Registered Nurses' Association of Ontario (RNAO)

# Speaking Notes to the Select Committee on Sexual Violence and Harassment

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Good Afternoon. My name is Kathleen Fitzgerald and I am presenting today on behalf of the Registered Nurses' Association of Ontario (RNAO). RNAO is the professional association for registered nurses, nurse practitioners and nursing students who practise in all roles and sectors in Ontario. Our mandate is to advocate for healthy public policy and for the role of nurses in enhancing the health of Ontarians.

The RNAO appreciates this opportunity to appear before this Select Committee on Sexual Violence and Harassment as you look for ways to both prevent and improve our response to Ontarians who have experienced sexual violence and harassment. As part of a comprehensive submission that RNAO will be making, my remarks today will concentrate especially on improving our response to those who have experienced sexual violence and harassment. I am a registered nurse who has worked as a sexual assault nurse examiner for over 25 years. For the last 15 years I have worked as Manager of the Sexual Assault/Partner Abuse and Safe Kids Programs as well as the Ambulatory Care Programs at Lake of the Woods District Hospital in Kenora. Our catchment area covers a vast geographical area the size of France. Over this far-flung terrain, I have the privilege of serving as an expert resource to health, social, and law enforcement colleagues, including 26 nursing stations providing health care services to First Nations' communities in the Sioux Lookout Zone.

RNAO thanks the many Ontarians from every walk of life who have bravely shared their experiences that prompted the government of Ontario to listen and release, *It's Never Okay: An Action Plan to Stop Sexual Violence and Harassment* released in March 2015. Today, I would like to speak to the specific Action Plan's commitment #7 to "strengthen supports provided by the hospital-based Sexual and Domestic Violence Treatment Centres to maintain 24/7 access to excellent, appropriate and timely care."[1]

Sexual Assault/ Domestic Violence Treatment Centres (SADVTCs) are hospital-based programs funded by the Ministry of Health and Long-Term Care. There are currently 35 SADVTCs programs across the province. When the programs were originally established, they were monitored under Priority Programs at the Provincial Ministry level to ensure standardized services and financial stability. In 2004, the programs were transferred to the MOHLTC's Regional Offices and then to the Local Health Integrated Networks as part of the base budget of hospitals.[2] As hospitals worked to balance their budgets, SADVTCs experienced deep program cuts. As a result, education, outreach, follow-up services, and

nursing positions were decimated. It is important to recognize that our current situation is that access to 24/7 services is NOT a reality at all 35 sites.

SADVTCs provide acute health care services, forensic services, emotional support, counselling, crisis intervention, mental health assessment, follow-up healthcare, sexual health education, research, outreach to community agencies and events, and education of professionals and the public.[3] Given the complexity of the clinical situations and the multitude of skills and knowledge required to perform this highly specialized service, education and training of staff is paramount upon hiring and throughout employment.[4] [5] [6] This is to ensure skills are up to date, best practices are being used, knowledge on emerging research is current, forensic evidence is sound to ensure its use in court proceedings, and errors and adverse events are avoided.

Sexual assault survivors want client-centered care that includes non-judgmental, sensitive, compassionate, empowering, and one-on-one care provided by Sexual Assault Nurse Examiners (SANEs). The Ontario Network of Sexual Assault/Domestic Treatment Centres (the Network) have developed the evidence-based *Standards of Care* that set the bar in this specialized area with clinical, organizational, program, education and outreach standards.[7] Health care services provided by emergency departments (EDs) have been known to cause revictimization and trauma to clients due to sexism, insensitivity, judgmental attitudes, and victim blaming, which has been called a second rape by survivors.[8] [9] That is why the Ontario Hospital Association has worked with the Network to develop *Hospital Guidelines for the Treatment of Persons Who Have Been Sexually Assaulted* to support standardization of service provision and collaboration with SADVTCs.[10]

SANEs were implemented to provide superior and specialized health care, psychosocial support, and forensic evidence collection to victims of interpersonal violence.[11] The research literature consistently demonstrates that SANEs provide better quality health care, decrease patient wait times for physical and genital examinations, and increase accurate evidence collection using documentation, photography, and the Sexual Assault Examination Kit.[12] [13] [14] [15]

Sexual assault does not happen in isolation and survivors need support from a variety of community partners. SANEs are able to gather additional information to help support clients and refer them for appropriate additional services. Research suggests that SANEs have better relationships with community partners such as

rape crisis centres, counselling services, schools, police, and prosecutors than ED physicians and staff.[16] [17]

A key barrier to access to SANES on a 24/7 basis has to do with staffing. The majority of SANES work on an on-call basis. Centres with high client volumes have replaced full-time (FT) and part-time positions with on-call hours due to program funding cuts.[18] [19] This makes it extremely difficult to recruit and retain nurses with an on-call rate of only $3.30 per hour.[20] If a nurse is called to see a survivor, she or he receives time and a half for four hours minimum. But this completely depends on client volumes, which is highly unpredictable. In order to meet their basic needs, SANEs must also obtain outside employment.[21] [22] Frequently SANEs are choosing to work straight time hospital shifts where they may earn a minimum of $31.02 for one hour,[23] in comparison to $26.40 for an eight hour on call shift. On call scheduling is causing large gaps where no services are provided and leaving clients without access to a specialized healthcare provider.[24]

Not having access to specialized care providers is poor quality health care for survivors. To avoid this, team coordinators are working an additional eight to one hundred plus hours a month to fill blank schedules, on top of their FT position managing the teams.[25] It is unacceptable, unfair, and dangerous to demand that one person take on the job of three FT RNs. And despite coordinators' attempts, clients are still being asked to wait unreasonably long hours for the next available SANE, are leaving without any care, being seen by untrained ED staff, and/or being transferred to other programs in neighbouring communities.[26]

On-call work is precarious, toxic, and associated with burnout, job dissatisfaction, depression, exhaustion, anxiety, stress, poor psychological health, decreases in quality and quantity of sleep, and increases in cardiovascular disease, mortality, and morbidity.[27] It also takes a toll on a nurse's happiness, personal and family life, which reduces quality of life and in turns contributes to burnout. These ill health effects are in addition to the high prevalence rates of burnout, compassion fatigue, vicarious trauma, and secondary trauma in SANEs related to helping victims of violence.[28] [29] [30] [31] It is unfair and short sighted to expect health care professionals to jeopardize their health and wellbeing. It impedes the ability of SANEs to provide high quality health care that survivors need and contributes to attrition of valuable health human resources.

Sexual assault is a complex process whereby a perpetrator purposefully exerts power and control over another using sexual and physical violence, threats,

intimidation, and humiliation, resulting in significant long term threats to physical and psychological health, and legal consequences that require ongoing support and attention by a specialized health care provider. [32]

Long term psychological effects include depression, anxiety, post-traumatic stress disorder, personality disorders, addictions, and psychosis, as well aggression, delinquency, poor social skills & academic performance, and relationship problems. Physiological effects include somatization, obesity, sexually transmitted infections, pregnancy and chronic pain. The most severe affects are self-harm, suicidal ideation and death.[33] [34] No survivor should have to suffer as a result of sexual victimization.

Follow-up services to help prevent, support, and treat the effects survivors endure include sexual and reproductive health, mental and emotional health, liaising with police and the judicial system, referrals to community agencies, social services, mental health providers, shelters and community housing, and support during the judicial process. Those who do not have access to SADVTCs end up requiring multiple providers and visits, and fragmented care that costs the system and client more money and time.[35] For example, survivors that see a primary care provider versus SADVTCs pay out of pocket approximately $1,108 for a 28 day supply of medication for post-exposure prophylaxis to HIV, $40 for prophylactic antibiotics, and $25 to $40 for Plan B to prevent unwanted pregnancy plus they are then often sent to a gynaecologist, HIV specialist, psychiatrist, and psychologist.[36] [37] [38] If a survivor has access to drug coverage through an insurance plan, many would rightly hesitate to use it for fear of being stigmatized and flagged as an actuarial risk due to the HIV medications. This is an excessive and unjust burden that survivors of violence must pay in order to protect their health. Unfortunately, follow-up clinics have lost their staff, reduced their hours considerably, and are unable to meet the needs of survivors due to hospital cuts.[39]

No one deserves to be sexually assaulted, harassed, or disbelieved. The services provided in SADVTC are imperative to the care and recovery of survivors who deserve competent, timely, specialized, and high quality healthcare. **Unless there is substantive and sustained funding to address SANE staffing issues, it will be impossible for SADVTCs to provide 24/7 care that is excellent, specialized, timely and "consistent with best international practices and standards of care."**[40]

The other recommendation that I would like to touch on is #8 having to do with the development of "up-to-date training for front-line workers in the health, community services, education and justice sectors."[41] I had the privilege of being the Panel Lead for the 2012 revision of RNAO's Nursing Best Practice Guideline on *Women Abuse: Screening, Identification and Initial Response.* This guideline as well as related resources are available without charge on the RNAO website.[42] Myself and other RNAO members who have expertise in this area are available as resources. Those of us who work in this field are clearly not doing it for the money. We are doing it from the conviction that every Ontarian who has been through such an ordeal deserves compassionate and high-quality, evidence-based services. Those of us who work in less urbanized parts of the province are especially mindful of the need for creative, respectful collaboration for seamless, client-centred care in our communities.

On behalf of Ontario's registered nurses, nurse practitioners and nursing students, I thank you, once again, for the opportunity to appear before this Committee. I would be delighted to respond to any questions.

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