Health professional's perceptions of sexual assault management: A Delphi Study

Dr Jonine Jancey (BSc hons, PhD)*
Research Fellow
Curtin University
j.jancey@curtin.edu.au

Associate Professor Lynn Meuleners (BA, MSc, PhD)
Curtin University
l.meuleners@curtin.edu.au

Dr Maureen Phillips (MB BS, Grad Dip Forens Med, MACLM)
Centre for Population Health Research, Curtin Health Innovation Research Institute, Curtin University, Western Australia
Maureen.Phillips@health.wa.gov.au

***corresponding author**

Abstract

Objective: To explore health professionals' perceptions of sexual assault management practices and identify issues related to these practices across Western Australia (WA).

Design: A two round electronic Delphi Study was undertaken with health professionals (medical doctors, registered nurses, social workers and managers).

Setting: Healthcare settings (emergency departments and community health centres) located in metropolitan Perth and rural WA.

Methods: Twenty-seven participants were recruited via a snowball sampling methodology. The first round questionnaire asked about perceptions of sexual assault management practices in WA and how to improve them. The round two questionnaire asked panellists their agreement to the identified issues and to prioritise solutions to the problems.

Results: Fourteen issues were identified of which three issues gained 100% agreement: limited services/resources in regional areas of WA; a shortage of culturally appropriate services; and the treatment of victims/survivors of sexual assault within the legal system. The main solutions included: a detailed manual providing clear guidelines; a flow chart detailing forensic data collection; improved services to support sexual assault cases; and a multi-sectorial management approach to sexual assault.

Conclusions: There is a need for a comprehensive management approach to sexual assault which include clear prescriptive guidelines; workforce training and development; equitable access to services; and community education. Sexual assault is a serious public health issue. The adoption of a multilevel approach will support change and improve health outcomes for this group.

Key words: sexual assault; public health; health care delivery; health promotion

Word count (2449)

Introduction

Sexual assault is a significant public health issue impacting on the community, the utilisation of health facilities, and the person who is assaulted. In all societies, women and girls are subject to sexual abuse that crosses income, class and culture.[1] In Australia, it is estimated that 1.3 million women (17%) have experienced an incident of sexual violence at some stage from the age of 15 years,[2] while 60% of victims report having experienced more than one incident.[3]

There are some groups who are more vulnerable to sexual assault. These include young people, women, and Indigenous Australian; though sexual assault is not limited to these groups.[4] For victims the consequences of sexual assault can be short and/or long-term. The immediate impact may be sexually transmitted disease or an unwanted pregnancy.[5] The emotional consequences include shame, disturbed sleep, shock, depression, anxiety, poor physical health,[6] self harm and suicidal ideation.[7] Sexual assault can affect friendships, family and intimate relationships, with victims or sexual assault being over represented among dependent drug and alcohol users.[8]

Women are more likely to make their first disclosure about an assault to a friend or family member, however, many women tell no one.[9] These reasons include shame, embarrassment; fear of not being believed, fear of the perpetrator or stigma, fear of a physical examination,[1, 5] as well as the limited availability of services.[6] Negative experiences with health service providers can exacerbate existing physical and psychological distress and delay recovery [10] as well as impact on legal outcomes.

The health care system needs to be able to recognise and respond appropriately to these women.[7] There is a need for comprehensive sexual health services that include the development of national resources and guidelines for the better management of sexual assault; workforce development and training; culturally appropriate services [5] and

intervention programs by government and a range of organisation at a local, national and international level.[1, 11]

Past research indicates that high quality sexual assault services can minimise physical and psychological harm experienced by victims/survivors of sexual assault.[10] However, little research both in Australia and internationally has been conducted on current services, even though it has been identified as a high priority area.[12] This Delphi study aims to explore health professionals' perceptions of sexual assault and to identify issues in the management of sexual assault across regional and metropolitan Western Australia (WA).

Methods

The Delphi method is a structured process for collecting information and establishing consensus from experts via a series of questionnaires. It is particularly helpful in gathering information from geographically diverse groups and avoiding barriers experienced in more traditional group discussions by promoting free expression of opinion. The recommended sample size of between 10 and 50 participants [13] is based on the discretion of the researcher and not on statistical grounds.[14] Our Delphi study incorporated two rounds of questionnaires, as reported to be sufficiently effective to establish a broad consensus of opinion.[15-16] Ethics approval was obtained from the Human Research Ethics Committee of Curtin University.

Panel Selection

The selection criteria required that panel members be health professionals (medical doctors, nurses, social workers and counsellors) who manage/treat victims/survivors of sexual assault within a range of health organisations (EDs of Public Hospitals, Women Health Centres,

Sexual Assault Centres, Aboriginal Medical Services) throughout metropolitan and regional WA.

Procedure

The Delphi research team identified 32 community organisations and hospital emergency departments (EDs) managing sexual assault cases throughout WA. Research staff contacted each organisation explained the study's purpose and asked if they would be available to participate, or able to identify a suitable representative from their organisation (snowballing effect). After the initial phone contact, all identified participants were sent an email reiterating the purpose of the study, an explanation of the Delphi procedure and the first round questionnaire using an online survey tool. Three participants requested hard copies of the questionnaire as they had limited internet access. These questionnaires were mailed and were returned in self-addressed envelopes.

First round Delphi Questionnaire

The web based questionnaire was developed after an extensive literature review and in consultation with the expert research committee consisting of a sexual assault researcher, medical doctor and allied health professional. The questionnaire was pre-tested for face and content validity by experts in the field, which included sexual assault physicians, injury researchers and health educators.

The round one questionnaire was emailed and contained two sections. The first section elicited information on participant demographics (age, gender, occupation, place of employment, length of employment and location of employment) and the second section

invited participants to contribute an unlimited number of comments in response to ten open ended research questions about their perception of current sexual assault management practices and protocols. The researchers had no fixed hypothesis, aiming to explore the issue and generate rich data from the panel members. This approach enabled participants' relatively free scope to elaborate on the topic under investigation.[17]

Second Round Delphi Questionnaire

The second round questionnaire was emailed to participants four months after the first round questionnaire. It comprised two sections and was piloted for logical sequence and sensitivity prior to actual data collection. The first section was grouped under eight areas of interest: i) provision of services; ii) staffing issues; iii) presenting cases of sexual assault; iv) holistic management; v) Indigenous and culturally and linguistically diverse (CALD) groups; vi) community attitudes; vii) funding ;and viii) the legal system formed the basis for round two. Within each of these identified areas of interest were 14 identified issues with a list of solutions to address the issue. Panel members were asked to place their level of agreement or disagreement using a four-point likert scale (strongly agree, agree, disagree, strongly disagree). Panel members were then asked to prioritise solutions to these issues by using a ranking system, with '1' being the preferred option to address the issue.

Data Analysis

The qualitative responses to the first round questionnaire were read to establish a broader understanding of the participants' responses. Qualitative content analysis was conducted to break down the data into units of information. The data was coded according to its content and managed using NVivo8. The categorised data were organised around the eight areas of

interest, as described earlier and were used in the construction of the subsequent questionnaire.

Demographic data collected in the second round Delphi questionnaire were analysed using SPSS 17.0. The data were summarised to measure the relative agreement of the issues identified, along with the preferred solution for addressing the issue.

Results

Demographics

In total, 27 panel members completed the second round of the questionnaire, a response rate of 64% (42/27). The majority of participants were female (88.9%), aged 31-50 (56%) and Registered Nurses (41%). Participants were from the Perth Metropolitan area (52%) and regional Western Australia (48%) and 48% had been in their current position for less than 10 years. Panel member demographic data are contained in Table 1.

(Insert Table 1 about here)

Table 1: Panel member demographics (n=27).

Delphi Responses

The responses to the 14 identified issues in round two of the Delphi study are presented in Table 2. The table shows the issues and the percent of respondents who agreed with the statement. Three issues had 100% agreement by panel members. These were ‘limited services and resources for sexual assault management in regional areas of WA; ‘a shortage of

culturally appropriate services (CALD and Indigenous); and 'the treatment and management of victims/survivors of sexual assault within the legal system needs to be improved'. In response to each of the 14 issues raised, panel members indicated their preferred solutions to the issue by ranking in order of perceived importance, with some solutions being considered of equal importance (the first two solutions are included only). The main solutions were around more prescriptive guidelines for the treatment, management and specimen collection for the victim/survivor of sexual assault; improved and ongoing training to health professionals; improved services to support sexual assault victims/survivors; and an indication of a need for a multi-sectorial approach to manage this public health issue.

(Insert Table 2 about here)

Table 2: Second round delphi outcomes - issues and solutions (n=27).

Discussion

The Delphi Technique was an appropriate method to explore health professionals' perceptions of sexual assault management practices. The study generated eight areas of interest, highlighting the complexity of this unique public health issue. These results illustrate the range of factors that impact on the decision making and service provision by health professionals for the victim/survivor of sexual assault.

Provision of services/staffing issues

The delivery of standardised and high quality services to the sexually assaulted person is paramount to positive health outcomes. All panel members agreed that there were limited sexual assault services in regional WA, with the majority reporting broad variation in the delivery of services (85.2%) and draw attention to the acknowledged disparity in health care delivery between the city and country.[18] In response panel members supported the provision of a standardised document detailing procedures; a well promoted 24 hour staff support hotline; and increased funding for the management of sexual assault.

Almost all panel members (92.5%) indicated that staff are unclear about the procedure for collecting and storing forensic data. It is important that health professionals seek clear prescriptive guidelines and training as to how any potential forensic evidence should be collected, handled and stored and direction on correct documentation of the assault history and physical examination. This information is extremely important as it may provide scientific information that can objectively complement any criminal investigation process.[19]

'Staff burnout' can be experienced by staff working in this emotionally demanding area and can be associated with vicarious trauma.[20] Although there is minimal research around how it should be managed, there are a number of recommendations to help maintain the health of staff. These include 'self-care' strategies, effective staff supervision, access to debriefing, staff and peer support, a safe and comfortable work environment, and a workplace culture that acknowledges the trauma of working in this area.[21] Unfortunately, ED's in regional areas may not be able to provide these supports due to a transient workforce, inexperienced and inadequately trained staff and lack of funding.

The inadequate training of ED staff in conducting forensic, medical and psychological examinations is seen as a major issue (88.8%) and may also contribute to the reported lengthy waits in EDs (77.8%). The suggested solutions, such as installation of a triage tool to fast track sexual assault cases to specialist services and an opportunity for training in the area, would assist in addressing these issues. In situations where trained staff are not available then clear prescriptive guidelines would be of great benefit.

The Division of Clinical Forensic Medicine at the Victorian Institute of Forensic Medicine has responded to staff shortages and access to sexual assault services by establishing the Forensic Nurse Examiner course.[22] The course aims to equip these nurse practitioners with the knowledge and skills to undertake medical and forensic service; to record injuries accurately and objectively; and to gain an understanding of the criminal justice system, along with the importance of objective evidence. A similar scheme may be worth implementing in WA.

Presenting cases/holistic care

Health care providers are trained to diagnose and treat those who are ill and are also accustomed to people adhering to management and treatment.[23] However, this method of healthcare can be counterproductive when working with victims of sexual assault as it may be like the controlling behaviour of a perpetrator and may heighten the risk of secondary trauma.[10] The panel members reported a need for clear communication by medical staff around all procedures and a detailed step by step guide that considers the victims/survivors rights. Sexual assault victims are often fearful and anxious; a non-directive, compassionate and empowering response is suggested as the best approach to help commence the recovery process.[23]

The SANE program[24] was developed in the United States to address sexual assault management issues in EDs. The comprehensive program provides specially trained forensic nurses who are available 24-hours-a-day. They are the first-response to care for sexual assault victims, thereby increasing consistency of care, support and follow-up. The absence of follow-up for victims/survivors of sexual assault is another area of identified need (85.2%), with a follow-up phone system and long-term counselling seen as potential solutions The SANE program distinguishes itself from traditional ED responses by being responsive to the emotional needs of the assaulted person. A program such as this may offer a solution to many issues related to managing sexual assault cases.

Indigenous and Culturally and Linguistically Diverse Groups

All panel members reported a shortage of culturally appropriate responses and services for minority groups. Australia's population is culturally diverse, appropriate services need to be provided to minority groups,[5] many of whom are not even aware of sexual assault services.[3] With the higher proportion of Indigenous women experiencing sexual assault,[25] the training of Aboriginal Health Workers to deal with sexual assault cases, along with cultural awareness training for staff was also supported by the participating panel members.

Community education

Panel members were mindful of the impact of negative community attitudes around sexual assault and documented the need for change. Almost all panel members (96.3%) believed that a well publicised telephone hotline for victims, family members and perpetrators was required along with educative social marketing campaigns. Social marketing is designed to change community attitudes, shift social norms with the long term aim of changing behaviour so that health endangering behaviours are reduced. This has been seen in smoking cessation,

and to a lesser extent campaigns directed at violence against women.[26] However, community education will not work alone, and legislation is recognised as being important.

Legal system

All panel members reported a need to improve the management of sexual assault victim/survivor within the legal system, acknowledging the role of specialist courts to reduce the waiting period so that the victim/survivor can move on. They also expressed support for an improved system for educating courts on sexual assault. This may indicate the need for closer interagency collaboration so that optimal outcomes for the sexual assault victim/survivor are achieved. Research has shown that multiagency collaboration can decrease the severity of negative consequences while improving both criminal justice elements and the victim health outcomes.[27]

Limitations

The purposive sampling of this approach and subject burden may have contributed to loss to follow-up and subject bias, making it unfeasible to make inferences at a population level.

Conclusion

The results of this study illustrate a need for a comprehensive management approach to sexual assault. Many of the issues raised were concerned with the acute management of victims/survivors of sexual assault, yet there was also acknowledgement of sexual assault as a complex multi-dimensional problem involving criminal justice, forensic, health and psychosocial services, requiring a comprehensive, expert, standardised and sensitive management approach.

Acknowledgements

The authors would like to acknowledge the staff at the Centre for Population Health Research, Curtin University.

References

1. United Nations. The world's women 2005: Progress in statistics. New York: United Nations, Department of Economic and Social Affairs, Statistic Division 2006.
2. Australian Bureau of Statistics. Personal safety survey. Canberra 2006 Contract No.: cat. no. 4128.0.
3. Neame A, Heenan M. What lies behind the hidden figure of sexual assault? Melbourne: Australian Insitute of Family Studies 2003.
4. Davies M. Male sexual assault victims: a selective review of literature and implications for support services. *Aggression and Violent Behaviour* 2002;**7**: 203-14.
5. Nesvold H, Friis S, Ormstad K. Sexual assault centers: Attendance rates and differences between early and late presenting cases. Acta Obstet Gynecol. 2008;**87**:707-15.
6. Vos T, Astbury J, Piers LS, Magnus, et al. Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. Bulletin of the World Health Organization. 2006;**84**(9):739-44.
7. Masho S, Odor R, Adera T. Sexual assault in virginia: A population based study. Women's Health Issues. 2005;**15**:157-66.
8. Cook B, David F, Grant A. Sexual violence in Australia. Canberra: Australian Institute of Criminology 2001.
9. McLennan W. Women's safety Australia. Canberra: Australian Bureau of Statistics1996 Contract No.: Cat. no. 4128.0.
10. Astbury J. Services for victims/survivors of sexual assault: Identifying needs, interventions and provision of services in Australia. Australian Institute of Family Studies. 2006;December(6):1-17.
11. Office of the Status of Women. National framework for sexual assault prevention

Barton, ACT: Department of the Primeminister and Cabinet 2004.

12. Australian Bureau of Statistics. Sexual assault in Australia: A statistical overview. Canberra 2004 Contract No.: Cat. no. 4523.0.
13. Whitman N. The committee meeting alternative:Using the delphi technique. JONA. 1990;**20**(7/8):30-6.
14. Duffield C. The Delphi technique. Aust J Adv Nurs 1988;**6**:41-5.
15. Adler M, Ziglio E . Gazing into the oracle: The delphi method and its application to social policy and public health. London: Jessica Kingsley Publishers; 1996.
16. Stonks K, Strijbis A, Wendte J, Gunning-Schepers L. Who should decide? Qualitaitive analysis of panel data from public patients, healthcare professionals and insureres fo priorities of health care. BMJ. 1997;**315**:92-6.
17. Powell C. The delphi technique: Myths and realities. J Adv Nurs. 2003;**41**(4):376-82.
18. Neame A, Heenan M. Responding to sexual assault in rural communities: Briefing. Australian Centre for the Study of Sexual Assault. 2004;3(June):1-23.
19. Hourmes B, Fagan M, Quintana M. Violence: Recognition, management and prevention. J of Emerg Med. 2003;**25**(1):111-21.
20. Baird S, Jenkins S. Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. Violence and victims. 2003;**18**(1):71-86.
21. Morrison Z. 'Feeling heavy':vicarious trauma and other issues facing those who work in the assault field. ACSSA Newsletter. 2007;**4**(September):1-12.
22. Annual Report 2007 - 08. Southbank: Victoria: Victorian Institute of Forensic Medicine 2006.
23. Feldhaus K. A 21st-century challenge: improving the care of the sexual assault victim. Ann Emerg Med. 2002;**39**:653-5.

24. Campbell R, Townsend S, Long R, Kinnison K. et al. Responding to sexual assault victims' medical and emotional needs: A national study of the services provided by SANE program. Res Nurs Health. 2006;**29**:384-98.

25. Avegno J, Mills T. Sexual assault victims in the emergencey department: analysis by demographic and event characteristics. J Emerg Med. 2008;**37**(3):328-34.

26. Egger G, Spark R, Donovon R. Health promotion strategies and methods. 2nd ed. Sydney: McGraw Hill; 2005.

27. Robinson A, Hudson K, Brookman F. Multi-agency work on sexual violence: Challenges and prospects identified from the implementation of a sexual assault referral centre (SARC). The Howard Journal. 2008;**47**(4):411- 28.

Table 1: Panel member demographics (n=27)

Demographics	**%**	**n**
Gender		
Female	88.9	24
Male	11.1	3
Age		
21-30	11	3
31-40	26	7
41-50	30	8
51 plus	33	9
Occupation		
Clinical/Registered Nurse	41	11
Medical Doctor	22	6
Managers-Health Agency	22	6
Counsellor/Social Worker	15	4
Locations		
Perth Metropolitan area	52	14
Regional Western Australia	48	13
Time current job		
< 1 year	30	8
< 5 years	22	6
< 10 years	48	13

Table 2: Second round Delphi Study outcomes - issues and solutions (n=27)

Provision of services			**Agreement**
Issue 1 **-** Limited services &resources for sexual assault management in regional areas of WA for both acute and longer term sexual assault cases.			100% (n=27)
Solutions	%	n	
Detailed step-by-step document/manual providing clear guidelines for the assessment/immediate treatment/specimen collection and equipment and facilities required for sexual assault cases available state wide. Incorporate a flow chart summarising procedures and assessments.	55.6	15	
Training of medical and nursing staff in management of acute and longer term presenting sexual assault cases.	48.1	13	
			Agreement
Issue 2- Broad variation in delivery of sexual assault services provided in metropolitan and regional areas of WA.			85.2% (n=23)
Solutions	%	n	
Detailed step-by-step document/manual providing clear guidelines for the assessment/immediate treatment/specimen collection and equipment and facilities required for sexual assault cases available state wide. Incorporate a flow chart summarising procedures and assessments.	63	17	
24-hour phone hot line providing advice on management of the sexual assault cases throughout the state that is actively promoted.	40.7	11	
Federal and State funding to support the standardisation of treatment and services throughout the state in EDs, Women's Health Centres and local medical practices**.**	40.7	11	
			Agreement
Issue 3- Comfort packs should be available.			85.1% (n=23)
Solutions	%	n	
Provision of comfort packs to be in detailed step-by-step	40.7	11	

document/manual for the management of sexual assault cases.		
Comfort packs to be funded as essential item for management of sexual assault cases and readily available in medical facilities throughout the state.	33	9
		Agreement
Issue 4 **-** Lengthy waits in Eds in metro & regional WA due to lack of staff expertise and availability.		77.8% (n=21)
Solutions	%	n
Triage tool notifying medical staff that a sexual assault case requiring a safe confidential environment.	59.3	16
Triage tool fast tracking sexual assault cases not requiring medical management to SARC services.	55.6	15
Staffing issues		**Agreement**
Issue 5 **- '** Burn out' due to high demands placed on sexual assault counsellors and staff.		96.3% (n=25)
Solutions	%	n
More Federal and State funding for sexual assault counsellors.	51.9	14
Provision for adequate sexual assault staff debriefing and support.	37.0	10
		Agreement
Issue 6 **-** Health staff unclear about procedures for collection & storage of forensic information, appropriate equipment & timeframes.		92.5% (n=25)
Solutions	%	n
Flow chart detailing the appropriate procedure for the collection of specimens and storage of collected items, with specified time-frames.	70.4	19
Staff education on collection, labelling and storage of samples/specimens	59.3	16
		Agreement

Issue 7 - Inadequate training of emergency staff in conducting forensic/medical/psychological examinations of presenting sexual assault cases.			88.8% (n=24)
Solutions	%	n	
Medical staff trained in process of medical, forensic and psychological examination of sexual assault cases.	55.6	15	
Ongoing training and updates for medical/nursing staff via regular SARC training sessions, either via on-site visits or video-conferencing.	40.7	11	
Presenting sexual assault cases			**Agreement**
Issue 8 - Presenting sexual assault cases can experience dis-empowerment in t assessment and management.			88.9% (n=23)
Solutions	%	n	
Clear communication and provision of information around issues of medical/forensic, psychological examination by medical/nursing staff.	51.9	14	
Detailed step-by step document/manual incorporating rights, legal procedures and available services for sexual assault cases - available state wide	40.7	11	
Holistic management			**Agreement**
Issue 9- Often no follow-up of cases presenting with sexual assault.			85.2% (n=23)
Solutions	%	n	
Follow-up phone system offering long-term support for the victim/survivor of sexual assault.	55.6	15	
Availability of long-term counselling services based on requirements not funding.	44.4	12	
			Agreement
Issue 10 - Management/treatment of sexual assault focused on the victim/survivor and no involvement of perpetrators (brothers/fathers/sons) and family. Focus on all parties has the potential to improve healing.			74.1% (n=20)
Solutions	%	n	
Provision of education/information for the perpetrator of the impact of	51.9	14	

sexual assault on the victim/survivor.			
Expert counselling provided to perpetrator in the short and long-term.	51.9	14	
Indigenous and culturally and linguistically diverse (CALD) groups			
Issue 11- Australia is a multi-cultural society, yet shortage of culturally appropriate responses and services (CALD and Indigenous).			100% (n=27)
Solutions	%	n	
Aboriginal Health Workers and Hospital Liaison Officers to be trained.	59.3	16	
Cultural awareness training for all staff.	44.4	12	
Community attitudes			**Agreement**
Issue 12 - Negative attitude exists in some sections of community towards people who experience sexual assault. Need to change attitudes so that sexual assault is considered unacceptable.			96.3% (n=26)
Solutions	%	n	
Resources - well publicised telephone hotline for sexual assault victims/survivors/family members/perpetrators.	51.9	14	
Advertising Campaign - campaign that clearly states 'no excuse for sexual assault'. Women who experience sexual assault need to be supported and believed.	40.7	11	
Funding			**Agreement**
Issue 13 - Sexual assault not taken seriously by governments.			74% (n= 20)
Solutions	%	n	
Lobbying of government for more funding to improve services.	66.7	18	
Increased funding for research into outcomes and attitudes to sexual assault.	51.9	14	
Legal system			**Agreement**
Issue 14- The treatment/management of victims/survivors of sexual assault within the legal			100%

system needs to be improved.		(n=27)
Solutions	%	n
Specialised courts that reduce the interval between the assault and court presentation so that the victim/survivor can finish the legal procedures and move on.	74.1	20
An improved system for educating courts that hear sexual assault cases.	40.7	11