Patients' experiences with the acute and follow up care by the Centre for Sexual and Family Violence Nijmegen.

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Abstract

Background: Sexual and family violence are highly prevalent problems worldwide. Care for victims is not adequate in the Netherlands. To improve the care, the Centre for Sexual and Family Violence Nijmegen (Centre SFVN) has been founded in 2012.
Objective: To evaluate the experiences of the patients who had contact with this Centre in order to optimize the acute and follow up care of the Centre SFVN.
Methods: Qualitative research with semi-structured interviews were performed. Data was collected by interviewing 15 patients. All interviews were recorded and transcribed verbatim. The data was analyzed with Atlas.ti and coded by two researchers independently.
Results: Positive experiences with the care of the Centre SFVN concerned the communication: explaining procedures; offering a listening ear to the victims and confirming that violence is not acceptable. Difficulties were experienced in the discouraging attitude of the police concerning reporting the violence. The patient's expectations about follow up care did not match the care that was given by the case manager, as the patients expected more practical help to be done for them. Barriers in context of the patient were seen in their feelings of powerless, finding it difficult to seek for help and safety issues.
Conclusion: The care of the centre SFVN is highly appreciated, especially the communication towards the patient by caregivers. Improvements can be made on account of the police by explaining clearly when to report or not. As there is a gap between what the patient wants and the care that is provided, the case managers must focus on understanding what the need of the patient is.

Introduction

Sexual and family violence are highly prevalent problems worldwide. Sexual violence is defined as any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting(1). Family violence is defined as any intentional or impulsive violent, threatening, coercive or controlling behavior that occurs in the domestic circle of the victim(2).

Of all women, 35% have experienced either partner violence or non-partner sexual violence(3). In the Netherlands, 1 in 20 men and a third of women become a victim of sexual violence(4). Family violence is seen in 45% of the Dutch population(5). Sexual and family violence are often seen together; 23% of cases of sexual violence against women have been committed by a (ex)partner(4).

Patients often suffer from physical and psychological damage as a consequence of violence and need professional help for it (6-8). Physical damage like injuries, chronic pain and sexually transmitted diseases are seen as a consequence of intimate partner violence (8). Injuries are seen in 39% of women and one out of four men after being physically assaulted. Approximately one third of injured victims receive medical care(9). Psychological problems such as suicide attempts, depression and post traumatic stress disorder are strongly associated with violence against women, although men are mostly not included in these studies (3, 7, 8). Only 12.4% of women and 4.7% of men who experienced sexual violence report this to the police(4).

Victims find it difficult to seek for help as they feel barriers in means of fear, shame, denial of their problem, lack of time and bad experiences with health care workers (6, 8, 10, 11). Easy accessible care is needed to prevent secondary victimization and physical and psychological damage. There must be a caring and safe environment for the patients, with different professionals who can provide specialized care (12-14). The acute and follow up care for victims of sexual and family violence is not adequate in the Netherlands (4, 15).

To improve the acute and follow up care for victims of sexual and family violence, the Centre for Sexual and Family Violence Nijmegen (Centre SFVN) has been founded in 2012. The Centre SFVN provides acute care at the Emergency Department (ED) of the Radboud University Medical Centre Nijmegen and works in cooperation with the police and Community Health Services. In cooperation with an university primary health care centre (UGC Heyendael) the follow up care is provided by case managers. The aim of this study is to get an insight in the experiences of the patients with the care of the Centre SFVN.

The research question was described as:

> *What are the patients' experiences with the care of the Centre for Sexual and Family Violence Nijmegen?*

With this knowledge, we hope to improve the care of Centre SFVN for victims of sexual and family violence and as a result of this reduce the later consequences of sexual and family violence in means of psychological and physical damage.

Methods

Study design

Different perspectives of individual patients with a broad variety of experiences can best be approached with a qualitative method. We used therefore semi-structured interviews.

Setting

Acute care
The Centre SFVN offers acute medical care to victims of sexual and family violence of all ages and sexes at the Emergency Department (ED) of the Radboud University Medical Center. Acute sexual violence is defined as violence taken place in the past seven days and acute family violence which has taken place in the past 24 hours or when care at the Emergency Department was needed. A protocol developed by the Centre SFVN consists of the following steps; 1. Provide medical care (this includes testing and treating sexually transmitted diseases); 2. Pregnancy counseling; 3. Provide information about legal steps and contacting the police; 4. Forensic physician; 5. Assess safety of the patient and his/her children; 6. Inform the patient about the follow up care of the Centre SFVN; 7. Inform the General Practitioner (GP) of the patient. All care is provided by physicians and nurses of the ED, except for step 4. When needed, medical specialists are called in for consultation. If the patient wants to report the event to the police, the police comes to the ED to inform him/her about the procedure. Due to legal obligations, the patient has to come to the police station for the formal report.

Follow up care
The first workday after the event, a case manager of the Centre SFVN contacts the patient by phone. She invites him/her for an appointment. It depends on the patients needs how many appointments and/or phone calls are necessary. The aims of the case manager are to provide 'a listening ear', to give practical support and to guide the patient with appropriate follow up care.
Besides the acute and follow up care, the Centre has an advisory telephone line as well. A general practitioner specialized in sexual and family violence can be contacted by health care professionals, mainly General Practitioners, for advice about patients that are (supposed) victims of sexual or family violence.

Study participants

Victims of sexual and/or family violence that received care from the case managers of the Centre SFVN were included in this study. They were referred to the case manager either by the ED physician after acute care or by the GP that executes the consultation function of Centre SFVN. When patients were younger than 16 years, mentally disabled or suffering from a severe psychiatric condition, the parents or caretaker was interviewed instead of the patient him/herself. Patients aged 16 or 17 years could be interviewed if both parents and the victim him/herself gave their informed consent.
Additional information was achieved by interviews with the two case managers.

Datacollection

Datacollection took place from October 2013 until August 2014. Interviews with the patients were conducted by two case managers of the Centre SFV Nijmegen. They were trained in interviewing skills. The case managers performed the interviews, because they were already in contact with the patients and had experience with the problems of this patient population. We expected that this would lower the threshold for patients to share their experiences and that the attitude of the interviewers towards the patients would be sensitive. The patients were contacted by their specific case manager at least one month after the violence has happened. They were informed about the study and were asked permission to participate. To give the patient ample opportunity to reconsider their agreement, the interview was conducted a week after first being asked to participate. Most interviews were done by phone in order not to burden the patient with travelling to the Centre SFVN.

Face-to-face interviews with the case managers were conducted in September 2014. All interviews were in Dutch without any language barriers. The interviews were recorded with permission of the patients/case managers and fully transcribed. Interviews lasted between 15-25 minutes.

Measures

We developed interview guides with semi-structured questions: for the patients and respectively for the case managers (appendix 1 en 2). The interview guide for the patients aimed to get sufficient insight into the experiences, both positive and negative, of the care by Centre SFVN. To optimize the care of the Centre and match with the needs of the patients we asked suggestions for improvement. A quantitative measurement was added by asking the patients how they rated the Centre on a scale from 0 to 10. The guide for the case managers focused on the process of care provided by the Centre SFVN to collect additional information.

Data analysis

The transcribed interviews were processed and analyzed with ATLAS.ti. Two researchers (EZ and LS) independently coded the first 5 interviews by the method of open coding developed by Corbin and Strauss(16). With open coding, the transcribed interviews are broken down into conceptual labels and categories in an interpretive process. The two researchers discussed their differences of interpretation and compared their findings. By discussing all codes and comparing the categories and labels systematically, errors were located and corrected. After the first five interviews, a code list was developed and used as the basis for future coding processes. The first 12 interviews were coded based on this list by two researchers independently (CM and LS). Because of a wide variability of experiences between the patients, new codes were added to the list. Codes were mainly described into comments concerning the ED, police or in context with the case managers and separated in to helping or hindering factors. For the last three interviews, no new codes had to be added. This implicates that we reached saturation of data. Further development of categories was done with axial coding; codes were put together or separated into new categories when needed and sub-categories were then related to categories by looking closer into the context. This way themes or main categories were made to create a better structure in the codes. The themes were discussed by a supervising team.

Ethical considerations

We followed the recommendations of the Dutch Central Committee on Research involving Human Subjects by assessing whether ethical approval was needed. Since our research was non-invasive and the time investment and the psychological burden were relatively low, it was not necessary to ask for ethical approval.

Results

Patients who received care of the case managers between the opening of the Centre in October 2012 until August 2014 were interviewed. Eventually there were 81 patients known with sexual and/or family violence. 59 patients were contacted by the case managers. However, 25 of them did not want or need follow up care. Of those who received follow up care; 12 of them were lost in follow up; In the case of three of the individuals the violence had taken place less than a month ago and four were not interviewed for other reasons (Appendix 3).

In total 15 patients were interviewed, 14 women and one man. They were aged between 14 and 55 years, with an average of 29.9 (SD=13.87). Ten of the victims experienced sexual violence, two had experienced family violence and three experienced both sexual and family violence. In four cases, a parent or care taker conducted the phone interview instead of the patient him/herself because the victims were younger than 16 years old. Of the 15 patients, 11 were referred to the case manager by the ED and four via the consultation specialist. Almost all interviews were phone interviews (N=12). Two interviews were conducted face-to-face. One interview was sent by email.

Table 1.

Characteristic	Frequency
Gender	
Female	14
Male	1
Type of violence	
Sexual violence	10
Family violence	3
Sexual and family violence	2
Age	
Underage (<18)	5
Aged 18-29 years	3
Aged 30-44	5
Aged > 45	2

Acute care

Attitude: The care received at the ED was appreciated as positive, especially the way health care workers communicated with the patients. There was someone to listen to the patient, procedures were clearly explained, and choices were given during the procedure. Almost half of the patients could not think about any improvement or had any comment about the care given at the ED. Positive comments towards the police were escorting the patient to the ED and showing compassion. However, mentioned as negative about the police were trivializing the problem and a lack of privacy.

> *'' We were well taken care of after arriving at the ED, and everything was precisely explained what would happen and everybody was introduced properly and felt at ease, so, it was good, we were satisfied''*

> *''A doctor took care of us at the ED, clearly explained what the consequences were of that night, what would happen and what would be the next steps; the forensic physician, the police would come. It was all very clear and good to know.***''**

> *''I went to the police office twice to make a declaration, because I did not dare to report. Then, you have to stand in front of a desk, were there is no privacy, and say what it is about. So you have to say it is about domestic violence.[…] you are standing 1,5 meter away from the one behind the desk, so you have to say it pretty loud''*

Long stay: A third of the participants mentioned the long time they had to wait at the ED as something to improve. At the same time, patients were understanding about this, saying it was necessary for further police investigation and that life threatening situations must be treated first. According to the case managers this has to do with the time it takes when the police and the forensic physician are called in at the ED. Some patients marked the overload of questions asked at the ED as tiresome.

> *''A few times the doctors came with the same questions and at some point we thought 'we are tired and want to go home' […] but it took a long time, so it was a long night.''*

> *''When I came there I was tired, and upset of course, taken together I found it tiresome. But they have to help you […] they ask a lot, they ask a lot of questions. They have to, but at that moment I found it very tiresome, because I wasn't really there, you understand?''*

One patient commented that he was treated in a room that lacked privacy as care workers were walking in and out.

> *''Yeah, well the room were the conversation was, because actually it was a kind of a passageway to the hospital I think […] there was someone walking in''*

Discouragement: The police discouraged some patients to report their violence arguing that it was not of any use to report. For one patient the argument was that it is of no use to report when the victim has been drinking alcohol prior to the incident. This made the patients feel rejected. A tension between health care workers and the police was experienced as health care workers encouraged the patients to report violence, whilst the police proceeded to discourage them. One patient mentioned that she had to sneak out of her house to go to the police, and when she finally got there, the police told her to come back in a few days.

> *'' I was told like 'you really have to report', so I was motivated, but it is like, I feel very disappointed […]that you say 'you have to do it' and 'it is good to do' and that you go to the police and they say 'how are sure altogether what really happened?' ''*

> *''Also at the police office that I was actually send away, because they say 'well, we will make a appointment when you want to report' and then you have to come back another time. […] maybe it was just this time I could get out of the house, on that moment I left the house with a excuse and than being send back. I really think that is awful.''*

Follow up care

The care given by the case managers consisted of both practical and emotional help.

Appreciated: Emotional help was provided by allowing patients to tell their stories and to express their doubts and fears, whilst encouraging them to release their anger and frustrations to impartial company. The emotional support provided by the case managers was highly appreciated not just by the patients themselves but also by the patients families, in particular the parents of underage victims. Also marked as positive was the way the case managers were pro-active in trying to get in contact with the patients. This included the case managers trying to call the patients, even when their first attempt was unsuccessful as well as calling up the patients for follow ups. A few patients said this made them feel comforted, like someone was watching over them.

> *''she was just calm, just calm, reliable, not in a hurry […] we just had a very good connection, really the feeling like I can tell my story''*

It was important for some patients to hear that the violence they experienced was not normal, they needed to be reassured that they were in fact victims of abuse.

''I liked our conversation, because, well, what happened, and I felt like she recognized things, especially she recognized that it was not good what was happening and that was pretty important to me.''

Tensions in providing practical help: Many patients were already in contact with other organizations and did not need any practical help. Other patients expected more practical help to be readily available, but instead of having everything arranged, the case managers assisted the patients towards the help they specifically needed. Some patients were dissatisfied about the knowledge of the case managers, especially when it came to juridical issues. According to the case managers, most patients wanted help with juridical questions, referrals to a psychologist and with housing arrangements. A barrier was seen towards providing practical help when patients lived far away.

''Well, I do not think she knew about that, I think it would be logical if you knew about those things[…] you have to make sure that you know about everything that is going on and how things work. Because you need that so much, to have things to hold on to and definitely to what the law says.''

Context of the patient

Safety: The context of the patients was very different from one to another, but what they had in common was their need of safety. In their effort to seek a safe environment, some patients requested the case managers to arrange new housing. The case managers mentioned that one mother told she kept seeing the perpetrators of her daughters rape, which made her angry but also scared for her daughters safety. According to the mother, the police did not seem to try its' best to capture the perpetrator and did not keep the family updated on the process, this made it hard for her daughter to move on. The case manager also described about the contact she had with a patient who really appreciated the contact, but did not dare have further conversations in case her husband found out, thus hindering her ability to seek further help.

Process of the patient: Patients described that on arrival to the ED they felt vulnerable, powerless and confused. Some patients cited it was difficult for them to step out of their violent situation as barriers were felt towards seeking help, especially towards the police. Doubts about the seriousness of their violence, fear towards the perpetrator and knowing that seeking help would get a whole care process started were mentioned as barriers. Many patients who did seek help did not know specifically what kind of help they wanted or needed. When the patients took steps towards seeking help they became disappointed in the care system when they figured out they still have to do a lot by themselves. This included getting answers on their juridical questions, making an appointment with their GP or other health care providers. For some patients they seemed to reach a point during the follow up care in which they became aware of the fact that they had to be the ones to change their situation. They regained control over their own situation.

''At that moment I had to flee and then you come there, confused and your body feels tired, so tired and you feel vulnerable.'' (Arriving at the ED)

''Because it was difficult for me to get out of this situations, that I actually thought, when I left here, what will be the next steps for me? Well, you notice then, that actually you still have to do a lot by yourself [...] I was always in doubt, like, is this real, not ok and, well about the divorce I don't know … it's like you cannot judge it well. Then you want to hear from someone else, that was nice, we talked about my situation of course, but what came after that I found just I thought, that I still had to do everything on my own […] yes, the first part was really nice

that I knew ''this is really not good, this has to change, it was for me a turning point like 'I'm done with it'. ''

The Centre

On a scale from 0 to 10 (with 0 valued very badly and 10 as perfect) patients appreciate the acute and follow up care with an average of 8.3(SD=0.86), ranging from 6 till 10.

Discussion

We found that the participants were highly satisfied with the acute care at the ED. They appreciated the attitude of the ED employees which was caring and attentive. Especially positively mentioned was the way ED employees communicated with the patient. The explanation about the procedure and the offered choices were highly valued by the participants. This corresponds with the findings of former studies (17-19). Patients feel more in control and confident in taking the next step to recovery when they are given choices and explanations at the ED (17). The participants were less positive about the advice of the police as some of the patients felt that the police discouraged them in reporting their incidents. To one patient the police argued that reporting would not be of any use, because the victim had been drinking prior to the incident. Another patient was told to come back later, although it was difficult for her to sneak out of her house. For the patients this was confusing, since other caregivers they came into contact with (e.g. ED employees and the case manager) encouraged them to report. This made the patients feel rejected by the police. In the literature it is found that victims of sexual and family violence feel a high threshold in reporting to the police, because they feel ashamed about what happened. They think the police cannot do anything for them, will not believe them or do not have their violence as their priority (6, 20). In the Dutch population 4.3% of men and 12% of women who experienced sexual violence report to the police(4). However, a study of the Dutch sexually assault centre of Utrecht shows that, 34% of sexually assaulted victims who have been to their centre report (21). Concluding, although our population faces difficulties towards reporting, a sexual assault centre lowers the threshold, and thereby hopefully leads to a higher amount of attackers being prosecuted. Additionally, we believe the negative comments towards the police can be limited by letting the patients report when they want to. This will also make the patient feel taken seriously.

Participants also remarked negatively upon the long time the victims had to spend at the ED. This long waiting time is due to the multidisciplinary approach the Centre SFVN stands for: it takes time to call in different specialists, the police or a forensic physician. On the other hand, patients who spent a long time at the ED and mention this as something to improve, are understanding about it. It did not become clear what exactly causes the long waiting times; the long time it takes before calling in other services, the long time it takes for these services to arrive at the ED or the time a victim has to wait to see a ED employee initially. To optimize the Centre's services, further research has to be done to explore what is causing the long waiting times and how this can be improved.

Patients were partly satisfied with the care of the case managers of the Centre SFVN. They appreciated the 'listening ear' of the case managers and had the feeling they could tell their story. They valued the understanding attitude and the emotional support. Other studies found that victims expect emotional support to be available, it makes patients feel safe and respected (17, 19, 22). Next to the emotional support, the pro-active approach of the case managers was highly valued. The case managers kept trying to contact the patients, even when they did not answer the phone several times. This made the participants feel protected and cared about. We think, due to this pro-active approach, patients experience less barriers towards seeking help. The patients were less satisfied about the practical care of the case managers. They expected more knowledge, mostly about juridical items, and more practical help being done for them by the case managers. This is in contrast

with a study from Feder et al (2006), which found that patients expect health care providers to share decision making with them(22). Taken together, we conclude that there is a mismatch between the expectations of the patients and the care provided by the case managers. Furthermore, many patients already received follow up care of other organizations. As described by Bicanic et al (2014), 45% of the Dutch population that came to a sexual assault centre already received care of the mental health services prior to the incident(21). However, despite the presence of follow up care, the participants of our study still requested help from the case managers. It became clear that patients find it difficult to explain what kind of help they want or need. It is important to know what kind of extra help they need or expect besides the care they already receive. By knowing this, the case managers can anticipate on the patients' wishes and thereby improve the care they provide.

The context of the interviewed patients of the Centre SFVN has two important features: first, the lack of safety, and second, emotions that are experienced by victims in an acute setting. Emotions such as powerlessness, confusion and vulnerability are cited. According to victims of intimate partner violence these emotions are reflected in their bodies through mental and physical health problems (Larsen). The consequences of this emotional state with psychological and physical health problems can be taken into account by the case managers. As for lack of safety, our population mentions different, individual stories of why they feel unsafe. Victims felt unsafe about contacting the case managers because they were afraid of their partner, did not feel safe in the house they lived in or were afraid the attacker would repeat his or her violence as he or she was not yet prosecuted. Barriers in seeking help such as fear, mostly towards the perpetrator, correspond with previous literature (10, 20, 23). In literature, causes of fear are also found in the patients' lack of trust in the confidentiality of the healthcare workers. This was confirmed by Greeson et all (2014) as being a challenge in their sexual response team (11). Anxiety about the confidentiality of the healthcare workers was not a topic mentioned by our participants. This could be due to the case managers only working together with other services by agreement of the patient, but it might also be due to the way case managers work with the patient, as equals, instead of being an authority. This makes the patients feel more in control of their own situation.

In our population, some patients had doubts about their violence, questioning if it is really wrong what happens to them. For them, it was very valuable that the caregivers of Centre SFVN confirmed that violence was unacceptable (22). This validation is important, since this makes the patient feel stronger in their position.

Strengths and limitations

In this study, the Centre SFV is evaluated based on interviews with the patients and case managers to optimize the acute and follow up care. Little research is done concerning assault centre's, especially not about the experiences of the patients (11). Getting insight in the experiences of the patients is therefore a considerable contribution to the existing knowledge and can be of great help in improving the care of assault Centres. We believe that by letting the case managers conduct the interviews with the patients, the patients felt a lower threshold for sharing their experiences.

Limitations of this study are the low number of patients that have been interviewed and the relative short length of the interviews. Also, all interviews were conducted by the case managers. The source of the additional information were the case managers as well. This gave us a broad range of information about the function of the case managers. However, other organizations which are part of the process of the care for a patient, like the ED or the police, were less addressed.

Implications for practice

As for the acute care, the police should explain clearly to victims when reporting is useful and when it is not useful. They should also discuss other options such as declaring. This should also be known and explained by the healthcare organizations involved to prevent contradictory advice of the police and

healthcare workers. It did not became clear way the care at the ED took much time, although suggestions have been made. Further research must look closely at the care process at the ED to be able to improve the long waiting time.

To prevent victims being disappointed in the case managers care, especially practical care, the function of the case managers must be explained more clearly in advance. To aid in the positively appreciated emotional support provided by the case managers, their function can be better explained as a 'professional friend'. It is important to use techniques such as motivational interviewing to guide the patients towards the practical help they need. These interviewing techniques could help with understanding the patients' needs, which could close the gap between the care patients need and the care that is given.

Asking about the safety of the patient must be high priority for the case managers in their first conversation. The case manager and the victim can decide together what the next steps must be to ensure safety. It is also important for the case managers to emphasize that violence is not acceptable. This way the patients will be strengthened in their decision of seeking help.

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Appendix 1

Interview guide patients

Questions:

1. Are you satisfied with the care provided at the ED?
2. What did you appreciate about the care at the ED?
3. What did you not appreciate at the ED?
4. Are you satisfied with the care provided by the case managers, this is the care you received after your visit at the ED?
5. What did you appreciate about the care of the case managers?
6. What did you not appreciate about the care of the case managers?
7. Did the care provided by the Centre SFVN help you? Why is that?
8. How could the care of the centre SFVN be improved?
9. How would you appreciate the care of the centre SFVN on a scale from 0 to 10?

Additional questions:

When there is time, all questions written below can be asked. When this is not the case, you can only ask the bold questions.

- When you where at the **ED** , did you feel taken seriously? **Were they listening to you?** Did they have time for you?
- **Did you feel, for as far as that is possible, safe and comfortable where you were receiving care?**
- About **follow up care:** could you tell your story? Was the help useful? **Could your questions be answered?** Was there enough phone contact? Would you have appreciated to see the case manager face-to-face? Did you want less or more contact?
- **Did you know who to call when you had any questions?**

Appendix 2

Interview guide case managers

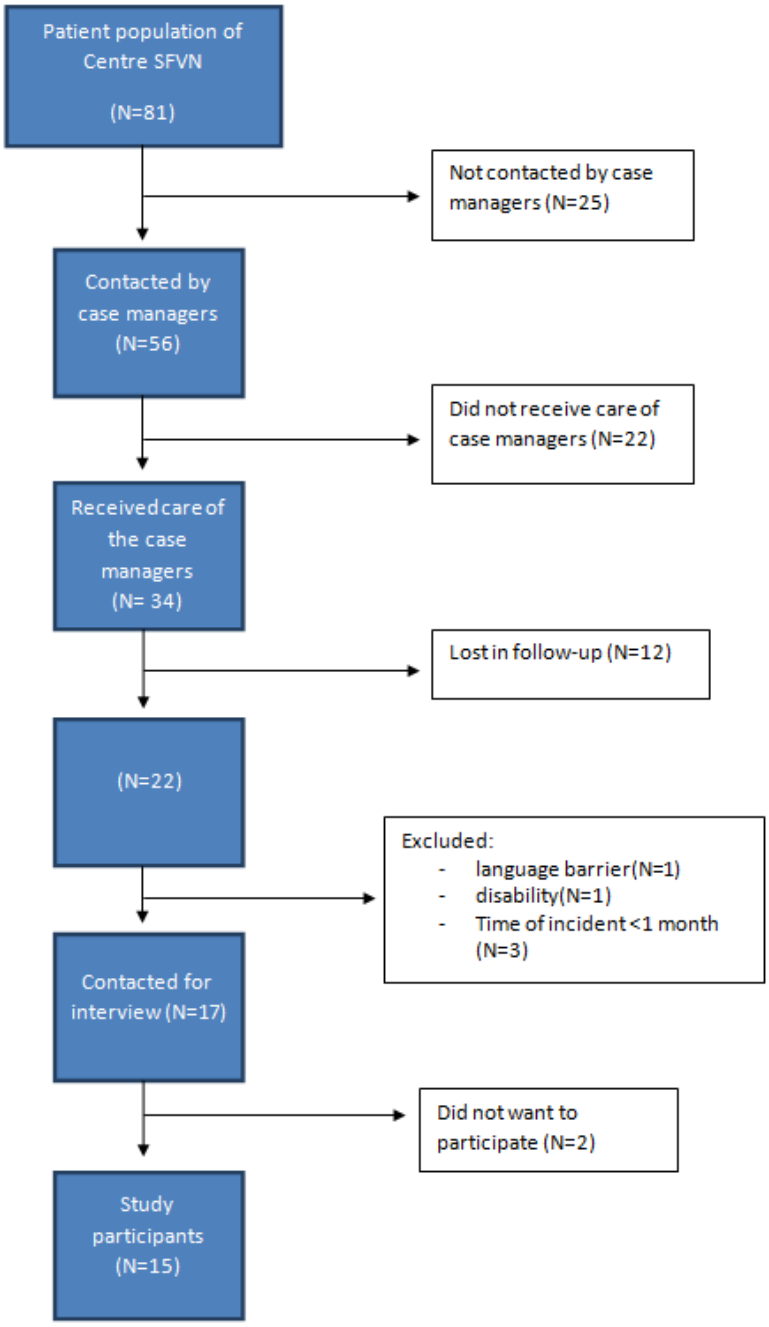
Questions:

1. Where there situations where the care was not right, were something went wrong?
   (Did not get a folder, patient does not want any help, too late in trying to get in contact, no privacy, miscommunication between health care professionals)

   Additionally ask specific about:
   a. Care at the ED
   b. Care of the police
   c. Care by the forensic physician
   d. Follow up care (also other organizations)

2. What were reasons to want or do not want to have contact anymore with the centre?
   (*Already were in contact with other organizations, does not need help, living situation far away, need in practical help, able to tell their story)*
3. Where there requests or proposals of the patient that you were not able to answer?
   (Juridical, medical, towards other organizations)
4. What did you do for this patient in means of practical help?
   (Referrals, pick up/bring to appointments, making an appointment with other organizations)

Appendix 3


Patient population of Centre SFVN (N=81)
Not contacted by case managers (N=25)
Contacted by case managers (N=56)
Did not receive care of case managers (N=22)
Received care of the case managers (N= 34)
Lost in follow-up (N=12)
(N=22)
Excluded:
- language barrier(N=1)
- disability(N=1)
- Time of incident <1 month (N=3)
Contacted for interview (N=17)
Did not want to participate (N=2)
Study participants (N=15)