

**SANE models in New Jersey and Michigan**

This material is excerpted from *Resisting Rape Law Reform*,  
forthcoming from New York University Press (2012)

Rose Corrigan  
Assistant Professor of Law & Politics  
Drexel University  
rose.corrigan@drexel.edu

## Two SANE models: New Jersey and Michigan

### *New Jersey*

In many ways the response to rape in New Jersey resembles that in the other states included in this study. Advocates in New Jersey contributed stories typical of and consistent with generally-observed problems with medical care: physicians and nurses unfamiliar with the rape kit, long waits for treatment, and a distinct lack of sympathy for rape victims. Unlike most other states, however, access to medical care was rarely mentioned as a problem since New Jersey is a small and very densely populated state with a large number of health care providers. RCC staff described attitudes from police that were consistent with problems nationally, such as questioning rape victims in public locations, refusing to let advocates meet with victims, and openly accusing victims of lying. Advocates in the state were overall more likely to describe tense and uncooperative relationships with police and prosecutors. Some of the difficulties in New Jersey may stem from criminal justice agencies that are likely to be better-funded, more professionalized, and more highly fragmented than in other states studied—these types of agencies may be more resentful of RCC intrusions into their “turf.”

In 2001 New Jersey became the first state to require SANE-SART programs. The legislation requires each county to establish (or to collaborate or contract with a neighboring county to share) a SART program. Advocates interviewed in 2001, one year after the law was enacted, described the difficult process of implementing the law against the backdrop of persistent resistance by medical and legal personnel to treating rape victims with competence and compassion.

The New Jersey SART program sets up a working relationship among rape care advocates, medical personnel, and law enforcement that is intended to provide all with equal power to shape the program and ensure a timely and effective response to victim needs. In this vision, it shares characteristics with other documented efforts to develop a more inclusive, less combative or

oppositional relationship with law enforcement (Campbell and Ahrens, 1998; Martin, DiNitto, Byington et al., 1992). Consistent with research on SANE-SART programs nationally, the initiative has produced significant benefits in some counties.

But the optimistic assessments do not reflect the struggles of most local centers in this state. In many counties SART has exacerbated existing problems and created new, unexpected ones. Law enforcement has edged out RCCs as the dominant player in defining the scope and delivery of services for rape victims, and the entanglement of RCCs with law enforcement has brought significant pressure to bear on RCCs to generally minimize the type and scope of advocacy efforts for rape victims.

In New Jersey, the SART playing field is heavily tilted in favor of the interests of prosecutors. Funding for the program is channeled through the state Office of the Attorney General, via the Department of Law and Public Safety, which is also responsible for handling and investigating complaints about county-level investigation and prosecution of sexual assault cases (An Act Establishing a Statewide Sexual Assault Nurse Examiner Program, 2001). Since funding for the program was administered by state law enforcement, advocates report that prosecutors are treated as the most important member of the SART.

In theory, any one of the three team members—rape crisis, prosecutors, or medical providers—can apply to administer the SART grant. But in practice, prosecutors have taken control of the program in almost every single county, often over the protests of advocates. The county prosecutor is given responsibility for hiring the SANE program coordinator, who would in turn be responsible for hiring and supervision of individual SANEs, as well as developing and implementing protocols and training for SART team members. This directs to county prosecutors—not RCCs—a significant share of the \$1.13 million in state funding to SART.

Prosecutorial control of SART programs has led to two typical outcomes: prosecutors who assumed formal leadership but refuse to move forward, despite the prodding from advocates, and those who took control of the program and implemented it aggressively, often without consulting rape crisis centers.

Some advocates battled their local prosecutor's offices over ownership and control of the SART programs. But, as one staffer said wearily, resistance from the prosecutor's office is difficult to overcome.

In [our county] the prosecutor has the [SART] grant. They do not have a SANE coordinator, they do not have a SART coordinator, they have no idea when they're starting, no SANEs hired... There's a lot of issues—they haven't gotten anything done. ... We care about the [SART] program.... I don't know if that's always true when it's in the prosecutor's office. (New Jersey, suburban)

Another advocate's efforts to get the SART program going were derailed when the prosecutor moved in to take control. The potential conflicts of interest in this relationship led her to question whether a cooperative, victim-centered response to rape was really the goal of the program.

Our county has been one of the most resistant in terms of getting [SART] going. I was given a grant to hire a SANE coordinator and I did and then several months later I was told that the grant was being transferred to the prosecutor's office. I wrote the grant, and got the grant, and the picture started changing pretty quickly. And the next thing I knew the [SANE coordinator] was being offered a desk at the prosecutor's office and they were doing the background check. ... The way the state has pushed this is now the nurse is hired and supervised by law enforcement, and it's really hard for me to see how when your paycheck comes from that group, how you can really be separate from that. (New Jersey, urban)

In either case, rape care centers are at a disadvantage. The downsides to SART are not just about struggles for political power with prosecutors. Advocates fear that a strong, highly visible connection between law enforcement and SART associates RCCs too closely with the criminal justice system, potentially compromising their independence in the eyes of rape victims.

If we are perceived as part of a team which includes prosecutors that treat the survivor badly, then [the survivor] may not get the help they need—the emotional support and the therapy and counseling. (New Jersey, suburban)

Advocates argued that once control of SART programs had shifted from medical and RCCs advocates to prosecutors, the tenor of the program itself changed. Prosecutors, who almost certainly prioritize forensic evidence collection over medical and emotional care for victims, were recruiting and hiring SANEs who saw the primary purpose of the program as evidence collection, not a more holistic and caring response to victims. This is consistent with recent studies showing that SANEs with a strongly prosecution-oriented approach are less likely to provide complete, victim-centered medical care,<sup>1</sup> but in 2001 was still a surprise to rape care advocates:

The focus of many of the [SANEs] has shifted from what is truly victim-centered to “I’ve got to get my evidence. I have to make sure everything’s documented properly,”—where that becomes the real motivating factor instead of what is best for this victim. ... I used to think, when we started ... that law enforcement—they were the member of the team we were going to have problem with. ... I never expected it to be from the nurses. (New Jersey, suburban)

And, with their training in the psychological aftermath of rape, SANEs in some counties not only saw their role as medical providers, but as offering sufficient emotional support so that RCC advocates were unnecessary. An RCC director expressed her discomfort with sending out volunteer crisis intervention counselors to SART calls because of the combative environment, with SANEs and police generally allied against the representative from rape crisis (New Jersey, urban). Another advocate stated bluntly that “one of [the] long-term goals [of SART] is to push the rape care advocate out” of the systems response to rape (New Jersey, suburban).

Nor are these problems isolated to particular counties in New Jersey. Indeed, only a few years after implementation the conflicts had become so entrenched that additional legislation was required in order to fix what had become widespread problems with SART. The New Jersey

---

<sup>1</sup> Patterson et al. analyzed data from three different types of programs: those which ranked as their primary goal as High Prosecution, Community Change, or Low Prosecution. The authors found that programs which prioritize prosecution were significantly less likely to provide victims with information about sexually transmitted infections, risk of pregnancy, emergency contraception, or safer sex practices. Overall, the authors found that “programs in the High Prosecution cluster provided fewer services than did those in Community Change cluster and the Low Prosecution cluster” (Patterson, Campbell and Townsend, 2006, 183).

Coalition Against Sexual Assault (NJCASA) released several official position statements that reiterated the importance of the role of rape care advocates and questioned law enforcement practices that infringe on the rights of rape victims. NJCASA pointed out that “despite the current New Jersey state statute... and the Attorney General’s *Standards*, many survivors of sexual violence are not made aware of their right to have confidential advocacy services or it even in cases where they are notified, many survivors are forced to endure extensive, probing questions and medical procedures without the support of a trained, confidential advocate, as codified by [state law]” (New Jersey Coalition Against Sexual Assault, 2006).

But the structure of the SART program itself may effectively quash the articulation and investigation of other significant problems at the local level. In addition to pitting RCCs against law enforcement, the NJ mandate creates perverse disincentives for advocates to confront problems with SART collaborators.

Concerns about advocacy for victims are heightened by the funding structure and accreditation requirements imposed by the SART law. In the pilot years of the program, participation in SART was voluntary and offered centers much-needed additional funding. As a result of the 2001 law, SART has become a requirement for RCCs to maintain their accreditation and funding by the state of New Jersey.

Our SANEs ... are all being funded through the Attorney General’s Office. It’s not the way rape crisis envisioned it from the beginning, but we were under a lot of pressure to get on board with it, and all the counties that I am aware of that had problems with it, it was a money issue. So when they were offered money, and wrote the grant, got the money, implemented—it’s most of the counties. What do you do? Still, who is paying the bill? There’s an implication there, who you’re really working for. ... I know that there seemed to be a lot of pressure from [the state oversight agency] to get on with SART. Well, it was written into the grant [for state funding to support centers], so to speak—that’s pressure.

Prosecutors who oversee SART grants also distribute victim assistance grants coming from the state, putting them in charge of a significant portion of RCC budgets. Though SART was intended to create a mechanism to address problems, it has also made advocates even more acutely

aware that much of their funding is administered by the very agencies they are called upon to oversee.

Everyone walks a very fine line on the local level ... especially the ones whose prosecutors hold their [SART] grants. How the hell can you go out there and start bashing the lack of prosecution and bashing the law enforcement procedures and then send your [volunteer] advocates out there in the middle of the night to face those same law enforcement officers? ... Now we're set up where you're bringing attention to their inadequacies and then saying, "Oh, but we want to be part of your [SART] program, and give us our funding." I think that's very difficult. (New Jersey, suburban)

Long before SART was developed, most RCCs were involved with some sort of systems advocacy to improve services to victims. Activities ranged from fighting to have cases re-assigned to a new investigator, to making statements supporting victims bringing official complaints, to praise and recognition for individual law enforcement officers who treated victims well. The close working relationships demanded by SART can provide a new avenue to criticize or attack RCCs, which are by far the most vulnerable member of the team.

We internally developed a grievance [procedure] among team members—I know what your role is supposed to be, you know what mine is supposed to be. It's become a tit for tat—"You screwed up last week so..." It's tough. ... We tend to criticize the same [police] departments over and over again—there are two or three of them. Well, they are gunning for us to make a mistake. And that's hard. That kind of set up with everyone watching everyone else could be positive but I think it's going more negative now. (New Jersey, suburban)

Given the negative climate, this particular director felt that she often could not risk advocating for survivors if it involved criticizing SART team members. She described the incident of a child victim whose case was dismissed by the grand jury because of police errors during the investigation:

[The victim's relative] was picketing the prosecutor's office and I couldn't even go out there and support her. As an agency I was not permitted to go out there and support her. We couldn't jeopardize our standing—we had just started SART. I couldn't jeopardize it by being out there protesting the prosecutor's office. ... And I felt bad about that. There are so many good things that could come out of SART that I felt like I couldn't jeopardize that. I guess I had to weigh that. Having SART was a better program than not having it. So maybe more good will come of that... I guess that's why I waited it out. (New Jersey, suburban)

Despite her desire to help, and her firm belief that the police had lost the case through sheer incompetence, this director believed that public criticism would backfire. An advocate from a

different county described an almost identical story, with the same concerns about advocacy for individual victims versus angering law enforcement by going public with their mishandling of a case.

In the current climate, however, some centers believe that the harder they push to implement SART and work on problems with law enforcement, the greater the possibility that their funding from these sources will be compromised or cut. These fears reinforce the perception that RCCs should handle problems with other team members quietly, not through open confrontation or formal grievance procedures. Several advocates said that they feel funding administered through the local prosecutor's office comes attached with expectations that centers will not make trouble—and most of them don't. Though rape crisis advocates did not have a long history of public confrontation with law enforcement agencies *before* SART, they now perceive their continued existence dependent on participation—and the silence about institutional problems that seems to require—in the program.

The emphasis on maintaining relationships and not antagonizing law enforcement has eliminated almost all public discussion about inadequacies in the state response to rape. Every director I interviewed preferred to work out disagreements through private channels in order not to antagonize public officials, jeopardize their funding, or compromise access to and treatment of victims. This accommodationist stance has ensured the survival of centers; it also reinforces public perceptions that the treatment of victims and prosecution of sex crimes have improved dramatically in the state. This effectively eliminates the possibility that advocates could or would employ a key tactic of the anti-rape movement: mobilizing community pressure to hold officials accountable and/or reform these systems. Lacking the political power or organizational resources to protect themselves or victims, RCCs have made a Faustian bargain to focus on individual advocacy which ameliorates some individual problems at the expense of the more risky strategy of public intervention. But given that most rape care programs in New Jersey receive insufficient state funding

to cover basic operating expenses, the potential loss of criminal justice funding would be a disaster. As a result, RCCs are clearly not well-positioned to engage in mobilization against criminal justice officials.

The unfolding of the legislative mandate in New Jersey illustrates the double-edged sword of closer relationships between community RCCs and law enforcement that SART programs require. In some communities, when partners are willing to acknowledge problems and pursue solutions, these collaborations can produce real benefits for victims and perhaps greater community and systems support for the work of community-based rape care advocates. But when systems are already premised on distrust and struggles over resources and legitimacy, SART programs can refigure these relationships in ways that compromise post-rape medical care for victims and the independence and advocacy of RCCs.

### *Michigan*

Hospital- or law enforcement-focused program are not the only ways to provide post-rape and forensic evidence collection to rape victims. Victim advocates in Michigan have developed a way of providing medical care to victims while challenging the “ownership” of the sexual assault exam by medical and law enforcement personnel. These advocates have combined one of the newest ways to provide care for rape victims—SANEs—with an old idea: that medical and legal institutions do not necessarily offer a supportive and respectful environment to victims. In Michigan, many local rape crisis centers have “taken rape away” from the state by setting up community-based sexual assault nurse examiner programs (CB SANEs), which offer forensic medical services to rape victims in locations other than hospitals.

While advocates offer a variety of reasons for these programs, a consistent theme is criticism of the continued resistance by legal and medical personnel to provide rape victims with minimally adequate services. Furthermore, CB SANEs can provide a measure of protection from hostile or

disinterested officials and institutions described by advocates in communities across the country. In creating CB SANEs, advocates have taken ideas that animated the original anti-rape movement—respect for a victim’s privacy, autonomy, and choice, insistence on providing a full range of effective medical care, and ensuring a compassionate response to victims and their families—in ways that go beyond the typical hospital-based SANE model. These centers not only offer quality medical care but also challenge the primacy of both law enforcement and medical expertise in determining care for survivors of sexual assault. While there are clear limitations with the move to distance post-rape medical care from the state, CB SANEs may also provide rape care advocates with significant opportunities to increase their independence, broaden their base of community allies, and hold police and prosecutors accountable for their failure to enforce the law.

As of May 2009, approximately half of the programs providing specialized post-rape care in Michigan are CB SANE programs.<sup>2</sup> I refer to these programs as “community-based” when all programmatic decisions are made by RCCs, including program funding, developing exam protocols, and hiring and supervising SANEs. Medical partners may have input in these decisions, but generally all entities agree that the responsibility for the program is in the hands of the RCC.

CB SANEs take a variety of forms, and sometimes look like SANE programs in other communities; the difference in Michigan is that the programs are totally controlled by RCCs regardless of the location. There were three models common across Michigan: RCC-supervised SANEs on-call for several hospitals in the area; programs operated by rape crisis and housed at a central hospital facility; and non-hospital-based SANE services. Depending on the type of CB SANE and the local protocol, the victim might be transported to an exam facility (in the community or at a central hospital), triaged over the phone by the SANE, or be treated in the hospital by an on-

---

<sup>2</sup> My own interviews included equal numbers of traditional hospital-run and CB SANE programs.

call SANE. Non-hospital programs may be housed in a forensic exam suite at the agency itself, or at a local community partner such as a county health department or a Planned Parenthood.

Because RCCs are responsible for overseeing the program they are also charged with raising funds for the CB SANE program and its related components. In a few cases private groups or medical facilities donated equipment for the CN SANE, but in other cases centers have had to raise up to \$50,000 to equip a SANE forensic suite with an exam table, colposcope, treatment supplies, and so on. Centers also take on the responsibility for on-going funding, typically supported through a mix of contributions from law enforcement (police and prosecutors), state/city grants or contracts, and community support. Many centers bear the financial burden of sending nurses to the SANE training, often asking for a minimum commitment to the center in exchange for the training. Though RCCs control these programs, almost all CB SANE programs report close collaboration with local medical personnel on hiring and supervising SANEs.<sup>3</sup>

Advocates whose agencies run CB SANE programs assert that the non-hospital approach has several important benefits: it provides the highest level of privacy for victims; offers services in a calm and supportive setting that privileges the needs of victims and advocates; and permits nurses to treat victims with the confidence that both medical and forensic needs can be handled appropriately. They further reported that the CB SANE was a good approach for ensuring high quality medical care without the need to oversee multiple hospitals within a service area.

Since rape crisis controls the exam process completely they are less likely to press victims to report to the police, and usually will complete the rape kit whether or not victims choose to speak with the police. In contrast to research showing lower levels of criminal justice involvement in

---

<sup>3</sup> Sometimes arrangements are quite formal—centers may have medical personnel (a doctor or experienced SANE) who serves as a paid medical director of the program. In other centers this role may be filled in an unpaid capacity by a doctor or nurse who is a volunteer and/or board member. One additional important function of consulting physicians was to provide standing orders for commonly-prescribed medications to treat sexually transmitted infections or prevent pregnancy, thus avoiding potential conflicts with hospital procedures.

SANE-only programs (Nugent-Borakove, et al., 2006), several directors said that they believed that because victims were were *more* likely to report to the police since they were respected and supported through the post-rape exam by nurses and advocates alike. Many CB SANEs also provided on-site storage of completed rape kits, usually for three to six months, and have staff make periodic contacts with victims to check in on how they are doing and to remind them that the evidence is available should non-reporting victims wish to go to the police.

Advocates who work with this set-up praise it highly, as did the nurses I interviewed in the state. They spoke with fierce pride about their ability to provide a safe, comfortable, dignified setting for victims, their ability to ensure that victims were given all appropriate medical treatment, and that experiences with the medical and legal personnel were determined by the victim's best interests rather than the convenience of those staff. Though there are certainly drawbacks, such as victims who don't want to travel to the SANE location, overall advocates reported that non-hospital programs worked extremely well to ensure high quality care for victims and also a safe, comfortable working environment for nurses and RCC crisis counselors. One advocate whose center had a non-hospital CB SANE program recounted how the usual difficulties with medical and legal providers have the impetus to bypass them completely:

We were seeing that people didn't know how to do a rape evidence kit. ... [T]hey would ask the advocate to do it. That's just, like, one example of a million horrible ones. There would be fights over getting blood draws from victims, you know, sometimes victims would wait for hours in the emergency waiting room, sometimes they would leave! I mean, it was really bad. ... I think once [hospitals] started getting educated that there were other alternatives, then they became interested. That there was actually a solution to the problem. That we could change it. And so our sexual assault nurse examiner program opened [several years ago]. And it's located in an advocacy center, which has its challenges, of course. ... If you don't have a nurse examiner program in your community [controlled by the RCC], you're still at the mercy of hospitals and police departments, that really don't know what they're doing yet, and will still charge [a victim for being seen in the ER]. ... [W]e know that the way that we've set up is really different, is really unique. For some communities, [SANEs] are not tied to their advocacy center at all, and we just can't even imagine that. ... [F]or the most part it's been really great. The headaches are worth the progress that we've made, I'll say that. (Michigan, suburban)

Directors whose centers set up CB SANEs reported that they did so because hospitals had shown repeatedly their lack of interest in serving rape patients. Advocates reported that hospitals were generally delighted to wash their hands of victims and let the CB SANE handle these difficult, time-consuming, and medically uninteresting cases. Two advocates whose organizations run CB SANE programs described their process of deciding to launch a community-based program, and the reactions from hospital staff.

*SANE:* We went through options of a free-standing location or hospital-based, too.

*Interviewer:* So why the decision to make it free-standing?

*SANE:* Because as ER nurses ... we realized that nobody wanted to take care of ... sexual assault patients. We figured our program would be a lot more successful to the patient-victims and for the providers if we could get those patients out of the ER. ... Nobody wanted to handle [a rape victim]. Not the nurses, not the physicians. ...

*Interviewer:* Was the hospital okay about letting those cases go? Did they fight for them at all?

*SANE:* [They were] eager! They kept asking, “When are you going to start? Come on, come on! Get it going here!” (Michigan, urban)

I had been in the ER when a domestic violence or sexual assault victim went in for treatment. It was far from high-quality. There were no female ER physicians. We had a lot of problems with the male doctors not being trained, not understanding the dynamics of sexual assault or domestic violence. So part of it was based on negative experience and part of it was based on the fact that it was a small community that needed a confidential service rather than a person coming into the ER with six police officers walking behind her. ... [The hospital staff] were very happy about this program opening. In fact, months before they were like “Ummm... When are you opening?” They really had no desire to keep sexual assault exams in the emergency department. ... When they looked at how it takes a nurse 3-4 hours to handle this—she can’t go to other patients—they figured out for financial reasons that it did not benefit them to keep these examinations there. They were more than willing to say, “You go ahead!” (Michigan, small city)

CB SANEs may also produce some additional role conflicts for nurses, especially the tension path between being a forensic nurse and being an advocate for the victim. But one SANE I interviewed saw these as complementary rather than in tension. She linked the increased attention to forensic documentation with providing better advocacy and more choices (especially about whether to prosecute at some point) for victims.

We do a really good job with documenting a medical forensic report on these cases. I think in the day and age where medical care tries to stay neutral to the point of passivity, they rarely document when a victim comes in, whether it be domestic violence or sexual assault, even in our ER, victims never get a picture taken [to document physical evidence of assault]. (Michigan, urban)

She went on to point out that though there can be real conflicts and tension over the SANE role, these can be reconciled (and should be, in her perspective) in favor of victim care.

When we first started our programs we [sent] a lot of mixed messages. ... When you go back and look at some of our literature that we produced early in our program, it talks about fighting crime and putting perpetrators away and that's the reason we're here. I think we've really clarified a lot of those issues in the last [few] years. ... Over the years with what's happened in the legal system, that role has become much more clear. I don't feel at all like I am an arm of law enforcement. I feel that I truly am here to provide medical care and make sure the patient is safe and that we provide follow-up that we can preserve their health. Move them into recovery as quickly and as healthfully as possible. (Michigan, urban)

The idea that CB SANEs could enhance the law enforcement response to rape while simultaneously remaining independent from those systems was echoed by a nurse from a non-hospital CB SANE program:

*Interviewer:* Do you ever worry about a conflict between victim care and law enforcement's interests?

*SANE:* We do. We had people who were like "You have to have your nurses commit to the investigator or the medical programs." Not being a nurse, I didn't understand this argument in the beginning. What I've grown to appreciate about that is that there is conflict often times in other communities. And you really have to make a stand that, "I am one hundred percent out of the investigative loop. My job is all about victim care and support and we're not going to bend any of our policies to help your investigation." That's a system, and we're not in that system.

*Interviewer:* When you say "we," who do you mean?

*SANE:* The nurses and the advocates in the SANE program. We are just not a part of the system. That's one perspective. The other perspective is, we can't. You know? I can't have a foot in the system and still make sure that the victim's rights are upheld and that they understand that they have the power to make a decision that will effect the rest of their life. We still talk nice to [the prosecutor] and law enforcement. Whether that's riding the fence or not ... well, we've found a way to do it in this community. It doesn't mean we don't butt heads sometimes. I've had officers show up sometimes and I can tell right away that they have a very different agenda. I have to make sure—even at the risk of making the law enforcement office mad—that I do my job. If I think that he's treating the victim inappropriately, then I'm the first person to say "Look, we're not going to do this that way." ... We pride ourselves on the fact that our number one priority is victim care. (Michigan, suburban)

Nurses in CB SANEs may be somewhat naïve about their participation in articulating a particular theory about rape, trauma, recover, and the intersection of legal and medical care. Nevertheless, the CB SANE provides some additional independence for nurses, and permits nurses like the one above to contest the increasingly prevalent idea that SANEs are one more group of

neutral and objective professionals (Bumiller, 2008; Rees, 2010). The insistence on putting victim care and support before law enforcement needs meant that both advocates and nurses in Michigan expressed greater willingness to confront police about poor treatment of victims, even telling stories about refusing police access to victims and intervening in questioning when police were being abusive.

The benefits of greater RCC control over post-rape exams are not limited to the medical benefits for survivors. One RCC director estimated that local police were failing to submit approximately 75% of adult rape kits, and about 50% of child sexual assault kits to the state crime lab. The fact that the RCC rather than the hospital controlled access to rape victims meant that they knew who was coming in for exams and the RCC could follow up on their cases. This director had staff routinely checking on the status of rape kits with the state crime lab, and were able to use the power of the program to pressure the county prosecutor to require local police to submit rape kits.

The fact that we had that connection with the crime lab, and we could find out, “Did you get that kit that ... we submitted?” “No! No we didn’t!” We could start calling [the police], and find out “What did you do with that?” And so there is more intensive follow-up on every level. People don’t fall through the cracks as much as they used to. (Michigan, suburban)

These problems were only visible and the intervention facilitated because the RCC had their own records of how many rape victims were receiving care at their center. Rather than approaching the prosecutor as a supplicant—so often the case since prosecutors may control significant sources of grant funding for RCCs—control of SANE programs gives RCCs a valuable bargaining chip in their relationship with law enforcement, and access to independent information to confirm or question how legal institutions handle rape reports. Rather than have to negotiate, demand, or cajole well over a dozen police jurisdictions to turn in rape kits, the RCC in this county was able to elicit prosecutorial support, relieving some of the burdens for oversight from the shoulders of already over-stretched advocates.

Though improving care for sexual assault survivors is a worthwhile goal in its own right, the real benefits for centers themselves—separate from serving victims more compassionately and effectively—may be political rather than medical. Centers that had set up CB SANEs seemed more likely to report that they had strong, positive relationships with law enforcement and medical providers.<sup>4</sup> Furthermore, directors of CB SANE programs often spoke about developing alliances and relationships with community partners who were new to struggles over sexual assault. SANE programs can be a valuable tool for law enforcement, and their control by rape care centers seems to give those programs a firmer footing to address inadequacies and failures in law enforcement performance. By making the decision to simply provide medical care, rather than to continue fighting hospitals, Michigan RCCs which created CB SANEs made a tactical decision that won't change laws, but does enable them to channel their scarce resources into creating the programs they actually *want*, rather than subjecting victims and advocates to unsatisfactory or ineffective arrangements dependent on the goodwill of hospital administrators and personnel.

---

<sup>4</sup> I hesitate to hypothesize that this is a *result* of CB SANEs, though, since centers which created non-hospital might be more likely to have higher levels of funding, more staff, and more effective leadership, all of which could translate into better relationships with legal and medical personnel prior to the creation of a CB SANE.

## REFERENCES

- Bumiller, Kristen 2008. *In an Abusive State: How Neoliberalism Appropriated the Feminist Movement against Sexual Violence*. Chapel Hill, NC: Duke University Press.
- Campbell, Rebecca, and Courtney E. Ahrens 1998. Innovative Community Services for Rape Victims: An Application of Multiple Case Study Methodology. *American Journal of Community Psychology*, 26.
- Martin, Patricia Yancey, Diana DiNitto, Diane Byington, and M. Sharon Maxwell 1992. Organizational and Community Transformation: The Case of a Rape Crisis Center. *Administration in social work*, 16:123-45.
- New Jersey Coalition Against Sexual Assault 2006. Official Position Statement on a Survivor's Right to a Confidential Sexual Violence Advocate. Trenton, NJ.
- Nugent-Borakove, M. Elaine, Patricia Fanflik, David Troutman, Nicole Johnson, Ann Burgess, and Annie Lewis O'Connor 2006. Testing the Efficacy of Sane/Sart Programs: Do They Make a Difference in Sexual Assault Arrest & Prosecution Outcomes? Alexandria, VA: American Prosecutors Research Institute.
- Patterson, Debra, Rebecca Campbell, and Stephanie M. Townsend 2006. Sexual Assault Nurse Examiner (Sane) Program Goals and Patient Care Practices *Journal of Nursing Scholarship*, 38:180-86.
- Rees, Gethin 2010. "It Is Not for Me to Say Whether Consent Was Given or Not": Forensic Medical Examiners' Construction of "Neutral Reports" in Rape Cases. *Social & Legal Studies*, 19:371-86.