Changing Perceptions of Sexual Assault:

Research Findings and Recommendations for Improving the Healthcare Response

MARCH 2023

Changing Perceptions of Sexual Assault.

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

Ending Violence ASSOCIATION OF BC

Land Acknowledgement

BC Women's Hospital + Health Centre and the Ending Violence Association of BC are located on the unceded traditional territories of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and sḏílwətaʔ (Tsleil-Waututh) Nations.

Gender-based violence, including sexual assault, is inextricably connected to the colonization of land, resources, and Indigenous communities and the violence that continues to disproportionately target Indigenous women, girls, and 2SLGBTQQIA+ people, as emphasized by the National Inquiry into Missing and Murdered Indigenous Women and Girls.[1]

Content Warning

This paper contains information and first-person accounts of sexual assault that some readers may find distressing or upsetting. If you feel you would benefit from support, you can **contact VictimLinkBC at 1-800-563-0808**. VictimLinkBC provides 24/7 toll-free, confidential, multilingual information (in up to 150 languages) and support for victims of violence, abuse, and other crimes.

For information about culturally safe and trauma-informed services, please visit the First Nations Health Authority website at https://www.fnha.ca/what-we-do/mental-wellness-and-substance-use/mental-health-and-wellness-supports.

Acknowledgements

We would like to acknowledge the Vancouver Foundation, the Canadian Women's Foundation, and the BC Women's Health Foundation for their support of this work to improve the healthcare response to sexual assault in British Columbia. We also wish to acknowledge the valuable guidance of the project's Community Advisory Board throughout the research process. Lastly, and crucially, we are deeply grateful to the participants with lived experience, health leaders, and service providers who have entrusted us with their experiences and perspectives.

Referencing this Document

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Research Team

The Changing Perceptions of Sexual Assault (CPSA) research project was led by Dr. Ann Pederson (BC Women's Hospital + Health Centre) and Dr. Kate Rossiter (Ending Violence Association of BC), and coordinated by Misha Dhillon, with data collection and analysis supported Dr. Jila Mirlashari (University of British Columbia/ Seattle University) and Chandra Berkan-Hozempa (University of Victoria).

Since its inception, this project engaged a number of people, each of whom contributed valuable time and expertise to the research. We would like to specifically acknowledge Caitlin Johnston, Tracy Pickett, Tracy Porteous, Aimee Nygaard, Nicole Prestley, Ronnalea Hamman and Jill Pascoe for their vision, guidance, and support.

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To learn more about CPSA and health care for sexual assault, contact pop.health@cw.bc.ca

To learn more about the Ending Violence Association of BC (EVA BC), visit endingviolence.org

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Executive Summary

Supporting coordination across the health and anti-violence sectors, and building on the strengths of specialized community-based anti-violence services, will support people who have been sexually assaulted to navigate the road to recovery.

Background

There is evidence that the COVID-19 pandemic and subsequent public health measures "contributed to increased risk of gender-based violence," as well as "substantial increases in both [its] prevalence and [its] severity."[2 (p1)] Sexual assault is a serious form of gender-based violence and a pervasive public health issue in British Columbia (BC) and across Canada.[2-4] People who have been sexually assaulted often experience "immediate and long-term harms to their mental, emotional, physical and spiritual health and wellness."[5] Some populations impacted by sexual assault, including people who are Indigenous,[6] recent immigrants,[7] transgender,[8] and/or living with disabilities[9] face significant systemic barriers to accessing health care in BC generally and sexual assault care specifically.

Health services and anti-violence services are fundamental sexual assault response systems. However, services are not always coordinated across sectors, creating gaps in services and responses. Cross-sector coordination of sexual assault services can increase access to care, more effectively address the impacts of sexual assault, decrease the risk of re-traumatization, and reduce the long-term effects of trauma, ultimately leading to better health outcomes for people who have experienced violence.[10-12]

BC Women's Hospital + Health Centre (BCWH) and the Ending Violence Association of BC (EVA BC) conducted the **Changing Perceptions of Sexual Assault (CPSA)** research project as a cross-sector partnership, with the administrative support of the BC Women's Health Foundation and funding from the Vancouver Foundation and the Canadian Women's Foundation. The CPSA project sought to understand the conditions and processes that supported and/or created barriers to disclosing sexual assault and accessing sexual assault services in the context of existing health and anti-violence services and systems in BC. A Community Advisory Board comprised of representatives from sectors that respond to sexual assault, organizations with expertise responding to the needs of diverse communities, and individuals with lived experience of sexual assault guided the project.

Data were collected in conversations with nearly 60 participants across the province in nine focus groups with 39 anti-violence and/or health service providers; nine interviews with individual health leaders in government, community-based health organizations, and health authorities; and 11 interviews with people with lived experience of sexual assault.

Data were collected in conversations with:

11	39	9
People with lived experience	Anti-violence and/or health service providers	Health leaders

Research Findings

Participants shared that decisions about seeking care are influenced by understandings of sexual assault, access to sexual assault services, and perceptions of safety when seeking care. People who have been sexually assaulted reported finding it difficult to navigate services due to the impacts of trauma; concerns about using healthcare resources, particularly during the COVID-19 pandemic; and uncertainty about accessing services that may not be gender-inclusive or gender-affirming.

The path to accessing post-assault support is not straightforward and healthcare services are often viewed as unsafe, especially when based in a hospital, due to previous negative experiences seeking health care and/or larger systemic patterns of discrimination and victim-blaming. Perceptions of safety also reflect uncertainty about what to expect when seeking care and/or fear of unwanted cross-sector involvement (e.g., criminal legal system, child welfare services). Moreover, people who have been sexually assaulted may fear being stigmatized or seen as partially to blame (i.e., victim-blaming) when seeking health services. Service providers and health leaders acknowledged systemic discrimination and bias contributing to inadequate sexual assault care for some communities. Participants expressed concern that some groups, such as transgender people, men who have sex with men, or people who use substances, may not access services due to systemic barriers. With the healthcare system consistently fast-paced, task-oriented, and event-focused, healthcare services struggle to provide trauma-informed care, putting those seeking sexual assault health care at risk of further harm or re-traumatization.

Training is a key means of building and maintaining service providers' capacity for trauma-informed, culturally safe, and survivor-centred care. Some service providers also spoke to the value of having sexual assault care, including forensic exams, available outside of a hospital setting and the value of expanding access to sexual assault health care provided by community nurses, public health nurses, primary care networks, and/or reproductive health services. Supporting coordination across the health and anti-violence sectors, and building on the strengths of specialized community-based anti-violence services, will support people who have been sexually assaulted to navigate the road to recovery.

Recommendations

While much work is underway to improve sexual assault response in BC, it is long overdue. More action is needed to establish sexual assault as a public health priority and ensure a wide range of supports is in place to provide survivors with meaningful options. Recommendations from the CPSA research project include:

1 Recognize Sexual Assault Response as a Public Health Priority

a. Name sexual assault as an urgent public health issue and expand Ministry of Health mandate commitments accordingly

b. Develop and implement a cross-ministry provincial sexual assault policy

2 Build Health Sector Capacity for Sexual Assault Response

a. Develop guidelines for survivor-centred sexual assault care

b. Mandate standardized sexual assault training for healthcare workers

3 Strengthen Health and Anti-Violence Sector Coordination

a. Invest in coordinated and integrated models of care

b. Establish a sexual assault systems navigator position in each health authority

4 Build Public Awareness of Sexual Assault and Available Services

a. Develop a centralized provincial resource hub for sexual assault services

b. Build public awareness of sexual assault and available services

Changing Perceptions of Sexual Assault Research Project

Introduction

The Government of Canada has explicitly identified gender-based violence, including sexual assault, as "one of the most pervasive, deadly and deeply rooted human rights violations."[13] There is evidence that the COVID-19 pandemic and subsequent public health measures "contributed to increased risk of gender-based violence," as well as "substantial increases in both [its] prevalence and [its] severity."[2 (p1)] Sexual assault is a serious form of gender-based violence and a major public health issue in British Columbia (BC) and across Canada.[2-4]

The term **sexual assault** refers to any unwanted sexual activity involving physical contact,[13] including imposed or forced mouth-to-mouth contact, imposed or forced mouth-to-genital contact, and imposed or forced penetration. Sexual assault is a form of **gender-based violence**, a term used to underscore the "unequal power relations and gender roles" underlying the disproportionate physical and sexual violence experienced by "cisgender women and girls, … transgender, non-binary, gender fluid, and gender non-conforming adults and youth."[14]

People who have been sexually assaulted often experience "immediate and long-term harms to their mental, emotional, physical and spiritual health and wellness."[5] Health services and anti-violence services are fundamental sexual assault response systems to address these harms.

This document uses the language of **people with lived experience of sexual assault**, at times, instead of the terms 'victim' or 'survivor.' This decision was made in collaboration with the Changing Perceptions' Community Advisory Board, to be inclusive of the various experiences and self-identifications of people who have been sexually assaulted.

Working Across Sectors

The Changing Perceptions of Sexual Assault (CPSA) research project was undertaken through a cross-sector partnership between BC Women's Hospital + Health Centre (BCWH) and the Ending Violence Association of BC (EVA BC), with the administrative support of the BC Women's Health Foundation and financial support from the Vancouver Foundation and Canadian Women's Foundation. A Community Advisory Board comprised of representatives from sectors that respond to sexual assault, organizations with expertise responding to the needs of diverse communities, and individuals with lived experience of sexual assault guided the project.

B.C. Women's Hospital + Health Centre, a program of the Provincial Health Services Authority, offers a range of specialized services that address the health needs of women of all ages and backgrounds, including sexual assault healthcare services. The BC Women's Sexual Assault Service provides emergency medical care and optional forensic services at Vancouver General Hospital, the University of British Columbia Hospital's Urgent Care Centre. BC Women's also supports public education and clinician training on gender-based violence.

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The **Ending Violence Association of BC** is a provincial association that trains and supports close to 300 anti-violence programs and cross-sector initiatives across the province that respond to sexual and domestic violence, child abuse, and criminal harassment.

Ending Violence ASSOCIATION OF BC

The CPSA project's research and analysis have benefitted from BCWH's and EVA BC's respective subject matter expertise, stakeholder relationships, and commitment to cross-sector approaches to addressing gender-based violence.

Context of Sexual Assault in BC

In British Columbia, it is estimated that 37% of women have been sexually assaulted at least once, since the age of 15.[3] An estimated 4.7 million women (30%) in Canada have been sexually assaulted at least once, since the age of 15.[3] Both nationally and within BC, there has been a substantial increase in police-reported sexual assault since 2019.[4] Compared with cisgender people, transgender and non-binary people in Canada are more likely to have experienced sexual assault.[15]

Rates of sexual assault in Canada are disproportionately high among those with intersecting marginalized identities, including younger women,[16] Indigenous women,[17] transgender people,[15] people who are not heterosexual, and bisexual people in particular,[15,16] people with disabilities,[9, 16] people who use substances,[18] and people who have mental health challenges.[18]

The social and political context of sexual assault has noticeably shifted over the past decade. One significant factor in this shift has been the #MeToo social media movement, which raised awareness about and prompted people to disclose (i.e., tell someone about) sexual violence, and led to people who have been sexually assaulted "feeling less self-doubt, more supported and more empowered."[12] In research exploring *Attitudes Related to Gender-Based Violence* and *#MeToo in Canada,*[19] the majority of respondents viewed #MeToo as having decreased the shame associated with reporting sexual violence (65%) and increased the likelihood of those reporting sexual violence being believed (57%). However, the research also exposed the backlash to the #MeToo movement, with almost half of male respondents (42%) believing that #MeToo overemphasized the issue of sexual violence, and over half of male respondents (53%) saying they felt that the movement had 'blurred the lines' between flirting and harassment.

In Canada, the #MeToo movement coincided with an increase in police-reported sexual assault.[20] However, reports of sexual assault to police remain rare with only an estimated 6% of sexual assaults reported to police. Sexual assault is Canada's most underreported violent crime.[16] Of the sexual assaults that are reported, police have determined that 14% are 'unfounded'[21] and only 11% of cases lead to a conviction.[22] People may choose not to report sexual assault to police for a variety of reasons, most frequently because they see their experience as too minor to report; consider it a private or personal matter; want to avoid dealing with police; believe that there is insufficient evidence; and/or believe that the offender will not be convicted or adequately punished.[18] The decision of whether to report to police may also be influenced by past experiences and/or fear of systemic racism and discrimination within the legal system, particularly in the case of Indigenous, racialized, transgender and disabled communities, as well as immigrants, sex workers, and others who are systemically marginalized.[23]

Health Care after Sexual Assault

Sexual assault can cause significant short- and long-term health impacts. While the majority (93%) of sexual assaults do not cause physical injury to the person assaulted,[18 (Table 8)] there are often mental, emotional, physical and spiritual health impacts. Sexual assault medical care typically involves treatment of injuries (e.g., wounds, bleeding, abrasions, pain, and infections), emergency contraception, pregnancy tests, abortion, prenatal care, diagnostic tests, post-exposure prophylaxis, and treatment of sexually transmitted infections (STIs), including syphilis and HIV.[24-27] Psychological impacts of sexual assault commonly include shock, depression, anxiety, difficulty sleeping and Post-Traumatic Stress Disorder (PTSD),[24-26] which impacts one-sixth of people in Canada who have been sexually assaulted.[18] Twenty percent of people who are sexually assaulted report experiencing victim-blaming (i.e., being made to feel at least partially responsible),[3] creating the potential for additional harm through secondary victimization or re-traumatization.[28]

In 2022, BC Provincial Health Officer Dr. Bonnie Henry identified gender-based violence as a public health priority, recognizing that "people who experience or witness gender-based violence often suffer immediate and long-term harms to their mental, emotional, physical and spiritual health and wellness."[5] This statement recognizing gender-based violence as a health issue follows BC Provincial Health Officer Dr. Perry Kendall's 2008 statement naming gender-based violence as a "significant factor … that needs to be recognized in the design and delivery of health care."[29]

Despite common short- and long-term health impacts, many people who have been sexually assaulted do not receive comprehensive healthcare. This is amplified by the severe shortage of general practitioners in Canada, and particularly in BC. Recent data document almost one million BC residents without a general practitioner, and nearly 60% of BC respondents report either having difficulty accessing or being unable to find a general practitioner.[30]

The Province of British Columbia has not yet established minimum standards for sexual assault response, leading to inconsistent delivery of and access to services. Dedicated healthcare services include "specialized responses to sexual assault victims … in a number of hospitals around the province."[31] (p13) BC Women's Hospital + Health Centre's Sexual Assault Service, for example, offers care for injuries and sexually transmitted infections; collection of forensic samples; medical reporting to police; and referrals to additional health, legal, and/or community-based support services.[32]

In the absence of national or provincial standards to guide sexual assault care, Canadian healthcare services are guided by the standards of the International Association of Forensic Nurses (IAFN).[33] A focus on hospital emergency care and forensic examinations tacitly prioritizes the criminal legal system response to sexual assault, at the expense of a holistic approach addressing patients' sexual and reproductive health, mental health, spiritual wellness, and social well-being. Healthcare responses may be further constrained by healthcare workers' limited understanding of sexual assault impacts and lack of trauma-informed practice skills.[34] Immediate and long-term impacts of sexual assault are more likely when care is not trauma-informed and centred on the needs of the person seeking care.[35]

Importantly, the groups most impacted by sexual violence are also those who face the most significant systemic barriers to accessing health care. Without low-barrier access to relevant and safe healthcare services, they are unlikely to receive comprehensive healthcare following a sexual assault.

Systemic anti-Indigenous racism can impede sexual assault care for Indigenous women, girls, and 2SLGBTQQIA+ people. Within the BC healthcare system, the *In Plain Sight* review documents the impacts of anti-Indigenous racism, which limits access to health care and contributes to negative health outcomes for Indigenous people, particularly Indigenous women and girls.[6] Though not implemented in Canada until 2021,[36] the 2007 *United Nations Declaration on the Rights of Indigenous People* asserts that Indigenous people have the right to "not be subjected to any genocide or any other act of violence."[37] (p9) This is reflected in the Truth and Reconciliation Commission of Canada's *Calls to Action*, which implore "those who can

Importantly, the groups most impacted by sexual violence are also those who face the most significant *systemic barriers* to accessing health care.

effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients."[38 (p3)]

Although immigrants in Canada may not face higher rates of violent victimization,[3] immigrants in BC may encounter distinctive systemic barriers to accessing sexual assault care. These barriers can be particularly acute for newcomers. Exploring the health of newcomer immigrant women in British Columbia, the BC Centre of Excellence for Women's Health contended that successful settlement in a new country "entails knowing when and how to seek health care should a need arise, as well as … understanding what services are available and insured."[7 (p7)] The project found that many newcomer immigrant women experienced difficulty in understanding provincial health insurance, variations in coverage, fees for accessing care (e.g., ambulances, prescription medications), the role of preventative healthcare, and how to locate a family doctor at all—much less one who "spoke their language, understood the settlement experience, and provided comprehensive women's health care."[7 (p11)]

Given that sexual assault is "by its very nature, physically invasive, and often involves genitals or parts of the body that people perceive as centrally connected to their gender identity," many transgender people experience difficulty in "exposing and talking about [their bodies] in the context of sexual assault."[39 (p43)] Although transgender people in BC have the right to equal access to healthcare services,[40] BC's Provincial Health Services Authority (PHSA) acknowledges that trans and gender-diverse people continue to encounter systemic barriers including "refusal of care, difficulties getting referrals, lack of provider information on trans issues, [and] uncomfortable or problematic interpersonal interactions."[8] In an important step toward gender-affirming care, the Government of Canada has announced over $3.8 million in funding to Trans Care BC to increase access to sexual and reproductive healthcare for Two-Spirit, trans, and non-binary people in Canada.[41]

Disability Alliance BC contends that systemic ableism "permeates all aspects of health care from systemic policies to frontline treatment by practitioners."[42 (p4)] People living with disabilities who have experienced sexual assault face persistent barriers to accessing services, including healthcare; these barriers include the absence of tailored healthcare interventions to identify violence or abuse; a lack of sensitivity training for professionals, including healthcare workers; and inadequate funding and resources to enhance accessibility to services.[9]

The COVID-19 pandemic and subsequent public health measures exacerbated the issue of gender-based violence internationally, creating what the United Nations has termed a 'shadow pandemic.'[43] In BC, research indicates that the COVID-19 pandemic and subsequent public health measures "contributed to increased risk of gender-based violence," as well as "substantial increases in both [its] prevalence and [its] severity."[2 (p1)] At the same time, the pandemic has created additional barriers to accessing support and care due to reductions in the capacity of health and social services, challenges presented by virtual health services, and reluctance to seek support services due to the risk of contracting COVID-19 and/or efforts to prevent unnecessary strain on the healthcare system.[2] The COVID-19 pandemic and related public health measures in BC have also, in many cases, increased barriers for systemically marginalized people seeking sexual assault care.[2]

Coordinating Sexual Assault Services

The Government of Canada has emphasized that gender-based violence is a "multi-faceted and complex issue that requires cross-sectoral approaches, with responses from education, health, justice, and social service sectors."[13] Access to sexual assault care can be supported through coordinated delivery of sexual assault services. Cross-sector coordination, including coordinated and integrated models of care, is considered a best practice for responding to gender-based violence.[11, 44, 45]

Services that are poorly coordinated create additional barriers to accessing care and support. Within this context, people who have experienced gender-based violence are less likely to seek and access care, negatively impacting their recovery.[46] Conversely, cross-sector coordination supports an "effective, immediate, and consistent services network," which increases safety and support for people who have experienced gender-based violence.[11 (p6)] Community-based anti-violence workers, with specialized knowledge and expertise regarding sexual assault, can support clients in seeking care and accessing other services, reducing the demands on the overall healthcare system in BC.

Coordinated models involve collaboration between relevant response services, commonly including medical care, community-based support, and the criminal legal system.[47] Coordinated models for addressing intimate partner violence in BC, such as Domestic Violence Units (DVUs) and Interagency Case Assessment Teams (ICATs), have proven valuable in responding to domestic violence.[48] DVUs are embedded within police detachments, bringing together "specialized police, community-based victim services and the Ministry of Children and Family Development (MCFD)/Delegated Aboriginal Agency (DAA) child protection workers."[49] ICATs are grounded in a "partnership of local agencies, including police, child welfare, health, social service, [and] victim support," and function to "respond to referrals of suspected highest risk cases of domestic violence with a goal of increasing safety."[50]

People in BC who have been sexually assaulted often "find entering a medical institution or police station unbearable as a result of current or past trauma, experiences of marginalization, and fear of being blamed."[12] In such cases, cross-sector coordination can lower barriers to seeking care

by providing information, advocacy, and/or accompaniment. Community-based anti-violence services in BC also work across sectors to help people who have experienced gender-based violence to navigate complex response systems through accompanying them to police interviews, forensic exams, healthcare appointments, legal services, and court proceedings.

Collaborative cross-sector models for sexual assault response in BC, such as Sexual Assault Response Teams (SARTs) and Sexual Assault Coordination Initiatives (SAC), work to "bring together responders to support and enhance survivor-centred, trauma-informed services such as medical care, emotional support, counselling, legal information, and other community supports for survivors of sexual violence in their community."[51] In some instances, there are established processes for coordination: Third Party Reporting (TPR) protocols, for example, have been established in BC to enable people to report sexual assault through community-based victim services, without needing to share identifying information with police.[31]

Integrated models take the concept of coordination a step further, increasing accessibility and reducing re-traumatization by providing multiple services at a single site.[52, 53]

Integrated models facilitate the co-location of services to provide a continuum of sexual assault care, supporting access to various services in one location, guided by the needs of the person seeking care. Victoria Sexual Assault Clinic, for example, describes itself as follows: "Located in the same building as the Victoria Sexual Assault Centre …the Victoria Sexual Assault Clinic will provide a confidential, accessible and welcoming environment for recent survivors of sexual assault to access the following services: medical exams; forensic exams; crisis support; options for reporting to police; connections to community supports and resources."[54]

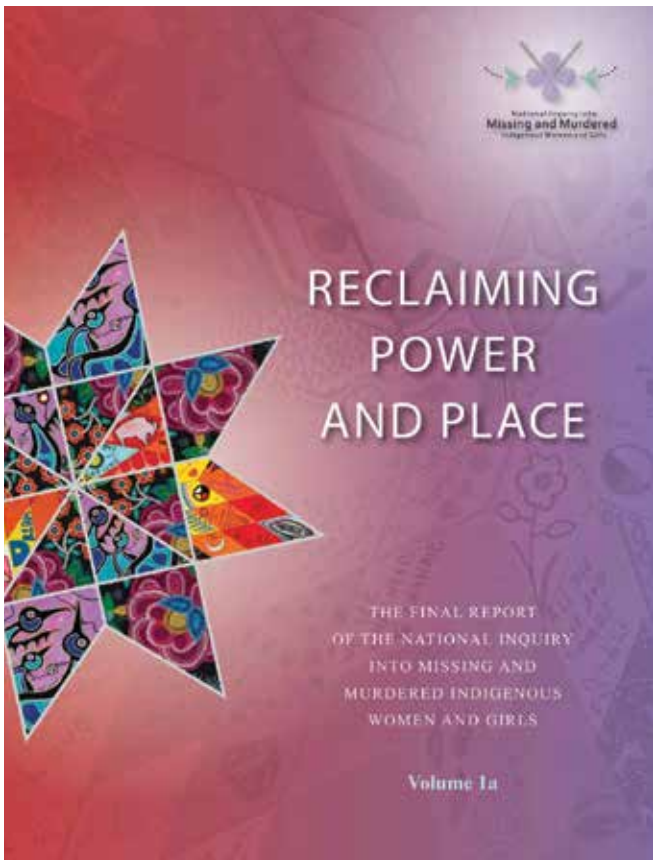
Currently, notwithstanding formalized provincial networks and protocols, coordination between health and anti-violence services remains largely informal and grounded in interpersonal relationships, reliant on the leadership and ingenuity of individual sexual assault service providers. Facilitating consistent cross-sector coordination and/or integration of sexual assault services would increase access to care, more effectively address the impacts of sexual assault, decrease the risk of re-traumatization, and reduce long-term effects of trauma, ultimately leading to better health outcomes for people who have experienced violence.[10-12]

Current Sexual Assault Policy

Over recent decades, the Government of Canada and the Province of British Columbia have made significant strides toward addressing gender-based violence, although comprehensive coordinated responses have been hampered by the absence of national and provincial sexual assault policies. Prior to the implementation of a national strategy, responses to gender-based violence in Canada have been "largely fragmented, often inaccessible, and can work to impede rather than improve women's safety."[55 (p365)]

In November of 2022, the Government of Canada released its *National Action Plan to End Gender-Based Violence*,[13] a ten-year plan focused on gender-based violence support, prevention, and justice system response that calls for implementing Indigenous-led approaches and developing social infrastructure (i.e., health and social services). The *National Action Plan* includes a commitment to facilitating "reliable and timely access to culturally relevant and accessible [gender-based violence] protection and services." A key focus of this work will be improving health, social, economic, and justice outcomes for people who have experienced gender-based violence.

The *National Action Plan* builds on the federal government's 2017 commitment to confronting gender-based violence through an earlier framework captured in *It's Time: Canada's Strategy to Prevent and Address Gender-Based Violence*,[56] as well as the 2021 *Joint Declaration for a Canada Free From Gender-Based Violence* made by Canada's Federal, Provincial and Territorial Ministers responsible for the Status of Women.[57] The federal government has also invested in gender-based violence prevention and response, including providing $30 million in funding to support crisis hotlines.[58] Within the past decade, gender-based violence perpetrated against Indigenous people has also been addressed as a national crisis, largely through the 2021 *Missing and Murdered Indigenous Women, Girls, and 2SLGBTQQIA+ People National Action Plan*[59] and the 2019 *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*,[1] which concluded that the disproportionate violence endured by Indigenous women, girls, and 2SLGBTQQIA+ people in Canada constitutes genocide.



Provincial policy in BC shapes the broad and specific aspects of gender-based violence response across the province. BC's Violence Against Women in Relationships (VAWIR) policy,[60] established in 2010, created the foundation to address intimate partner violence in the justice and social services sectors. However, the health sector was not—and is not—included in this policy despite the distinct health needs of people experiencing violence in relationships. This means that health services in the province focus on sexual assault rather than both sexual assault and intimate partner violence (in contrast with Ontario, for example). Additionally, BC has not yet established a comparable provincial sexual assault policy. Moreover, since the 2002 elimination of their core funding, sexual assault centres in BC have largely relied on precarious, short-term, and/or grant-based funding.

The Province has made recent commitments toward improving these aspects of service provision. BC established a provincial Gender Equity Office (GEO) in 2018, which is mandated to lead work "to develop an action plan to end gender-based violence, including minimum standards for sexual assault response, more training for police, crown council and justices, and establishing core funding for sexual assault centres."[61 (p3)] The Ministry of Public Safety and Solicitor General is mandated to support the GEO in this work.[62] Notably, the BC Ministry of Health's mandate letter[63] did not include any such mandate, despite the health impacts of sexual assault and the role of healthcare in sexual assault response. In absence of a Ministry of Health mandate, it is unclear whether or how minimum standards for sexual assault care will apply to healthcare services. Recently, Ministry of Health mandate commitments have been expanded to include commitments to address gaps in healthcare services experienced by women, trans and non-binary people with the support of the Parliamentary Secretary for Gender Equity and key partners.[64] While this commitment signifies movement towards equitable access to health services for women, trans and non-binary people, it remains unclear if sexual assault and gender-based violence response will be an explicit priority for the Ministry of Health.

Without the foundation of a coordinated, cross-ministry-led multi-sector provincial strategy, and subsequent sector-specific guidelines and policies, BC's efforts to address sexual assault will remain fragmented and continue to reinforce existing gaps and barriers within and between sectors. In 2016, the BC Ministry of Advanced Education and Skills Training (now the Ministry of Post-Secondary Education and Future Skills) implemented the *Sexual Violence and Misconduct Policy Act*, which mandated publicly-funded post-secondary institutions to implement policies addressing campus sexual violence and misconduct.[65] They continue to support post-secondary institutions with $500,000 support from the federal government to enhance its Sexual Violence Prevention and Response Training Series and an additional $500,000 from the Province of BC to help institutions "implement new or enhance existing [sexual violence] services that are trauma-informed, survivor-centric, and easily accessible to students."[66]

In 2021, the Province of BC announced their intention to "deliver a multi-year action plan to address gender-based violence by the end of 2022" through providing financial support for coordinated, community-based sexual assault response services; establishing minimum standards for sexual assault response; and funding for counselling, outreach, and crisis

support for people who have experienced gender-based violence.[67] Beginning in 2023-24, the province has committed to providing core funding exceeding $10 million annually for "service providers who offer victim-centred, trauma-informed, co-ordinated, cross-sector support to survivors of sexual assault."[68]

Reflecting on the state of sexual assault support services in British Columbia in early 2020, Grace Lore (BC's former Parliamentary Secretary for Gender Equity), Dalya Israel (Executive Director, WAVAW), and Tracy Porteous (Founding Executive Director, EVA BC) contended that, "in the wake of #MeToo, the transformations and conversations in society have not permeated the world of policy and government services for sexual assault survivors."[12]

While much of this work is well underway, it is long overdue and must be supported by mandates, policies, and practices establishing sexual assault as a public health priority.

Image: Gender Spectrum Collection Creative Commons License 4.0.

The Changing Perceptions of Sexual Assault (CPSA) project sought to understand the conditions and processes that supported and/or created barriers to disclosing sexual assault and accessing sexual assault services in the context of existing health and anti-violence services and systems in BC.

Community Advisory Board

A Community Advisory Board comprised of representatives from sectors that respond to sexual assault, organizations with expertise responding to the needs of marginalized groups, and individuals with lived experience of sexual assault guided the project.

Research Approach and Methods

Qualitative interviews and focus groups were conducted with three groups of participants: people with lived experience of sexual assault; sexual assault service providers in the health and anti-violence sectors; and health leaders.

Participants were identified through BCWH's and EVA BC's networks of healthcare and anti-violence workers across the province (i.e., non-probability sampling). Semi-structured interviews and focus groups were conducted by research team members with experience in qualitative interview methods and conducting research on sensitive topics. Interviews and focus groups took place in person and, where necessary due to the COVID-19 pandemic, remotely via videoconference or telephone.

The CPSA research team engaged in conversations with nearly 60 participants in:

- nine focus group discussions with 39 anti-violence and/or health service providers across the province;
- nine interviews with individual health leaders in government, community-based health organizations, and health authorities; and
- 11 interviews with people with lived experience of sexual assault.

Data were transcribed verbatim and analyzed by the research team using thematic analysis.[69]

In the research findings, participants with lived experience of sexual assault are referred to using pseudonyms, with any identifying details redacted. The locations, organizations, and roles of service providers and health leaders are also not specified to support confidentiality and privacy. Contextualizing details are included to the extent that they are directly relevant.

Research Findings

Three themes emerged from the research: decisions around seeking care after sexual assault, experiences of accessing sexual assault healthcare services, and considerations for facilitating a more comprehensive response to sexual assault care in BC.

Deciding to Seek Sexual Assault Care

People who have been sexually assaulted may consider seeking health care to address a range of health concerns related to the assault, treat sexually transmitted infections, and/or collect forensic evidence of the assault. Health leaders, sexual assault service providers, and people with lived experience described decisions about seeking health care as influenced by understandings of sexual assault, knowledge of and access to sexual assault services, and perceptions of safety when seeking care.

Understandings of Sexual Assault

Participants stressed that inadequate access to information about the issue of sexual assault can impact decisions about disclosing and seeking care. If someone does not recognize what happened to them as sexual assault, they may not consider seeking care.

Unclear definitions of sexual violence can lead to uncertainty about what services may be relevant: Janice shared that she had initially asked a provincial telephone service "if what had happened to [her] was assault." Service providers shared examples of how different cultural understandings of sexual assault can affect how someone makes sense of what happened to them, especially for newcomers and immigrants navigating language barriers. Service providers described these situations as particularly complex when sexual assault is perpetrated by an intimate partner. A service provider observed that they were providing services to some immigrant women "really terribly affected by rape in their home country," noting that when the perpetrator is an intimate partner, "they are then rejected by their families … so they're isolated, blaming themselves in a new country." One service provider revealed her own experience as an immigrant, sharing that she had for a long

time understood that "providing for [her] ex-husband [sexually]…, even though [she] hated it, was [her] responsibility." Another service provider said that, in some cultural communities, sexual violence is "so normalized that it's just not considered an emergency [or] a medical problem."

Service providers, health leaders, and participants with lived experience also discussed how sexual assault stigma and victim-blaming may impact decisions about seeking care. Service providers consistently relayed the fear expressed by racialized people, immigrants, and/or refugees who had been sexually assaulted, due to the risk of social ostracism (e.g., being disowned, being 'outed,' bringing shame to their family). Service providers shared that men who have been sexually assaulted may face particular shame and stigma, as cisgender men are often "just not seen as victims."

Participants also described how victim-blaming may be internalized; as one service provider observed, "Every single survivor [of sexual assault] deals with some degree of shame," which can impact their willingness to disclose, report, and seek care. Another service provider acknowledged "this feeling we all have about speaking about these things, it's a discomfort," with the assurance that "if you don't feel like sharing [disclosing], that that's totally okay and totally acceptable."

Where sexual assault is misunderstood or is accompanied by judgment, people who have been sexually assaulted may not seek care at all. If they do seek care, it may be to address their symptoms (e.g., STIs, head trauma, lacerations, strangulation) without disclosing the sexual assault itself. This presents a significant barrier to accessing comprehensive care, leaving healthcare providers unable to follow any institutional policies or practices that may be in place specifically to support sexual assault response.

Knowledge of and Access to Sexual Assault Services

Research participants indicated that sexual assault services in BC are often not known by, or accessible to, people who have been sexually assaulted, which constitutes a crucial barrier to seeking sexual assault care.

Health leaders identified a scarcity of accurate information about sexual assault services, with one noting that "it's very hard to even understand where the services are. … even going [online] isn't really a great wealth of information." This was echoed by participants with lived experience, who described their knowledge of sexual assault services as limited. Bella noted, for example, "They don't teach you this in school, like, what to do when this happens" and that "generally, [she] wasn't aware of the resources prior to the assault." Molly identified a need for "letting people know that these things [services] are available to them," and Bella suggested having a "place that they can go and click on different links and see the different resources" available, possibly through social media or other virtual platforms.

…sexual assault services in BC are often *not known by,* or accessible to, people who have been sexually assaulted…

It is important to consider the impacts of trauma on navigating sexual assault services. Bella shared that after she was sexually assaulted, she "wasn't really in the mindset of … sitting down or doing research" to explore her options for seeking care and accessing support. Another participant, Lily, shared that she was "in such a fuzzy head," with her initial weeks following the sexual assault focused on "just coming to terms with what happened and not dissociating so much. … It's not just the knowledge but in the mindset that you're in when something like that happens. You really do not know what to do and who to listen [to]."

Decisions about seeking care were also impacted by uncertainty about whether the impacts of a sexual assault were deserving of healthcare resources. A service provider described this as a "type of internalized barrier that people put in place for themselves" where a person who has been sexually assaulted "[doesn't] want to take away your time from someone who's in more need" than they are. This was illustrated by Janice, who shared her experience seeking sexual assault care: "What I initially felt going in there was guilt because I mean, I'm not injured. Like, I didn't like almost die or anything." This was particularly true with hospitals, which participants described as a key avenue for accessing care. In the current climate, it is well known that emergency services are over-extended and the public is encouraged to limit their use of such services. Accordingly, one service provider shared that, for some clients, "just accessing the hospital is a very scary thing for them, and a lot of the times going to hospital is like a very serious matter, that's why you go to the hospital." The COVID-19 pandemic may heighten this; discussing her decision to seek hospital care, Molly shared that she felt "guilty for going in the middle of a pandemic" and felt that "maybe [she] shouldn't be there," "taking up space" by accessing health care during a time of heightened need. Uncertainty and hesitation when accessing urgent care is particularly important given guidelines for completing forensic medical exams within seven days of a sexual assault.

Access to care and support may also be limited by gender-specific services. Many anti-violence organizations originated as services for cisgender women and, as one health leader asserted, "our current system is very much modelled to support women sexual assault survivors." Service providers explained that, within this context, services may not be accessible to transgender, non-binary, and gender-diverse people. Cisgender men may be excluded from services or be unwilling to seek care from services they view as focused on women.

Within this context, the path to accessing post-assault support is neither clear nor straightforward. As a salient example, Janice shared that she had first "called the non-emergency [police] line and they were too busy." She was put "on hold for about half an hour [and] just didn't want to wait," so she then "emailed their [police] Sex Crimes Unit." While waiting for an email response, she called a provincial health telephone service where "the operator was very sympathetic" and was able to refer her to another provincial telephone service for victims of crime, which was then able to make a referral to additional support services. Another participant described trying to contact a provincial telephone support line but needing to call four different services before reaching one in her locale.

Perceptions of Safety When Seeking Care

The perception that services are unsafe also poses a significant barrier to people with lived experience seeking care. Service providers and health leaders conveyed that traditional sexual assault response services, such as police and hospital-based health care, were often regarded as unsafe by those seeking sexual assault care, especially in the context of systemic marginalization. While safety in accessing hospital-based services was a main focus of discussion, service providers also relayed that many people with lived experience also feel unsafe accessing care through family doctors, nurse practitioners, walk-in clinics, and/or mental health services. Such concerns were described by health leaders and service providers as well-founded. One service provider observed that "there's a lot of mistrust of the systems and fear of the systems," and that, as a service provider, "you don't want to try and convince them [to] go forward cause they're absolutely right about the experience that they might have."

Perceptions of services as unsafe were seen as primarily a function of previous negative experiences seeking care—whether the direct experiences of the person who was sexually assaulted, experiences of others in their community, and/or larger systemic patterns of discrimination and victim-blaming. A service provider shared that Indigenous clients who were sexually assaulted were "much less likely to go forward to any of the services, the healthcare, the police" due to "fear of not being treated very well," which they acknowledged "does happen pretty regularly." A health leader also named the impact of intergenerational distrust, recognizing that some communities carry a substantial legacy of adverse experiences when seeking care. One service provider shared their own experience as a transgender person seeking sexual assault care, recalling, "Hell no am I going to the hospital as a trans person," noting that they "would have sought care had [a new trans-inclusive clinic] existed at the time." Another service provider shared that people who have "experienced some criminalization of their mental health in the past" may be fearful about being pathologized or involuntarily hospitalized.

Seeking care may be considered unsafe due to misconceptions about what to expect. Service providers identified the common perception that forensic exams involve a "huge lack of [the patient's] consent" where "if they say yes to one thing that means they have to say yes to all the things." When they do seek sexual assault care at a hospital, some people "are very surprised that they have all these choices and they have all these options."

People with lived experience also feared unwanted cross-sector involvement. Health leaders conveyed that the public generally perceives sexual assault response systems as interconnected, with healthcare services tied to both police and child protection services. Service providers consistently identified concern about police involvement as a key reason people who had been sexually assaulted did not seek care; there is a widely-held assumption that seeking health care necessarily involves an invasive forensic exam, coupled with an assumption that accessing forensic exams automatically leads to police involvement. One service provider shared that going to the emergency department carries "the implication that … if you're coming there, you are getting police involved, first of all, [and] that you are doing a full forensic exam." Another service provider stated that "often people believe that if you seek medical attention that has to be coupled with a disclosure with police."

It is a challenge to create safety for people with lived experience of sexual assault. As one service provider stated, referring to someone who had been sexually assaulted, "[She had previously] chosen not to disclose to be safe, and she has chosen at this point to disclose to be safe." It is the responsibility of healthcare services to ensure that care is indeed safe.

Accessing Sexual Assault Health Care

Diverse factors impact people's experiences of health care following a sexual assault. Health leaders, service providers, and people with lived experience discussed the healthcare focus on emergency care and forensic exams, victim-blaming when accessing services, systemic discrimination, and safety and accessibility.

Focus on Emergency Care and Forensic Exams

Health leaders and service providers suggested that current BC healthcare policy regarding sexual assault care is directed toward a technical, medicalized, and hospital-based approach. Within this context, basic emergency care and forensic examinations are often prioritized at the expense of holistic, ongoing care oriented toward the needs of people who have been sexually assaulted.

Although hospital emergency departments are a primary pathway for accessing sexual assault care, service providers maintained that they are not "a low-barrier way of accessing care." They described hospital emergency departments as "not a welcoming environment," given that they are often chaotic, "sterile and cold," with patients subjected to loud, crowded, insecure waiting rooms and long wait times. For someone who has just been sexually assaulted, these delays risk further harm; Molly shared that she "was waiting for way too long" to see somebody, noting that a shorter wait "would have been maybe a little bit less traumatizing." Those seeking sexual assault care through an emergency department are also required to disclose through the triage system, a process described by service providers as intimidating, with little privacy and limited confidentiality, especially within smaller communities. While some institutions may have triage policies in place to ensure that people who have been sexually assaulted

are prioritized and/or receive specialized care, persistent staff shortages and turnover impact the extent to which these policies are consistently upheld.

As one service provider shared, "When sexual assault survivors come to the hospital, the emphasis always is the discussions about the forensic exam. But really that's just a small, small, small piece of our sexual assault care." A health leader called for comprehensive care, sharing that "you can go into a hospital. You can receive care. We'll give you the morning-after pill [emergency contraception] and test you for STDs [sexually transmitted diseases] and send you on your way. It's this notion that that is good enough and you should be thankful for it."

In discussing her own experience seeking sexual assault care, Elizabeth shared that "it's the aftermath that doesn't really get look[ed] at … and they don't really teach you anything or give you any sort of help in that to be able to process these things." Describing her experience accessing sexual assault services, Bella shared that "having that access of counselling was great for my mind, but there was still trauma living in my body" which she ultimately had treated by "a person that would release energy through myofascial tissue." Those seeking long-term care to address trauma impacts, such as counselling support, often face additional barriers. Kate said that it "seems ridiculous that [she has] to pay out of pocket" in order to "get help for something that [she] didn't choose to happen." While free support services like counselling may be offered, service providers and participants with lived experience pointed to significant wait lists, which inhibit timely access to urgently needed care.

The healthcare emphasis on emergency sexual assault care was seen by health leaders as at odds with the multiple potential entry points to care. Health leaders felt this was compounded by siloed health care. Emergency response, primary care, and public health services are segregated, with defined scopes of practice impacting who offers what types of care within what contexts.

Health leaders recommended establishing a continuum of care, providing meaningful support for people with lived experience through disclosing sexual assault, navigating and accessing services, and proactive follow-up care. People with lived experience similarly called for follow-up care, with Elizabeth sharing that one thing she thinks "would be beneficial is having some sort of counselling or some sort of follow up in place, at least for a month or two after, like, after discharge from the hospital when you come in for something like [sexual assault]."

Victim-Blaming and Accessing Services

Health leaders, service providers, and people with lived experience also discussed how healthcare services are impacted by misperceptions and assumptions about sexual assault. People who have been sexually assaulted may be stigmatized or judged by healthcare service providers. Participants shared examples of victim-blaming in healthcare settings, such as when patients who were sexually assaulted were framed as partially at fault—particularly if they had been out on the streets, inebriated, and/or using substances.

One service provider shared that people with lived experience may choose to "talk to their family doctor, but a lot of the times [their] family doctor has a lot of judgement around these issues and they say a lot of things that are really discouraging." When she went to a physician for sexual assault care, Kate described how "she [the physician] just walked out of the room without even saying once, 'I'm sorry that happened to you.'" Kate shared that she had "walked out of the clinic just feeling like it [the sexual assault] was [her] fault." Another service provider had witnessed a hospital physician and police officer stigmatizing and blaming a person seeking sexual assault care "because she had come from a music festival, and she had been drinking." Another service provider shared the story of a young person who, when seeking care after being sexually assaulted, "felt like everybody would say it was her fault because she was using [substances]"; this fear was based on her "really bad experience with the police as well as the health staff" when she had sought care for sexual assaults previously. One service provider shared that, "for a lot of healthcare professionals in [their] community" there is "still that mentality that well, if you weren't out there [on the streets], then that wouldn't happen to you. A little bit of victim blaming."

Systemic Discrimination

Health leaders and service providers also pointed to systemic discrimination and biases as contributing to inadequate sexual assault care for patients who are women of colour, drug-dependent, Indigenous, immigrants, sex workers, not cisgender, and/or otherwise marginalized.

Health leaders saw systemic discrimination as impacting sexual assault health care and policy, with one participant expressing doubt that existing services were sufficiently meeting the needs of marginalized patients. A service provider shared that, for patients accessing sexual assault services, "the healthcare worker … may have those perceived perceptions of 'this is who they are, this is what has happened.'" Street-based sex workers, for example, encounter barriers to care, with one service provider noting that they are "stigmatized even in the hospitals."

Service providers expressed concern about who does not access services due to systemic barriers: "We know violence is happening specifically to MSM [men who have sex with men] and to trans people in high numbers and we are not seeing those numbers walking through the door." Transgender people seeking sexual assault care face barriers that include the risk of being mis-gendered or having "their bodies and anatomy referred to in ways that don't feel good," which can be "incredibly re-traumatizing especially if there has been, and largely there is, bodily harm that has been done."

Service providers also described how healthcare workers' assumptions that people who use substances are seeking drugs presents an additional barrier to seeking care, leading to some people being ignored, neglected, and/or improperly assessed when seeking care. Importantly, one service provider argued that this discrimination against people who use substances reflects a fundamental failure to "understand or recognize the coping strategies that survivors [of sexual assault] develop." This echoed what another service provider shared: if the person seeking services is using substances, "the first question becomes [whether] she is … capable of sharing her story rather than looking at why she's there [and] she has to … come off the high before she gets any other service. That's a huge, huge, huge barrier."

Safety and Accessibility

Healthcare services often fail to provide trauma-informed care, putting those seeking sexual assault care at risk of further harm or re-traumatization. Service providers and people with lived experience described impersonal and clinical approaches to sexual assault care, with the healthcare system consistently fast-paced, task-oriented, and event-focused.

Echoing a sentiment expressed by many, one service provider shared the tangible importance of trauma-informed practice:

> *"Because we work from the trauma-informed perspective, we understand that some of what we're seeing in the women's reactions are part of trauma. ... [Others might see] woman acting crazily or she's erratic or she's not stable or ... if she's dissociative or shutting down she's not cooperative, she's not responsive. So there's sometimes ... that lack of awareness around what the reasons are for why she's presenting that way and that she's kind of in that survival mode state."*

Some participants with lived experience highlighted what they found helpful when they sought care, much of which reflected what health leaders and service providers elsewhere described as a trauma-informed approach. For example, Elizabeth appreciated that the health services she accessed "kept things kind of private" and avoided "drawing attention to [her]" and also appreciated that the health services she accessed "give you as many breaks as you need. You could be there for hours if you need to. There's no rush." Similarly, when accessing counselling services through a hospital, Bella appreciated that "even if [she] wasn't feeling good that day, [she] could go a bit early and kind of hang out there and go to [her] appointment." She valued having a welcoming, "safe place to go to" where she felt "comfortable to talk." These examples illustrate that providing trauma-informed care is possible, suggesting that efforts be made to ensure it is consistently available.

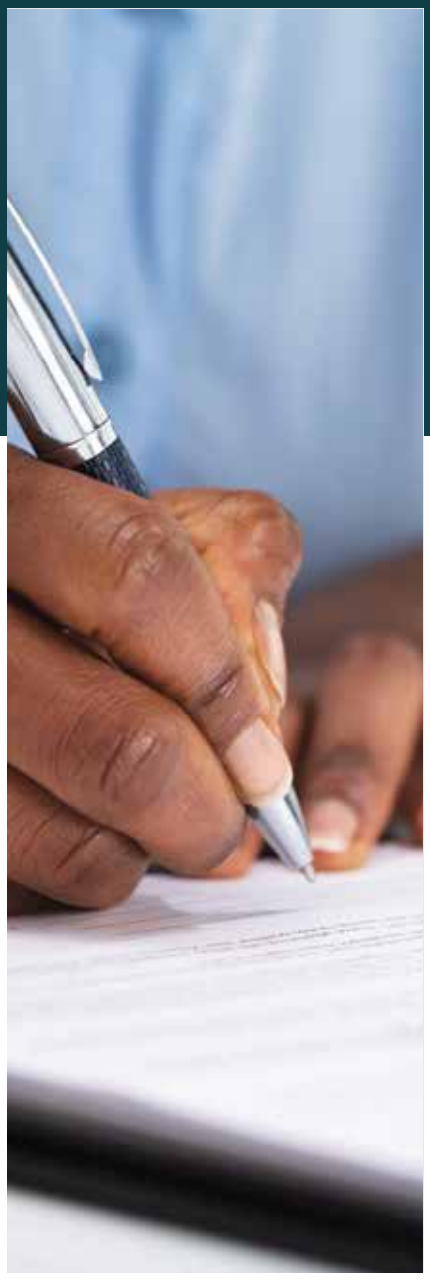
Research participants highlighted the importance of retaining autonomy when seeking care. Service providers commented on the strength of sexual assault services that were flexible and guided by the choices of the person seeking care. One service provider shared their service's approach of "[giving] them as much relevant information as possible to be able to make the best decision for them. We come from a model of supporting folks no matter what they decide, if they report, who they report to." For example, after she had completed "the rape kit [forensic exam] and all the testing," Elizabeth shared she was "able to consent" to what was done with that forensic evidence, knowing that it was held by the hospital and that "when [she's] ready then [she] could always make that call" to report to police.

Service providers commented on the *strength* of sexual assault services that were flexible and guided by the choices of the person seeking care.

It is also important to consider how and where services are offered; the ability to access care remotely was described as significant for those with limited access to in-person services. Participants with lived experience appreciated being able to access services remotely (through phone or videoconference), particularly when in-person services were far away or required planning to meet accessibility needs. Some remote access was enabled by the unique circumstances of the COVID-19 pandemic when some sexual assault services were offered remotely out of necessity. While many people with lived experience and service providers expressed a preference for in-person services, where possible, it is worth considering how various modalities of care may enhance accessibility, especially where there are limited options for seeking care. One participant with lived experience went to a hospital with specialized sexual assault services primarily because it was in the same urban centre as the anti-violence services she had accessed; she said she likely would not have gone had she needed to travel far from home. Additionally, while specialized supports do exist in many smaller communities, the lack of anonymity can act as a barrier to accessing services.

Facilitating Comprehensive Sexual Assault Care

Drawing upon their experience and expertise, health leaders and service providers identified some key considerations for better supporting people with lived experience of sexual assault. To move toward comprehensive sexual assault care in BC, they emphasized the need to standardize the healthcare response, prioritize trauma-informed care, expand options for sexual assault care, reduce systemic barriers for diverse communities, and support coordination across sectors.



Standardizing the Healthcare Response

Establishing healthcare practices and protocols for sexual assault response has not been sufficiently prioritized in BC: one service provider expressed frustration that "they've been working on a sexual assault policy in the [provincial] government for four years now," without tangible results. Health leaders noted that, where gender-based violence policy does exist, it tends to focus on intimate partner violence rather than sexual violence. Within the healthcare system, participants emphasized the limitations of current policies and practices for sexual assault response, including unequal allocation of financial resources to sexual assault response. Within this context, health leaders noted that some in the healthcare sector perceive sexual assault response to be the role of the anti-violence, education, and police sectors, contributing to a lack of healthcare leadership in sexual assault response.

Service providers shared that many individual institutions do have established policies and procedures for service providers responding to sexual assault including expedited care, private spaces for waiting and treatment, and accommodating gender preferences. However, health leaders shared that such sexual assault policies and directives do not necessarily easily translate into daily healthcare practice. Advocating for trauma-informed care, one service provider gave the caveat that "there may be barriers, systemic barriers, that are preventing somebody ... [who is] trauma-informed from actually giving the kind of care they want." Service providers and health leaders shared numerous systemic constraints on the sexual assault care healthcare workers can provide, especially in hospital and emergency department settings. These barriers include high workloads, staffing shortages, individual impacts of the work (e.g., overwhelm, burnout, vicarious trauma), and social and cultural factors such as judgments about sexual assault. Another service provider described the challenge of creating "a safe space for someone to disclose [sexual assault]," explaining that "building trust is not possible" in an "environment where it's not as private or … you can tell someone's maybe a bit uncomfortable."

Health leaders and service providers emphasized the need for sexual assault healthcare to be consistent and standardized across the province. Service providers shared that current sexual assault policies and practices vary significantly and can be location-dependent, identifying more structured programs as a means of ensuring the quality of services and support. A service provider commended structured 'wraparound' programs "where you've got social workers involved and you've got physicians and a whole team if you will. Not just independent practitioners."

Even where practices are well established, service providers spoke to the importance of formalizing processes, with one participant stating:

> *"So informally, for instance, if the sexual assault nurse at the hospital calls us, says, 'We've got somebody who's just come in' - we'll triage, and that person can come in immediately. No questions asked. So recent sexual assaults, we take immediately. But ... we need that in writing."*

Further, health leaders and service providers pointed to inconsistencies in sexual assault services depending on location and facilities. In rural and remote BC communities, for example, people seeking sexual assault care often face limited options (e.g., only hospital emergency and police services), limited hours of service, challenges maintaining confidentiality (e.g., within a small community), and lack of service providers able to provide forensic exams. Inconsistencies in sexual assault response contribute to misunderstandings and miscommunications about the care, services, and supports available to people with lived experience. One striking example of this sits at the intersection of police and healthcare responses: although healthcare services often have institutional policies and practices protecting against unwanted involvement from police, service providers shared that police involvement is sometimes required due to operational policies around what is required for evidence collection and storage.

Discussing variation in the provision of sexual assault care, service providers highlighted the need for establishing consistent practice; as one participant emphasized, "It's got to be a system-wide thing."

Prioritizing Trauma-Informed Care

Service providers and health leaders consistently emphasized the need for trauma-informed care to be widely adopted, guiding all healthcare services, regardless of whether the person seeking care has disclosed a traumatic experience such as sexual assault. Health leaders described trauma-informed health care as care that prioritizes developing trusting relationships between patients and providers; allowing time and space to enable open communication; creating safe and supportive environments to minimize shame and judgment; offering autonomy to those seeking care; and focusing on health care needs, rather than reporting to police.

Health leaders and service providers viewed training as a crucial means through which service providers could build their capacity for trauma-informed care. Health leaders recommended offering more training at undergraduate, professional, and system levels (such as management, administrative, and leadership). Service providers shared that some facility-based providers may have an easier time developing and maintaining their competency, due to institutional supports whereas 'fee-for-service' providers may have to forego earning income should they want to participate in training.

Yet maintaining competency is key. One service provider considered that "a provider in a rural community who's been practicing for a long time … may not know that it's become more common to offer self-swabbing and that a lot can be done without having to do a physical exam." Maintaining competency can be difficult in rural, remote, or isolated settings, where service providers may be less frequently providing care to people with lived experience of sexual assault. One participant shared that, in her isolated rural community, they "don't see a lot of [sexual assault] cases," so she also travels to work in busier urban centres "to keep up [her] skills."

Supporting trauma-informed care across the healthcare system facilitates better responses to disclosures, regardless of where a person with lived experience seeks care. A service provider emphasized that "you're going to get likely a better experience in disclosure from someone who's trauma-informed … just, like, less traumatic hopefully." Another service provider gave the example that "maybe your family physician's office feels like a less safe place than going to an STI clinic or working with an outreach worker." Service providers shared that widespread trauma-informed practice would enable service providers to build trust with, and ultimately provide better support for, those seeking sexual assault care.

Expanding Options for Sexual Assault Care

The barriers to seeking safe, trauma-informed, and comprehensive sexual assault care can be significant. As one service provider shared, "When you're engrossed in this every day, you see the barriers [to seeking care]. The barriers look bigger than the doors." To support the provision of safe, trauma-informed health care, service providers spoke to the value of expanding options for sexual assault care.

Service providers described specialized sexual assault services as safer for those accessing care, with "more sensitivity around the subject" and greater awareness of promising practices in sexual assault response. Across BC, service providers emphasized the value of specialized

sexual assault services with nonjudgmental, safe, trauma-informed approaches that facilitate disclosure, a description that reflects the principles of anti-violence services. Health leaders also called for building capacity for sexual assault service provision across the province, with services equitably distributed, consistently high quality, and tailored to communities' needs.

Some service providers also spoke to the value of having sexual assault care, including forensic exams, available outside of a hospital setting. A service provider stated that, "pulling it out of the hospital environment itself is a huge piece. So [our] multidisciplinary team has been in place for a very long time, and that definitely works. But it's in that hospital environment. Pulling it out means that we have a much more private place." Integrated and coordinated models of care, such as clinics with co-located sexual assault services, were highly regarded by many service providers. As one service provider observed, "most of what can be done … can be offered in a clinic outside of a community hospital"; they also shared that this model has been or is being implemented in a couple of urban centres, noting that "the challenge or the barrier is just space and money."

Service providers described other possibilities for expanding access to sexual assault health care through community nurses, public health nurses, primary care networks and reproductive health services. For example, one participant noted that nurse practitioners "can definitely do this work" in a primary care setting. Another participant shared that "it does increase access to services … having community nurses as well and public health nurses … that first point of contact really having an ability to identify sexual assault and really be knowledgeable in terms of the resources."

Reducing Systemic Barriers for Diverse Communities

Service providers and health leaders reflected on how sexual assault healthcare services can be more accessible for all people with lived experience, particularly those who are most marginalized and face the most significant barriers to accessing care. Health leaders emphasized the importance of reinforcing equity across the healthcare sector and of having healthcare policy and protocols avoid replicating discriminatory and exclusionary practices when providing care for patients who are Indigenous, racialized, immigrants, sex workers, trans or gender-diverse, and/or who use substances.

It is essential that Indigenous patients have access to culturally safe sexual assault care. Health leaders spoke about the importance of elevating Indigenous approaches to health, including through holistic care. As an example of what this may look like in practice, one service provider described the success of "an open structure" group supporting Indigenous women which was co-facilitated with Indigenous partners and "integrated traditional teachings and practices" and ensured their discussion of the impacts of trauma "incorporat[ed] the intergenerational trauma piece."

Health leaders and service providers also spoke to the importance of culturally responsive care for immigrants and refugees. Service providers advocated for culturally-informed education about sexual assault. One service provider, who primarily worked with new immigrants who were not English-speaking, noted that often "they are bringing that same perception of what they've seen their mothers or other women in their families go through and then just continuing with [that perception]." The need for culturally diverse service providers was highlighted as a means of giving people options for care that feel safer and/or better meet their needs. In some cases, patients may want to disclose to someone who shares their culture but, as one service provider observed, "Not everyone from my community wants to see somebody from their community cause there's a fear that the community may know each other." Another service provider spoke to the "power of the cultural groups" in the community, observing that having "high concentrations of [specific] cultural groups at our clinic" is an indication that "the supports targeting that specific culture are really good, and they're bringing the women in."

Access to specialized, tailored, and/or inclusive sexual assault services can be a key support for diverse and/or marginalized people seeking care. A health leader shared that "it's our job to be standardized but also to have that... community by community kind of response to the population as well. What works in [a marginalized community] very likely won't work in [a more affluent community]." Health leaders described developing leadership and ally-ship with those in the community as important to enhancing sexual assault care and support for diverse communities.

It is *essential* that Indigenous patients have access to culturally safe sexual assault care.

Supporting Coordination across Sectors

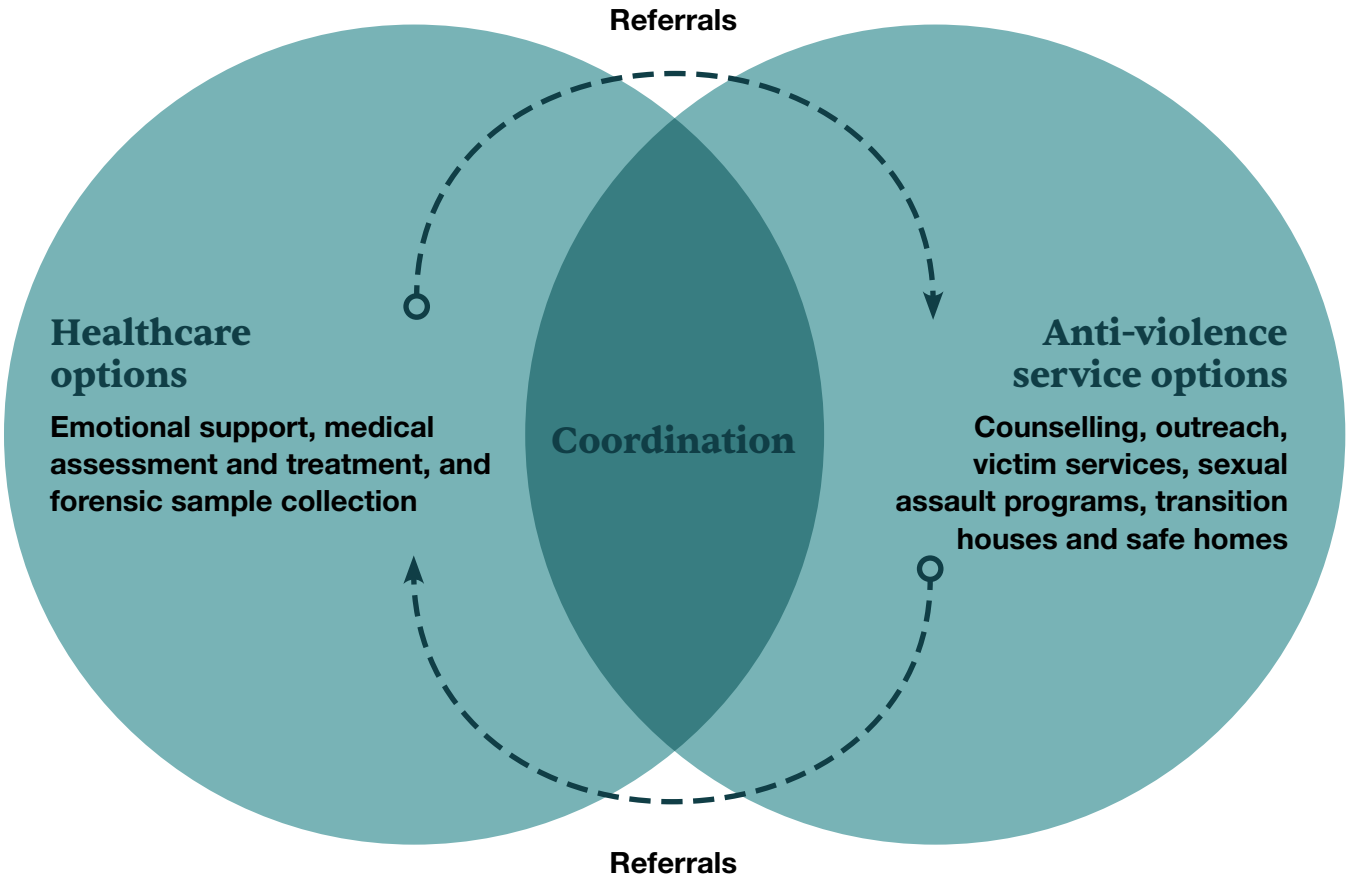
Health care represents only one aspect of the myriad services and supports needed by people with lived experience of sexual assault. Discussions with sexual assault service providers in the health and anti-violence sectors and health leaders highlighted the importance of cross-sector collaboration, noting that a continuum of care would facilitate connections with and referrals to other services, enabling access to additional sexual assault care and support as needed.

Service providers emphasized the importance of a seamless, holistic approach that includes both healthcare and anti-violence workers. Anti-violence service providers can provide trauma-informed support and accompaniment to people accessing sexual assault care; for example, one service provider shared that "the forensic nurses can call us directly when a woman is wanting a support worker during the forensic exam."

Participants with lived experience shared some positive experiences of cross-sector coordination, including being referred to or given information about other resources and services available to them. After accessing sexual assault care, Bella found it helpful that the hospital gave her "a booklet or like a Ziploc bag of a few information things of what had all just happened and what to do next." Janice shared that she had initially reached out to a provincial telephone service for victims of crime that referred her to a community-based anti-violence service where she received support in navigating her options for health care (e.g., emergency contraception, STI testing), reporting to police (i.e., directly or through an anonymous Third Party Report), and referral to counselling services. Elizabeth shared that she "came in and they had the E.R. doctor look at [her], then they had their [sexual assault] team" talk to her, with additional support from "social workers in the community [who] kind of come in and they not only assist the forensic nurse … they're mainly to support the patient." Cross-sector coordination can also increase accessibility for those seeking care. Janice had sought care "around one a.m. so the bus that would have gone to [the hospital] stopped. So that's why [a community-based anti-violence service] had offered to give me a ride there."

Conversely, insufficient coordination can mean patients are not getting the sexual assault care and support that they need. Kate shared that she "had clear bruises around [her] neck and [she] could still feel [the perpetrator's] hands around [her] neck" when she saw a physician for sexual assault care. Despite this, the physician "never offered to refer [her] to any support services or there's [an] organization [she] can talk to." Failures to effectively coordinate across systems can also contribute to uncertainty and lack of clarity for those seeking care. Sarah, who had recently sought sexual assault care, shared that "they took evidence" and she gave a statement to police, but they "haven't followed up with [her] on it" and her "rape kit is still in the hospital [and she doesn't] know if they're even going to analyze it." It is unclear whether she had been provided information about the procedures in place at the particular facility or how she might find out more about her case. Service providers shared that institutional variation in policies, lack of formal policy, and staff turnover can also contribute to those seeking care receiving inaccurate information and referrals.

While coordinated care across sectors was consistently valued, effective coordination requires dedicated time and resources. In one community, one service provider shared that "a lot of [sexual assault response] systems bump up against each other, but they don't really interact," while another service provider in the same community commented that, "there's no interconnection" because "everybody has too much work to do." It is evident that, to be effective, cross-sector coordination needs systemic support and appropriate resourcing.



Recommendations

Grounded in the perspectives of people with lived experience of sexual assault, health and anti-violence sexual assault service providers, and health leaders, the CPSA research project has identified four over-arching recommendations to improve the healthcare response to sexual assault in British Columbia.

1 Recognize Sexual Assault Response as a Public Health Priority

1a. Name sexual assault as an urgent public health issue and expand Ministry of Health mandate commitments accordingly

Addressing sexual assault is relevant to the work of numerous ministries, including the BC Ministry of Health. The Province of BC's Gender Equity Office and Ministry of Public Safety and Solicitor General were mandated, in 2020, to "develop an action plan to end gender-based violence, including minimum standards for sexual assault response."[61, 62] The BC Ministry of Health's mandate letter[63] lacked such a commitment to addressing gender-based violence, fundamentally at odds with Provincial Health Officer Dr. Bonnie Henry's assertion that gender-based violence is a "public-health priority" in BC.[2]

The December 2022 mandate letter to the Minister of Health specifically requests that the health sector address gaps in healthcare services experienced by women, trans, and non-binary people, with support from the Parliamentary Secretary for Gender Equity and in consultation with partners.[64] This mandate supports continuing efforts toward the development of a provincial gender-based violence action plan that includes minimum standards for sexual assault care being a requirement of the BC Ministry of Health. It will be important to consult with the Office of the Provincial Health Officer, particularly Dr. Danièle Behn Smith, Deputy Provincial Health Officer, Indigenous Health. Other relevant ministries, including the Ministry of Attorney General, Ministry of Indigenous Relations and Reconciliation, Ministry of Mental Health and Addictions, Ministry of Children and Family Development, Ministry of Post-Secondary Education and Future Skills, Ministry of Municipal Affairs, and Ministry of Social Development and Poverty Reduction, should be considered among the Ministry of Health's key partners.

1b. Develop and implement a cross-ministry provincial sexual assault policy

Provincial policy focused on sexual assault response must be an urgent priority within BC's forthcoming action plan to end gender-based violence, including the establishment of minimum standards for sexual assault care. Policy development should involve subject matter experts such as EVA BC and representatives from equity-seeking groups.

The cross-ministry provincial sexual assault policy must:

- **Detail the implementation of minimum standards of care** for all sectors with a responsibility to respond to sexual assault, including health, anti-violence, and police,
- **Create clear referral pathways** to establish a continuum of care, and
- **Facilitate cross-sector coordination** of sexual assault services.

In alignment with the goals of the Government of Canada's 2022 *National Action Plan to End Gender-Based Violence*,[13] the provincial sexual assault policy should be "victim/survivor-centric" and "trauma and violence-informed"; remain "flexible in response to regional and sectoral realities"; and be "grounded in an intersectional approach" that is "culturally safe, relevant, accessible, and appropriate" and inclusive of "Indigenous-led solutions."

The policy must recognize the historic and ongoing impacts of gender-based violence broadly, and sexual assault specifically, in Indigenous communities. The policy needs to support innovations in service models that facilitate and support access by Indigenous women and girls, as well as Two-Spirit, trans, and non-binary people. Investment will be required in education, staffing and facilities that support decolonized approaches to care and address systemic and historic anti-Indigenous racism, including health services such as Indigenous patient navigators and culturally safe spaces.

Parallel to the Province of BC's 2010 Violence against Women in Relationships (VAWIR) policy, the provincial sexual assault policy should outline each sector's roles and responsibilities in responding to sexual assault. VAWIR delineates sector-specific yet intersecting roles and responsibilities for numerous sectors, including police, Crown counsel, victim services, Ministry of Children and Family Development, and family justice services.[60]

2 Build Health Sector Capacity for Sexual Assault Response

2a. Develop guidelines for survivor-centred sexual assault care

Minimum standards of sexual assault care need to be defined and supported by provincial guidelines detailing policy and procedures.

These provincial guidelines for sexual assault care in BC should:

- **Delineate health care as independent from the criminal legal system,** and include clear procedures for where these systems intersect (e.g., forensic examination and police involvement),
- **Broaden the scope of sexual assault care** beyond forensic examinations and emergency care to include sexual and reproductive health, mental health, spiritual wellness, and social well-being,
- **Standardize sexual assault care** to ensure services are consistent across the province and achieve minimum standards of care,
- **Ensure all aspects of sexual assault care are trauma-informed, culturally safe, and survivor-centred,** including care accessed through emergency department triage,
- **Strengthen primary care providers as a pathway** for accessing sexual assault care (e.g., through training and resources),
- **Support flexibility in service delivery,** so that services can be responsive to community-specific contexts and needs,
- **Address long-term needs for sexual assault care,** including trauma impacts, and
- **Support the integration of trauma-informed and consent-based practice** into all areas of health care (e.g., in sexual, reproductive, and prenatal care).

2b. Mandate standardized sexual assault training for healthcare workers

Healthcare services should be provided by clinicians with a minimum baseline of knowledge and skill to minimize re-traumatization and support wellness.

Building the health sector's capacity to respond to sexual assault requires that all healthcare workers be mandated to participate in training on sexual assault and trauma-informed practice. At a minimum, healthcare workers should be mandated to complete the existing online learning series, *Gender-Based Violence: We All Can Help*, which is focused on improving the health sector response in BC and includes a course dedicated to understanding sexual assault and care for people who have experienced sexual assault.[70] Following the development and implementation of a provincial sexual assault policy and minimum standards of care, dedicated resources should be allocated to enhance and/or develop new training that is in alignment.

To address the needs of all patients seeking sexual assault care effectively, it is important that mandated sexual assault training build healthcare workers' capacity to provide:

- **Culturally safe care** to meet the needs of Indigenous communities, as called for by the Truth and Reconciliation Commission of Canada,[38 (p. 3)]
- **Culturally responsive care** to meet the needs of culturally diverse immigrant and refugee communities, including newcomers,[7]
- **Accessible care** to meet the needs of people living with disabilities, as identified in DisAbled Women's Network (DAWN) Canada's More Than a Footnote campaign[71] and Disability Alliance BC's Inclusion in Practice guide,[9] and
- **Gender-affirming care** to ensure equal access to healthcare services for trans and gender-diverse people.[40]

Systemic challenges in health services (e.g., fast-paced, task-oriented, and event-focused environments) create challenges for the provision of trauma-informed care and health sector workers' ability to participate in continuing professional development activities and training. As such, mandated training must be backed by institutional support, with funding allocated to backfill staff that are in training and incentives provided for primary care providers (i.e., through Doctors of BC, BC College of Nurses and Midwives).

3 Strengthen Health and Anti-Violence Sector Coordination

3a. Invest in coordinated and integrated models of care

Strengthening effective cross-sector coordination between health and anti-violence services can provide significant support for sexual assault care. Cross-sector coordination of sexual assault services is a primary means through which the Province of BC can increase access to care, more effectively address the impacts of sexual assault, decrease the risk of re-traumatization, and reduce long-term effects of trauma, ultimately leading to better health outcomes for people who have experienced violence.[10-12]

The Province of BC should invest in coordinated and integrated models of sexual assault care, which involve cross-sector collaboration between relevant sexual assault response services, generally including medical care, community-based sexual assault support, and the criminal legal system.[47] This investment will build on the successes of BC's current coordinated sexual assault services, such as Sexual Assault Response Teams (SARTs) and Sexual Assault Coordination (SAC) Initiatives,[51] and contribute to establishing integrated models of care in more communities throughout the province, where multiple sexual assault services can be accessed at a single location.[52, 53]

3b. Establish a sexual assault systems navigator position in each health authority

Navigating sexual assault services is often not straightforward and can be particularly challenging for people who are dealing with the impacts of trauma from sexual assault. Establishing a full-time Sexual Assault Systems Navigator position in each health authority would further facilitate connections between health and anti-violence services. Community-based anti-violence services are an important resource for the healthcare sector, supporting the provision of trauma-informed sexual assault care centred on survivors' self-identified needs. Anti-violence workers can support people who have been sexually assaulted as they navigate healthcare systems, often including accompaniment services (e.g., to a hospital).

A Sexual Assault Systems Navigator, whether within the health system or community-based, will hold vital cross-sector knowledge and relationships within their health authority, supporting access to seamless sexual assault care across services; ultimately, the integration of Sexual Assault Systems Navigators will create a more trauma-informed healthcare system within which patients can disclose and access sexual assault care.

4 Build Public Awareness of Sexual Assault and Available Services

4a. Develop a centralized provincial resource hub for sexual assault services

Plain language information about sexual assault support and care must be readily accessible to both healthcare providers and people who have been sexually assaulted. A comprehensive provincial resource hub for sexual assault services would increase access to sexual assault care by providing information and resources for both healthcare providers and people who have been sexually assaulted. The hub must meet accessibility standards and information should be available in multiple languages.

The Ontario Network of Sexual Assault/Domestic Violence Treatment Centres[72] has demonstrated how such a hub can effectively provide information for both those seeking care and those providing care. A similar information hub in Alberta offers an accessible and straightforward guide to services for "medical care and emotional support after sexual assault."[73]

A provincial resource hub for sexual assault services in BC would provide people who have been sexually assaulted with information on:

- **What sexual assault is,** including the social context of gender-based violence,
- **Provincial resources** for people who have been sexually assaulted and those supporting them,
- **Virtual sexual assault services available,** including crisis lines and web-based resources,
- **Sexual assault services in their local community,** where such dedicated services exist, including details about
    - **How they can access these services,**
    - **Their options while accessing services** (e.g., health care without forensic exam, what evidence is collected, accompaniment from a support person, forensic exam without police report),

- **Potential barriers to accessing care** (e.g., absence of some services, inability to store forensic samples, accessibility considerations), and
- **What to expect in accessing sexual assault services,** including any potential barriers to access (e.g., accessibility of building, government identification requirement, gender-specific services)

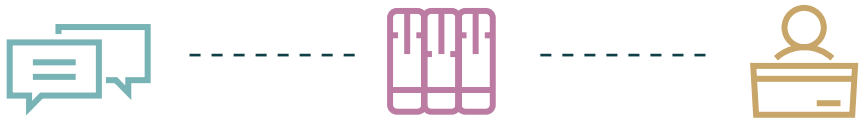
- **How people in communities without dedicated sexual assault services can access services,** both virtually and in-person, and
- **Specialized supports available** to increase accessibility for those seeking care (e.g., language interpreters, visual interpreters, Elders, anti-violence advocates, system navigators).

To support access to care, this resource must be developed with consideration of the needs of people trying to seek care while dealing with sexual assault trauma and health impacts.

Healthcare workers should have access to information on:

- **The issue of sexual assault,** including health impacts,
- **Resources to guide trauma-informed, culturally safe, and survivor-centred** sexual assault care, and
- **Training and other professional development opportunities** to build capacity for sexual assault response.

This resource hub must be reviewed and maintained on an ongoing basis to ensure it remains accurate and up-to-date.



4b. Build public awareness of sexual assault and available services

There is a clear need for increased public awareness about both the issue of sexual assault and the breadth of options in sexual assault services.

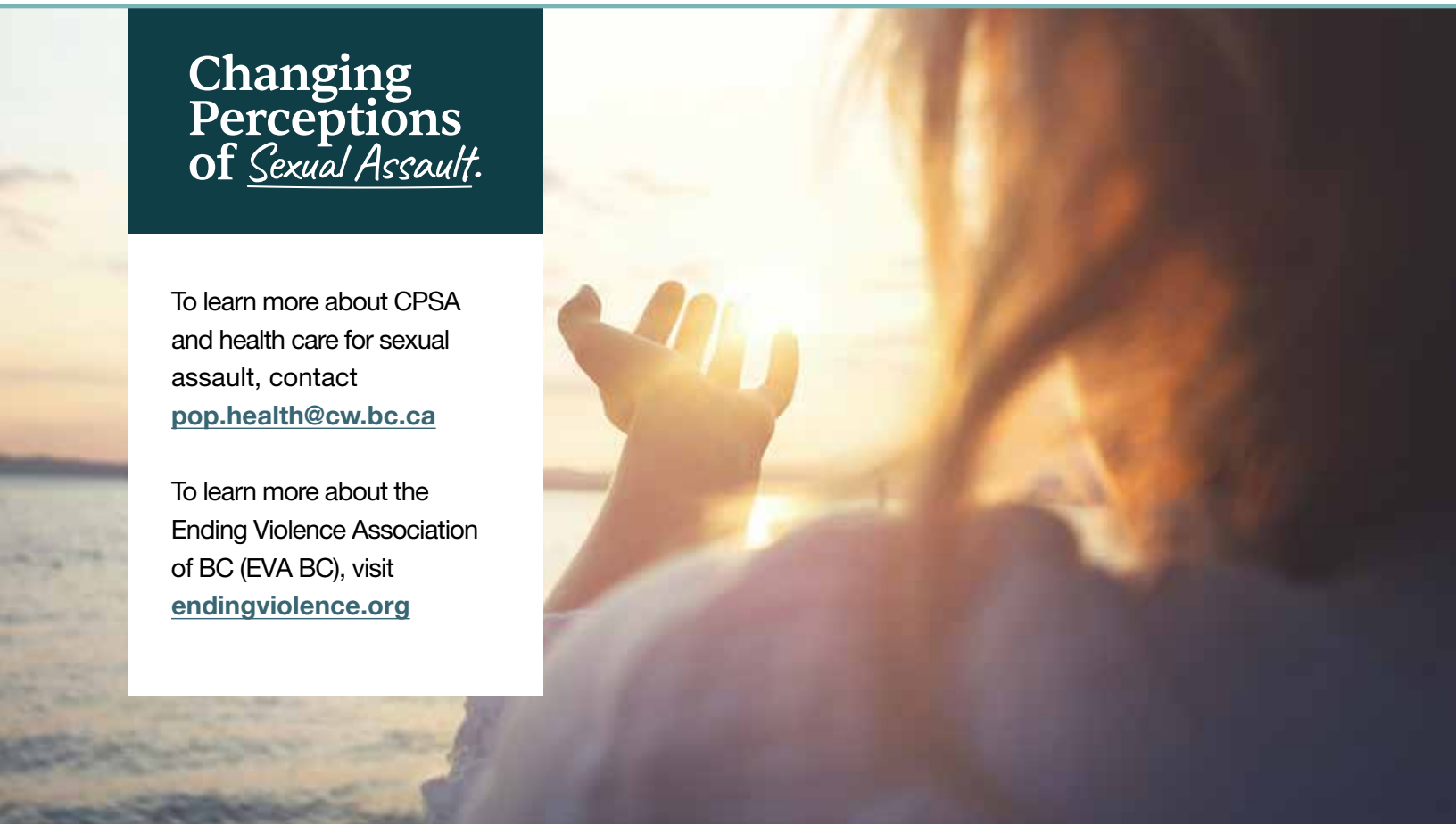
There is significant public awareness about the option of reporting sexual assault to police. However, it is particularly important to increase public knowledge of additional options for support and the need for, and availability of, health care and anti-violence services after a sexual assault. There is also a need to clarify the relationship between criminal legal system responses, healthcare services, and anti-violence supports; clarification is especially needed where health care may be perceived as overlapping with, or in service of, the criminal legal system (e.g., collection of evidence through a sexual assault forensic exam).

There are numerous avenues through which public awareness can be enhanced, including public information campaigns (e.g., transit ads), increased information in various healthcare settings (e.g., walk-in clinics, physicians' offices, hospitals, dental offices, physiotherapy), increased signage for local sexual assault services, social media campaigns, and takeaway resources (e.g., pamphlets).

Conclusion

Sexual assault is a serious human rights violation and an *urgent public health issue.*

The Changing Perceptions of Sexual Assault research project documented the challenges and opportunities to improve the healthcare response to sexual assault in BC through coordination with other sectors, training of healthcare workers, eliminating bias and systemic discrimination, and supporting trauma-informed practice. While much work is underway to improve sexual assault response in BC, it is long overdue. More action is needed to recognize sexual assault as a public health priority and ensure people who have been sexually assaulted have a broad range of supports in place to provide them with meaningful options.



Changing Perceptions of *Sexual Assault.*

To learn more about CPSA and health care for sexual assault, contact pop.health@cw.bc.ca

To learn more about the Ending Violence Association of BC (EVA BC), visit endingviolence.org

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