# Unpacking Northern Ontario's sexual assault evidence kits: a mixed methods approach to understanding the barriers preventing comprehensive care for survivors

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## Abstract

**Background:** Sexual assault evidence kits (SAEKs) are used to gather forensic evidence from survivors following sexual assault. Forensic evidence collection also coincides with comprehensive post-assault care and referrals to follow-up services. One third of Canadian women have experienced sexual assault, however many hospitals lack staff trained in SAEKs and sexual assault care. Most of these deficits fall in rural areas, forcing survivors to travel long distances to receive care; Northern communities are known to especially lack access to comprehensive sexual assault care and SAEKs. This lack of resources has implications for both rural and urban Northern communities, and can also result in re-traumatization and poor survivor mental health.

**Objectives:** This study aimed to gain insight into the current state of post-sexual assault care in Northwestern Ontario from the perspective of healthcare providers, and to assess challenges to SAEK access in the North, with the ultimate aim of informing better access to care.

**Methods:** We employed a sequential explanatory mixed methods design. An online survey of healthcare providers working in 11 communities based in Northwestern Ontario was completed. The questionnaire was used to gain an overall picture of Northern healthcare providers' access to SAEKs in their communities. The survey was followed by nine in-depth semi-structured interviews with healthcare providers from Northwestern Ontario. The interviews covered content about barriers and recommendations to providing sexual assault care, as well as psychosocial supports available to practitioners and the training they have received. Interview transcripts were analyzed using an inductive thematic analysis approach.

**Findings:** The findings of this study include four overarching barriers and one provider recommendations theme. These barriers and recommendations were found in both the survey and interview phases of the study. Barriers to care provision included poor training and fear of legal implications, lack of supports, resource constraints, and socio-cultural barriers related to the credibility and believability of survivors. Difficulties for care arose related to rurality, the 'triage, treat, transfer' nature of Emergency Departments, limited psycho-social supports for providers, and the lack of specialized sexual assault nurse examiners. Additionally, rape myths and stereotypes were noted as barriers to equitable care.

**Conclusion:** Sexual assault trauma hinders many survivors from seeking care, especially when care has been inadequate in the past. It is essential that few barriers deter post-assault care, and that the care received is comprehensive and trauma-informed. This research will provide further insight into the rural health challenges of Northern Canada, as well as the difficulties faced in the provision of sexual assault care.

## Résumé

**Contexte :** Les trousses de preuves d'agression sexuelle (TPAS) sont utilisées pour recueillir des preuves médico-légales auprès des survivants à la suite d'une agression sexuelle. La collecte de preuves médico-légales coïncide également avec des soins compréhensifs consécutifs aux agressions sexuelles et l'orientation vers des services de suivi. Un tiers des femmes canadiennes ont subi une agression sexuelle, mais de nombreux hôpitaux manquent de personnel formé aux TPAS et aux soins suite aux agressions sexuelles. La plupart de ces déficits se situent dans les zones rurales, obligeant les survivants à parcourir de longues distances pour recevoir des soins ; les communautés du Nord en particulier sont connues pour manquer d'accès aux soins compréhensifs suite aux agressions sexuelles et aux TPAS. Ce manque de ressources pose des répercussions sur les communautés rurales et urbaines du Nord et peut causer également un nouveau traumatisme et une mauvaise santé mentale des survivants.

**Objectifs de l'étude :** Cette étude vise à mieux comprendre l'état actuel des soins suite à une agression sexuelle dans le nord-ouest de l'Ontario du point de vue des fournisseurs de soins de santé, et à évaluer les difficultés d'accès aux TPAS dans le Nord, dans le but ultime d'améliorer l'accès aux soins.

**Méthodes :** Nous avons utilisé une conception d'étude axée sur des méthodes mixtes explicatives séquentielles. Une enquête en ligne a été menée auprès de prestataires de soins de santé travaillant dans 11 communautés du nord-ouest de l'Ontario. Le questionnaire a été utilisé pour obtenir une image globale de l'accès des fournisseurs de soins de santé du Nord aux TPAS dans leurs communautés. L'enquête a été suivie de neuf entretiens semi-structurés approfondis

avec des prestataires de soins de santé du nord-ouest de l'Ontario. Les entretiens ont porté sur les obstacles et les facteurs facilitant la prestation de soins en cas d'agression sexuelle, ainsi que sur les soutiens psychosociaux dont disposent les praticiens et la formation qu'ils ont reçue. Les transcriptions des entretiens ont été analysées à l'aide d'une approche inductive d'analyse thématique.

**Constatations :** Les constatations de cette étude comprennent quatre obstacles généraux et un thème de recommandations pour les fournisseurs. Ces obstacles et recommandations ont été trouvés dans les phases d'enquête et d'entretien de l'étude. Les obstacles à la prestation de soins comprenaient une formation médiocre et la peur des répercussions juridiques, le manque de soutien, les contraintes de ressources et les obstacles socioculturels liés à la crédibilité des survivants. Des difficultés de soins sont survenues en raison de la ruralité, de la nature « triage, traitement, transfert » des services d'urgence, des soutiens psychosociaux limités pour les fournisseurs et du manque d'infirmières examinatrices spécialisées en agression sexuelle. De plus, les mythes et les stéréotypes sur le viol ont été notés comme des obstacles à des soins équitables.

**Conclusion :** Les traumatismes liés aux agressions sexuelles empêchent de nombreux survivants de rechercher des soins, en particulier lorsque les soins ont été inadéquats autrefois. Il est essentiel que peu d'obstacles empêchent les soins consécutifs aux agressions sexuelles, et que les soins reçus soient complets et respectueux des traumatismes. Cette recherche permettra de mieux comprendre les défis de la santé rurale dans le Nord du Canada, ainsi que les difficultés rencontrées dans la fourniture de soins en cas d'agression sexuelle.

"*Victims exist in a society that tells us our purpose is to be an inspiring story. But sometimes the best we can do is tell you we're still here, and that should be enough. Denying darkness does not bring anyone closer to the light. When you hear a story about rape, all the graphic and unsettling details, resist the instinct to turn away; instead look closer, because beneath the gore and the police reports is a whole, beautiful person, looking for ways to be in the world again.*"

-Chanel Miller

This thesis is dedicated to all survivors of sexual assault.

May you find a way to be in the world again.

This thesis is also dedicated to all those committed to researching sexual violence, and to caring compassionately for survivors.

May we look into the darkness in order to bring others closer to the light.

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knowledge with others. To be a part of the Indigenous initiatives they have fostered within the Department made me all the more dedicated to advocacy and equity in our healthcare systems.

Researching sexual assault – while more distal than providing care to survivors – is not without an emotional toll. Thank you to my close friends and classmates who supported me throughout my degree. You all know you are. I think I might have been a bit loopy by the end of this thesis if it wasn't for my friends who patiently listened to my frustrations about care inequities, while still keeping me grounded with non-academic activities and conversations about the every-day. I appreciate you for telling me when to close the computer and walk away for a bit. Special thanks to my lawyer friend Camila Franco for informing me on the legal aspects of sexual assault.

Lastly, thanks always to my family. Mom, you are my rock. Dad, you are my adventure buddy who is always down for a Northern road trip. Marcel, I can always rely on you for mutual support on this rollercoaster that is academia. April – the future of forensic science needs you! Grandma Rose, you always pick up my phone calls and have unwavering confidence in me. Spencer, thank you for reminding me of human tenacity and kindness. In many ways, my family is my inspiration for this research. My passion for health access began when watching my brother struggle to attain specialist psychiatric and addictions care in the rural area where we live. Furthermore, my grandparents immigrated to rural Canada with money sewn into their clothes and no knowledge of English – post-secondary just wasn't in the cards for a farming immigrant family. It is therefore with immense gratitude that reflect on my rural roots as I pursue higher education and research in health.

## Contribution of Authors

Conception and design of the study was done by myself, Sydney Timmermans (ST), and my supervisor, Dr. Kathleen Rice (KR). Data analysis and interpretation was done by ST and KR. All chapters of this manuscript were written by ST, with feedback from KR. Additional input was given from thesis committee members Dr. Jodie Murphy-Oikonen and Dr. Kirsten Johnson.

## Clarification of Terms

**Care Providers:** The term care providers will be used in this thesis to describe healthcare workers that treat survivors of sexual assault. This includes (but is not limited to) registered nurses, emergency physicians, sexual assault nurse examiners, nurse practitioners, registered practical nurses, resident physicians and physician assistants.

**Survivors and Care Seekers:** Many terms have been used to describe individuals who have been sexually assaulted. Throughout this thesis, the terms 'survivor' and 'care seeker' will be used. The terms 'patient' and 'victim' will not be used unless citing another piece of literature or a participant who used the term. We believe that the term 'patient' pathologizes the individual and presumes the presence of disease, which is not necessarily the case for survivors of sexual assault. The term 'victim' assumes a legal setting, which is also not the focus of discussion for this thesis. Sexual assault can impact all genders, therefore gender neutral terminology will be used to describe the survivors of sexual assault (unless a specific example is cited).

**Sexual Assault Evidence Kits (SAEKs):** Also known as 'rape kits'(or the 'kit'), these medico-legal tools are used to collect forensic evidence from individuals following a sexual assault.

**Sexual Assault Nurse Examiners (SANEs):** Nurses with specialized training in sexual assault care and the forensic evidence collection associated with assault are known as SANEs.

**Sexual Assault and Domestic Violence Treatment Centre (SADVTC):** As a specialized unit operating out the emergency centre of a hospital, a SADVTCs is designated by the Ontario Network of Sexual Assault and Domestic Violence to provide acute and follow up care to sexual assault and domestic violence survivors.

**Rural/remote:** The rural and remotes regions described in this thesis are defined as having a population of less than 10,000 people (Vodden et al., 2021).

**Emergency Department (ED):** May also be referred to as the 'Emerg' by the participants.

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# Chapter 1: Introduction

## Background

Sexual assault evidence kits ("SAEKs" or 'rape kits') are used to gather forensic evidence from bodily surfaces and orifices following an assault (Campbell et al., 2018). If survivors lack the evidence provided by the kits, convictions depend largely on the quality of survivors' narratives, which can be retraumatizing to recount (Haskell & Randall, 2019). In these situations, justice is much less likely, survivor mental health often suffers, and the perpetuation of abuse in communities continues (Campbell et al., 2018). Lack of sexual assault resources has been found to lead to higher rates of mental illness, chronic health disorders, substance abuse and re-victimization, putting further strain on emergency and mental health services (Brooker & Tocque, 2016; Carter-Snell, 2020; Jakubec et al., 2013; Khadr et al., 2018). Given that 30% of Canadian females have experienced at least one sexual assault and nearly 90% of all sexual assault survivors are women, this represents a heavily gendered burden for both individuals and the healthcare system (Conroy & Cotter, 2017). Despite this, it is estimated that 40% of Canadian hospitals do not have SAEKs available and/or lack trained staff on site to use the kits, and most of these deficits fall in rural and Northern areas (Carter-Snell, 2020; She Matters, 2021). While research on SAEK access is limited, it *is* known that a "justice gap" exists, whereby certain women receive imperfect justice following assault due to socioeconomic and geographical factors (Haskell & Randall, 2019). The noted geographical areas also coincide with some of the highest rates of sexual assault, especially amongst Indigenous women and girls, as 46% of this population will experience sexual violence within their lifetime (Heidinger, 2022). Therefore, the purpose of this study is to gain the perspectives of Northern healthcare providers about access to sexual care in their communities.

## Study Objectives

This research project used qualitative interviews guided by survey questionnaires, to fill a gap in the literature about the access to sexual assault care in Northern Ontario. The experiences of participants, as shared through in-depth interviews and survey responses, were analyzed to contribute to the greater knowledge base of challenges and facilitators for healthcare providers working in the North. These insights are especially reflective of care seekers and health care spaces that are impacted by rural and remote health system challenges. The objectives of this study are to:

1. Gain insight into the current state of acute sexual assault care in Northwestern Ontario from the perspective of emergency healthcare providers.
2. Assess the challenges to SAEK access and use in the North, with the ultimate aim of informing better care.

## Sexual assault as a gendered issue

Sexual violence is an umbrella term that encompasses sexual assault and sexual harassment. Sexual assault (SA) is described as any unwanted touching, kissing, fondling or intercourse; absence of consent to any of these actions is illegal in Canada (Women's Legal Education & Action Fund, 2014). Sexual assault can happen to anyone, regardless of their gender, sexual orientation, cultural background, religiosity, social status, occupation, etc. However, this does not mean that sexual assault will impact everyone equally. Decades of research in gender-based violence and data-collection have shown time and again that women and girls, members of the 2SLGBTQIA+ community, and racialized individuals carry a much higher risk for experiencing sexual assault (Cotter & Savage, 2019; Jaffray, 2020; Warrier, 2022). In fact, Statistics Canada states that 30% of Canadian women reported having been sexually

assaulted at least once since age 15 (Cotter & Savage, 2019). On the contrary, 8% of Canadian men reported being sexually assaulted since age 15 (Cotter & Savage, 2019). Therefore, despite the inclusive and gender-neutral language that will be used in this thesis, it is important to bear in mind the heavily gendered burden of sexual assault in Canada.

**Barriers to sexual assault care**

Multiple socio-cultural, interpersonal and physical barriers currently exist to reporting and seeking care following sexual assault (Orchowski et al., 2022). Sexual assault survivors face stigmatization; many survivors fear reporting their assault to health and/or judicial systems because of judgement, disbelief of personal narratives, and victim blaming practices (Orchowski et al., 2022). Furthermore, disclosure may lead to poly-victimization, whereby the individual is bullied, harassed or physically abused as a result of or as a consequence to their assault (Mennicke et al., 2021). Social labelling due to stigma and poly-victimization may be especially relevant in small rural community hospitals, where the resident populations are low and health providers may be known personally to survivors seeking care.

Survivors may avoid seeking care from healthcare systems as a result of poor care or judgement in the past. This fear is especially relevant for Indigenous care seekers; systemic racism and colonial medical practices have caused harmful and negative experiences with Western healthcare systems (McCallum & Perry, 2018). In addition, Indigenous care seekers may also fear police and judicial systems due to a host of colonial and historical factors (Cotter, 2022). The Statistics Canada General Social Survey in 2020 reported that 22% of Indigenous Canadians reported little or no confidence in the police (Cotter, 2022). Destructive impacts of colonization and inter-generational trauma have also contributed to high rates of sexual assault amongst Indigenous women (Heidinger, 2022). Indigenous women also report experiences of

feeling revictimized by police interrogation, and not being believed by police and judicial systems (Murphy-Oikonen et al., 2021).

Finally, physical barriers may inhibit survivors from reaching emergency centres for acute sexual assault care. Physically large distances to health centres represent a challenging reality for residents of Northern Ontario, given its huge geographical expanse. Familial challenges such the need for child-care coverage whilst seeking care also may present an obstacle to care attainment (Mulla, 2014). Survivors may fear child-services will remove their children due to the presence of assault, especially if the violence is domestic related (DeVoe & Smith, 2008).

Given the complex barriers that exist before a survivor can even walk through the doors of an emergency room, it is paramount that those who do succeed in seeking care for assault are not turned away, and instead are treated with a comprehensive, knowledgeable, and trauma-informed approach. Otherwise, the system risks retraumatizing survivors due to poorly informed or under-resourced medical interventions, which may deter survivors from seeking acute care in the future.

**Regional Overview**

The focus region for this project was the Northwest Local Integrated Health Network (LHIN) of Ontario, Canada. The LHIN approach to provincial health was launched in 2006, as a step forward in regionalizing health systems by allowing local authorities to coordinate their services (Born & Sullivan, 2011). There are 14 LHINs in the province of Ontario, however the Northwest LHIN is by far the largest in terms of geography (Local Health System Integration Act, 2006). The Northwest LHIN (Figure 1) encompassed 47% of Ontario's land mass (Thunder Bay Regional Health Sciences Centre, n.d.). This region stretches from the western Manitoba-

Ontario border, east to White River, north to the Hudson Bay, and south to the United States border. This geographically vast, sparsely populated, and largely lower income region driven by resource extraction economies has previously noted difficulties with healthcare deliverance (Health Quality Ontario, 2017; Statistics Canada, 2016). Multiple factors, such as the large rural demographic of the region, the remoteness of communities located within the region, high reported rates of sexual assault, and the presence of a large urban healthcare hub (i.e. the Thunder Bay Regional Health Sciences Centre) all make this region of unique interest for addressing this study's objective of investigating the current state of post-assault care in rural health systems (Health Quality Ontario, 2017; Levesque, 2022).


*Figure 1: The Northwest Local Integrated Health Network encompasses the purple area indicated in on the map.*

### The SA/DV model of care

In 1993, the Ministry of Health and Long-Term Care established the Ontario Network of Sexual Assault and Domestic Violence Treatment Centres (SADVTC) (Ontario Network of Sexual Assault/Domestic Violence, n.d.-a). There are 37 hospital-based SADVTCs across Ontario (Figure 2), each offering services for both acute and non-acute care following sexual assault and/or domestic violence (Ontario Network of Sexual Assault/Domestic Violence, n.d.-a). Acute care includes forensic examinations and evidence collection, treatment for STIs, emergency contraception, risk assessment, safety planning, referrals, emotional support and crisis intervention (Ontario Network of Sexual Assault/Domestic Violence, n.d.-b). Follow up care includes monitoring prophylactic use, reviewing and repeating tests, re-documentation of injuries, assistance with access to social services, and consults for overall wellbeing (Ontario Network of Sexual Assault/Domestic Violence, n.d.-b). This thesis project involved the services of SADV treatment centres located in four major health hubs in Northwestern Ontario.


*Figure 2: Map of Sexual Assault and Domestic Violence Treatment Centres of Ontario Network (Ontario Network of Sexual Assault/Domestic Violence, n.d.-a). Figure used with permission.*

### What is a SAEK?

A SAEK is a forensic tool used to collect and document evidence of a sexual assault. The forensic evidence collected is used to establish if an assault occurred, if force was present, and the identity of the perpetrator through subsequent DNA analysis (Doe, 2012). SAEKs represent a critical juncture between the law and the health care system; they are used by care providers in a medical setting, however their purpose is to document assault for further review by legal personnel. Their objective is not directly linked to the health of the survivor like other resources used in acute sexual assault care (i.e., STI tests, emergency contraception, blood tests).

SAEKs are sealed boxes that include paper drop sheets, bags, combs, envelopes, swabs, bottles, documentation forms, instructions and blood sample materials (Rape, Abuse and Incest National Network, n.d.; Toronto Police Service, n.d.). Physical forensic evidence is best collected within three days after an assault, however evidence may still be available for collection up to 12 days (Toronto Police Service, n.d.). It is recommended that survivors keep their clothing from the time of the assault, and try to avoid showering, bathing and urination prior to the forensic exam (Toronto Police Service, n.d.). The forensic exam's length depends on a variety of factors (such as the degree of assault and the cognitive state of the survivor) however the whole process can generally take 2-4 hours (Rape, Abuse and Incest National Network, n.d.). Provided here is a summary of the steps involved in the forensic evidence examination, as per the Ontario Hospital Association's 'Hospital Guidelines for the Treatment of Person Who Have Been Sexually Assaulted' (2018). The order of the tasks presented here are subject to variation depending on the survivor as well as the practitioner involved in the examination. Additionally, not all these steps may be completed, as the degree of assault and the consent of the patient is integral to the kit's usage.

**Forensic Examination and Data Collection Overview**

1) Clothing and Drop Sheet: Patient undresses over drop sheet so any pertinent forensic evidence is collected from their clothing. Patient's undergarments and clothing are also collected into bags.
2) Oral Samples: Swabs are taken from the gums and teeth margins of the patient.
3) Fingernail Samples: Swabs of the fingernails and fingernail clippings are collected from the patient.

4) Skin Samples: Swabs are made of any locations on the patient's body where the perpetrator is thought to have touched.
5) Blood Sample: A sample of blood from the patient is obtained for forensic analysis. Blood samples are additionally collected at this time for Hepatitis B and HIV screening.
6) Pubic Hair and Foreign Material: Pubic hair containing any deposits is cut and stored. Pubic hair is combed for loose hair and fibres.
7) External Genitalia Samples: Swabs of external genitalia are collected.
8) Vaginal Samples: Swabs of the vaginal fornix are taken.
9) Anal Canal Samples: Swabs of the anal canal and surrounding area are taken.
10) DNA Reference Sample: Patient rinses mouth with sterile water, then a swabbed sample is taken from the inside of their mouth. This will be used as a reference for the previous samples taken.
11) Urine Sample: Urine is collected from the patient and stored in the refrigerator.
12) Upon completion, the contents are sealed into the kit and it is stored at room temperature or in the freezer till it can be given to police officers or sent to a storage unit (in events where the patient has not consented to police involvement).

It is important to also note that once the kit is open, the practitioners are to never leave the evidence unattended. This is done to prevent tampering of the kit, as the contents are legal evidence.

### SANEs and Trauma Informed Care

Sexual assault nurse examiners (SANEs) are registered nurses with specialized training in the treatment and forensic evidence documentation of survivors of sexual assault (Ontario Network of Sexual Assault/Domestic Violence, n.d.-b). The Ontario Network offers SANE training to Ontario practitioners, which entails the completion of online training modules, a synchronous virtual training, and clinical shadowing experiences (Ontario Network of Sexual Assault/Domestic Violence, 2022). These training sessions typically occur twice a year for staff who currently work in the emergency departments of hospitals with a SADVTC (Ontario Network of Sexual Assault/Domestic Violence, 2022). The SADVTCs that are discussed in this thesis typically onboard pre-existing emergency care staff to the SADVTC, and thus route them through the Ontario Network for their SANE training (S. Timmermans, personal communication, December 13, 2022). This enables SANE-trained emergency staff to care for sexual assault care seekers if they present during their shifts.

In addition to being trained in aspects of sexual assault acute and follow up care, SANEs are trained in how to utilize a trauma informed approach when caring for survivors. Trauma informed care can be described as an approach that is grounded in an understanding that the patient may be bringing past or ongoing traumatic experiences into the care encounter (Reeves, 2015). Efforts are made to maximize patient autonomy and minimize distress to the patient, and the care is sensitive to the unique needs of the patient (Reeves, 2015). Previous research by Poldon et al. in 2021 found major components of trauma informed care with SANEs to include an understanding of the patient's experience, developing strong rapport with the patient, emphasis on patient autonomy in care, reconstruction of patient strengths, and acknowledgement

of resilience to support healing. These factors are important to bear in mind when discussing the facilitators to sexual assault care for survivors.

### Study justification

This study is important for a number of reasons. Firstly, it critically discusses the operationalization of rural emergency health systems, especially where they intersect with certain medico-legal structures of our society. It also investigates how urban treatment centres are impacted by the presence of large rural catchment areas. Further, this study investigates how health care practitioners engage with sexual assault survivors, thus lending insight into the way that sexual assault is viewed by emergency care providers of the North. It also allows us to make inferences into the kind of care health providers are able to provide, and how various beliefs and attitudes can shape care provision. Lastly, the largely qualitative nature of this study allows for the barriers and facilitators of acute sexual assault care to be explored in a profound manner, as providers were able to provide depth and description as to what is and is not working in the systems they work in (Green & Thorogood, 2014). Qualitative research has the power to reveal the socio-cultural factors at play in healthcare in a more explanatory way than its quantitative counterpart (Aranda, 2020; Green & Thorogood, 2014). Given the subjective, stigmatized and sensitive subject matter of sexual assault, it is necessary to address the diverse factors that affect care provision. Findings of this study will contribute to the knowledge of health structures in the Northwest LHIN, but will also raise conversations about the provision of sexual assault care in rural medical contexts.

## Chapter 2: Methodology

This study employed a sequential explanatory mixed methods approach. The first phase involved a survey questionnaire and the second phase was characterized by in-depth semi-structured interviews. The survey phase of this study was small-scale and aimed primarily at informing the interview component of the study.

### Phase I: Survey

The questionnaire used for the survey phase of this study aimed to gather information about the overall landscape of sexual assault care in Northwestern Ontario. The questionnaire gathered information about the presence of SAEKs in rural hospitals, the training participants had for conducting forensic exams, participant perceptions of their care competency in treating survivors, participant perceptions of their facility's sexual assault care, the frequency of SAEK usage at their facility, any noted times of the facility's failure to offer a SAEK to survivor, and the availability of psychosocial supports for care providers. The survey was delivered online, and used the LimeSurvey platform. The 18 question survey contained a mixture of multiple choice and free response questions, and was developed for this study specifically by ST with assistance and reviewing from KR and thesis committee members. See Appendix I for the questionnaire used. The survey was tested by a rural Southwestern Ontario emergency department nurse prior to its use in the study. This nurse provided feedback on the accessibility and clarity of the questions, as well as the user-friendliness of the survey platform and structure.

### Phase II: In-Depth Interviews

The semi-structured in-depth interviews ranged from 30 to 90 minutes in length, depending on the amount of information the participant wished to share. Interviews were audio-recorded with the consent of the participant. An interview guide was used to guide the structure of the

interview and to ensure relevant topics were discussed. The guide was developed based upon the research questions and purpose of the study, exploration of the literature, and feedback from thesis committee members. Topics covered in the interview included, occupational background, patient population demographic, guidelines for sexual assault care and/or use of the kit, training for treating survivors and performing forensic exams, instances where care and/or a SAEK was not provided to a survivor, frequency of SAEK usage, ease of SAEK use, challenges of treating survivors, and the psychosocial supports available to themselves as well as survivors. See Appendix II for the Interview Guide used. The interview guide was piloted with a registered nurse who currently works at an emergency department in rural Southwestern Ontario. This consultation verified the interview guide in its present state, and also confirmed that the questions were clear and understandable to those working as care providers in a rural Emergency Department. It also affirmed that the probes for the questions in the guide were important to break down questions into different variations if the respondent was unsure about the initial question asked.

**A) Sampling Site**

All participants for both study phases were drawn from the Northwest Local Health Integrated Network (LHIN) of Ontario. As explained in the Introduction section of this thesis, the Northwest LHIN represents a vast and sparely populated rural region, with previously noted high rates of sexual assault (Levesque, 2022; Thunder Bay Regional Health Sciences Centre, n.d).

**Participant Inclusion and Exclusion Criteria**

Participants were included in this study if they worked (or had recently worked) at a healthcare facility located in the Northwest LHIN that provides acute care to survivors of sexual assault. Participants also needed to be emergency department health care providers in (e.g.

registered nurses, emergency physicians). Providers who had recently worked at such facilities but had since moved on from that location or were retired were still included. We believe that their experiences still offered invaluable insight into the care survivors received, even if they were not actively working in their role. Staff working at emergency centers and/or specialized SADVTCs were included. Individuals excluded from this study were other SA resource workers not trained in health care (e.g. survivor justice advocates, victim services workers, social workers). Those working in more clerical roles that do not provide direct care to patients in emergency departments were also excluded (e.g. medical secretary).

**Sampling Method**

Convenience sampling was used for the survey portion of this study, to access the survey participants that met the inclusion criteria for the study (Marshall, 1996). Participants were offered the opportunity to participate in the survey when the questionnaire link and study information was emailed to them by their hospital administrator or supervisor. Furthermore, they could also opt to participate in the interview phase of the study by expressing their interest and leaving their email at the end of the questionnaire. Other means of obtaining interview participants included purposive sampling. Purposive sampling was used to select participants that could speak extensively on their experiences and expertise in sexual assault care (critical case sampling), and it was also used to obtain participants recommended to us by existing participants (Marshall, 1996). Purposely sampled participants were referred to us by local sexual assault researchers while on-site, or based upon pre-existing research connections.

**Recruitment Process**

The link to the online survey questionnaire was sent to hospital leadership (e.g. the chief of staff or chief nursing officer) of all of the 11 hospitals with emergency rooms located in the

Northwest LHIN. Hospital leadership was asked to forward the questionnaire link and study information to their staff in their emergency department and/or SADVTC. The last question of the questionnaire asked if the survey participant was interested in participating in an interview to provide more insight. Those that indicated they were interested were followed up with by email to confirm interest and plan an interview date. Thesis committee member Dr. Jodie Murphy-Oikonen (social work researcher in sexual assault) at Lakehead University was also able to refer participants to us for the survey and interviews based on past research in the region. Dr. Kathleen Rice (thesis supervisor and medical anthropologist) also referred a few survey and interview participants based on her pre-existing research connections in Northern Ontario.

**Sample Size and Participants**

This study aimed to survey approximately 50 participants and to interview around 10 participants from a variety of Northwestern health centres. We aimed for 50 participants for the survey phase based upon our understanding of the total number of participants at the sites which we aimed to recruit from. In similar studies of this size and scope, 10 interview participants had been found to obtain a sufficient amount of qualitative data for analysis, however it is important to note that the interview data was reviewed and discussed during the interview process in order to ensure sufficient data was obtained. It was found that adequate data was collected after nine interviews.

The survey portion of this study included a total of 32 respondents from across facilities in the Northwest LHIN. Of the survey participants, 16 were registered nurses, 14 were physicians, 1 was a registered practical nurse, and one did not specify their role. 11 of the participants worked at urban health centres, while the other 21 participants worked at rural health centres. Of the 32 respondents, nine respondents answered they would be interested in being

contacted for an interview. However, of the nine emailed, only five participants responded to schedule and successfully complete an interview. Four more participants were included for interviews based on snowball sampling. In total, nine participants were interviewed.

Of the interview participants, two were physicians, three were registered nurses, and three were registered nurses with SANE training. Three men and six women were interviewed. Five of the interviewees worked at rural facilities and four of the interviewees worked in an urban center. All SANEs worked in an urban facility (at a SADVTC) and were women.

## B) Data Collection

### Ethics

Ethics approval was sought and obtained from Research Ethics Boards at both McGill University Faculty of Medicine and Health Sciences, and Lakehead University. Lakehead University has a reciprocal agreement with Thunder Bay Regional Health Sciences Centre (TBRHSC), so this ethics approval option was used to conduct research with participants working at TBRHSC in a timely fashion. McGill University REB approval was obtained in August, 2022. Lakehead University REB approval was also obtained in August 2022, with TBRHSC ethics approval being finalized in November 2022.

### Data collection process

This project is a mixed methods study, therefore both quantitative data from the survey phase as well as qualitative data from the interviews were collected. Survey data collection took place online from the beginning of October 2022 to the middle of December 2022. Interviews were conducted both on Zoom and i-person throughout November and December 2022. Some interviews were conducted on Zoom for feasibility purposes, given the expansive geographical

area of the Northwest LHIN. Other interviews were conducted in-person when I travelled to Thunder Bay and the surrounding area for data collection.

**The impact of COVID-19 on data collection**

Given the pandemic related stressors of work in emergency care at this present time, the number of participants free to partake in an interview was expected to be low. Additionally, survey uptake was low due to the limited availability of both the hospital leadership communicating the study to staff, as well as the care providers who work in EDs. It is believed that these individuals had limited availability due to the unprecedented staff shortages facing EDs at the time of this thesis' data collection, as well as the "tri-demic" of COVID-19, Influenza and Respiratory syncytial virus (RSV) cases. It was therefore difficult to engage participants in this research given their strenuous work hours and taxing work conditions. Nevertheless, given the largely qualitative nature of this study and the depth of discussion in the interviews completed, the data collected is still of critical importance. In addition, there was a pervasive commonality in the topics of discussion with participants, as well as the perspectives raised during the interviews. The repetitive nature of some of the experiences and recommendations brought up across the nine interviews is indicative of a sufficient sample size, which occurred when further interviewing results did not result in the development of new themes (Green & Thorogood, 2014; Varpio et al., 2017). Therefore, these commonalities indicate that the data has effectively captured critical narratives and subsequently common themes regarding access to acute sexual assault care in the region.

## C) Data Analysis

### Transcription

All interviews were digitally recorded with the permission of the participants. A recording was made on the Zoom for the virtual interviews, or by use of an audio recording device for in-person interviews. ST transcribed the interviews with assistance of Otter.ai software. Otter.ai protects the privacy of all data; all personal identifiable information, transcripts and recordings are kept confidential (Otter.ai., 2023). All identifying information (names of participants, patients, hospitals and towns) were removed or altered during the transcription process. Heavy use of filler words (i.e. like, umm) were removed where they were found unnecessary in order to clean up the data. Non-verbal utterances (such as sighs, laughs, etc.) were also added into the transcripts where applicable in order to lend context. All participants were additionally given an pseudonym during this stage. Transcripts were then downloaded and subsequently uploaded to NVivo software (Release 1.7.1) (QSR International, 2022).

### Data analysis framework

This study was of an explanatory sequential design, where quantitative data was first collected and assessed to inform the collection of qualitative data. In this way, we were able to see what quantitative results from the survey required further explanation in the interview phase. The survey results were read and topics of repeated occurrence by the survey participants were made note of (e.g. limited training, transportation challenges). Questions regarding these topics were incorporated into the interview questionnaire. Survey responses also served to fortify and support findings from the interviews.

Thematic analysis was used as the analysis framework for this study–specifically the Braun and Clarke approach (2006)–as this framework would allow for the identification,

organization, description and reporting of study themes in a manner than fit with the research question (Nowell et al., 2017). The six steps of the thematic analysis framework were used to guide the process. In step 1, ST was familiarized with the data during transcription of the interviews. Following transcription, two interview transcripts were read through entirely and initial codes were developed by both the KR and ST (step 2: code generation). These steps of the analysis were characterized by an inductive approach. The initial codes noted from this phase were discussed between KR and ST, and a code book was formed from the initial codes. Then ST used the coding framework to code all nine transcripts in the NVivo software. A deductive approach was used in the coding phase, however new codes were added as necessary throughout this process. Hereby, the flexibility of thematic analysis as a framework was suited to this project and its research question, as it allowed for both a "bottom up" and "top down" approach to the data (Clarke & Braun, 2018).

The resulting codes from this stage of analysis were then reviewed at the end with KR to determine which were most relevant to the research question, and also to gain a sense of how these codes interconnected and formed themes (step 3: theme generation). Through review of the data and discussion, it was also determined that two major categories of barriers were formed by the themes that discussed challenges to care (steps 4 & 5: reviewing, defining and naming themes). In step 6, themes were presented to and reviewed with the thesis committee (utilizing exemplar quotes) to gain feedback and allow for further expertise involvement in the data analysis.

Due to the unequivocal and heavily gendered nature of sexual assault, the qualitative data of this project was viewed using a feminist theory approach. In particular, materialist feminism theory was considered, which acknowledges agency, authority of the human experience, and the

division between object and subject aspects in the healthcare interaction (Aranda, 2020). This theory addresses the dynamic agency held by both the human body of the survivor and the non-human object of the SAEK (Aranda, 2020). Further, the concept of shifting from 'what is told' to 'what is produced' is kept in mind in terms of the societal shift from the telling of sexual assault narratives to the production of forensic evidence (Aranda, 2020). The flexibility of the thematic analysis framework allowed for code and theme development to occur alongside feminist theory, enabling further exploration about the social meaning of the findings (Clarke & Braun, 2018; Clarke & Braun 2019).

**Assessing for rigour and trustworthiness**

The data collected from the interview phase of this project was analyzed in conjunction with assessing other literature regarding rural health system challenges, provision of sexual assault care, and research taking place in the Northwest LHIN. This allowed us to understand that the data found was consistent with research findings in the area of sexual assault and rural care. After coding all nine interview transcripts, very few new codes were developed. This, in conjunction with a review of relevant theory, critical case sampling, and the specificity of the research question, allowed us to conclude that sufficient information power was achieved by the sample size of nine interviewees and 37 survey respondents (Varpio et al., 2017).

Formal member checking was not used for this study, as it was not viewed as feasible given the taxing work schedules of the health care providers participating. However, the interviewer would often summarize what was said by the participant during the interview, in order to clarify the accuracy of personal accounts.

Credibility was established by matching the method (mixed: survey and in-depth interviews) to the research question of the project. A mixed methods approach was chosen in

order to reach a broad amount of participants in rural hospitals of the LHIN (with the survey phase), and then to engage with a number of the participants in a more explanatory and in-depth manner. Credibility was also ensured through the informed consent process and prolonged engagement with the data. Triangulation was achieved through representing multiple participant voices in the data, and also by the inclusion of care providers from a number of different hospital sites across the LHIN.

The themes of the project were co-analysed with supervisor Dr. Kathleen Rice, who has expertise in the area of qualitative health research methods and feminist theory. Furthermore, findings of the study were presented to the thesis committee, whose members were also able to comment on their relevance of the findings due to their range in expertise. This process ensured that the project's findings were verifiable; they were compatible with known qualitative research frameworks, as well as the research question itself.

# Chapter 3: Findings

## 1) Survey Findings

The survey phase of this study was designed to gain insight into the state of sexual assault care in the Northwest LHIN. The findings from the survey informed the interview guide for use in the qualitative stage of the research. A copy of the questionnaire that was used can be found in Appendix (I).

The survey received a total of 37 responses. Participant demographics are depicted in Table 1. The majority of the survey respondents were care providers working at rural facilities that did not have SADVTCs (67.6%). There was a near even number of nurses and physicians that responded from both rural and urban facilities, with 12 nurses and 10 physicians working at rural hospitals, and four nurses and four physicians working at urban hospitals.

*Table 1: Demographics of Survey Respondents*

| **Type of Health Care Provider** | **Rural Hospital without SADVTC (n=25, 67.6%)** | **Urban Hospital with SADVTC (n=12, 32.4%)** | **Total (n=37, 100%)** |
|---|---|---|---|
| Registered Nurse | 12 (32.4%) | 4 (10.8%) | 16 (43.2%) |
| Registered Nurse with SANE training | 2 (5.4%) | 3 (8.1%) | 5 (13.5%) |
| Physician | 10 (27.0%) | 4 (10.8%) | 14 (37.8%) |
| Physician's Assistant | 0 (0.0%) | 1 (2.7%) | 1 (2.7%) |
| Registered Practical Nurse | 1 (2.7%) | 0 (0.0%) | 1 (2.7%) |

I have organized my survey findings to be reflective of the major themes that were addressed in the questions of the questionnaire.

**SAEK availability and sexual assault training**

The vast majority of the emergency care providers who participated in the survey responded that their facilities had SAEKs (n=28, 75.6%). The majority of respondents also believed that the kits were readily available for use in the hospital and did not require police involvement prior to use (n=29, 78.3%). One participant (n=1, 2.7%) believed that police involvement was required in order use the kit.

In terms of training, six of the survey respondents (16.2%) were trained to the level of a Sexual Assault Nurse Examiner (SANE). Eight respondents (21.6%) reported training from within their hospital/department, and ten (27.0%) reported receiving sexual assault training during their professional education. Nine participants reported they had received no training (24.3%), and five described other forms of training (13.5%), such as virtual information sessions or workshops from local SADVTCs and/or the Ontario Network.

Interestingly, for those that had received any form of training on sexual assault, many reported the time devoted to the training was only 1 hour or less (n=7, 18.9%), or 2-5 hours (n=9, 24.3%). Two participants reported 5-10 hours' worth of training (5.4%), and four reported more than 10 hours of training (10.8%). These more highly trained participants were those who had received SANE training and were working at SADVTCs in some capacity.

The vast majority of the participants (n=21, 56.8%) responded that they wished there were more opportunities for sexual assault training in their job. The types of training they desired included: the collection and documentation of forensic evidence, charting on sexual assault, hands on training opportunities, general interview skills and how to discuss sexual assault with

patients, knowledge on what supports exist for patients, patient navigation and road maps for sexual assault care, and trauma informed nursing practices. For example, one participant noted within the survey their desire to have more trauma informed patient care training: "*[I would like] training specifically on supporting the physical and mental health needs of survivors of sexual assault"* (Participant 19). Participants also made note of their desire for more accessible training, and wished that leadership would provide more opportunities for skills improvement in this area.

**Frequency of sexual assault care provision and perceived challenges**

Participants were asked how many times they had provided care to survivors of sexual assault in the past six months. Some of the participants had not treated sexually assaulted care seekers at all in the past six months (n=9, 24.3%). Seven participants had treated sexually assaulted care seekers once (18.9%), and an additional seven had treated this group 2-3 times (18.9%). Four respondents treated survivors 4-5 times (10.8%), and another four treated survivors 6 or more times (10.8%). Though the frequency of exposure to sexual assault survivor seems quite variable, the majority of cases were seen by urban practitioners. Seven out of the nine urban practitioners (78%) cared for survivors two or more times in the last six months. On the other hand, 16 out of the 23 rural practitioners (70%) noted caring for sexual assault survivors once or not at all in the past six months.

For 12 participants, to their knowledge there had been occasions where their hospital was unable to provide a forensic examination to survivors (32.4%). This had happened once for six of the respondents (16.2%), 2-3 times for three respondents (8.1%), and 4-5 times for an additional three respondents (8.1%). Reasons given for being unable to provide forensic exams for survivors included a lack of adequately trained staff (n=9, n=24.3%)), staffing shortages (n=10,

27.0%), and running out of SAEKs (n=2, 5.4%). Three participants from rural hospitals further explained that they do not have the human resources in their Emergency Department to complete the lengthy forensic examination process, since they usually operate with only one physician and one nurse overnight (n=3, 8.1%). The time-consuming aspect of the kit was noted to slow or even stop the Emergency Department's flow of patients, as one survey respondent said: "*In a busy ER and being the sole physician, doing one of these kits is difficult to maintain the flow of the ER"* (Participant 41). Patients were asked to wait till another care provider could be located, however some patients opted to leave 'AMA' (against medical advice).

**Perceived competency in sexual assault care provision**

Participants were asked if they believed that the services available at their facility met the physical and mental needs of survivors. Findings demonstrated a nearly equal division of affirmative and negative responses. Thirteen participants agreed that the services did meet survivor needs (35.1%), while 11 disagreed that the services met the needs of survivors (29.7%). Six participants were undecided about their facility's services (16.2%).

Respondents were also asked if they believed that they possessed the skills to use a SAEK for a patient presenting after a sexual assault. The majority of the respondents (n=19, 51.4%) did not believe they had the skills, while 12 participants believed they had the skills (32.4%). The majority (n=15, 40.5%) of those who did not believe they possessed adequate skills were from rural centres.

**Psycho-social supports**

The questionnaire also asked about the availability of psycho-social supports for care providers who treat survivors of sexual assault. It was described to participants in the questionnaire that these supports could include team debriefs, counselling, time off work, or

anything else that the respondent perceived as a support to their mental health and wellbeing. Nineteen participants responded that they felt they had access to psycho-social supports (51.4%), while nine responded they did not (24.3%). When asked what supports the participants had access to, respondents stated post-event debriefing, in-house social work, and counselling through the Employee Assistance Programs (EAP) and the Ontario Medical Association (OMA) physician health program.

Participants were also asked what psycho-social supports they wished they had more access to. One participant described how their facility is supposed to have team debriefs following critical incidents, but the debriefs do not happen as frequently as they would like (2.7%). Five participants remarked how they wish they had access to some variation of trauma debriefing, with a trained third-party facilitator (13.5%). Another participant remarked that in-house social support is supposed to be confidential, yet private information makes it way to the floor and can be shared with other staff. Furthermore, given the small size of many of the communities in the study, another participant cited a desire to have individual third-party counselling, which would offer more confidentiality.

**2) Interview Findings**

A total of nine participants were interviewed for phase two of this study. The interview participant demographics can be found in Table 2. There was a balanced number of participants from rural (5) vs urban (4) centres. Three of the participants interviewed were men and the other six participants were women. The participants ranged in age from late 20s to early 60s.

*Table 2: Demographics of Interview Participants*

| ***Type of Health Care Provider*** | ***Rurality*** | | *Total* |
|---|---|---|---|
| | **Rural** | **Urban** | |
| **Physician** | 2 | 0 | 2 (22%) |
| **SANE** | 0 | 3 | 3 (33%) |
| **Registered Nurse** | 3 | 1 | 4 (44%) |
| *Total* | 5 (55%) | 4 (44%) | 9 participants |

The interview guide was informed by results of the survey, and from the existing literature. Findings from the survey were read through prior to the interviews. Commonly cited answers and topics were incorporated into interview questions for further examination. The interview guide can be found in Appendix I.

The findings described here are based on my thematic analysis of the interviews, which was conducted using an inductive approach (Clarke & Braun, 2018). Through the analysis I developed five themes. The themes are presented here as follows:

1) **Training and Legal Implications:**

This theme focuses on lack of technical and trauma informed sexual assault training for use of the SAEK and the overall care of sexual assault survivors. Challenges associated with the kit's use are presented, such as its intimidating legal aspects, onerous instructions, and its use of time.

2) **Lack of supports:**

This section will address the paucity of psychosocial supports for providers who treat sexual assault survivors. Additionally, I will examine how the current system structure increases the burden placed on key leaders in health centres who possess sexual assault training.

3) **Resource constraints:**

The second barrier is the health resource constraints that arise in the North; these relate to distance to reach health centres, staffing shortages, and lack of follow up services in rural areas. Resource depravities were also noted to lead to interpersonal tensions amongst healthcare providers.

4) **Socio-cultural barriers:**

The final theme and barrier, which I term socio-cultural barriers, was derived from the perceptions of healthcare providers when they discussed the care of acute sexual assault survivors. Factors such as police involvement, intoxication and Indigeneity will be discussed in the context of sexual assault. The ways in which providers discussed past care incidents, as well as the language used in discussing (or speaking of) survivors, lent insight into the barriers arising from the stigmatization and marginalization of sexual assault in the Northwestern Ontario LHIN.

5) **Facilitators:**

This theme will present the recommendations and facilitators that were proposed by participants to address the structural related barriers (such as lack of supports, expertise and transportation).

Please note that all names used throughout this thesis are pseudonyms and identifying information has been removed.

**Theme 1: Training and Legal Implications**

Participants noted many difficulties with using SAEKs when documenting forensic evidence of assault. Most of these noted challenges came from participants who did not have SANE training; these participants were rural practitioners whose only exposure to the evidence

collection process was simply reading through the kit instructions each time it was used during care. The SAEK challenges highlighted by participants included the complex instructions of SAEKs, the onerous length of the forensic exam (variably 2-4 hours), the frequency of their use, as well as the intimidation of legal aspects associated with the SAEK. As one participant noted of the SAEK, "*They can seem really overwhelming."* Feelings of intimidation from the legality of the kit refers to providers' apprehensions about potentially collecting evidence incorrectly due to their lack of education on SAEKs, which could affect the legal outcomes of sexual assault cases. They also felt intimidated by the potential to have to testify in court regarding the case, particularly given their lack of training.

If staff at smaller rural hospitals found they needed more practise with SAEKs, this was something that they had to seek out on their own in order to feel prepared. Some participants recalled looking up information about the kits in their free time in order to familiarize themselves with the exam process. Others stated that they take 10 minutes before beginning the forensic exam to go through the detailed instructions to help with the flow of the exam once they begin.

Another challenge of the SAEK is the time it takes to complete the forensic exam. The entire process can take anywhere from two to four hours – or even more. The lengthiness of the forensic exam is only compounded by lack of proper training on how to use the kit, and thus the provider's competency with this skill. Staff without formal SAEK training (such as Laura), found they need to read all the specific instructions as they go along: *"It's a process. Like, they're very well laid out. Like it tells you exactly what to do. But it is very time consuming."* Furthermore, many small rural hospitals may only have one nurse and one physician working each shift.

Complications can arise if additional patients arrive during the forensic exam process. The following quote brings together the issues of survivor vulnerability, the lengthy time commitment that exams entail, and the issue of staff absence for the broader healthcare team:

> It's exhausting for the patient to deal with this for four hours straight, that I'm constantly poking, prodding and, you know, looking at them naked, and then having to touch them then. But it's also difficult for my staff, my co-worker that I've left in the department by themselves. (Louise, Emergency Department nurse, rural hospital)

Many participants found the potential legal implications of assault and the SAEK to be intimidating. Maintaining the legality of the kit was described in a devout and grave manner by participants. In order to preserve the chain of evidence, care providers went to lengths to ensure that the kit was used in a way that conforms to the rule of law, however uncertainty about the legal specifics created tension for the provider:

> There's that underlying anxiety of like if we do something in the wrong order, if we take this swab first versus that spot, like is that going to invalidate the kit? Because it's one of those circumstances where the legal aspect just seeps so heavily into what we're doing. (Gabe, Emergency Department physician, rural hospital)

Likewise, the extensive devotion to the chain of evidence is emphasized in how the participant brought legal evidence to the lunchroom with her to protect it from possibly tampering:

> So, we finished the kit and I literally carry that kit with me, until one of either our Treaty 3 officers–which is our Indigenous police–or our OPP come and pick it up. I've even brought a kit to lunch with me. (Louise, Emergency Department nurse, rural hospital)

Care providers also emphatically stated how they didn't want to "*screw it up*" for the survivor, and therefore be the reason why a sexual assault case didn't hold forensic rigor in a court of law. They also feared the potential of having to testify in court about the incident. This uneasiness – in combination with their perceived incompetence due to lack of training – made them more apprehensive about performing the forensic exam. The uneasiness that interviewees had about legal aspects of the kit's object surfaced in multiple conversations with care providers. In the following quote from nurse Ryan, we can see the connection between poor training and the consequential legal implications that can have for the survivor:

> I don't want to get into this because I don't want to want to tamper it, to screw it up. Because then me screwing up leaves this patient out to dry and then it turns into nobody's fault, because I did something wrong. And I think–from even listening to myself talk–it's like, I don't have the adequate information to be able to provide appropriate care. (Ryan, Emergency Department nurse, urban hospital)

The documentation of the assault can have implications beyond the patient encounter, and this serves as a source of anxiety for many care providers, especially those with less training. However, participants also noted that the intimidation aspect of the kit can also come from the emotional demand of caring for someone who is emotionally traumatized. For example:

> There's a lot of trepidation. Myself included. That you're going to screw it up, for lack of better words. That you're going to get it wrong. You're going to jeopardize– you're either going to jeopardize the evidence chain, or you're going to traumatize the patient unnecessarily or inappropriately.
>
> (George, Emergency Department physician, rural hospital)

All of the interview participants noted a lack of training for sexual assault care in the education for their respective professional degrees. Participants stated that they could not recall discussion of sexual assault care in any meaningful capacity, nor training about the basics of the forensic examination process. When asked about the training they received in nursing school, a SANE responded with, "*Zero. Zero. Nothing. Not at all."* Furthermore, an ER physician spoke about the lack of formal training in sexual assault:

> No, this is abysmal. So, I went to [university] for my undergrad medicine as well as residency. And to my recollection, it didn't even come up. Not just the kit, but how to manage patients you know, following sexual assault. Maybe passing mentioned in some other gynecology lecture or something. But it's abysmally under trained, or not trained, or ignored, or whatever, whatever you want to call it.
>
> (Gabe, Emergency Department physician, rural hospital)

Others learned from leaders at their workplace who had seen the need for some level of SAEK training:

> My preceptor was really big on this, and it was good because, you know we don't see these every day, right? So, it's something that, you know, might sit on the top shelf in the Emergency Department and if you don't open that…you know? So, with my preceptor–it was actually a few night shifts–they had a practice kit, and what we did was just go through the whole thing, just so she knew that I was aware.
>
> (Nicki, Emergency Department nurse, rural hospital)

Others still learned in very experiential manners while they were working in hospital. For example, one participant recalled how they had to learn how to use a SAEK for the first time by just reading through the instructions while conducting the examination with the survivor who presented to the hospital following assault. Throughout the interviews, it was clear that SAEK training at rural hospitals was very minimal compared to that of SADVTCs. One SANE reflected on the differences in training between her past job at a rural hospital and her current SADVTC role:

> I didn't have any [cases] while I was working there, and the training that they gave there was not great compared to what it is that you get here. Their training for sexual assault– because you would have to do it– was basically: a sexual assault comes in, this is the kit, this is the binder, go through it at the time and just follow the steps.
>
> (Sam, SANE, urban hospital)

Sam highlights a key point about forensic exams in rural Emergency Departments: they don't come in often, but when they do, you *have* to do them. Given the sheer distance to an SADVTC from a rural site, providers at rural hospitals must be able to provide a forensic exam to survivors who wish to have one. However, rural providers are expected to competently use SAEKs but with much less training than their SANE counterparts.

Aside from the technical aspects of the forensic exam, non-SANE participants also experience uncertainty due to lack of training on how to converse with traumatized survivors. Care providers were unsure of how to navigate difficult conversations about the assault, and also how to provide care for survivors in a trauma-informed manner. The following quote exemplifies the desire to provide sexual assault care in a way that accounts for patient autonomy while recognizing the invasive nature of the forensic exam:

> Even just like, what is the trauma informed part of it? I don't want to feel like I'm doing this to you. I want to feel like I'm doing this *for* you. And I think that that's maybe something that just a little education piece or something on just like how to better approach it with people? Because they are, they're invasive.
> (Laura, Emergency Department nurse, rural hospital)

Additionally, participants acknowledged the strength in building rapport with their patients, something that is crucial to any healthcare interaction, but debatably more so in those involving a stigmatized and highly personal subject like sexual assault. Therefore, care providers expressed their desire to have more training in how to communicate with survivors in ways that fostered

trusting relationships, while recognizing the role of trauma in the care encounter. For example, when asked what she envisioned for future training opportunities, rural nurse Nicki responded the following: *"I think counselling-like trainings, because I have no intention of ever saying the wrong things, or you know coming across…but it's hard because these are very sensitive topics. And you know that trusting relationship is huge to build, right?"* However, just as before with the technical training aspects of sexual assault, a trauma-informed approach does not appear to be included in any memorable way in the formal education of clinician. As one rural physician stated: *"Trauma informed care, just since you mentioned that phrase, like absolutely not something we got in medical school or residency."*

The display of emotion was viewed by SANEs as an aspect of care that fostered trust in patient-provider relationships, and education holds potential to teach providers empathy skills. As Pamela explains, emotion signals to the patient that you are human:

> I won't lie, there have been times that I have cried with a patient. But not, like in an uncontrollable fashion. Still, you know being the one that's sort of in charge and caring for the patient, but also a human. I don't think we have to not be human.
> (Pamela, SANE, urban hospital)

However, for some participants, emotionality was interpreted as a weakness and barrier to good care. For example, George believed that sympathy could be detrimental:

> Personally, I find it very hard to be emotionally objective. Because you feel immediate sympathy for the patients, which is sometimes not useful. You lose all of your objectivity with this, these stories, which can be a detriment to your patient care.
> (George, Emergency Department physician, rural hospital)

The regulation of emotions in the face of human suffering was seen as a difficult aspect of the job for many of the participants. As we can see from the above examples with Pamela and George, a unique difficulty arose from the emotional line that participants walked in terms of showing too much or too little empathy for their patients.

**Theme 2: Lack of Supports**

Participants were asked about the accessibility and receipt of psychosocial supports available to them as providers to sexual assault survivors. Those who worked in SADVTCs remarked that the psychosocial supports available to them through employee assistance programs (EAP) did not meet their needs. The underlying reason for this was a lack of knowledge and awareness about the specificity of their work with survivors. Lack of psycho-social supports would make for an isolating occupation, if it wasn't for the support supplemented by colleagues in the profession. As Amanda put it:

> Like on paper, I should be able to go to leadership for support. But the issue is nobody knows what I do. And the only person in the hospital who really knows what I do are the nurses that are trained to cover for me or help me in the office. It's like a lot of mutual support that happens. (Amanda, SANE, urban hospital)

Care providers learned to become reliant on each other to work through the emotionally tolling aspects of their job. They recognized the vicarious trauma of working with sexual assault survivors, and how this impacts their mental health. For example, Sam describes the support she receives from her colleagues:

> I don't know if I would really be able to do this job [without support provided by coworkers], because you do have the burnout with this as well, right? I mean, there is that real burnout that you can have with seeing this type of clientele for so long. And I don't know if without that support, if I would be able to do it for long term, right? It works because we are so supportive. (Sam, SANE, urban hospital)

It is apparent from the conversations with participants who specialize in SADV that the job takes a certain type of person; SANEs noted their ability to "*tolerate a lot of really horrible information*". SANEs also spoke highly of being able to be there for survivors *"at times in their lives that they are really the most vulnerable, in tremendous pain, and really being challenged in many ways".* However, in addition to mutual support, participants still expressed the need to discuss experiences confidentially with a third party, and also how to debrief encounters with survivors in a healthy manner. Amanda describes how she pays for external support to facilitate debriefs with the SADVTC staff:

> I pay for my own debrief training once a week. I pay $180 once a week to do that formally because I don't get it here. I have attempted to access different things. We have

> like a care program and I met with that person. It was not what I needed. Again, because they probably didn't have an understanding of what I do. So, I pay for that now. I pay for my own debrief training. (Amanda, SANE, urban hospital)

It is important to note that the lack of formal debriefs is not specific to sexual assault cases. Participants noted that structured team debriefs were also lacking for other types of traumatic calls in the ED, especially in rural hospitals. For example:

> Our hospital is not great about like a formal debrief like a few days later kind of thing. Largely we don't have the time, we're all like overworked, we wouldn't be able to schedule it, etcetera, etcetera. So even other types of major clinical events… like we haven't done our, our morbidity and mortality rounds in like, a year or something? So, no, we're not good about formal debriefs.
> (Gabe, Emergency Department physician, rural hospital)

Lack of supports for providers is also related to lack of time and resources to provide it. Staffing shortages and impacts of the COVID-19 pandemic have only compounded the ability of staff to have formal debriefs and discuss emotional aspects of their work, in addition to the technical ones. The result appears to be frustration, burnout, and feelings of isolation amongst the care providers, which exacerbated by emotion heavy cases like sexual assault. As nurse Ryan stated, "*It's eating nurses alive, this healthcare system right now. It's like demolishing us."*

Lack of supports for staff results in a reliance on one key individual for the expertise and psycho-social assistance crucial to treating sexual assault survivors. This reliance on one person was a recurring theme throughout the interviews with participants from both rural and urban centres. If an individual on staff at a rural hospital sought out SANE training, they would be referred to for all future sexual assault cases and usually placed on-call to treat sexual assault. However, with a single person responsible for the majority of sexual assault examinations, problems could arise when that individual is absent. For example, the following participant described a SANE trained member of staff who was referred to as the sexual assault "*guru"*.

> She was our guru. So if someone would come in, we would phone her. And she would come in and do every single one of them. But she retired. So now we're doing them. (…) Her experience alone made it so she could probably do [a forensic exam] in two hours. (Louise, Emergency Department nurse, rural hospital)

However, having only one person on staff with sexual assault expertise resulted in problems providing care when that person was unable to come in. As Louise mentions, the *"guru"* used to do all the exams, but now since her retirement, the non-trained staff have had to rise to the occasion, albeit without the proper training. Furthermore, the lack of care providers has resulted in leaning on only one person to provide that care in the first place. Lack of psychosocial-support from the system results in that key person being leaned on for emotional support from their colleagues as well. One SANE spoke of her supervisor, saying: "*She is literally my only support. Probably not, but she is probably the biggest support. And it's like everything."* Reliance on one person for expertise, care and support presents a sustainability issue if that key person were to

leave their position. Furthermore, it is important to understand that the heavy weight of responsibility on certain key individuals comes with certain risks, especially if organizations were to lose those leaders to burnout. This was reflected upon by another participant who had witnessed the burden of responsibility on their coworker:

> For somebody so passionate, there needs to be supports there for her. Because for somebody who's doing so much work in the field… to lose that? Because of stress and because of workload? That's not fair to her, then not fair to the patients. But then now that whole forward moving motion is gone because she's burnt out.
> (Ryan, Emergency Department nurse, urban hospital)

**Theme 3: Resource Constraints**

Northern Ontario is no stranger to a lack of adequate healthcare resources. Given the huge expanse of land that the Northwest LHIN encompasses for a relatively sparse population, unique resource constraints arise when delivering healthcare. Sexual assault care is unique in that any limitations presented at the healthcare level will also have implications for legal justice.
Given this vast geography, transportation was an issue for many healthcare providers. It was noted by participants that the transportation of care seekers to SADVTCs (or even to non-SADVTC hospitals) is an issue, especially in rural and remote locations. Most care seekers travel to the hospital closest to them following sexual assault, if they chose to seek medical attention. However, these hospitals may not have SANE practitioners on staff, especially if they are extremely rural sites. From my conversations with rural care providers, care seekers will usually be offered a SAEK and sexual assault care despite not being a SADVTC. However, some staff

may refer survivors to SADVTCs based on their comfort with treating the patient, the degree of assault, and the age of the care seeker. Travelling to a SADVTC may require extensive transportation, which is especially difficult when survivors are in a vulnerable state. Additionally, survivors are discouraged from showering, changing their clothes, and urinating to preserve forensic evidence. The care delay due to transport is illustrated by the following SANE nurse:

> Some of the really Northern communities sometimes might have to wait for that Ornge transport, like helicopter or plane or whatever. So that might take a little bit longer, especially in the winter, because it's just harder to be able to leave and take off and land in those places. So sometimes that puts a delay, especially for those acute cases that have to come in, because we're supposed to see them in within a certain period of time. (Sam, SANE, urban hospital)

Pediatric cases especially, are to be seen by pediatric specialists at SADVTCs. There is only one pediatric specialist in the region, and thus pediatric cases require transportation to reach specialist care. Accessing paediatric emergency care therefore has additional challenges, as addressed by an emergency room nurse :

> We have had requests to do kids before, like pediatric ones. And those ones, to my knowledge, we've never had anybody touch it with a 10-foot pole. Those ones we usually send off to [the SADVTC]. But then a lot of times that like transportation is an issue to get to [the SADVTC] and back and then just like the trauma of it, we usually kind of get people that will decline to go. (Laura, Emergency Department nurse of rural hospital)

Participants spoke about several barriers that the long commute to urban centers created for survivors. One such barrier was the noted lack of family support and the added stress of leaving a familiar environment; this caused some survivors to decide not to seek care or evidence collection. Due to the complex difficulties associated with long commutes to SADVTCs, rural hospital leadership have told staff to simply treat and examine adult sexual assault survivors on-site, as opposed to sending them to the SADVTC.

However, this option is also not without challenges because as previously explained, many rural care providers lack SANE training. Additionally, the time consumption factor of the forensic exam (two-four hours) was described as a problem for those rural practitioners that work in centers with only one nurse and physician on staff during the night. This results in forensic examinations being put off till the next day when an extra staff member can be located, thus increasing wait times for the care seeker. Transportation issues also occur for survivors seeking follow up care; some care seekers may not be able to secure transit to and from appointments, or even childcare for their time away from home. Pamela illustrated her experiences with this as a SANE: "*Can you get to the hospital for your appointment? Maybe you'd love to get your bloodwork repeated. But coming on the bus might take you two hours, and you have a two year old and a three year old and a four year old.*"

Taxi vouchers were cited by Emergency practitioners as a means to assist with transportation issues for survivors, but funding for that service was severely reduced, which caused difficulties in making sure survivors could get home safe. Furthermore, since SADVTCs operate out of an

Emergency Department, survivors may be in the care of non-SANE providers at the time of their discharge. This transition of care could result in discharge and transportation complications. For example:

> So yeah, like the SADV nurse would come in, we would do our thing, then we would pass the patient back to the Emergency Department if there were other care factors that need to be seen by the physician or cleared, discharged, whatever. And so it happened that they sent a developmentally disabled girl home on the city bus very late at night after a sexual assault. (Pamela, SANE, urban hospital)

In the above example, a taxi voucher would have been helpful for the survivor to get home safely. These findings highlight that although transportation to and from hospitals can be challenging for any kind of patient, sexually assaulted care seekers experience added emotional vulnerability due to trauma. Participants recognized that this meant safe transport to and from hospital was even more critical for these individuals.

Workplace challenges such as staffing shortages, on-call system difficulties, and the overall Emergency Department environment caused added constraints for care providers of sexual assault. These challenges resulted in tensions amongst care providers, and between care providers and the hospital leadership. When a sexually assaulted care seeker presents to an Emergency Department, the staff member who performs the forensic examination with that patient must give them their undivided attention for the next 2-4 hours (or more, depending on the situation) to protect the legal chain of evidence. Therefore, the patient care load that the

provider had prior to the sexual assault survivor's arrival will be redistributed to the other Emergency Department care staff, as the following participant explains:

> You got your area, there's the A, B, C, and D area, right? So, there's say in C, five or six nurses, who were at six [patients each]. Now, the one nurse in the middle is the SADV trained nurse and she gets pulled to do the SADV case. So now, her patients need to get dispersed, because she's pulled within the team, right. So now you have an influx of six critical patients depending on what areas. You have to deal with that SADV case. I think that's where some of the frustration comes from.
>
> (Ryan, Emergency Department nurse, urban hospital)

Participants stated that the redistribution of patients–and the subsequent increase in patient care loads–following the arrival of sexual assault survivors to the Emergency Department would create a sense of animosity towards sexual assault cases. Resentment included overburdening other nursing staff with high-acuity cases, and the perception from staff and administration that SANE nurses were making these decisions that disrupt the patient flow. Although most participants spoke of their frustration with respect to the circumstances, one interviewee recognized how this frustration also extended to the patient level. Ryan described how appalled he was by the lack of empathy displayed by colleagues when sexually assaulted care seekers arrived at the hospital.

> It's not so much animosity towards the [SADV] team, it's more animosity towards the situation of the patients and or towards the patient, is way that I perceived it. And then it

> just trickles down, right? (…) It's like, "ugh I can't believe there's another patient here that needs that." You know? Because like I said before, it takes away that nurse from the already taxed nursing staff in that department.
>
> (Ryan, Emergency Department nurse, urban hospital)

High turnover and poor staffing in overtaxed Emergency Departments also created strained and tense situations, which were exacerbated when sexually assaulted patients arrived:

> It's that turnover rate is so high. So now there's a lot of new people in Emerg, whether they're new grads or just new nurses to Emerg. It's a different kind of nursing. So, trying to juggle the different caseload and the different responsibilities that you have in Emerg, as opposed to working on the floor, or as a new grad, is really difficult to do. And then if you put extra patients on top of it because one of your coworkers gets pulled [to treat a sexual assault], it's even worse. And I think that's also contributing to burnout.
>
> (Sam, SANE, urban hospital)

The pressure of high patient loads for their colleagues caused those care providers treating survivors to feel rushed through forensic examinations. This was noted by participants to be at odds with their desire to provide slow and consensual sexual assault care and documentation:

> I feel bad, I feel like I have to rush, they're knocking on the door. So much so that I've made a laminated sheet that they flip over when we have a patient that says, do not knock on the door, if it's an emergency and you need to talk to me call the phone in the room.

> Because we were being interrupted so much about things that like, being rushed into it. (Amanda, SANE, urban hospital)

Care providers said that additional staff could be called in to assist when high patient care load situations arose. However, these attempts to locate more staff were usually unsuccessful, because there are so few staff and also because they are overworked. This again may result in survivors needing to wait multiple hours for the kit to begin, as they would need to wait till another care provider was available. Participants reflected that despite these long wait times, they tried to work with the resources that they had in order to meet the needs of the survivors. This usually meant discussing with the survivor to arrange a time they could come back to the hospital or providing them with a bed to rest in till the forensic examination could be provided.

Some SANE trained participants found that their fellow Emergency Department co-workers did not understand the detailed extent of their job, and the undivided attention to the patient that it requires. Lack of resource allocation to this area of emergency care has certainly served to deepen the perceived disconnect of providers, which impacts the ability of SANEs to do their job. In the following quote, Amanda discusses how lack of time and resources to serve gaps in knowledge about sexual assault in the ED perpetuates this disconnect:

> Our charge nurses, our leadership, our other Emergency Department team members don't know the process, don't know the assessments, don't know the questions, don't know what's actually going on when the SADV nurse steps behind that door with the patient. So, I think that still–even after how many years–is a gap area. But there's not been kind

> of the time and resources set aside to address that so that they can have a better understanding. (Amanda, SANE, urban hospital)

Another SANE recalls an incident where this disconnect is apparent when a physician asked her to do a forensic exam for a survivor in an unreasonably short amount of time, with an intoxicated patient. Survivors are required to be sober to consent to forensic examinations, however the physician in this example didn't want to keep the survivor in the ED all night.

> I can just remember one physician telling me that I should do the kit and that it would only take him an hour [to complete]. (…) The patient was intoxicated. So, I was refusing to do the kit till they could sober up and give proper consent, or else the kit would be useless. And so [the physician] was annoyed by that. Because you see, keeping a patient in Emerg all night until they sober up is not what Emerg wants to do.
> (Pamela, SANE, urban hospital)

A few SANE participants also wished that their non-SANE co-workers had a greater baseline level of knowledge in caring for survivors. Deficits in knowledge about sexual assault is noted as resulting in a "*siloed"* approach to care for survivors. As one SANE described: *"There was– there still definitely is– a silo when it's like, oh, it's an SADV? Hands off, I don't have to do anything. The SADV person will do it."* (Amanda, SANE, urban hospital).

Some participants perceived that hospital leadership too exhibited a lack of understanding about sexual assault care. The leadership of some hospitals involved in this study allegedly attempted

to train all care providers of the Emergency Department to the level of SANE. However, participants from this center believed this approach was flawed, and stated "*voluntelling people*" results in "*watered-down service*", survivors walking out of the ED, and not returning for follow-up care. As one SANE stated of this model: "*I'm telling you right now, the mess that you'll have to clean up afterwards is much more significant."* Recently however, hospital management has significantly cut the amount of training time allocated to the SANE on-boarding process, again exemplifying their disconnect to the work of SANEs and their lack of awareness about the depth of SANE training. Here a SANE describes the change in SANE training time at their facility:

> It went from three full eight-hour days and shadow shifts to – well, they tried to give me just four hours. And I said that's absolutely insane. So now I get a four-hour day and an eight hour day [to train new SANEs]. And no shadow shifts. So, we went from three full days to 12 hours. I have had to create documents and checklists and videos and all of these things to try and bridge that gap and hope that the people that are being trained will review that information. I jam pack so much information into them in that 12 hours. (…) I want the hospital and our leadership to invest time and resources into adequate proper training, to develop a baseline for even the leaders who are supposed to be able to support the team and the work that we do. (Amanda, SANE, urban hospital)

It appears that the resource constraints in Northwestern Ontario result in pressure being placed by leadership on the SANE team, which then leads to interpersonal tension and disconnect in the workplace.

I want to call attention now to the variations in follow-up for survivors of sexual assault at one rural hospital and one urban hospital with an SADVTC, in an effort to paint a better picture about the potential continuation of care for survivors after discharge from the Emergency Department. The first example is of a survivor seeking care at a small rural hospital:

> She came in in the middle of the night and it was kind of a bizarre story. She had been drinking, but she like was out in the football field at the High School. And she just like wandered in, and with no pants on…but she didn't want the police called. And it was just me and the doctor and we just read through [the SAEK instructions]. And then she didn't want anybody called, she just… We found her pants–we have like a clothing cupboard thing–so we just... We gave her [township] victim services' number if she wanted to follow up with in the morning and she finished walking home.
>
> (Laura, Emergency Department nurse, rural hospital)

In rural hospitals, follow-up care is not scheduled at the hospital, nor do the survivors receive a call back from the care providers. If they are given a prescription for prophylactic HIV treatment, their information is supposed to be recorded in the system, enabling staff at the nearest SADVTC to follow up with them. However, due to staff turnover and lack of training on sexual assault, this is not always the case. The result is some survivors leaving the emergency room without a framework for follow-up care and treatment.

The protocol at SADVTCs is to schedule at least four follow-up appointments with the survivor after the initial acute visit, as the SADVTCs have the human resources to ensure continuity in

care. These appointments occur at months one, three, six and twelve and can entail mental health assessments, safety planning, bloodwork, repeat injury documentation, forensic photos, strangulation follow-up, and monitoring of any other side effects, injuries, and medications. Participants from SADVTCs also stressed the importance of crisis intervention at these follow-up appointments, and they described how they assumed a counselling role for the survivors. One SANE recognized how this may be the survivor's only access to health care, and as a result she frequently found herself saying: *"Okay, well, I don't know the answer. But let me figure out and make a few calls about someone who does."*

Another protocol of the SADVTC (that is possible given their designated staff and resources) is to never give up on calling the survivor to attempt to make a follow-up appointment. While other facilities may stop calling the patient after three or four times, the SANEs prided themselves on never giving up on a survivor's chance to stay connected to the center, as they recognized the precarious situations they may be in that may prevent them from coming in for follow-up care. As Pamela describes of one survivor:

> I can remember having a patient that, you know, I maybe caught up with her once in the whole, you know... Finally, at about a year, I tried her phone number again. And she actually answered and she came in to see me. And she said to me that, at first she didn't think I was for real. Like nobody in her life had ever tried that hard or cared for her. Right? And so, she just didn't believe when we were calling and leaving messages that we really did want to have her come in and get care. But how much she appreciated that, that we didn't give up. Because other people in their lives have given up on them.

(Pamela, SANE, urban hospital)

This study is not meant to compare rural vs urban care (or SADVTCs), since that was never the objective of the study. However, it is striking to note that two survivors in the same system could receive such wildly different approaches to follow-up care, whether this experience is dependent on location or not. The availability of resources in the form of care staff designated to assist survivors appears to inform the protocols on follow up care that exist in centres with and without SADVTCs. Additionally, there appears to be an absence of policies that exist as resources to guide sexual assault related decision making in rural centres, further complicating care interactions with survivors and making follow-up care less accessible.

**Theme 4: Socio-cultural barriers: credibility and decision making**

Socio-cultural barriers were found influence the provision of sexual assault care in Northwestern Ontario. Such barriers included racism, the stigma associated with heavy alcohol and drug use, and preconceptions about police involvement. These barriers influenced the way that survivors were perceived by care providers, and they also determined the credibility afforded to care seekers presenting in the ED. Pre-conceived notions about sexual assault, rape myths, and who qualifies as an 'ideal victim' all featured in the interviews. These factors impacted how believable and empathy worthy the care seeker seemed to the care providers, and thus would have an impact on the use or non-use of the SAEK.

Many of the sexually assaulted care seekers spoken of in the interviews were intoxicated or under the influence of substances, as exemplified by the following quote*:*

*"I'd say typically there's always like alcohol or drugs involved. Especially like, just around here."* (Laura, Emergency Department nurse, rural hospital). It was understood by care providers in Northwestern Ontario that there are high levels of substance use in the area. Furthermore, alcohol was also cited as a factor related to revictimization and the return to the ED:

Louise: *She was in three times in one weekend.*
Interviewer: *And do you think that was more domestic violence related?*
Louise: *Um, no, I think it was alcohol involved. Most of our assaults are alcohol involved.*

The state in which the care seeker presented to the Emergency Department had an impact on the way the survivor was perceived–and treated–by the care provider. A SANE recalls a time she witnessed the treatment of an intoxicated care seeker. She recalled negative treatment from the staff who did not provide basic comforts to the care-seeker due to their judgement of her use of alcohol. This exhibited to the SANE the bias of others on the care team, and how that bias and lack of compassion negatively impacted an individual who had already been through a traumatic experience. The nurse recalled the interaction of staff when the patient left a personal item on the hospital bed they were using and she inquired with their co-worker about the patient's whereabouts:

> I noticed that there was a lighter on the stretcher and said "oh, hey, is so and so coming back?" And she goes "oh, no, she's going home". I said "oh, I thought she was just going to the washroom" because her pants were all wet. So, she had been incontinent with urine at some point. So, she had been there, I guess intoxicated for the night, been incontinent

> of urine, was now waking up in the morning and being discharged. And that nurse was sending her home with pee pants. And I said, "oh, like, wouldn't you go to the clothing cupboard and get her some new pants?" She goes, "hmm, I don't know". And I said, "oh, did you give her a sandwich for the road or anything?" And she was like, "no". I'm like, "oh okay". So, we were going by the B desk at that time. And she says, "hey, what do you guys do for your HBDs?" So, your Has Been Drinking. The one guy said, "I don't give them anything. They're lucky if they get a glass of water."
>
> (Pamela, SANE, urban hospital)

As we see from this exchange, some interviewees recounted conversations that showed a lack of empathy for the survivor, given the challenging circumstances that had brought them into the Emergency Department in the first place. Pamela describes differential treatment of a patient (i.e., not providing them with food or potentially even water) due to their intoxicated disposition. When she brought her concerns over this situation to the attention of the management, she was met with indifference. To her knowledge, no follow-up actions were taken after her reporting of the situation.

Intoxication in relation to sexual assault was also noted by many participants to impact the care seeker's ability to remember what happened. In some instances, the survivors want from the forensic examination was to either prove or disprove they had been assaulted. One participant said the following about one survivor she treated three days post use of alcohol:

> Her want from the kit wasn't to press charges, or wasn't to have any STD testing or any of that kind of stuff. Her expectation of us doing the kit was to like, confirm or deny if she had actually been assaulted. She couldn't remember. (Laura, nurse, rural hospital)

Furthermore, lack of cognition while intoxicated increased the amount of time the care seeker spent in the Emergency Department; care providers could only conduct the forensic examination when the individual was sober and able to consent. This requires monitoring till they are able to provide informed consent:

> If the person is not able to consent at the time–so maybe they are not able to hold meaningful conversation because of substances or a different medication or something like that–then we keep checking in until they're able to consent.
> (Amanda, SANE, urban hospital)

Intoxication was also perceived by care providers to be related to other factors surrounding sexual assault, such as police involvement and Indigeneity. Many of the hospitals included in this study are in close proximity to Indigenous communities, which was also alluded to by several of the participants in terms of the names of the First Nations reserves that their patients travelled from:

> So, we have a lot of people who are on welfare or disability, or our Indigenous people get their checks the end of the month, and that tends to be when more alcohol is consumed. And that's when [sexual assaults] tend to happen. We have some very wealthy reserves

> around us and they tend to get payments every three or four months of substantial amounts. That's usually when you'll see them too, because they've gone out and spent their money and drank a lot... (Louise, nurse, rural hospital)

Indigenous patients were also noted to be among some of the most marginalized survivors treated and were reported by participants as being over-represented as survivors seeking sexual assault care. As one SANE also noted: *"The degree of violence that Indigenous women suffered was often greater than what the non-Indigenous experienced. It was just a harsher degree of violence."* However, despite the disproportionate representation of Indigenous people among care seekers and the greater violence perpetuated against them, participants recalled times that racism was present in the care interaction. Recall the interaction in the ED that Pamela explained involving an intoxicated care seeker who had urinated themselves and was not offered a clean pair of pants; this care seeker was an Indigenous individual. Furthermore, where Indigeneity meets intoxication, participants reported a lack of cultural safety and increased stigmatization of the survivor. It is important to call attention to the factor of Indigeneity in sexual assault care, due to the prevalence of sexual assault in this population, and also to raise concerns about the presence of racism in the care encounter.

Police too, were noted by some care providers as having different responses to Indigenous survivors as compared to non-Indigenous survivors. Pamela describes the differential treatment police gave to Indigenous vs non-Indigenous survivors:

> I physically worked in that department to provide SADV care and was able to witness some really shitty things. And you know interestingly enough, like the police would bring in an Indigenous victim and sort of drop her off. But if they were white? They would wait. (Pamela, SANE, urban hospital)

Indeed, police involvement was cited in many of the sexual assault examples provided by participants. Though police involvement is not actually required for a survivor to receive care for sexual assault or even to receive a forensic examination, the presence–or absence–of police in sexual assault cases changed the ways in which care providers perceived survivors and their stories. For example, in the following exchange it is evident that the participant believed the involvement of police would make a survivor's assault more veracious. Here, it appears that police involvement would also increase the care provider's encouragement of the survivor to have a forensic examination:

> [The decision to do forensic examinations] is case by case, kind of how much you believe it, the validity of the claim. If we seriously think that there's something going on and that this is something that needs to be addressed, and even in saying that like, depending on if they have police involvement or not, do you know what I mean? It's kind of like, you really need to, you really should call the police here, like we really need to–then our encouragement [motivation] would be higher, right? But if it's kind of like, "no, I was drunk this past weekend and like, I can't remember", then it's like...
> (Laura, Emergency Department nurse, rural hospital)

As this quote suggests, the presence of police for certain sexual assault incidents appeared to incline the provider to believe the assault was more 'realistic'. This assumes that individuals who had not 'truly' been assaulted would prefer to avoid police involvement. Nevertheless, if survivors were brought in while they were under police custody, some care providers viewed the claim of sexual assault to be less veracious due to their incarcerated state. The following quote illustrates a situation where a sexually assaulted care seeker was brought to the hospital while in custody of the police:

> This girl had been picked up on outstanding warrants. (…) And she's sitting in the back of the cruiser. And she's like, "well, like, you know, I was just like raped tonight. It was his fault." So now they have a due diligence to bring her to the hospital. So, they bring her to the hospital, they do the kit, they take her statement and everything else and then… but she's still being picked up for her warrants, right? And then they go and they get her boyfriend, and it's just… (…) In that situation, her making that claim, in that moment... it might have happened, like I'm not going to tell her it didn't happen. Like I'm really not. But it's just kind of like..." (Laura, Emergency Department nurse, rural hospital)

Laura believed that some care seekers under police custody used the claim of sexual assault and the need for a forensic examination as a means to "escape" police custody for a period of time. The term used by Laura and her coworkers to describe this type of situation was 'incarceritis', whereby the individual pretends to become ill due to their incarcerated status. It is important however, to point out that not all care providers shared in this disbelief of survivor narratives based on the circumstances of their presentation to Emergency Department. In fact, one

participant tried to prolong the care of an incarcerated survivor out of sympathy for their situation:

> [She was a] very small person. Not young, but small. Two big police officers bring her in, she was really intoxicated, been sexually assaulted. I take her in my exam room, try to do some history. I feed her a sandwich, she throws up. I give her something to drink, and then she throws up some more. The police are outside waiting to take her back to jail. I know they're going to take her back to jail. So, I just kept her as long as I possibly could. Because for whatever reason, she needed somebody to care for her. And that happened to be me. And I'm okay with that. And she was assaulted anyway. But you know, if people fake a story like that because they need to be cared for, I'm okay with that.
> (Pamela, SANE, urban hospital)

Care providers described a difficulty being able to differentiate care aspects of their job from the forensic documentation, and therefore their role in the legal side of sexual assault. Pamela was keenly aware of how at odds these two factors may be with one another, and how police involvement may deter survivors from seeking the treatment (rather than forensic documentation) aspect of acute assault care.

> Police involvement was always a choice. And that is one real, real deterrent to patients coming in to Emerg for care, whether it's sexual assault or domestic violence, it is most people don't realize that the hospital and the police are not in cahoots. Right? So, people are afraid to come to Emerg because they think that we have to tell the police, or that

> we're going to tell the police. They don't understand that the police are a choice. I'm not sure the police always like being a choice. And I, you know, I get that. But my job is to protect the patient. (Pamela, SANE, urban hospital)

Pamela and the other SANEs I interviewed understood the importance of survivor choice for police involvement, but the non-SANE care providers weren't so sure. Lack of training on the specifics of police involvement resulted in confusion for some practitioners, such as this rural physician: *"The little implications of what order things get done to hand off to the OPP and stuff like that, when should OPP get called… like I have no idea."* Others still viewed police involvement as a necessary factor to credibility and quality care, as depicted in Laura's accounts.

Conversations regarding the survivor's choice to involve police were mirrored by those regarding the choice to have a forensic examination. Some care providers described "*pushing*" care seekers to undergo forensic examinations, as they believed that this was the right thing to do. The approach of advocating for the kit's usage on survivors was discussed more by the participants who had very little sexual assault training. Take the following quote from rural physician George as example *"One [patient] I had to pressure. (…) I'm taught that people or victims are reluctant for a number of reasons. So, if it's even suggested, generally, I do push them and I'd say my colleagues do as well."*

Participants with little sexual assault training also viewed the decision to use a SAEK as something that is the responsibility of the care providers rather than the survivor: *"I think I would say lots of us kind of rely on our physicians to kind of make the final determination about*

*like, doing it or not."* (Laura, Emergency Department nurse, rural hospital). When asked if the physician would default to the survivor's decision to have the exam done, the participant responded that it would rely on the veracity of the survivor's claim (refer to Laura's quote on page 71). Reliance on police narratives regarding circumstances of the assault were also taken into account: *"Well how did [police] pick them up? Or like, where were they found or what was what was the room like or were they walking along the side of the street… right, so we rely on [police]."* Here, elements of intoxication, police involvement, and circumstantial characteristics were seen as factors to be considered when care providers decided about a survivor's need of a SAEK. In another example, a physician communicates their reluctance to do a forensic examination for a survivor by prolonging the survivor's wait time till the survivor eventually leaves the hospital:

> *I don't know if it's like a game to [physicians], but they'll play the waiting game where it's like, if I make this person wait long enough, they won't have to do the whole [sexual assault evidence] kit. (…) It was like a 50/50 patient slash physician problem–but they waited like, like a good six hours. (…) Like the physician didn't really want to do it. And the patient couldn't really make up her mind.*
>
> (Laura, Emergency Department nurse, rural hospital)

Here, Laura describes a time when a SAEK was not used. There was a "*50/50 problem*" where the patient couldn't decide if they wanted a forensic examination and the physician "*didn't really want to do it*". Therefore, the physician opted to "*clean out the Emerg*" (i.e. treat all other

patients) before treating the sexually assaulted survivor. The situation ended with the patient leaving without a forensic examination after waiting for six hours in the waiting room.

On the contrary, those with SANE training believed that the decision to have the forensic exam was up to the survivor. Throughout the entire care process, SANEs described placing great emphasis on survivor autonomy. As articulated by the following SANE: *"So that first contact with the SADV nurse is essentially to say, here are all your care options. You are allowed to choose any of them or none of them. You don't have to accept this right now."* (Amanda, SANE, urban hospital). Another SANE described how even within the forensic examination there is great capacity for survivor autonomy and consent:

> If all they want to do is give you their underwear, put it in a paper bag, then you know, that's a great piece of evidence. We don't need to swab every orifice, right? And every time you embark on doing a kit, it requires a lot of teaching and a lot of explanation. And at every step, the patient needs to be consented. (Pamela, SANE, urban hospital)

The insights offered by these SANEs provides a glimpse into the depth of understanding that SANEs have regarding consent and trauma in the care encounter.

**Theme 5: Provider Recommendations**

It is apparent from the above findings that participants of the study recognized the structural issues involved in the care of sexually assaulted care seekers. However, participants were also asked about any recommendations they may have that improved their ability to provide care. Moreover, participants were asked in both the survey and interview components if there were

any forms of training or psychosocial support that they wished they had access to that they currently do not. Recommendations for sexual assault care in Northwestern Ontario included telehealth, improved psychosocial supports, more sexual assault training, and the simple addition of 'cheater sheets' to SAEKs.

One participant was spearheading a telehealth initiative for the treatment and forensic examinations of sexually assaulted care seekers at facilities lacking SANE trained providers. This would allow the survivor the option to stay in their community and receive care through the online service platform Ontario Telemedicine Network (OTN), as opposed to commuting to a major health centre for care. She discussed the patient's options as follows:

> If a patient wants to stay and wants their care where they're at, that's obviously a very significant factor. If they on the flip side, want to leave, then they can come out [to the SADVTC]. (…) If for safety reasons or otherwise, they want to come out, then yeah, 100%, they'll come out. (…) But if they're medically stable and they don't have any injuries that need advanced care… If it's medication, testing, completion of the kit, then we can actually do that all virtually. So, the health care provider on the other end and I, and the patient, all sit on the OTN and I basically guide the care and make sure that they get everything that they need. (Amanda, SANE, urban hospital)

Additional suggestions were made regarding the need for improvements in psychosocial supports to prevent burnout and compassion fatigue related to the vicarious trauma of sexual assault. Providers also expressed a desire to have more psychosocial supports that were geared towards sexual assault in particular.

Furthermore, rural care providers expressed their wishes to have more opportunities for accessible training, in order to acknowledge rural healthcare realities (where you don't see these cases every day). Participants cited a need to have "*point of care*" resources, because for rural care providers, this is where the "*rubber hits the road"*:

> I think pre-recorded material that can be watched – especially any material that is designed to be done at the time of. (…) Some point of care training would be quite useful because frankly, nursing doesn't and isn't going to have the time to review miles in advance. I feel like a lot of the training that exists currently is based as if you're going to train people once and have them know it and do it. Whereas it would be useful to have some point of care, so you can say, "Okay, here's a rough and dirty outline of how this is going to be done at the time." (George, Emergency Department physician, rural hospital)

Another participant pointed out the strengths of practise-based learning for healthcare professionals, that could include the opportunity to have a mentor to work through the forensic examination with. "*Training wise I truly think as nurses we all learn best doing it."* She discussed how this mentorship process could include discussion of the legalities, charting, and any novel words in the SAEK that may not be known to nurses.

Similar to the point of care training described by George, many participants expressed a desire to have a flow chart depicting the overall treatment of sexual assault survivors, as well as possibly a summarized sheet for the SAEK (referred by most participants as a 'cheater sheet'). The following quote is one several that depicts what participants envisioned of this:

> We could definitely improve in terms of like a flowchart algorithm or something that reminds us what we're supposed to do. (…) Having some sort of simple flow sheet sticking on the box that has our kits in it. So that before we pull the kits off the shelf or like "oh, yeah, this is what we're going to do when" kind of thing would be helpful.
>
> (Gabe, Emergency Department physician, rural hospital)

The insights care providers offered into possible solutions to increase accessible sexual assault care, as well as other topics presented first in the findings, will be discussed in greater detail in the following chapter.

# Chapter 4: Discussion

The first-hand accounts of practitioners in Northwestern Ontario hospitals regarding sexual assault examinations provide important context to understanding the unique challenges in Northern healthcare institutions. In this study, questions are raised about the implications of training, leadership and the current forensic examination practises and care policies for sexual assault in Northern Ontario. It was found that these factors influenced the care survivors received, as well as the mental health and psychosocial supports available to care providers. Additionally, geographical barriers, resource depravities, socio-cultural factors, and the medico-legal context of the forensic examination influenced whether or not SAEKs are completed. Five major themes were thus presented: training and legal implications, lack of supports, resource constraints, socio-cultural barriers and provider recommendation for SA care. These concepts, first presented in the findings chapter, will now be further examined in this chapter.

## Training and Trauma Informed Care

All participants of the study reported that there was little or no training on sexual assault in their respective educational degrees to become healthcare providers. Regardless of the degree of inclusion of sexual assault care in the medical and nursing school curriculums, it is reasonable to conclude that any mention of sexual assault care approaches in formal training programs were not impactful, given applicable methods for practice were not retained by the participants. Lack of training about sexual assault in medical curriculum has been echoed by current medical students. In a 2022 piece by Canadian medical students Healey et al., gaps in SADV training for medical school curriculum were highlighted, and the Ontario Medical Students Association called for the implementation of course material in line with current Medical Counsel of Canada objectives. This would include inclusion of course information on forensic examinations, the

legal aspects of evidence collection and reporting, trauma informed physical exams, and communicatory and interview skills for survivors of sexual assault. Furthermore, the findings presented here indicate that training should extend to address biases related to drug and alcohol use in relation to sexual assault, as well as the impacts of racism in post-assault care (Healey et al., 2022).

Previous research has been conducted on didactic and simulation-based trainings for healthcare students. Specifically, those regarding trauma-informed approaches to sexual assault care were found to improve communication between care providers and survivors (Chandramani et al., 2020; Gore et al., 2021; Nathan & Ferrara, 2020). Curriculum training for practising clinicians developed by researchers of Women's College Hospital has also been met with positive reception and learned engagement (Mason & Du Mont, 2015). Furthermore, such training initiatives could serve to relieve the pressure placed on solely SANEs, and work to reduce the distinct siloed approach to sexual assault. To address the lack of appropriate communication with survivors, research has found that training on trauma informed approaches have improved patient outcomes and care equity (Befus et al., 2019; Laughon, 2019). Trauma informed training additions could prevent burnout in providers as well; reduced personal accomplishment (including feelings of incompetence) has been linked to higher rates of burnout in healthcare providers, which adds more strain to the already overburdened system (Patel et al., 2018). Education systems should incorporate practical training about trauma informed care that can be used in cases of sexual assault, while also being of great use to *any* patients coping with trauma (Center for Substance Abuse Treatment US, 2014). The widely applicable nature of trauma informed practice will allow for more active application of the approach while working in rural facilities that may not encounter sexual assault daily (Reid et al., 2023). It was clear from

care providers of this study that their lack sexual assault training resulted in low competency and confidence in caring for survivors. However, given improvements to curriculum and training have been successful, further implementation of sexual assault training (both technical and trauma-informed) in education and workplace should be investigated as means to improve the experience of survivors seeking care and also to mitigate burnout in providers.

Emotional regulation was another theme touched upon by participants. The idea that objectivity is required of care providers in medical settings is not a new concept. Michel Foucault termed this the 'medical gaze', where the patient's story must fit into a "*biomedical paradigm, filtering out what is deemed as irrelevant material*" (Misselbrook, 2013, p. 312). In the context of sexual assault, what may be deemed as 'irrelevant material' are those emotional components of trauma (i.e., crying, silence, and other signs of shock and distress) (Haskell & Randall, 2019). The added pressure of the judicial system in the medico-legal context of assault serves to further encourage the provider to assume an objective stance. As anthropologist Sameena Mulla states: *"The eye that weeps and the eye that sees may be one and the same, but the forensic nurse will, analogically, defer or submerge her weeping because she retreats to a position from which she may only discern her own eye as one that sees for the law."* (2014, p. 101). However, severing body from mind and emotion will only cause further trauma to the survivor, and also serve to assert a power differential between the care provider and survivor (Greenhalgh, 2001). The symptoms of trauma resulting from sexual assault need to be acknowledged, rather than filtered out in the pursuit of objectivity (Mulla, 2014). For it is in this acknowledgement of the effects of emotion on the bodies of both the survivor and care provider, that care undertakes a trauma-informed approach.

Attempts by hospital leadership at facilities to implement Emergency Department wide SANE certification were reported to be failures. As SANE and participant Amanda stated, "*not everyone is cut out for this".* The desire to train all providers in sexual assault care speaks to the generalist approach required in Northern and rural contexts. Training for rural providers in any area of health – not only sexual assault – faces the difficulty of covering all topics that may be required of providers working in areas that lack access to specialist care (Tesson et al., 2005). The result is the expectation that they will become a 'jack of all trades' and exhibit a broad range of expertise in all health emergencies (Strasser & Cheu, 2018). As per the findings presented, resource limitations and vast geographical landscapes combined with few healthcare institutions in the region suggests that there must be a different model of training used to approach care and examination of rural sexual assault survivors. Just as rural health rotations begin early in medical education in order to improve knowledge of generalist care, these findings indicate that solutions regarding the training of care providers for sexual assault should preferably begin prior to entering the workplace. Furthermore, we must consider implementing creative tactics and tools to be of use to providers that are working in rural centers. Tools such as the 'flow chart' of the sexual assault care sequence of events as well as a 'cheater sheet' for the SAEK can help healthcare providers improve their competency in situations they do not encounter each day. As participants pointed out, training on how to do an entire forensic exam many years in advance may not be remembered on the day it is actually needed. But the ability to access a quick *"refresher"* resource in the moments prior to providing care is more in line with the reality of rural healthcare systems. Development of such flow charts and/or cheater sheets could be done in conjunction with Ontario Network experts, emergency department care providers, experts of

trauma-informed care, and hospital leadership. Collaboration when creating such a resource could allow for specific attention to be paid to the site-specific and regional nuances.

### Emergency Departments and Structures of Care

Emergency Departments are designed to allow for the continuous flow of patients from the stages of triage, treatment, and transfer/discharge (Nugus et al., 2014). As described by Nugus et al., (2014) an Emergency Department is structured like a 'carousel', whereby patients can fill a fixed number of seats (beds), stay for a period of time, and then will be released from the carousel to go elsewhere (transfer or discharge). If certain patients require more care and/or absorb more of the clinician's time prior to their departure from the carousel, they can "gridlock" or "bottleneck" the Emergency Department (Nugus et al., 2014). This would especially be true of care seekers in the rural hospital settings where only one nurse and one physician may be working at a time.

As previously discussed, forensic examinations may require 4+ hours of care. Additionally, once the provider begins the examination, is it difficult to stop entirely and tend to another patient, for that would break protection of the legal chain of evidence. There is the additional necessity with sexual assault survivors for slow moving care that requires informed consent at each step of the four-hour process, so as not to retraumatize the patient (Ontario Hospital Association, 2018). Furthermore, care providers may risk contaminating the legal evidence for the potential case if they rush the process, as they may miss a step or perform part of the exam incorrectly (Ontario Hospital Association, 2018). These factors combined result in time-consuming and meticulous care – something that is at odds with the Emergency Department's carousel model to 'keep things moving'. Participants from both phases of this

study expressed concerns about forensic examinations slowing the 'flow' of the ER, especially where only one physician or nurse may be working at a time ("*In a busy ER and being the sole physician, doing one of these kits is difficult to maintain the flow of the ER"*).

If you combine the time consumption factor with the lack of sexual assaulting training present in many of the facilities studied in this project, the result is system pressures that leave care providers feeling exasperated and burnt-out (Zelman et al., 2022). This opens the door for victim blaming, increased wait times for survivors, and a lack of trauma informed care. Furthermore, "*pulling*" a clinician from the care team so that they may provide prolonged and specialized care to a sexual assault survivor usually results in the redistribution of patient care to other staff, which causes greater workloads and stress for the rest of the team. Despite a higher patient to provider ratio, care providers are still expected to keep the Emergency Department 'carousel' moving at the same speed. This study showed that the stressful environment elicited by the arrival of a sexually assaulted care seeker can result in animosity towards the survivor themselves, as was stated by participants. This then begs the question, what kind of care are sexually assaulted care seekers met with upon arrival to the Emergency Department if their arrival causes a certain level of upheaval for the care providers working? Furthermore, disconnect between ED staff about roles in sexual assault care and misunderstandings about sexual assault in general led to confusion about proper patient care. Recall the earlier example where a recently sexually assaulted individual with an intellectual disability was sent home alone on the city bus at night. This example highlighted a lack of understanding about sexual assault and its psychological impacts may have played a role in the facilitation of this transport decision, a phenomenon that has also been documented by sexual assault researchers. Poldon et al. (2021) found that a lack of understanding from fellow ED staff about the role of SANEs lead to

confusion and misunderstandings about proper patient care. Situations such as these which relate to the structure of the emergency department and communication within it seem to indicate that the Emergency model of care is not designed for long forensic examinations that may tie up a care provider for half of their shift. It is important to ask, should these structures continue to care for sexual assault survivors?

### Supports for Care Providers

At the time of writing, Emergency Departments across Canada are facing unprecedented crisis. The Canadian Association of Emergency Physicians wrote in an open letter titled "Canadian Emergency Care is Being Crushed" to the health ministers and premiers in January 2023 about the current state of affairs (Canadian Association of Emergency Physicians, 2023). The letter discussed the extreme wait times in emergency rooms, rash ED closures, and severe staff shortages. It is within this context that this study was conducted, and it is therefore vital to recognize the impacts that the current situation has on sexual assault care, the retention of healthcare personnel, and staff burnout.

Treating survivors of sexual assault can lead to vicarious trauma and burnout, according to a number of studies (Baird & Jenkins, 2003; Maier, 2011; Zelman et al. 2022). Issues reported in this study about psychosocial supports for participants included a lack of supports specific to vicarious trauma and sexual assault, as well as limited formal debrief structures and privacy concerns over confidential support. Vicarious trauma associated with sexual assault can cause hypervigilance, disengagement, self-blame, and intrusive thoughts in care providers, thus negatively impacting their personal and professional lives (Padmanabhanunni & Gqomfa, 2022). Furthermore, it appeared from this study that many responsibilities (both logistical and

psychosocial) appeared to fall onto the shoulders of one individual at each facility. The reliance on one key person at facilities to maintain optimal sexual assault care raises concerns about burnout for key individuals, as well as the continuity and security of such programs in the absence of such key individuals.

Participants recognized the impact of vicarious trauma in their work, yet those with SANE training did not find there were adequate supports to meet the specific demands of their work. Mutual support from SANE colleagues was cited in our study as a major support tool that enabled their work. The vicarious trauma of sexual assault care and the resulting mutual support of coworkers has been previously noted by Poldon et al. (2021), where SANE participants of the study cited coworker support as a crucial and necessary aspect of their job.

Debriefing in emergency care has been linked to better management of stress, improved patient care, and more effective teamwork (Rose et al., 2022; Sweberg et al., 2018). In both phases of our study, a lack of post-incident debriefs were noted by participants in both rural and urban facilities. This touches on the fact that in overloaded emergency systems where psychosocial supports and debriefs are crucial to the mental health of care providers, it is actually *less* likely that care providers will receive the supports that they need due to staff shortages and other resource challenges (Floridis, 2023). Lack of debriefs can lead to further disconnect amongst emergency department team members in a time when cohesion and collaboration is most necessary (Sweberg et al., 2018).

The role of hospital leadership in staff support was also brought up by participants of this study. Previous research by Hunsaker et al. (2015) found that low levels of managerial support for Emergency Department staff was a significant predictor of high levels of burnout and compassion fatigue, while increased organization support was additionally found by Townsend &

Campbell (2009) to decrease prevalence of burnout in SANEs. Therefore, health leaders and policy makers with the potential to strengthen individual supports, train more SADV personnel, and make space for team debriefs can greatly impact the wellbeing of staff, and thus the care that survivors receive.

The ramifications of poor leadership and a lack support for SANEs can be seen in Canada. At the time of this thesis, at least six of the thirteen SANEs who work at the Winnipeg's Health Sciences Centre resigned due to lack of staffing and support from leadership (Gibson, 2023). It is evident from these recent occurrences that the findings presented here regarding lack of support and the disconnect from leadership are not specific to just the facilities included in this study; rather, this study's findings corroborate the experiences of SANEs at Winnipeg's Health Sciences Centre. The issues described in this project are also present in other sexual assault programs and health systems across Canada. Therefore, they have the potential to offer insights and solutions to issues that are occurring in hospitals beyond the Northwestern Ontario sites specific to this study.

### Rural Dilemmas and Telehealth Solutions

Unique challenges arise in rural emergency contexts, as care providers who work in these settings are required to have comprehensive understanding of how to treat a wide variety of medical emergencies and traumas, yet they may rarely encounter respective cases (Strasser & Cheu, 2018). Staff retention is a noted difficulty for rural health centres (Soles et al., 2017) and there are also logistical barriers associated with the distance from health care facilities and access to specialist care (Pong, 2008; Sibley & Weiner, 2011; Strasser, 2003). Additionally, there are specific rural health problems related to social isolation, rural poverty, and substance use (Nielson et al., 2017; Pijl et al., 2022). The situation in Northwestern Ontario is particularly

complex given the recently documented migration of low-income, working age people with complex health needs (Rice & Webster, 2017).

The rural and Northern healthcare environment of this study therefore has unique implications for sexual assault survivors. Recent findings by Miyamoto et al. (2021) have found rural sexual assault care faces barriers related to lack of clinician training, low volume of sexual assault cases (which impacts care proficiency), financial constraints, as well as turnover and burnout. The ability of survivors to reach facilities for sexual assault care is impacted by long commutes as well as the cost and accessibility of transportation (Northern Policy Institute, 2015). Public transit is poorly developed in these regions and may be costly or non-existent (Northern Policy Institute, 2015). Moreover, the trauma induced by sexual assault makes travelling long distances to reach care appear more daunting and challenging. This is especially true if you are unsure what quality of care you will be greeted with upon arrival; individuals with previously negative experiences with the healthcare system (such as some Indigenous folks) may be less inclined to pursue sexual assault care for these reasons (McCallum & Perry, 2018).

Upon reaching the hospital, if rural survivors are met with long wait times and unexperienced care, re-traumatization may be more likely. Rural factors such as these therefore have consequences for the survivor's ability to access justice through the legal system, due to the way that sexual assault and forensic evidence collection is enmeshed into the healthcare system. For those facing rural related barriers to adequate sexual assault documentation through the health care system, a justice gap is formed, whereby their legal case and access to justice is consequentially impacted (Carroll, 2023; Keene et al., 2020).

Participants of this study reflected on how large travelling distances impacted the motivation of some survivors to obtain sexual assault care. Care providers reported their hospital

leaders changing protocols on the treatment of sexual assault survivors; in some rural facilities, the previous procedures of referring survivors to the nearest SADVTC was replaced with directives to treat survivors on site. These policies would allow care seekers to stay in place, however the rurality of such facilities usually means that they lack SANEs or advanced sexual assault care of any kind, resulting in an increased risk of survivor re-traumatization, potential for improper forensic evidence collection, and care provider apprehension of treating survivors.

Telehealth is a form of healthcare deliverance that has gained traction since the COVID-19 pandemic, and it offers practical implications for access to care in rural areas (Patterson et al., 2022). It is described as a care interaction with a patient and care provider(s) that is facilitated by videoconferencing with a secure electronic network (Jong et al, 2019). It has also been described by participants of our study as a novel way to allow survivors to be treated at a facility close to their home with one of the care providers on-site, while still receiving connection to a SANE and their SA expertise through virtual connection. Telehealth for sexual assault care in rural areas is especially beneficial because it allows the survivor to make a decision about what best suits them, as described by participants in our study.

The possibility of expanding telehealth for sexual assault care has been explored very recently by a number of researchers across North America. Despite its potential benefit to the survivor, it is important to also recognize that implementation of such programs will still require training, organization leadership, and continual monitoring (Miyamoto et al., 2021). The two care providers both instructing and receiving guidance require training for the telehealth encounter, and proper facility equipment for virtual care is also needed (Allison et al., 2023). Ultimately, the survivor's ability to choose between in-person vs virtual care options is paramount; telehealth simply provides another option to the survivor to ensure that care post-

assault best meets their needs. Nevertheless, knowledge about the legal aspects of sexual assault, including the chain of custody of forensic evidence, are still needed for practitioners partaking in virtually assisted or in-person SA care. Furthermore, the basic tenets of trauma informed care approaches are still needed for the treatment of survivors receiving care through telehealth models.

Telehealth for sexual assault is limited by security challenges, technical difficulties, and the ability to provide personable and comprehensive physical examinations (Gajarawala & Pelkowski, 2021). Given the novelty of this care model, it is important that policies continue to monitor ongoing research on telehealth for SA intervention, and also defer to survivor choice over the decision to receive in-person or virtually assisted care in rural areas.

### Factors Informing the Decision to Use the SAEK

Factors relating to the patient's disposition and presentation upon arrival to the Emergency Department – such as intoxication, police involvement, and Indigeneity – all played into the decision of care providers to conduct a forensic examination, as well as the quality of care the patient may have received. Additionally, rurality of the facility and the training background of the care provider impacted the provider's approach to use of SAEKs for survivors.

Intoxication or substance use was brought up in an about half of the examples of sexual assault that were discussed by interview participants. However, due to the inability to provide informed consent (i.e., a voluntary and educated decision about a procedure) for a forensic exam while intoxicated, substance use was also noted to prolong a survivor's stay in the Emergency Department (Ontario Network of Sexual Assault/Domestic Violence, 2007; Shah et al. 2022). Forensic examinations are not considered "treatment" under the Health Care Consent Act of

1996 (Ontario Network of Sexual Assault/Domestic Violence, 2007). As consequence, ED care providers found that intoxication of sexual assault patients blocked the 'carousel' of care. As a result, intoxicated survivors were viewed with disdain; they prevented care providers from being able to keep the flow of patients moving in the facility. This is especially concerning when considering how substance use is more prevalent in marginalized survivor populations - such as Indigenous and/or houseless individuals (Assembly of First Nations, 2022; Urbanoski, 2017). The intersectionality of these factors may result in increased stigmatization of intoxicated survivors and negatively impact the care they receive (McCallum & Perry, 2018).

Moreover, intoxication is related to an abundance of stereotypes about survivors and patients in general. Substance use served to decrease the care providers' belief in the survivor's credibility, which is a trend that has been noted previously by other researchers (Chalmers et al., 2023; Ullman et al., 2019). For many people with dependencies, using substances isn't truly a choice. Underlying trauma (and even inter-generational trauma) or mental illness is masked by substance use (Spillane et al., 2022). More broadly speaking, in communities where alcohol and drugs are quite ubiquitous, and access to mental and psychiatric resources is limited, the "choice" to use substances is highly constrained (Pilj et al., 2022). However, some care providers may still view the use of substances as a choice, and this therefore limits their empathy afforded to the survivor. For example, if the survivor "chose" to consume drugs or alcohol, it was implied that their assault claims may be less veracious due to their inability to remember what had happened.

Previous studies have found that the intoxication of patients in the emergency department negatively impacts the mood of care providers, increases staff stress, and increases the perceptions of workload associated with the patient (Gunasekara et al., 2011; Verelst et al., 2012; Warren et al., 2012). The combination of the extended amount of time intoxicated survivors may

require, as well as the stereotypes labelling substance users results in a perfect storm. Providers did not find the survivor credible due to substance use stereotypes and their inability to recall, and additionally they cost the emergency team more time and work.

The presence or absence of police for sexual assault cases in the emergency department was also noted to have an impact on the way the care seeker was perceived by care teams. If survivors chose to have police involved, their stories were seen as more credible and legitimate. However the casual term 'incarceritis' was also used by some Emergency personnel to describe patients who feigned sexual assault in order to receive medical attention and avoid police custody (Berry, 2014). In these cases, police involvement of incarcerated survivors increased suspicion of the survivor's claim. Given the decision to not involve the police is viewed as an abnormal request thus meriting suspicion, and incarceration of survivors *also* increased suspicion of the survivor's claim, the results in both cases is care providers who disregard survivors. Furthermore, police were noted by participants to be less likely to remain in the hospital with Indigenous care seekers, which has the effect of making white survivors appear more credible. Care providers who are disbelieving of the survivor's story may result in the decision to forgo a forensic examination, which expands the justice gap for such survivors.

It is also important in these situations to ask, why would a survivor potentially not want the police to be involved? Certain survivors may have had negative experiences with the police, especially Indigenous people who have a historically complex and traumatic relationship with police and judicial systems (Cotter, 2022). In Murphy-Oikonen et al.'s (2021) recent article, Indigenous women were found to feel less believed by the police when reporting incidents of sexual assault. Given the high rates of sexual assault affecting Indigenous women and girls in Canada (Heidinger, 2022), as well as the high proportion of Indigenous peoples living in the

Northwest LHIN, it is plausible to conclude that many individuals affected by sexual assault in this region may be Indigenous and therefore may also not wish to involve police due to the reasons presented here.

All of the above factors (intoxication, police involvement, and Indigeneity) influenced the formation of an "ideal victim" of sexual assault. The concept of an ideal victim implies that there are certain individuals who have more credibility as survivors due to the circumstances of their assault as well as aspects of their identity. As Melanie Randall states,

> The archetype of the ideal sexual assault victim still functions to disqualify many complainants' accounts of their sexual assault experiences. To this extent, the "ideal victim" myth continues to undermine the credibility of those women who are seen to deviate too far from stereotypical notions of "authentic" victims and too far from what are assumed to be predictable and "reasonable" victim responses. (2011, p. 397-398).

The 'ideal victim' concept is also supported by rape myths. According to former Canadian Supreme Court Justice Claire L'Heureux-Dubé (2001), rape myths include some of the following: the rapist is a stranger, women with previous sexual relations are less credible and more likely to consent, and women must be emotional as symptom of the assault. When lack of sexual assault training meets system challenges, staff shortages, institutional racism and harmful SA stereotypes, the result is care providers who are less inclined to perform a forensic examination for a survivor. This removes autonomy from the survivor and places it in the hands of the institution, when what survivors need is affirmation of their own choices. The way survivors are perceived and treated by health care providers in a state of vulnerability (such as

that brought about by sexual assault) can inform their decisions to seek emergency care from health systems in the future. They may be less inclined to seek care if past experiences were negative.

Given the small sample size of interviewees in this study, it is difficult to draw concrete conclusions regarding differences between SANE and non-SANE providers, as well as providers who work in rural vs. urban centers. However, it is beneficial to note that the 37 survey responses from a variety of rural and urban centers (including both SANE and non-SANE providers) echo the interview findings about nuances in care resulting from demographic characteristics of the care providers. Research has found that there is a significant difference in attitudes towards sexual assault patients if the provider has SANE training. Nielson et al. (2015) found that those with SANE training had more positive attitudes towards survivors than those without SANE training. This again reflects the power of sexual assault training to disprove harmful rape myths and better address the specific needs of sexual assault survivors, resulting in improved patient outcomes.

### The Medico-Legal Frame of the Forensic Examination

Sexual assault is located conceptually and logistically at the intersection of medical and legal spheres. This has valuable implications for the deliverance of care for the survivor as well the accessibility to the justice system through health care. Furthermore, it is important to consider the very gendered natures of the nursing, medicine, and the legal profession, with nursing being female dominated while medicine and policing are male dominated (Mulla, 2014). In addition, the sexual assault survivor – likely female according to statistics – represents the epitome of a feminized subject in vulnerable state (Conroy & Cotter, 2017). Gender has unique consequences for the three actors (health care, police, and survivor) of the forensic examination

encounter. As anthropologist Sameena Mulla points out in her book 'The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention':

> The flux of gender and power catches all three actors within a relational dynamic in which the [forensic nurse examiner], seeking to have her expertise acknowledged, often identifies and allies herself with the police force while appropriating the masculine power of policing. (2014, p. 15)

In our study, this dynamic was seen when female nurses reported defaulting to the opinion of police or physicians to make decisions about the use of a SAEK, rather than having that decision rest solely with the survivor. Decision making is influenced by the biases and myths held by care providers when treating sexual assault survivors as previously discussed. Factors related to survivor identity have been reported to impact sexual assault care in Emergency Departments; survivors who were intoxicated, Black, Hispanic, Indigenous, or had mental illness were more likely to experience disbelief from care providers (Chalmers et al., 2023).

However, it is important to note that the harmful stereotypes that influence care are not person specific; rather they signify problematic bias and racism built in the healthcare system and our society. Authors McCallum & Perry (2018) in their book "Structures of Indifference: An Indigenous Life and Death in a Canadian City", argue that it is the institutional racism imbedded into Canadian health systems that results in the abhorrent and sometimes fatal care of racialized and Indigenous individuals. For example, McCallum & Perry critically examine the death of Brian Sinclair in 2008 at Winnipeg's Health Sciences Centre Emergency Department, where he waited 34 hours for care before dying of an easily treatable infection. The stereotypes placed

upon Sinclair due to his presentation as an Indigenous man with a physical disability influenced the lack of care he received. Decades of active and passive discrimination as well as assimilation measures placed upon Indigenous peoples resulted in a healthcare system that viewed an Indigenous person seeking medical care in an ED as an individual seeking shelter to 'sober up' from alcohol use.

More recently, Indigenous woman Joyce Echaquan died after not receiving equitable care in a hospital in Trois-Rivières. Coroner reports found her death to be 'accidental', as she was not given the care she was supposed to receive (Nerestant, 2021). Coroner Géhane Kamel who presided over the inquest into the death stated that Echaquan was labelled as a manipulative drug user, despite no evidence suggesting such. Kamel stated "*Although this may be difficult to hear, it is a system imprinted with prejudice and biases that contributed to [health-care staff] not taking the situation seriously,"* (Nerestant, 2021).

Similar to the disbelief of sexual assault survivors presenting following or after substance use, extra suspicion is given about the credibility of a health or abuse claim made by an Indigenous individual due to the colonialism built into Canadian health systems (McCallum & Perry, 2018; Murphy-Oikonen et al., 2021). Therefore, solutions to equitable sexual assault care must be angled at not only the individual health system players but the greater structures and policies that shape how individuals are perceived and thus cared for.

From the findings presented here, we can see how the SAEK is a forensic evidence tool that is often misperceived by care providers to be a healthcare tool. Care providers of this study (particularly those lacking advanced sexual assault training) were found to equate sexual assault forensic examination to care for survivors. The reality is that justice for sexual assault in the Canadian legal system is difficult to come by and can often have detrimental impacts on survivor

mental health and their healing process (Craig, 2018). Lawyer Elaine Craig, author of 'Putting Trials on Trial: Sexual Assault and the Failure of the Legal Profession', says: "*For many of the women who serve as complainants in sexual assault cases, the experience is brutal. The trial process, which is largely designed and operated by able-bodied white people, is even worse for disabled, racialized, and Indigenous complainants."* (2018, p. 21). Additionally, less than 1% of sexual assaults in Canada will result in a legal outcome for the perpetrator (Johnson, 2017). Therefore, it is important to bear in mind what expectations care providers and survivors have about SAEKs and their role in their recovery from trauma. As SANE and interview participant Pamela aptly said:

> Really a kit is not healthcare. It's a legal procedure. And I think we tie up recovery with the justice system. And that is really a bad thing. Because if women have to rely on the justice system to recover from the trauma, then you know, that's a sad state of affairs. So we have to really sever recovery and kits and justice. We need to support women in all of their choice.

In concluding, it is necessary to look critically at the role of SAEKs in sexual assault care and discern their legal use from therapeutic intervention. Additionally, some barriers to comprehensive care may be less obvious than we think; we must call attention to the harmful impacts of bias, rape myths, and stereotypes in the provision of care to survivors.

# Chapter 5: Conclusion

The final section of this thesis will discuss the implications of the major findings from this research, notably the topics of training, leadership and support systems, as well as rape myths and discriminatory practices in healthcare. I will also discuss potential areas for future research that could delve deeper into the findings uncovered by this project, as well as study limitations. Finally, I will look critically at the sexual assault evidence kit and reflect on its future as a tool in sexual assault care.

## Study Implications

The implications of this study lie in sexual assault training, psycho-social supports for care providers, sexual assault care policies and addressing harmful rape myths.

*a) Training Implementations*

This study calls attention to the lack of sexual assault training of any kind for healthcare providers. The in-depth training for SANEs results in optimal and beneficial care for survivors treated at SADVTCs, however those survivors who live in areas that do not have easy access to SANE care are treated by care providers with very knowledge of SAEKs, post-assault follow up care, and also how to care in a trauma-informed manner. Lack of sexual assault training results in care that can potentially retraumatize the survivor, discourage them from seeking care in the future, and increase the burden and stress on care providers working in Emergency Departments. Participants of this study expressed their interest in having more opportunities for trauma informed care training, as well as clinical tools like flowcharts and cheater sheets to aide in care situations with survivors. The results of this study indicate also that clinician curriculums should include more meaningful educational opportunities to learn about sexual assault and the specific nuances of communicating and working with sexual assault survivors in any healthcare setting.

Emergency Department sexual assault training opportunities have been researched and trialed in Ontario hospitals by Du Mont et al. (2018) with preliminary improvements in provider perceived competencies. Future training programs such as these, as well as other curriculum adaptations, should be subjects of future research.

*b) Leadership and Support*

This study also raises questions about the importance of leadership in hospital settings, especially those under pressure. The ability of leaders to support a team was found to greatly impact certain aspects of care provider's jobs, and incline them to feel more or less burnout, a phenomenon which has been supported by other literature (Mudallal et al., 2017). In order to ensure the continuity of sexual assault care programs and avoid the burnout and resignations of SANEs and care providers across Canada's Emergency Departments, support from health leaders (both logistically and psychosocially) must be provided. The impact that key people in the healthcare system have on fellow staff was recognized as a major aspect of sexual assault care in Northwestern Ontario. Future research should include the voices of key hospital and emergency department leaders to understand the key barriers that face in the organization of support systems for care providers. It may also be beneficial to conduct research with ED and SADV care policy makers, in order to gain more information about the knowledge of mutual supports systems in Emergency Departments, as well as the psychosocial supports required for sexual assault care providers.

*c) Towards Ending Rape Myths and Institutional Racism*

This study is not revolutionary in its exposé of the harmful rape myths and stereotypes present in the Canadian healthcare system. As noted previously, scholars McCallum & Perry have analyzed the structures of indifference in the medical system, specifically where this indifference is

directed towards Indigenous peoples. Anthropologist Sameena Mulla has noted the presence of such rape myths in the medico-legal context of sexual assault care. She states the following about rape myths: "*These myths persist in the recesses of institutional memory, perpetuated not because of the biases or intentions of individual actors, but because of the social lives of forensic documents, protocols, and legal instruments.*" (2014, p. 152)

The findings of this research does, however, add to the growing body of literature pointing to the need for structural changes in the ways sexual assault survivors are perceived by the health care system that they place trust in. Qualitative research like that presented in this project allows for the amplification of the voices that need to be heard by policymakers, so a change can occur. However, other modalities of research dissemination should also be considered in order further bring these discussions to public attention. As always, discussions such as these should include the voices of survivors and others who are proximal to sexual assault. As writer and survivor Chanel Miller wrote:

> I did not come into existence when he harmed me. 'She found her voice!' I had a voice. He stripped it, left me groping around blind for a bit, but I always had it. I just used it like I never had to use it before. (2019, p. 288)

**Study Limitations and COVID-19**

This study took place during the COVID-19 pandemic and was thus shaped by pandemic related factors. Most notably was the difficulty in accessing Emergency care providers to participant in this study. Emergency Department pressures that existed prior to the pandemic have worsened; staffing crises, capacity shortages, staff turnover, long wait times and ED closures all impacted the ability of care providers to devote time to interviews and survey

response (Canadian Association of Emergency Physicians, 2023). Due to these reasons it was also difficult to obtain interview participants from every hospital located in the Northwest LHIN. Despite the value and the support that the survey findings added to the interview findings, the results would have been even more thorough if interviewees from each hospital were able to participate. Additionally, due to the short nature of a Master's degree, this project was subject to a time constraint and therefore more time could not be spent on improving participant recruitment.

Qualitative research has its limitations. The researcher's presence during the interviews may have affected the responses that participants gave or their ability to speak truthfully (e.g. social desirability bias). Rigor is also more difficult to assess in qualitative research; for example, some participants may have decided to forgo sharing certain difficulties associated with their job or specific incidents. A benefit and drawback of qualitative research is the voice of the researcher in the data; the research voice is a key component to the analysis and understanding of the data, however it can also contribute to bias. Luckily, this was mitigated by the involvement of thesis committee members who also reviewed the results and provided expert opinions. Quantitative research on sexual assault should accompany these research findings in order to understand both the 'what' and the 'why' of the difficulties associated with Northern sexual assault care.

Another limitation of this study is the lack of female Indigenous voices included. Some participants did openly identify as Indigenous, however there were no known female Indigenous participants. Given the statistically high reported rates of sexual violence in this demographic (Heidinger, 2022), it would have been beneficial to include more Indigenous care provider perspectives in this study. Provider-patient cultural and language concordances have been found to have beneficial influences on patient outcomes; therefore it would be interesting to note this

impact on sexual assault care (Waibel et al., 2018). Logistical reasons (such as time constraints and reduced survey uptake) made it difficult to ensure that there were Indigenous care providers amongst the survey and interviewee sample. It is recommended that future studies include a cohort of Indigenous practitioners to examine any differences in perceptions amongst care providers that may originate from cultural and socialization factors.

The purpose of this study was to gain insight into the state of sexual assault care in Northern Ontario and also to assess the challenges providers face when delivering care. Some inquiries were additionally made into the recommendations that providers had in relation to some aspects of their care and their jobs (training and psychosocial supports) in order to contextualize the data on limitations and to more importantly provide directions for future research. However, the bulk of the inquiries and the main focus of the project was on the difficulties currently facing Northern sexual assault care. Therefore, this study contains limited data on provider recommendations and care facilitators. The extensive information on barriers presented here will serve as a beneficial resource to future studies that may focus on recommendations and facilitators to SA care in the North.

### The Future of the SAEK and Sexual Assault Care

It is important to place the findings of this study within the context and realities of the current Canadian legal system. An important question raised by this study is the value of the sexual assault evidence kit as a forensic evidence tool. As evidenced by these study findings, the use of a SAEK can potentially retraumatize survivors of assault, cause increased ED stress, and be confused as care for the survivor rather than being a forensic tool. However, given that approximately 80% of sexual assaults are committed by someone who is known to the survivor

(Government of Canada, 2006), the criminal defense may not be swayed by forensic evidence of the crime, instead arguing that the assault was consensual. In these circumstances, forensic evidence thus provided by the SAEK is rendered somewhat null. Rather, the narratives of the survivor and the accused are more heavily relied upon as assault evidence.

This is not to say that SAEKs should be disregarded or abandoned entirely. Alternatively, their use should be analyzed with a critical lens. Who decides to use a SAEK? Survivors should have the ultimate say in this decision, and it should be an informed one. There should be full transparency as to what the forensic examination will entail, and also what the legal proceedings may be if the survivor choses to report the assault. Additionally, if the survivor decides to have a forensic examination, trauma informed patient-provider communication is necessary to facilitate consent at each step of the process. Are Emergency Departments the place correct place for SADV care? Certainly, there is the major advantage of their 24/7 service, but we need to be realistic in light of rurality and staff shortages. The carousel-like movements of Emergency Departments does not appear to unanimously suit the needs of survivors and also care providers. If a survivor is required to wait for upwards of 6 hours in an Emergency Department waiting room for sexual assault care, or if they are told to return 12 hours later due to lack of trained staff on-call, perhaps SADV care would be better suited to a lower paced clinical environment. Or moreover, the overall system pressures related to emergency care in Canada needs to be addressed in order to repair gaps in the services that are provided to not only sexual assault survivors, but all individuals seeking emergency care.

Does the SAEK 'heal' a survivor after sexual assault or does it cause more harm? The goal of healthcare is to heal or maintain health; not to do more damage to an individual. To do so would go against one of the very basic tenets of medicine outlined in the Hippocratic oath: "*First*

*do no harm".* It is one of the unique realities of the SAEK, that a person could go to the hospital to receive a procedure that has no core motivation for healing what ails them. Moreover, it is the pursuit of societal justice that the survivor is expected to be complicit in. As Mulla puts it, "*The victim's body is no longer simply a parchment of her own displacements, but rather, the displacement of her singular narrative by the foundational narrative of the state."* (2014, p. 218). The discussion of the kit and its legal implications then raises the greater societal question of who does the kit benefit? This question has been raised by other sexual assault researchers and clinicians since the SAEK's inception (Doe, 2012). We need to continue to discuss the kit in order to ensure that our definition of survivor healing is not conflated with society's pursuit of justice.

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## Appendix I: Questionnaire for Northwestern Ontario LHIN Hospitals

1. Which hospital/health centre do you currently work at?
    a. Thunder Bay Regional Health Sciences Center (Thunder Bay)
    b. Lake of Woods District Hospital (Kenora)
    c. Sioux Lookout Meno Ya Win Health Centre (Sioux Lookout)
    d. Santé Manitouwadge Health (Manitouwadge)
    e. Riverside Health Care Facilities (Fort Frances)
    f. Dryden Regional Health Centre (Dryden)
    g. Nipigon District Memorial Hospital (Nipigon)
    h. Red Lake Margaret Cochenour Memorial Hospital (Red Lake)
    i. Atikokan General Hospital (Atikokan)
    j. Geraldton District Hospital (Geraldton)
    k. North of Superior Healthcare Group (Terrace Bay)
    l. Other: _____

2. What type of healthcare-provider are you?
    a. Registered Nurse
    b. Physician
    c. Nurse Practitioner
    d. Registered Practical Nurse
    e. Other:_____

3. How often in the last 6 months have you treated a patient who required attention for immediate post-sexual assault care?
    a. Not at all
    b. Once
    c. 2-3 times
    d. 4-5 times
    e. 6+ times

4. Which of the following training have you received to care for sexual assault survivors? (select all that apply)
    a. Sexual assault nurse examiner (SANE)
    b. In-hospital/department training
    c. Training within my respective healthcare practitioner degree
    d. None
    e. Other:_____

5. If you received any training for treating sexual assault survivors, how many hours were devoted to the training?

a. An hour or less
b. 2-5 hours
c. 5-10 hours
d. More than 10 hours

6. Does the hospital at which you currently work have any sexual assault evidence kits ('rape kits')?
    a. Yes
    b. No

7. If yes to question 6, how readily available are the sexual assault evidence kits for use?
        a. The kits are available in the hospital
        b. We require RCMP/OPP/police to obtain the kit
        c. Other:_____

8. In your role as a healthcare provider, do you feel you have the skills to use a sexual assault evidence kit for a patient who presents following a sexual assault?
    a. Yes
    b. No

9. Has there been an occasion to your knowledge when your hospital has been unable to provide a sexual assault forensic exam for a survivor of sexual assault?
        a. Yes
        b. No

10. If yes to question 9, how many times has this happened?
        a. Once
        b. 2-3 times
        c. 4-5 times
        d. 6+ times (please specify how many times you remember): _____

11. If yes to question 9, what was the reason for not being able to provide care? (select all that apply)
    a. Lack of SAEK/rape kit
    b. Lack of trained staff to administer forensic exam
    c. Patient refused
    d. I did not wish to
    e. Staff shortage
    f. We were able to provide care

g. Other (please specify): _____

12. As a health care provider that treats survivors of sexual assault, do you have access to psychosocial supports through your place of work? (Psychosocial supports include anything that protects or promotes your mental health and wellbeing, and examples may include individual or group counselling, team debriefs, time off work, etc.)
    a. Yes
    b. No

13. If yes to question 10, please specify what supports were available to you: _____

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14. What kinds of supports or services would you like to have access to, but currently do not?:

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15. Do you wish there were more opportunities to receive training for sexual assault treatment in your job?
    a. Yes
    b. No

16. If yes to question 15, what kinds sexual assault related training would you like to have access to, but currently do not?:

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17. The services available for sexual assault survivors at our facility meet the physical and mental health needs of survivors:
    a. Strongly agree
    b. Agree
    c. Undecided
    d. Disagree
    e. Strongly Disagree

18. Would you be interested in being contacted to participate in a short 30 minute interview to provide more insight into this subject? *This interview would be confidential and would not affect your employment. If you select yes at this time, you are still free to not participate if you change your mind.*
    a. Yes
    b. No

19. If you are interested in being contacted for an interview on this subject, please leave your email address for contact: _____

    (please note that your survey results will still remain confidential if you chose to do so)

## Appendix II: Interview Guide Questions

*Preamble*
Thank you for agreeing to participate in this interview. We are interviewing you to better understand your experiences delivering sexual assault care in your community, and what barriers or facilitators may exist for you to provide care to sexual assault survivors. There are no right or wrong answers to any of the questions. I'm interested in your experience, and in the insight that you can offer because of your expertise.

You have signed the consent form and are aware of your rights as a participant (*give them a copy and keep signed copy for yourself*). The interview
should take approximately 30 to 60 minutes depending on how much information you would like to share.

With your permission, I would like to audio record the interview because I don't want to miss any of your comments. All responses will be kept confidential. This means that your deidentified interview responses will only be shared with my Primary-Investigator, Dr. Kate Rice. We will ensure that any information we include in our report does not identify you as the respondent, and also will not identify any of your patients. You may decline to answer any question or stop participating in the interview at any time and for any reason. May I turn on the digital recorder?

*Questions about Occupation/Demographics*

1. What is your role here?
   Prompts: How long have you worked in this occupation? How long have you worked at this site? What was your motivation to enter this career? What other types of providers do you work with here? How long have you lived in this region?

2. Can you walk me through a typical day in your job?
   Prompts: What sorts of things do you do? How would you describe your job to someone who is not working in health care?

3. What kinds of medical and health crises do you encounter frequently in this department?
   Probe: Why do you think those issues are so prevalent here? What challenges do your patients face in terms of living with or recovering from these crises/conditions?

   How many new sexual assault cases do you treat each week? Do you remember the last time you had a SA case?

*Sexual Assault Care Questions*

4. Does your hospital have a standard response or guideline for responding to sexual assault survivors?
   Prompt: If so, can you please explain the process?
   Prompt: If not, how do you determine your role in working with survivors?

Prompt: If you send survivors on to a designated SA/DV TC, is there a road map/standard procedure for this process? Can you provide **an example** of what you would say to such a patient?

5. Do you treat many sexually assaulted patients who come from rural areas, to your health centre? How do those patients get here? Are there challenges for sexual assault survivors from rural areas in receiving health care?
   Prompt: Can you **provide an example** of a patient that travelled a long distance to receive your care?
   Prompt: Where are SA patients coming from?

6. Do most patients want to have the sexual assault forensic examination done? Can you **tell me about a patient** that you recall who wanted/did not want a forensic exam done following sexual assault?
   Probe: What do you think stops them from getting the exam done if they decide not to do it? Do you have any specific example of reasons why patients have decided to forgo this exam in the past?

7. Have you ever had to turn away a sexually assaulted patient because you were unable to provide care for them?
   Probe: Can you **provide a specific example** of the situation? If so, where did the patient go? Do you know if they received alternate care/services?

**SAEKs**

8. What resources to treat sexual assault survivors do you have at your disposal at your hospital ?

Prompt: Do you have sexual assault evidence kits/rape kits? How many do you believe are available at any given point in time in your facility? Are there any barriers to your use of the kit?
Probe: Do you require RCMP in order to administer the kit?

9. How often do you use sexual assault evidence kits?
   Prompts: When was the last time you used a SAEK? How many times per week or per month do you use the kit, in general?

10. If you have used SAEKs before, do you find them easy to use? How long does one forensic exam usually take you?
    Prompt: Is there anything that you find challenging about administering the kit? If so, what? What makes using the kit easier?

**Training**

11. Do you have specialized sexual assault nurse examiners (SANEs) on staff? If you do, are there always some trained SANEs on for each shift, or do they operate on an on-call basis?
    Prompt: If not, how do you advise the survivors? How often do you not have SANEs available to do a forensic exam?

12. Has there been any major shifts in recent years regarding the treatment of sexual assault survivors in your emergency department? If so, can you please walk me through those changes?

Probe: Have any of the formerly developed sexual assault response teams been dismantled?

13. What training have you received to treat patients of sexual assault? Please be as specific as possible.
    Probes: How many hours did this training take? What organization was it through? Was it beneficial?

14. Does your facility/department offer opportunities to further your training in this area? If so, is the training paid for by the system or does it come at your own expense?

15. What do you find challenging about treating survivors of sexual assault?

Follow up: Can you tell me what training, resources or supports would be helpful to you to respond to sexual assault survivors in an optimal manner?

Probe: Do you feel equipped to optimally treat sexual assault survivors?

16. Have you considered pursuing further training to become a sexual assault nurse examiner? Please explain your thoughts surrounding why/why not.
    Prompt: If yes, discuss any barriers in achieving this goal. Is funding provided to do so? If not, would you be willing to pay independently?

17. What kinds of training do you believe would be beneficial for your facility to offer for treating survivors of sexual assault?

**Psychosocial Support:**

18. What types of psychosocial supports are available to you as a healthcare provider for sexual assault survivors? What works well, or what do you wish you had access to in terms of supports?

**Cool-Down:**

1) Is there anything that I have forgotten to ask you, or that you would like to add? Do you have any recommendations?

Thank you very much for your time and the information you shared today. Your insights go towards bettering the care that sexual assault survivors receive, and will help other providers like yourself to better support them.