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Development and evaluation of sexual assault training for emergency department staff in Ontario, Canada

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ABSTRACT

Objective: The purpose of this evaluation was to assess the efficacy of a training in improving competence to address sexual assault among Emergency Department (ED) staff, as well as to compare in-person and online training modalities.

Methods: A total of 1564 staff from 76 EDs in acute care hospitals across Ontario participated in either on-site (n = 828 staff) or online (n = 736 staff) training sessions, of whom 1366 (87%) completed *both* a pre- and post-training questionnaire. Mean pre- and post-training scores measuring perceived competence in responding to victims/survivors of sexual assault were compared using paired *t*-tests. The mean gain score for in-person and online training was then compared using the Mann-Whitney *U* test. Finally, in-person and online participants' ratings of the training content and delivery were compared using the Mann-Whitney *U* test.

Results: There were significant improvements for all 16 self-reported measures of competence following training. The mean gain in knowledge and skills was higher for in-person training participants. Participants in the in-person modality more strongly agreed that the information they learned would help in providing care for sexual assault victims/survivors, and were more satisfied with the training overall. However, these participants less strongly agreed that there was an appropriate amount of time allotted for the scope of material presented.

Conclusions: Overall, the training led to immediate improvements in ED staff perceived understanding and ability to address the needs of victims/survivors of sexual assault, with particular advantages to the in-person training.

1. Introduction

Hospital emergency department (ED)s are one of the key possible entry points into the healthcare system for individuals having experienced sexual assault (Avegno et al., 2009). However, ED staff may not be (fully) trained to meet the complex range of needs of victims/survivors including the provision of acute medical care, mental health care, and referral to other appropriate services (Amey and Bishai, 2002; Patel et al., 2013). Moreover, EDs often do not offer the services needed to effectively assist victims/survivors of sexual assault, such as routine provision of antibiotics needed to prevent sexually transmitted infections and emergency contraceptives (Amey and Bishai, 2002; Patel et al., 2013).

To address this gap in care and better meet the needs of sexual assault victims/survivors, sexual assault treatment centres or response teams increasingly have been established in hospitals across the globe (Du Mont and Parnis, 2002). In North America, these programs are frequently staffed by specially trained on-call forensic nurse examiners, who provide a comprehensive range of services that include crisis support, physical examination, documentation of injuries, provision of prophylactic medication for the prevention of pregnancy and sexually transmitted infections (including HIV), forensic evidence collection, referral to on-site follow-up medical care and counselling, and community agencies for ongoing support (Campbell et al., 2005; Du Mont and Parnis, 2002).

The implementation of such programs has been shown by Sampsel et al. (2009) to reduce wait time for initial clinical evaluation from 30 min to 22 min and increase time devoted to medical examination among individuals requiring acute sexual assault care, administration of sexual assault evidence kits (also known as rape kits), and use of

Abbreviations: ED, Emergency department; SA/DVTCs, Sexual Assault/Domestic Violence Treatment Centres; OHA, Ontario Hospital Association

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acute care services such as pregnancy and sexually transmitted infection prophylaxis. Such programs have been shown to provide more rigorous collection and storage of forensic evidence which can improve prosecutorial outcomes (Campbell et al., 2012; Sievers et al., 2003). Victims/survivors seen by these programs also have reported increased psychological well-being (Campbell et al., 2008) and, in a study of Ontario, Canada's 35 hospital-based sexual assault/domestic violence treatment centres (SA/DVTCs), high levels of satisfaction with the delivery of care (Du Mont et al., 2009; Du Mont et al., 2014).

Despite efforts to ensure that Ontario's SA/DVTCs are widely accessible across the province, victims/survivors presenting to an ED in hospitals are often not referred to these programs for care (Ontario Network of SA/DVTCs Coordinator Meeting, 2017, June 8). There are approximately 125 EDs across Ontario without a directly affiliated SA/DVTC that potentially could provide a referral point to SA/DVTC services at other hospitals for victims/survivors of sexual assault (Ontario Ministry of Health and Long-Term Care, 2014). Victims/survivors may arrive at one of these EDs seeking care either because they are not aware of an available SA/DVTC service elsewhere or the service is perceived as too far away. ED staff may be unprepared or unaware of what to do in this situation, which can result in an inadequate response to the individual.

Additionally, even victims/survivors who present at hospitals that have a SA/DVTC have sometimes reported poor treatment by ED staff, which is responsible for medically clearing them before paging the forensic nurse examiner (Du Mont et al., 2014). In a study conducted at 30 SA/DVTCs, 2009 to 2011, some clients indicated dissatisfaction with their treatment in the ED due, specifically, to judgemental attitudes. One client commented “When I went to the Emergency Room, the staff [triage nurse] was very rude and treated me with disrespect. She refused to connect me with the Sexual Assault Centre. It should be addressed so that people would not suffer the same treatment.” (Du Mont et al., 2014, p. 129).

In order to address the gap in the continuum of care provided to victims/survivors of sexual assault and reports of ED staff insensitivity (Du Mont et al., 2014; Maier, 2008), the Ontario Hospital Association (OHA), in collaboration with Ontario Network of SA/DVTCs and ECHO, a former agency of the Ontario Ministry of Health and Long-term Care, developed Guidelines for the Treatment of Persons who have been Sexually Assaulted (OHA, 2013). The OHA guidelines recommend that standardized and consistent sexual assault care is provided at hospitals province-wide. These guidelines outline the importance of a more responsive and supportive environment for victims/survivors who present to EDs and appropriate referral by all ED staff to local SA/DVTCs for further care. To facilitate the uptake of these guidelines, in 2014, the SA/DVTCs, in collaboration with Women's College Research Institute (JDM), developed and implemented an interactive in-person and later online training on sexual assault for ED staff.

The primary purpose of our evaluation was to assess this training using Kirkpatrick's model (Kirkpatrick, 1994), an internationally accepted method of developing and evaluating training by examining changes in participants' perceived competence in caring for victims/survivors of sexual assault, as well as their satisfaction with the content and delivery (Du Mont et al., 2017). A secondary objective was to compare the in-person and online training modalities. The knowledge and skills assessed in this evaluation could be relevant to other jurisdictions globally for improving the care provided to persons who have been sexually assaulted presenting in EDs.

2. Methods

This evaluation was granted exemption from research ethics review by the Women's College Hospital Research Ethics Board management staff in 2013.

2.1. Development of Training

A standardized in-person training was developed for ED staff which included material from a resource document on enhancing supportive responses to sexual assault developed by Baker et al. (2012), the OHA guidelines (OHA, 2013), and multiple other resources (see Macdonald et al., 2015). The training focused on improving competence in caring for victims/survivors of sexual assault across three primary domains of knowledge and skills: context of sexual assault (e.g., definition of sexual assault, risk factors for sexual assault), response to victims/survivors of sexual assault (e.g., facilitation of disclosure of sexual assault, impacts of sexual assault), and role in treating sexual assault victims/survivors (e.g., hospital guidelines for the treatment of persons who have been sexually assaulted, memorandum of understanding between ED and local SA/DVTC).

The in-person training was developed by the evaluation leads (JDM, SM) and a curriculum developer (SL) based on principles of adult learning (Brookfield, 1986) that included building on the strengths of learners and use of interactive components and practical scenarios (e.g., case studies to simulate challenges faced in clinical settings, quizzes). An advisory group of five experienced sexual assault nurse examiners, an ED physician, and a social worker who provide leadership within Ontario's SA/DVTCs supported the development of the training and associated tools, including a standardized PowerPoint presentation and facilitator's guide (Macdonald et al., 2014a; Macdonald et al., 2014b). An online training, adapted for individual use over the internet was developed (JDM, SM, SE) to enhance the availability and accessibility of the training, was made available in April 2015 to offer maximum flexibility to ED staff to complete the training (Macdonald et al., 2015).

2.2. Implementation of the Training

In-person training was delivered by SA/DVTC program managers/coordinators who were provided with the facilitator's guide, PowerPoint presentation, as well as training on how to deliver the in-person training sessions. These facilitators travelled to the various EDs located in their region. The duration of in-person training sessions ranged from 30 min to 1 h due to variations in lengths of discussions; the online training took approximately 30 min to complete.

2.3. Data Tools and Collection

Data were collected during the in-person sessions from January 2014 to November 2015 and online April 2015 to April 2016 via several questionnaires developed by the evaluation team. On pre- and post-training questionnaires, participants were asked to rate their level of agreement, measured using a 5-point Likert scale (strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree) with 16 statements relating to perceived competence in responding to sexual assault patients presenting in the ED (e.g., defining sexual assault, identifying myths about sexual assault, identifying barriers to disclosure of sexual assault) (see Table 2 for a full list).

The pre-training questionnaire also collected information about the participant's age, gender, ethnicity, years of experience working in their ED role, and any previous direct experience in providing care for a patient of recent sexual assault.

On the post-training questionnaire, participants were also asked to rate their level of agreement with 10-statements related to the content and delivery of the training (e.g., The sessions objectives were stated clearly and met; see Table 3 for full list) on a 5-point scale. They were also asked for feedback on the training in several open-ended questions (i.e., As a result of training, do you feel better equipped to respond to sexually assaulted patients and use the OHA Guidelines to provide appropriate care?; What aspects of training were most helpful?; What aspects of this training did you like the least and why? What would you change for the future?; Do you have any additional comments about the