

Post-Assault Health Care for Sexual Assault Survivors During COVID-19: A Mixed Methods Analysis of Service Rates in a Predominately African American Community

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Abstract

This study examined how the COVID-19 pandemic affected sexual assault healthcare services in a predominately African American U.S. city. In mixed methods research design, we used quantitative interrupted time series modeling to evaluate changes in service rates for three core post-assault healthcare services—medical forensic exams (MFEs), medical advocacy MFE accompaniment, and counseling—from January 2019 through June 2021. We also conducted qualitative interviews with 12 sexual assault advocates to understand how their clients were impacted by COVID and how their agency adapted services to respond to the needs of their community. Both the quantitative and qualitative data revealed marked disruptions in service

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provision. The number of MFEs, medical advocacy accompaniments, and counseling sessions significantly decreased during the pandemic's initial surge, and survivors feared seeking hospital-based health care due to concerns that they might contract COVID-19 in hospital emergency departments. The number of MFEs performed by program staff did not return to pre-pandemic levels during this study's observation period, but the number of medical advocacy accompaniments and counseling sessions did significantly rebound. Counseling services eventually exceeded pre-pandemic levels as agency staff supported clients with both assault- and COVID-related trauma and loss. These results underscore the need for community-based sexual assault healthcare services, so that if public health emergencies limit the availability, accessibility, and safety of hospital emergency department care, sexual assault survivors have other settings for obtaining post-assault health care.

Keywords

Adult victims, sexual assault, reporting/disclosure, support seeking

The COVID-19 pandemic has had devastating health, economic, and social impacts that have disproportionately harmed marginalized and minoritized communities (Alcendor, 2020; Dalsania et al., 2021; Louis-Jean et al., 2020; Muñoz-Price et al., 2020; Tai et al., 2021). In the U.S., BIPOC (Black, Indigenous, People of Color) are at heightened risk of contracting the virus and subsequent poorer health outcomes due to limited access to health care (Mackey et al., 2021; National Center for Immunization and Respiratory Diseases [NCIRD], 2020; Zelner et al., 2021). The pandemic has also elevated the risk of interpersonal violence (Boserup et al., 2020; Evans et al., 2020; Humphreys et al., 2020; Piquero et al., 2020), but the availability of sexual assault and domestic services has decreased due to economic strain and public health restrictions (Johnson et al., 2020; UN Women, 2020; World Health Organization, 2020). These patterns raise concerning questions about how survivors of Color have been impacted by the co-occurring traumas of COVID-19 and interpersonal victimization. To explore these issues, we studied how the pandemic affected sexual assault healthcare services in a predominately African American U.S. city that endured a surge of COVID infections.

Sexual assault victims are advised to seek health care within 24–72 hours after the assault (Department of Justice [DOJ], 2013). Typically, survivors are directed to hospital emergency departments whereby healthcare practitioners can perform a medical forensic exam (MFE), which includes: diagnosing and treating injuries sustained in the assault, offering emergency contraception to prevent pregnancy (if applicable), and administering prophylaxis for sexually

transmitted infections that might have been contracted from the assault (DOJ, 2013). The MFE can also include the collection of a sexual assault kit (SAK, also known as a “rape kit”) to preserve forensic evidence, such as semen, blood, saliva, and/or hair samples (DOJ, 2013). In a growing number of hospital emergency departments throughout the U.S., MFEs and SAKs are performed by sexual assault nurse examiners (SANE), who have specialized training in forensic health care (International Association of Forensic Nurses, 2017). If a community does not have a SANE program, hospitals must still provide post-assault care to all presenting victims (Government Accountability Office, 2018; Zweig et al., 2014). The national DOJ (2013) protocol also recommends that survivors have access to medical advocates for crisis intervention, support, information, and referrals. Community-based rape crisis centers/victim service agencies routinely offer medical advocacy accompaniment to victims seeking MFEs in hospital emergency departments (Martin, 2005), and SANE programs often have advocates on staff to work alongside program nurses (Patterson et al., 2006). Even with these supports in place, navigating hospital-based health care immediately after a sexual assault is often stressful for survivors (Campbell, 2008).

The experience of seeking post-assault health care has been undoubtedly complicated by the COVID-19 pandemic, which has had profound effects on healthcare access and utilization (Zhang et al., 2021). The number of hospital emergency department visits declined significantly during COVID, largely due to the fears of contracting the virus in healthcare settings (Hartnett et al., 2020; Jeffery et al., 2020; Muldoon et al., 2021; Schriger, 2020; Wong et al., 2020). Data from the U.S. National Syndromic Surveillance Program revealed that the overall number of emergency department visits declined by 42% at the beginning of the pandemic (March 31–April 27, 2020; Hartnett et al., 2020). A similar pattern was documented for sexual assault health care. In a Canadian study, Muldoon et al. (2021) compared the number of patients seeking sexual assault emergency department health care in March and April 2019 to those same 2 months in 2020, and found that the weekly count of sexual assault cases significantly declined by 53% during the pandemic. In a U.S. study of MFEs conducted in a large academic midwestern hospital, Munro-Kramer et al. (2021) documented that the mean number of MFEs per month in 2019 was 9 cases per month (range 7–11), which fell to zero cases in April 2020. After an initial rebound back to 9 exams per month in May 2020, this hospital continued to track lower-than-average numbers for MFEs from June–November 2020, (3–6 per month).

These studies identified significant disruption in post-assault MFE health care for sexual assault survivors, but it unclear whether service trends stabilized as the pandemic extended into 2021 and as shelter-in-place orders lifted and vaccines became available. Quantitative modeling studies with longer follow-up periods are warranted to determine whether service

utilization rates have rebounded. Furthermore, because national protocols emphasize the importance of co-occurring advocacy services and connecting survivors to counseling services (DOJ, 2013), it is important to expand the scope of inquiry to examine changes in utilization rates for these services as well. However, a purely quantitative approach of modeling the number of exams, advocacy accompaniments, and counseling sessions cannot fully convey the impact of COVID-19. For example, in Wood et al. (2022, 2022) mixed methods study, quantitative data revealed severe impacts on survivors' sense of safety and need for services, but qualitative data showed how the pandemic exacerbated existing vulnerabilities and disparities (see also Dalsania et al., 2021; Haynes et al., 2020; Louis-Jean et al., 2020; Tai et al., 2021). These patterns emphasize the need for mixed methods research on how COVID impacted post-assault health care for marginalized and minoritized sexual assault survivors.

To that end, the purpose of the current study was to examine how utilization rates of three post-assault healthcare services—MFE, MFE advocacy, and counseling—changed over time in a large sexual assault agency in Detroit, MI. Detroit has a long history of racial and economic disparities (Ray et al., 2021). Currently, the city's population is 80% African American and at least 50% live below the poverty levels (Ray et al., 2021). Detroit's emergency, social, public health, and healthcare services have been chronically understaffed for decades, and the city is still recovering from its 2013 bankruptcy. These long-standing vulnerabilities created a “perfect storm of poverty and very rudimentary public health conditions” (Chapman et al., 2020, para. 9), such that Detroit was among the first U.S. cities to be hard hit by the pandemic. In March 2020, Michigan ranked 4th in the U.S. in COVID infections and COVID-related deaths, behind more populous states (New York, New Jersey, and California) because of the COVID surge in Detroit (Chapman et al., 2020). As COVID-19 swept through the city, a clear pattern of racial health disparities emerged such that African American citizens had higher infection and mortality rates, less health insurance coverage, and less access to hospitals than did White residents of the city (Ray et al., 2021). Furthermore, the spillover effects of the pandemic were more severe for African Americans, who experienced more instability in employment, housing, food access, money, childcare, and education (Ray et al., 2021).

During these crises, Detroit's sexual assault agency remained open to serve survivors. They have operated a de-centralized SANE program since 2006 whereby forensic nurses and advocates provide care in three hospital emergency departments throughout the city, plus one non-hospital community clinic site. Medical advocates accompany survivors to exams, explain medical and legal service options, and provide a “soft hand-off” to the agency's counseling program for post-assault crisis counseling and, if needed, longer-term mental health services. Throughout the pandemic, the agency's

counseling program also remained open, albeit with limited in-person services as they transitioned to telehealth sessions. Our research team has had a long-term partnership with this SANE program, and we were conducting a different study on MFEs and SAKs when the pandemic began, so we worked with agency staff to develop a secondary project on how COVID-19 affected service provision. In a mixed methods design, we used quantitative interrupted time series analyses to model changes in service rates from January 2019 through June 2021. We also conducted in-depth qualitative interviews with advocacy staff to understand how clients were impacted by COVID and how the program adapted services to respond to the needs of their community.

Methods

Sample

Quantitative. The quantitative sampling frame was defined by service type and service date. We documented the number of MFEs, medical advocacy accompaniments, and counseling sessions provided by this Detroit-area SANE/sexual assault service agency to adult sexual assault survivors from January 2019 to June 2021. This frame provided 14 months of pre-pandemic baseline data (January 2019–February 2020), and 16 months of pandemic-era data (March 2020–June 2021). Because the pandemic response in the U.S. has varied considerably by state (Hale et al., 2020), we note the following key historical events that occurred within the 16 months of pandemic-era data we collected. In this state (Michigan), the governor issued a stay-at-home order in March 2020 (commonly referred to as the “shutdown”) that limited all non-essential travel and closed non-essential operations to curb the spread of the virus. In Detroit specifically, emergency services, health care, and homeless shelters remained open, as did public transportation (after a brief work stoppage in March 2020). The stay-at-home order was lifted in June 2020, and businesses and other operations re-opened in phases throughout the summer and fall of 2020. Vaccine distribution in this state began in late December 2020 for targeted populations (e.g., healthcare workers), and expanded to the general population in March 2021.

Qualitative. The qualitative sampling frame was defined as advocacy staff who provide advocacy and/or counseling services. When the COVID-19 pandemic began, we were conducting a qualitative study on advocacy services for survivors who had untested SAKs (commonly referred to as the “rape kit backlog”). We were required per our university’s COVID-19 protocols to suspend all data collection with human research participants. During that suspension, we worked with agency staff to modify the study methods to include research questions on the impact of COVID-19 on post-assault MFEs,

medical advocacy, and counseling services. We were allowed to resume remote data collection in July 2020. Agency staff were eligible to participate in these interviews if they were currently employed as an advocate/counselor and (given the other aims of the project) they had provided services to survivors with untested/backlogged SAKs: $N = 14$ eligible advocates, which was, at that time, the agency's full population of advocacy staff. All eligible staff were emailed a request to participate in a remote interview via Zoom, and $N = 12$ advocates agreed to participate in this study. Nearly all of the interviewed staff were women (92%), and almost half (46%) were Black/African-American. Participants ranged in age, though a sizable proportion (38%) were between 25 and 34 years old. Most staff (62%) held a master's degree, typically a Master of Social Work (MSW).

Procedures

Quantitative. The agency's advocacy director provided a de-identified spreadsheet that summarized the number of completed adult MFE exams performed by the agency's SANEs, the number of MFE medical advocacy accompaniments conducted by advocates, and the number of counseling sessions provided by advocates/counselors, per month from January 2019 through June 2021. No client information was provided to the research team.

Qualitative. The advocates were interviewed July-September 2020 via Zoom by one of two graduate students who had completed a training protocol in trauma-informed interviewing methods. The interviews were conducted via Zoom, and with consent of the participant, they were audio recorded using Camtasia. No video recordings were captured, and participants had the choice of having their camera on or off during the Zoom interview. At the conclusion of each interview, participants were reminded that all identifying information would be redacted from the transcript, and they were asked if there was any other information they wanted redacted prior to analysis. The average length of the interview was 67 minutes ($SD = 23$ minutes). Advocates were not compensated for their participation but were allowed to conduct the interview during work time.

Measures

Quantitative. The quantitative variables were operationalized and collected by our partner agency based on standardized requirements from their funders. First, they record the total number of completed adult MFEs performed by the agency's SANEs each month, whereby "adult" means the patient was age 18 or older and 'complete' means the SANE conducted a full MFE and collected a SAK. Second, they track the number of medical advocacy MFE

accompaniments provided by advocacy staff. This variable captures the number of patients' advocacy staff supported, regardless of whether the patient decided to have an exam/SAK collection. As such, this variable includes both completed and incomplete exams, and instances where patients decline the exam entirely and instead avail themselves of other healthcare and/or crisis intervention services (e.g., emergency contraception, medications for sexually transmitted infections). By its nature, the monthly values for this variable will typically be higher than the first variable (which captures only completed exams/kits performed by programs SANEs). Finally, the agency tracks the number of counseling sessions provided by advocates/counselors. This variable will have higher values than the other two variables because this service is available to all survivors (not just those who seek post-assault health care), and it is measured in the number of sessions, not the number of clients. It is not possible to disaggregate agency data to capture only the number of sessions provided to survivors who had post-assault medical care or the number of unique survivors who received counseling.

Qualitative. We developed a semi-structured interview protocol with consultation from the agency's leadership team and advocacy staff. The first two-thirds of the interview focused on their experiences supporting survivors who had untested/backlogged SAKs (per other study aims, see *Deleted to Ensure Blind review*), and the final third of the interview focused on their experiences providing advocacy and counseling during the COVID-19 pandemic. Participants were asked to describe unique considerations for survivors who were assaulted during the COVID-19 pandemic, with specific probes on how the pandemic may have impacted survivors' decisions to seek medical care and/or report to the police (e.g., "How, if at all, have you seen the pandemic impact survivors deciding whether or not to seek medical care or forensic evidence collection after the assault?" "How, if at all, have you seen the pandemic impact survivors' engagement in advocacy services, support groups, counseling, etc.?). Advocates were directed to formulate their answers based on direct observations, interactions, and/or conversations with clients (rather than their general beliefs or perceptions). Advocates were also invited to reflect on specific case examples to illustrate and elaborate upon their answers, but were not prompted to provide identifying information about survivors or their assault experiences.

Analytic Methods

Quantitative. We used an interrupted time series design to determine whether there were changes in service rates as result of the COVID-19 pandemic, whereby March 2020 was defined as the intervention point at which the COVID-19 stay-at-home order was implemented. We conducted three

segmented regression models (one for each of our focal variables: number of MFEs, number of medical advocacy MFE accompaniments, number of counseling sessions) to determine whether there were significant changes in the intercept associated with the onset of the pandemic (March 2020) and whether there were significant slope changes thereafter, reflecting potential rebound in service rates. Because the data were from the same organization and therefore observations were not independent, all models were evaluated for potential autocorrelation of residuals using the Durbin–Watson test. This test evaluates the null hypothesis that the model’s Durbin–Watson statistic, d , is not significantly different from the ideal value of 2, which indicates non-autocorrelation (Savin & White, 1977). The Durbin–Watson test statistics for Models 1–3 were 2.02, 1.52, and 1.47, respectively, none of which were significantly different from 2 at the 1% level of significance according to Savin and White’s (1977) table of critical values. Therefore, no significant autocorrelation was indicated and no correction for autocorrelation was included in the models.

Qualitative. We used Braun and Clarke’s (2006) methods for thematic analysis to identify and describe content themes in the advocates’ narratives. In the first phase of this analysis, two coders reviewed the transcripts to identify sections of text related to the COVID-19 pandemic. Coder 1 then reviewed four transcripts to identify an initial set of descriptive codes (i.e., codes that summarized the basic content of interview passages). These codes were developed inductively from the data, rather than a priori. After these four interviews were coded, Coders 1 and 2 refined the list to collapse redundant codes. Each code was reviewed and discussed one-by-one until the coders reached consensus. The coders then independently reviewed the remaining eight interviews, creating new descriptive codes as needed. The coders reviewed their work together and collapsed redundancies, resulting in a final list of 57 descriptive codes (e.g., “high demand for support groups” and “survivors were deprioritized by hospitals”).

In the second phase of the analysis, the coders identified associations and conceptual linkages across these descriptive codes (Braun & Clarke, 2006). Each coder independently grouped the descriptive codes into broader content themes that synthesized the meanings and relationships between descriptive codes. For example, the descriptive codes “fear of hospital kept survivors from seeking medical care” and “survivors were deprioritized by hospitals” were synthesized into the theme “barriers to seeking/receiving acute medical care.” The coders developed these themes independently, reviewed the draft themes together to reach consensus. Again, each theme was discussed one-by-one until the coders reached consensus (there was minimal disagreement between coders on these broader content themes).

In the third phase of the analyses, the full research team reviewed the list of content themes to identify any that needed additional explanation or clarification. After finalizing the themes, the coders rechecked the raw data passages to verify that they aligned correctly with their assigned/coded theme. The coders selected exemplar data passages/quotes to illustrate each theme. Our main consideration in selecting quotes was whether the quote provided a clear illustration of the theme, and whether the quote offered additional nuance or represented the breadth of a theme. The coders tracked their selection of exemplar quotes to ensure that they did not over-represent specific participants.

Results

The quantitative modeling and qualitative interviews converged to show a clear pattern of disruption in post-assault health care in the early months of the pandemic, followed by a complex and uneven process of recovery. We have organized our results around these two distinct phases, interweaving the quantitative and qualitative data to present an integrated analysis of how COVID-19 impacted sexual assault health care in Detroit.

Disruption: How the Onset of COVID-19 Impacted Survivors' Post-Assault Healthcare Utilization

In March 2020, the governor of this state issued a stay-at-home order to curb the spread of the virus and protect public safety. Emergency services, including hospital emergency departments and police departments, remained open, and the focal SANE program had forensic nurses available to treat sexual assault patients in both hospital and non-hospital clinic settings. However, few sexual assault survivors were seeking post-assault health care. The interrupted time series segmented regression model analyzing the number of adult MFE exams over time revealed marked disruption in services due to the pandemic, with significantly fewer exams conducted after the start of the pandemic ($F(3,26) = 5.25, p < .01$, adjusted $R^2 = .31$). The baseline number of adult MFEs conducted monthly was approximately 30 ($b = 29.51, SE = 3.88$), and prior to the pandemic onset, there was no significant month-to-month change in the number of MFEs ($b = -.02, SE = .46, t = -.04, p = ns$). Immediately after the pandemic onset, the number of exams decreased significantly by approximately 16 per month ($b = -15.70, SE = 5.01, t = -3.14, p < .01$). As shown in [Figure 1](#), in March 2020, this SANE program performed 24 adult MFEs; in April 2020, that number fell to 13; and in May 2020 it fell further to only 5. In the prior year (2019), this SANE program was typically performing 28–37 exams per month in March, April, and May. In our qualitative interviews with program advocates, they also reported a precipitous drop-off in the number of adult sexual assault MFEs: “*I think maybe*

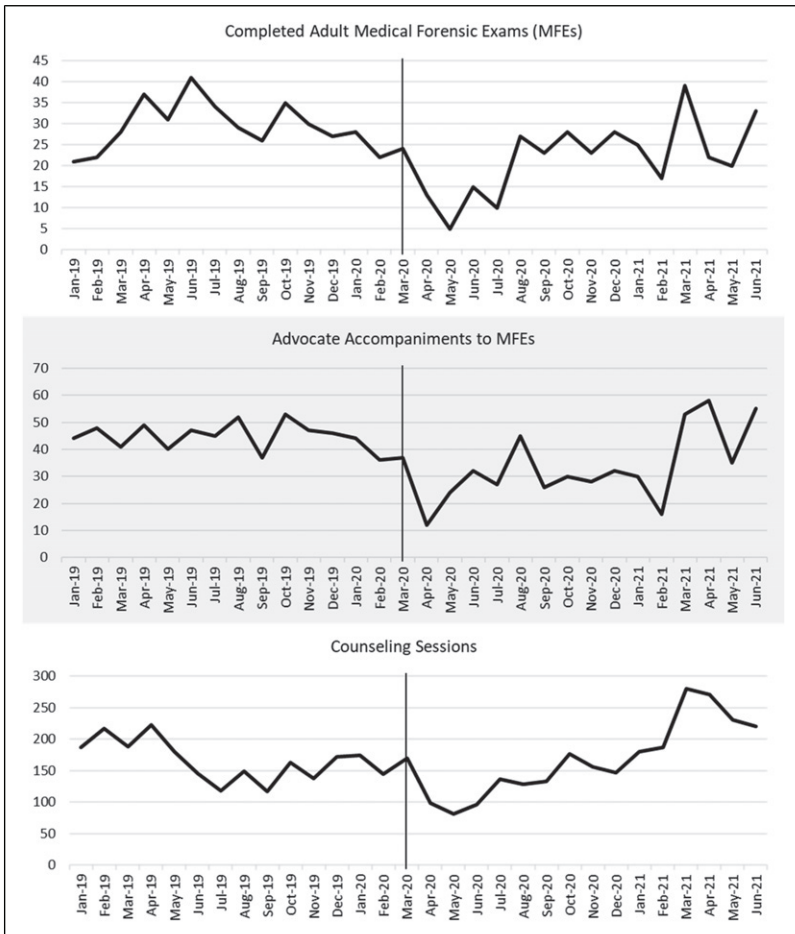


Figure 1. Medical forensic exams, medical advocacy, and counseling sessions by month, January 2019—June 2021.

in like April, there was maybe...I can't remember the exact number, like 15 exams, versus what we do every month...it was very noticeable" [Participant 5].

The advocates highlighted many reasons why the number of MFE dropped so suddenly. For example, many survivors are referred to their SANE services by law enforcement personnel and/or other hospital staff, but during the pandemic, these referrals essentially stopped, as one program advocate explained: "*Our acute calls from hospitals, from police, went to zero*" [Participant 13]. Program staff were concerned that incidence rates of violence

had not fallen to near-zero levels, but post-assault help-seeking was markedly low; elaborating on this difference, one advocate noted:

So there were many nights that we, like a lot of people were not getting any calls whatsoever because people who were getting assaulted were not coming to the hospital...I know people are getting assaulted, but we're not getting calls because people are too scared to go to the hospital ...if they're getting assaulted at home, it's like, okay, well where else am I going to go? If all the shelters are closed...or not closed, but maybe full. And now I have to fear about going to the hospital and maybe contracting something. So, so I'm sure there was many, many layers to why our cases did drop. [Participant 7]

Advocates also emphasized that because Detroit's infection rate was so high, survivors were scared to seek care in hospital emergency departments in fear that they would be exposed to the virus from COVID-positive patients seeking emergency health care. This SANE program offers MFEs in multiple locations, including a community clinic setting because even in non-pandemic conditions, survivors may be hesitant to seek care in a chaotic hospital emergency department right after being sexually assaulted. However, the number of exams performed in the community clinic site also fell to near-zero levels, as this advocate explained:

Even though we know there was a greater number of assaults most likely during this shut down ...we weren't seeing those numbers. We weren't seeing survivors coming in. I think that's mostly because they assume they have to go to the hospital. I think that becomes an issue on our part of survivors not necessarily knowing that we have offices outside of the hospital. So we had issues of survivors not necessarily wanting to come forward and have exams done because the fear of going into a hospital, because that's where you're most likely to get it in their minds...some of our survivors who unfortunately may have been victimized multiple times call[ed] in to say, Hey is it possible to see you in a different setting? I don't want to come here, but I want to have an exam done. [Participant 6]

Options for non-hospital MFEs existed in this community before the pandemic and this SANE program tried to promote this resource during the COVID surge. Police and other collaborative partners knew about the community clinic site, but inter-agency communication and referral networks were extremely strained in the early months of the pandemic, so even if survivors had reached out for help, they may not have been given complete information about all MFE site locations.

For survivors who did seek post-assault health care, advocates expressed concerns that the nature of those services was negatively impacted by the

pandemic. Most notably, hospitals instituted restrictions such that patients were not allowed to have support persons with them (for all types of care, not just sexual assault health care). As is recommended best practice (DOJ, 2013), this SANE program employs medical advocates who work on-site with program nurses to support patients, but due to hospital restrictions, advocates were not always allowed to provide support to sexual assault patients seeking MFEs. The quantitative data revealed a significant decrease in the number of medical advocacy accompaniments per month ($F(3,26) = 6.56, p < .01$, adjusted $R^2 = .37$). The baseline number of advocacy accompaniments was approximately 46¹ per month ($b = 46.17, SE = 5.20$), and before the pandemic, there was no significant month-to-month change in the number of accompaniment sessions ($b = -.17, SE = .61, t = -.27, p = ns$). After the onset of the pandemic, the number of accompaniments decreased significantly by approximately 23 sessions per month ($b = -22.56, SE = 6.72, t = -3.36, p < .01$). As shown in Figure 1, there were 12–37 MFE accompaniments per month in March–May 2020, whereas the prior year (2019), there were 40–49 per month for that same time period. In the qualitative interviews, the advocates expressed frustration regarding these changes in their core services:

There were a couple of weeks where we had no cases or there were instances where maybe only our nurse responded to a hospital because of all these restrictions and stuff that were in place with COVID at the time. [Participant 13]

It's been difficult, because...a lot of our clinic sites are in the hospitals, so there was a time where we couldn't advocate, specifically couldn't even get into the hospital to provide that advocacy. [Participant 5]

The limitations on advocacy services were particularly concerning because healthcare staff were exhausted and stressed from caring for COVID patients, and advocates noted that they did not have bandwidth to offer comprehensive care and referrals for sexual assault patients:

I think a lot of the hospitals also push survivors just to the back. They were more focused on COVID patients and...getting them isolated or quarantined. I'm sure there's a lot of people who just went home after visiting the ER and didn't know the next step. [Participant 5]

A key “next step” that advocates typically provide is a referral to the agency’s extended advocacy services and counseling program. Without advocates to make that “soft hand-off” and to assure survivors that the agency was still open and able to provide after-care, the program also saw a significant decline in their counseling sessions ($F(3,26) = 12.17, p < .001$, adjusted $R^2 = .54$). The baseline number of counseling sessions was

approximately 197 per month ($b = 196.95$, $SE = 18.38$), and there were no significant month-to-month changes in counseling sessions prior to the onset of the pandemic ($b = -4.20$, $SE = 2.16$, $t = -1.95$, $p = \text{ns}$). After the pandemic, monthly counseling sessions decreased by approximately 56 sessions per month ($b = -55.79$, $SE = 23.75$, $t = -2.35$, $p < .05$). As shown in Figure 1, in March 2020, the agency provided 170 counseling sessions, which dropped to 98 sessions in April 2020, and 81 in May 2020. For contrast, in the prior year (2019), the agency was typically providing 180–223 sessions per month (for March, April, May). Advocates were concerned that survivors may have assumed their agency was not open at all, and/or that survivors did not have the resources (i.e., phones, computers, internet access) for remote counseling sessions:

I know a lot of clients...who may have not had like internet access or...who may only have minute phones and [might not have] wanted to have conversations...either over the phone or through a computer. [Participant 7]

Because Detroit was hard hit by the pandemic, advocates noted it was challenging to get the word out through media and other communication networks that their agency was open and able to provide post-assault healthcare and counseling services.

Recovery: How Survivors' Post-Assault Healthcare Utilization Changed as the Pandemic Continued

In June 2020, the governor of this state eased restrictions as infection rates declined, and many city businesses and services re-opened. Detroit's sexual assault agency had remained operational throughout the shutdown, but they expected more survivors might reach out for help now that the city was slowly re-opening. However, the interrupted time series segmented regression model revealed that there was not a significant rebound in the number of adult MFEs performed through June 2021 ($b = 1.02$, $SE = .59$, $t = 1.73$, $p = \text{ns}$). As shown in Figure 1, this SANE program conducted only 15 adult exams in June 2020, 10 in July 2020, and 27 in August 2020; in 2019, they performed 29–34 exams per month during that summer. The number of exams performed did not return to pre-pandemic numbers until March 2021, which coincided with the availability of COVID vaccines. The number of medical advocacy MFE accompaniments slowly rebounded, and by June 2021 there was a significant positive change in the month-to-month trend ($b = 1.63$, $SE = .79$, $t = 2.07$, $p < .05$). Again, this service code is more expansive than the MFE exam code as it captures advocacy support for any type of healthcare services received. The number of counseling sessions also significantly rebounded through June 2021 ($b = 14.30$, $SE = 2.79$, $t = 5.13$, $p < .001$), and in fact, the number of

sessions eventually exceeded the agency's pre-pandemic numbers. As shown in Figure 1, in March 2021, the program provided 280 counseling sessions per month, which was strikingly higher than any of their 2019 monthly totals or the 2019 average of 167 sessions per month.

In the qualitative interviews, the advocates predicted that the need for counseling services would likely to increase over time. Advocates noted that survivors might have forgone MFEs and filing police reports for assaults that occurred during the initial surge of the pandemic, but now want to explore options for delayed reporting and emotional support:

Now we're having survivors slowly coming and calling to receive counseling services or to have assistance with filing a police report and then the concerns they have, well I didn't get a kit done...because I was scared. At the time, I was scared of going to the hospital and trying to have to explain to them that having a kit is not necessarily a requirement of filing a police report. [Participant 6]

Other survivors had no intention of ever reporting to the police, but they did want counseling to process the trauma of the assault:

COVID is still having a big impact on everything. But now that our office is open...we're going to get a lot of calls for counseling, for people who were, who may have been assaulted during the pandemic and didn't get a kit, but wanted to at least process what happened. [Participant 7]

Advocates also noted that the survivors who sought counseling from their agency needed help not only with the trauma of the assault, but also the trauma of how COVID impacted their lives:

And the first time I saw her again, after the start of the pandemic...she had lost four family members and her boyfriend to coronavirus...losing five people in the span of five months is so traumatizing, five separate times it's traumatizing. And then also having your own traumas to work through, it's just so much. So that's also something that we've done is engaged in a lot of virtual trainings for how to work with survivors who had implications from coronavirus. And that was really helpful because now the assault is on the back burner. And now we're working through feelings of grief and survivor's guilt...It's definitely a shift where now a lot of us are working with survivors who've been very severely impacted by coronavirus and that's at the forefront of our counseling sessions. [Participant 3]

Thus, the number of counseling sessions significantly increased over time, and the nature of those sessions changed qualitatively as agency counselors

were providing therapy to help survivors with the trauma of the assault, as well as the grief and loss they experienced due to COVID.

Discussion

COVID-19 has caused world-wide suffering, and in the U.S., the pandemic has disproportionately harmed communities of Color (Alcendor, 2020; Muñoz-Price et al., 2020). Incidents of gender-based violence have also increased during the pandemic (Piquero et al., 2020), so it is critical to understand how victim service programs have been affected, particularly in communities of Color. In this study, we examined how COVID-19 disrupted sexual assault healthcare services in a predominately African American city, Detroit, MI. Using an interrupted time series design, we documented significant decreases in MFEs, medical advocacy accompaniments, and counseling during the pandemic's initial surge. Qualitative data revealed that survivors feared seeking hospital-based health care due to the risks of contracting COVID-19. These fears were justified, as Detroit experienced an early surge in COVID-19 cases and deaths, and it was well-publicized in local and national media that Detroit hospitals were overwhelmed caring for COVID patients (Chapman et al., 2020).

This study tracked sexual assault healthcare services for a full year after the statewide shelter-in-place order was lifted and the initial rollout of vaccines began (i.e., through June 2021). The rate of MFEs did not fully return to pre-pandemic levels during this study's observation period, but medical advocacy accompaniment did significantly rebound. Survivors may have felt more comfortable seeking specific healthcare services (e.g., emergency contraception, medications for sexually transmitted infections) rather than consenting to a full MFE with SAK collection, which take considerably more on-site time, and therefore pose a greater risk of exposure to COVID-19. Counseling services not only rebounded, but eventually exceeded pre-pandemic levels. Given the devastation COVID-19 caused in Detroit, particularly among its Black residents, the agency had to expand its counseling services to help survivors process their pandemic-related grief and loss.

This study was planned and executed during a global pandemic, and we acknowledge this work is largely descriptive and atheoretical in nature. Our primary aim was to document the challenges facing a sexual assault service agency in a predominately African American city, with an eye toward identifying policy recommendations for future public health emergencies. That said, we did not assess community rates of violence and victimization in Detroit during the pandemic, so we do not know how extensively the need for assistance exceeded service capacity. We were unable to interview survivors directly, but we did collect data from advocates who had direct contact with

survivors. Advocates could relay what was shared with them by survivors (e.g., their expressed fears, concerns, and experiences), but we do not know survivors' internal feelings and motivations. Furthermore, this study captures information about survivors who sought help from this agency during the pandemic, so our data likely under-estimate the full extent of survivors' needs. Finally, we note that our qualitative interviews were conducted between July and September 2020, so we have limited data regarding how this agency (specifically) and this city (generally) transitioned to 'new normal' operations after the shelter-in-place order was lifted. Our quantitative data extended to June 2021, which provides some insight into how service utilization changed as vaccines became more widely available. Longer-term follow-up data are needed to understand the full impact of COVID on survivors and victim service agencies.

With these caveats in mind, this study can offer guidance to practitioners and policymakers for improving access to post-assault health care. Advocates emphasized that survivors were scared to go to hospital emergency departments during the pandemic, which raises questions about the necessity of conducting MFEs/SAKs in hospital settings given that most sexual assault victims do not sustain injuries that need trauma intervention (Sugar et al., 2004; Zilkens et al., 2017, 2018). The results of this study suggest there may be unintended negative consequences of locating so many SANE programs in hospital emergency departments because public health emergencies can compromise the accessibility, availability, and safety of these sites for non-emergent sexual assault patients. Some SANE programs operate in community-based clinics, either as their sole location or as a satellite location to a primary hospital-based program, with established protocols for medical transfers should patients need trauma care (Campbell et al., 2005, 2022). However, community-based SANE programs are far less common in forensic nursing practice, comprising less than one-fifth of all U.S. SANE programs (Logan et al., 2007; Campbell et al., 2005). The Detroit SANE program had a community clinic site, but it was challenging to publicize this option in the flood of pandemic-related information. A key lesson learned by this community during COVID-19 was that they needed more options for community-based sexual assault healthcare services, so in September 2020, the Detroit SANE program opened an additional community clinic site for MFEs, SAK collection, and sexual assault health care. Future research should examine patients' experiences in hospital- versus non-hospital-based SANE programs and whether community-based programs can improve access to post-assault health care for survivors who do not have trauma injuries.

Improving post-assault health care also requires a closer look at how survivors are referred to SANE programs or other care settings. In this community—and in many others throughout the U.S.—law enforcement personnel and hospital staff are key referral sources who connect survivors to

sexual assault agencies/SANE programs (Campbell et al., 2010). Given the rapid early surge of COVID-19 cases and deaths in Detroit, hospital staff were overwhelmed, and a large portion of Detroit's police force was either infected or in quarantine (Chapman et al., 2020), which severely compromised this community's referral network. Our findings highlight the need for developing broad-based networks that do not over-rely on police and hospitals, which can become strained in large-scale emergencies. For example, Ray et al. (2021) emphasized the importance of collaborating with community gatekeepers and pillars (e.g., Black churches, Black-owned businesses) to create robust, sustainable pathways to social, health, and educational services. While our partner program has some connections to these types of organizations, this study underscores the need to diversify outreach efforts. Prior research consistently finds that Black/African-American survivors are more likely to turn to informal sources of support, rather than more formal system-based supports (Ahrens et al., 2010; Lindquist et al., 2016; Long et al., 2007), so sexual assault agencies need stronger connections with community pillars to increase the likelihood that survivors' friends and family members are aware of options for trauma-informed health care. During periods of intense stress and trauma, such as the COVID-19 pandemic, communities must have strong referral networks and multiple service options to ensure continued access to sexual assault health care.

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Note

1. Monthly advocacy accompaniments may exceed the number of monthly completed adult MFEs because advocacy accompaniments were recorded even in cases where a patient may have declined to have an exam, elected not to complete a full MFE, or opted to receive only select healthcare and/or advocacy services.

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