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Sexual Assault Services in the Pandemic: Lessons Learned

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Abstract

Problem: Sexual assault rates rise significantly during disasters. International guidelines emphasize prioritizing and ensuring sexual assault services during disasters to reduce the risks and resulting consequences of assault. The impact of the COVID-19 pandemic and stay at home mandates on sexual assault services (counselling and healthcare) in Canada was unknown. **Purpose:** The aim was to explore the impact of the pandemic on sexual assault service provision, changes in client flow, effects on staff and clients, and lessons learned. **Methods:** A descriptive qualitative design was used. Semi-structured interviews were conducted with counselling and healthcare services across Canada. Content analysis was used for data. **Results**: Most services were disrupted but in different ways. Counselling centres were typically forced to close temporarily until they could find a way to safely provide services with distancing or virtually. Healthcare services mainly remained open as they were affiliated with healthcare sites such as Emergency, but client flow dropped off markedly initially in most sites. Healthcare staff were typically redeployed, leaving teams short-staffed when lockdowns were lifted. Both services found the severity and complexity of client needs was much worse when volumes resumed. The client complexity and workload created stress in addition to pandemic concerns, but staff support was variable, particularly in healthcare. Networks helped support staff but were largely informal. **Conclusion**: Sexual assault services were not given priority, nor were experts consulted in community messaging. I**mplications**: Forensic nurses and counsellors have a key role in advocating for sexual assault care as an essential service in disasters.

Keywords: rape, sexual trauma, sexual assault, crisis intervention

Sexual Assault Services in a Pandemic: Lessons Learned

Sexual assault affects millions worldwide, especially women and children. International prevalence data across 161 countries revealed approximately 30% of women experience physical or sexual violence either by partners or non-partners (World Health Organization-WHO, 2021). National survey data in Canada were consistent with these estimates, with 30% of women and 8% of men reporting that they had been sexually assaulted at least once since age 15 (Cotter, 2021). Canada – a 2018 national survey identified that approximately 30% of Canadian women and 8% of men in 2018 had been sexually assaulted at least once since age 15 (Cotter, 2021).

Rates and risk for sexual assault increase even further during disasters and pandemics (World Health Organization-WHO, 2020), especially if there is displacement or evacuation and that disaster responses can impact accessibility of women to services and care. These increased rates are of concern due to the significant health consequences for those affected. A history of sexual assault results in increased healthcare utilization and increased health concerns (Ullman & Brecklin, 2016). Posttraumatic stress disorder (PTSD) is a particular concern as it is common in survivors of sexual assault (Carter-Snell & Jakubec, 2013). As many as 75% of sexually assaulted clients meet the criteria for PTSD in their first year post-assault (Dworkin & Schumacher, 2018; Dworkin et al., 2021), much higher than for most other types of traumatic events. There are clear linkages between stress disorders such as PTSD and development of other mental health problems such as depression, anxiety, substance abuse, suicidality (Eisenberg et al., 2016; McLean et al., 2014; Pohane et al., 2020), and revictimization (Brenner & Ben-Amitay, 2015; Chu et al., 2014). The resulting stress disorders, in turn, are linked to physical health issues such as cancer, heart disease, diabetes, and autoimmune disorders, pain, and other physical disorders (McCall-Hosenfeld et al., 2014; Scioli-Salter et al., 2016; Wolf, 2016). The high rates of sexual assault and resulting significant consequences highlight the urgent need to understand risks for sexual assault in pandemics and, to either prevent them, or be able to intervene effectively. Early comprehensive sexual assault services have been shown to reduce the risks of PTSD (Dworkin & Schumacher, 2018), thus limiting these consequences.

Despite risks of rising rates of sexual assault and intimate partner violence during the pandemic (MacGregor et al., 2022; Muldoon et al., 2021; Pallansch et al., 2022), the public were advised initially to stay at home unless it was a health emergency. Despite the traumatic nature of sexual assault, in the authors' experience, victims of sexual assault or intimate partner violence are not always injured physically, and therefore may not always see their assault as a high priority "emergency" requiring care. Reluctance to seek services during the pandemic was also found to be due to fear of contracting COVID-19 from enhanced exposure in health care setting, or adherence to the stay at home orders (Muldoon et al., 2021; Sorenson et al., 2021). If they did choose to seek help, women experiencing the violence may not have received the required services due to changes in staffing or reduced availability of services during the pandemic (MacGregor et al., 2022). Sexual assault services may have been relocated or shut down, and staff may have been redeployed to provide basic counselling or healthcare services versus sexual assault services

The isolation with the pandemic and restrictions on contact have therefore created difficulties for both access to and delivery of healthcare and counselling services post-assault. The actual extent of changes in healthcare and counselling services during the pandemic in Canada is unknown. Many urban areas have dedicated sexual assault examiner teams-nurses and/or physicians, as well as sexual assault counselling centres. Services in rural areas or cities without

dedicated teams are sometimes less comprehensive. Rural areas do not often have specialized sexual assault services and struggle to provide comprehensive services even in non-disaster condition (Carter-Snell et al., 2019; Corbett et al., 2022). If they are reliant upon the one physician on duty to take the required time to provide services, it comes at the disadvantage of other clients in the Emergency. There may not be local counselling services or supports available without travel required, adding challenges of transportation and access (Jakubec et al., 2013). The added effects or strain of the pandemic on these services across Canada were unknown. The purpose of this study was to gain an understanding of the impact of the pandemic on healthcare and counselling services across Canada following recent sexual assault. Specific areas of interest included any changes in service delivery and use, perceived impact on clients and staff, and on lessons learned for future pandemics or disasters.

Methods

This project received ethics approval from Mount Royal University in Calgary. The principal investigator is a PhD prepared certified sexual assault nurse examiner (SANE) who has worked and researched aspects of sexual assault and intimate partner violence for many years. She conducted all the healthcare interviews, coordinated the project, and led the data analysis. The research assistant was a recent graduate and registered social worker. A consultant, a master's prepared social worker with years of experience in sexual assault support, was hired to interview the counselling centre professionals, and to assist with verification of data analysis.

The method included use of a descriptive qualitative design (Sandelowski, 2010; Vaismoradi et al., 2013). Semi-structured interviews were conducted with professionals from sexual assault services across Canada. These agencies usually provide services to clients, mostly women, who have experienced a "recent" sexual assault- typically within approximately a week.

Sample

A purposive quota sample was sought, with an attempt to represent both urban and rural perspectives, as well as healthcare and counselling, within each province or territory. F our major Canadian regions: Western (British Columbia, Alberta, Saskatchewan), Central (Manitoba, Ontario, Quebec), Eastern (New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland), and Northern (Yukon, Northwest Territories, Nunavut).

Professionals were eligible to participate if they delivered either counselling or healthcare services for clients after recent sexual assault, and if they were able to be interviewed in English. Each province provides counselling and healthcare services differently for sexual assault. The researcher and consultant are aware of some of these differences and key agencies to contact but may have been unaware of changes within a province that may have occurred during the pandemic. Potential participants were identified both through the investigator's contacts and publicly available listings of sexual assault services in each province or territory. Some provinces had networks of services so some participants were able to provide both urban and rural experiences. Snowball sampling was used with participants during the interview, asking participants to recommend other potential contacts if they thought another region in their province or territory had a different experience.

Some of the counselling agencies (93 in total) received emergency funding during the pandemic to assist with their operations provided by the Women and Gender Equity Canada ("WAGE" funding), distributed through the Canadian Women's Foundation. If participants in

this study had received WAGE funding, there was interest in how the funds were used and whether they were helpful during the pandemic.

Data Collection

A semi-structured approach was used to conduct interviews with all participants who consented. These were conducted virtually and audio-recorded for later transcription. The interviewers each took field notes during and after the interview to add depth to the context. These interviews took place between August and November 2021. The core questions included the following information, along with spontaneous prompts from the interviewers as needed:

- Demographics- type of services typically provided, location (urban vs. rural), clients served
- Core questions included the following:
  - What changes in service use, if any, have you seen during the pandemic?
  - What changes did you have to make, if any, to the services you deliver?
  - What factors have influenced your ability to deliver services or the changes you made?
  - What is the personal or professional impact on staff because of the pandemic or changes?
  - What is the perceived impact on clients, because of the changes?
  - What lessons have you learned. or would you take forward for future disasters or pandemics?
  - If you received WAGE funding from Canadian Women's Foundation during the pandemic, please explain the impact of this funding.

Analysis

Content analysis was used to examine the interview data (Vaismoradi et al., 2013). The process consisted of inductive open coding of the data and creating categories. There was also a comparison of data from urban and rural sites, regional locations, and between counselling and healthcare. The steps included reading/re-reading interviews and field notes individually to identify main points, then to condense into codes and then categories/themes. This was done vertically (individual interviews) and then horizontally (across interviews). NVivo version 12 was used to help organize the data given the number of anticipated interviews. The principal investigator conducted the initial analysis and coding, and then the consultant was asked to review these themes for credibility. Discussion was held to ensure consensus and identify any potential gaps in coding or observation and a coding journal was maintained throughout data collection and analysis.

Rigor

Numerous measures were introduced to support trustworthiness of the study (Forero et al., 2018; Morse, 2016). These included establishing credibility, dependability, confirmability, and transferability. Both the principal investigator and consultant participated in each others' initial interviews to ensure consistency of data collection. The principal investigator did the initial coding and then discussed it with the second team member and then the research assistant until

consensus was reached. These measures supported dependability. The two main researchers were both experienced sexual assault professionals (one in healthcare and one in counselling) and the assistant a registered social worker, thus enhancing credibility. Confirmability or auditability was supported through keeping a coding journal in NVivo and field notes. Descriptions of the participant characteristics and settings were included to support considerations of transferability.

Results

Sample and Settings

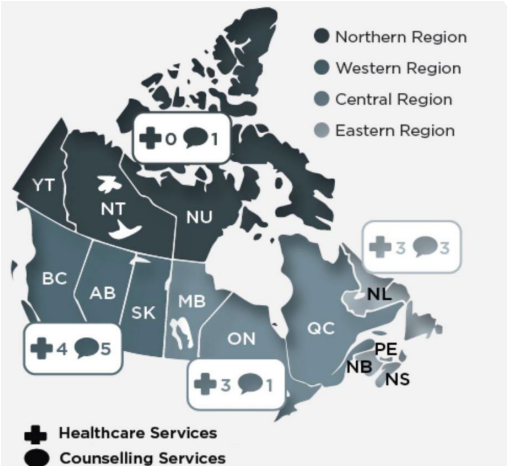
Twenty interview sessions were conducted with 21 participants (one interview included two participants at the same location). Ten interviews were with professionals from counselling centres and ten were from healthcare agencies (table 1). Many of the healthcare agencies also served clients after recent intimate partner violence, with or without experiencing sexual assault. Almost all healthcare agencies were in or near Emergency Departments, while the counselling centres were typically community based. Some provinces had standardized or shared protocols and province-wide healthcare coverage for sexual assault (in Central and Eastern Canada). At least one province had a provincial network of counselling centres.

Table 1.
Participants and Locations

Region	Counselling (n=10)	Healthcare (n=10)
Eastern (Maritimes)	3	3
Central (Ontario, Quebec, MB)	1	3
Western (SK, AB, BC)	5	4
Northern (NWT, Yukon, Nunavut)	1	0

Although attempts were made to represent all provinces and territories (Figure 1), as well as urban and rural in those regions, participants from some areas were not available. Despite numerous attempts and use of snowballing techniques, no one from Quebec participated. One of the healthcare coordinators from a nearby province, however, worked closely with Quebec as well as had worked in Quebec, and was able to provide some information on their services. The Northwest territories and Nunavut were also not represented directly but participants from neighbouring provinces provided care and support for clients who travelled from these areas and could speak somewhat to their experience. The sexual assault healthcare in the territories is either provided locally in the Emergency Department by staff on duty, or more commonly, clients are transported to nearby provinces for the medicolegal examination and treatment. Some of the provincial services covered the territories' clients, in part accounting for the limited response in the northern region. In at least two instances, the counsellors were also able to speak to healthcare services, as they either managed the services or worked closely with them. Both rural and urban representatives were obtained in most provinces, or the urban centre/network staff were able to speak to the differences in rural centres.

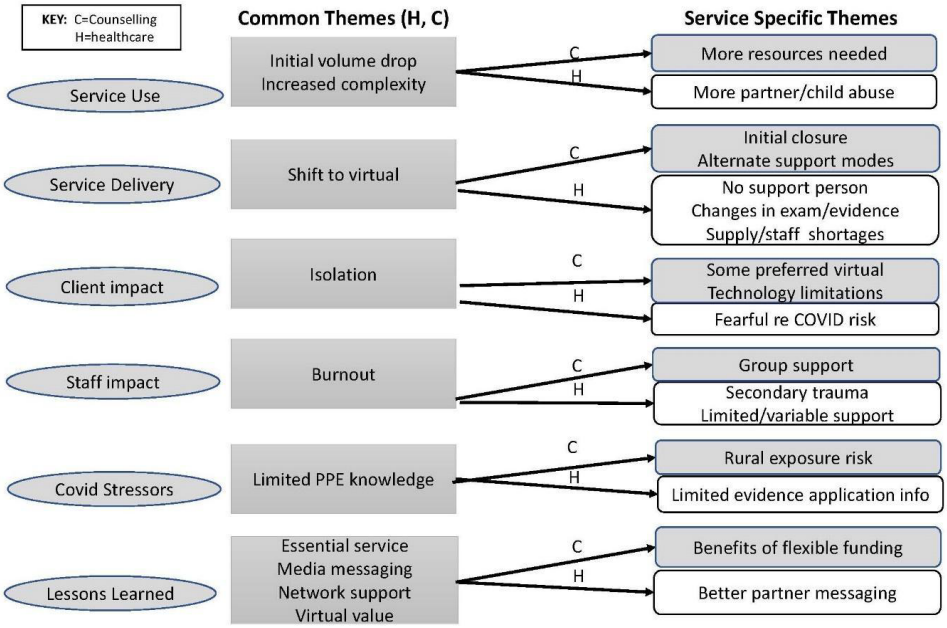
Figure 1.
Distribution of Participants across Canada



Categories and Themes

Content analysis revealed 10 consistent themes between healthcare and counselling professionals in the six major areas of interest: Service use, service delivery, client impact, staff impact, COVID stressors, and lessons learned. There was also consistency in the information provided related to the major focus areas of interest (changes to service delivery or use, changes in clients, COVID stressors, impact on staff and clients, and lessons learned). Themes within these categories are summarized in Figure 2. There were also differences in experiences, predominantly between the two groups of professionals, but also some urban/rural differences, and regional differences.

Figure 2.
Themes



a) Service Use

Most of the provinces described an initial drop in both counselling centre use and healthcare visits. The Eastern region reported less impact of COVID cases and minimal impact on their initial visits. The rate of visits increased as the lockdowns were eased and eventually resumed pre-pandemic levels. Some areas, mainly in Western and Central regions, surpassed their pre-pandemic volumes. Participants from provinces that experienced the initial drop indicated public messaging that instructed people to stay away from hospitals unless it was severe or an emergency. Both counselling and healthcare professionals described clients as not thinking their sexual assault was "severe enough" to burden the Emergency departments so chose to stay home. The professionals both described increased levels of complexity and/or severity of their clients and more mental health issues among their clients. Counsellors explained the complexity as clients needing more types of resources and referrals, and a need to increase suicide and safety checks. Healthcare professionals in most of the regions described increased severity and lethality of injuries, such as strangulation attempts, as well as a rise in intimate partner violence cases. Some healthcare agencies reported also seeing more child sexual abuse cases, acute and historic. Sexual assault volume appeared similar to pre-pandemic levels in most areas, although a few experienced increases.

b) Service Delivery

Both groups of services had some form of shift to virtual services. The shift to a virtual format for counsellors was necessary as most had to initially close with the lockdowns and could only keep crisis phone lines open. There was a delay in order to get the virtual services set up especially if affiliated with healthcare agencies, due to concerns related to security of health information. Decisions about which services to offer virtually were also required, as the nature of counselling changed with the pandemic. The focus was often described as being less on trauma counselling and more on managing the immediate crisis of the pandemic. Some counselling modalities transferred more easily than others. Centres had to become more creative with alternative ways to provide support for communities as well, such as creating support groups and mailing out aids for counselling sessions to community groups to run effectively. The adoption of virtual formats was also of mixed- use in service delivery. Some agencies found that cognitive based modalities transferred more easily than somatic or art therapies but that was not universal.

The healthcare agencies also adopted virtual services for their medical follow-up, and some used it to provide access to virtual counsellor support during the healthcare visit. COVID protocols limited the ability to support people to come into the healthcare exam. The healthcare services were able to remain open as they were part of healthcare services, but some had to relocate to Emergency to continue operating. Service delivery of healthcare was impacted in a number of regions by supply shortages (e.g., swabs and toluidine blue dye) but also by redeployment of staff. Although they could remain open, most provinces had not identified sexual assault services as essential, so nurses were often pulled into other clinical areas to meet demands. Some agencies were no longer able to provide 24/7 coverage. For example, o ne province was able to quickly set up an information line for the public to call and see which agency had a nurse examiner available shift by shift.

c) Client Impact

Both groups of service professionals described various forms of isolation experiences by their clients. Some counselling clients appreciated the virtual services, as it reduced barriers to

accessing the services even beyond the pandemic. Examples were those with limited mobility or those with limited transportation options. Other clients had difficulty with the virtual or remote delivery and felt more isolated. This isolation, in turn, worsened their trauma-related symptoms as informal supports (friends, family) were not available. Rural communities were impacted most often by the service delivery changes. They were typically challenged with access to reliable internet or lack of technology with which to access the internet. Some agencies had access to flexible funding which they were able to use for purchasing technology for community access.

d) COVID Stressors

The impact of dealing with COVID-19 was stressful, both directly and indirectly, for both counsellors and healthcare staff. Direct impacts related to the unknowns of dealing with how to use personal protective equipment, navigating understanding and fears related to risks of transmission, and having to restrict access of client support people during service provision. There was an urban/rural tension in some provinces related to vaccination cultures- the rural areas had higher rates of unvaccinated clients which created a tension around staff providing services if in person. Healthcare staff were unsure how to interpret the emerging infection transmissibility data to ensure they weren't passing on the virus. As an example, when it was unknown if the virus was spread by surface contact, one centre retained evidence kits for an additional 10 days before transferring to the police to ensure the virus would not be transmissible to them. This was later found to be unnecessary. There were no data available to guide the application of COVID protocols for forensic evidence collection and transfer, and staff had to adapt what was known based on clinical judgement. Some teams were able to create informal or formal networks to share their opinions and protocols and to discuss, share and plan courses of action. The indirect impact for all professionals was the added role strain that many carried during lockdown such as homeschooling, caregiving, and protecting family from transmission of the virus in addition to heavy workloads. Healthcare staff were frequently redeployed to Emergency, ICU, or other areas and, many continued to work extra shifts with the sexual assault teams. Coverage of all shifts 24/7 was not possible in some areas due to both redeployment and staff illnesses.

e) Staff Impact

There was a common sense of trauma across both healthcare and counselling groups. While there is slippage in terminology in the literature, there are three main forms of trauma professionals may experience: burnout, compassion fatigue, and vicarious trauma. The definitions used for this analysis are those of the Tend Academy (Mathieu, 2019). Burnout occurs when someone experiences trauma resulting from organizational issues and lack of control of the workplace. Compassion fatigue results from repeatedly caring and being unable to decompress or "refuel" the compassion satisfaction. Vicarious trauma, also called secondary traumatic stress, is the result of experiencing trauma through others. Using these definitions, burnout was the predominant form of professional trauma. The additional hours, redeployment, added workload and role strain, and professionals' personal fears and concerns about COVID-19 were all contributors to the burnout trauma. The added work of caring was seen as contributing to compassion fatigue. The experiences of their clients and severity or complexity of their experiences affected them, which is consistent with vicarious trauma. The shared experiences of these multiple forms of trauma were described by the counsellors as "collective trauma". Added to this was a sense of loss in not working together with their teams. All the counselling participants described additional measures they put into place for group support, staff incentives and rewards, debriefing sessions, and strategies to support staff. The healthcare staff similarly

described burnout with covering shifts for redeployed staff, additional home responsibilities and the uncertainty of how to manage their unique forensic needs with COVID. Healthcare staff also experienced some secondary trauma with the more severe injuries and the increased number of abused children. There was significant variability across the country in the support available to healthcare staff. At one extreme, staff in one location had to ask permission of their manager to contact Employee Assistance if stressed, while at the other extreme, teams created an informal network and reallocated funds to have a vicarious violence counsellor join regular virtual calls with staff.

f) Lessons Learned

The lessons learned continued across the last two years, as mandates and cases shifted as well as policies. Four key areas of learning were identified: the need for involvement in public messaging, recognition of sexual assault services as essential, the potential to continue virtual services, and, the value of pre-established networks and phone lines.

- Media/Public messaging. The impact of the "stay at home" messaging on clients' reluctance to seek services had not been anticipated and was in some cases harmful; possibly contributing to the severity of cases with delays. Participants expressed a need in the future to liaise with emergency services and community partners to modify the message and to ensure the community knew they were open and receiving clients.
- Recognition of sexual assault services as essential. Another key learning was the need for sexual assault service - both healthcare and counselling - to be recognized as essential services. Healthcare services were more likely to continue as they were located in health facilities, but staff were often reallocated, while counselling was often drastically reduced until they shifted to virtual.
- Continuation of virtual services. It was often commented that the virtual services were found helpful in many uses and hoped to continue with them as an option going forward. There continued to be issues with access to high-speed lines across Canada and technology so funding support would be required. In disasters or pandemics, the needs for technology or access to internet may also change. Many of the counselling communities received additional funding from the Canadian Women's Foundation (known as "WAGE" funds). The recipients learned how valuable it was to have undesignated or unrestricted funds such as these to allow them to respond quickly to the complex and unique needs of the community.
- Pre-established networks and phone lines. Networks were helpful both for providers and for the community. The networks between service providers were exceptionally helpful and more commonly found in counselling. Only a few of the provinces had any prior network set up and these were expanded, often with limited funds and volunteer time. The networks were helpful in assessing best practices given evolving evidence about COVID transmission, service delivery and supports. The networks also supported discussions of the implications for virtual service delivery (e.g., consent for services, safety strategies, best platforms, and software licensing). An added bonus of networks was a vehicle to connect staff, reduce isolation and sharing. They were used for sessions with vicarious violence counsellors, sharing circles, discussion of issues, and provision of general peer support. Support of staff was more common in counselling than in healthcare, which was a concern in some provinces. Some requested more robust types of services beyond

employee assistance for those on the front lines. Networks and access to support professionals on the networks would be one source to promote staff resilience. The networks were also helpful for community support and access. One province has a one number to call system staffed by a counsellor so community members can call in and find out where to go for services and be screened for safety. Another province set this up with existing phone lines so the community could find out which hospitals in the province had a sexual assault nurse available, but it was a phone not known to the community and advertising it added an extra burden on staff.

Discussion

Limitations

The focus of qualitative research is to understand the lived experience of participants rather than to quantify or predict with specific findings. There are not, therefore, simultaneous data to support the relative frequency of use and severity of injuries or client needs. Our confidence in the findings, however, is supported by the measures taken to establish rigor, saturation of themes, as well as consistency of the findings with other emerging literature. The cross-Canada representation of the participants and participant descriptions allows for determination of fittingness and transferability of the findings.

Implications for Practice, Education and Research

As noted, early effective interventions after recent sexual assault have been shown to reduce risks of posttraumatic stress disorder (PTSD),(Dworkin & Schumacher, 2018) which in turn can reduce clients' risks of further mental and physical consequences. Effective interventions are reliant upon provision of services by professionals who have specialized knowledge of comprehensive services and support. Despite the need for increased sexual assault services during disasters and pandemics, this has not been typical of the response and a consistent pattern of reduced or absent services is found at these times (Carter-Snell et al., 2022). Even when specialized counsellors or healthcare staff are available, they are typically deployed to other areas and their expertise is not put to use. International standards for disaster require that sexual assault services be made a priority during disasters given the increased risk (Interagency Working Group on Reproductive Health in Crisis, 2019; United Nations Population Fund-UNFPA, 2015). Despite these standards, there are not typically any gender-based violence guidelines implemented in North American disasters (Carter-Snell et al., 2022). The following recommendations for education and practice were derived from the participants and themes as well as the international recommendations.

Education and Practice

a) Prevention pre-event.

Strategies to prevent sexual assault during pandemics and other disasters are required. The nature of these varies with the type of pandemic or disaster but sexual assault professionals are well connected in the communities and are the best to determine resources. Emergency management agencies and health services disaster planning should include collaboration with sexual assault professionals both before an event and throughout. Service availability may change over time and the specialized professionals will know how to ensure comprehensive services

remain available. Sexual assault professionals provide excellent programming to prevent or reduce sexual assault and these efforts need continued support, promotion, and funding.

b) Media messaging/partners.

Inclusion of sexual assault professionals in disaster planning would allow emergency management teams to develop more effective public messaging and media. The "stay at home" order resulted in women not believing their assaults were "emergencies" and some delayed coming for help until effects were severe. In addition, the specialists are familiar with intersectionality and would be able to help focus messaging and identification of high risk or vulnerable populations where concentrated resources may be required. Messaging to partners was also an issue; for example, police were not always familiar with which services were available, or where to bring clients.

c) Essential services recognition and prioritization.

Government policy is required to ensure provision and continuation of sexual assault services along with prioritization of funding for sexual professionals, including sexual assault nurse examiners, health care teams, and counselling agencies. Without this support, sexual assault health care in particular, is often minimized or left to Emergency staff who are not typically familiar with best practices. Recognition of sexual assault counselling and healthcare as essential services helps ensure continued services during disaster and prioritization of re-opening services if closure is unavoidable. It would also limit the redeployment of specialized staff to other areas and reduce the burden and strain on remaining personnel.

d) Networking.

Each disaster or pandemic is unique. The importance of networking became clear in terms of assessing the best evidence and developing best practice protocols. These continued to evolve; so again, the network was valuable to share this information in a timely fashion. Only one counselling network and two healthcare networks were in place prior to the pandemic and only two of these were professionally developed, organized, and supported. The other was expanded using existing virtual networking and phone lines. The networks should be easy for staff to access and use. Healthcare teams within each province or territory and counselling services should be supported financially and with appropriate equipment to network. This also allows faster ability to pivot as needed when evidence changes and to provide consistent services. Networking for community awareness was also important to let partners and the public know where to go or what services remained. One province has a tollfree line already in existence, staffed by a counsellor to call and receive this information about where to go. Another province had to close some healthcare agencies due to redeployed staffing and decided to use an existing phone line staffed by volunteers for the community to call and find out which Emergency Departments had examiners on duty. Without a prior dedicated line, public awareness of this line a concern in the pandemic. A pre-established 24/7 phone line in each province would be preferred, with paid staff familiar with gender-based violence to answer calls, screen for safety and direct potential clients to best services. Familiarity with these lines would allow the community to know where to call during disasters and for staff to funnel information about what services remain accessible.

e) High speed internet Access and Technology

The virtual visit option was helpful and ideally will continue for some agencies. Rural areas in Canada do not consistently have access to high-speed internet, however, or may not have the

technology such as laptops or tablets to use for virtual visits. Support is needed in provinces and territories to provide internet, and to ensure potential clients can access the internet via technology. Many communities provide access through community spaces, health centres or libraries. Flexible funding to sexual assault agencies also supports purchase of some of these tools to ensure counsellors can connect with clients in healthcare.

Research

This study raises many questions and opportunities for further research. Examples of these include the following:

- Effectiveness of technology for various modalities of treatment and client support
- Models of networks, their development and sustainability for community support and staff support
- An environmental scan of protocols for virtual support that were used during the pandemic or other disasters and their relative effectiveness
- Staff impact burnout, compassion fatigue and vicarious violence- the occurrence of each, best practices in support and interventions, and facilitation of posttraumatic growth
- Client impact, including quantification of factors such as client satisfaction, feelings of being supported, incidence of mental health issues with various levels of support, and patterns of injury and injury characteristics with the pandemic.

Conclusion

The pandemic had an observable and important negative impact on sexual assault services accessibility, delivery and subsequent impacts on client and staff health. This study provided a beginning understanding of each of these impacts. Although limited by sample size and method, the gaps and findings were quite consistent across settings, and similar to findings of other studies. For instance, there were other reports of clients not knowing where to seek help as services were shut down or staff redeployed (Montesanti et al., 2022; Wood et al., 2021). The severity and complexity of client needs during the pandemic was also found elsewhere (Wood et al., 2021; Wood et al., 2022) as was the trauma experienced by staff (Haag et al., 2022). Challenges with conversion to virtual delivery were also described by others (Montesanti et al., 2022). These similar findings enhance the confidence and credibility of the findings. Implications for practice, research were identified to reduce risks of service gaps in future pandemics or disasters.

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