SFU FACULTY OF HEALTH SCIENCES

Master of Public Health
Capstone Project

Online Counseling Service for Survivors of Sexual Assault in British Columbia: A Business Case

By Owanari Kingson, BSc, MPH Candidate.

Senior Supervisor: Dr. Kate Tairyan, MD, MPH.
Second Reader: Caitlin Johnston, BA, MSc.

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DEFINITION OF TERMS

Sexual Violence: is defined "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work". For example rape, sexual abuse, forced marriage, forced abortion etc. (WHO, 2002).

Sexual Assault: occurs when physical, sexual activity is engaged in without the consent of the other person, or when the other person is unable to consent to the activity (RAINN, 2016). The activity or conduct may include physical force, violence, threat, intimidation, ignoring the objections of the other person, causing the other person's intoxication or incapacitation (through the use of drugs or alcohol) or taking advantage of the other person's intoxication (including voluntary intoxication).

- Sexual Assault Level 1- Any form of sexual activity forced on another person (i.e., sexual activity without consent), or non-consensual bodily contact for a sexual purpose (e.g., kissing, touching, oral sex, vaginal or anal intercourse). Level 1 sexual assault involves minor physical injury or no injury to the victim.
- Sexual Assault Level 2- A sexual assault in which the perpetrator uses or threatens to use a weapon, threatens the victim's friends or family members, causes bodily harm to the victim, or commits the assault with another person (multiple assailants).
- Sexual Assault Level 3- (Aggravated sexual assault) a sexual assault that wounds, maims, or disfigures the victim, or endangers the victim's life.

Crisis Line (Hotline): A phone number people can call to get immediate telephone counselling usually by trained volunteers.

Telephone Counselling: The delivery of counselling services for a variety of mental health and life problem concerns via telephone. Services range from crisis lines provided by paraprofessionals to traditional mental health counselling provided by licensed mental health professionals (Weiner & Craighead, 2010).

E-Counselling: the counsellor and client exchange e-mail instead of meeting face-to-face. Typically, e-mails are exchanged once a week for an average period of 3 weeks (Health Canada, 2012).

Access to Healthcare (Support service): the degree to which individuals and groups are able to obtain needed services from the medical care system

INTRODUCTION

Sexual assault is a serious public health and safety issue, a criminal justice issue and a threat to human rights globally (Shahali et al., 2014; Decker et al., 2014; Rossiter, Yercich, & Jackson, 2014). In Canada and around the globe, sexual assault is highly gendered (Benoit et al., 2015; Ontario Ministry of the Status of Women, 2015). Women are more likely than men to experience some form of sexual assault and this is persistent across time and provinces. In 2014, women self-reported 553,000 incidents of sexual assaults and accounted for about 92% of all police-reported sexual assault victims in Canada in 2008 (Canadian Women Foundation, 2016; Vaillancourt, 2010). In BC, 3.6% of the population reported having experienced sexual assault in the 2009 General Social Survey (GSS) (Rossiter, Yercich, & Jackson, 2014). Nonetheless, between 2014 and 2015 the national rate of police-reported level 1 sexual assault increased by 3%, the rate for level 2 sexual assault increased by 13% while the most serious sexual assaults (level 3) declined by 11% (Allen, 2016). Additionally, some women are even more vulnerable to sexual assault compared to the rest of the female population due other factors like their cultural and ethnic background, immigrant status, income and educational level, age, sexual orientation and physical, cognitive and emotional abilities (Zweig, Schlichter & Burt, 2002). This does not mean men are not survivors of sexual assault. However, due to more focus on female sexual assault survivors the nature and prevalence of sexual assault in the male population is limited.

Broader social and political contexts also contribute to and shape the prevalence of sexual assault in Canada. Structural violence in the form of historical, political-economic and social processes of Canada shape the way women are treated by the judicial system and the society at large. Dominant gender roles, rape myths and inherent biases in investigatory procedures of sexual assault cases all reveal the gendered structural violence women face in their daily lives

(Benoit et al., 2015). That being said, the prevalence of sexual assault in Canada is difficult to quantify since only a small proportion of sexual offences are formally documented (Brennan & Taylor-Butts, 2008). Additionally, interactions between different aspects of a person's identity and social location (determined by socio-economic status, age, race, ethnicity, ability, sexual orientation and employment status) can play a significant role in making certain persons more vulnerable to sexual assaults than others (Benoit et al., 2015). For example, Aboriginal women in Canada are 3 times more likely to be victims of violence compared to non-Aboriginal women- 21% Aboriginal women compared 6% non-Aboriginals experience some form of physical or sexual violence (Province of Newfoundland and Labrador factsheet, 2008; Brennan, 2011). Furthermore, violent victimization including sexual assault was 2-4 times higher for women with disabilities than those without (Martin et al., 2006; Canada Dept. of Justice).

Sexual assault may result in severe and long-lasting mental as well as physical health consequences (Luce, Schragger & Gilchrist, 2010). Compared to Canadian men, women are more likely to be physically injured, experience disruption in their daily lives and more likely to fear for their lives (Ontario Ministry of the Status of Women, 2015). Physical health impact of sexual assault includes assault related injuries, sexually transmitted infections, unwanted pregnancies, pelvic pain, gastrointestinal disorders, vaginal bleeding or infections, urinary tract infection, gynecological problems, a range of chronic pain disorders, short and long-term sexual health problems (Benoit et. al., 2015). Mental health effects of sexual assault include problematic substance use and substance dependence, posttraumatic stress disorder, clinical depression, anxiety, suicide ideation or attempts (Campbell, Dworkin & Cabral, 2009; Haskell, 2010). Sexual assault experienced by Aboriginal women has been linked to higher incidence of homelessness, self-harming behaviour, attempted suicide and suicide as well as other mental

health issues. Survivors of sexual assault may also experience stigmatization and ostracism from family and friends (Krug et al., 2002; Benoit et. al., 2015). Finally, sexual assault has great economic costs for Canadians. The direct cost of sexual assault in Canada (based on police reported incidents and estimates based on police, court, health care, social service costs and personal and productivity costs) is estimated to be about $546 million per year. If the physical and emotional pain and suffering are included the estimated cost rises to about $1.9 billion (Benoit et. al., 2015).

The goal of this capstone was to develop a business case for an online sexual assault counselling service that can be used by BC Women's Hospital (BCWH). The business case will be shared with BCWH Sexual Assault Services team, who will use it as a starting point to develop a more detailed business case. The following sources were drawn on to develop a business case that best fit the online counselling project: 1) reading of related literature 2) course-based knowledge 3) Some knowledge of the organizational structure of BCWH sexual assault services.

PROJECT BACKGROUND.

BC Women's Hospital and Health Centre Sexual Assault Services (SAS) comprises of specially trained female nurses, nurse examiners, doctors, and counsellors. They provide free services to people of all gender aged 13 and over who had experienced an assault within 7 days of their assault. The service options include assessment and treatment of injuries, sexually transmitted infections, and pregnancy prevention, as well as forensic sample collection and a report for police (for those patients who want to involve police). They also provide referrals to health, legal, and community-based support services. In addition to patient care, they provide training and education to health care providers and other professionals working in the area of sexual assault.

In 2015, the SAS team decided to expand their counselling services by providing a province-wide service that caters to clients/patients that are attended to by the Sexual Assault Nurse Examiners (SANEs) at VGH and UBC Hospital's urgent care as well as any other sexual assault survivors who for some reason could not access support services. This decision was made in order for the SAS department to accomplish one of their strategic goals. The goal is to be a provincial resource for sexual assault survivors and counselling services by providing up-to-date referral information on available services, increasing the reach of counselling service and increasing the number of minority populations accessing support services.

In order to understand the need for an online counselling service, it is important to discuss the various approaches to sexual assault prevention. Sexual assault interventions are usually targeted towards the three public health prevention categories:

1. Primary prevention: approaches that take place before sexual assault occurs to prevent initial victimization e.g. public education.
2. Secondary prevention: Immediate responses after sexual assault has occurred to deal with the short term consequences of violence e.g. immediate crisis counselling for survivor, medical attention in case of injuries.
3. Tertiary Prevention: Long-term response after sexual assault has occurred to deal with the lasting consequences of victimization (e.g. by providing ongoing counselling for survivors) and providing evaluation and treatment of the perpetrators (Centers for Disease Control and Prevention (CDC), 2004; Marshal, Laws & Barbaree, 2013).

BC Women's Hospital and Health Centre Sexual Assault Services (SAS) participates in all three categories of sexual assault prevention. However, until recently BCW's sexual assault services has been focused on its secondary prevention strategies. This includes assessment and treatment

of injuries, pregnancy prevention, forensic sample collection, medical reports and referrals to community-based support services. They offer these services through Vancouver General Hospital emergency department and UBC Hospital's urgent care centre. BC Women's SAS also provides follow up counselling care to survivors who indicate their willingness to be called by the SAS resident counselor.

EXECUTIVE SUMMARY

BC Women's Sexual Assault Counselling Service

Project Description

The need this project hopes to address includes the long waiting list for and lack of access to counselling services for survivors of sexual assault. The proposed service is an online and/or phone counselling services for survivors of sexual assault. The service aims to reach those who may not have available services (for example, only a few physically available services which serves wide geographical regions as is the case in Northern BC) or those that may be reluctant or unable to seek face-to-face services (e.g. male, marginalized women etc.) (Finn & Hughes, 2008).

Project goal

To provide confidential, non-judgmental telephone/online support, crisis intervention, information and referral services.

Project objectives

- To double the number of sexual assault survivors in BC receiving crisis counselling and support services by 2020.
- To facilitate continuity of care and support for 80% of clients by providing accurate referrals upon completion of a counselling session.
- Upon completion of counselling services, 25% of survivors will have a referral plan to necessary community services.
- To double access to respectful, empathetic and emotionally supportive counselling services and 70% increase survivors coping skills, knowledge at the end of each section.
- To increase the number of men and marginalized populations seeking sexual assault counselling and support services by 15% by 2025.

Current Situation

Sexual assault may result in severe and long-lasting mental and physical health consequences (Luce, Schragger & Gilchrist, 2010). Very few survivors seek post assault care services.

Barriers survivors face include:

- Long waitlists for survivors seeking counselling appointments in community-based programs. Of clients on a waitlist with Stopping the Violence (STV) counselling programs, 80% receive individual counselling within three months and 88% receive group counselling within three months. The ideal practice is to reduce wait time for those in need.
- Members of the LGBTQ+ community, marginalized and minority women (e.g. Aboriginal women, immigrant and refugee women, women with disabilities, sex trade workers) may be at higher risk of experiencing violence including sexual

asssault along with unique barriers to support and protection (Rossiter, Yercich, & Jackson, 2014). These include inaccessibility of existing services and resources, lack of specialized services that target their particular need and social isolation, lack of awareness of available services (Clifford, Porteous & Varcoa, 2007; Logan et al., 2005). For Aboriginal survivors, there is added fear of being isolated and shamed by their community, lack of confidentiality, distrust of "white institution", multiple barriers such as substance abuse, mental health issues etc. (BC Ministry of Public Safety and Solicitor General, 2007).

- Finally, there are much fewer cultural, social and physical support system for males (Bullock & Beckson, 2011; Donnelly & Kenyon, 1996).

The project would be an addition to BC Women's Hospital Sexual Assault Services. The project would implement a new telephone/online platform. The telephone aspect of the project would be modelled after BC Women's CARE counselling service. The online would be modelled after other online chat counselling services in Ontario as well as RAINN, USA.

1 BACKGROUND

[BC Women's Sexual Assault Counselling Service]

1.1 PROBLEM / OPPORTUNITY

The problem this project hopes to address is the long waiting lists common with most community-based sexual assault services program in BC. It also aims to improve access to counselling services for survivors of sexual assault from diverse populations. This creates a need for innovative ways to increase access to post-assault services across BC. The proposed service is an online and/or phone counselling services for survivors of sexual assault. The goal of this Project is to provide confidential, non-judgmental telephone/online support, crisis intervention, information and referral services. The service aims to reach those who may not have available services (for example, only a few physically available services which serves wide geographical regions as is the case in Northern BC) or those that may be reluctant or unable to seek face-to-face services (e.g. male, marginalized women etc.) (Finn & Hughes, 2008). Additionally, this project builds on existing infrastructure at BC Women's Hospital such as the CARE program.

1.2 CURRENT SITUATION

In 2014, Canadian women self-reported 553,000 incidents of sexual assaults while the rate of police-reported sexual assault of women by intimate partner rose by 17% between 2009 and 2013 (Canadian Women Society, 2016). Interpreted in terms of proportion, 39% of Canadian adult women reported having had at least one experience of sexual assault since the age of 16 (Ontario Ministry of the Status of Women, 2015). In BC, 3.6% of the population reported having experienced sexual assault in the 2009 General Social Survey (GSS) (Rossiter, Yercich, & Jackson, 2014). Sexual assault may result in severe and long-lasting mental and physical health consequences especially when left untreated (Luce, Schragger & Gilchrist, 2010; Finn and Hughes, 2008). Research shows that sexual assault survivors are 13 times more likely to attempt suicide than non-crime victims and 6 times more likely than victims of other crimes (Finn and Hughes, 2008; Munro, 2014). However, very few survivors seek out acute care services following a sexual assault. Many Sexual Assault Nurse Examiners (SANE) programs in accordance with recommendations from the World Health Organization (WHO) schedule a follow-up service within two weeks of the initial exam with survivors who reach out to the

program (Darnell et al., 2015; WHO, 2003). This follow-up provides a medical checkup and assessment for needs for psychosocial and mental health service. Unfortunately, linking sexual assault survivors to follow-up assessment of medical and psychosocial needs is challenging resulting in many survivors not receiving needed services (Darnell et al, 2015; Ullman, 2007). In addition, most survivors do not pursue mental health services or counselling within the year of the assault and some survivors would never seek mental health services for problems related to the assault. This has resulted in low utilization of mental health services by sexual assault survivors (Darnell et al., 2015; Logan et al., 2005).

Marginalized and minority women (e.g. Aboriginal women, immigrant and refugee women, women with disabilities, sex trade workers) may be at higher risk of experiencing violence including sexual assault along with unique barriers to support and protection (Rossiter, Yercich, & Jackson, 2014). For example, Aboriginal women in Canada are 3 times more likely to be victims of sexual assault compared to non-Aboriginal women- 21% Aboriginal women compared 6% non-Aboriginals experience some form of physical or sexual violence (Newfoundland and Labrador factsheet, 2005; Brennan, 2011). Furthermore, violent victimization including sexual assault was 2-4 times higher for women with disabilities than those without (Martin et al., 2006; Canada Dept. of Justice). Marginalized survivors also suffer from societal traumas which include intergenerational trauma, race-based trauma, sexism, racism, classism, heterosexism, historical trauma, insidious trauma, cultural violence etc. These may result in mental health effects for example PTSD, physical health disparities and substance abuse that predate the sexual assault trauma. However, current models for recovery may not fully address the mental health needs of minority survivors (Bryant-Davis, Chung & Tillman, 2009; Ullman, 2007).

Barriers in Accessing Support Services

The impact of the social determinants of health as well as an individual's socioeconomic status, ethnic and racial background on healthcare access disparity has been well documented (Carillo et al., 2011). According to the Health Care Barriers Access model, there are three categories of modifiable healthcare access barriers- Financial, Structural and Cognitive/Individual barriers. All three categories of barriers are mutually reinforcing and affect health care access individually and synergistically. Financial barriers to healthcare access occurs when patients are uninsured or

underinsured i.e. individuals with health insurance who cannot access healthcare due to financial burden imposed by addition fees (Parikh et al., 2014). Structural barriers can be defined as "forces that work outside the individual and beyond the individual's control to foster or impede health or health behaviors, and they often distally impact health outcomes in diffuse and indefinite ways" (Levi et al., 2014). They describe healthcare system's availability and such barriers may be found within or outside the healthcare facility. Examples of structural barriers include lack of transportation, inability to obtain convenient appointment times, limited availability and proximity of facilities (Carillo et al., 2011; Kroll et al., 2006). Cognitive/Individual barriers are based on an individual's beliefs and knowledge of disease, prevention and treatment as well as the communication between client and provider. Example of individual barriers include lack of awareness of accessible facilities, linguistic barriers etc. (Carillo et al., 2011).

One major barrier survivors experience in accessing mental health and counselling services is long waitlists for women seeking support in community-based centres (Women against Violence against Women (WAVAW), 2016). Of clients on a waitlist with STV counselling programs, 80% receive individual counselling within three months and 88% receive group counselling within three months (Suleman, & McLarty, 1997). There is also the social constraint placed on community-based services as they typically operate during business hours which could exclude patients who work during these hours and cannot afford to take off-days. Additional barriers may also include travelling to and from appointment and for care-givers (for example those taking care of children) searching for additional support while they attend their appointment (Ritterband et. al., 2009). The unique barriers faced by all marginalized populations include- inaccessibility of existing services and resources (due to physical availability or because of perceived inaccessibility), lack of specialized services that target their particular need, lack of awareness of available services, social isolation and stigma (Clifford, Porteous & Varcoa, 2007; Logan et al., 2005; Munro, 2014).

Specifically, survivors with disabilities face barriers in accessing services due to inadequate services, immobility and difficulty in physically accessing services. For example, physical accessibility to those who are sight-impaired or hearing impaired is often incomplete or non-existent (BC Ministry of Public Safety and Solicitor General, 2007). They may be isolated from

sources of social support and assistance and maybe unaware of available services. Immigrant women may not know about the availability of services available to them. They may also lack knowledge of immigration and refugee laws and rights. They could face language barriers, isolation and if the abuse is occurring within marriage, the threat of being sent back home (BC Ministry of Public Safety and Solicitor General, 2007). Those with precarious citizenship status or no legal status may be afraid that their stay in the country may be jeopardized and hence would be reluctant to seek services for fear of deportation (Benoit et. al., 2015). Gay and lesbian survivors may have problems in (perceived) accessibility of sexual assault services in general and support services in particular as mainstream services were originally designed for heterosexual women. A research indicates that lesbian women were unlikely to use any resources but rather needed more lesbian- or women-centred resources. However, in Canada, there is still a scarcity of gay/lesbian specific services and many members of the LGBTQ+ are unaware of mainstream services that are sensitive to their needs (St. Pierre & Senn, 2012; BC Ministry of Public Safety and Solicitor General, 2007). For Aboriginal survivors, there is added fear of being isolated and shamed by their community, lack of confidentiality, distrust of "white institution", other barriers such as substance abuse, mental health issues etc. (BC Ministry of Public Safety and Solicitor General, 2007). In addition, counselling of Indigenous patients using methods used by the cultural mainstream has been said to perpetuate colonial oppression. Hence, many Indigenous people often do not/would not engage in services that do not value their way of knowing (King, Smith & Gracey, 2009; WAVAW, 2014).

Although many victim service programs serve women with multiple barriers, very few of these services specifically tailor services to the unique needs of such clients (Zweig et. al., 2002). Current services in BC are "provided mainly in English, are not suitable for all age ranges of women, rarely make accommodation for physical and mental health issues, are often Euro-centric and are primarily aimed at heterosexuals" (Haskell, 2010). This creates accessibility issues for many marginalized populations that do not fit into the dominant culture of these support services. In 2007, there were fourteen victim service programs in BC which focused on Aboriginal crime victims. Of the fourteen programs, only three specialized in serving domestic or sexual assault victims and only one specifically served youths. Furthermore, only four victim service programs specifically serve immigrant victims of crime, two of which specialize in serving survivors of sexual assaults (Clifford, Porteous & Varcoa, 2007). The number of services

has not increased since 2007 due to lack of funding for "women's" services (WAVAW, 2016). However, organizations like WAVAW connects Aboriginal women with available Friendship Centres and cultural centres located in British Columbia (WAVAW, 2014). Nevertheless, as Aboriginal women in Canada are more vulnerable and are 3 times more likely to be victims of sexual assault compared to non-Aboriginal women, WAVAW alone cannot cater to the entire population in need (WAVAW, 2014).

The publicity of sexual assault as a "female-only" issue has contributed to the neglect and isolation of male survivors of sexual assault (Davies, 2000). This neglect together with the social gender norms that view men as sexually aggressive, strong and better able to protect themselves makes it difficult for men to admit to that they have been sexually assaulted. Additionally, male survivors may be reluctant to disclose their experiences for fear of being labelled future perpetrators or homosexual, as well as fear of treated as social outcasts, liars or emotionally weak. Finally, there are much fewer cultural, social and physical support systems for males victims (Bullock & Beckson, 2011; Donnelly & Kenyon, 1996; Neame & Heeman, 2003; McDonald & Tijerino, 2000). Most community-based victim service programs in BC (usually run and managed by women) cater mainly to female and children survivors although some programs have provisions for all genders. In fact, there are only about 3 male specific support services in BC. This is problematic for male survivors as they similarly suffer from the emotional and mental effects of assault that their female counterparts face. Additional societal pressures may cause more unique mental health issues requiring men to have targeted services that can help address these unique challenges brought on by cultural norms. Some examples of this unique mental health issues include self-identity crisis, sexual dysfunction and frequent sexual activity with many partners (McDonald & Tijerino, 2000)

Severity of Sexual Assault

As previously stated, sexual assault may result in severe and long-lasting mental and physical health consequences. Women in Canada are more likely to be physically injured, experience disruption in their daily lives and more likely to fear for their lives compare to men (Benoit et al., 2015). Physical health impact of sexual assault includes assault related injuries, sexually transmitted infections, unwanted pregnancies, pelvic pain, gastrointestinal disorders, vaginal bleeding or infections, urinary tract infection, gynecological problems, a range of chronic pain

disorders, short and long-term sexual health problems (Benoit et. al., 2015; Kimerling & Calhoun, 1994). For Aboriginal women, in particular, sexual assault has been linked with the rising rates of HIV/AIDS (Hawkins, 2009). Physical health problems including those related to stress, substance abuse and risk taking can also arise from the mental health consequences of sexual assault (Benoit et al., 2015).

Mental health effects of sexual assault include problematic substance use and substance dependence, posttraumatic stress disorder, clinical depression, anxiety, suicide ideation or attempts (Campbell, Dworkin & Cabral, 2009; Haskell, 2010). Sexual assault experienced by Aboriginal women has been linked with higher incidence of homelessness, self-harming behaviour, attempted suicide and suicide as well as other mental health issues. Survivors of sexual assault may also experience stigmatization and ostracism from family and friends (Krug et al., 2002; Benoit et. al., 2015). Finally, sexual assault has great economic costs for Canadians. The direct cost of sexual assault in Canada (based on police reported incidents and estimates based on police, court, health care, social service costs and personal and productivity costs) is about $546 million per year. If the physical and emotional pain and suffering are included the estimated cost rises to about $1.9 billion (Benoit et. al., 2015).

2 PROJECT DESCRIPTION

2.1 PROJECT DESCRIPTION

The project's goal is to provide a telephone and internet-based one-to-one counselling and referrals to support services to survivors of sexual assault. Online and telephone services would utilize both licensed and student counsellors who are also trained in sexual assault survival counselling as well as E-counselling. Additionally, volunteer counsellors who are trained in crisis intervention, support skills, and information and referral at their local rape crisis centre or at BC Women Sexual Assault Services will provide support for the program. The counsellors would be in charge of providing sexual assault counselling, education and information, provide referrals to assist with other needs and offer crisis intervention. Resource materials for example educational materials regarding criminal justice, medical and emotional issues would be provided to the volunteers to supplement their knowledge of sexual assault crisis information. Counsellors would be able to access information during a session and can send them to the client. Clients would be able to access the telephone/online service through various ways including search engines, referrals, through print media, by word of mouth etc.

2.2 OBJECTIVES

This project has several objectives

- To double the number of sexual assault survivors in BC receiving crisis counselling and support services by 2020.
- To facilitate continuity of care and support for 80% of clients by providing accurate referrals upon completion of a counselling session.
- Upon completion of counselling services, 25% of survivors will have a referral plan to necessary community services.
- To double access to respectful, empathetic and emotionally supportive counselling services and 70% increase survivors coping skills, knowledge at the end of each section.
- To increase the number of men and marginalized populations seeking sexual assault counselling and support services by 15% by 2025.

2.3 SCOPE

Timeframe: Continuous- Project to start within the next fiscal year

Department/Organization: Sexual Assault Service (SAS) - BC Women Hospital + Health Centre, Vancouver

Function: This project would be an expansion of BC Women's sexual assault counselling services which currently offers in person and over the phone sessions with survivors examined at VGH or UBC Hospital. BC Women's SAS would be in charge of directing and overseeing/supervising the counselling service.

Technology: The project would include a toll-free telephone/online platform. The telephone aspect of the project would be modelled after BC Women's CARE counselling service. The online component of the counselling would be modelled after other online chat counselling services in Ontario and RAINN in the US. Currently, there is no system in place for sexual assault online counselling in BC.

2.4 RATIONALE FOR ONLINE SERVICES

The rational for an online counselling service is based off: 1) existing research that show that the rate of sexual assault for Canadians age 15 to 24 is 18 times higher than that of Canadians age 55 and older (Brennan & Taylor-Butts, 2008). 2) The increasing use of internet especially by young people to obtain information and social support. (Finn & Hughes, 2008). There 25.5 million internet users in Canada making them the heaviest users of internet in the world (Mental Health Commission of Canada, 2014). 3) Increasing evidence that online therapeutic services are as effective as face-to-face counselling (Beattie, Cunningham, Jones, & Zelenko, 2006; Cook & Doyle, 2002; Richards, 2009). 4) Reluctance of many victims to report victimization to traditional authorities (Finn & Hughes, 2008).

Additionally, an evaluation conducted on the RAINN national sexual assault online hotline USA reported that volunteers were able to meet a variety of long-term health and mental health needs through empathy, problem solving, and information and referrals (Finn & Hughes, 2008; Finn, Garner, & Wilson, 2011). Patients of other online counselling services have reported decreased stigma with distance services when compared to face-to-face services (Mental commission of

Canada, 2014). Finally, BC Women's Hospital currently operates a hotline service for their abortion and pregnancy CARE program hence, this project would be building on knowledge and resources acquired by the CARE program.

2.5 Anticipated Outcomes

This section itemizes specific and measurable deliverables of the project. Each outcome includes an estimated time frame of when the outcome/deliverable will be completed (in terms of elapse time from project start).

Outcome/Deliverable	Estimated Completion
50% increase in knowledge of online sexual assault counseling by counsellors	1-3 months
10% Increased clients' awareness of options and available resources	6 months- 1 year
5% increase in number of disclosed sexual assault cases to formal sector (counselling services)	1 year
15% increase in number of SA survivors seeking counselling and support services	2 years
5% increase in the number of men and marginalized population seeking counselling and support service	2-3 years
15% increase in practice of effective coping and self-care strategies	2-3 years
25% increase in the number of sexual assault survivors receiving crisis counselling and support services	5 years
15% increase in the number of men and marginalized populations seeking sexual assault counselling and support services in BC	6-10 years

2.6 STAKEHOLDERS

Stakeholders:	Overview of Business Requirements
Primary – Internal	
BC Women's Sexual Assault Service- Counselling	Understanding of operation of telephone/online counselling service. Location for the operation of telephone/online counselling services.
Primary – External	
Sexual assault counsellors	Training on online and telephone counselling Supervising student counsellors
Secondary – Internal	
PHSA	Provision of ongoing funding to the Project
Sexual Assault Survivors	Active use telephone and online counselling services.
Secondary – External	
WAVAW	Collaboration with BC Women to provide support, training and recruitment of counselors.
Community-based Rape Crisis Centres	Recruitment of volunteer counsellors. Dissemination of information to survivors and volunteers.
BC Royal Canadian Mounted Police (RCMP) and Vancouver Police Department	Dissemination of information to survivors

3 STRATEGIC ALIGNMENT

Description:

Review the business plans of all internal stakeholders and identify specific goals that the project will help achieve. Identify the level of impact the project has on achieving the various business plan's goals by scoring the impact high, medium, or low, using the following guidelines:

High indicates that the project is critical to the achievement of the goal

Medium indicates that the project directly impacts the goal but it is not critical to its attainment

Low indicates an indirect impact to the achievement of the goal

Goal from BC Women's Business Plan	Level of Impact	Explanation (if required)
Be a provincial resource for information and education	Medium	
Expand counselling services to reach Northern parts of BC	High	
Providing inclusive service to diverse population	High	

4 ENVIRONMENT ANALYSIS

Description:

While there is currently no online (chat-based) counselling service in BC for sexual assault, there is a telephone and texting helpline - WAVAW 24-hour crisis line. In Ontario, they have a number of telephone, texting and online (web-chat) counselling options with many starting to include video-chatting as part of their services (example SACHA sexual assault centre, an Aboriginal specific helpline- Talk4healing). Alberta has the Central Alberta Sexual Assault Support Centre which includes web-chat options available during operating hours (9am-4:30pm). In the United States, there is a national sexual assault online hotline (RAINN- USA). Australia also has sexual assault online counselling services for most of their jurisdiction and various stages of patient recovery (Forgan, 2011).

WAVAW 24-hour crisis line: The 24-hour telephone crisis line has been in existence for 25 years and offers services to women in Vancouver and the rest of Lower Mainland. The goal of the project is to provide a year around, toll-free, 24-Hour Crisis Line. In 2015, WAVAW responded to 3,956 crisis line calls and had 33 women who volunteered to answer after hour crisis line calls. WAVAW attributes the success of their program to their volunteer program which provided about 200 hours of volunteer training. While WAVAW received $707, 000 as donations (about 50% of their total funding) in 2015, it is difficult to ascertain how much was spent on the 24-hour crisis line.

RAINN (Rape, Abuse& Incest National Network): This is the largest anti-sexual violence network in the United States. They operate a National Sexual Assault Hotline, accessible 24/7 by phone and online and closely with more than 1,000 local sexual assault service providers across the country. They aim to offer confidential support services to survivors regardless of where they are in their recovery. Since their inception, their telephone and online hotlines have helped more than 2.5 million survivors. According to their financial audit for 2015, RAINN spent a total on $3,337,653 on their victims' service program of which the telephone/online hotline is the major component.

SACHA Sexual Assault Centre: This provides free telephone support services to women survivors of sexual assault. They work in coalition with the Ontario Coalition of Rape Crisis

Centres. This year, they started a pilot online (web-chat and text) option which runs on Fridays 6pm to 2am and Mondays 6pm to 12am. This pilot program would be carried out until December, 2017 and would hopefully be expanded following an extensive evaluation.

Talk4Healing: Provides telephone and live chat hotline services to Aboriginals in Ontario. The service is available in English, Ojibway, Oji-Cree and Cree provided by trained Aboriginal counsellors. Their goal is to provide services for women living in urban, rural and remote communities both on and of reserve in a culturally specific manner. By the second year of their operation, they responded to 4,395 phone calls from Aboriginal women living in their target region. It was impossible to find out the operational cost of the program.

5 ALTERNATIVES

Due to the nature and the impact of sexual assault on the survivor, there are very few alternatives available to survivors to improve their health outcomes.

Alternative 1: Do nothing (Status Quo). There are over 60 community-based programs located throughout the province that assist victims of family and sexual violence including sexual assaults (BC's Criminal Justice System, 2017). The current number of available services helps meet a critical need for support of sexual assault survivors. However, there are more people needing services than can be attended to due to long waiting list in most of these community-based programs. Additionally, most programs operate normal business hours could make it difficult for some members of their target population to access their services. Finally, current community-based services may not be able to reach marginalized or other unreached populations who cannot leave their house for various reasons.

Alternative 2: Telephone only service. A telephone crisis line is the most common option that has been used to tackle sexual assault crisis intervention. Although, there are numerous 24-hour crisis lines available in BC, there are only about three telephone counselling services targeted at sexual assault survivors.

One major advantage of this system is that calls can be made toll-free thereby reducing economic worries for survivors. Another advantage is the ubiquitous availability of telephone services globally- In British Columbia, 99.4 per 100 households subscribe to landline and/or mobile wireless telephone services (Canadian Radio-television and Telecommunications Commission (CRTC), 2016). However, this option has a few limitations. Firstly, there is some indication that youths perceive chat/online counselling quality to be equal or marginally better than telephone counselling options (Fukkink & Hermanns, 2009; Finn, Garner, & Wilson, 2011). Secondly, group counselling options are unavailable for difficult to reach populations that may desire or require this service.. Additionally, the cost of running a telephone only service is only marginally less than a combination of telephone and online service.

Alternative 3: Telephone and online service (**Recommended**). There is an increasing amount of evidence on the efficacy of online therapy. Evidence suggests that a combination of telephone and online counselling services may have a better reach than just telephone or online services. This is because some clients may prefer to write out their discussions rather than talk about their experience. Having online as well as telephone services provides these options to clients. Evidence from an online

counselling service for children and youths in Australia found that young people with more serious cases used online services more than telephone services. They also found that patients stayed in a counselling section longer than telephone and reported a greater sense of safety, anonymity and control in their interactions with a counsellor than on the phone (Beattie et al., 2006). Additionally, there are major opportunities of creating targeted portals within the online platform, making it easier to provide culturally sensitive as well as specific support for multi-barriered clients. The presence of a permanent record provides the client and counsellor opportunities to review and reflect on the process. Finally, online counselling also provides an opportunity for more in-depth research of counselling interactions. This is the most expensive in monetary and training costs however, the health and non-health benefits balance the costs.

6 BUSINESS AND OPERATIONAL IMPACT

Description:

For each stakeholder (outlined in Section 3) all business (strategic, longer term focused) and operational (procedural, detailed focused) impacts that may arise from the project have been identified.

For each impact use the following guidelines:

High indicates that the magnitude of impact is significant and stakeholder support and preparation is critical to the alternative's success

Medium indicates that there is a manageable impact to the stakeholder

Low indicates the alternative will have a minor impact to the stakeholder

None indicates that the stakeholder will not be impacted by the alternative

Impact & Description	**Alternative 1**	**Alternative 2**	**Alternative 3**
Stakeholder 1: BC Women Sexual Assault Services- Counselling.			
Business impact- change in mode of service delivery	Low	Medium	Medium
Operational impact- Recruitment and training of counsellors required	Low	Medium	Medium
Operational impact- Redirection of funds from other SAS Projects	Low	High	High
Stakeholder 2: Sexual Assault Volunteer counselors			
Operational impact- increased number of working hours	Low	Medium	Medium
Operational impact- Number of training and information required.	Low	High	High
Stakeholder 3: PHSA			
Business impact- Change in budget for sexual assault services	Low	Medium	Medium
Stakeholder 4: WAVAW			

Operational impact- number of people visitors to WAVAW centre	Low	Medium	Medium
Operational impact- Number of callers on telephone service	Low	Low	Low
Stakeholder 5: Sexual Assault Survivors			
Operational impact- Number of survivors accessing services	Low	High	High
Stakeholder 6: Rape Crisis Centre			
Operational impact- Number of visitors to community-based programs	Low	High	High

7 PROJECT RISK ASSESSMENT

7.1 RISK OF PROJECT AND EACH VIABLE ALTERNATIVE (NOT INCLUDING STATUS QUO)

Project Risk Assessment	**Telephone only service**		**Telephone and Online service**	
	Probability	Impact	Probability	Impact
Risk 1 – Lack of support from PHSA	Medium	High	Medium	High
General Mitigation Strategy:	***Specific strategy***		***Specific Strategy***	
Provision of evidence relating to the need and efficacy of project	Evaluation report of existing services tailored towards sexual assault.	Refining of business case/plan.	Evaluation report of existing services tailored towards sexual assault	Refining of business case/plan
Risk 2 – Inability to free-up critical business resources	Medium	Medium	Medium	High
General Mitigation Strategy	***Specific Strategy***		***Specific Strategy***	
Identification and utilization of alternate cost-effective project inputs and/or alternate funding	Locating and utilizing cost effective project inputs. For example cost-effective telephone subscription, use of volunteers etc.	Identifying alternative funding sources for example fundraising.	Locating and utilizing cost effective project inputs. For example cost- effective computer software, telephone subscription, use of volunteers etc.	Identifying alternative funding sources for example fundraising. Collaboration with other stakeholders in sexual assault services across BC.
Risk 3- Inadequate Counsellors	Low	High	Medium	High

General Mitigation Strategy	***Specific Strategy***		***Specific Strategy***	
Continuous assessment of staffing needs	Continuous feedback from staff and clients	Periodic recruitment of new counsellors Provision of practicum placements for students in counselling and social work	Continuous feedback from staff and clients	Periodic recruitment of new counsellors Provision of practicum placements for students in counselling and social work
Risk 4: Project would not reach varied target population	Medium	Medium	Medium	Medium
General Mitigation Strategy	***Specific Strategy***		***Specific Strategy***	
Media awareness be framed for different populations	Collaboration with local communications firm to produce population specific and relevant promotional and educational material.	Conduct a test launch in small regions of target population and refining project from the results of test launch.	Collaboration with local communications firm to produce population specific and relevant promotional and educational material. Creating culturally sensitive web image and design.	Conduct a test launch in small regions of target population and refining project from the results of test launch.
Risk 5: Secondary Victimization of clients	Medium	High	Medium	High
General Mitigation strategy	***Specific Strategy***		***Specific Strategy***	
Continuous feedback from clients through survey.	Continuous training of	Re-assignment of	Continuous training of supervisors	Re-assignment of counsellor

	supervisors and counsellors	counselor responsible for victimization	and counsellors	responsible for victimization
Risk 6: Cost estimates unrealistic	Medium	Medium	Medium	High
General Mitigation Strategy	***Specific Strategy***		***Specific Strategy***	
More thorough Cost analysis of industry standards	Industry expert prediction using proven practices to 15% margin of error	Reduce the number of initial startup counselling stations	Industry expert prediction using proven practices to 15% margin of error	Start with telephone counselling and then introduce online component after telephone counselling service stabilizes.
Risk 7: Vicarious trauma for student counsellors	High	High	High	High
General Mitigation strategy	***Specific Strategy***		***Specific Strategy***	
Provide support system for counsellors	Debriefing counsellors after every shift	Limit the amount hours working with clients per month	Debriefing counsellors after every shift	Limit the amount hours working with clients per month
Risk 8: Overwhelming already stretched community-based services.	Medium	High	Medium	High
General Mitigation strategy	***Specific Strategy***		***Specific Strategy***	
Active collaboration with community-based services to distribute clients	Periodic meeting with discuss redistribution of clients	Active retention of clients on the online service	Periodic meeting with discuss redistribution of clients	Active retention of clients on the online service

7.2 Risk of Not Proceeding with Project (Status Quo)

Project Risk Assessment	**Status Quo**	
	Probability	Impact
Risk 1 – Number of people needing counselling services increases	Low	High
General Mitigation Strategy	*Specific Strategy*	
Create awareness and increase utilization of already existing alternate support services.	Increase availability and awareness of self-help coping strategies.	Increase awareness of benefits of group counselling sessions.
Risk 2 – Staff burnout in community-based programs	Medium	High
General Mitigation Strategy	*Specific Strategy*	
Increase critical business resources available to community-based programs.	Increase funding available to community-based programs. Increase awareness of human resource need through media campaigns.	Increase the use of blended staffing methods i.e. a mix of paid staff and volunteers. Restructure of current delivery model to be more targeted.

8 COST/BENEFIT ANALYSIS

8.1 ESTIMATED COSTS

Timeframe:

Ongoing monitoring system should be in place to capture call volume and the quality of service. A process evaluation should also be conducted annually to assess the impact of the counselling service on the target population.

Estimated startup for telephone only service

Budget Item	**Description**	**Subtotal**	**Total CAD**
Personnel	Coordinator 1 FTE	$3,800/Month x 12 months	$45,600
Personnel	Trained full-time counsellors x 3 Office manager (for computer system and data management)	- $4,347/month per person x 12months - $4,200/month x 12 months	$206,492
Project expenses	Equipment and supplies - Telephone lines x 6 - Computers x 3 - Telephones x 6 - Desks and chairs x 6 - Automatic call distribution (ACD) system - Management Information System - File cabinet x1 Counsellor Training - IPC skills training for telephone counselling (10 participants for 11 weeks)	 - $1,100 - $3,000 - $1,000 - $1,320 - $45,000 - $30,000 - $185 - $1000 per week	$81,420 $11,000

Project expenses	Other Direct costs - Basic telephone services - Monthly service charge for internet access - Office costs (copying, paper, mail etc.) - Promotional material	 - $300/ month x 12 months - $45/month x 12 months - $180/month x 12 months - $2,200	$8, 500
Project management	Monitoring and Evaluation activities	$10,000	$10,000
Project management	Communication/Correspondence etc.	$2,500	$2,500
Project Management	Report writing	$1,000	$1,000
Administration	Counselling Supervisor	$300/month x 12months	$3,600
Financial audit/Review	$3,000 per fiscal year		$3,000
			$373,112

Estimated start-up budget for Telephone and online option.

Budget Item	**Description**	**Subtotal**	**Total CAD**
Personnel	Coordinator 1 FTE	$3,800/Month x 12 months	$45,600
Personnel	Trained counsellors x 3 Office manager (for computer system and data management)	$4,347/month x 12months $4,200/month x12 months	$206,492
Project expenses	Equipment and supplies - Telephone lines x 6 - Computers x 6 - 32’ LCD monitors x 6 - Dual monitor stands x 6	 - $1,100 - $6,000 - $1,224 - $984	

	- Telephones x 6 - Desks and chairs x 6 - Integrated Automatic call distribution (ACD) system and Computer telephony integration (CTI) - Five9 cloud contact system software. - File cabinet x 1 - Website design - Management Information System Counsellor Training - Skills training for web-based counselling (10 participants for 11 weeks)	- $1,000 - $1,320 - $60,000 - $185 - $20,000 - $30,000 - $1,000 per week	$121,813 $11,000
Project expenses	Other Direct costs - Basic telephone services - Monthly service charge for internet access - Office costs (copying, paper, mail etc.) - Promotional material	- 300/ month x 12 months - 45/month x 12 months - 180/month x 12 months - 2,200	$8, 500
Project management	Monitoring and Evaluation activities	10,000	$10,000
Project management	Communication/Correspondence etc.	2,500	$2,500
Project Management	Report writing	1,000	$1,000
Administration	Counselling Supervisor	$300/month x 12months	$3,600
Financial audit/Review	$3,000 per fiscal year		$3,000
			$413,505

8.2 Qualitative Analysis – Non-Financial Benefits & Costs:

Telephone and online counselling services

Qualitative Summary	**Description**	**Stakeholder(s) Impacted**
Benefits:		
Health Benefits	Decreased stigma with distance services when compared to face-to-face services (Mental commission of Canada, 2014). Support for survivors to recover from or at least manage the mental health effects of sexual assault (Finn & Hughes, 2008). Gateway to users to whom access to traditional means of sexual assault support are not available. Reduces inhibition of clients which may increase the likelihood of disclosure (Finn & Hughes, 2008)	- SAS Counsellor - Volunteer counsellors - SA survivors
Non-Health Benefits	Accessibility for remote/marginalized survivors (Beattie et al., 2006). Freedom from geographical and temporal restrictions. Cost-effectiveness, self-determination for clients, leveling the power balance between client and service provider and presence of a permanent record which provides the client and counsellor opportunities to review and reflect on the process (Beattie et al., 2006; Cook & Doyle, 2002).	- SAS Counsellor - Volunteer counsellors - SA survivors

8.3 ASSUMPTIONS

Overall Assumptions

- The project would use a blended staffing model using both paid counsellors and volunteers.
- The Project would be ongoing
- Increased use of counselling services by survivors

9 CONCLUSIONS AND RECOMMENDATIONS

9.1 CONCLUSIONS

This business case clearly supports the telephone and online counselling option

Alternative	Business & Operational Impact	Project Risk Assessment	Cost/Benefit Analysis
Alternative 1	Low	Low	-
Alternative 2	Medium	Medium	$373,112
Alternative 3	High	High	$413,505

9.2 RECOMMENDATIONS

Recommend the implementation of Alternative 3 since its strategic alignment is high while being only marginally more expensive than Alternative 2.

9.3 PROJECT RESPONSIBILITY

The initial phase of the Project should be managed by the current Program manager of BC Women's sexual assault services. She would be in charge of directing, implementing and monitoring the progress of the project. Subsequently, the project coordinator would be in charge of overseeing the operations of the project.

9.4 PROJECT ACCOUNTABILITY

The project should be sponsored by the Provincial Health services Authorities. As such all reports and accountability should be directed to PHSA

10 IMPLEMENTATION STRATEGY

See Appendix I for logic model

CRITICAL REFLECTION

There were several strengths in developing a business case. Firstly, I am very passionate about working on sexual and reproductive health issues. Although sexual assault is quite a complex social problem, I find it particularly rewarding to be working in an area that requires a systems thinking approach to address it. Through my practicum and this project, I have come to appreciate the difficulty and complexity of sexual assault and its impact on not just the survivor but on the perpetrator as well as the society at large. This experience has enriched my understanding of how health and health outcomes influence and are influenced by broad social context in which individuals are located. Although this was taught in most of my classes, it was difficult to conceptualize how this operates in a real world setting. Furthermore, I wanted to my capstone to be relevant in practice and so was very pleased when I was asked to develop a business case for this BC Women's SAS counselling service. I consider myself very fortunate to have come in contact with my preceptor and the rest of the team at BC Women's SAS who inspired me to take on this project.

Secondly, the business case gave the opportunity to apply many of the skills I had gathered through my two year career as a Master in Public Health candidate. I was able to apply the knowledge I had gained from program planning and evaluation as well as health promotion courses to name a few. I believe all my courses developed in me the capacity to conduct in-depth research of literature, critically appraise them and then draw reasonable conclusions from them. This skill was very important for this capstone project because it required mining for information on gaps in tertiary prevention for sexual survivors as well as the efficacy of telephone and online counselling services for dealing with trauma. Additionally, I was able to apply a systems thinking perspective in many sections of the business case. I found this quite challenging and

very rewarding. Finally, the MPH program helped to teach me important professional skills like collaboration and communication which was the foundation of this project. The capstone required a lot of input from both the resident counsellor at SAS as well as the project manager in order to decide the format of the business case as well as the details for the actual project.

Although developing the business case was a very rewarding endeavor, I found the project quite challenging at times. Firstly, there is no standard business case template which made it very difficult for me begin my capstone. Once the initial selection was done, I found that some of the sections were very difficult to complete. For example, it was extremely difficult to draw a budget for the counselling service as similar services did not publish their financial statements. I also have very limited experience in designing budgets for organizations. This leads me to my second challenge- I found that time was a bit of a constraint as I did not have the time to sit with the team from SAS to draft what would be an appropriate budget for the Project. I would also have liked to reach out to some of the community-based services that were identified in the review to have gotten their input in the design of the project. I believe this can still be done before the project is finalized so that it would be relevant to both the practitioners and clients.

Overall, it was a rewarding experience and I am hopeful that this project would prove to be beneficial to BC Women's and other community-based services that work in the field of sexual assault. I am grateful for the opportunity to be exposed to a variety of perspectives from my coursework and practicum. I look forward to entering the professional world of public health practice and facilitating change in my community.

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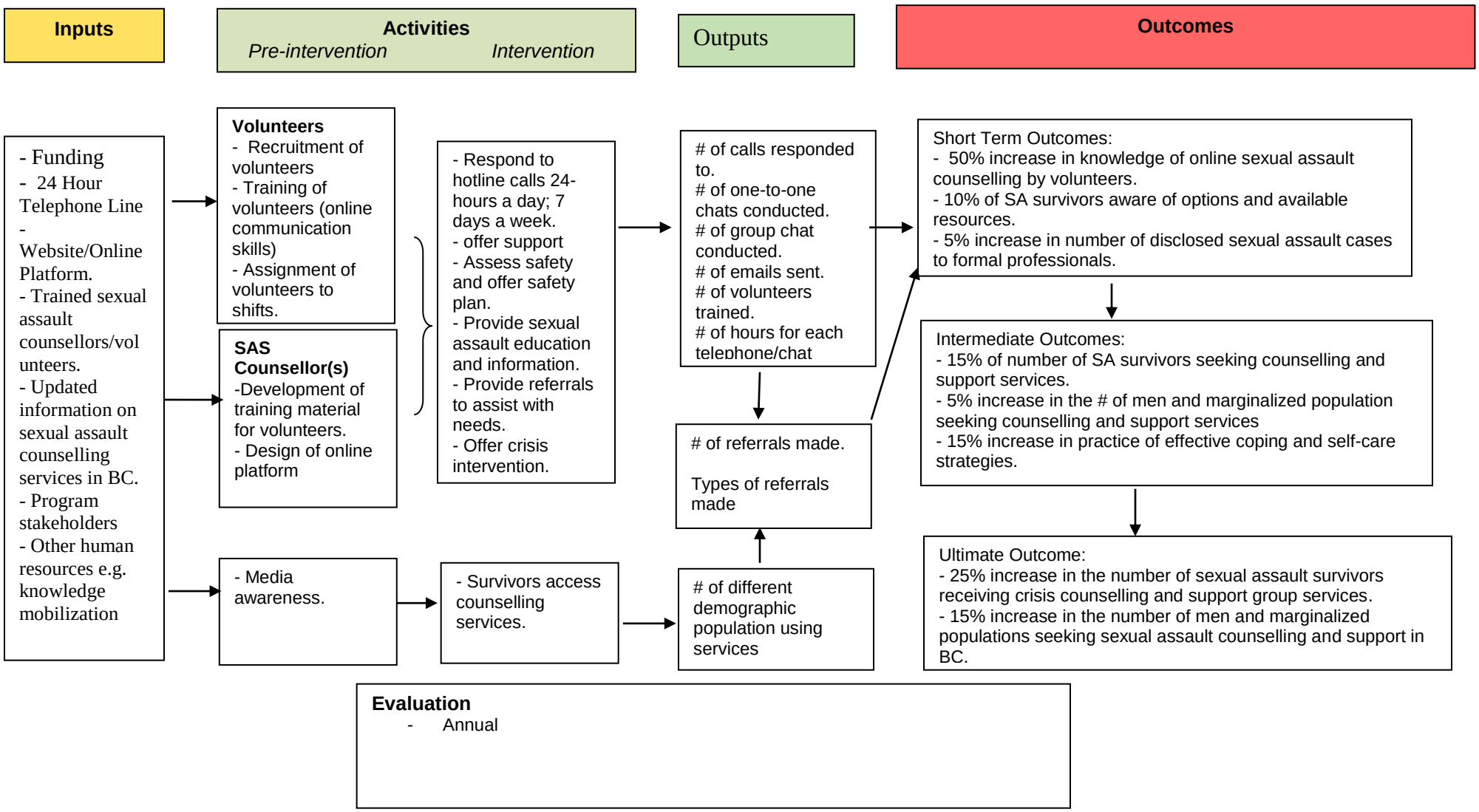
Appendix 1

Program: Online Counselling Sexual Assault Logic Model

Program Goal: To provide confidential, non-judgmental 24-hour telephone/online support, crisis intervention, information and referral services



Assumptions:
Project activities would largely match the needs assessment
Various demographic populations would access the service based on its demonstrated advantages e.g. Men would prefer chat option to face-to0face services.

External Factors
-Change in funding mechanism from PHSA.
- Environmental/Natural disasters e.g. flooding