

Provincial Coordinator Update

You have probably received the new Sexual Assault Evidence Kits by now. Unfortunately the new SAEKs came out before we had time to do staff training. The format is different with some changes to evidence collection. There will be some corrections to the kit when the Centre of Forensic Sciences (CFS) finds time.

One of the more difficult logistical changes concerns the consent form. There are now two (2) parts to the consent form: one (1) portion for the collection of evidence (*which the nurse obtains*); one (1) portion to release the evidence to the police. It is now the responsibility of the police to obtain the second consent. This was done because it is a police responsibility to explain the legal system to the client and what her/his rights are. Some SATCs indicate that the investigators don't generally come to the hospital and the uniformed officer may not be able to give this information, so - how do they get consent?

The change to the consent form was made because clients have often said that they didn't realize what happens once police are involved. Although the previous consent form was an easier process, the issue is whether it is *informed consent*. Perhaps we (*SATCs & police*) need changes to procedures to ensure that conditions for informed consent are met. For example, why can't we store the kit at the hospital, give the uniformed officer the second consent portion to take to the investigator and - once an explanation has been given to the client - she/he can sign the consent and the police can pick up the kit? There's no reason for the police to take the kit immediately except in exceptional circumstances. Samples are not usually analyzed right away at the CFS.

I would be interested in knowing how you address this.

HIV Project

The funding for the HIV project has been secured, the physician researcher has been hired and planning for implementation is now underway. We hope to have protocols out to all 31 Centres early in the new year for the provision of HIV prophylaxis. There is very little research available world-wide on the issue of sexual assault and HIV, so one of our hopes is that the findings of this research will be useful beyond the Ontario borders.

We will be presenting the project at the Coordinators meeting in October. We plan to bring together the SATC medical directors and Coordinators for further training (*probably in the new year*) with team member training after that.

Corrections

I need to make two corrections to the July 2002 newsletter in acknowledgements - my apology for the errors. Karen Connor, R.N. SAFEKIDS program in Windsor organized the training session in June. Donna Mitchell, Coordinator Brantford SA/DV program wrote the article titled '*Making Positive Connections*'.

Website Changes

We are always looking for ways to improve our website and make it more interesting and accessible to the user. Let me know if you have any ideas for us. Log on at www.satcontario.com

**Sheila Macdonald R.N.
Provincial Coordinator**

Making the Process Better ...POLICE INVESTIGATIONS

Generally speaking, there've been noticeable improvements in regards to police sensitivity on sex assault cases since the formation of the Sex Assault Unit within our local Police Department. When a case is transferred to this Unit, it's expected their level of expertise and insight will lead to increased sensitivity towards the survivor. This is for the most part true. And when there is a complaint within the Sexual Assault Police Unit, it seems to be looked at more seriously.

Most regular police officers, however, do not appear have this same degree of specialized training and focus on sensitivity. As a result they are more likely to respond and interact with victims in ways that can create discouragement, distress and disillusionment. Feedback from clients includes complaints about the investigation process, and police behaviour when the initial complaint was taken. I continually hear the same story, "*On my own, I was asked whether it happened - was I responsible - should I have done something different - should I have been in that situation , etc.*" These questions tend to reinforce the self-doubt, often graduating it to self-blame.

This has created a moral dilemma, one I have tackled by researching and interviewing police officers. The answer: there is a need for neutrality by the police officer so they will not be clouded in their decision-making process, and so innocent people do not get charged. Neutrality can be done with sensitivity, and with provisions to ensure that the victim is moved on in a healing versus a traumatized way. The following 3 ideas are aimed at making the police investigation process more sensitive.

Our SATC (*in collaboration with our local rape crisis centre and police department*) is currently designing & implementing a Police Sensitivity Training Video to become part of the standard police orientation procedure. It will contain experiences related by actual survivors talking about the police investigation process concerning: what worked, what didn't, and what police officers can do to help the healing process. It's hoped first-hand information will give the officers more insight and empathy, and positively change their behaviour during a sex assault investigation.

Another idea, (*still a theory*) is to have officers explain before or after investigating a sex assault, why they must be so straightforward and neutral in the investigating process - much like the introductory information a social worker gives a client at the intake level (*re: the service, confidentiality*). One client said when the officer took 1-2 minutes to explain the process and his conduct (*which was investigative not insensitive*) it made an essential difference - she realized the police officer's questioning was not about her but was a standardized process. With no explanation, it's no wonder victims are confused, and to make sense of the situation, blame themselves.

A third idea is for police to give sex assault clients a '*Healing Booklet*' consisting of principles such as '*You are not alone...You are not to blame...You can heal/overcome*'. It would contain key ideas, outlooks, examples, strategies etc. such as those used by our counsellors in sessions. It's not therapy - the boundary and division lines are clear - but a reference of good ideas & principles aimed at beginning healing, with a clear suggestion of follow-up with the SATC to further the healing process. This idea is based on the fact that many victims never make it to sexual assault services until months and/or years later, if at all. For those who go to the police initially but never to SATC-ER or SATC counselling, this information could start the healing process.

I am realistic in realizing that the larger system will likely not change drastically. However after seeing many clients for specific sessions addressing abreaactions from police investigations - which is common - it is clear to me that being more proactive is important.

Your comments, concerns and questions are wanted and appreciated. If you have done something similar or are thinking about such programs feel free to call us at the Niagara SATC.

Sucann Miller-Koren, MSW
Niagara SATC

A Project Spawning a Project ...MORE FOLLOW-UP

This spring and summer, our Centre worked with Brydon Gombay on the 3rd phase of the *Sexual Assault & Medicolegal Evidence Project* conducted by Drs. Deborah Parnis of Trent University & Janice Du Mont (*Centre for Research in Women's Health*). This study involved recruiting & interviewing sexual assault clients who had accessed our Centre in the past 5 months. Our role was to present the project to our hospital ethics committee for approval, then to select and successfully recruit clients who had made different post-assault choices: choosing to have a sexual assault evidence kit done, and choosing *not* to, receiving only medical care. One research goal was to identify *reasons* for those choices. Another goal was to ascertain if the services that health care workers provide at Centres are truly empowering and beneficial for clients, in other words, '*What is helpful and what is not?*'

As often occurs with research, in the course of recruiting clients for these purposes we uncovered an unrelated, but important, bit of information. In contacting seven (7) people, and successfully recruiting four (4) clients within the specified post-assault time frames, we found that each of the 7 clients still had unresolved issues that related to either the justice system, or counselling and support. As a result, we provided each client with the support and referrals they requested and required. Some needs were as simple as connecting them with VWAP or a counsellor/counselling service. Others were more complex and involved client advocacy.

After reviewing and discussing the needs of these 7 clients, our Centre decided to pilot a *1 Month Follow-up Phone Call* project for our sexual assault clients. We'll offer this option to clients during the initial 48-72 hour follow-up phone call...and we've developed a specific guideline to use during this study. After 6 months, we'll assess it, evaluating: what client needs existed and whether we were able to provide client assistance in meeting those needs - as well as determining how many clients chose the 1-month follow-up call and how many did not. The answers will assist us in assessing if we should continue with this option.

Our work is constantly evolving in relation to the needs of clients. We look forward to the result of this pilot and are hopeful it will meet the ongoing and changing follow-up needs of the clients we see in our region.

**Norah Holder, Manager
Orillia RSDAP**

Need for Policies & Procedures ...PHOTODOCUMENTATION

We are all familiar with the old adage that *"...a picture is worth a thousand words."* Pictures can have a powerful impact in a court of law and can capture far more than our written words. As forensic nurses we acknowledge the importance of photographs in preserving the moment that gives testimony to a recent past event of violence. We also acknowledge that photographs aren't a substitute for written documentation and the use of body diagrams. But, do we need policies and procedures for photodocumentation? I believe I have found the answer with the aid of a literature review.

"The term forensics...is defined simply as pertaining to the law...Therefore, any subdiscipline of science that practices its specialty within the arena of the law is practising the principle of forensic science." (Lynch, 1995). At a training session for Forensic Nurse Examiners being presented by Virginia Lynch, Amy Kistnasamy (Chief Prosecutor) one of the speakers, highlighted that *"Forensic nurses are vital links in the chain of evidence'...Ms Kistnasamy called on the nurses to follow the correct procedures at all times, including documentation."* (McGlew, 2001). *"High profile criminal cases hinging on forensic evidence have spotlighted the important role forensic nurses play in identifying injury, preserving evidence, maintaining the chain of custody, producing documentation, including written reports, as well as photography that will withstand the scrutiny of the courts."* (McPhail, 2002)

"A well thought-out policy must therefore be in effect for photodocumentation prior to the arrival of any forensic category of patient...There will come a day when hospitals and healthcare providers will be sued for not photographing the injuries due to trauma and/or violent crime. This will be an act of neglect on the part of the clinicians." (Pasqualone, 2001). Ms Pasqualone, a clinical forensic nurse, points out that clients have the option to refuse photographs but that nurses should be recognizing injuries as evidence and *"...preserving them for any future litigation."*

"The careful description of an injury can be very helpful in the investigation of a crime. Follow a standard evaluation process each time a wound is described." (Allen, 2002). Eileen Allen, a clinical forensic nurse, recommends describing the injuries (*size, shape, margins, position and location*), using a body diagram, and the use of photographs. There should be a policy in place and an informed consent obtained. The policy should include an identifying photograph, a mid-range photograph identifying location, a close-up photograph, and a close-up photograph with a ruler.

The practice of using Polaroid pictures has the advantage of producing an instant photograph, however, they pose problems in storage and for court preparation - they fade overtime and are expensive. An alternative is the use of digital technology. *"You must have standard operating procedures (SOPs) in place to ensure that evidence you gather and present will be accepted by courts of the law."* (Blitzer & Kammen, 2001).

It is my belief that photographs should be a standard of documentation for forensic nurses. Some of our Centres today are using photodocumentation as a tool during the process of documenting an injury. This practice enables the injury to be photographed at the time of the physical assessment and saves the client having to expose their injuries to another person. The process of our Provincial Network of Sexual Assault and Domestic Violence Care Centres adopting policies and procedures for photodocumentation and including the knowledge in the training of forensic nurses will enhance our documentation process.

The literature reviewed strongly recommends that policies and procedures *must* be in place, not only as a chain of evidence, but also to demonstrate the integrity of the forensic nurse as a witness. *"The testimony of a witness is evidence and the image is an 'exhibit' to that testimony...the key to successful use is in control of the procedures employed."* (Blitzer, 2001)

**Margaret Stevenson, RN, SANE
Kenora SATC**

A Viable Counselling Tool ...EMDR

Over the past several years, social workers/counsellors within our Network have obtained training in the therapeutic procedure known as EMDR. Founded by Dr. Francine Shapiro in 1987, EMDR has been widely used and successful with survivors of post traumatic stress, and in particular, with sexual assault survivors.

Through bi-lateral (*visual, auditory or tactile*) stimulation, it is believed the brain can reprocess traumatic memories and resolution can be achieved. I have been trained in EMDR Levels I & II, and am working towards certification. Over

the past 2 years, I have used EMDR in my therapeutic work with clients and have found it empowering and beneficial to both the clients and myself.

Some of the benefits of EMDR include its structure in terms of the preparatory process (*including strength building, resource development, cautions & readiness assessments*) as well as in the set-up of the actual procedure. Another benefit is that the EMDR process deals comprehensively with the 4 types of after-effects survivors of sexual assault commonly encountered including: negative emotions, thoughts, behaviours, and recurring physical sensations. I have found it crucial to receive both individual and group supervision in my efforts to successfully utilize EMDR, and would highly recommend it as an essential component of its use.

For more information, please contact me at jramage@thc.on.ca or another member of the Network Social Work Committee. Also, here are some useful websites on EMDR: www.emdria.org and www.emdr.com. Sue Fraser, an Approved EMDR Trainer and Certified Trauma Specialist, has spoken at a couple of our Network conferences. Her e-mail address is: www.frasercounselling.com. Our team has also done some work with Jan Yordy on using EMDR and Energy Psychology with children in preparing to expand our services to meet the needs of the paediatric population. Jan's email address is: yordy@energyconnectiontherapies.com.

**Jennifer Ramage, MSW, RSW
Mississauga SACCC**

Developing New Guidelines ...DV STUDY

The issue of domestic violence is gaining increased public attention through various Coroners' inquests, including the most recent one on the deaths of Gillian Hadley and Ralph Hadley. Domestic violence impacts upon women's health in many ways: physical trauma, long-term disabilities, depression, miscarriage, chronic medical conditions, and substance misuse.

The health care system is the most common resource accessed by women who experience partner abuse. Thus, the health care system and health care workers are integral in identifying women who have been abused, and in referring them to appropriate programs and services. *Unfortunately, very few women who are abused are identified by the health care sector.* A more integrated and comprehensive approach to woman abuse by the health care sector is much needed.

The Ontario Hospital Association, in conjunction with the Woman Abuse Council of Toronto and Education Wife Assault, has initiated a project to work towards amendments of the Canadian Council on Health Services Accreditation (CCHSA) Guidelines to provide appropriate health-related care for women who have been abused. Our Regional Sexual & Domestic Assault Treatment Centre at Orillia Soldiers' Memorial Hospital (OSMH) is one of ten sites in the province, chosen to participate in this project to conduct discussions with focus groups from various hospitals throughout Ontario.

Local partner hospitals participating in this project with our Centre are: Alliston Stevenson Memorial Hospital, Midland Huronia District Hospital, Collingwood General & Marine Hospital, Huntsville & District Hospital, and OSMH.

The goals of the focus groups are to determine to what extent screening for domestic violence is already taking place in hospitals, and to identify barriers to screening for woman abuse. The data will be collated and presented to the CCHSA.

Obtaining input from hospitals across the province is crucial to the success of the development of appropriate accreditation guidelines that will enable women who are assaulted by their partners to be offered timely and supportive services and resources by the health care system. Obtaining input from our partner hospitals will also ensure that the unique needs of abused women in our region are articulated on both a provincial and national level.

**Cathie Beacock, Outreach RN
Orillia RSDAP**

North Bay ...CENTRE FOCUS

The North Bay General Hospital-Near North Nurse Practitioner Services SANE Team is pleased to become a part of the Ontario Network. The Team's inception results from the collaboration between various agencies in Nipissing District, including: Sudbury SANE team, Amelia Rising Sexual Assault Centre, local & OPP, Victim Crisis Assessment & Referral Services, Public Health, area Crisis Centres and Transition Houses, and consumers - among others. Services began in March 2002.

Team members hail from diverse areas including: North Bay General Hospital's Emergency Department, Telephone Triage, Victorian Order of Nurses, Canadian Forces Base North Bay, Laurentian University, and Near North Nurse Practitioner Services. Each brings their own blend of skills and shares it with others to promote growth. Because of the team's small size, the contribution of team members has been considerable, and of enormous value. The leadership demonstrated by these SANEs deserves recognition, and

I would like to take this opportunity to acknowledge and thank team members: Roz Fournier, Susan Boudreau, Penny Andrews, Laurie Peachey, Paula Doucet, Karen Trainor, Chantal Miljours, and Sharon Goodwin.

**Sue LeBeau, Coordinator
North Bay SANE Team**

...FOR YOUR INFORMATION

Upcoming Events

Domestic Violence Conference (*Windsor SA/DVTC*)
November 7 -8, 2002
Caboto Club, *Windsor*, ON

Dr. Dan Sheridan will speak on Day 2

Annual Conference for SA/DV Treatment Centres
May 1 & 2, 2003
Sheraton Centre, *Hamilton*, ON

Articles of Interest

Rape - Related HIV Risk Concerns Among Recent Rape Victims. *Journal of Interpersonal Violence*; Beverly Hills, July 2002; Vol.17, Iss.7: 7462.

23, Male sexual assault victims: a selective review of the literature and implications for support services. *Journal Article - (Pergamon)- Aggression and Violent Behaviour 7 (2002) 203 - 214*