

Sanctuary in the Emergency Department

Establishing a Sense of Safety: Sexual Assault Exam Program and Environment

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Planning and Managing the Workplace

Phase B



“Medical care cannot be separated from the buildings in which it is delivered... [T]he quality of space in such buildings affects the outcome of medical care”

- Robert C. Horsburgh Jr.



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Intro

- S.A.N.E., S.A.F.E., and S.A.R.T programs
- Issue: therapeutic environment and process
- Importance of design and policy implementation





What are S.A.N.E., S.A.F.E., and S.A.R.T programs?

“SANE programs distinguish themselves from traditional ED care, not only by the comprehensiveness of services provided, but also by how practitioners interact with sexual assault patients” (Campbell, Townsend, Long, Kinnison, Pulley, Adames, & Wasco, 2006).

S.A.N.E.: Sexual Assault/Abuse Nurse Examiner
 S.A.F.E.: Sexual Assault/Abuse Forensic Evidence
 S.A.R.T.: Sexual Assault/Abuse Response Team

} interchangeable

The SANE program operates with a collaborative multi-disciplined team approach.

- “Trauma-informed physical and mental health care” (Jane Doe Inc., 2001).
- The staff consists of specially trained nurses, physicians, and counselor-advocates.
- The continuum of care (multiple disciplines) includes child-protective services, law enforcement, and homeless/domestic violence shelters.
- 24-hour-a-day first-response care from specially trained SANE nurse and counselor-advocate



Medical Center
 SANE Program
 24-hour-a-day first-response care from specially trained SANE nurse and counselor-advocate
 Office line: 607.327.3200



How did the SANE program come about? What needs should be met by SANE programs?

SANE services “represent a variety of interests: for victims, services for their physical and emotional health; for public health, services for screening and treatment; and for prosecution, procedures to obtain forensic evidence documenting the crime” (Campbell et al., 2006).

“Sexual assault victims have extensive medical care needs, including injury detection and care, forensic examination, screening and treatment for sexually transmitted infections (STIs), and pregnancy testing and emergency contraception (EC). Victims traditionally have been advised to seek this treatment in hospital emergency departments, (EDs) but previous research suggests that most patients do not receive the services they need in these settings. To address these gaps in patient care, nurses created Sexual Assault Nurse Examiner (SANE) programs throughout the United States **to provide comprehensive medical and emotional care** for sexual assault victims” (Campbell et al., 2006).

SANE programs offer a variety of services, to a variety of different people, and vary from one Emergency Department to the next depending on the particular needs of the local community.

- Medical
- Emotional
- Legal



Issue: emotional safety

“SANE programs were to distinguish themselves from traditional ED care by being more responsive to victims’ emotional needs” (Campbell et al., 2006).

Multi-faceted issues facing sexual assault survivors

- Psychosomatic
 - Physical injury
 - Mental trauma
- Psychosocial confusion

SANE staff must keep in check feelings/senses of

- Safety
- Dignity
- Comfort
- Support
- Trust
- Orientation
- Privacy



Importance of design and policy implementation:

Benefits for implementation of a therapeutic environment and process

“Our developing understanding of the longer-term health impact of sexual assault must be used as the basis for the development of new programs and models” (Jane Doe Inc., 2001).

- Avoid / mitigate unforeseen patient costs
 - “Hospitals may be more amenable to assuming SANE program costs after learning that they are already assuming hidden costs associated with treating victims in a far less efficient manner” (Houmes, Fagan, & Quintana, 2003).
 - “The health effects of violence against women are extensive. In addition to possible acute injuries sustained during sexual assault or dating or domestic violence, physical sexual, and psychological abuse are linked to numerous adverse chronic health conditions. These include arthritis, chronic neck or back pain, frequent migraines or other types of headaches, visual problems, sexually transmitted infections, chronic pelvic pain, increased gynecological symptoms, peptic ulcers, and functional or irritable bowel disease” (“Improving the Health,” 2006).

- Improve staff morale; reduce turnover
 - “Secondary traumatic stress” (also termed “vicarious traumatization”) – occurs when patients’ emotional trauma begins to affect staff as if it were happening to them directly. A therapeutic environment would help to alleviate this process.
 - A therapeutic environment implies that the staff is also valued



Analysis – Behavior Profile Approach

- Profile analysis
 - Who
 - What
 - Where

- Role-playing; problem analysis
(at Cayuga Medical Center; current and recently renovated Emergency Department)
 - Check-in
 - From entrance to SANE room
 - In the SANE room
 - The SANE bathroom
 - Interaction with staff

- Analysis of related settings
 - Domestic violence shelter
 - Mental Health / Psychiatric Facility
 - CMC radiation medicine



Profile analysis

“Sexual assault is not limited to a particular victim age, race, gender, or cultural background” (Houmes et al., 2003).

“Only 40% of the victims in the National Victim Center Survey (1992) and 49% of women in the Campbell et al. (2001) sample of urban sexual assault victims received information about the risk of pregnancy” (Campbell et al., 2006).

■ Who

- Varied groups – “non exclusive” (CMC SANE brochure)
 - College students, girls, boys, teens, women, men, elderly
 - Regardless of sexual orientation, religion, ethnicity, race, income level
- Feelings
 - Confusion, disorientation, fear, anger, helplessness, sadness, shame
 - Altered sense of trust; majority of the time the perpetrator is someone you knew and trusted (CMC SANE brochure)
- Who accompanies patient?
 - Child(ren)
 - Friend(s)
 - Family
 - Police escort

■ What

- Situation – what has taken place?
 - Rape
 - Domestic violence
 - Sexual abuse
- Services and information provided
 - Pregnancy test
 - Emergency contraception (EC)
 - Sexually Transmitted Infection (STI) and HIV prophylaxes
 - Forensic evidence collection
 - Referrals to other services (mental health, legal, shelter)
 - Safety planning (domestic violence)

■ Where

- Referred from
 - Police, student health center, shelter, family physicians, self-referral
- Discharged to?
 - Sometimes patients are fearful about going home, so establishing a sense of security as much as possible in the SANE environment is especially important
 - friend's/family member's
 - shelter



Role-playing; problem analysis

Check-in

“Once one enters the facility, rapport must be immediately established. There should be a clear indication of the procedure to follow, including where to obtain information” (Willis, 1980).

- **Way-finding**
 - Knowing where to go upon entering a ED waiting-room for all emergent patients can be blurred by operating in crisis mode.
 - A victim of sexual assault is especially vulnerable during the time it takes to get from the entrance to a private exam room out of public view.
 - An immediate visual connection with ED personnel is even more important than clear signage in reducing anxiety.
- **Privacy**
 - Check-in procedure for a sexual assault victim may feel like they are on-stage for anyone within site and earshot.
 - A triage nurse is sometimes available for private consultation during check-in; signage directs patients to check-in with triage nurse.
- **Waiting**
 - If the SANE exam room is occupied by other patients (during high-volume times this will happen due to other emergent patient-overflow) and ED protocol does not require immediate sequestering of the patient, the patient must wait in the public waiting room.

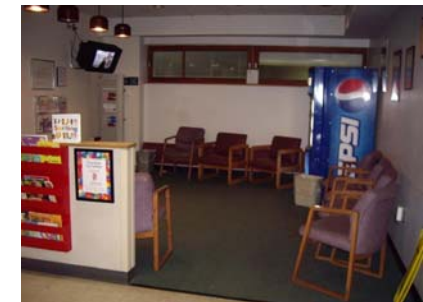
A patient may spend “4 to 10 hours in the ED before they are examined (Littel, 2001). During this wait, victims are not allowed to eat, drink, or urinate so as not to destroy physical evidence of the assault (Littel, 2001; Taylor, 2002)” (Campbell, Patterson, & Lichy, 2005).



Check-in window

Triage-nurse's office

CMC (current) view of check-in from entry door



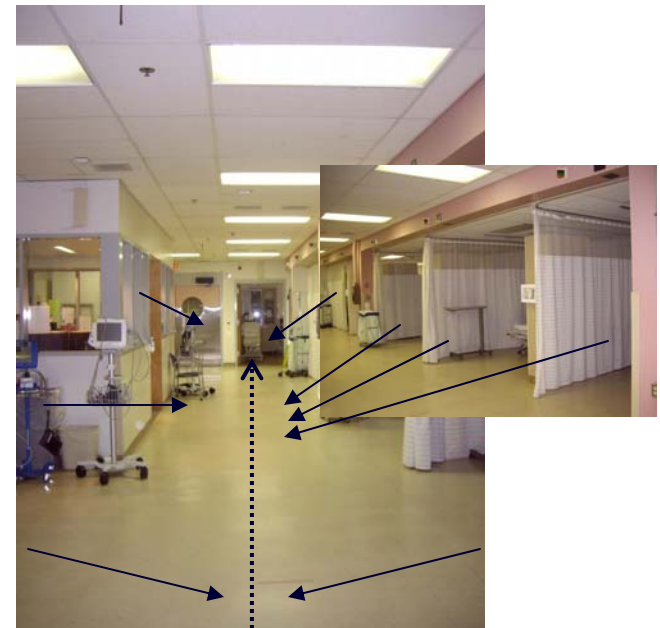
CMC (current) waiting area

Role-playing; problem analysis

Patient's approach to SANE room: Visual transparency to public, patient, and staff views

In both the current and renovated ED, the SANE room is located in the furthest corner from the entrance and waiting room.

- Feeling of paranoia; people looking at you, judging you
- Feeling of guilt in comparison of your trauma to other patients' conditions
- Pass by in full view of several other patients and visitors
- Passing by decentralized nursing station – feeling of being seen by several people at once



CMC (current) approach to SANE room



CMC (renovated) approach to SANE room

- > Lines of vision
-> Assault victim's pathway



Role-playing; problem analysis

Anti-therapeutic elements of the physical environment

*mental health facility
setting problem
analysis:*

“mirrors, glass, highly polished floors, and other reflective surfaces should be avoided, particularly in settings where social interaction often occurs. The reflections may create multiple images and distortion, compounding confusion” (Willis, 1980.)

Reflective surfaces / Mirrors

Concept of self at the time may be construed by physical appearance, which can intensify mental distress

CMC (current) perspective



SANE room entrance is here;
victim's line of sight goes straight to mirror

CMC (renovated) perspective



SANE room entrance is here;
victim's line of sight goes straight to mirror

Role-playing; problem analysis

Anti-therapeutic elements of the physical environment

- View of ceiling
 - During exam patient's view is unpleasant
 - Harsh florescent lighting, bright exam lighting
 - drab ceiling panels

- Window
 - small
 - Appears out of place

- Computer
 - Situated so that nurse must face away from patient during intake; very impersonal
 - Fastened to wall, prevents flexibility in seating configuration



Role-playing; problem analysis

Victim state of mind

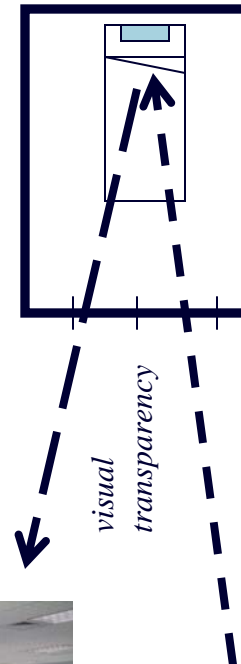
- If the exam table / bed is oriented to face the exam room door, it is also conceptually facing a space full of people
- If the victim-patient can see practically every station from the patient exam room, the patient may feel paranoid about who can see them
- The victim may feel metaphysical exposure even with the curtain barrier between themselves and the door



CMC (current) view from SANE exam table



CMC (renovated) view from SANE room



CMC (renovated) nurse's view of SANE room

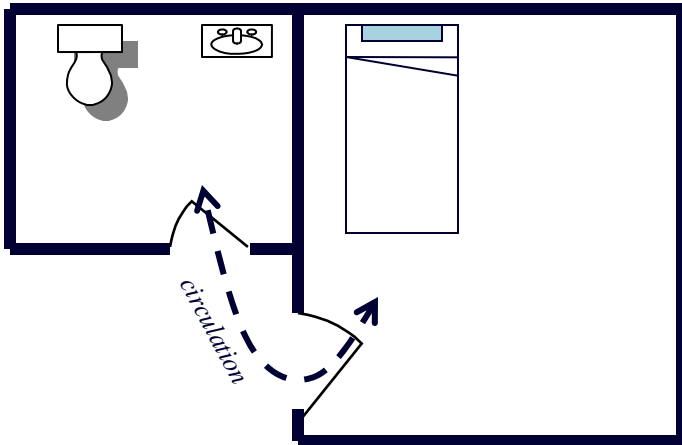


CMC (current) nurse's view of exam table

Role-playing; problem analysis

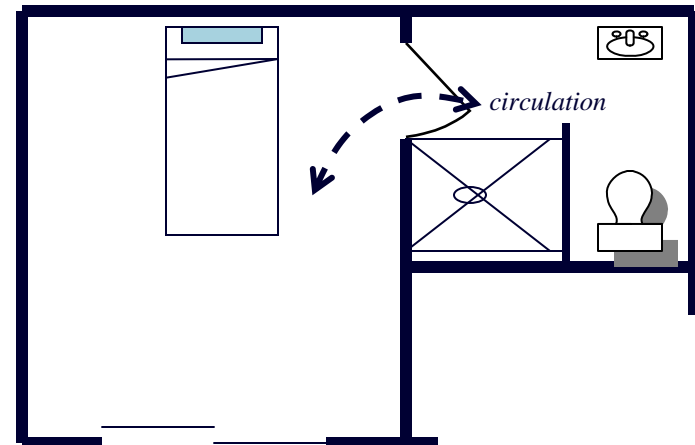
SANE bathroom configuration

Current SANE exam room bathroom - problematic



- Circulation from exam room to the bathroom back out into public view
- No shower / bath available for assault-victim

Renovated SANE exam room bathroom – problem has been addressed



- Direct circulation from exam room to the bathroom is private
- Private SANE shower available for assault-victim

Analysis of related settings

- Domestic Violence Shelter
 - Victims operating in crisis mode
 - Immediate need: physical safety
 - Therapeutic team approach
 - Security
 - Confidential location
 - 24-hour-a-day security

- Mental Health Facility
 - Patient-staff initial interaction is essential in establishing rapport
 - Furniture layout can facilitate or hinder therapeutic process
 - release / discharge procedures
 - Privacy
 - Ambiguous elements of environment can cause confusion

- CMC Radiation Medicine
 - Spa-like setting
 - Comfortable robes instead of gowns
 - Private changing rooms



Synthesis

Mission Statement:

to establish an environment that enhances a sense of safety, sanctuary, and dignity for the S.A.N.E./S.A.F.E. program

- Reevaluate protocol for SART (Sexual Abuse Response Team) collaboration
 - Collaboration within SART
 - Collaboration with other services

- Reevaluate protocol for SANE patient-staff interaction
 - Creating a supportive environment for patient
 - What / How to communicate to client



Synthesis

Reevaluate protocol for SART collaboration

domestic violence shelter protocol insight:

“The quality of relationship, communication, and trust among staff directly translates to the process with clients. Therefore, it is understood that in order to facilitate a safe, creatively rich, and healing environment, the staff must reflect these qualities among themselves as individuals in a group” (Madsen, Blitz, McCorkle, & Panzer, 2003).

- Collaboration within SART:
SART response to SANE case
 - Structured procedure establishes rapport with patients
 - Upon notification of SANE case, on-call SANE nurse and SANE counselor-advocate are called in
 - Sarah’s Law stipulates that either nurse or advocate arrive within one-hour of call

 - Collaboration with other services:
Continuum of care
 - Collaboration with domestic violence shelters
 - Referral to mental health support

“Because Rape Trauma Syndrome and Post-traumatic Stress Disorder are common in assault victims and often can be mitigated by proper intervention, early counseling and referral is important” (Houmes et al., 2003).

 - Flexibility for varied populations and referral to services for specific needs
- “Programs should be capable of examining and treating all patients, although some localities have specialized referral centers for adults, pediatric, and gay and lesbian populations” (Houmes et al., 2003).



Synthesis

Reevaluate protocol for SANE patient-staff interaction

Creating a supportive environment for communication

- Staffing protocol stipulates that someone is always with the victim-patient
 - Unless the patient would like to be alone, a nurse or counselor-advocate will sit with them while they are waiting
 - If the patient is accompanied by a child, either the counselor-advocate or nurse will sit with the child during the exam

- “A client’s current troubles are understood as something that has happened to her, rather than as something that is wrong with her” (Madsen et al., 2003).

- staff must work to understand the unique state a victim-patient is in, but remember that a person in crisis is still human and has multifaceted feelings and needs.

“As Maslow’s hierarchy is a theory of motivation based on high-achieving, health individuals, it may be that the prioritization of human needs shifts and changes like a kaleidoscope when humans undergo difficult or life-threatening experiences” (Clark & Malone, 2006)





Synthesis

Reevaluate protocol for SANE patient-staff interaction

“Most nurses indicated that the pelvic examination itself and talking about the assault were difficult for sexual assault victims. To address these and other concerns, they carefully explained all steps in the examination process. Nurses also mentioned that they try to be sensitive to victims’ emotional state by talking in a soothing tone of voice, not using medical jargon, reflecting a calm demeanor, moving through the examination at a pace comfortable for the victim, and reminding the victim that they were now safe” (Campbell et al., 2006).

What / How to communicate to client

“prevent revictimization – where individuals post-assault face the further indignity of an impersonal or inadequate examination” (Houmes et al., 2003).

- Skilled, sensitive medical care
 - All procedures, services, and information should be offered to patient as options; putting the patient in control of their situation.
 - Example of language used with patient: “Would you like me to take pictures for evidence for the police?”

- Establish routine procedure guidelines for dealing with a SANE-case, to ensure that patients are consistently receiving all aspects of medical attention, emotional support, and crucial information regarding their options for care now and in the future
 - pregnancy testing
 - EC (Emergency Contraception)
 - Forensic evidence collection
 - although patient is not likely ready to consider legal implications at the time, inform how forensic evidence collection now can be beneficial if patient decides to take legal action in the future
 - patients’ medical cost options
 - “Patients are eligible to apply for reimbursement of treatment costs under many state crime victim compensation programs” (Houmes et al., 2003).



“safe, comfortable, nonthreatening, and readily comprehensible set of surroundings. The messages sent by the physical environment convey sincere respect for the patient and sensitive concern for his or her physiological and psychological well being, which are important contributors to the therapeutic process” (Gross, Sasson, Zarhy, & Zohar, 1998).

Invention

- Therapeutic policy and process
 - Language: use SAFE instead of SANE
 - Volunteer staffing
 - Victim-patient arrival / check-in procedure
- Short-term: environment interventions in existing space
 - Small comforts
 - Monitoring patient / preserving privacy
 - Lighting
 - Window
 - Furniture
- Long-term: renovation or new construction
 - Overall concept diagram; adjacencies
 - Provide adjoining secondary SAFE room
 - Furniture



Invention

Therapeutic policy and process: Solutions that will help achieve a higher level of therapeutic performance

“Responsibility for assuming the role of the examiner has been claimed at times by family physicians, internists, obstetrician / gynecologists, pediatricians, emergency physicians, and even forensic pathologists. Those calling themselves Sexual Assault Forensic Examiners (SAFE) have included nurses, nurse practitioners, physician’s assistants, and physicians” (Houmes et al., 2003).

- Language: use SAFE acronym instead of SANE
 - SANE has negative connotations; the word is very close to “insane”
 - “safe” is the actual focus of the program
 - SAFE acronym also stands for process of recovery; “Safety, Emotions, Losses, and Future” (Madsen et al., 2003)
 - leaving out the “N” (for nurse) emphasizes the multi-disciplinary nature of the program
- Volunteer staffing
 - To mitigate strain on ED nurses for the one-on-one attention needed by a SANE case; so that other emergent patients can receive needed attention
 - Volunteers can assist in streamlining the intake process
 - Volunteers can be specially trained to provide comfort to patient until advocate/SANE nurse arrives
 - Volunteers can sit with victim-patient’s child / friend / family while nurse / advocate are with patient
 - Recruit male volunteers for on-call volunteer time-slots for (less-frequent) occasions where patient is male and/or when male child is involved.
- Victim-patient arrival / check-in procedure
 - when communication from dispatch notifies that a SANE/SAFE case is coming in, have available nurse/volunteer ready and waiting to “receive” patient and direct patient into SAFE room. This will help to establish rapport and ease anxiety in obviousness that there is a structured procedure
 - if available, bring victim-patient in through different entrance to improve privacy
 - Intake volunteer / SAFE nurse / advocate should go through intake forms with patient “in a single record-taking session. The client is thus not subjected to the indignity of undergoing repetitive questioning by various personnel in multiple locations” (Willis, 1980).



Invention

Short-term: environment interventions

- Small comforts
 - comfortable robes instead of uncomfortable, exposing gowns
 - provide option of a change of clothes - unisex and for all sizes
 - Blankets – exam table can be set up more like a comfortable bed before/after exam
 - teddy bears
 - offer tea, food
 - minimize chaos – maintain order in moveable elements (e.g., furniture) whenever possible
 - comfortable temperature

- Monitoring patient / preserving privacy
 - auditory
 - provide fan for option of white noise; if noises from outside patient room can be heard patient will assume others can hear what is being said in the exam room.
 - Provide CD player and varied options for therapeutic music choices, or even calming nature sounds. Leave option of music choice (music playing at all) up to patient
 - pull chord in bathroom
 - Allows patient to call for help if needed
 - Does not require nurse to be in or right next to bathroom while patient is bathing in case patient needs assistance



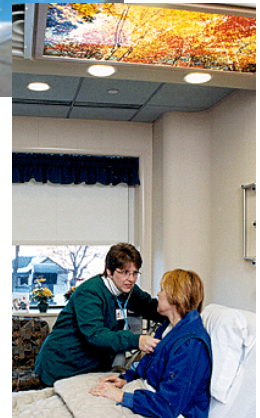


Invention

Short-term: environment interventions

“Local incandescent lighting of a residential nature, such as table and floor lamps, are more relaxing and effective than nonvariable ceiling-mounted fluorescent systems” (Willis, 1980).

- Lighting
 - provide option lighting with table and floor lamps before/after exam
 - diffused lighting fixtures in ceiling where possible
 - translucent nature view panels over fluorescent light panels
- Window
 - Provide option to client to have blinds open or keep closed
 - some patients may be experiencing paranoia and wish to have blinds closed
 - others may be feeling trapped or overwhelmed by the intensity of conversation with nurse/advocate and would feel relieved by “visual release... providing a reason for disengaging oneself from intense eye contact” (Willis, 1980).





Invention

Short-term: environment interventions

Room configuration

□ Seating

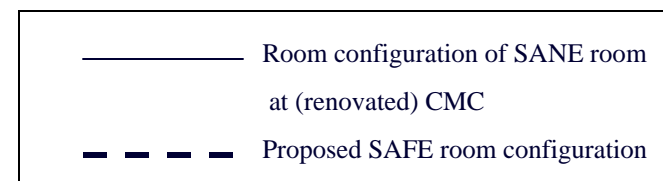
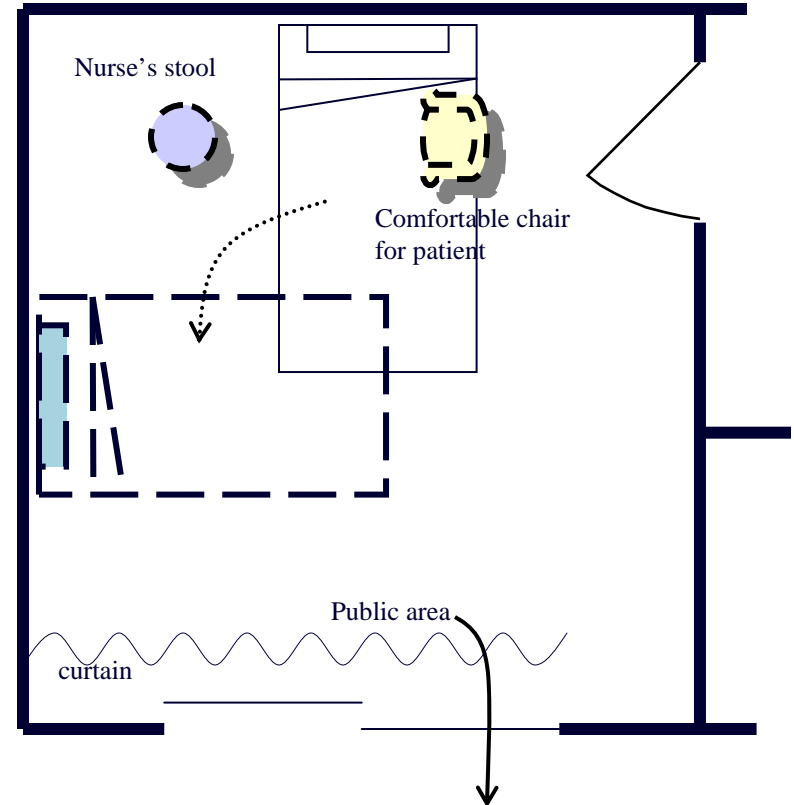
- Provide comfortable chair for patient to sit in before/after exam, instead of on the exam table
- Patient may feel trapped if nurse/counselor-advocate is between themselves and the exit

mental health seating configuration insight:

“It is preferable that the therapist does not occupy a chair between the client and a single entrance to the room, or the client may feel trapped” (Willis, 1980).

□ If possible, change the orientation of bed so that patient is not facing door during exam

- may help to mitigate the feeling of being exposed to the public area
- Sideways orientation offers option of additional privacy-barrier between patient and public area while sitting with nurse/counselor-advocate



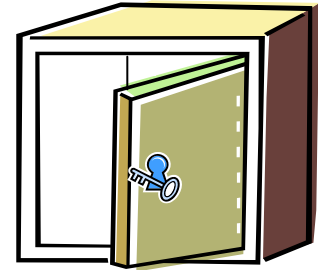


Invention

Short-term: environment interventions

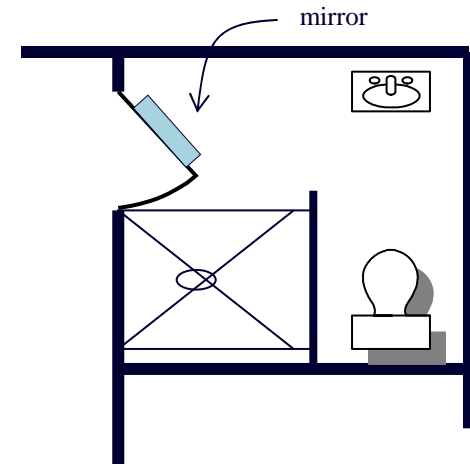
- Provide secure place for patient's possessions
 - High rates of theft in Emergency Departments
 - The patient's sense of security has to do with possessions as well as personal security
 - If patient leaves SAFE room, patient should feel confident that possessions will be safe

- mirrors
 - Eliminate mirrors except for one; located in SAFE bathroom
 - Locate small single mirror on the back of bathroom door (for patient privacy)



Domestic violence shelter setting insight:

“The [patient] must be assured that, even in a temporary environment, [they have] an identity and [their] possessions are respected” (Willis, 1980).





Invention

Long-term: renovation or new construction

Overall concept diagram; adjacencies to SAFE exam room

“People who are distressed seek privacy, and do not wish the exposure and social confrontation imposed by a large open public space” (Willis, 1980).

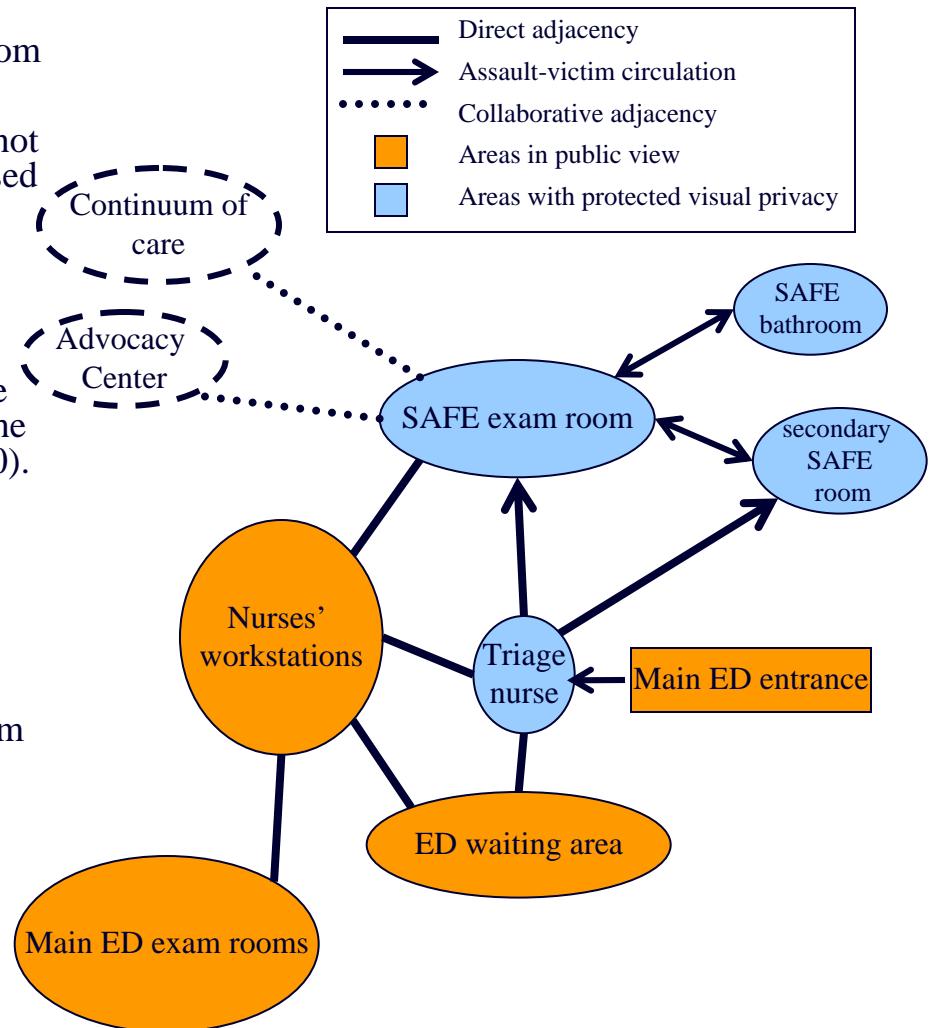
- Main ED entrance and triage nurse

“The information and reception counter should be easily accessible from the entrance, eliminating the need to walk through waiting areas” (Willis, 1980).

- Nurses’ workstations

- SAFE bathroom

- Secondary SAFE room (also direct adjacency from triage nurse station when SAFE exam room is occupied)



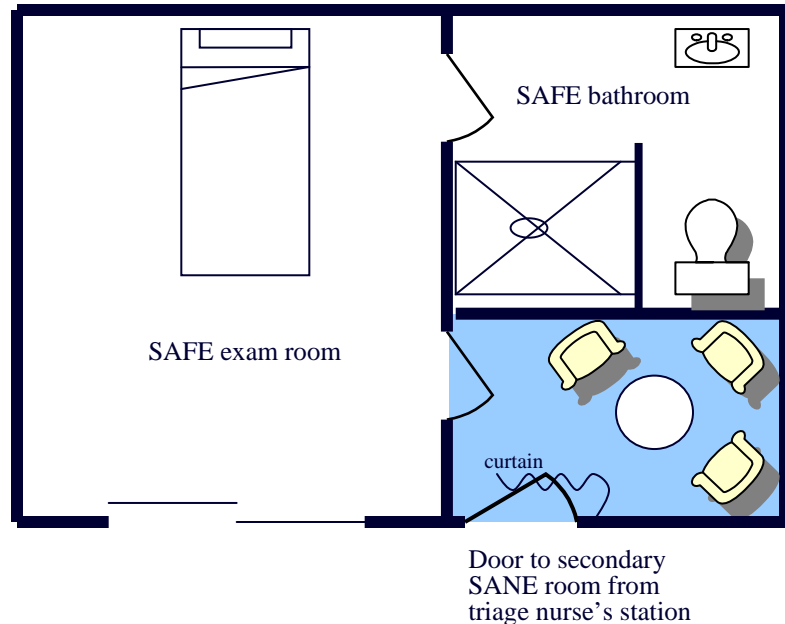


Invention

Long-term: renovation or new construction

“A minimum of one furnished examination room should be available, with an additional counseling or meeting room (with a telephone) designated for family members” (Houmes et al., 2003).

“Sliding doors with curtains offer the maximum flexibility to “visualize” patients and protect patient privacy” (Zilm, 2003).



Provide adjoining secondary SAFE room

- ❑ Counseling / meeting / sub-waiting room designated for SAFE
- ❑ In design layout, when the SAFE-bathroom is added, a “dead-space” is created – this space could be used for the secondary SAFE room
- ❑ Available for victim-patient to wait if SANE exam room is occupied by another patient (SANE case or emergent patient overflow during high ED volume)
- ❑ Sub-waiting room for friend/family
- ❑ Private, comfortable space for victim-patient’s child and counselor-advocate to meet during patient’s exam



Invention

Long-term: renovation or new construction

Furniture in secondary SANE room

- low round table for information pamphlets, *mental health setting insights*:
 - “for children, coloring or drawing pictures is therapeutic in handling a traumatic event. A child will almost immediately start to draw pictures interpretive of their feelings when given paper and crayons” (P. Surratt, child social-worker, personal communication, November 22, 2006).
 - “A central table provides people with a device for defining personal territory, and it is a fixture to which most people are accustomed” (Willis, 1980).
- Carpeting for a “softer” feel



“The seating group in this therapist’s office is open and flexible. Natural light and some residential-like accessories, including a low-center table, help establish a nonthreatening atmosphere” (Willis, 1980).



Invention

Long-term

- Computer: “C.O.W.” (computer on wheels)
 - instead of screen and keyboard attached to wall
 - facilitates mobility and nurse’s ability to face patient while typing to show that she is engaged

related mental health seating configuration insight:

“The therapist generally no longer sits behind his desk or work surface during the therapy session, which eliminates the imposing authority figure of the past” (Willis, 1980).

- “Universal” exam table
 - versatile/flexible design for different groups
 - ADA accessible
 - Different age groups; include children and elderly
 - Obese persons
 - Different genders



**CMC (current)
SANE computer
set-up**



C.O.W.



ADA accessible exam table



Conclusion

In future SAFE design, a User-Participation Approach would be beneficial

- “Advocacy and counseling groups, law enforcement agencies, and prosecuting attorneys should be consulted when designing protocols for individual EDs” (Houmes et al., 2003).
- *Domestic Violence Shelter insight into user-participation design:*
“The administrative and clinical staff have been primarily white and hold higher education degrees, while the direct care staff...closely match the cultural socioeconomic, and ethnic background of the majority of shelter residents. Prior to the implementation of Sanctuary, the clinical staff took the lead in major case planning for the shelter residents, while the life experience and cultural awareness of the direct care staff was often not utilized. The direct care staff, however, were expected to implement the plans developed by the clinical staff. **The lack of communication and sharing of different perspectives of the clients’ experience led to conflicts within the staff and limited the effectiveness of these plans**” (Madsen et al., 2003).



“The question of whether clients undergoing treatment are consciously aware of the quality of the esthetic and functional environment is sometimes raised. It appears that great variation exists. At one extreme, clients may be intensely aware of their setting, to the point of fixating on minute detail. At the other extreme, they may be totally oblivious to the environment. **Unquestionably the most vital progress in treatment results from the human interaction situations, the face-to-face relationships. At the same time, the physical environment can provide the settings and props to facilitate the interactions. The space and its furnishings can help in meeting basic client needs: needs for safety and security . . .**” (Willis, 1980).

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