickness are generally sufficient. The dose may need to be repeated if an EC user vomits within 1 hour of taking the medication. An episode of vomiting after 2 hours does not require a replacement dose.

## **9. In addition to temporary side effects, are there any serious complications of EC?**

The short-term nature of the regimen makes any vascular complications such as thrombosis highly unlikely. Menstrual cycle changes such as heavier bleeding, headache, dizziness, and breast tenderness may be experienced by as many 16 % of EC users. Because of the presumed effects on tubal motility with POP regimens, caution should be exercised in evaluating the possibility of ectopic pregnancy in users who experience abnormal bleeding for. There are very few contraindications to using EC: women should not use EC who are already pregnant or who have genital bleeding of unknown cause.

## **10. What if a woman is already pregnant or if EC fails to prevent pregnancy? What problems may occur?**

The use of EC is contraindicated during pregnancy. A woman with a problem pregnancy needs evaluation, counseling, and advice. A woman with an unplanned but desired pregnancy needs exactly the same care from her physician. Menses may be delayed after EC use, and a follow-up visit should be scheduled within 1-3 weeks to check for possible pregnancy. Based on studies of pregnancies where EC failed to prevent pregnancy, there is no that there is any increased risk of birth defects or other problems for the ongoing pregnancy. This finding is consistent with the knowledge that early exposure to estrogen or progestin formulations does not produce adverse embryonic or fetal effects.

## **11. Should a pregnancy test be performed before using EC?**

A pregnancy test is not a prerequisite to the use of EC. It can be useful in determining the need for EC if the woman has experienced more than one episode of unprotected or incompletely protected intercourse in the cycle and at least one episode was greater than 72 hours preceding evaluation. A positive test will allow the woman or her physician to begin the appropriate care for early pregnancy.

# Emergency Contraception Practice Guidelines and Policy Statements

By Professional Organizations with Physician Membership

(Updated 12/14/2005)

## American College of Emergency Physicians

[www.acep.org](http://www.acep.org)

Policy statements on emergency contraception:

Management of the Patient with the Complaint of Sexual Assault: [Link](#) to [www.acep.org](http://www.acep.org)

Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy: [Link](#) to [www.acep.org](http://www.acep.org)

Relevant papers on emergency contraception:

Amey AL, Bishai D. Measuring the quality of medical care for women who experience sexual assault with data from the National Hospital Ambulatory Medical Care Survey. *Annals of Emergency Medicine*. 2002;39(6):631-638.

Ciancone A, Wilson C, Collette R, Gerson L. Sexual assault nurse examiner programs in the United States. *Annals of Emergency Medicine*. 2000;35(4):353-7

Feldhaus K. A 21st Century Challenge: Improving the care of the Sexual Assault Victim. *Annals of Emergency Medicine*. 2002; 39(6): 653-655

Feldhaus K, Houry D, Kaminsky R. Lifetime sexual assault prevalence rates and reporting practices in an emergency department. *Annals of Emergency Medicine*. 2000;36(1):23-27 5) Kuhn WF, Heape DE, Caudell MJ. The literature of emergency contraception. *Sexual Assault: An annotated bibliography. American Journal of Emergency Medicine*. 1999;17(7):726-734

Linden JA. Sexual Assault. *Emergency Medicine Clinics of North America*. 1999; 17(3):685-696

## American College of Obstetric-Gynecologists

[www.acog.org](http://www.acog.org)

Practice guidelines on emergency contraception:

Emergency oral contraception. ACOG practice Bulletin--Clinical management guidelines for Obstetrician Gynecologists. March 2001; Number 25. Contact (800) 762-2264 for orders; no web link.

Sexual Assault. ACOG Educational Bulletin Number 242, November 1997(under revision) Contact (800) 762-2264 for orders; no web link.

Policy statements on emergency contraception:

On the Failure of the FDA to Approve OTC Status for Plan B. May 7, 2004. [Link](#) to [www.acog.org](http://www.acog.org)

## American College of Physicians-American Society of Internal Medicine

[www.acponline.org](http://www.acponline.org)

Policy statements on sexual assault or emergency contraception: None

Practice guidelines: None

Relevant papers:

Grimes, David A, Raymond, EG. Emergency Contraception. *Annals of Internal Medicine*. 2002; 137: 180-189

**American Academy of Pediatrics**

**www.aap.org**

Policy statements on emergency contraception:

Care of the Adolescent Sexual Assault Survivor (RE0067)

American Academy of Pediatrics, Committee on Adolescence, Pediatrics June 2001; 107(6): 1476-79. [Link](#) to [www.aap.org](#)

Adolescent Assault Victim Needs: A Review of Issues and a Model Protocol (RE9643)

American Academy of Pediatrics, Task Force on Adolescent Assault Victim Needs, Pediatrics November 1996; 98(5): 991-1001. [Link](#) to [www.aap.org](#)

Roye CF, Johnsen JR. Adolescents and emergency contraception. [Review] Journal of Pediatric Health Care. 16(1):3-9, 2002 Jan-Feb.

Practice Guidelines: None

Relevant Papers: None

**American Academy of Family Physicians**

**www.aafp.org**

Policy statements on sexual assault or emergency contraception: None

Practice guidelines: None

Relevant papers on sexual assault and emergency contraception:

Newell A, Richardson C, Eyer AE. Treatment of the adolescent survivor of sexual assault. Clinics in Family Practice. 2000;2(4): 883-917

Petter LM, Whitehill DL. Management of Female Sexual Assault. American Family Physician. September 15, 1998 58(4):920-929. [Link](#) to [www.aafp.org](#)

**American Medical Association**

**www.ama-assn.org**

Practice guidelines on emergency contraception: None.

Practice guidelines on emergency contraception-related issues:

American Medical Association. AMA Guidelines for adolescent preventive services (GAPS) recommendations monograph. Archives of Pediatric Adolescent Medicine. 1997;151(2):123-128.

Policy statement on emergency contraception:

H-75.985: Access to Emergency Contraception. [Link](#) to [www.ama-assn.org](#)

Policy statements on emergency contraception-related issues:

H-75.987: Reducing Unintended Pregnancy

H-75.988: Extension of Medicaid Coverage for Family Planning Services

H-75.998: Opposition of HHS Regulations on Contraceptive Services for Minors

H-75.999: Teenage pregnancy

H-75.990: Development and Approval of New Contraceptives

H-75.995: Contraceptive Advertising

## Ethical and Religious Directives

The *Ethical and Religious Directives for Catholic Health Care Services*, which govern Catholic facilities, prohibit the routine provision of contraception. However, Directive 36 makes a specific exception for emergency treatment of victims of sexual assault, offering the following guidance:

*Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.*

Over the years, some Catholic hospitals had decided that prohibiting the provision of emergency contraception was the only way to be in compliance with this somewhat confusing guidance, given the medical impossibility of determining what is spelled out in the last sentence of Directive 36. Other facilities had developed various inexact ways to trying to approximate the requirements of that sentence through such efforts as giving the patient an ovulation test.

Recently, however, there has been helpful new guidance for hospitals on this subject from the Catholic Health Association. As a result, many Catholic hospitals are now adopting policies of offering EC to rape victims. You may wish to refer to two articles in recent issues of *Health Progress*, the journal of the Catholic Health Association (which is available at [www.chausa.org](http://www.chausa.org)):

- “Emergency Contraception and Sexual Assault,” an article appearing in the September-October 2002 issue, concludes that the “appropriate testing” requirement mentioned in Directive 36 can be fulfilled by giving a standard pregnancy test to the rape victim before offering her ECPs. (If the patient is already pregnant, she does not need emergency contraception.) In this article, Dr. Ronald Hamel, PhD, senior director, ethics, for the Catholic Health Association, and Micheal Panicola, PhD, corporate vice president, ethics for SSM Health Care, argue against the ovulation method, saying “the pregnancy approach is responsive to the needs of the woman who has suffered untold trauma from being sexually assaulted and is consistent with the Catholic moral tradition generally and Catholic teaching on this matter particularly.”
- In the July-August 2003 issue, “A Venue for Theological/Ethical Issues” CHA President Father Michael Place reported that the United States Conference of Catholic Bishops’ Committee on Doctrine “concluded that testing only for pregnancy unrelated to sexual assault is not inconsistent with Directive 36.”

# Directory of Wisconsin Rape Crisis Centers

## *Northwest Region*

### **Ashland – New Day Shelter**

PO BOX 88 ASHLAND, WI 54806  
PHONE: (715) 682-9566  
CRISIS LINE: (800) 924-4132 / (715) 682-9565 (24 HRS)  
FAX NUMBER: (715) 682-6865

### **Chippewa Falls – Family Support Center**

PO BOX 143 CHIPPEWA FALLS, WI 54729  
PHONE: (715) 723-1138  
CRISIS LINE: (800) 400-7020 (24 HRS)  
FAX NUMBER: (715) 723-8460

### **Eau Claire – Bolton Refuge House**

PO BOX 482 EAU CLAIRE, WI 54702  
PHONE: (715) 834-0628  
LEGAL ADVOCATE: (715) 834-0628  
CRISIS LINE: (715) 834-9578 / (800) 252-4357 (24 HRS)  
FAX NUMBER: (715) 834-9634

### **Hayward – LCO Oakwood-Haven**

13394 W TREPANIA RD HAYWARD, WI 54843  
PHONE: (715) 634-9360  
CRISIS LINE: (877) 552-7474 (24 HRS)

### **Ladysmith – Time-Out Family Abuse Shelter**

PO BOX 406 LADYSMITH, WI 54848  
PHONE: (715) 532-6976 (8:00 - 4:00)  
CRISIS LINE: (715) 532-7089 / (800) 924-0556 (24 HRS)  
FAX NUMBER: (715) 532-0972

### **Medford – Stepping Stones**

PO BOX 224 MEDFORD, WI 54451  
PHONE: (715) 748-3795 (8:30-5:00)  
CRISIS LINE: (715) 748-5140 (24 HRS)  
FAX NUMBER: (715) 748-2398

### **Menomonie – The Bridge to Hope**

PO BOX 700 MENOMONIE, WI 54751  
PHONE: (715) 235-9074 (8:00-4:30)  
CRISIS LINE: (715) 235-9074 or (800) 924-9918 (24 HRS)  
FAX NUMBER: (715) 235-9073

### **Milltown – Community Referral Agency**

PO BOX 365 MILLTOWN, WI 54858  
PHONE: (715) 825-4414  
FAX NUMBER: (715) 825-4418  
CRISIS LINE: (715) 825-4404 / (800) 261-SAFE (7233) (24 HRS)  
Burnett County Outreach Office: (715) 349-7272

### **River Falls – Turningpoint**

PO BOX 304 RIVER FALLS, WI 54022  
PHONE: (715) 425-6751  
CRISIS LINE: (800) 345-5104 (24 HRS)  
FAX NUMBER: (715) 425-6908

### **Superior - CASDA**

2231 CATLIN AVE SUPERIOR, WI 54880  
PHONE: (715) 392-3136 (9:00 - 4:00)  
CRISIS LINE: (800) 649-2921 / (715) 392-3136 (24 HRS)  
FAX NUMBER: (715) 392-8463

## *Northeast Region*

### **Algoma – Violence Intervention Project**

1405 DIVISION ST ALGOMA, WI 54201  
PHONE: (920) 487-2111 (9:00-3:00)  
CRISIS LINE: (877) 847-3223 (24 HRS)  
FAX NUMBER: (920) 487-2110

### **Antigo – AVAIL**

PO BOX 355 ANTIGO, WI 54409  
PHONE: (715) 623-5177  
CRISIS LINE: (715) 623-5767 (24 HRS)  
FAX NUMBER: (715) 627-4901

### **Green Bay – Sexual Assault Center**

300 CROOKS STREET  
PO BOX 22308 GREEN BAY, WI 54305-2308  
PHONE: (920) 436-8890  
24 HOUR CRISIS PHONE: (920) 436-8899  
FAX NUMBER: (920) 432-5966

### **Marshfield – Central WI Area Sexual Assault Victim Services (SAVS)**

503 CHERRY AVE, STE 2 MARSHFIELD, WI 54449  
PHONE: (715) 387-2729  
CRISIS LINE: (715) 384-5555  
FAX NUMBER: (715) 387-4526  
Wisconsin Rapids Crisis Line: (715) 421-2345

### **Merrill – HAVEN**

PO BOX 32 MERRILL, WI 54452  
PHONE: (715) 536-1300  
CRISIS LINE: (715) 536-1300 (24 HRS)  
FAX NUMBER: (715) 536-1801

### **Oconto – Oconto County Sexual Assault Center**

1210 MAIN STREET OCONTO, WI 541535  
MAILING ADDRESS: PO BOX 22308  
GREEN BAY, WI 54305  
24 HOUR CRISIS PHONE: (920) 846-2111  
FAX NUMBER: (920) 432-5966

**Rhineland – Tri-County Sexual Assault Center**

PO BOX 233 RHINELANDER, WI 54501-0233  
PHONE: (715) 362-6841 (8:00 - 4:00)  
CRISIS LINE: (800) 236-1222 (24 HRS)  
FAX NUMBER: (715) 362-9650

**FOREST COUNTY OFFICE**

PO BOX 158 CRANDON, WI 54520  
PHONE: (715) 478-3780 (8:00 - 4:00)  
CRISIS LINE: (800) 236-1222 (24 HRS)  
FAX NUMBER: (715) 478-3796

**VILAS COUNTY OFFICE**

PO BOX 1867 EAGLE RIVER, WI 54521  
PHONE: (715) 479-2912 (8:00 - 4:00)  
CRISIS LINE: (800) 236-1222 (24 HRS)  
FAX NUMBER: (715) 479-1072

**Shawano – Safe Haven**

PO BOX 665 SHAWANO, WI 54166  
PHONE: (715) 524-6759  
CRISIS LINE: (715) 526-3421  
FAX NUMBER: (715) 524-6763

**Stevens Point – Sexual Assault Victims Services**

1608 WEST RIVER DRIVE STEVENS POINT, WI 54481  
PHONE: (715) 343-7101  
CRISIS LINE: (800) 472-3377  
FAX NUMBER: (715) 343-7175

**Sturgeon Bay – Door County Sexual Assault Center**

827 N. 8TH ST STURGEON BAY, WI 54235  
MAILING ADDRESS: PO BOX 22308 GREEN BAY, WI 54305  
24 HOUR CRISIS PHONE: (920) 746-8996  
FAX NUMBER: (920) 432-5966

**Wausau – The Women’s Community**

2801 SEVENTH ST #300 WAUSAU, WI 54403-3222  
PHONE: (715) 842-5663 (8:00-4:30)  
CRISIS LINE: (715) 842-7323 OR (888) 665-1234 (24 HRS)  
FAX NUMBER: (715) 842-7051

**Southwest Region**

**Baraboo – Hope House**

PO BOX 432 BARABOO, WI 53913  
PHONE: (608) 356-9123  
CRISIS LINE: (800) 584-6790 (24 HRS)  
FAX NUMBER: (608) 356-9863

**Beloit – Sexual Assault Recovery Program**

MAIN OFFICE:  
423 BLUFF ST BELOIT, WI 53511  
PHONE: (608) 365-1244  
CRISIS LINE: (866) 666-4576 (24 HRS)  
FAX NUMBER: (608) 365-4097

**JANESVILLE OFFICE:**

YWCA CARE HOUSE  
1126 CONDE ST JANESVILLE, WI 53546  
VOICE PHONE: (608) 305-0193

**GREEN COUNTY OFFICE:**

THE MONROE CLINIC  
515 22ND AVE MONROE, WI 53566  
VOICE PHONE: (608) 324-2444  
FAX NUMBER: (608) 324-2499

**Janesville – YWCA Alternatives to Violence**

1735 S WASHINGTON ST JANESVILLE, WI 53546  
PHONE: (608) 752-5445  
CRISIS LINE: (608) 752-2583 or (800) 750-7990 (24 HRS)  
FAX NUMBER: (608) 755-4743

**La Crosse – Gundersen Lutheran Sexual Assault Counseling Program**

1910 SOUTH AVE LA CROSSE, WI 54601  
PHONE: (608) 782-7300 EXT. 53845  
CRISIS LINE: (800) 362-8255 (24 HRS) OR (608) 775-5950  
FAX: (608)775-6342

**La Crosse – Safe Path/Franciscan Skemp Healthcare**

800 WEST AVE SOUTH LA CROSSE, WI 54601  
PHONE: (608) 791-7804  
CRISIS LINE: (800) 362-5454 x7804 / (608) 791-7804 (24 HRS)  
FAX NUMBER: (608) 791-9834

**Madison – Rape Crisis Center**

128 E OLIN AVE MADISON, WI 53713  
PHONE: (608) 251-5126  
CRISIS LINE: (608) 251-7273 (24 HRS)  
FAX NUMBER: (608) 251-6229  
[www.danecountyrcc.com](http://www.danecountyrcc.com)

**Platteville – Family Advocates**

PO BOX 705 PLATTEVILLE, WI 53818  
PHONE: (608) 348-4290  
CRISIS LINE: (608) 348-3838 / (800) 924-2624 (24 HRS)  
FAX NUMBER: (608) 348-4291

**Richland Center – Passages**

PO BOX 546 RICHLAND CENTER, WI 53581  
BUSINESS PHONE: (608) 647-8775 SHELTER: (608) 647-6317  
CRISIS LINE: (800) 236-4325 (24 HRS)  
BUSINESS FAX: (608) 647-2720

**Tomah – Monroe County Domestic Abuse Project**

PO BOX 161 SPARTA, WI 54656  
PHONE: (608) 374-6975  
CRISIS LINE: (866) 346-0374 (24 HRS)  
FAX NUMBER: (608) 269-7063

### ***Southeast Region***

#### **Appleton – Sexual Assault Crisis Center Fox Cities**

17 Park Pl. Suite 950 Appleton, WI 54914  
PHONE: (920) 733-8119  
CRISIS LINE: (800) 722-7797 OR (920)733-8119  
FAX NUMBER: (920) 733-8190  
[www.SACC-foxcities.org](http://www.SACC-foxcities.org)

#### **Beaver Dam – People Against a Violent Environment (PAVE)**

PO BOX 561 BEAVER DAM, WI 53916  
PHONE: (920) 887-3810  
CRISIS LINE: (800) 775-3785 (24 HRS)  
FAX NUMBER: (920) 885-2270

#### **Elkhorn – Association for the Prevention of Family Violence**

461 E. GENEVA ST ELKHORN, WI 53121  
PHONE: (262) 723-4653  
CRISIS LINE: (262) 723-4653 (24 HRS)  
FAX NUMBER: (262) 723-8367

#### **Fond du Lac – ASTOP Sexual Abuse Center**

430 EAST DIVISION ST FOND DU LAC, WI 54935  
PHONE: (920) 926-5395 (8:00 - 4:30)  
CRISIS LINE: (800) 418-0270 (24 HRS)  
FAX NUMBER: (920) 926-4306  
[www.astop.org](http://www.astop.org) or [www.feelsafe.org](http://www.feelsafe.org)

#### **Kenosha – Women & Children’s Horizons**

1511 56TH ST KENOSHA, WI 53140  
PHONE: (262) 656-3500  
CRISIS LINE: (800) 853-3503 (24 HRS)  
FAX NUMBER: (262) 656-3402

#### **Manitowoc – Sexual Assault Resource Center**

333 REED AVE  
P.O. BOX 1450 MANITOWOC, WI 54221-1450  
PHONE: (920) 320-8560  
CRISIS LINE: (920) 320-8555 (24 HRS)  
FAX NUMBER: (920) 320-8635

#### **Menasha – REACH Counseling Services**

United Way Agency  
1244C MIDWAY RD MENASHA, WI 54952  
36 BROAD ST OSHKOSH, WI 54901  
PHONE: (920) 722-8150 / (920) 426-1460 (8:30-4:30, PM BY APPT.)  
CRISIS LINE: (920) 722-8150 OR (920) 426-1460 (24 HRS)  
FAX NUMBER: (920) 722-0142  
[www.reachcounseling.com](http://www.reachcounseling.com)

#### **Milwaukee – Counseling Center of Milwaukee**

2038 NORTH BARTLETT AVE MILWAUKEE, WI 53202  
PHONE: (414) 271-2565 (M-TH 8:30 A.M. 9:00 P.M.; F 8:30 4:30;  
SAT 9:00 A.M. 12:00 P.M.)  
CRISIS LINE: (414) 271-9523 (24 HRS)  
FAX NUMBER: (414) 271-0102  
[www.tccmilw.org](http://www.tccmilw.org)

#### **Milwaukee – Sexual Assault Treatment Center**

SINAI SAMARITAN MEDICAL CENTER  
960 NORTH 12TH ST, ROOM 2120 MILWAUKEE, WI 53201

#### **WEST ALLIS MEMORIAL HOSPITAL**

8900 W LINCOLN AVE MILWAUKEE, WI 53214  
PHONE: (414) 219-5850  
CRISIS AND INFORMATION LINE: (414) 219-5555 (24 HRS)  
FAX NUMBER: (414) 219-7570

#### **Milwaukee – The Healing Center**

611 W NATIONAL AVE, 4TH FLOOR MILWAUKEE, WI 53204  
PHONE: (414) 671-4325 (671-HEAL)  
CRISIS LINE: (414) 671-4325 (24 HRS)  
FAX: (414) 671-6836  
[www.thehealingcenter.org](http://www.thehealingcenter.org)

#### **Racine – Sexual Assault Services**

1220 MOUND AVE. SUITE 304 RACINE, WI 53404  
PHONE: (262) 619-1634  
CRISIS LINE: (262) 637-7233 (24 HRS, COLLECT CALLS  
ACCEPTED)  
FAX NUMBER: (262) 619-1638

#### **WESTERN RACINE COUNTY OFFICE:**

480 SOUTH PINE ST BURLINGTON, WI 53105  
PHONE: (262) 763-6226

#### **Saukville – Advocates of Ozaukee**

PO BOX 80166 SAUKVILLE, WI 53080  
PHONE: (262) 284-3577  
CRISIS LINE: (262) 284-6902 (24 HRS)  
FAX NUMBER: (262) 284-4403

#### **Sheboygan – Safe Harbor**

PO BOX 582 SHEBOYGAN, WI 53082  
PHONE: (920) 452-8611 (9:00 - 5:00)  
CRISIS LINE: (920) 452-7640 (24 HRS)  
FAX NUMBER: (920) 453-6642

#### **Waukesha – Women’s Center**

505 NORTH EAST AVENUE WAUKESHA, WI 53186  
PHONE: (262) 547-4600  
CRISIS LINE: (262) 542-3828 OR (888) 542-3828 (24 HRS)  
FAX NUMBER: (262) 522-3882  
[www.twcwaukesha.org](http://www.twcwaukesha.org)

#### **West Bend – Friends of Abused Families**

PO BOX 117 WEST BEND, WI 53095  
PHONE: (262) 334-5598, EXT 104  
CRISIS LINES: (262) 334-7298 (24 HRS)  
(262) 255-9488 (24 HRS)  
(262) 673-7298 (24 HRS)  
FAX NUMBER: (262) 334-7725

## Wisconsin SANE Programs

For information on developing a SANE Program, please visit: [www.sane-sart.com](http://www.sane-sart.com)

### All Saints Health Care System, Inc.

3801 Spring Street  
Racine, Wisconsin 53406  
Contact: Barbara Campbell  
Phone: 262-636-8970

### Aurora Health Care—Sinai Medical Center

945 North 12th  
Milwaukee, Wisconsin 53233  
Contact: Debbie Donovan  
Phone: 414-219-555  
Email: [debbie.donovan@aurora.org](mailto:debbie.donovan@aurora.org)

### Berlin Hospital SANE Program

225 Memorial Drive  
Berlin, Wisconsin 54923  
Contact: Jess Kuklinski, RN  
Phone: 920-361-5525  
Email: [berlinsane@hotmail.com](mailto:berlinsane@hotmail.com)

### Community Memorial Hospital

855 South Main Street  
Oconto Falls, Wisconsin 45154  
Contact: Rozanne Brehmer  
Phone: 920-846-3444 ext. 1244  
Email: [rosebr@cmhospital.org](mailto:rosebr@cmhospital.org)

### Franciscan Skemp Healthcare SANE Program

700 West Avenue South  
LaCrosse, Wisconsin 54601  
Contact: LuAnne Kratt  
Phone: 608-791-9720  
Email: [kratt.luanne@mayo.edu](mailto:kratt.luanne@mayo.edu)

### Meriter Hospital SANE Program

202 South Park Street  
Madison, Wisconsin 53715-1599  
Contact: Jill Poarch, RN, BSN, SANE-A, Coordinator  
Phone: 608-267-5916  
Email: [jpoarch@meriter.com](mailto:jpoarch@meriter.com)

### Sacred Heart Hospital

900 West Claremont Avenue  
Eau Claire, Wisconsin 54701  
Contact: Rose Jadack, PhD, RN, SANE Coordinator  
Phone: 715-839-4222  
Email: [jadackra@uwec.edu](mailto:jadackra@uwec.edu)

### SANE St. Mary's Hospital

1044 Kabel Avenue  
Rhineland, Wisconsin 54501  
Contact: Denise Counter  
Phone: 715-369-6700

### SANE Program St. Elizabeth ER Department

1506 South Oneida Street  
Appleton, Wisconsin 54915  
Contact: Rosemary Dvorachek, Coordinator  
Phone: 920 738-2100  
Fax: 920-730-5912

### SANE Program St. Lukes Hospital & St. Mary's

3801 Spring Street  
Racine, Wisconsin 53406  
Contact: Barbara Campbell, RN  
Phone: 414-636-4201

### SANE St. Mary's Medical Center

1726 Shawano Avenue  
Green Bay, Wisconsin 54303  
Contact: Marlene Scheffen  
Phone: 414-498-4563

### Southeastern Wisconsin Region

252 McHenry Street  
Burlington, Wisconsin 53105  
Phone: 262-767-6100

### St. Croix Valley Sexual Assault Response Team, Inc.

730 10th Avenue  
Baldwin, Wisconsin 54016  
Contact: Kristi Pavek, RN, SANE, Executive Director  
Phone: 715-688-2194  
Email: [kristi@stcroixvalleysart.org](mailto:kristi@stcroixvalleysart.org)  
Website: [www.stcroixvalleysart.org](http://www.stcroixvalleysart.org)

### St. Croix Valley Sexual Assault Response Team, Inc.

121 N. Fremont (Summer 2006)  
River Falls, Wisconsin 54022  
Contact: Kristi Pavek, RN, Executive Director  
Phone: 715-425-6443; 866-650-SART Toll-free  
Email: [Kristi@stcroixvalleysart.org](mailto:Kristi@stcroixvalleysart.org)  
Website: [www.stcroixvalleysart.org](http://www.stcroixvalleysart.org)

### St. Joseph's Hospital

611 St. Joseph Avenue  
Marshfield, Wisconsin 54484  
Contact: Julie Schuppel, RN  
Phone: 715-387-7676

### St. Vincent Hospital SANE Program

PO Box 13508  
Green Bay, Wisconsin 54307-3508  
Contact: Paula Hafeman, RN, MSN, CEN  
Phone: 414-433-8391

# CCRV Wisconsin Resource Guide

## *Organizations*

### **Wisconsin Coalition Against Sexual Assault (WCASA)**

[www.wcasa.org](http://www.wcasa.org)

(608) 257-1516 or (608) 257-2537 tty

(608) 257-2150 fax

Email: [wcasa@wcasa.org](mailto:wcasa@wcasa.org)

### **Wisconsin Coalition Against Domestic Violence (WCADV)**

[www.wcadv.org](http://www.wcadv.org)

(608) 255-0539

(608) 255-3560 fax

### **Compassionate Care for Rape Victims Coalition (CCRV)**

[www.wiawh.org](http://www.wiawh.org)

(608) 251-0139

### **Sexual Assault Nurse Examiners Sexual Assault Response Team (SANE SART)**

[www.sane-sart.com](http://www.sane-sart.com)

(612) 873-2434

### **International Association of Forensic Nurses (IAFN)**

[www.iafn.org](http://www.iafn.org)

(410) 626-7805

Email: [info@iafn.org](mailto:info@iafn.org)

### **WI Chapter of the International Association of Forensic Nurses (IAFN)**

Contact: Bonnie Donovan

(414) 219-5850

[Debbie.donovan@aurora.org](mailto:Debbie.donovan@aurora.org)

### **Wisconsin Department of Health & Family Services**

[www.dhfs.state.wi.us](http://www.dhfs.state.wi.us)

(608) 266-1865

### **American College of Emergency Physicians**

[www.acep.org](http://www.acep.org)

(800) 798-1822 or (972) 550-0911

### **American College of Obstetricians and Gynecologists (ACOG)**

[www.acog.org](http://www.acog.org)

(202) 638-5577

### **American Medical Association**

[www.ama-assn.org](http://www.ama-assn.org)

(800) 621-8335

### **U.S. Department of Justice – Office on Violence Against Women**

[www.usdoj.gov/ovw](http://www.usdoj.gov/ovw)

(202) 307-6026

### **U.S. Department of Justice - Office for Victims of Crimes**

[www.ovc.gov](http://www.ovc.gov)

(202) 307-5983

## *Hotlines*

### **SAFEta Sexual Assault Nurse Examiner Technical Assistance Helpline**

(877) 819-SART

### **National Sexual Assault Hotline**

(800) 656-HOPE

### **Emergency Contraception Provider List**

(888) NOT-2-LATE

[www.not-2-late.com](http://www.not-2-late.com)

### **Wisconsin EC Hotline**

(866) EC-FIRST

### **Planned Parenthood**

(800) 230-PLAN

[www.ppwi.org](http://www.ppwi.org)

## *Patient Resources*

### **Rape, Abuse & Incest National Network (RAINN)**

[www.rainn.org](http://www.rainn.org)

(202) 544-1034 or (800) 656-4673, x 3

[info@rainn.org](mailto:info@rainn.org)

### **National Sexual Violence Resource Center (NSVRC)**

[www.nsvrc.org](http://www.nsvrc.org)

(877) 739-3895 or (717) 909-0710

(717) 909-0715 tty

### **National Center for Victims of Crime**

[www.ncvc.org](http://www.ncvc.org)

(202) 467-8700

## **Resources**

### **Sexual Assault Nurse Examiner (SANE) Development & Operations Guide**

[www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf](http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf)

### **International Association of Forensic Nurses (IAFN) Professional Publications**

[www.iafn.org/publication/publicationTools.cfm](http://www.iafn.org/publication/publicationTools.cfm)

Includes:

- Coping with Sexual Assault and the Nursing Guide for the Care of the Sexual Assault Patient Pocket Card
- The Examination Preparation Guide

### **IAFN Education**

[www.iafn.org/cmpublic/education/list.cfm](http://www.iafn.org/cmpublic/education/list.cfm)

### **National Alliance of Sexual Assault Coalitions, Library of Information**

<http://connsacs.org/learn/library.html>

### **National Violence Against Women Prevention Research Center**

[www.vawprevention.org](http://www.vawprevention.org)

### **Not-2-Late: The Emergency Contraception Website**

Provides EC information in Spanish, English, French and Arabic

<http://ec.princeton.edu>

## **Publications**

The Alan Guttmacher Institute. (2003). Emergency Contraception: Increasing Public Awareness. *Issues in Brief*, No. 2.

American College of Emergency Physicians (2002). Management of the patient with the complaint of sexual assault. *ACEP Policy Statements*. <http://www.acep.org/1,614,0.html>.

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Goldenring, J.M. & Allred, G. (2001). Post-rape care in hospital emergency rooms. *American Journal of Public Health*, 91(8): 1169-70.

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- Jones, J. & Whitworth, J. (2002). Emergency Evaluation and Treatment of the Sexual Assault Victim. *Topics in Emergency Medicine*, 24(4): 47-61.
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- Trussell, J., Ellertson, C. & Stewart, F. (1996). The effectiveness of the Yuzpe regimen of emergency contraception. *Family Planning Perspective*, 280(2): 58-64.
- Trussell, J., Koenig, J., Ellertson, C. & Stewart F. (1997) Preventing Unintended Pregnancy: The Cost-Effectiveness of Three Methods of Emergency Contraception. *American Journal of Public Health*, 87(6): 932-37.
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# Sample Hospital Protocol



<b>Title:</b>	<b>Sexual Assault – Evidence Collection and Treatment</b>
<b>Effective Date:</b>	<b>June 1997</b>
<b>Review Date:</b>	<b>August 2006</b>
<b>File In:</b>	<b>ED Manual</b>
<b>Copies to:</b>	<b>Emergency Room</b>

_____	ER Nurse Manager	_____
<b>Diane Holschbach</b>	<b>Title</b>	<b>Date</b>
_____	Director, Patient Care Services	_____
<b>Penny Block</b>	<b>Title</b>	<b>Date</b>
_____	ER Medical Director	_____
<b>Dr. Vidalakis</b>	<b>Title</b>	<b>Date</b>

- POLICY:** The management of the sexual assault survivor requires a multi-disciplinary approach involving medical, law enforcement, and supportive personnel. Essentials of treatment are:
- A. Assessment and care of physical injuries
  - B. Provide initial crisis intervention and arrange for ongoing emotional support.
  - C. Documentation and collection of forensic evidence
  - D. Detection and prevention of venereal disease and pregnancy
  - E. Arrange follow-up times for additional testing as necessary.

**PROCEDURE:**

Responsibility of ER Staff:

1. Upon arrival to the Emergency Department escort patient to the Emergency Room and complete initial triage evaluation to determine whether there are any physical injuries requiring treatment.
  - A. Check vital signs
  - B. Examine patient for injuries
  - C. Document findings on Emergency Room record
2. Contact S.A.N.E. as soon as possible after survivor arrives in Emergency Room.
3. If triage assessment does not disclose any obvious injuries that require immediate medical attention the survivor will be taken to the family room to await the arrival of the S.A.N.E.
4. Initiate emergency room admission paperwork. 2 pages of labels are needed.
5. Explain to the survivor that a S.A.N.E. nurse has been called and will arrive as soon as possible.
6. If the survivor is willing to report the assault, and has not done so, call the police to come and take the report.
7. If female patient needs to void, obtain a urine specimen and have lab check urine for sperm and mobility. Ask patient to dab only, do not wipe.

## Responsibility of Sexual Assault Nurse Examiner

1. Offer survivor the option of having an advocate from Domestic Abuse Support Center (DASC) come to the Emergency Room, if they decline give them handouts from DASC and encourage them to call at a later date. DASC phone number is (715) 526-3421. A DASC representative is available 24 hours a day.
2. If sexual assault was within 72 hours, survivor is offered forensic exam as well as gynecological exam, health assessment, and treatment.
3. The survivor will be interviewed in a private room if available, away from exam area. After introductions, the S.A.N.E. will briefly describe the exam process.
4. A history and health assessment will be documented and treatment initiated. The sexual assault history will be taken in a sensitive and professional manner, which will enhance the control and self-esteem of the survivor. Maintaining the chain of evidence for legal purposes is imperative; therefore, this procedure will adhere to collection standards as determined by the State of Wisconsin Crime Lab and the District Attorney's staff. In the state of Wisconsin, an adult is anyone 18 years and older.
5. Survivor signs the consent form for evidentiary exam, the consent to have HIV testing done, and Release of Medical Information form for release of information to police (if chosen).
6. The survivor is taken to the exam room for health assessment and evidence collection.
7. Head to toe health assessment, including inspection, auscultation and palpation.
8. Evidence collection:
  - A. If an evidentiary exam is being done, a police officer may wait outside the exam door.
  - B. Use a State of Wisconsin Sexual Assault Evidence Collection Kit. When collecting evidence follow the instructions found inside of the kit.
  - C. Examine body based on history for areas to swab, e.g., bite marks, foreign material, licking, etc. If present or suspected, swab area using 2 swab method, and dry then place in envelope, seal, label and sign. If foreign material is suspected to be semen a woods lamp may be used to floresce specimen. (Semen will floresce yellow to violet under a woods lamp.)
  - D. Photographs, particularly self-developing ones are useful for documentation. All pictures should be labeled with the patient's name, the date, time and the photographer's name.
  - E. Fingernail scrapings are not usually collected, unless the patient scratched the assailant and has a great deal of tissue present under the fingers. Put scrapings from each hand in a separate labeled paper envelope.
  - F. Pelvic Examination (speculum examination) using warm water as a lubricant should be performed on all female victims of sexual assault. Using a woods lamp or other filtered ultraviolet, the perineum and upper inner thighs should be examined to detect stains. Specimens should be taken from any areas that floresce. The genital area should be examined for signs of trauma and the findings documented.
  - G. After the forensic evidence has been collected, obtain medical specimens:
    1. Cultures-a baseline Neisseria Gonorrhoea culture and forensic Chlamydia culture should be done on all victims of sexual assault. Specimens should be collected from the endocervix rather than from the vaginal vault. If rectal penetration has occurred, rectal culture should also be obtained. The culture should be repeated in 2 weeks to document any change.
    2. Serology-A VDRL should be drawn on all patients to establish a baseline. A conversion of the VDRL from negative to positive may be evidence supporting the claim that sexual assault has occurred. The test should be repeated in 6 weeks if initial test is negative. A test for HIV, Hepatitis B&C should also be done initially and repeated in 6 weeks.
    3. Pregnancy Test-serum pregnancy testing does not need to be a routine procedure on all sexually assaulted patients, however, a serum pregnancy test should be performed on any patient who thinks she may be pregnant.
    4. Slides-a slide for Vaginal Trichomonas and a slide to check for sperm motility may also be done.

- H. Rectal examination should be performed routinely in cases of anal intercourse.
  - I. Appropriate x-rays should be taken, depending on site of injury.
9. Treatment-
- A. Counseling may be invaluable in assisting the victim to recover from this event. Give victim information on DASC.
  - B. Venereal disease prophylaxis-
    - 1. Indications- Victim's request, assailant infected, multiple assailants, follow-up unlikely, signs and symptoms of STD in victim, high incidence of STD in community.
    - 2. Drugs-  
Drug of Choice:  
Tetracycline 500 mg QID for 7 days  
Alternatives:  
Doxycycline 100 mg po BID for 7 days  
Amoxicillin 3 g po plus Probenecid 1 g po as a single oral dose  
Ampicillin 3.5 g po plus Probenecid 1 g po as a single oral dose
    - 3. Postcoital contraceptives:  
If there is a risk of pregnancy, the drug of choice is Ethenyl Estradiol/Norgestral (Orval). The reported failure rate is less than 1%. Recommended dose: 2 tablets po then 2 more tablets in 12 hours.
10. Disposition and discharge:
- A. Fill out entire Discharge Planning Page, making sure to document type of pregnancy test done, STD coverage, safety issues, follow-up phone call, rape counseling, and medical follow-up. Have survivor and S.A.N.E. sign discharge plan after discussing these issues.
  - B. Social Services: If a survivor is under 18 years of age, call Shawano or Menominee Social Services to report assault.
  - C. Call survivors primary care provider and inform him/her of survivor's experience and the exam results. Set up follow-up care; advise survivor to call PMD and set up appointment for a follow-up exam in \_\_\_\_ amount of time. When lab results are available (about 72 hours), call these results to survivor and PMD. Offer specific counseling resources (ie, DASC again).
  - D. Set up mutually agreed upon day and time when S.A.N.E. will call survivor for follow-up phone call(s). If phone calls are not acceptable, establish alternate plan to follow-up calls, i.e., mail, neighbor.
  - E. Validate survivor can get a safe plane in a safe manner!
11. Documentation-  
Completely fill out the questionnaire provided in the evidence kit. Document any statements made by the victim on the nurses notes. This may be very helpful in a trial.
12. ER physician to be consulted as medically necessary. Case is to be discussed with ER physician who will sign prescription orders, medication(s), and the Emergency Room record. PMD to be notified by phone on all survivors.
13. If S.A.N.E. is not available to do exam, the Emergency Room Staff will follow these guidelines to complete exam.
14. After closure with the survivor and physician(s) copy of chart to:
- A. Police (if reported)
  - B. Medical Director
- Original goes to Medical Records

**REVIEWED: 8/00, 6/9/04, 8/05**  
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## Glossary of Terms

**Conception-** Conception occurs when an egg is fertilized by sperm. Medically speaking, conception is not synonymous with pregnancy. Pregnancy begins after conception, when a fertilized egg successfully implants on the wall of the uterus.

**Forensic Examination-** An examination provided to a sexual assault victim by health care personnel trained to gather evidence of sexual violence in a manner suitable for use in a court of law generally using a standardized forensic evidence collection kit. The examination includes a patient interview, examination for physical trauma and collection of evidence at a minimum.

**“Morning-after-pill”-** Another name for emergency contraception. Reproductive health professionals are using this term less often because it gives the false impression that the medication can only be taken the morning after unprotected sex, when in actuality, it can be taken up to five days later.

**Pregnancy-** The medical definition of pregnancy is that it begins when a fertilized egg is successfully implanted on the wall of the uterus.

**RU-486-** This is also known as medication abortion and can be used to end an established pregnancy up to seven weeks into gestation. It is not the same thing as emergency contraception, or the “morning-after pill.”

**Sexual Assault Counselor/Advocate-** A staff member or volunteer at a rape crisis center who represents and supports a victim of sexual violence with the victim’s permission. The counselor/advocate provides the victim with counseling, advocacy and options available to the victim through the medical, legal and counseling process.

**Sexual Assault Forensic Exam Kit-** A designated box or bag containing envelopes and other items for holding possible evidence from a sexual assault forensic exam. Examples are envelopes of debris (e.g. leaves, grass, sand), hair combs and small boxes or envelopes for vaginal, anal and oral swabs. Clothing and other relevant items are also collected and placed in the kit. The kit is sealed and signed by everyone who handles it (e.g. the examiner, police, lab staff); this list of names is known as the chain of evidence or chain of custody. Many states have specifically designed dedicated kits. Another term for sexual assault forensic exams is physical evidence recovery kit (PERK).

**Sexual Assault Nurse Examiner (SANE)/Sexual Assault Forensic Examiner (SAFE)-** A registered nurse or physician trained to provide comprehensive care, timely collection of forensic evidence and testimony in sexual assault cases.

**Sexual Assault/Rape Crisis Center-** Facilities that provide crisis counseling and intervention to victims/survivors of sexual violence and their significant others (most 24 hours a day) as well as information and referrals.

**Sexual Assault Response Team (SART)-** A multidisciplinary team working collaboratively to provide specialized services for victims of sexual violence in the community. The team includes at a minimum, a medical director, a sexual assault forensic examiner, a sexual assault counselor/advocate, a law enforcement representative and a prosecutor. Other members of the community can be part of the team.

**Sexual Violence/Sexual Assault-** Any time a person is forced, coerced and/or manipulated into unwanted sexual activity. Sexual assault is legally defined in states.

**State/Territory Sexual Violence Coalition-** State/territory-wide network of sexual assault crisis programs which work to end sexual violence through victim assistance, community education and public policy advocacy.

**Victim vs. Survivor-** When a person presents at the emergency department after a sexual assault, the person has been victimized. The person eligible for crime victims’ compensation and the police, generally speaking, view the person as a victim of crime. In the anti-sexual assault field, the term “survivor” is also used to describe a victim of sexual assault, because they have lived through this terrible experience. “Survivor” is often a personal term which victims/survivors may use once they have reached a certain stage of healing.