



HEALTHCARE RESPONSE
TO
SEXUAL VIOLENCE:
IMPLEMENTATION GUIDE

Healthcare Response to Sexual Violence

Implementation Guide

Developed by the YWCA of Greater Harrisburg of Dauphin and Perry
Counties, Pennsylvania

Produced by the Pennsylvania Coalition Against Rape

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The Project

Project Background

Research shows that adverse childhood experiences, including sexual violence, can follow individuals over the course of their lives, manifesting themselves in a wide range of adulthood struggles (Felitti & Anda, 2006). Such struggles can include obesity, substance abuse, depression, sexually transmitted diseases, pulmonary disease, hepatitis, heart disease, diabetes, teen pregnancy, mental health issues, eating disorders, suicidal propensity, interrupted education and employment, difficulties in interpersonal relationships, and others (Felitti & Anda, 2006). Unfortunately, any victim/survivor of sexual violence may experience these long-term effects—whether their victimization occurred 20 years ago or yesterday, whether it occurred when they were children, teenagers, adults, or seniors.

While research shows that sexual violence can be the root of many health complications and diseases, many victims/survivors of sexual violence revolve in and out of healthcare settings for years without ever being asked about their victimization. Concerned with bridging this gap, in 2005, the YWCA of Greater Harrisburg (YWCAGH) applied for and received special initiative funding through the Pennsylvania Coalition Against Rape (PCAR) to develop a tool to train healthcare providers in screening for and responding to sexual violence. This special initiative project culminated in the enclosed PowerPoint presentation titled, *Healthcare Response to Sexual Violence*.

Project Goal

Victims/survivors of sexual violence will have greater access to healthcare and rape crisis services as a result of systematic and routine screening and referrals by providers in healthcare settings.

Project Activities and Outcomes

The following activities are offered as suggestions to aid rape crisis centers in their sexual violence screening and training efforts. While this project's focus was limited to training, advocates may achieve greater success if they devote their efforts to all of the activities. The activities do not have to occur sequentially. For example, trainings can presume before the task force is formed. However, the

establishment of a task force of individuals invested in the issue of sexual violence may make the trainings more feasible and effective. Much of this work may be ongoing and unfold over multiple years.

Activity One: Build Coalition or task force on sexual violence within the healthcare setting and/or community.

Activity One Outcomes:

Initial	Task force will gain awareness and knowledge about sexual violence, impact on victims, and need for response.
Intermediate	Task force will generate support throughout healthcare setting for implementing, training, and evaluating sexual violence screening methods.
Longer-term	Task force will foster an environment sensitive to the needs of victims/survivors in healthcare setting.

Activity Two: Create and obtain approval for screening method in healthcare setting.

Activity Two Outcomes:

Initial	Administrators and leaders responsible for review and approval of screening method will increase their awareness, knowledge, and sensitivity to sexual violence, the needs of victims, and proper institutional response.
Intermediate	Healthcare providers will implement screening into their daily practice with victims/survivors.
Longer-term	Victims/survivors of sexual violence will be connected to appropriate healthcare and rape crisis services, which will support their healing process.

Activity Three: Train healthcare providers on sexual violence and screening/response method.

Activity Three Outcomes:

Initial	Participants of trainings will increase their awareness, knowledge, and skills regarding sexual violence, the needs of victims, and screening/response.
Intermediate	Participants will screen patients for sexual violence and refer them to the appropriate healthcare and rape crisis services.
Longer-term	Victims/survivors of sexual violence will be connected to appropriate healthcare and rape crisis services, which will support their healing process.

The Audience

Audience

This training tool was developed for rape crisis centers—and more specifically, medical advocates—to use when training healthcare providers in their communities. Ideally, all medical personnel that come in contact with victims/survivors should be trained. This may include but is not limited to nurses, physicians, physician assistants, medical assistants, nurses' aides, admissions/intake coordinators, medical students, residents, nursing students, paramedics, emergency medical technicians, social workers, psychologists, and other counselors.

The Trainings

Possible Training Settings

Below is a list of possible settings in which rape crisis advocates may consider delivering *Healthcare Response to Sexual Violence* trainings.

- Local hospitals
- Medical, nursing, and allied health schools
- Private practices
- Community health clinics

Ideally, entire health facilities will be trained in sexual violence but when time and resources are limited, it might help to prioritize those areas or departments where the most impact is possible. Therefore, it might make sense to start with the following departments/areas:

- Emergency
- Women's health/OB-GYN
- Psychiatry
- Pediatrics
- Internal Medicine
- Family Medicine
- Gerontology

Who to Contact

When contacting a hospital, medical school, health clinic, or private practice for the first time, it might be helpful to begin with the social work or counseling department. Social workers/counselors often coordinate trainings on topics that fall outside of the realm of traditional medicine. They may already be invested in preventing and addressing sexual violence in the medical setting and can be important allies in getting your message to other departments.

Scheduling Trainings and Recruiting Participants

The following are some tips to consider when scheduling trainings and recruiting participants:

- ***Build relationships.*** The importance of building relationships with healthcare providers cannot be overstated. Cultivating relationships with key contacts in the facility—such as administrators, social workers, counselors, head nurses and physicians, and other healthcare providers invested in the issue—will not only open doors for advocates to provide trainings; these relationships will also ensure that the healthcare facility's policies, protocols, and screening methods are victim- or survivor-centered. Utilize the connections center board members may have with medical providers. Also work with your local medical society in your training and advocacy efforts.
- ***Schedule trainings through the facility's education teams.*** If the facility has education teams for specific departments and/or professionals, you may need to schedule your trainings through them. Cultivating a relationship with

members of these teams is crucial, as they may be the "gatekeepers" of the staff development process.

- ***Go to the participants if they cannot come to you.*** Healthcare providers are under considerable time constraints, especially in emergency departments or urgent care settings. Ideally, this PowerPoint would be delivered in a conference or training room for two to three hours without interruption. However, this is not always possible. The best you can do might be an ad hoc training with eight or nine providers huddled around a laptop in an empty exam room. Participants may have to leave to care for a patient. Interruptions may be frequent. Under these conditions, the hope is that at the very least, healthcare providers receive enough information about sexual violence and the available resources to continue their own research into the issue and reach out to local rape crisis centers when patients are in need. It is important that trainings are available to all shift workers.
- ***Feed participants when possible.*** If possible, presenters may wish to provide refreshments to participants, even if it is just light fare. This may encourage attendance especially for those providers who may have to choose between attending your training or running out for breakfast, lunch, or dinner.
- ***Give participants free, promotional materials.*** Distribute your agency's promotional materials, such as pens, cups, mugs, notepads, T-shirts, stickers, and other items. Not only do participants enjoy receiving these items; it helps publicize your agency's name and contact information throughout the healthcare setting and community.
- ***Offer continuing education credits to participants.*** You may be able to offer participants credit(s) for attending your training. Nurses, physicians, counselors, and other healthcare professionals are required to obtain a minimum number of continuing education hours/credits every year. The healthcare facility's education teams may be able to assist with this process. The Pennsylvania Department of State, Bureau of Professional and Occupational Affairs may also be a helpful resource (<http://www.dos.state.pa.us/bpoa/site/default.asp> or 717-787-8503). PCAR is also available for technical assistance on this matter (1-800-692-7445).

The Screening Tool

Screening Questions

This project promotes the SAVE screening method, developed by the Florida Council Against Sexual Violence (Florida Council Against Sexual Violence, 2002).

Adapted with permission from the Florida Council Against Sexual Violence

Screen all of your patients for sexual violence.

Anyone could be a victim of sexual violence.

- Ask the patient when no one else is in the examining room.
- Make direct eye contact and actively listen to the response.

Ask direct questions in a non-judgmental way.

Avoid technical or medical language. Begin by first normalizing the topic. For example:

- "I need to ask you some personal questions. Let me explain why. Asking these questions can help me care for you better."
- "Since I am your doctor, we need to have a good partnership. I can better understand your health if you would answer some questions about your sexual history."
- "I ask all of my patients these questions because it is important for me to know what has gone on in their lives."

Next ask the patient directly:

- "Have you ever been touched sexually against your will or without your consent?"
- "Have you ever been forced or pressured to have sex?"
- "Do you feel that you have control over your sexual relationships and will be listened to if you say "no" to having sex?"

Validate your patient's response.

- "Thank you for telling me about such a difficult experience."
- "I'm sure that was hard for you to tell me. It is good that you told me."

- "Rape is devastating in many ways. Let's talk about some of the ways you need support."

Be sure to document the response in your chart using the patient's own words.

Evaluate, Educate and make Referrals.

If your patient says "yes,"

- Immediately evaluate present-day level of danger, other violence, drug and alcohol use and health habits. Mention the disclosure again during another visit and ask about the patient's needs.
- Request a one to two-week follow-up appointment if necessary.

If your patient says "no,"

- offer education and prevention information and provide follow-up at next visit.

If your patient is "not sure,"

- evaluate the experience(s) with the patient and provide education about violence and consent.

Offer all patients the local rape crisis center information.

Implementing the Screening Tool

Implementing Sexual Violence Screening Policies and Protocols in a Healthcare Setting

While the need to screen patients for sexual violence may seem overwhelmingly clear to rape crisis advocates and healthcare providers, systemic barriers may obstruct the swift implementation of new policies and protocols in some settings. For instance, in a large hospital, it may take several years to establish a task force, generate support, construct the screening questions, develop the protocols, obtain approval from each department, train providers on implementation, and evaluate the process. Whether advocating in a large hospital or a small, private practice, it is important to understand and address the facility's barriers and resources. It is

also paramount to remember that change is possible, even if it is achieved incrementally.

While each healthcare setting will have its own unique set of circumstances, below is list of possible barriers and corresponding strategies to consider when advocating for sexual violence screening.

Barrier: *Lack of investment in the issue of sexual violence from the top down and bottom up.*

Strategy: Build a task force on violence and invite key stakeholders from the healthcare setting and community to the table. Possible members may include healthcare administrators, healthcare providers (such as doctors, nurses, social workers, and others invested in or pivotal to the issue), faculty from the medical school if relevant/appropriate, rape crisis advocates, police officers, prosecutors, and allied professionals from the community.

Educate fellow task force members about sexual violence; prevalence; short- and long-term biopsychosocial and economic effects on victims/survivors, significant others, and communities; the immediate and long-term needs of victims; models of collaboration; and community resources. A useful tool might be *The ACE Study*, a two-video series linking adverse childhood experiences with adult health implications, available through the PCAR library (www.pcar.org or 1-800-692-7445). Provide model policies and practices upon which task force members can build their own policies and protocols concerning sexual violence screening. Invite task force members to co-facilitate discussions and trainings throughout the healthcare setting on issues of sexual violence.

Training frontline healthcare providers may also help to create institutional change and build support around screening for sexual violence. The hope is that the trainings cause participants to think differently about screening and bring new information back to their floors/practices, where they can discuss these issues with other healthcare providers, thereby creating a ripple effect of change.

Barrier: *Complex and time-intensive approval process for screening questions.*

Strategy: Research the process used by the healthcare facility in reviewing, approving, and implementing screening questions. Invite key stakeholders in this

process—such as administrators, head physicians and nurses, and others—to participate in the abovementioned task force on violence to generate their investment in the issue. Be patient and persistent. Find a champion of sexual violence issues among the medical, nursing, and other staff.

Barrier: *Fear among healthcare providers of opening "Pandora's box" with patients and not knowing how to respond.*

Strategy: Provide *Healthcare Response to Sexual Violence* and other trainings to healthcare providers to increase their comfort level in asking about and responding to sexual violence with patients. Some healthcare providers may feel like they should only ask patients about "conditions" they can "fix" or "treat." Because they may feel like sexual violence cannot be addressed through traditional medical means, they may be reluctant to open "Pandora's box."

Defining the role of the healthcare provider and rape crisis advocate may allay these fears. Underscore the importance of asking patients not only about sexual violence but other adverse childhood experiences (Felitti & Anda, 2006). Explain that the healthcare provider does not need to become a counselor or social worker; other professionals are available to fulfill those roles within the medical facility and in the community. Emphasize that the rape crisis advocate is available to respond to the emotional and advocacy needs of victims within the healthcare setting and community.

Build relationships with healthcare providers outside of the training environment, serving as an ongoing resource to them. PCAR is available for technical assistance, to support you in these efforts.

Barrier: *Lack of privacy in some healthcare settings.*

Strategy: It is critical that screening occur in a safe, private, comfortable space without a third party present. Sometimes this is easier said than done, especially in busy emergency departments where a patient may only have a curtain between him and other patients and where healthcare providers, counselors, patients and their families and friends, police, paramedics, and others are constantly buzzing about. Screening should not occur in front of children older than two years. Medical advocates can work with healthcare providers in identifying suitable locations in

the facility and opportunities for screening. It is important that the questions are asked but it is equally important that they are asked in the right way.

Barrier: *Screening policies, protocols, and questions are victim blaming.*

Strategy: Medical advocates can provide healthcare administrators and task forces with model policies, protocols, and questions to ensure they are victim-centered. Examples of victim-centered policies and protocols are those that prioritize the patient's dignity, privacy/confidentiality, self-determination, rights, needs and requests. Victim-centered screening questions are those that are free of medical jargon, judgment, or victim-blaming language. The Florida Council Against Sexual Violence's *SAVE Method* is one model to be considered (Florida Council Against Sexual Violence, 2002).

Barrier: *Disconnect between policy and implementation.*

Strategy: Medical advocates can provide ongoing training and technical assistance to healthcare providers to ensure screening is occurring as intended and victims are being connected to services. It is important to periodically check in with providers and administrators to ensure effective policy implementation. Evaluation can also help shed light on the factors influencing implementation (see Evaluation section for more information).

The PowerPoint

Training Objectives

At the end of the PowerPoint presentation, participants of *Healthcare Response to Sexual Violence* will be able to:

1. Define sexual violence and its prevalence;
2. Describe the healthcare impact of sexual violence on victims/survivors;
3. Recognize the unique healthcare impact of sexual violence on special populations;
4. Identify three barriers that prevent victims/survivors from disclosing in a healthcare setting;
5. Identify three barriers that prevent healthcare providers from screening;
6. Describe the four steps of the SAVE Method of sexual violence screening
7. Apply the four steps of the SAVE Method of sexual violence screening

Content

This PowerPoint is largely informed by *Put Down the Chart, Pick up the Questions: A Guide to Working with Survivors of Sexual Violence*, a guide that walks healthcare providers through the process of screening patients for sexual violence and responding to their needs (PCAR, 2006). This guide is an essential accompaniment to the PowerPoint and should be distributed to all participants, if possible. To order free copies, contact PCAR at 1-800-692-7445.

The PowerPoint's contents include the following:

- Goal and Objectives
- Definition of sexual violence
 - Continuum
 - Myths & Facts
 - Prevalence of sexual violence
- Special Populations
 - Pregnant and gynecological patients
 - Male patients
 - Patients with disabilities
 - Adolescent patients
 - Pediatric patients
 - Elderly patients
- Impact on victims, including video clips of victims telling their stories
- Barriers to disclosing and screening
- The SAVE Method of screening
- Documentation
- Resources

This training can be adapted and condensed according to the audience, time restraints, available resources, and other parameters. For instance, if the audience is strictly comprised of pediatric providers, the presenter may wish to skip the other special populations sections and hone in on the needs of pediatric patients and mandated reporting.

If time allows, the presenter may wish to incorporate interactive exercises during the training. Some potential opportunities for audience interaction may include the following.

- **Myths & Facts:** Assign small groups to identify three myths they have heard about sexual violence, victims, or perpetrators. Ask each small group to share their myths with the larger group and discuss the facts.
- **Barriers to Disclosing and Screening:** Assign small groups to identify three barriers to disclosure that victims/survivors might experience and three barriers that may prevent healthcare providers from screening for sexual violence. Ask each small group to "teach-back" to the larger group and discuss.
- **SAVE Method:** After reviewing each component of the SAVE Method of screening, ask each participant to find a partner for a role play exercise. Give each duo a patient-provider scenario.

One example might be: You are a family doctor in a private practice. A female patient you have been seeing for several years tells you she is not sure why, but she has been having trouble sleeping lately. She's been having nightmares and just feels so tired during the day. She has been taking care of her aging father, which has brought up a lot of childhood memories. What questions do you need to ask her?

Each partner should have a chance to play both the patient and the provider. This will give all participants the opportunity to role play and practice the SAVE Method.

Accompanying Materials

Because presenters may have limited time with participants, it is important to supply them with reading materials they can take to read and reference as needed. Such materials may include but are not limited to the following:

- Copy of PowerPoint slides
- Your agency's brochure of services and contact information
- Your business card and/or contact information
- Brochure on Pennsylvania's Victim Compensation and Assistance Program, available through the Pennsylvania Coalition Against Rape or the Pennsylvania Commission on Crime and Delinquency

- Brochures on sexual violence, available through the Pennsylvania Coalition Against Rape
- *Put down the Chart, Pick up the Questions: A Guide to Working with Survivors of Sexual Violence*, available through the Pennsylvania Coalition Against Rape
- *A Guide for Friends & Family of Sexual Violence Survivors*, available through the Pennsylvania Coalition Against Rape
- *Emergency Contraception: A Guide about Sexual Assault*, available through the Pennsylvania Coalition Against Rape
- *Sexual Violence: A Guide for Healthcare Providers*, available through the Pennsylvania Coalition Against Rape
- *How to screen your patients for sexual assault: A guide for health care professionals*, the Florida Council Against Sexual Violence

It is important to provide healthcare providers with materials in the languages of the patients they commonly see. Many of PCAR's print materials are available in multiple languages. For more information, contact PCAR at 1-800-692-7445.

Evaluation

Process Evaluation

Process evaluations can help to track the success or barriers of policies, protocols, and implementation. Such an evaluation might include partnering with healthcare providers in systemically reviewing patient charts to determine a.) if screening occurred; b.) how it occurred, i.e., what questions were asked; and c.) what responses ensued if the patient answered "yes," "no," or "unsure." Advocates would want to see that patients who answered "yes" were referred to the rape crisis advocate and patients who answered "no" or "unsure" were still given a minimum of education and information about sexual violence and services.

Another component of the evaluation might include a needs assessment or survey of healthcare providers to determine what barriers, if any, might obstruct the screening and referral process. The Pennsylvania Coalition Against Rape can provide technical assistance to medical advocates on developing and implementing evaluations (1-800-692-7445).

Summative/Outcome Evaluation through Pre- and Post-test

The following test should be conducted with all participants before and after the training. Answers are provided for presenters at the end. Advocates may find it necessary to shorten this test. If that is the case, the following question numbers are recommended to keep in the shortened version: 1, 2, 3, 4, 5, 10, 11, 13, 14, 15, 16, and 17. Testing at pre- and post-program enables rape crisis centers to determine if their program achieved intended outcomes and met stated objectives. Showing outcomes not only ensures that the rape crisis center is making a positive impact; outcomes also help build credibility with funders and clients, opening doors to new programs, relationships, and trainings.

Pre- and Post-test

1. How do you define sexual violence?
2. One in four girls and one in six boys will be sexually assaulted by the age of 18.
True or False
3. Most sexual assaults are perpetrated by a stranger.
True or False
4. Victims of sexual violence provoke the attack by inappropriate dress and/or behavior.
True or False
5. What are three chronic health issues that are related to sexual violence?
6. Pregnant women are at increased risk for sexual and physical violence by their partners.
True or False
7. Male victims of sexual violence have access to the same services as female victims.
True or False
8. People with disabilities are four to ten times more likely to be sexually assaulted than people without disabilities.
True or False
9. Adolescents are least likely to be victimized sexually.
True or False
10. Children are most often victimized by strangers outside of the home/family.
True or False
11. Ideally, the forensic exam should be conducted within (circle one answer):
5 days of the assault
3 days of the assault
6 days of the assault
two weeks of the assault
12. A victim/survivor of sexual violence MUST report the incident to law enforcement.
True or False
13. What are three reasons why a victim/survivor might not disclose to a healthcare provider?

14. What are three reasons why a healthcare provider might not screen for sexual violence?

15. I do not screen for sexual violence because (finish the sentence):

16. If I saw a victim/survivor of sexual violence in my practice tomorrow, I would know how to screen and respond.

Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

17. The role of the rape crisis advocate from the local center is to (finish the sentence):

Answers to Pre- and Post-test

1. Sexual violence is any sexual contact forced upon a person without his or her consent.
2. True
3. False
4. False
5. Any of the following: smoking, alcoholism, substance abuse, obesity, depression, sexually transmitted diseases, pulmonary disease, hepatitis, heart disease, diabetes, suicide, teen pregnancy, and others.
6. True
7. False
8. True
9. False
10. False
11. 3 days of the assault
12. False
13. Any of the following: fear, shame, self-blame, lack of safety, taboo, social stigma, pressure from family/friends, lack of appropriate services, denial, trauma, lack of memory/dissociation, victim-blaming responses in the past, not ready, etc.
14. Any of the following: fear; lack of education, awareness, and skills; fear of opening “Pandora’s Box;” afraid of offending the patient; lack of time; biases and attitudes; personal victimization; lack of policies and protocols; sexual violence is a “non-medical” issue; etc.
15. No “right” or “wrong”
16. No “right” or “wrong”
17. The role of the rape crisis advocate is to provide the victim/survivor with emotional support or counseling during crisis and short-term; crisis intervention; accompaniment to the forensic rape exam, police interviews, court, public assistance offices, and other systems; and systems advocacy.

References

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