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POSITION STATEMENTS



EMS Care of Survivors of Sexual Assault – A Position Statement and Resource Document of NAEMSP

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ABSTRACT

Caring for sexual assault survivors requires interdisciplinary collaboration, pre-planning, and education. The purpose of this document is to guide emergency medical service (EMS) agencies and clinicians in the patient-centered management of survivors of sexual assault.

The National Association of EMS Physicians Recommends:

- *Trauma-Informed Care*: EMS clinicians should recognize that sexual assault is a traumatic event, and we recommend a trauma-informed care approach. Some recommended actions include, but are not limited to, asking questions that validate a survivor's experience, asking permission before doing an exam to acknowledge a patient's choice, and allowing a support person during the physical exam.
- *Physical Injuries after sexual assault*: EMS clinicians should assess for serious traumatic injuries associated with sexual assault including strangulation.
- *Collaboration with Sexual Assault Forensic Examiner Organizations*: EMS clinicians should understand general forensic guidelines and state-specific regulations relevant to prehospital care. Indications for forensic exams vary by state, thus partnerships between EMS and sexual assault forensic examiner organizations can facilitate access to forensic examiners who can provide clear guidance on available forensic resources.
- *Transport to Sexual Assault Forensic Examiner-resourced facilities*: EMS systems should identify local facilities that are resourced to care for sexual assault survivors or systems designed to provide these resources to the survivor and preferentially transport stable survivors to these destinations for medical and forensic evaluation. If there is concern for a life-threatening injury, patients should be transported to a trauma center for evaluation.
- *Documentation*: In addition to awareness of local regulations, EMS clinicians should be complete, accurate, and culturally competent in their documentation. They should minimize bias in their documentation.
- *Evidence Preservation*: EMS clinicians should be aware of best practices for evidence preservation and be trained in evidence collection in the prehospital setting, including avoiding showering, eating, changing clothes before the forensic exam, and maintaining chain of custody.
- *Consider other special populations*: EMS clinicians should be aware of high-risk special populations for sexual assault with unique medical, cultural and/or regulatory considerations including, but not limited to, the pediatric, elderly, transgender, gender diverse, LGBTQ (lesbian, gay, bisexual, transgender, queer), pregnant, and male survivors.

ARTICLE HISTORY

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Introduction

Sexual assault and rape are a pervasive public health problem in the United States (U.S.). Approximately one in five women (19.6%) and one in 26 men (7.6%) surveyed have experienced completed or attempted rape in their lifetime. Of those women sexual assault survivors, nearly 80% reported that they were first raped before the age of 25 years, and 41% before the age of 18 years (1).

The terms “rape” and “sexual assault” are sometimes used interchangeably, and the legal definitions of both terms vary across states. Sexual assault is a crime of violence and aggression and encompasses a spectrum of sexual activity ranging from sexual coercion to contact abuse to rape (2). Rape, as re-defined by the Federal Bureau of Investigation in 2013, is “Penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the

consent of the victim (3).” This definition is agnostic to gender of the survivor and perpetrator and excludes any reference to force. The age of the survivor and the relationship to the abuser can be used to characterize sexual assault and rape including acquaintance rape, date rape, statutory rape, child sexual abuse, and incest. See [Table 1](#) for terms & definitions.

Annually there are over 55,000 post-sexual assault emergency department (ED) visits in the U.S. representing a more than 1500% increase over the past decade (4). Almost half of these patients may present *via* emergency medical services (EMS) (5). Although EMS clinicians are well versed in caring for patients with traumatic injuries and collaborating with police officers, patients who experience sexual assault have specific medical, forensic, and psychological needs that differ from other prehospital patients. The objective of this position statement and resource document is to guide EMS agencies and clinicians in the patient-centered management of survivors of sexual assault. We have proposed a model EMS protocol at the end of this resource document.

Methods

Search Strategy

To inform our position statement and resource document, we performed a structured rapid review of the literature relevant to EMS care of sexual assault survivors. Structured rapid reviews provide a streamlined approach to synthesize evidence to produce information in a timely manner based on simplified principles of a systematic review of the literature. The search strategy used was to identify sexual assault relevant to EMS is provided in [Table 2](#). We searched PubMed (*via* National Library of Medicine) for articles on June 1, 2024.

Screening of Publication

Records were uploaded into Covidence (Melbourne, Australia). Duplicate publications and publications without a full-text were excluded. Two authors (DHY and AMB) independently screened records on relevance to the care of sexual assault survivors in the EMS setting through two stages: title and abstract screening and full-text screening. Discordance was resolved through discussion and consensus by both authors. Each publication was summarized.

Results

The strategy identified 87 articles available for screening. No articles were excluded for being a duplicate and four articles were excluded because we were unable to locate full-text articles. Seventy-six articles were excluded because they were not relevant to the care of sexual assault survivors in the EMS setting. This resulted in seven articles for consideration by all authors to inform this position statement and resource document ([Figure 1](#) and [Table 3](#)). In the absence of a robust body of prehospital evidence-based literature, recommendations for this position statement are based on this literature, professional guidelines, as well as author expertise (6–8).

Discussion

Trauma-Informed Care

EMS clinicians should recognize that sexual assault is a traumatic event, and we recommend a trauma-informed care approach. Some recommended actions include, but are not limited to, asking questions that validate a survivor’s experience, asking permission before doing an exam to acknowledge a patient’s choice, and allowing a support person during the physical exam.

Table 1. Terms & definitions.

Term	Definition
Sexual Assault (Contact sexual violence)	An act of violence and aggression encompasses a spectrum of sexual activity that ranges from rape, being made to penetrate someone else (males only), sexual coercion, or contact abuse.
Sexual Coercion	Unwanted sexual penetration that occurs after a person is pressured in a nonphysical way. Sexual coercion refers to unwanted vaginal, oral or anal sex after being pressured in ways that include being worn down by someone who repeatedly asked for sex or showed they were unhappy; feeling pressured by being lied to, being told promises that were untrue, having someone threaten to end a relationship or spread rumors; and sexual pressure due to someone using their influence or authority.
Contact Abuse (unwanted sexual contact)	Unwanted sexual experiences involving touch but not sexual penetration, such as being kissed in a sexual way or having sexual body parts fondled, groped, or grabbed.
Physical Violence	Includes many behaviors from being slapped, pushed, or shoved to severe acts that include being hit with a fist or something hard, kicked, hurt by having hair pulled, slammed against something, beaten, burned on purpose, attempted to be hurt by choking or suffocating, and having a knife or gun used on them.
Sexual Assault Based on Relationship of Survivor/Perpetrator and Age	
Acquaintance rape and date rape	Sexual assault committed by someone the survivor knows
Incest	Sexual assault when the perpetrator is a family member of the survivor.
Statutory rape	Consensual sexual intercourse with an individual younger than a specific age. The age at which an adolescent may consent to sexual intercourse varies by state and generally is 16–18 years.
Sexual abuse*	Defined by the Child Abuse and Prevention Act as “the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other forms of sexual exploitation of children, or incest with children”

*from 42 U.S.C. 2017:§5106 g.

Trauma-informed care (TIC) is widely recommended in sexual assault care literature as it focuses on ensuring the emotional and psychological safety of survivors during medical treatment to avoid further traumatization. Applying TIC principles may lead to better outcomes by reducing re-traumatization and improving communication (9). Although the practice and study of TIC is highly heterogeneous, it broadly uses de-escalation techniques, active listening, and avoiding practices which could cause further trauma (10).

Trauma-informed care training for EMS clinicians is crucial for enhancing interactions with patients and improving overall care quality. Survivors' interactions with the emergency care setting often leads to re-traumatization (11). Small studies within the emergency department and prehospital environment suggest that even minimal training can significantly boost clinicians' comfort with recognizing

and delivering TIC. Such training equips EMS personnel with the skills to recognize and respond to the impact of trauma on individuals, emphasizing empathy, safety, and support. Some TIC practices include, but are not limited to, asking questions that validate a survivor's experience, allowing a support person during the physical exam, and asking permission throughout the patient encounter to acknowledge a patient's choice. These TIC practices should include using a survivor's preferred terminology, including anatomical terms and pronouns. By integrating these practices, EMS clinicians can offer more compassionate and effective care, ultimately enhancing the well-being of those they serve (12).

Physical Injuries after Sexual Assault

EMS clinicians should assess for serious traumatic injuries associated with sexual assault including strangulation.

Emergency medical services clinicians should consider traumatic injuries that are more common among sexual assault survivors. Extragenital trauma is present in 36-67% of sexual assault survivors and is more common in women (5,13). It is more common than anogenital trauma (70% vs 27%) and generally includes bruises, abrasions, or erythema on the thigh, upper arm, face, or neck. Strangulation is also relatively common, with a prevalence of approximately 23% and is more frequent in domestic violence situations (14). An external genital exam is not recommended unless medically necessary. Emergency medical services clinicians should be educated on considerations

Table 2. Search terms.

Search number	Query Pubmed	Search on 6/1/2024
#1	((“Sex Offenses”[Mesh]) OR (((“human trafficking”[Title/Abstract]) OR (rape[Title/Abstract])) OR (sexual assault*[Title/Abstract] OR sexual abuse*[Title/Abstract] OR sexual offense*[Title/Abstract])))	43,373
#2	((“Emergency Medical Dispatch”[Mesh] OR “Emergency Medical Service Communication Systems”[Mesh] OR “Emergency Medical Technicians”[Mesh] OR “Transportation of Patients”[Mesh] OR “Paramedics”[Mesh] OR “Firefighters”[Mesh] OR “Emergency Medicine”[Mesh] OR “Air ambulances”*[Mesh]) OR (“emergency medical services”[Title/Abstract]))	50,240
		87

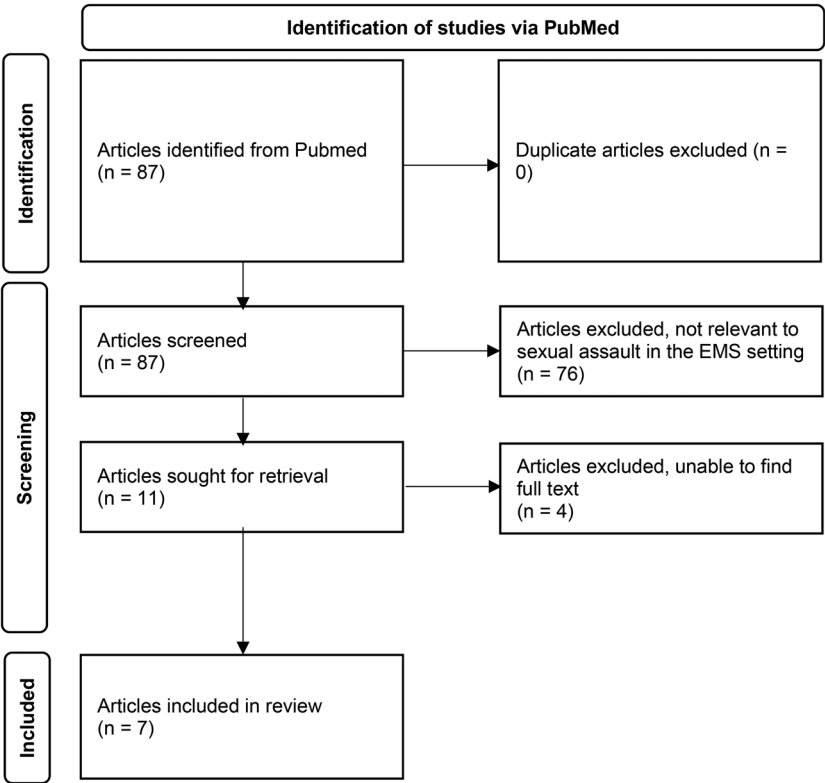


Figure 1. PRISMA diagram.

Table 3. Summary of rapid review findings relevant to EMS and sexual assault.

Citation	Summary
Bressler CJ, Malthaner L, Pondel N, Letson MM, Kline D, Leonard JC. Identifying Children at Risk for Maltreatment Using Emergency Medical Services' Data: An Exploratory Study. <i>Child Maltreat</i> . 2024 Feb;29(1):37–46. doi: 10.1177/10775595221127925. Epub 2022 Oct 7. PMID: 36205182.	Retrospective observational study of Electronic Medical Services (EMS) electronic health records to identify phrases associated with child maltreatment. The use of the word "Sexual" showed the strongest positive association (Odds Ratio 6.17 95% CI 4.67,8.15) with EMS encounters and children at risk for maltreatment.
Campbell R, Bybee D. Emergency medical services for rape victims: detecting the cracks in service delivery. <i>Womens Health</i> . 1997 Summer;3(2):75–101. PMID: 9332152.	147 survivors of sexual assault were interviewed about the Emergency Room experience demonstrating variability in offered services. There was significant variability in the services offered based on the hospital characteristics, the relationship of the assailant to the survivor and survivor characteristics. Survivors taken to hospitals with coordinated response teams (e.g., Sexual Assault Response Team) were more likely to receive some forms of treatment.
Hodell EM, Sporer KA, Brown JF. Which emergency medical dispatch codes predict high prehospital nontransport rates in an urban community? <i>Prehosp Emerg Care</i> . 2014 Jan-Mar;18(1):28–34. doi: 10.3109/10903127.2013.825349. Epub 2013 Sep 12. PMID: 24028558.	Retrospective observational study that aimed to identify Medical Priority Dispatch System code categories associated with the highest rates of prehospital non-transport. Dispatch codes categories for "Assault/Sexual assault" routinely had non-transport rates exceeding 40%.
Qualls C, Hewes HA, Mann NC, Dai M, Adelgaiz K. Documentation of Child Maltreatment by Emergency Medical Services in a National Database. <i>Prehosp Emerg Care</i> . 2021 Sep-Oct;25(5):675–681. doi: 10.1080/10903127.2020.1817213. Epub 2020 Oct 12. PMID: 32870747.	Retrospective observational study of EMS clinician reporting of abuse and neglect among children less than 3 years of age using the National Emergency Medical Services Information System (NEMSIS) database. Of identified abuse and neglect cases, 28.2% (27/124) were related to sexual abuse.
Rinker AG Jr. Recognition and perception of elder abuse by prehospital and hospital-based care providers. <i>Arch Gerontol Geriatr</i> . 2009 Jan-Feb;48(1):110-5. doi: 10.1016/j.archger.2007.11.002. Epub 2007 Dec 26. PMID: 18160115.	Prospective survey of 272 EMS and 127 hospital clinicians to evaluate exposure, knowledge and attitudes to elder abuse and neglect. One in three clinicians indicated they would suspect other reasons (dementia, depression, etc.) for the report of a sexual assault in an elderly patient.
Shah MN, Bishop P, Lerner EB, Czapranski T, Davis EA. Derivation of emergency medical services dispatch codes associated with low-acuity patients. <i>Prehosp Emerg Care</i> . 2003 Oct-Dec;7(4):434-9. doi: 10.1080/312703002132. PMID: 14582093.	Retrospective observational study of dispatch codes associated with basic life support (BLS) level prehospital care as a proxy for low acuity illness. The authors identified that 95.2% (CI 93.2–96.7) of "assault/sexual assault" were transported BLS.
Faul M, Aikman SN, Sasser SM. Bystander Intervention Prior to The Arrival of Emergency Medical Services: Comparing Assistance across Types of Medical Emergencies. <i>Prehosp Emerg Care</i> . 2016 May-Jun;20(3):317-23. doi: 10.3109/10903127.2015.1088605. Epub 2016 Jan 25. PMID: 26807490; PMCID: PMC4933010.	Retrospective observational study of NEMSIS database investigating circumstances associated with bystander intervention during a 9-1-1 call. The type of injury/illness that prompted the lowest likelihood of bystander assistance was Sexual Assault/Rape (aOR = 1.64, 95% CI 1.57–1.71)

for doing an exam, including but not limited to 1) patient acuity, 2) informed consent, 3) privacy considerations, and 4) emotional trauma.

Collaboration with Sexual Assault Forensic Examiner Organizations

EMS clinicians should understand general forensic guidelines and state-specific regulations relevant to prehospital care. Indications for forensic exams vary by state, thus partnerships between EMS and sexual assault forensic examiner organizations can facilitate access to forensic examiners who can provide clear guidance on available forensic resources.

Sexual Assault Forensic Examiner (SAFE) programs were developed to provide enhanced service for survivors, health care agencies, and law enforcement and offer survivors care that emphasizes comprehensive, multisystem service delivery and enhance the treatment and recovery of sexual assault survivors. Sexual Assault Forensic Examiner clinicians are specially trained in evidence collection techniques and the use of specialized equipment, chain-of-evidence requirements, expert testimony, injury detection and treatment, pregnancy and sexually transmitted infection screening and treatment, rape trauma syndrome, and crisis intervention.

Medical facilities that offer SAFE programs have been shown to enhance the care of sexual assault survivors by (a) promoting the psychological recovery of

survivors, (b) providing comprehensive and consistent medical care, (c) ensuring accurate and complete documentation of forensic evidence, and (d) improving prosecution of sexual assault cases. Emergency departments offering comprehensive services for sexual assault survivors have been shown to be more helpful in terms of treatment rendered, forensic exams performed, and an overall supportive experience for the patient (15–20). Sexual assault survivors seeking medical attention in hospitals without specialized services face problems such as long wait times and longer exam times (21). In addition, the quality of medical care offered to sexual assault survivors, regarding administration of emergency contraception and screening and treatment for sexually transmitted infections, is lower in hospitals that do not have a sexual assault treatment program (19,22).

Transport to Sexual Assault Forensic Examiner-Resourced Facilities

EMS systems should identify local facilities that are resourced to care for sexual assault survivors or systems designed to provide these resources to the survivor and preferentially transport stable survivors to these destinations for medical and forensic evaluation. If there is concern for a life-threatening injury, patients should be transported to a trauma center for evaluation.

Sexual Assault Forensic Examiner programs were developed to provide a forensic examination for survivors of

sexual assault and use of these programs have been shown to improve the quality of care that survivors receive. Because these programs are unique to each state and region, each EMS agency should define a destination criteria, or a specific location, for their EMS clinicians to bring these patients, in collaboration with their local SAFE program. For example, in California, nine of 34 local EMS agencies offer destination criteria for patients to receive a forensic exam (23). In the absence of a local SAFE program, which is common in many rural communities, each EMS agency should identify emergency departments that have access to telehealth capabilities as well as the nearest SAFE program (24–26).

Documentation

In addition to awareness of local regulations, EMS clinicians should be complete, accurate, and culturally competent in their documentation. They should minimize bias in their documentation.

The top priority for the medical management of survivors of sexual assault is the patient's physical and mental health paired with the collection, maintenance, and security of forensic evidence. The role of law enforcement is the performance of the criminal investigation. In that process, multiple written reports are generated. Analogous to all medical records, the documentation for cases of sexual assault must be complete and accurate. While the medical record is an important element of continuity of care, one should also be cognizant that it will play a key role in the representation of the incident, physical examination, readily identified injuries, and forensic evidence in a court of law where the jury is typically comprised of laypersons with little or no medical training.

Whether overt or unconscious, all of us inherently have bias and as related to medical record documentation, words matter. Electronic medical records enhance the efficiency of completing documentation; however, clicking a button in a robotic fashion is not always the ideal action in cases involving sexual assault. A person who reports being punched in the arm may not have any motor or sensory deficits, gross deformity, or bruising. However, if tenderness is present, this should be documented as such instead of choosing the "normal" option based simply upon the findings seen on visual inspection. A patient may be alert, oriented, and neurologically intact leading one to click the "normal" option. However, if the survivor is sobbing or emotionally detached, this finding can be written into the document. Failure to include pertinent details and positive findings, particularly due to lack of a descriptor option within the electronic medical record software, results in missing elements that may be critical in a court of law. There will be jurors who will be convinced by defense attorneys that "normal" means that no injury was sustained. Written narratives can reduce or eliminate doubt that may be cast upon the patient's credibility.

Likewise, the clinical impression in the medical record is important. The primary duty of the EMS clinician is to

provide care to support the patient's physical and mental health. The determination of the burden of proof and identification of the perpetrators is the duty of law enforcement and forensic personnel. The determination of innocence or guilt is the duty of the justice system. The documentation of the clinical impression is as equally important as the patient assessment. As one example, the term "alleged" is a legal term to describe an event that is questionable or not proven to be true. In the minds of some, this word implies that the event did not happen. For this reason, it is preferable to document the clinical impression as a "reported sexual assault" in addition to the findings from the patient assessment rather than an "alleged sexual assault." Emergency medical services agencies should work with the justice system and local SAFE programs to provide guidelines related to documentation related to sexual assault.

Evidence Preservation

EMS clinicians should be aware of best practices for evidence preservation and be trained in evidence collection in the prehospital setting, including avoiding showering, eating, changing clothes before the forensic exam, and maintaining chain of custody.

Evidence collection in the setting of sexual assault is essential, especially if the patient would like to press legal charges at any time in the future. Emergency medical services clinicians should always get consent to treat from the patient and respect all patient boundaries. Immediate medical management is always the top priority and takes precedence over evidence collection. Notably, having a forensic exam or collection of evidence does not require reporting to law enforcement and in some states can be reported up to 20 years later. Except for child abuse or survivors of cognitive impairment, patients retain the right to refuse to engage with law enforcement. Immunity protections for reporting to law enforcement varies among states. Evidence collection generally can take place up to 96 h after the assault and 90% of all evidence collection takes place in the ED (27). For evidence preservation, the patient should be instructed to avoid showering, bathing, douche, smoking, eating, drinking, using the bathroom, or changing clothing/bedding. Gloves should always be worn for any patient care or handling of linens, clothing or bodily fluids. Any clothing should be placed in a paper bag and should be brought to the hospital with the patient. Paper bags are preferred over plastic bags because packaging biological evidence in plastic promotes the degradation of biological evidence, rendering DNA testing useless (28). If clothing needs to be cut off, any holes should not be cut through, and any time a ligature is in place, the knot should not be cut through (29). Ambulance linens should also be collected and placed in a paper bag. If a patient produces any emesis, urine, spit or other bodily fluids, these should be collected and brought to the hospital. This evidence is especially important with drug-facilitated sexual assaults. If the patient consents, EMS clinicians should coordinate with

law enforcement on scene for evidence collection and preservation. Once evidence is collected, EMS clinicians should make all reasonable effort to maintain evidence chain of custody. Chain of custody requires documentation of evidence transfers and should be noted in the patient care records.

Consider Other Special Populations

EMS clinicians should be aware of high-risk special populations for sexual assault with unique medical, cultural and/or regulatory considerations including, but not limited to, the pediatric, elderly, transgender, gender diverse, LGBTQ (lesbian, gay, bisexual, transgender, queer), pregnant, and male survivors.

Pediatric Survivors

An important consideration in the prehospital setting, is the specific care of pediatric survivors of sexual assault. Any survivor of sexual assault under the age of 18 can and should be evaluated at a pediatric hospital or pediatric-specific ED. However, special attention must be provided to patients under 12 years of age, as this particularly vulnerable patient population is best served and should be transported to a pediatric SAFE-designated hospital, whenever possible.

When transporting any patient less than 18 years of age with a concern for sexual assault, there are a few guidelines that are important for EMS clinician education and protocols. First, the focus has to be on keeping the patient comfortable, providing reassurance, and allowing them to stay or be transported with a preferred guardian or adult, when possible. Second, there should be no interviewing of pediatric patients, especially those less than 12 years of age. Emergency medical services clinicians should also limit any follow-up questions to spontaneous comments made by the patient. Third, the patient should be kept in their clothing and any other clothing, including underwear, that may have been worn at the time of assault should be brought with the patient, when possible. For those less than 12 years of age, it is recommended that their bedding be brought in as well for evidence collection. Fourth, the patient should not receive anxiolysis or sedation in the prehospital setting when possible. Lastly, EMS clinicians should refer to their local mandatory reporting guidelines to the Department of Children and Families or the analogous agency within the jurisdiction.

There are additional considerations for those older than 12 years of age in addition to what is outlined above. A high proportion of pediatric sexual assault occurs during adolescent years, with recent reports finding a lifetime experience of 26.6% for girls and 5.1% for boys in experiencing sexual assault by 17 years old (30). Additionally, there are a number of barriers to adolescent patients seeking help including fear of mandated reporting, lack of understanding of the need for medical care and evaluation, and barriers to care including, but not limited to, lack of transportation and fear of

cost (31). Other barriers include fear of repercussions for survivors such as under aged drinking admissions and school expulsions.

Elderly Survivors

Sexual assault and abuse are often underrecognized in patients aged 65 years and older due to cultural biases. However, elder abuse, including sexual assault can happen in all racial, social, and economic backgrounds. Most commonly, sexual violence is by a known perpetrator (up to 90% of the time) and often involves other forms of abuse such as physical, financial, psychological, and/or neglect (2). Emergency medical services clinicians should refer to their local mandatory reporting guidelines within each jurisdiction if elder abuse or neglect is suspected.

Transgender, Gender Diverse and LGBTQ Survivors

Nearly half of transgender and gender diverse (TGD) people have been sexually assaulted during their lifetime—with 10% sexually assaulted in the last year alone. Personal violent crime prevalence is four times greater in TGD people as compared to the general population. Transgender and gender diverse, as well as LGBTQ, populations have unique barriers to care that include hesitancy to trust medical professionals, knowledge gaps in people treating them for sexual assault, and relationships that may look different than heterosexual relationships making it difficult for health care clinicians to build rapport with sexual assault survivors (32–36). Emergency medical services clinicians should not assume a patient's sexual orientation or gender identity. Emergency medical services clinicians should use the patient's preferred terms for anatomy and integrate other TIC practices.

Pregnant Survivors

Pregnancy is a high-risk period for interpersonal violence and sexual assault with one in six women experiencing the first episode domestic violence while pregnant (2,37). Sexual assault and domestic violence are most common in the first trimester and inquiring about known pregnancy status is

Table 4. Priority items for implementation of recommendations.

	Priority Items
EMS Protocol	Review EMS Protocol related to sexual assault for potential opportunities for improvement. If no EMS protocol exists, adapt Figure 1 and/or Figure 2 for the local EMS agency.
Education	Update EMS Protocol related to sexual assault Create education on 1) trauma-informed care, 2) physical injuries in sexual assault, 3) medical documentation and 4) evidence collection and preservation.
Collaboration with local SAFE organizations	Provide education to EMS clinicians Identify SAFE organization leadership and setup initial meetings Develop a collaborative relationship with the local SAFE organization to: 1. identify destination criteria 2. improve EMS clinician education 3. identify local resources for patients that refuse transport

Patient Care Goals

To provide trauma informed medical care and preserve forensic evidence for survivors of sexual assault

Patient Presentation**Inclusion Criteria**

Any form of non-consensual conduct/contact with another person, or the inability of the victim to give consent due to age, cognitive disability, or voluntary/involuntary incapacitation by substances.

Exclusion Criteria**Patient Management****Assessment:**

1. Keep the assessment brief and injury-focused:
 - i. Do not interview the patient about the assault
 - ii. In the absence of hemorrhage there is rarely a need to visualize genitalia
 - iii. Assess the patient for strangulation injuries, as this is common with sexual assault

Treatment and Interventions

1. Explain in advance each treatment/procedure and offer the patient simple choices (e.g. to sit up or recline on the gurney) empowering them to feel in control.
2. Mirror the patient's language (e.g. do not say "rape" or "sexual assault" if the patient has not used those words).
3. Preserve the physical evidence:
 - iv. Transport the patient "as found". Discourage showering, removing/changing clothes, brushing teeth, using mouthwash, smoking, eating, drinking, or washing or cleaning their hands.
 - v. If clothes have been removed, place clothing in a paper bag. Do not use plastic bags; they collect moisture, which degrades important organic material. If it is necessary to cut off the patient's clothes, cut around soiled, torn or damaged areas by 6 inches.
 - vi. Do not clear, irrigate or apply ointment to wounds. If necessary, apply dry sterile gauze to wounds.
 - vii. If the patient needs to urinate, or vomit, preserve in a clean container (e.g. urinal, emesis basin). This evidence is especially important with drug-facilitated sexual assaults.
 - viii. Chain of custody must be maintained for each item to be valuable in the forensic process. This is best accomplished by having the patient keep all

Figure 2. Proposed EMS protocol document.

This is an adult sexual assault protocol. It can be modified in collaboration with local pediatric resources and local reporting guidelines related to child abuse. The protocol is based on the format used in the NASEMSO National Model EMS Clinical Guidelines (https://nasemso.org/wp-content/uploads/National-Model-EMS-Clinical-Guidelines_2022.pdf)

evidence collected at the scene in their possession or law enforcement maintaining possession. 4. Transport the patient to a facility capable of performing the sexual assault forensic exam. The forensic exam can be performed up to 5 days after an assault. a. Adult patient: <<insert local facility>> b. Pediatric patient: <<insert local facility and age cut off>> 5. If no transport: a. <<insert local resource / advocacy resource>> b. <<provide counseling based on local resources>> c. <<local advocate phone number>> <u>Patient Safety Considerations:</u> 1. Collaborate with local << law enforcement>> for when to engage them. <u>Notes/Educational Pearls</u> <u>Key Considerations</u> 1. Special populations 2. Local regulations 3. Local resources <u>Quality Improvement</u> <u>Associated NEMSIS Protocols (eProtocol.01) (for additional information, go to www.nemsis.org)</u>
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Figure 2. Continued.

advised. Pregnant survivors require an integrated care approach, which addresses physical impacts of sexual assault to both the pregnant patient and fetus.

Male Survivors

Although men make up a minority of sexual assault survivors, male survivors may experience a greater sense of shame or stigma due to societal expectations about masculinity. Additionally, stimulation associated with anal penetration can result in involuntary erection and ejaculation which can cause misinterpretation of consent by survivors, medical professionals, and the judicial system. Research indicates that these factors can prevent male survivors from reporting assault and accessing support (38).

There are other special populations to consider related to sexual assault. They include, but are not limited to: survivors with limited English proficiency, cultural considerations, differently-abled, survivors with developmental delay, and human trafficking survivors.

Considerations for Implementation

We recognize that there are numerous barriers to improving the patient-centered management of survivors of sexual assault within EMS agencies. First, much of the data supporting our recommendations rely on research

originating from emergency departments. However, we provide recommendations that are feasible for application in the prehospital environment. Second, the ability to improve patient-centered management of survivors is dependent on the local environment of each EMS agency. For example, local SAFE organizations may not exist, or preferred destination criteria may be outside the catchment area of an agency. Thus, local barriers should be considered in implementation of this position statement's recommendations. We outline priority items to help facilitate implementation within an EMS agency (Table 4). Finally, implementation requires the development of relevant education and protocols and collaborate with local SAFE programs. Synthesizing these recommendations into a protocol, the authors have proposed Figure 2 in the format used in the National Association of State EMS Officials (NASEMSO) National Model EMS Clinical Guidelines. We provide Figures 2 and 3 as example protocols for local adaptation.

Conclusions

Emergency medical services clinicians frequently encounter survivors of sexual assault, and it is important the care they provide is trauma-informed, clinically and medicolegally appropriate. Future EMS research should focus on barriers to prehospital care with emphasis on medicolegal outcomes and patient experience.

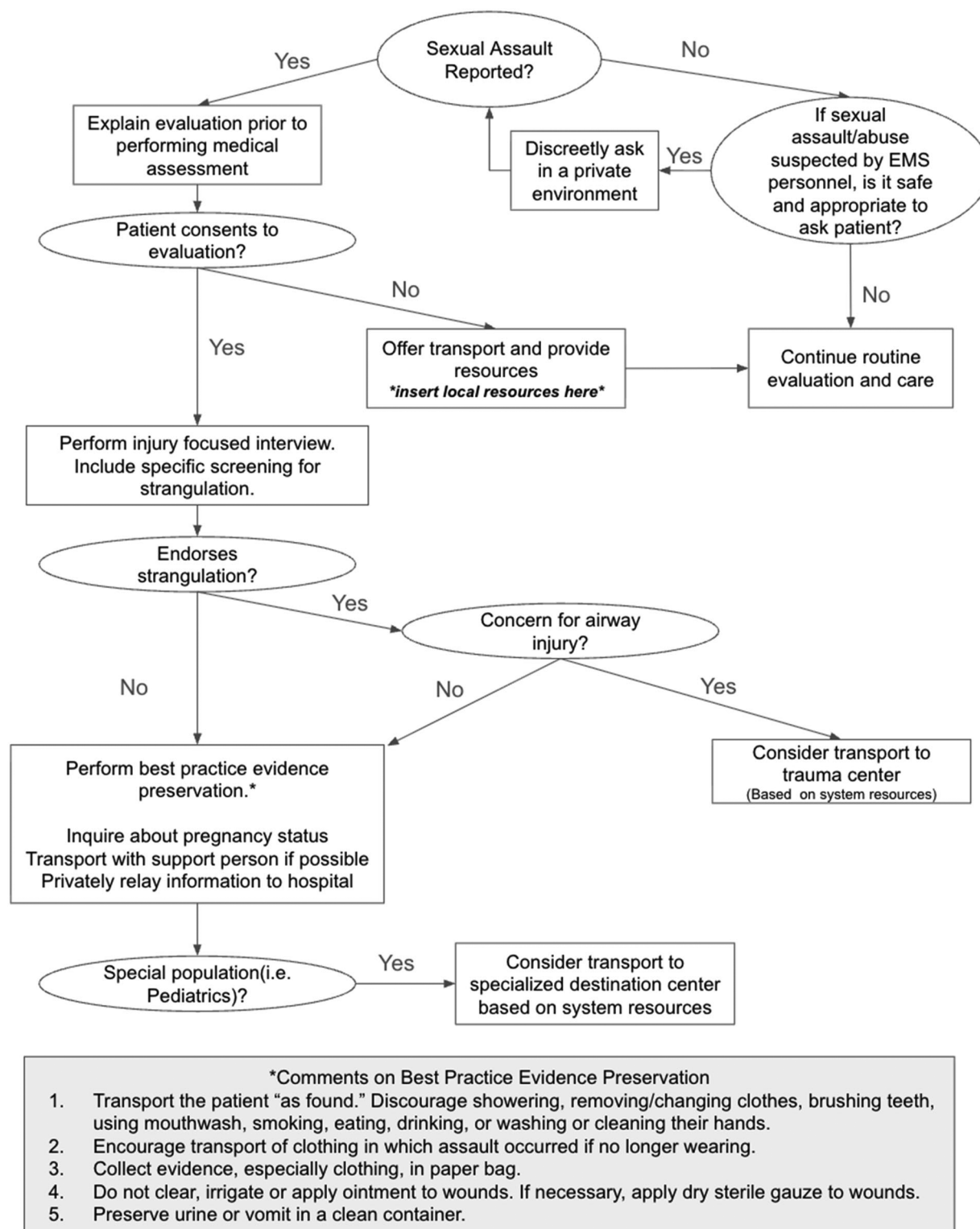


Figure 3. Proposed EMS protocol document: Sexual assault flow chart.

Authorship Statement

Dr. Yang had full access to all the data in the study and takes responsibility for the integrity of the data.

Concept and design: Yang, Breyre.

Acquisition, analysis, or interpretation of data: Yang, Breyre.

Drafting of the manuscript: All authors.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Not applicable.

Administrative, technical, or material support: Breyre.
Supervision: Breyre.

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Lauren K Friend reports no competing interests to declare.

Christie L Fritz reports no competing interests to declare.

Zita I Konik reports that she is a medical director of a sexual assault nursing examiner-sexual assault response team.

Niloufar Paydar-Darian reports no competing interests to declare.

Mikaela T Middleton reports no competing interests to declare.

Carol A Cunningham reports no competing interests to declare. However, she is the co-principal investigator for the National Association of State EMS Officials National Model EMS Clinical Guidelines.

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The authors did not use a generative artificial intelligence (AI) tool or service to assist with preparation or editing of this work. The author(s) take full responsibility for the content of this publication.

External Review

This document was created solely by NAEMSP and was not subject to review by external parties.

Updating Procedure

Pursuant to NAEMSP Standards & Clinical Practices Committee procedures and practices, this position statement and resource document will be reviewed and updated five years after its publication. Applicable NAEMSP review and revision practices that are current as of the time of the review will be followed. At a minimum the review process should include a search and synthesis of any new and relevant evidence that is published since the printing of this document.

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References

- Basile KC, Smith SG, Kresnow M, Khatiwada S, Leemis RW. The national intimate partner and sexual violence survey: 2016/2017 report on sexual violence. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2022.
- Committee on Health Care for Underserved Women. Intimate Partner Violence. Committee Opinion No. 518. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2012;119:412–7.
- Justice USDo. FBI—Rape 2014. Available from: <https://ucr.fbi.gov/crime-in-the-u.s/2013/crime-in-the-u.s.-2013/violent-crime/rape>.
- Vogt EL, Jiang C, Jenkins Q, Millette MJ, Caldwell MT, Mehari KS, Marsh EE. Trends in US emergency department use after sexual assault, 2006–2019. *JAMA Netw Open*. 2022;5(10):e2236273. doi:10.1001/jamanetworkopen.2022.36273.
- McCormack D, Subburamu S, Guzman G, Calderon C, Darapaneni R, Lis R, Sima N, Sperling J, Corbo J. Traumatic injuries in sexual assault patients in the emergency department. *West J Emerg Med*. 2022;23(5):672–7. doi:10.5811/westjem.2022.1.53994.
- Management of the Patient with the Complaint of Sexual Assault. 1992. updated February 2020. Available from: <https://www.acep.org/patient-care/policy-statements/management-of-the-patient-with-the-complaint-of-sexual-assault/#:~:text=ACEP%20believes%20that%20all%20patients,and%20prosecution%20of%20the%20incident>.
- National Training Standards for Sexual Assault Medical Forensic Examiners. 2018. [updated August 2018]. Available from: https://www.safeta.org/wp-content/uploads/2021/12/training_sexualassaultforens.pdf.
- CDC. Sexual Assault and Abuse and STIs - Adolescent and Adults 2021; 2021. [updated July 22, 2021]. Available from: <https://www.cdc.gov/std/treatment-guidelines/sexual-assault-adults.htm#>.
- Harris M, Fallot RD. Envisioning a trauma-informed service system: a vital paradigm shift. *New Dir Ment Health Serv*. 2001;2001(89):3–22. doi:10.1002/ym.23320018903.
- Berring LL, Holm T, Hansen JP, Delcomyn CL, Søndergaard R, Hvidhjelm J. Implementing trauma-informed care-settings, definitions, interventions, measures, and implementation across settings: a scoping review. *Healthcare (Basel)*. 2024;12(9):1–26. doi:10.3390/healthcare12090908.
- Chalmers K, Parameswaran R, Dussault N, Farnan J, Oyola S, Carter K. Impact of sexual assault survivor identity on patient care in the emergency department. *J Interpers Violence*. 2023;38(3–4):3244–78. doi:10.1177/08862605221104522.
- Administration SAaMHS. Treatment improvement protocol. Rockville (MD): Trauma-Informed Care in Behavioral Health Services; 2014.
- Riggs N, Houry D, Long G, Markovchick V, Feldhaus KM. Analysis of 1,076 cases of sexual assault. *Ann Emerg Med*. 2000;35(4):358–62. doi:10.1016/s0196-0644(00)70054-0.
- McQuown C, Frey J, Steer S, Fletcher GE, Kinkopf B, Fakler M, et al. Prevalence of strangulation in survivors of sexual assault and domestic violence. *Am J Emerg Med*. 2016;34(7):1281–5.
- Bechtel K, Ryan E, Gallagher D. Impact of sexual assault nurse examiners on the evaluation of sexual assault in a pediatric emergency department. *Pediatr Emerg Care*. 2008;24(7):442–7. doi:10.1097/PEC.0b013e31817de11d.
- Campbell R. Rape survivors' experiences with the legal and medical systems: do rape victim advocates make a difference? *Violence Against Women*. 2006;12(1):30–45. doi:10.1177/1077801205277539.
- Fehler-Cabral G, Campbell R, Patterson D. Adult sexual assault survivors' experiences with sexual assault nurse examiners (SANEs). *J Interpers Violence*. 2011;26(18):3618–39. doi:10.1177/0886260511403761.
- Sievers V, Murphy S, Miller JJ. Sexual assault evidence collection more accurate when completed by sexual assault nurse examiners: Colorado's experience. *J Emerg Nurs*. 2003;29(6):511–4. doi:10.1016/j.jen.2003.08.010.
- McLaughlin SA, Monahan C, Doezema D, Crandall C. Implementation and evaluation of a training program for the management of sexual assault in the emergency department. *Ann Emerg Med*. 2007;49(4):489–94. doi:10.1016/j.annemergmed.2006.07.933. Cited in: PMID: 17011075.
- Campbell R, Patterson D, Lichty LF. The effectiveness of sexual assault nurse examiner (SANE) programs: a review of psychological, medical, legal, and community outcomes. *Trauma Violence Abuse*. 2005;6(4):313–29. doi:10.1177/1524838005280328.
- Maier SL. Sexual assault nurse examiners' perceptions of the revictimization of rape victims. *J Interpers Violence*. 2012;27(2):287–315. doi:10.1177/0886260511416476.
- 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. *Ann Emerg Med*. 2002;39(6):631–8. doi:10.1067/mem.2002.123357.
- Konik Z, Francies N. An EMS system's approach to sexual assault patients: can we do more? *J Emerg Med Serv*. 2023.
- Miyamoto S, Thiede E, Dorn L, Perkins DF, Bittner C, Scanlon D. The Sexual Assault Forensic Examination Telehealth (SAFE-T)

- Center: a comprehensive, nurse-led telehealth model to address disparities in sexual assault care. *J Rural Health*. 2021;37(1):92–102. doi:10.1111/jrh.12474.
25. Miyamoto S, Thiede E, Wright EN, Berish D, Perkins DF, Bittner C, et al. The implementation of the sexual assault forensic examination telehealth center: a program evaluation. *J Forensic Nurs*. 2021;17(3):E24–E33.
 26. Thiede E, Miyamoto S. Rural Availability of Sexual Assault Nurse Examiners (SANEs). *J Rural Health*. 2021;37(1):81–91. doi:10.1111/jrh.12544.
 27. Ladd M, Seda J. Sexual assault evidence collection(archived). StatPearls. Treasure Island (FL): StatPearls Publishing; 2025.
 28. Justice NIO. Proper evidence collection and packaging; 2023. Available from: <https://nij.ojp.gov/nij-hosted-online-training-courses/forensic-dna-education-law-enforcement-decisionmakers/leveraging-limited-resources/proper-evidence-collection-and-packaging#proper-evidence-collection-and-packaging>.
 29. Linden JA. Clinical practice. Care of the adult patient after sexual assault. *N Engl J Med*. 2011;365(9):834–41. doi:10.1056/NEJMcpl102869.
 30. Finkelhor D, Shattuck A, Turner HA, Hamby SL. The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *J Adolesc Health*. 2014;55(3):329–33. doi:10.1016/j.jadohealth.2013.12.026.
 31. Kamke K, Mullin TM, Goodman KL. Barriers to seeking medical care among youth victims of sexual violence. *J Adolesc Health*. 2023;73(6):1077–82. doi:10.1016/j.jadohealth.2023.06.034.
 32. Berishaj K, Morrissey S, Kennedy MM. Sexual assault nurse examiner knowledge and confidence in providing care for transgender patients following sexual assault. *J Interpers Violence*. 2025;40(11-12):2449–66. doi:10.1177/08862605241270062.
 33. Flores AR, Meyer IH, Langton L, Herman JL. Gender identity disparities in criminal victimization: national crime victimization survey, 2017–2018. *Am J Public Health*. 2021;111(4):726–9. doi:10.2105/AJPH.2020.306099.
 34. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. The Report of the 2015 U.S. transgender survey. Washington DC: National Center for Transgender Equality; 2016.
 35. Morris SM, Gunter KE, Jia JL, Baig AA. Factors influencing shared decision-making between healthcare providers and lesbian, gay, bisexual, transgender, and queer people of color about intimate partner violence. *J Interpers Violence*. 2025;40(1-2):489–509. doi:10.1177/08862605241248434.
 36. Hong T, Case V, Farcas AM, Whitfield D, Muller G, Schlesinger SA, Haamid AS, Middleton MT, Breyre A, Buaprasert P, et al. Caring for transgender and gender diverse prehospital patients: a NAEMSP position statement and resource document. *Prehosp Emerg Care*. 2025;29(3):302–14. doi:10.1080/10903127.2024.2411723.
 37. James L, Brody D, Hamilton Z. Risk factors for domestic violence during pregnancy: a meta-analytic review. *Violence Vict*. 2013;28(3):359–80. doi:10.1891/0886-6708.vv-d-12-00034.
 38. Thomas JC, Kopel J. Male victims of sexual assault: A review of the literature. *Behav Sci (Basel)*. 2023;13(4):1–22. doi:10.3390/bs13040304.