ENFERMERÍA Y PERSPECTIVA DE GÉNERO

Identifying Rural Sexual Assault Service Strengths, Concerns and Educational Needs in rural and Aboriginal communities Alberta, Canada

Identificación de las fortalezas, preocupaciones y necesidades educativas del Servicio rural de agresión sexual en las comunidades rurales y aborígenes de Alberta (Canadá)

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ABSTRACT

Women in rural communities do not regularly receive comprehensive health care following sexual assaults, resulting in increased rates of mental illness, substance abuse, re-victimization, and chronic health problems. Additionally, women are at risk for secondary victimization, the stigmatization and re-victimization that results from the responses of others to the assault. Secondary victimization is amplified when victims must be transported out of a rural community for treatment, receive delays in services, when professionals react negatively towards them, or provide incomplete services. A research study sought to find ways of addressing these risks and understanding the educational resources needed for crisis care workers in rural and Aboriginal communities. The findings from focus group interviews with interdisciplinary professionals in rural Alberta, Canada, identified strengths, challenges and priority educational needs for those caring for sexual assault victims.

RESUMEN

Las mujeres en las comunidades rurales no reciben regularmente la atención integral de salud debida después de haber sufrido agresiones sexuales, lo que resulta en un aumento de las tasas de enfermedad mental, abuso de sustancias, revictimización, y problemas de salud crónicos. Además, las mujeres corren el riesgo de una victimización secundaria, de una estigmatización y de una revictimización derivada de las respuestas de los otros a la agesión. La victimización secundaria aumenta cuando las víctimas deben ser transportadas fuera de la comunidad rural para su tratamiento, debido a las demoras en los servicios, cuando los profesionales reaccionan de forma negativa hacia ellas, o sencillamente prestan unos servicios incompletos. Un estudio de investigación se hace necesario para abordar estos riesgos y comprender la necesidad de recursos educativos para los trabajadores que están a cargo de la crisis en las comunidades rurales y de aborígenes. Los hallazgos

de las entrevistas de grupo con profesionales interdisciplinarios en las zonas rurales de Alberta, Canadá, identificaron algunas fortalezas, pero también revelan desafíos y la prioridad de una educación necesaria para aquellas personas que cuidan de las víctimas de agresión sexual.

INTRODUCTION

Sexual assault is a traumatic and life-altering act of violence. Internationally, population-based studies show alarming rates of sexual assaults of women in developing and developed countries alike. With varying reporting and statistical recording strategies some countries report a lifetime prevalence of sexual assault as low as 4% while other countries report sexual assault rates higher than 44% of all women.[1] At least half of Canadian women have been sexually assaulted by age 16, yet less than 10% report to police and only 30% will seek health care.[2] The severity and rates of sexual assault in rural and Aboriginal communities are difficult to determine, but are expected to be even higher given the predominance of non-stranger sexual assault and fears of reporting in a small community.[3] Women assaulted by someone they know are significantly less likely to report.[4] Aboriginal Canadian women, half of whom live in rural areas, have significantly higher rates of sexual assault and are more likely to be hospitalized for their injuries.[5]

Sexual assault is associated with many life-altering consequences. Up to half of sexually assaulted women develop posttraumatic stress disorder (PTDS) as well as other challenges such as depression, substance use, chronic health problems and suicide attempts[6,7] These consequences result in increased health care utilization, difficulties in work or school functioning, disrupted family relationships, and impaired community economic development. The rate of PTSD is even higher if women face further stressors after the sexual assault, a factor known as secondary victimization.[8]

Secondary victimization, also called the "second rape",[9] results when victims experience further stress or trauma when seeking help. It can occur from practices such as victim blaming, insensitive communication techniques, delays in care, disbelief, shame, stigmatization, or from having the experience minimized by others.[10]

Family, friends and media all play a role in secondary victimization, however those entrusted to provide professional help such as police, nurses, physicians and social service workers are not immune to the victim-blaming beliefs and behaviors that contribute to secondary victimization.[11] These responses, or even the fear of these responses, impact the help-seeking of sexual assault victims, resulting in reluctance to access medical, social and legal interventions. [12]

Secondary victimization may also occur if victims receive incomplete or fragmented care, if their case does not proceed to the courts, or if the assailant receives minimal sanctions. This poses individual and societal risks related to a lack of reporting when victims believe they will not be taken seriously or that they will be blamed for the assault.[13,14] Recognizing the magnitude of the problem, the World Health Organization launched the Sexual Violence Research Initiative in 2004, with considerable interest in developing knowledge of best practices for health and legal interventions post-assault.[15] The purpose of our study was to identify a way of addressing the risks of secondary victimization within rural practice, building on existing strengths, and understanding the educational resources needed for crisis care workers in rural and Aboriginal communities.

BACKGROUND

Rural Context

There are a number of factors affecting risks for secondary victimization for women in rural and Aboriginal communities including: isolation, having to remain in close proximity to the assailant, limited services, and lack of transportation.[16] The focus of our study, however, was on risk factors which could be addressed by professionals providing services in rural communities.

a) *Rural Constraints*

Women have described barriers to reporting sexual assault to police or health care professionals due to fear of rejection or disbelief. [2] Women also report a reluctance to become involved with the police or courts [17] particularly if the assailant is known to them.[2] The latter is especially concerning for women living in rural communities where they might encounter the assailant, or where professionals may know or even be related to the victim or the assailant. Women living in very remote rural communities may need to report their assault to police in order to access transportation to a health care service outside of their community; even if they did not want to file a police report. [18] This removes one more choice for them – whether or not to report in their unique circumstances.

b) *Rural Services*

Women who reported to police or sought health care also reported stressors related to their help seeking. Some of these stressors included: a slow police response, limited services, delays in receiving care, lack of anonymity, breeches of confidentiality, health providers' lack of knowledge of sexual assault care, and insensitive or patronizing attitudes of the people they accessed for help. [19] Some North American urban centers have introduced specialized sexual assault nurse examiners (SANEs). SANEs provide crisis intervention and support, as well as comprehensive health services and, if requested by the victim, facilitate police involvement and evidence collection. This practice is associated with increased completeness of care, improved psychological patient outcomes, improved quality of evidence collection and increased desire to report their assault to the police.[20] SANEs are not available in all urban areas of Alberta, or in any rural communities. Funding, training, and maintenance of skills are all difficulties in the provision of more specialized services. This is especially true in rural areas where fewer women report for health care following sexual assaults.

Rural and Aboriginal women who seek health care following a sexual assault will often travel to the nearest emergency department or clinic. In these health care settings, sexual assault patients are typically assigned a triage level designation of two or three on the Canadian Triage Acuity Scale. [21] This designation means that patients should be seen within 30 minutes to 120 minutes depending on other factors such as injuries that may be contributing to the situation. Typically, patients in a rural setting will wait much longer as the emergency is staffed by a lone Emergency physician. It may take in excess of two to three hours before the physician can be freed for the entire interview and examination. In a rural venue, with limited training in sexual assaults, there are perceptions that this block of time is required to maintain standards for evidence collection and only the physician is qualified to perform the assessment. Unfortunately this means women may wait for several hours before the interview and

examination, a wait that contributes to their distress. American studies have revealed that women who have been sexually assaulted experienced more distress after reporting to police or health care than professionals realized and that the vast majority would not seek services if ever assaulted again.[22] Sources contributing to their distress included experiencing shame, blame or disbelief, feeling stigmatized, experiencing delays, or receiving incomplete health care.

If women report their assault, facilitating police involvement and evidence collection is only one cornerstone of complete sexual assault services. The standard evidence collection kit used in southern Alberta is typically the Royal Canadian Mounted Police (RCMP) sexual assault kit, a kit currently being updated due to several invasive and obsolete practices and instructions. Local practices and understandings of concepts such as chain of custody vary due to the unique knowledge and experience of the police and health practitioners. Some police interpret the standards to mean that they have to remain in the room with the woman during evidence collection. As well, forensic care concepts are not routinely included in either nursing or medical education, further contributing to variations in practice and expectations about who can and should conduct which aspects of the health assessment and documentation.

Rural facilities may choose to transport women to urban centers for SANE services, but this is not without its drawbacks. Transportation of women away from the community to urban centers has been associated with increased suffering for the victim including: further delays, isolation from their community support, [23, 2] as well as potential loss of evidence and removal of already limited police resources from the rural area. [24] Rural women reported a lack of cultural sensitivity or awareness of their more isolated situations if treated outside their community. [2] Similarly Aboriginal women were reluctant to seek help outside their communities due to lack of sensitivity to their cultural concerns. [25]

Searching for Solutions

Despite concerns about confidentiality, anonymity, and issues of proximity to their assailant, generally speaking, women reported preferring being treated in their own communities. How, then, can rural centers provide sensitive, comprehensive, multidisciplinary care in a manner that builds on existing strengths and resources? The use of SANEs in rural communities is not a viable option, as a limited number of cases reported preclude the opportunity for nurses to gain the required experience, and limited funding and nursing staff availability makes the model difficult to implement. Lamont[2] recommends a model of interdisciplinary victim-centered services for sexually assaulted women in rural and remote communities, including police, counselors, and health professionals.

We contend that it is possible in many instances to provide sensitive, comprehensive care for victims of sexual assault within a victim's own community. This may be supported through provision of educational resources and/or real time support accessed from a distance when victims seek services. It cannot be assumed that the same strategies for reducing secondary victimization will apply in all rural or Aboriginal communities. To be viable, it is important that the solutions come from the community and are tailored to each community's resources. [2] Furthermore, distrust of outsiders and solutions that come from urban areas are additional barriers to reporting for rural women. For these reasons, the researchers involved in our study sought to identify the educational needs and essential supports required by service providers in rural and

Aboriginal communities. The focus of this article is the in-depth analysis of three sets of group interviews in which strengths, challenges and potential solutions were explored with expert informants from 3 rural communities in southern Alberta Canada.

METHOD: FOCUS GROUP INTERVIEWS

Theoretical Approach

The approach to the in-depth focus group interviews and analysis was a critical feminist standpoint of anti-oppressive educational theory. [26] Such a perspective recognizes oppression, contexts, and the interplay of power within social relations and organization. This standpoint is both consequential to the topic of concern (sexual assault and re-victimization) as well as the notion of power and organization important to rural local social contexts, within rural health services and the delivery of professional education.

Research Strategies: Method, Participants, Interview Questions, Ethics and Analytic Process

Guided by critical feminist and anti-oppressive theory, researchers invited groups of expert informants working with victims of sexual assault in rural communities to participate in focus group interviews focused on strengthening rural sexual assault services. Participants (8-20 participants in each of the 3 group interviews for a total sample size of 40) voluntarily attended interviews held on-site at a rural health center, a rural hospital and a rurally-based Aboriginal health center, all in southern Alberta, Canada. The sites represented various community sizes and proximities to the nearest urban area. Those who consented to be interviewed represented interdisciplinary aspects of rural care of sexual assault victims and included 15 nurses, 6 police/RCMP, 1 physician, 11 counseling/victim services professionals, as well as 4 administrators or coordinators of related services, and 3 Aboriginal elders.

The interviews were each 60 to 90 minutes in lengths and were digitally recorded. All participants were asked to respond to the same round of questions to ascertain 1) strengths, 2) concerns, and 3) priority educational needs, as well as preferred methods of presentation of supportive educational materials. Informed consent was obtained by all participants in this study. Ethical approval was obtained from Mount Royal University's Human Subjects Research Ethics Board.

Data was transcribed into texts. In a first reading of the texts, notes were made of major issues that arose from the data, considering the topics of strengths, challenges and priorities for education. A re-reading of the text with annotations followed, and the text was examined, more closely, line by line, in order to facilitate a micro analysis of the data. Initial and broad themes emerged by organizing items relating to similar topics into categories. Data were then organized with tables identifying line references so that categories could be collapsed and modified.[27] Thematic analysis was applied to the interview data as well as data from extensive field notes taken by the two lead authors who facilitated the focus group interviews.

This analysis was inductive and not a-theoretical. The lens of anti-oppressive feminist education guided our reading and representation of this data, illuminating needs for anti-oppressive health practice and recommendations from the data. While a broad pattern from the data was initially sought, more refined themes were identified in a final

team research process in order to attend to principles of local engagement, education and anti-oppressive practice. The lead analysts, in collaboration with project collaborators, namely the 3rd and 4th authors of this paper, allowed for a review of the relevance of themes and establishing trustworthiness. [28, 29] This level of analysis also assisted in establishing resonance with experts working in the field, as well as the researchers who were present at the interviews. This final team analysis focused closely upon the underlying meaning of each theme within the narratives and contexts. It is this meaning that is presented in the findings to follow.

FINDINGS

Findings are described, to follow, in the order with which they were discussed in the focus groups: 1) Strengths, 2) Concerns and 3) Educational Resource Needs/Preferred Approaches.

1. *Strengths*

Strengths of rural practitioners were found first and foremost in a deep concern and commitment for women experiencing sexual assault. Collaborative, consultative approaches, close physical proximity and closeness to be able to make referrals and provide in-house assessment and intervention were all identified strengths. This closeness allowed for follow-up in a way that referrals into urban areas could miss, with more attention to immediate emotional and cultural needs. Lastly, an overarching resourcefulness and willingness to work together was emphasized.

Deep concern and commitment

The strong response to the focus group invitation itself was a testament to the deep concern and commitment in rural communities to improve services for sexually assaulted women. All of the focus groups were well attended (averaging 12 participants in each of the three groups). One participant spoke to the importance of improving protocols, procedures and quality of care:

> "We're all excited to be able to have some input about what we can do, when we need to do it, and do it well."

Another participant explained some of their rationale for this concern and commitment, and asked the question themselves:

> "We know we're not providing the best, because of the resources available. But what can we do to better use our resources with training?"

It is this deep concern for improving health care and service that gave the impetus and motivation for ongoing education for rural administrative and front line crisis workers.

Consultative approaches

Overwhelmingly, rural crisis workers had close working relationships within and across service agencies for the provision of services for women following sexual assault. Being familiar with each other as "neighbors" and knowing what each could contribute strengthened their work together. Personal knowledge and comfort in each other enabled rural professionals to contact each other in a timely way and to offer support

for each other in this sensitive, emotional time for victims and professionals alike. For some, their familiarity enabled more seamless referrals on to the available services for follow-up services (for instance victim's services support or mental health services) as they and the victims may know the referral agency or contact personally.

Police informants reported that they were almost always contacted in sexual assault cases. This was seen as indicative of a consultation process that had far reaching benefits for the victim and the community. Strong practices of consultation occurred within and across professionals and agencies, as well as a way of consulting *with* the victims themselves.

> "We have been trained in sensitivity issues dealing with communicating
> with the victim as appropriately as possible."

This concern, sensitivity, and focus on the protection of the victim's privacy were all identified strengths. Sometimes this sensitivity was expressed in the promptness of the patient care, ensuring private spaces for interviews, expediting their assessment at the emergency department, or through direct communication. Communication approaches were discussed which focused only on specific services that were required immediately, knowing that with victims living in the community referrals to other services could be made following the resolution of the immediate crisis situation. Stated one informant from acute health services:

> "We try not to ask too many questions, because having to answer the
> same questions over and over, is pretty traumatic"

Another policing informant in our focus groups explained:

> "We usually get our best evidence from the initial statement, and we
> find for the most part, people haven't told their story five or six times
> before they've come and seen us – this helps everyone."

Physical Proximity and Immediacy

As a result of the closer proximity of rural facilities "we are not sending the victim all over the place…it is efficient and less scary [for the victim]". Rural practitioners described a good likelihood that victims would receive follow-up when mental health, sexual health and victim's support agencies were in close proximity. Services in close proximity were an important part of the highly consultative approach lauded previously. Stated one of the health professionals:

> "I think the biggest mechanism that's going to work well, is the connection
> between community health and emergency and that we're actually in the
> same building…that's really convenient…it's not like we're sending the
> victim to a different building."

While strong consultative practices for crisis and follow-up services were available in rural areas, the limits of staff on-call for many community needs were also considerations. The potential for over-work and burn-out, particularly considering the emotional charge of sexual assault care, was a potential conflict within the strength of collaboration and close proximity of services.

Emotional sensitivity at that first point of contact for victims was also acknowledged by police and health services. In some cases police would alert the health care workers they would be arriving at the care center, subsequently staff would expedite appropriate placement within the department with the police for the victim, side-stepping the triage desk. Regardless of the first point of contact, immediate emotional support was viewed as a step towards comprehensive sexual assault services. In particular, rural crisis workers could readily identify contextual and cultural awareness that could be missed if a victim would be assessed outside of the community. Follow-up and acute care linkages to local referral sources for further mental health support, immigrant support or traditional (Aboriginal) forms of healing were also factors that contributed to strong rural crisis sexual assault care. One informant spoke of this particular strength:

> "What we can offer through our program is being aware of the culture aspect of each situation that comes to us, and also being able to communicate with victims of sexual assault through our First Nation language."

Providing immediate emotional support also involved family, who would have a greater likelihood of being called in as supports and, to also receive support, when the services were in close local proximity. Readily available local supports could involve family or provide respite for family included any number of activities.

Everyday tasks of talking through what victims and families could expect of the health and social services, or policing and legal system were quite often viewed as the biggest strengths of the rural practitioners. One informant spoke of these activities as some of the important links that could happen in the rural setting:

> "Providing emotional support, transporting to and from the hospital or court… just making sure that family members are present with them, if they request that additional support, are among the strengths we provide."

Follow up beyond the acute situation and needs

Links to family, culture and referral resources for other supports demonstrated attention to follow up beyond the acute sexual assault situation and needs. Stated one informant:

> "It's the follow up afterwards that matters…we see them for a short period of time considering what their whole traumatic experience is going to be."

Similarly, another community worker explained:

> "It's the support after the hospital, after the initial, and it's ongoing support, and it's support through the court system as well… and referrals, we do a lot of referrals…and we follow up until the case is finished especially for the court part of it. I mean it's really scary if they've got to testify."

Working inter-professionally and with families was a central concern of professionals in their care of acute sexual assault victims. These primary strengths, again, relate to a rural health care ethos, as one informant put it:

"making it work the best we can with what we have".

2. Challenges

Despite the many recognized strengths of rural supports and practitioners, several challenges to the provision of acute rural sexual assault services were identified, and included: uncertainty, lack of familiarity, constantly changing protocols/systems, role confusion, personal difficulties with the interviewing, unsupportive social environments, minimal consistency/sustainability for support programs, and limited trust in the process.

Uncertainty, lack of familiarity, constantly changing protocols/systems

Perceptions of constantly changing protocols and systems for assessment, referral and quality of collection of evidence were concerns for acute sexual assault care and treatment. Stated one informant:

> "I don't see them [victims of sexual assault] that often, so how many people are becoming properly equipped to do the best we can for them…just for the continuity of care, and knowing have we done everything we can?"

Another health worker reinforced this challenge of lack of familiarity, and her difficulties remaining confident and competent in her skills. She said:

> "Eight years, and I've probably done about eight [sexual assault specimen collection] kits, and it's always different. There's always a different set of opinions, we never really know. Is the officer inside the curtain, is the officer outside the curtain? And is all this going to get thrown out of court because we did one thing wrong?"

The concern of familiarity and "doing the right thing" often arose from the possible legal ramifications of the assessment and investigation. A lack of familiarity resulted in some professionals desiring specialized care for victims in the city, or replication of specialized services in the rural areas (specialty training for SANEs for instance). This did not diminish the responsibility felt by staff treating victims in rural areas however. One staff nurse reported this sense of responsibility amidst uncertainty of protocols in this comment: "We want to know exactly what the latest is. We want to do it right."

Crisis professionals were plagued by concerns that in the combination of policing, nursing/ medical assessments and interviews things could be missed because of the lack of familiarity or even simply being "pressed for time", which would amplified if one was a novice at administering an examination or collecting evidence with the rape protocols. Feeling rushed, unfamiliar and anxious about the ramifications and potential for a later court process were all notable concerns. According to one rural health administrator:

> "I have had doctors actually refuse to do them [physical exams for the sexual assault kit] and there are issues with that [lack of familiarity], and of course, the fact that they're going to be subpoenaed for court and they're a witness."

Lack of familiarity with procedures was also thought to cause delays, adding to the victim's anxiety. Delays also created greater anxiety for professionals who were concerned with the traumatizing experiences of victims. The results of delays could mean that follow-up wouldn't happen or patients would leave without seeing anyone, increasing the likelihood of mental health problems, and hindering prosecution and access of supportive care. Increased professional education was thought to be one way to expedite the acute assessment and investigation.

Role confusion

While professional differences and interdisciplinary approaches could be strengths, role confusion and professional differences also provided a level of confusion during the crisis work. Responsibilities could be addressed in any number of ways depending upon the point of entry to sexual assault crisis professionals (police, emergency department, community health, general practitioner, mental health worker and so on); one approach does not fit all situations. Every department has different staffing and demands which can change within minutes, so shared training for tasks that could be shared were identified. For example, in one center it was seen as possible for nurses to take on the history taking and non-genital assessment thereby reducing the time the physician would be taken away from the emergency department.

Numerous staff with different roles and responsibilities contributed to the difficulty in communicating both *amongst* professionals and *with* the victims. A rural community social worker explained:

> "There are times, that I will come in on a Monday morning, and there is a referral to follow up on a sexual assault victim we were not called about. Then I am calling this stranger up and say *"hey, I'm from social work, just wanting to see how you're doing, can you give me a call back?"* It could be so much less awkward."

In some communities accessing social support workers after usual working hours was a challenge.

Personal difficulties with interviewing

The sensitive nature of sexual assault interviewing was another concern. In some cases, the emotional challenges for police were so great that police officers hoped that calls to respond to sexual assaults wouldn't result in a full investigation. This concern was accentuated by gender differences, for instance when a young male police office was investigating the assault of a woman assaulted by another young man. One rural police officer explained:

> "You're talking about even anatomy of females, and stuff like that is uncomfortable for a lot of guys. If it isn't a female, then you're dealing with a male, and that is almost as intimidating, so sometimes guys [police] are hoping that maybe that it's a nothing call, because they don't want to have to investigate."

Beyond gender relations, personal difficulties with the emotionally charged situations of sexual assault were acknowledged by the crisis workers. Having just one staff person available could mean that regardless of capacity, the crisis professional on

duty would need to take responsibility, whether or not they were comfortable with the emotional aspects. Additional conflicts arose as health workers were caught in a dilemma of wanting to help new staff learn, facilitating the observation/mentoring system of health training for doctors and nurses, while still attending to the sensitivity of victims and families. In an experience recounted, a rural staff nurse explained:

> "This [care of a sexual assault victim at the rural hospital] is something that's very personal. Does that person lying on that stretcher want another person just observing?

Additional concerns about conducting victim interviews included having knowledge of the correct clinical questions to ask without interfering with the police investigation, as well as having knowledge of required documentation. Developing these skills and knowledge was deemed to be pivotal to prevention of secondary victimization.

Services and social environments are not supportive for follow-up

At times, subtly or even overtly unsupportive practices were identified. These were practices where confidentiality or victim blaming posed risks to the victims. One informant questioned the level of support available in her community, asking:

> "Do victims feel like they can trust and feel respected within the community, and that what happens in the community isn't going to be spread around like gossip? I think that's a concern for a lot of patients"

During discussion it was noted that in some Aboriginal communities the perpetrator and the victim might be living in close proximity, or even in the same household, which could cause family disputes and discord. According to another informant, lack of support from family and friends could mean that victims would halt treatment or prosecution, in an effort to avoid conflict amongst the families or community.

> "[the victim] is further victimized by the family. So they have a tendency not to say anything. They don't want to open up a whole can of worms."

Material and physical resources in communities were also potential challenges to comprehensive acute sexual assault services. In some cases, living rurally, meant transportation was an issue and that a victim could not get access to a health center or rural hospital easily following a sexual assault. A rural health worker explained:

> "And it's not just transportation. It's even communication...a lot of people don't even have telephones to call for help."

Lack of consistency/sustainability for support programs

The sustainability of services and support programs were also deep concerns of the informants. In rural and Aboriginal communities, changeable funding and mandates of governmental or non-governmental services proved to be a challenge to the provision of consistent, competent and complete sexual assault services. One health services coordinator reported:

> "My concern is the funding aspect… in Aboriginal communities we're always looking for funding."

Different services and programs often have distinct mandates, so providing what one informant called "packages of funding or service" together could interrupt provision of a consistent service. This was true of Aboriginal communities, as well as other rural communities. In many services the designated worker (for instance in mental health or sexual health) may have one or two designated days per week, often changeable, and at the whim of funding and priorities their services may be redirected elsewhere. Sometimes funding that *was* available would not be able to be targeted towards sexual assault services. In other cases, the work involved in seeking more targeted resources, would detract from actual provision of sexual assault services.

Limited trust in the process and concerns about re-victimization

A sense of community distrust in the existing process was consistently described by rural professionals. Potential breeches in confidentiality and privacy were identified by professionals as one of the aspects of distrust. Stated one Aboriginal professional:

> "There's always that fear our clients have that we're going to go out and start telling everybody... concern with re-victimization is very high. It happens on the nation [First Nation reserve] all the time, especially with sexual assault."

It was suspected that community members feared seeking police assistance or prosecution feeling it would not be worth the personal risks. This risk was thought to be greater when victims believed they could have control in the process. According to one professional:

> "To go through an event like that [sexual assault], and then having to come to talk
> to… I mean, the police are intimidating… to have to give such intimate, personal details, embarrassing details to a stranger who's collecting evidence. Then to go through the medical process, the very invasive collection of evidence then, again, to be re-examined in court, if it goes to court. It's just horrible ..."

The reality of familiarity in rural communities complicated the re-victimizing experiences and the police officer, nurse or physician may all be personal associates of the victim, or there may have been previous history with these associates – good or bad.

3. Educational Resources

Some of the priorities identified to manage the challenges were: knowing the most crucial information to document and collect as evidence, considerations of who should receive education and/or priority /target audience for educational resources, a routine/integrated process for updating (to include updates about follow-up resources), as well as consideration of culture and literacy. Key modalities identified for delivery of the educational materials included print (brief check lists with more comprehensive updated information), web-based, video, and advisor on call approaches.

With few staff, broad training in these special concerns was desired over having one "specialist" trained who may or may not be available when the unfortunate situation of

sexual assault would arise. "We all need [educational] resources for doing it the right way" was the repeated request from health and crisis professionals, and as a health professional commented:

> "It's mainly the procedural questions, we have. We have no problem
> with injuries, or care. It's just doing it the right way."

Among the important procedural tasks identified were: "health assessment" and, from a law enforcement point of view the security of the evidence collected. Consistent processes and care were seen as crucial for the education of crisis workers. This emphasis on clarifying procedural expectations was focused on the collection of evidence and documentation. Educational resources would need routine updating and staff would require ongoing reminders and prompts to integrate this knowledge and new skills.

Strategies for educational resources need to be available in a number of different formats. This was emphasized by Aboriginal crisis support workers who said:

> "We need to make sure that we have every population, or target group
> covered, from children to the illiterate, to the disabled, to the handicapped,
> to elders, women, men and teenagers."

Overwhelmingly, the preferred approach was a collection of written resources with simple lists focused on procedural aspects of immediate sexual assault services. Web-based educational resources were also supported by informants. A web-site link was viewed as one place to store a written resources and lists that could be updated as required. Other resources, for instance video or podcasts, were considered useful mediums for education on sexual assault services. An on-call advisor approach was supported by all informants. Stated one rural nurse:

> "Phone is the easiest… if only you could have that conversation in the
> moment… if only we had an expert available."

An on-call advisor was not a strategy intended to eliminate professional responsibility, but rather to provide a resource and supplement other educational resources. Maintaining professional currency and attending to educational updates was not always simple or internally motivated for some professionals. For some professionals, particularly physicians, without compensation, training that was not mandated was perceived as a potential challenge so the combination of real-time support and educational training resources and simple check-lists were all desired.

DISCUSSION AND RECOMMENDATIONS

Strengths of rural health and community services practitioners were found in the deep concern and commitment for women experiencing sexual assault. Closeness, collaboration, cultural awareness and community and resourcefulness were all identified strengths for rural sexual assault services. Several challenges to the provision of acute rural sexual assault services were also identified, including the lack of familiarity and actual staff, changing protocols/systems, role confusion, personal difficulties with the interviewing, environments not conducive to follow-up and inconsistent services and funding. Some of the key priorities for educational resources involved: knowing the most crucial information to document and collect as evidence,

considerations of who should receive education and/or priority /target audience for educational resources, and a routine/integrated process for updating these resources, as well as consideration of culture and literacy.

There appeared to be a strong emphasis from crisis workers towards the protocols of evidence collection rather than comprehensive sexual assault services. Not all women choose to report to police or for health and social care [30]; however, and the ability to choose to report is essential to recovery and consistent with our framework of critical feminism and reducing power inequities. Isolation and lack of transport to urban centers should not force the woman into reporting to police and thus to be subject to the sexual assault evidence gathering procedures that may re-victimize the sexual assault survivor[31].

Although there is only one type of sexual assault evidence kit with standard instructions, changes to these procedures have not uniformly been communicated to professionals. There is also variability by region based on local crown prosecutors, prior experience of physicians and nurses, and differences in interpreting concepts such as chain of custody. We heard staff requesting "permission" as to who would be allowed to document on the sexual assault record or obtain the evidence, and fears of evidence being dismissed as a result of their actions or inactions. Staff requested written lists of roles, both as quick reference as well as in part to verify they were permitted to perform those roles. Such tools may facilitate the staff's reallocation of roles to accommodate local contexts and staffing needs.

These areas of uncertainty, and the expressed desire for additional educational and real-time advisory resources, are instructive to those coordinating services, nursing educational and staff development. While an effective service, specialized SANEs may not always be the answer in all communities. [32] The basic procedures for sexual assault assessment and care should not be perceived as somehow beyond the scope of the average practitioner. Ultimately, it is generalists who are actually available and most able to provide compassionate, comprehensive care in rural communities, those health, social services and policing staff "doing the best we can with what we have."

CONCLUSIONS

Complete sexual assault care includes crisis intervention, provisions for safety, a thorough assessment for effects of sexual assault with preventative treatment for pregnancy and common sexually transmitted infections, ability to report to police with evidence collection if needed, and access to counseling services for follow up. Emergency physicians and nurses, police and other community supports are experienced in the provision of services. These skills can be an asset in sexual assault care even within a rural setting where resources are limited. Supporting the capacity of rural crisis workers through educational resources to enhance their abilities to provide comprehensive sexual assault services is a priority for reducing the risks of secondary victimization and other mental health impacts.

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