

**AN OVERVIEW OF THE SEXUAL ASSAULT CARE AND TREATMENT CENTRES  
OF ONTARIO**

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for the  
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## EXECUTIVE SUMMARY

This report, prepared for the World Health Organization as part of its larger initiative to evaluate health-based responses to rape and sexual assault world-wide, is a revised and expanded version of *An Overview of the Sexual Assault Care and Treatment Centres of Ontario*, which was released in May 1997. It is a comprehensive review of the Sexual Assault Care and Treatment Centre (SACC/SATC) model of health care services offered to persons who have been sexually assaulted in Ontario, Canada. The report profiles the history and work of the SACCs/SATCs across the province. Drawing on semi-structured interviews conducted with program coordinators as well as existing documentation, it describes the inception of the centres and the range of services provided, highlights accomplishments, achievements, and advancements in service provision, discusses existing constraints and limitations of the model, and sets out a vision and strategic plan for the future.

In response to community concerns regarding the medical treatment of persons who had been sexually assaulted, the first SACC/SATC opened its doors in Toronto in 1984. Subsequent years saw the continued need for coordinated services and expertise in the treatment of sexual assault in communities across the province. To date, 31 centres have been funded by the Ontario Ministry of Health and Long-Term Care (MOHLTC) to provide or coordinate effective, comprehensive, and sensitive sexual assault health care services. These centres are mandated to attend to the medical, emotional, social, and medicolegal needs of women, men, and children who have been recently sexually assaulted. Services provided include: crisis counselling, emergency medical and nursing care, forensic evidence documentation and collection, medical follow-up, short-term counselling provided in-house or by other community agencies, safety appraisal and court support, and education and community consultation.

In keeping with the former Health Services Restructuring Commission's vision for health services across Ontario, the SACCs/SATCs have distinguished themselves as unique, essential, regional resources that work well with other community agencies to provide integrated, accessible, high quality care to sexually assaulted persons. Staff members, recognized as leaders in both the treatment and prevention of sexual assault, have been innovative in responding to community needs. In this respect, centres have secured funding for emergency and follow-up care for women who are experiencing domestic violence.

Despite constraints and limitations that impede the value of the model from being fully realized in Ontario, the SACCs/SATCs are committed to serving better persons who have been assaulted and to creating healthy, violence-free communities. Many program coordinators see their centres providing a fuller range of services to women, men, and children, whose lives have been affected by violence, both past and present. As part of this vision, they have identified the need to: enhance services provided to prepubertal children and women experiencing domestic violence, improve service accessibility to underserved populations, develop standardized training modules and educational packages, strengthen collaborations with agencies, organizations, and institutions who work with victims/survivors, and establish and refine 'best practices' by supporting and expanding data collection efforts. Over the next year, program coordinators will meet to discuss, further articulate, and define their vision for the future of SACC/SATC services.

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## I. INTRODUCTION

Worldwide, there are a variety of health-based responses available to persons who have been sexually assaulted. One such response, known as the Sexual Assault Care and Treatment Centre (SACC/SATC) model, is well established in Ontario, Canada, where it has been in operation for nearly two decades. This overview chronicles the inception, evolution, and contributions of the SACCs/SATCs and their vision of service provision in the twenty-first century. It is not intended as an evaluation of individual centres, but rather highlights features common to all.

The remainder of this section lists the sources of information upon which this report is based. Section II profiles the history of the SACCs/SATCs. In Section III, the mandate, philosophy, values, organizational framework, and staffing (including training) of the centres is examined along with the range of services provided. Included in this section is a discussion of client rights and issues pertaining to privacy, confidentiality, and consent. Section IV highlights some of the accomplishments, achievements, and advancements in service provision and discusses the challenges, constraints, and limitations associated with maintaining current levels of care, enhancing services, and increasing accessibility. Section V concludes the report with a vision and strategic plan for the future of SACC/SATC services.

The following materials were drawn upon in preparing this report:

- ◆ *An Overview of the Sexual Assault Care and Treatment Centres of Ontario* by Janice Du Mont, Sheila Macdonald, and Robin Badgley. Released in May 1997, this report was based on: SACC/SATC program coordinators' responses to a 14-page questionnaire developed by the first author and the Research Committee members of Ontario Network of Sexual Assault Care and Treatment Centres (ONSACTC), existing SACC/SATC and ONSACTC documents to March 1997, and over 100 letters written in support of the SACCs/SATCs by various community partners and clients in response to requests for service feedback;

- ◆ Responses to a semi-structured interview schedule developed by a consultant to the World Health Organization in Geneva. Eleven interviews were conducted with SACC/SATC program coordinators by a Research Associate at the Centre for Research in Women's Health in August and September 2002;
- ◆ Existing SACC/SATC and ONSACTC documents to September 2002.

## HISTORY

By the late 1970s, it had become clear that hospital emergency rooms were not meeting the needs of persons who had been sexually assaulted. Long waits, inexperienced or untrained nurses and physicians, and insensitive reactions to victims/survivors were commonplace. Concerned health professionals, lawyers, and women's organizations, both formal and grassroots, identified the need for more responsive and timely sexual assault care. In 1979, the Ontario Provincial Secretariat for the Justice Consultation Group (composed of the Ontario Women's Directorate and the Ontario Ministries of Health, Attorney General, and Solicitor General) recommended that specialized hospital programs for round-the-clock treatment of sexual assault and collection of forensic evidence be established. The Ministry of Health's commitment to setting up these programs began in 1983. District Health Councils were asked to: determine if there was a need for hospital-based sexual assault care through community consultation, designate an appropriate hospital, and submit a proposal to the Ministry for funding. The Sexual Assault Care Centre at Women's College Hospital (now Sunnybrook and Women's College Health Sciences Centre) was the first to open its doors in 1984. Since this time, the Ministry of Health (now the Ministry of Health and Long-Term Care [MOHLTC]) has funded an additional 30 centres, as the need for coordinated services and expertise in the treatment of sexual assault has continued to be identified in communities across the province.

In 1993, the Ontario Network of Sexual Assault Care and Treatment Centres was

established to increase networking and support between centres, standardize service provision, and implement professional development opportunities. The MOHLTC provided funding to hire a provincial coordinator to facilitate these objectives and explore the viability of developing a sexual assault nurse examiner program for Ontario.

## **POLICY**

### **1. Mandate**

The Sexual Assault Care and Treatment Centres (SACCs/SATCs) are located in different regions of the province and serve catchment areas ranging from 11,000 to 1,000,000 people. They were established to provide a high standard of comprehensive care to persons who have experienced a recent sexual assault--a recent sexual assault being defined as any form of sexual activity with another person without her/his consent occurring within the previous 72 hours.<sup>1</sup> Their mandate was to attend to the medical, emotional, social, and medicolegal needs of clients in a prompt, professional, and compassionate manner and to provide leadership in the prevention of sexual assault. This was to be accomplished either through the coordination of sexual assault services or through the establishment of multidisciplinary hospital-based sexual assault teams. Services to be provided/coordinated included:

- ◆ Crisis counselling
- ◆ Emergency medical and nursing care
- ◆ Forensic evidence documentation and collection
- ◆ Referral to community agencies for longer-term counselling, issues of safety, and court support
- ◆ Education and community consultation

In response to individual, community, and program needs, other services were to be established as required. Many centres were mandated or evolved to include

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<sup>1</sup> SACCs/SATCs , however, will offer victims/survivors emergency care up to two weeks post-sexual assault.

counselling, emergency care for children and adolescents, follow-up medical care, and research and evaluation.

## **2. Philosophy**

The SACCs/SATCs operate from a feminist perspective that recognizes the embedded social, cultural, and systemic imbalances within society that promote and maintain violence. Sexual assault is regarded as a crime of violence where sexual acts serve as a vehicle for acting out aggression and hostility and establishing dominance and control.

The centres are committed to promoting choice, respect, and empowerment, and honouring differences among clients.

## **3. Values**

The manner in which services are delivered by the SACCs/SATCs is based on the following precepts:

- ◆ To provide care in a nonjudgemental manner
- ◆ To help clients reclaim their autonomy
- ◆ To encourage clients to make decisions about their own care
- ◆ To deem assailants responsible for the violent behaviour
- ◆ To recognize that sexual assault is a critical issue that must be addressed by the health care, legal, social, and political systems

Care for persons who have been sexually assaulted must be individualized, consistent, sensitive, and nonjudgemental as well as ensure that:

- ◆ Special needs are met
- ◆ All options in medical, therapeutic, and legal procedures are made available and thoroughly explained
- ◆ Adequate time is given to process the information so that informed, appropriate decisions can be made
- ◆ Full and well-informed consent is given
- ◆ Any delays in the acute phase of treatment are minimized
- ◆ Well-coordinated follow-up is provided

#### **4. Rights**

In order to assist clients in dealing with the aftermath of sexual assault and to expedite the recovery process, SACC/SATC staff have a responsibility to act in the best interests of clients at all times and to respect their right to:

- ◆ Be treated in a considerate and sensitive manner
- ◆ Confidentiality and privacy
- ◆ Have services, treatments, and/or procedures explained in detail
- ◆ Decline services, treatments, and/or procedures or to change their mind without explanation
- ◆ Have access to information collected about them
- ◆ Decide what happens to their body
- ◆ Decide whether or not to involve the police
- ◆ Be believed regardless of when the sexual assault occurred or who the assailant was
- ◆ Be listened to, supported, and respected
- ◆ Have a cultural interpreter present
- ◆ Display or express whatever emotional response to the sexual assault they may be experiencing without judgement

#### **5. Privacy, Confidentiality, and Consent**

Privacy and confidentiality are ensured at all times. Sexually assaulted persons are asked to wait in a private area in the emergency department and are seen alone, although support persons are permitted at their discretion. When the on-call nurse examiner/nurse arrives, a client is moved to the SACC/SATC, a private set of rooms typically removed from the emergency department. All information and documentation obtained during assessment and treatment is considered extremely confidential and is not released without the client's consent. It should be noted, however, that these records could be subpoenaed for use in court. As well, if a person is under age 16, the nurse examiner/nurse has a duty to report the case to the Children's Aid Society, which, at its discretion, will inform the police. Valid consent must be obtained for treatment. Consent is also required in cases where a sexual assault examination kit is

administered. Documents and specimens collected as part of the examination are forwarded to the police only when the client has provided written consent to do so. If a client is unable to provide consent, for example, by reason of age or disability, it must be obtained from a parent or legal guardian. The client can revoke consent anytime during a visit.

## **6. Organizational Framework**

Although all Ontario SACCs/SATCs provide an integrated response to sexual assault, and each new centre draws and builds on those already established, variations in service delivery, organization, and funding can be found across the province. These variations are captured in the following two groupings:

### **6.1 Hospital-Based Centres**

- ◆ Emergency and counselling services are located in-hospital and provided by SACC/SATC hospital personnel (i.e., nurse examiners, nurses, physicians, program coordinators, and counsellors) and are funded by the Ontario Ministry of Health and Long-Term Care (MOHLTC).
- ◆ Emergency services are located in-hospital and provided by SACC/SATC hospital personnel (i.e., nurse examiners, nurses, physicians, and program coordinators). Clients are referred to community agencies for counselling services. The MOHLTC provides funding for emergency services only.

### **6.2 Hospital/Community-Based Centres**

- ◆ Emergency services are located in-hospital and provided by SACC/SATC hospital personnel (i.e., nurse examiners, nurses, physicians, and program coordinators). Counselling services are offered through community agencies via purchase for service agreements with the hospital. The MOHLTC provides funding for both types of services.
- ◆ Emergency services are located in-hospital and provided by SACC/SATC hospital personnel (i.e., nurse examiners, nurses, and physicians). Program coordination and counselling services are community-based. The MOHLTC provides funding for both types of services.

## 7. **Staffing**

Centres differ in terms of staffing and hire on the basis of needs and the availability of resources. Staff may include program coordinators, administrative assistants, secretaries, medical directors, researchers, counsellors, nurse examiners, nurses, and physicians. Much of the office support staff is part-time. Nurse examiners, nurses, and physicians are typically on-call and work on a casual part-time basis. The latter are paid on a fee-for-service basis and reimbursed through the Ontario Health Insurance Plan. Nurse examiners/nurses are paid a small on-call fee and an hourly wage when service for a client is provided. Staff is predominately female, with exceptions occurring most often among physicians.

The duties and responsibilities of staff may vary from centre to centre. The more common positions are highlighted below:

### 7.1 **Program Coordinator**

Program coordinators are usually registered nurses (RNs) or social workers who are responsible for the provision of direct service to clients and their families and friends and for overseeing:

- ◆ Administration and supervision of the program
- ◆ Education of staff, students, other service providers, and community members
- ◆ Program development, implementation, and evaluation
- ◆ Research relevant to the program

Program coordinators ensure that SACCs/SATCs provide coordinated, standardized, and effective services for persons who have been sexually assaulted. They also develop and maintain cooperative working relationships with the community and represent their individual centres at the quarterly and regional meetings of the ONSACTC.

### 7.2 **Secretary/Administrative Assistant**

Secretaries/administrative assistants respond to requests for information from the public

and refer callers to services as required. They are also responsible for maintaining nurse and physician on-call rosters, keeping inventory of office and treatment room equipment, and ordering supplies. Secretaries may assist with office management, in particular payroll, compiling statistics, and correspondence.

### 7.3 Medical Director

Medical directors are most often family practitioners. They oversee the medical management of the centres and, in collaboration with program coordinators, monitor the overall management of services. Their duties may include chart reviews, administrative support and recruitment, and orienting and supervising new on-call staff. They may also provide education to centre staff and the community and publish current standards of forensic care.

### 7.4 On-Call Nurse Examiner

On-call nurse examiners are RNs who have undergone extensive training qualifying them to provide comprehensive sexual assault care including supportive crisis counselling, physical assessment and examination, documentation of injuries, collection of forensic evidence, and testing and treatment for sexually transmitted infections (STIs) and/or pregnancy, with little physician involvement and according to established protocols. They may also be required to testify in court.

### 7.5 On-Call Physician

On-call physicians are typically family practitioners and are responsible for providing medical treatment to persons who have been sexually assaulted, including a complete physical examination to check for internal and external injuries. On-call physicians also document injuries, collect forensic evidence, test and provide treatment for STIs and/or pregnancy, dispense medication, and offer or initiate follow-up care. They are available to consult with nurse examiners and may also be required to testify in court.

## 7.6 On-Call Nurse

On-call nurses are usually RNs or, in some jurisdictions, registered practical nurses (RPNs). They attend to the emotional and physical needs of sexually assaulted persons and provide information and referrals. Working in partnership with physicians and/or nurse examiners, on-call nurses assist with the forensic examination and, in some cases, document physical injuries and collect and label swabs, specimens, and samples. They may also be required to testify in court.

## 7.7 Follow-Up Nurse Examiner

Follow-up nurse examiners provide care to clients following their initial visit to a SACC/SATC. They assess the emotional state of clients and, if necessary, offer crisis support on site or over the phone. They document and describe new physical findings and injuries (e.g., muscle soreness and bruising may have a delayed presentation), re-administer STI tests, and inform clients of previous test results. As well, safety, risk, and suicidal ideation are assessed and referrals to appropriate agencies are made. Follow-up nurse examiners may also be required to testify in court.

## 7.8 Social Worker

Social workers are university-educated and have been trained in various trauma-based techniques. They provide follow-up counselling to clients and their families and friends and, in some centres, work on-call in partnership with nurse examiners/nurses. They also assess clients for the psychosocial sequelae of sexual assault (e.g., nightmares, safety) and offer individual or group counselling sessions. Emphasis in these sessions is on reducing symptoms of rape trauma syndrome and enhancing coping skills. Social workers may also provide education to service providers and members of the community and accompany clients to court.

## **8. Training**

### **8.1 Core Requirements**

The use of different sexual assault training protocols across centres results in some variation in nurse and physician expertise province-wide.

Nurses. Nurses who are part of the SACC/SATC roster do not participate in a standard training program. For instance, one centre offers a two-day orientation composed of readings, experiential techniques, and simulations, a one-day training session on pelvic examinations, and a buddy system for administering the initial four sexual assault evidence kits (SAEK).<sup>2</sup> At another centre, nurses are simply given a SAEK and informed that they are to read the instructions as well as program policies and procedures.

Physicians. There is no standard training program for sexual assault physicians in Ontario. Some participate in a three-hour orientation led by the medical director and/or program coordinator, which describes the service and the protocols used for the provision of medical treatment and the collection of forensic evidence. In other centres, training takes the form of qualified nurses overseeing physicians' administration of the SAEK. A few centres rely solely on medical services provided by emergency department physicians. At these centres, some physicians receive no sexual assault training while others receive a one-to-two hour briefing.

### **8.2 Professional Development**

Further training is offered through professional development opportunities.

Support and Networking. The Provincial Coordinator of the Ontario Network of Sexual Assault Care and Treatment Centres (ONSACTC) provides direct support to

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<sup>2</sup>The SAEK, developed by the Ontario Ministry of the Solicitor General (now known as Ministry of Public Safety and Security), is a standardized protocol containing the instructions, implements, and forms required to systematically collect bodily samples and specimens as well as document injuries and statements concerning the assault.

program coordinators on an individual basis and produces a quarterly newsletter that is distributed to all 31 SACCs/SATCs. This newsletter contains information relevant to sexual assault and service provision, upcoming workshops and conferences, and any other materials that individual program coordinators want to share with one another. Program coordinators meet three times a year to discuss issues and concerns related to standards of care and 'best practices.' As well, regional coordinators (e.g., central Ontario, northern Ontario) meet periodically to share resources and identify trends in sexual assault. Staff of individual centres also meets regularly to stay informed on important issues and deal with administrative concerns.

Continuing Education. An annual conference provides an opportunity for SACC/SATC staff (both administrative and clinical) to increase their knowledge of the various dimensions of sexual assault, including the provision of acute medical care, counselling, crisis intervention, and forensic evidence collection. The most recent meeting, held in April 2002, focused on paediatric and adolescent care and was attended by over 325 SACC/SATC staff and community representatives. Since September 1997, educational opportunities for clinical SACC/SATC staff have been made more accessible through the use of teleconferencing.

Sexual Assault Nurse Examiner Program. In 1995, the Sexual Assault Nurse Examiner (SANE) training program was developed in collaboration with the ONSACTC Provincial Coordinator and SACC/SATC program coordinators and was funded by the MOHLTC. Following the program's inception in 1995, a training manual was written, a course curriculum designed, and funding secured for the training of nurses across the province (see Appendix A for the qualifications necessary to participate in and the core curriculum of the SANE program). Nurses who have completed the 40-hour SANE training program are qualified to provide comprehensive emergency medical care to

adolescent and adult clients with minimal or no physician support. The program is intended to increase continuity of care, decrease the time it takes to provide clients with services, and reduce provincial health insurance costs. As of February 2002, a total of 375 nurses across Ontario have completed the training program, which is offered on a biannual basis. The training manual is in the process of being updated and revised.

## **9. Services**

### **9.1 Emergency Care**

The SACCs/SATCs provide emergency services 24-hours a day, seven days a week to women, men, and/or children who have been sexually assaulted within the previous 72 hours. Victims/survivors may present on their own, be brought by police, representatives from community agencies (e.g., rape crisis centres, shelters), parents, or health care professionals, or be referred by other hospitals. Access to care is through the emergency department of the hospital, where the triage nurse meets the client. After ensuring the person is medically stable, emergency department staff page the on-call nurse examiner, nurse, and/or physician, who typically arrive(s) within 30 to 45 minutes. The client waits in a private area until moved to the SACC/SATC where all options for medical, forensic, psychosocial and follow-up care are explained. Emphasis is placed on the decision-making abilities of clients and respect for their opinions and preferences.

The average examination and treatment time for a client seen for emergency care is four hours. The services provided by the on-call medical team member(s) include:

- ◆ Crisis counselling: Emotional support, explanations of treatment and forensic options, and referrals to on-site or community agency-based longer-term counselling.

- ◆ Medical care:  
Assessment, documentation, and treatment of injuries; counselling, testing, and treatment for STIs; assessment for pregnancy and treatment and counselling for pregnancy prevention; and blood collection for future HIV testing.
- ◆ Forensic evidence collection:  
Administration of the SAEK within 72 hours (24 hours for children) of the sexual assault for potential use in criminal proceedings. Clothing, samples (e.g., blood, semen) and other evidence of forced sexual contact are collected for the purpose of identifying the assailant, linking the victim/survivor and assailant to the crime scene, and establishing the occurrence of recent sexual activity. The client is given the option of freezing the SAEK for up to six months while police involvement is contemplated.
- ◆ Anonymous third party reports to police
- ◆ Referral to community-based agencies (where services not provided):  
For assistance with safety plans, lodging, job and financial issues, and support in deciding whether to press charges, preparing for court appearances, and attending court.

## 9.2 Follow-Up Care

All clients who receive emergency care and consent to a follow-up telephone call are contacted by the program coordinator or nurse examiner/nurse 24 to 72 hours after their initial visit. These staff members review and discuss clients' emotional and physical health concerns, ensure adequate supports are in place, and answer any questions or concerns that may have arisen. Crisis counselling is provided along with safety and risk assessment and referrals to community agencies are made. A follow-up visit is also recommended, at which time clients are given the option of further documentation of injuries, physical assessment, crisis intervention and support, safety planning, risk assessment, and referrals to community resources. Test results are also provided. Clients may be offered another follow-up visit at three weeks.

## 9.3 Short-Term Counselling and Social Support

Psychosocial care is offered to adult clients (and to children where services are available) of the emergency medical service and recently sexually assaulted adults that

have been referred by community agencies. Services are either offered on-site or at affiliated community agencies for up to 12 weeks. The SACC/SATC counsellors are typically social workers or registered nurses who have expertise in working with acute sexual assault victims/survivors. Clients may be offered either individual or group counselling sessions depending on the availability of these treatment options. Because sexual assault may disrupt home, school, and work life, the goal of counselling is to assist clients in coping with the effects of trauma and to return to their previous level of functioning as quickly as possible. Counsellors may also refer clients to other services (e.g., shelters, the Criminal Injuries Compensation Board), advocate on their behalf (e.g., negotiate time off work and/or school), assist them with documents (e.g., victim impact statements), and accompany them to court. As well, emotional support and information are offered to the families and friends of clients as needed.

#### 9.4 Education and Community Consultation

Every SACC/SATC in Ontario is committed to increasing public awareness about the prevalence and sequelae of sexual assault. Staff are extensively involved in training other professionals (e.g., police, Crown attorneys), making presentations to student and community groups (e.g., high schools, universities, crisis intervention centres), and developing and implementing public awareness campaigns. Much of this work focuses on strategies to prevent and ultimately eliminate sexual assault and is done in collaboration with other agencies that provide services to victims/survivors (e.g., rape crisis centres, family counselling centres).

#### 9.5 Monitoring, Evaluation, and Research

Monitoring, evaluation, and research are essential components of SACC/SATC services as they provide information to funders, client-groups, administrators, staff, and other relevant constituencies. For this reason, program coordinators complete quarterly

statistical reports for the Provincial Coordinator of ONSACTC, who then prepares a summary for the MOHLTC (see Appendix B for 2001/2002 data). The SACCs/SATCs also have community advisory committees composed of agencies, organizations, and individuals that serve sexually assaulted persons in their catchment areas. These committees are expected to review referral and utilization patterns and to suggest improvements in service provision. The hospitals in which SACCs/SATCs are located record sexual assault clients/visits on Form 13 of the annual Hospital Operating Plans. As well, quality assurance policies ensure that audits (of practice, documentation, key functions, and safety features) are completed regularly and some centres conduct user evaluations.<sup>3</sup> Finally, service data collected from the SACCs/SATCs has formed the basis of several research projects, some of which are being/have been conducted in partnership with ONSACTC and some spearheaded by individual centres with or without university involvement. Such studies have focussed primarily on documenting and improving services offered to clients, challenging misconceptions about sexual assault, and examining the legal processing of sexual assault cases (see Appendix C for a list of representative publications).

#### **IV. PRACTICE**

##### **1. Accomplishments, Achievements, and Advancements**

Within a period of a few years, the Sexual Assault Care and Treatment Centres of Ontario (SACCs/SATCs) have become fully operational, coordinated, and highly valued services meeting the needs of persons who have been recently sexually assaulted.

Their mandate and evolution are congruent with the former Health Services

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<sup>3</sup>SACCs/SATCs are also working with the Ontario Women's Directorate's ongoing initiative to evaluate the effectiveness of several types of services for women who have experienced violence. Questionnaires inquiring about experiences and perceptions of the care provided are being distributed to SACC/SATC clients. Program coordinators then enter the data into a government-secured database for collation and feedback.

Restructuring Commission's vision of developing an integrated, interactive, and dynamic health services system.<sup>4</sup> With respect to the principles of organizing and providing services as set out in this vision, the SACCs/SATCs provide: integrated, comprehensive, accessible, and high quality care; strong leadership in meeting the current and evolving needs of victims/survivors; and essential work toward the prevention of sexual violence.

### 1.1 Comprehensive Care

In collaboration with community-based agencies, the SACCs/SATCs provide comprehensive care to all persons who have been recently sexually assaulted. The SACC/SATC treatment components include emergency medical and nursing care, crisis intervention and trauma-based counselling, follow-up care, and referrals to community agencies for other types of support. In response to community-specific needs, some centres also provide on-call social work support, native healing and awareness, medicolegal assessments, court assistance, 24-hour crisis lines, and shelter support. Sexual assault community advisory committees composed of agencies, organizations, and individuals with expertise in the area of sexual assault have been developed in partnership with the SACCs/SATCs to ensure that an effective and coordinated system of services is in place to meet the needs of victims/survivors. Stemming from this active participation of related community agencies, program coordinators report that the more comprehensive and better coordinated care currently provided has increased the number of clients served, hastened their healing from abuse, and reduced duplication in services. General hospital staff endorses the comprehensive and responsive approach

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<sup>4</sup>Health Services Restructuring Commission. (1997, January). *A Vision of Ontario's Health Services System*, Toronto. The Health Services Restructuring Commission was established in April 1996 with a four-year mandate to make decisions on restructuring Ontario's public hospitals and recommendations to the Minister of Health and Long Term-Care on reinvestments in and restructuring of other parts of the health system.

to sexual assault treatment, particularly in terms of improved victim/survivor care and increased efficiency in service delivery.

## 1.2 High Quality Care

SACC/SATC staff undergoes training specific to sexual assault that ensures excellence in standards of care and uniqueness in service provision. For most on-call staff, this training typically includes crisis intervention, history taking, documentation of injuries, forensic evidence collection, provision of prophylactic treatments (e.g., for hepatitis B, pregnancy), emotional sequelae, and rape mythology. Nurse examiners, nurses and physicians are also trained in new technological procedures such as colposcopy.

Ongoing educational and professional development opportunities (e.g., teleconferencing, annual conferences, Sexual Assault Nurse Examiner [SANE] training, regular staff meetings) serve to enhance skills and knowledge. Counsellors are university educated and maintain a high level of therapeutic expertise through ongoing training in trauma-based techniques. In some centres, expert witness designations have been developed and some staff members have been trained and certified to present at court hearings. Quality is assured in a variety of ways, including peer supervision and review, educational rounds, monthly newsletters, multidisciplinary team meetings, new product demonstrations, audits, program evaluations, and staff and client satisfaction surveys. Program coordinators report that appropriate, up-to-date, and better-educated care providers have reduced the need for more expensive medical services (e.g., psychiatric treatment and in-patient hospital care) and have increased the number of offenders prosecuted. Hospitals, police services, community organizations, and educational facilities all comment that highly skilled and knowledgeable SACC/SATC staff has aided in the passage of justice and saved time and monies.

### 1.3 Accessibility

The SACCs/SATCs provide emergency services 24-hours a day, seven days a week to women, men, and children who have recently been sexually assaulted. Counselling is offered to adult clients (and children where services are available) who receive emergency care as well as to those who have been referred through community agencies. Appointments are arranged in advance and available throughout the week. Clients from diverse ethnic, cultural, and economic backgrounds are welcomed and respected, with efforts made to reach populations traditionally underserved. Community outreach initiatives to First Nations reserves, gay/lesbian organizations, disability agencies, men's groups, and multicultural centres have broadened awareness of SACC/SATC services. French language services, Telephone Devices for the Deaf, cultural interpreters, wheelchair access, and specialized examination chairs have been part of the ongoing efforts to increase accessibility. In addition, many community agencies report that compassionate and respectful care, offered in a private and secure environment, has reduced the revictimization historically experienced by individuals who report a sexual assault, thereby making the services more welcoming.

### 1.4 Leadership

The SACCs/SATCs provide strong community leadership in developing and implementing programs for sexual assault treatment and prevention. Staff members educate, train, and consult with other health care professionals, community workers, teachers, police officers, as well as the media. They participate in college/university training programs for medical, nursing, and social work students. They have devised protocols for treating sexual assault victims/survivors at regional hospitals, training programs for community agencies working with children and adults who have been sexually assaulted, abuse prevention programs in elementary schools and senior

residences, and 'date rape' programs in high schools. Two videos have been created; the first on the provision of sexual assault services at SACCs/SATCs and the second on screening, identifying, and responding to domestic violence in emergency room settings. One centre recently launched a coaster campaign to raise awareness about the increasing incidence of drug facilitated sexual assault. The slogan of another centre, "A community that cares...is aware", captures the responsibility of the general public in ending violence and providing care to those affected by it. As well, research programs at several centres have expanded the theoretical knowledge of violence against women, men, and children and the application of this research to practice has helped shape services. Staff members in hospital emergency departments have reportedly benefited most from SACC/SATC training initiatives, as better-informed and more sensitive health care professionals facilitate disclosures of sexual assault. Program coordinators believe that over time prevention efforts will decrease the incidence of sexual violence in society as a whole.

### 1.5 Strategic Alliances

The SACCs/SATCs have fostered extensive community networks of local, district, and regional agencies working with victims/survivors of sexual violence. Effective partnerships have been forged with and between the police, Crown attorneys, hospitals, child protection services, boards of education, shelters, rape crisis centres, multicultural agencies, sexual health clinics, military bases, and other victim/survivor services. Successful collaborative endeavours have grown out of town hall meetings, community advisory boards, increased liaison and public relations work, clinical consultation, and community outreach activities. Workshops and conferences, sexual assault and domestic violence protocols, and grant applications for research funding have all emerged from collaborative endeavours. Staff members at various agencies sit on each

other's boards. Recognition of complimentary services has increased interagency referrals and has enhanced victim/survivor care. Centres report that sharing resources and expertise fosters a more integrated, coordinated, and efficient system of dealing with sexual violence. Other agencies and services support this, stating that they have benefited in several ways from working collaboratively with the SACCs/SATCs, including better success in investigations, court proceedings, and in coordinating a client's long-term follow-up and support in the community.

#### 1.6 Efficiency

Greater efficiency has resulted from the provision of streamlined, comprehensive, coordinated, high quality, accessible, and consistent care. Frustrations and costs have declined, as victims/survivors are no longer required to wait in crowded emergency departments for physicians who could be more effectively deployed elsewhere.

Continuity of care for victims/survivors has improved and Ontario Health Insurance Plan (OHIP) expenditures appear to have decreased as a result of the SANE training program which cuts down on the cost of physician involvement.<sup>5</sup> Except in very specific circumstances, nurse examiners provide all aspects of treatment--from history-taking to documentation of injuries and forensic evidence collection--eliminating the need for clients to retell their stories and reducing overall treatment time. The police and Crown attorneys report that greater consistency in the documentation and collection of forensic evidence for courtroom testimony has increased the number of offenders apprehended and cases successfully prosecuted. Having one qualified professional attending to medical and forensic needs of victims/survivors reduces the number of witnesses required to appear in court, which represents cost-savings to both the health care and the criminal justice systems. Family and child services also note that the ability to

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<sup>5</sup>A preliminary analysis of OHIP data by the former Ministry of Health suggested a decrease in billings for sexual assault treatment following the inception of the SANE program.

provide specialized care to child victims of sexual assault within 24 hours is invaluable in terms of ensuring that information is quickly forthcoming to child protection agencies for the purposes of risk assessment in these difficult cases.

### 1.7 Meeting Special Needs

The SACCs/SATCs are client-centred services. They were established to ensure that the medical, emotional, and social needs of sexually assaulted persons are met in a sensitive and timely manner, in a safe and supportive environment. Feedback from clients suggests that SACCs/SATCs have been successful in meeting these objectives.

For instance, results obtained from a survey of 123 victims/survivors who presented to one centre between April 2001 and March 2002 revealed that 75% were "very satisfied" and 25% "satisfied" with the emergency-based sexual assault care and treatment they had received. Former SACC/SATC clients also state that they would not have been able to pursue criminal action, to heal psychologically, and to once again become contributing and fully functioning members of society without the treatment and support provided by centre staff. One client wrote: "I cannot imagine how I would have coped emotionally and physically if these wonderful people were not there for me . . . [I] would never have found the strength to even report my issue and to stand up for myself in front of a judge . . . I am depending on the help of [the SACC/SATC] counsellor so one day I can put the past behind me, believing I justifiably stood up for my human rights and possibly prevented another victim of such a crime."

### 1.8 Innovation through Research

Du Mont, Macdonald, and Badgley's 1997 overview of the scope and dimensions of the services provided by the SACCs/SATCs revealed that women assaulted by their partner form a high-risk and underserved population. In response to this research as well as

increasing media attention to the issue,<sup>6</sup> in late 1997, the Ontario Ministry of Health and Long-Term Care provided funds to seven centres to pilot programs for domestic violence. After these programs were favourably evaluated, funding for domestic violence was secured for 23 other SACCs/SATCs. To date, all 30 centres designated to provide emergency medical and follow-up care to assaulted women have programs that are either under development or operational. Those that are up and running have already enhanced the response to women experiencing domestic violence through the provision of timely and sensitive care by specially trained health professionals (see Appendix D for a fuller description of the domestic violence services provided). Interviews with criminal justice personnel, nurse examiners/nurses, and victims/survivors themselves reveal that these programs help break the cycle of abuse that is characteristic of so many domestic violence situations. As well, prosecution of such cases has been aided by the "comprehensive, detailed and credible" medical forensic documentation of injuries (including photographs).<sup>7</sup>

## **2. Challenges, Constraints, and Limitations**

As a hospital-based model of integrated care, SACCs/SATCs have been enormously successful in responding to persons who have been sexually assaulted. There remain, however, constraints and limitations that impede the value of the model from being fully realized in this province. These challenges fall into the following categories: structure, resources, community networks, and research and development.

### **2.1 Structure**

Inherent within the SACC/SATC model is several structural tensions. Although centres possess a unique mandate and specialized principles regarding the care and treatment

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<sup>6</sup> In 1996, the *Toronto Star* produced a series on domestic violence that sparked a public outcry.

<sup>7</sup> KPMG Consulting LP. (1999, December). *Evaluation of Domestic Violence Pilots - Final Report*. Toronto: Ontario Ministry of Health and Long-Term Care.

they offer, the hospitals they are located in subscribe to their own set of values, which tend to coincide with a 'disease-oriented' paradigm. As a result, SACC/SATC staff, especially program coordinators, must meet dual agendas and often find themselves struggling to represent and preserve the interests of sexual assault centres in the hospital environment. Convincing co-departments and co-workers that sexual assault victims/survivors are 'healthy' people that have needs that extend beyond the care traditionally provided in standard hospital facilities can be a formidable task. Some program coordinators have reported that sexual assault cases are not always regarded as priority in triage and that some medical personnel are unsupportive. Misperceptions of hospital-based SACCs/SATCs also occur beyond the walls of the medical establishment. For instance, one program coordinator noted that being in a hospital, a so-called "legitimate institution," signalled to some that the SACCs/SATCs are an arm of the police.

For some SACC/SATC staff members, tensions also arise from what some have deemed the contradictory goals of post-sexual assault health care/treatment and forensic evidence collection.<sup>8</sup> Research conducted in collaboration with the ONSACTC has revealed that practitioners may occasionally have difficulty remaining objective when collecting evidence, while at the same time, having to deliver health care that is client-centred, nonjudgemental, and sensitive.<sup>9</sup> Program coordinators interviewed for this report indicate that despite the dual nature of the health care professional's role, medical care unquestionably takes precedence. One suggested that it must be emphasized in training that "they are nurses first...not investigators at the service of the courts." Almost every other respondent reinforced this view; stating that supporting the

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<sup>8</sup> See, for example, Savage, S., Moon, G., Kelly, K., & Bradshaw, Y. Divided loyalties? The police surgeon and criminal justice. *Policing and Society*, 7, 79-98.

<sup>9</sup> Du Mont, J., & Parnis, D. (in press). Forensic nursing in the context of sexual assault: Comparing the opinions and practices of nurse examiners and nurses. *Applied Nursing Research*.

client is most important in providing post-assault care for the person who “has lost power.” This is not surprising given that many coordinators stated that they were aware of problems with forensic evidence in adult sexual assault cases. It was noted that the standardized collection of forensic evidence appears to increase consent defences and is generally not useful in cases involving known assailants. These insights reflect broader research indicating that forensic evidence collection may have a limited effect on the legal processing of sexual assaults where complainants are older than 16 years of age.<sup>10</sup>

## 2.2 Resources

Issues of resource availability are salient and stand as ongoing challenges for SACCs/SATCs. Although adequate funding is required to maintain and expand services, many centres witnessed a reduction in funds in the mid- to late-1990s when their respective hospitals redirected monies to meet other budget requirements. The effects of these cutbacks negatively impacted on staff morale, court support and advocacy, community education and outreach activities, professional development and continuing education opportunities, counselling services, and 24-hour emergency care. Some centres were unable to fulfil their commitment to provide counselling and training in underserved areas. Cutbacks also made it difficult to expand beyond English-only service provision and create culturally sensitive educational materials. While funds continue to be routed through individual hospitals and centres remain vulnerable to budget cuts by their host institution, as of this fiscal year, the Ontario Ministry of Health

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<sup>10</sup> Du Mont, J., McGregor, M.J., Myhr, T.L., & Miller, K-L. (2000). Predicting legal outcomes from medicolegal findings: An examination of sexual assault in two jurisdictions. *Journal of Women's Health and Law*, 1, 219-233; Du Mont, J., & Parnis, D. (2000). Sexual assault and legal resolution: Querying the medical collection of forensic evidence. *Medicine and Law*, 19, 779-792; McGregor, M.J., Du Mont, J., & Myhr, T.L. (2002). Sexual assault forensic medical examination: Is evidence related to successful prosecution? *Annals of Emergency Medicine*, 39, 639-647.

and Long-Term Care has combined and annualized the monies allocated to SACCs/SATCs for sexual assault and domestic violence care.

Staffing SACCs/SATCs remains a key and perennial resource concern. The employment structure poses a serious challenge for on-call staff recruitment and retention; program coordinators often struggle to staff 24-hour rosters. In the context of a shortage of nurses and physicians province-wide, program coordinators face the added challenge of trying to recruit personnel to work in the area of sexual assault when it is often misunderstood and marginalized in the hospital environment. Even when practitioners join a sexual assault team, retaining their services is a challenge. On-call staff members are required to fund most of their professional development and educational activities themselves and what they earn can be meagre. For instance, nurse examiners/nurses are employed on a part-time, on-call basis (including time spent or waiting to testify in court), for an on-call fee of \$2.70 per hour. This arrangement necessitates that they hold full-time positions elsewhere. Practitioners may also experience vicarious trauma and burnout as a result of repeatedly hearing stories from victims/survivors, another obstacle to retention efforts. Finally, as centres have become increasingly staffed by nurse examiners, physicians are conducting fewer forensic examinations and are beginning to fall behind in their expertise. As a result, many are hesitant to include their names on on-call rosters. As the SACC/SATC mandate is enhanced and expanded (e.g., domestic violence, child sexual assault/abuse), these recruitment and retention problems may escalate and some program coordinators worry that sustaining this already over-taxed system may become untenable.

### 2.3 Community Networks

Community networks are key to the success of the SACCs/SATCs. Interagency

collaboration fosters strong local and regional networks, ensuring few gaps or duplications in services. As previously noted, the SACCs/SATCs work effectively with the police, hospitals, community health centres, and rape crisis centres. However, delivery of services to populations and individuals who are difficult to reach and linkages with agencies who work closely with these groups (e.g., women's shelters, seniors homes, First Nation's health centres, gay and lesbian organizations) must be strengthened. In this regard, some communities face greater obstacles than others. For example, one SACC/SATC is expected to respond to a vast area and population including rural and urban residents, a Canadian Forces Base, a large deaf community, and a First Nations reserve. Given the need for and the complexity of delivering care in some jurisdictions, a well-integrated and effective response to sexual assault is contingent on the continued funding of a wide range of community services for abused persons (e.g., if referrals to a shelter are to be made, shelters must be available). Such funding, however, is often conditional and unstable, presenting a challenge in terms of providing coordinated, high quality, and comprehensive community-oriented care.

#### 2.4 Research and Development

Research is key in determining the effectiveness of SACC/SATC services. Information collected can be used to improve service delivery so that it is more efficient and cost-effective, verify that the centres are operating within their mandate, identify gaps between policy and practice, and determine whether the needs of target populations are being met. For example, a research project is currently underway that is seeking to develop a protocol that can be used by centres for identifying the circumstances under which HIV prophylaxis should be offered to clients. Nonetheless, more evaluation of SACC/SATC services is needed. Existing data, in many cases, reveals little about the characteristics and perceived needs of clients who access services. As well, issues

such as the prevalence of drug facilitated sexual assault should be examined.<sup>11</sup> The lack of sufficient and appropriate documentation on these types of concerns has made strategic planning difficult and stems largely from inadequate research funding and the dearth of SACC/SATC staff with skills to conduct evaluation research.

## **V. FUTURE DIRECTIONS**

### **1. Vision**

The Ontario Network of Sexual Assault Care and Treatment Centres' (ONSACTC) vision of the future is one where violence is widely recognized as an issue integral to health and health care. To this end, Sexual Assault Care and Treatment Centres (SACCs/SATCs) would have full-time, on-site health care professionals responding across all hospital departments to the needs of women, men, and children whose lives have been affected by violence, both past and present. As part of this vision the SACCs/SATCs have identified the need to:

- ◆ Expand their mandate to include care for children experiencing ongoing abuse and counselling for women experiencing domestic violence
- ◆ Improve service accessibility for underserved populations and ensure that the needs of disadvantaged groups already accessing services are being met
- ◆ Build on the extensive educational programs currently offered by developing standardized training modules and educational packages that may be used by all centres for professional training (e.g., police, Crown attorneys) and public outreach
- ◆ Collect, compile, and analyze data pertaining to client visits to promote increased understanding of the origins of violence, the harms incurred, and effective treatment and prevention strategies

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<sup>11</sup>If empirical research indicated that drug-facilitated sexual assault is on the rise, then changes to the forensic processing of these cases may be warranted. Presently, samples are given to the police, who then forward them to the provincial Forensic Sciences Centre for analysis. This process is slow and requires the victim/survivor to report the assault to the police. If centres had access to a private laboratory, clients would be given test results more quickly and could use them in deciding whether or not to involve law enforcement authorities.

## **2. Strategic Plan**

A number of strategies are being developed and implemented to meet current challenges and to move SACCs/SATCs in this province closer to the vision of addressing the abuse of women, men, and children across the lifespan.

### **2.1 Enhancing Programs**

Federal funds transferred to the Ontario Ministry of Health and Long-Term Care (MOHLTC) will be used to enhance services provided to sexually assaulted/abused children over the next five years. To date, the emergency response for sexually assaulted children has been underutilized as most paediatric cases involve chronic abuse, making forensic documentation, which is time-sensitive, of little value. To be better equipped to deal with recurring abuse, the SACCs/SATCs will establish nonurgent day-clinic services staffed by child sexual assault/abuse teams composed of nurse examiners/nurses, paediatricians, and social workers. This initiative will also strengthen the emergency medical response for prepubertal children and will involve relevant community agencies, such as the Children's Aid Society. MOHLTC has also provided funds to SACCs/SATCs for emergency and follow-up care for victims/survivors of domestic violence. To offer a wider range of services to women abused by their intimate male partners, centres will also seek funding for short-term counselling. Program coordinators could draw on the expertise of SACC/SATC social workers who are developing a standardized training module for working with sexual assault victims/survivors in implementing such a service.

### **2.2 Reaching Underserved Populations**

Given the diversity of populations served by centres, ONSACTC has recognized the importance of developing a better understanding of the needs of culturally, racially, economically, and differently abled persons; both those who are currently using

SACC/SATC services and those who are not. Client satisfaction surveys could be standardized and employed province-wide as one method for soliciting feedback from current users of the system. Census data could be used to determine the particular cultural and linguistic characteristics of a particular region and health care practitioners who might be more representative of the community at large could be recruited. As well, each SACC/SATC could bring together key players from agencies working with underserved populations to identify client needs and to develop plans that would address barriers to accessing services (e.g., improved access to sign language, additional support for the visually impaired, funds for transportation and childcare). Finally, mobile teams capable of travelling to other health care facilities and community agencies (e.g., shelters) could be used to improve population outreach.

### 2.3 Expanding Training and Education

To expand education and training opportunities, enhance outreach programs, and save staff time, the ONSACTC will develop standardized training modules and information packages that can be accessed by all centres and utilized province-wide. Standardized training programs for nurses and physicians on on-call rosters could also be implemented, as current initiatives, where they exist, differ across centres. Building on the knowledge and expertise acquired through founding the Sexual Assault Nurse Examiner training program, the Network could develop and implement a similar module for nurse examiners who will be working with children experiencing recurring abuse. As part of the long-term vision of increasing awareness of violence as a health issue, it could also seek opportunities to play a role in core curriculum development for nursing degree programs, incorporating materials on awareness of sexual assault and domestic violence as health issues; violence prevention, prevalence, and sequelae; screening techniques for detecting sexual assault/abuse and domestic violence; and approaches

and standards for the care and treatment of assaulted persons, both acute and chronic.

#### 2.4 Strengthening Government and Community Collaboration

The SACCs/SATCs recognize that no one type of agency can successfully prevent and treat sexual assault/abuse and domestic violence. The enhancement and expansion of services and the generation of solutions to eradicate violence in society require a multisectoral, multidisciplinary effort that can further foster service integration and enable agencies to draw upon each other for support and expertise. In maintaining current and forging new interagency alliances, the SACCs/SATCs could convene regular meetings of key players from funding bodies (e.g., the Ontario Ministries of the Attorney General and of Health and Long-term Care) and funded agencies (e.g., the Coalition of Rape Crisis Centres) that serve victims/survivors of violence. Bringing together policy makers, community workers, and other professionals will be necessary to establish a fully coordinated response to chronically abused children and will allow for the development of protocols necessary to ensure that no child falls between the cracks.

#### 2.5 Developing 'Best Practices'

Although the SACCs/SATCs are well established and highly regarded services, their continued success is contingent upon efforts to (re) establish and (re) define 'best practices.' This necessitates regular review of the processes and activities that characterize centres (contextualized within the broader institutional, social, cultural, and economic milieu in which they operate) to determine if they remain consistent with the mandate, philosophy, values, and visions set out for the model. In turn, determining the effectiveness of existing practices and generating strategic plans requires a solid, well-resourced, and comprehensive research program. Establishing new and strengthening existing linkages with academic and community researchers who might work in both an

advisory and participatory capacity could facilitate this. Building on the expertise of centres currently supporting research programs, ONSACTC has proposed developing a central database of SACC/SATC client information for applied research purposes and standardizing further data collection efforts among centres. As very little research has looked at the experiences of sexually assaulted persons with respect to post-sexual assault institutional responses, including health care and forensic evidence collection, research inquiries of this nature would benefit administrators, practitioners, and clients alike. These efforts would advance the leadership role that the SACCs/SATCs have played in the area of sexual violence and would facilitate improved sexual assault care through the identification and promotion of effective treatments & prevention strategies.

While there are still gaps in knowledge and understanding surrounding certain SACC/SATC services, there can be little doubt that an ethic of client-centred care is reflected in current 'best practices.' Program coordinators, without exception, are most proud of and committed to practices that uphold the philosophy of empowering sexually assaulted persons through unhurried, one-on-one attention, support, and advocacy. The commitment to administering sensitive and individualized care is not only deemed the strongest feature of the SACC/SATC model, but believed to be the aspect of care most easily transferable to other settings, including those that are resource poor. A model based on a team of practitioners mutually dedicated to the philosophy of client-driven service is the starting point for establishing 'best practices' across all types of health-based sexual assault services. Increasing global awareness of violence as a health issue, however, will be essential for setting the context from which health care providers and other stakeholders can strive to secure the resources necessary for ensuring high quality and comprehensive care for all forms of violence, across diverse populations, and at all stages of the lifecycle.

## APPENDIX A

### **Sexual Assault Nurse Examiner (SANE) Program**

The minimum qualifications to participate in the SANE training program are:

- ◆ Current registration with the College of Nurses of Ontario
- ◆ A minimum of one year's experience on a current SACC/SATC roster
- ◆ Skills and experience in physical assessment
- ◆ Counselling skills
- ◆ Written and oral communication skills
- ◆ The ability and willingness to testify in court
- ◆ A commitment to multiracial approaches to understanding sexual assault
- ◆ A commitment to breaking down stereotyping of sexual difference and lifestyle choices
- ◆ The ability to separate feelings and remain impartial in regard to sexual preference or lifestyle, while aiding a sexual assault victim/survivor
- ◆ An understanding of and practice consistent with a feminist analysis of violence

The components that make up the curriculum of the SANE training program include:

- ◆ History and philosophy of the program
- ◆ Perspectives and experiences of the sexually assaulted person
- ◆ Rape trauma syndrome
- ◆ Legal options available to the sexually assaulted person and the criminal justice process
- ◆ Medical examination, including genital and extra-genital injury identification and treatment, sexually transmitted infections and pregnancy testing, and prophylactic treatment
- ◆ Collection of forensic evidence, including the documentation of injuries
- ◆ Cultural diversity issues
- ◆ Testifying in court

## APPENDIX B

### **Statistical Profile**

Figures are available for the fiscal year 2001/2002 for 28 of the 31 SACCs/SATCs (see Box I for highlights). During this period, 2,369 clients received emergency care, of whom 95.1% were female and 23.8% were under 16 years of age. Slightly more than one-half of emergency care clients were seen by nurse examiners (51.6%) and involved the police (50.6%). Sexual assault evidence kits were completed in 43.1% of cases; of these, one in five was frozen. Nurse examiners/nurses made follow-up phone calls and visits to 4,297 and 719 clients, respectively. A total of 3,450 clients received counselling and over 26,000 representatives from the police, community agencies, schools, and other organizations attended lectures, presentations, and workshops given by SACC/SATC staff. Contact in the form of visits, meetings, and/or phone calls was made with 4,656 police, 935 Crown attorneys, 1,789 members of the Children's Aid Society, and 9,520 community workers (e.g., rape crisis centres).

### **Box I**

**In 2001/2002:**

- ◆ 2,369 clients were seen for emergency care
- ◆ 3,450 clients received counselling
- ◆ 26,563 people attended lectures, presentations, and workshops
- ◆ 16,900 police, Crown attorneys, Children's Aid Society staff and community agency employees were contacted

Based on 28 of 31 SACCs/SATCs

## APPENDIX C

### **Scholarly Publications**

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## APPENDIX D

### **Domestic Violence Care**

Victims/survivors of domestic violence may present to SACCs/SATCs on their own, be brought by police, representatives from community agencies (e.g., rape crisis centres, shelters), or be referred by other hospitals. As is the case with sexual assault, they access domestic violence care through the emergency department of the hospital. The triage nurse meets the assaulted woman. After being medically cleared by the emergency physician, she is seen by the on-call nurse examiner/nurse who is specially trained in responding to domestic violence. Before being moved to the centre, any immediate concerns that the client may have are addressed (e.g., the safety of her children). Once at the SACC/SATC, the on-call staff member:

- ◆ Documents and photographs injuries  
(for potential use as medical forensic evidence in court)
- ◆ Provides crisis support and information
- ◆ Assesses risk and assists in safety planning
- ◆ Refers to other community agencies and services  
(e.g., shelters, victim/witness programs, counselling)
- ◆ Schedules follow-up appointments