

A10: Sexual Assault

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Introduction

Responding to a sexual assault call requires survivor-centered, culturally safe, trauma informed care. Paramedics need to address the physical and psychological trauma while ensuring the sexual assault survivor maintains their autonomy. Many survivors experience continued powerlessness, shame and guilt while accessing services due to insensitive treatment by health service workers. However, when treated with care, compassion, clear explanations and choice, survivors experienced positive associations with health care and can feel “humanized”. These positive interactions may be viewed as positive social support, which has been proven to diminish psychological impact of stressful life events.

Best practice for paramedics has been largely adapted from research on sexual assault nurse examiner programs with identified positive outcomes, the World Health Organization’s guideline, “Responding to Intimate Partner Violence and Sexual Violence Against Women,” and the British Columbia Ministry of Health Trauma-Informed Practice Guide.

Essentials

- Use trauma-informed practice as an assessment structure:
 - Trauma awareness
 - Safety and trust
 - Choice, collaboration, and connection.
- Believe the survivor, and tell the survivor you believe them. Fear of not being believed is a major barrier for survivors in accessing care and services, which may have long-term physical and psychological consequences.
- Consider the possibility of sexual assault for any patient who describes a possible drugging, or who is found with a decreased level of consciousness in a precarious situation or abnormal environment (e.g., found with an altered level of consciousness in the bathroom of a bar with missing underwear, or waking up in the bushes in a park with no recollection of antecedent events).
- Ask if the survivor would like to share any information, but be clear that this is not required. Re-telling of stories can be re-traumatizing. Best practices for trauma-informed care minimizes and reduces the number of times a survivor needs to recount what happened. Focus on questions related specifically to patient care.
- Manage physical injuries according to license levels. *Always* request consent prior to touching the patient. Assess for traumatic brain injuries, signs of strangulation, and consider the possibility of human trafficking.
- Preserve items (such as clothing) for forensic evidence if the patient consents. Where possible, have the patient remain in their clothing. Do not place clothing on the floor, and do not cut through deformities in clothing, or wipe off contaminants (including dirt).
- Document all injuries. Record any trigger words (i.e., words that create a reaction in the patient such as wincing, shaking, refusing to speak) found during the assessment, as well as any description of the events shared by the patient.
- If a health authority agreement is in place, transport to a sexual assault receiving facility, or a hospital that has the ability to complete a sexual assault forensic examination. If major trauma criteria are met, follow local trauma guidelines as these supersede the need for sexual assault forensics.
- If no health authority agreement is in place, and a sexual assault receiving hospital is within a reasonable distance, ask the survivor about destination preferences (local hospital versus sexual assault receiving hospital). If the survivor consents to be transported to the sexual assault receiving hospital, confirm the transport destination with the on-duty unit chief. If clinical issues exist, consult with CliniCall for destination selection guidance.

Additional Treatment Information

- Obtain consent before each and any physical interactions with the patient. Patient consent can be given for one

interaction but not another, and may be withdrawn at any time.

- External physical injuries may not exist, or may not be apparent. Do not cut and expose clothing unless consent is received, or there is a high suspicion of injury in an unconscious patient.
- Alcohol or drug use is common by perpetrators of sexual assault. (Diphenhydramine and alcohol, gamma hydroxybutyrate (GHB), and rohypnol are examples of substances used.) Paramedics must be aware of drug reactions, and treat these as required.

In cases involving children, the survivor most often knows the perpetrator. Consider the safety of the patient and any other children or vulnerable individuals at the location of the incident. Follow mandatory reporting procedures (Appendix B).

Referral Information

- If the patient refuses to be transported, they should be advised of the location of the sexual assault receiving hospital (or, if more comfortable for the patient, the closest hospital), and options for reporting, including third party reporting. Survivors may be more likely to seek medical attention if accompanied by a support person; this individual can also provide transport in cases of refusal.
- Survivors may be refusing transport because of a fear of a forensic exam. Empower the survivor by reassuring them that they can refuse forensics, and only receive medical care; they are able to change their mind about whether to undergo a forensic exam, or not, at any time.
- If the patient is not being transported, ensure that adequate safety planning has been completed prior to leaving the scene (see appendix C). Refer to VictimLink BC for access to support services.

General Information

Sexual Assault and Consent

Sexual assault is an act of violence. It is defined as any non-consensual sexual contact, as found in the *Criminal Code of Canada*, Section 271. The *Criminal Code of Canada* also notes that consent cannot be given if the individual is intoxicated, drugged, unconscious, asleep, or if they are incapacitated in any way. Consent must be freely given, without coercion or threats. Consent can be revoked at any time and can be provided for one act, but not for another.

Trauma Informed Practice and Assessment Structure

Trauma informed practice (TIP) is a framework for understanding the effects of trauma in individuals. It provides physical, emotional, spiritual, and cultural support and safety by giving patients choice and control, allowing them to collaborate in their care planning and treatment. It allows the practitioner to see the patient's reactions as a symptom of a trauma injury, rather than non-compliance or resistance.

Trauma is a psychological and emotional response to a terrible event that overwhelms an individual's ability to cope. Examples include natural disasters, war, major accidents, and rape. One individual's reaction to trauma may be different from another's; some individuals may react expressively, while others may show no reaction at all. Sexual assault survivors may be sobbing and crying, or stoic, or anything in between – there is no "correct" or "right" reaction to trauma.

The re-telling of stories can be re-traumatizing for survivors, causing significant distress. The World Health Organization's guidelines for responding to intimate partner violence, supported by extensive research, includes recommendations to reduce the number of services and providers a survivor has contact to, and where they must recount their story. In taking a clinical history, paramedics with trauma awareness should not press the survivor to tell their story, to exercise patience, and to understand regardless of the survivor's reactions.

Sexual assault survivors

Survivors of sexual assault often experience a range of emotions following their assault. These emotions and feelings vary from individual to individual. Many survivors experience fear, shame, a loss of control, embarrassment, self-doubt, self-blame, grief, and confusion. Helpful words or phrases can include "I believe you," and "this is not your fault." "You are safe now" is also helpful, provided it can be guaranteed that the perpetrator will not have access to the patient.

In the assessment and treatment of sexual assault survivors, cultural safety requires acknowledging and addressing the power imbalances that exist between the practitioner and the patient, the patient and the health care system,

and the patient and society. Cultural safety also requires self-reflection on the part of the practitioner, in an effort to identify and challenge personal biases, conscious and unconscious.

Without safety and trust, the patient may not allow paramedics to come close, or to touch them. Safety and trust can be established by ensuring practitioners introduce themselves, and explain their purpose. Paramedics should adapt their environment to help survivors feel safer. This might involve asking the patient if they would like to change locations for the assessment; it can also involve offering the patient a blanket to keep warm, or for protection from the elements. Paramedics should follow the survivor's lead. To continue developing both safety and trust, paramedics must always clearly explain what they would like to do, and seek consent before performing any exam or intervention.

Offering choice and working collaboratively with survivors enhances feelings of safety and trust. Throughout the assessment process, paramedics should give the patient choice, and provide an opportunity to express their views on the types of treatment they might receive, and how it can be delivered. Some survivors will not want any assessment or treatment, wanting only to be taken to hospital. Paramedics must respect the patient's autonomy over their body, and power over what happens in their care – control over the self was lost during the assault, and returning it can promote more safety and trust between paramedic and patient.

This also extends to the ambulance and transport. Patients must be given choices throughout the call. Paramedics must be aware that telling the patient to lie on the stretcher may trigger a negative reaction (the assailant may have told them something similar). Similarly, words or phrases such as "this will be easier if you let me do this" or "stop fighting," or "you are going to the hospital no matter what" are unhelpful – these take away power and control, and mirror the experience of the assault.

Indigenous Survivors

Indigenous people of all genders have a rate of self-reported sexual assault that is nearly three times higher than non-Indigenous Canadians. Indigenous women with a parent who attended a residential school are 2.35 times more likely to be sexually assaulted compared to Indigenous women whose parents did not. Additionally, Indigenous women are specifically at much higher risk of violence, with self-reported rates of sexual assault that ranges from three times higher in the provinces, and six times higher in the territories, compared to their non-Indigenous counterparts. They are also twelve times more likely to be assaulted and suffer serious injuries.

The legacy of colonialism, racism, systemic and societal discrimination, intergenerational trauma, poverty, the continued impact of residential schooling and the 60s scoop, loss of individual and cultural identity, limited educational opportunities, poverty, isolation, and substance abuse all contribute to violence against Indigenous women, and affect the wellness of Indigenous people, their families, and communities. For Indigenous sexual assault survivors, cultural safety is of the utmost importance. Recognizing how these elements influence the survivor's perception of care and treatment will assist paramedics in developing an approach to these patients.

Introduction to Indigenous Health: <https://learninghub.phsa.ca/Courses/16926/introduction-to-indigenous-health>

San'Yas Indigenous Cultural Safety training: <https://learninghub.phsa.ca/Courses/11374/sanyas-indigenous-cultural-safety-training-ics-online>

Physical Injuries

Survivors of sexual assault may not have immediate or apparent life-threatening injuries, and may only require minimal medical interventions in addition to emotional support and transportation. Paramedics should be aware of the possibility that survivors may have been drugged, strangled, or suffering from traumatic brain injuries; a high index of suspicion should be maintained when patients are disoriented, have disorganized thoughts, or an inconsistent story – though note that this can also be a trauma stress reaction. Traumatic brain injuries are under-recognized in cases of intimate partner violence; some studies cite the incidence of traumatic brain injury at over 90% of individuals with a history of interpersonal violence.

Signs and symptoms of a traumatic brain injury include headaches, nausea and vomiting, blurred vision, and memory problems. Traumatic brain injuries can produce physical, emotional, behavioural, and intellectual changes in patients. See CPG H04 for additional guidance on the management of traumatic brain injuries.

Patients who have been strangled often have symptoms with a delayed onset that can have severe consequences. Strangulation is a form of asphyxia resulting from external pressure on the neck, occluding blood vessels and the airway. Very little pressure on the jugular veins is needed to produce venous outflow obstruction, which leads to congestion of blood vessels, increased cerebral venous pressure, and elevated intracranial pressure. Stagnant hypoxia and cerebral edema can result. Occlusive pressure on the carotid arteries will result in loss of consciousness within 8 to 10 seconds; the obstruction of oxygen delivery to the brain can produce clots. Pressure

on the carotid sinus can cause bradycardia, which may lead to cardiac arrest. The tracheal cartilage can also be fractured.

Early signs and symptoms of strangulation include:

- Dysphonia (hoarse voice)
- Dysphagia
- Dyspnea, tachypnea, or feelings of an “asthma attack”
- Sore throat
- Neck or jaw pain
- Lightheadedness
- Loss of consciousness
- Urinary and fecal incontinence
- Injuries to the lips or tongue
- Nausea and vomiting
- Headache
- Seizure
- Changes to hearing or vision
- Swelling in the neck, scratches or red marks under the chin or around the neck
- Petechiae, particularly around eyelids, the eyes, face, scalp, neck, behind ears, or on the soft palate and under tongue
- Scleral hemorrhage or edema

Later signs and symptoms of strangulation:

- Neck swelling or bruising around neck
- Stroke symptoms (ie. paralysis, slurred speech)
- Memory problems
- Ptosis
- Miscarriage

Strangulation assessment tool for first responders: <https://www.familyjusticecenter.org/wp-content/uploads/2018/09/Strangulation-Assessment-Card-v10.12.18.pdf>

Forensic Evidence and Reporting

Many sexual assault programs collect forensic evidence samples up to seven days post-assault. Some forensic exams can take place beyond those seven days, depending on circumstances. The collection and documentation of forensic evidence requires continued consent from the survivor. A survivor cannot consent to the forensic collection if they are impaired or incapacitated. While at the hospital, the survivor has three options for care:

1. To receive medical care only.
2. To receive medical care with a forensic exam, with the samples stored where possible. Police reporting does not take place, though the survivor may elect to report later.
3. To receive medical care with a forensic exam, with all evidence and documentation reported to the police.

In all cases, the medical needs of the survivor take priority over the forensic examination and collection of evidence.

Survivors also have three options for police involvement in their case. They may or may not choose to report their assault to police, or they may elect for a third-party reporting (TRP) process, which allows the survivor to remain anonymous while still providing information about the assailant to police. Third party reporting is conducted through community-based victim services; as the survivor's identity will be withheld from police, the Crown will not pursue the assailant in these cases. These reports may be made at any time – there is no time limit to reporting sexual assault.

Documentation

The documentation of any call is an important record of a patient's care. In cases of sexual assault, paramedic (and other health care team) records can be requested and used in legal proceedings. Proper documentation can

help the Crown with the laying of charges, and provide valuable evidence at trial.

Paramedics must ensure that notations and records represent objective observations. They should detail the size, location, and type of all injuries (new versus old and healing), any disclosures from the patient, and any “trigger words” and their reactions. Statements made by the survivor must be recorded verbatim.

Human Trafficking

Survivors of sexual assault may also be victims of human trafficking. Warnings for trafficked patients include:

- Delays in seeking care.
- A person with the patient, often identified as a “friend” or “boyfriend,” with controlling behaviour, or who controls the conversation, answers questions for the patient, or acts as the sole interpreter.
- Survivors who change their story of what happened, or who was involved.
- Branding or tattoos on survivors (such as gang symbols or names).
- No BC Services Card or insurance.
- Worries about the cost of care
- Survivors who are uncertain about where they are.
- Individuals who report being homeless, having “just moved,” or who are “just visiting.”
- Survivors who are not allowed to answer questions.
- Individuals who appear isolated.
- A child or youth who is dressed more provocatively, or who has cash or expensive items that are “gifts” from a friend or boyfriend.

At scenes, be aware of:

- Residences with rooms with multiple mattresses on the floor, or where locks are on the outside of doors.
- Individuals who live in the same place as where they work, sometimes with multiple other people.
- Unsafe or unsuitable living conditions or workplaces.
- Minimal amounts of food considering the total number of residents.
- Children or youth found in hotel rooms.

If human trafficking is suspected, separate the patient from the “friend,” “boyfriend,” or handler. Move the patient to a safe space, such as the back of the ambulance, and assess using trauma informed practice. Avoid invasive questions; instead, listen to the patient’s statements. Many people who are trafficked do not perceive themselves as victims of trafficking. Concentrate on their immediate needs and any health or medical concerns. Transport the patient to hospital without escorts from the scene. If an interpreter is required, use PHSA Language Link, not an on-scene interpreter. Notify the triage nurse of suspicions.

Female Genital Mutilation

Female genital mutilation (FGM) is any procedure that involved the removal or cutting of some, or all, external female genitalia for non-medical purposes. It is practiced in many different cultures and countries, and is usually performed on minors, from infants to girls up to 18 years of age. FGM is internationally recognized as a gender-specific violation of human rights; it can be used to control women and girls’ sexuality, or it can be performed due to misinformation about female sexual organs. Regardless of the reason, FGM is fundamentally rooted in gender inequality. Because FGM does not involve sexual contact, it does not qualify as a sexual assault under the *Criminal Code of Canada*; instead, it is considered aggravated assault, under Section 268(3). It is also illegal to send children to another country for the purpose of undergoing an FGM procedure.

The prevalence of FGM in Canada is unknown. The diversity of Canada’s population, however, suggests that women and girls from countries where FGM are commonly practiced are living here; some of these women may have already had FGM, and younger girls may be at risk.

Female genital mutilation presents many immediate and long-term physical, psychological, and sexual health issues. Immediate complications include severe pain, hemorrhage, infection, sepsis, shock, and death. Over the longer term, problems include urinary tract infections, child birth complications, menstrual complications, chronic pain, depression, anxiety and low self-esteem.

Interventions

Emergency Medical Responder – All FR interventions, plus:

- Use trauma informed, culturally safe practice throughout patient assessment and management.
- Allow conscious patients autonomy over treatment, position, and disclosure.
- Provide airway management as required.
- Control life-threatening bleeding. For vaginal or anal bleeding, consider use of abdominal pads. Do not throw out gauze or pads used on genitalia – preserve in paper bag (if possible) or wrapped in a blanket or towel for forensic collection.
- Do not clean external wounds unless absolutely necessary; if the patient consents, these may be swabbed for forensic purposes. Covering with dry non-adherent dressings or gauze is acceptable.
- Assess for strangulation injury and traumatic brain injury.
- Assess for signs of human trafficking and sexual exploitation.
- Consider asking patient to defer washroom use until arrival at hospital – urine samples may be collected for forensic purposes.
- Transport to sexual assault receiving or forensic-capable hospital, if available in area. Otherwise, transport to closest hospital.
- Provide notification to hospital to assist in safe placement of patient.
- For pediatrics: notify Ministry of Children and Family Development.
- Document using applicable sexual assault impression code on the ePCR.

Primary Care Paramedic – All FR and EMR interventions, plus:

- Consider pain management:
 - [→ E08: Pain Management](#)
- Consider vascular access in cases of significant bleeding.
 - [→ D03: Vascular Access and Fluid Administration](#)
 - Consider [tranexamic acid](#) where indicated
 - See also:
 - [→ D01: Shock](#)
 - [→ D02: Bleeding](#)

Advanced Care Paramedic – All FR, EMR, and PCP interventions, plus:

Caution: consider sedation only in extreme circumstances (if the patient is a risk to themselves or others). Most sexual assault survivors can be calmed through verbal interactions, the provision of safe spaces, promotion of individual autonomy, and transported without medical sedation. Patients may still be emotionally distraught, but this agitation is rarely physical. Sedation can delay options in care, and inhibits the ability to consent to a medical forensic examination and evidence collection.

References**Appendix A: List of SANE Programs or Forensic Hospitals****Vancouver Island Health Authority**

- Campbell River General Hospital
- Cowichan District Hospital (Duncan)
- Lady Minto Hospital (Salt Spring Island)
- Nanaimo Regional Hospital
- Port Hardy Hospital
- Tofino General Hospital
- Victoria General Hospital
- West Coast General Hospital (Port Alberni)
- Oceanside Health Centre (Parksville)

- Comox Valley Hospital (Courtenay)
- [South Island sexual assault destination guideline and patient pathway](#)

Vancouver Coastal Health Authority

- Vancouver General Hospital
- BC Children's Hospital
- [Vancouver Coastal Sexual Assault Pathway](#)

Fraser Health Authority

- Surrey Memorial Hospital
- Abbotsford Regional Hospital

Interior Health Authority

- Kelowna General Hospital
- East Kootenay Regional Hospital (Cranbrook)
- Kootenay Boundary Hospital (Trail)
- Royal Inland Hospital (Kamloops)
- Penticton Regional Hospital
- Queen Victoria Hospital (Revelstoke)
- Vernon Jubilee Hospital

Northern Health Authority

Northwest Facilities

- Northern Haida Gwaii Hospital (Masset-Northern Haida Gwaii)
- Haida Gwaii Medical Centre (Queen Charlotte)
- Stewart Health Centre
- Prince Rupert Regional Hospital
- Mills Memorial Hospital (Terrace)
- Kitimat Hospital & Health Centre
- Wrinch Memorial Hospital (Hazelton)
- Stikine Health Centre (Dease Lake)
- Bulkley Valley District Hospital (Smithers)

Northern Interior Facilities

- Lakes District Hospital & Health Centre (Burns Lake)
- St John Hospital (Vanderhoof)
- Stuart Lake Hospital (Fort St James)
- University Hospital of Northern British Columbia (Prince George)
- GR Baker Hospital (Quesnel)
- Valemount Community Health Centre
- McBride & District Hospital

Northeast Facilities

- Chetwynd General Hospital
- Fort Nelson General Hospital
- Fort St John Hospital
- Dawson Creek Health Unit
- Hudson's Hope Health Centre

Appendix B: Creating a Safety Plan

The purpose of the Safety Plan is to assist the Survivor in being prepared should they decide to leave the potentially unsafe situation they are in. This can be used in situations of known to the Survivor perpetrator of sexual assault, Survivors of intimate partner violence, Survivors of Domestic Violence or any Survivor who fears the perpetrator will come back to their residence.

List Adapted from the Province of British Columbia Ministry of Justice "Creating a Safety Plan" booklet (2015). To see full version, visit: <https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/victims-of-crime/vs-info-for-professionals/training/creating-safety-plan.pdf>

- Reassure the Survivor that this is not their fault.
- Encourage the Survivor to develop self-care strategies for their psychological, spiritual and physical wellbeing.
- Ask the Survivor to develop an emergency exit plan, should the perpetrator come through the front door/back door/garage door.
- Ask the Survivor to name people and places they can go that they feel safe and supported. If the Survivor does not have anyone, refer to VictimLink for sources of support and emergency shelters in the area.
- Ensure the Survivor has important cards in their wallet and not stored elsewhere ie. Bank card, credit card, SIN card, driver's license, medical card (and those of their children, if applicable), phone card.
- Ask the Survivor to make photocopies of important documents (ie. Passport, birth certificates, BC ID/ driver's license, Income Assistance documentation, Immigration forms/work permits, etc). Place photocopies in a different place than the originals; hide the originals somewhere safe. Alternatively, scan and email the documents to themselves, as long as the perpetrator does not have access to the Survivor's email.
- Ask the Survivor to prepare a "Go Bag" containing immediate needs in case Survivor needs to leave their home quickly (ie. change of clothes, medications, comfort toy for children, medications, small items of sentimental value).
- If the perpetrator comes back, remind Survivor to call 911 and ask for Police. If the Survivor calls from a landline, the call can be traced so if it is unsafe for the Survivor to speak, 911 can still find the address of the emergency. This is not true for cellphones or satellite phones.

References

1. Campbell, R. (2008). The psychological impact of rape victims. *American Psychologist*, 63(8), 702-717. Electronic version retrieved from: <https://www.ncbi.nlm.nih.gov/pubmed/19014228>
2. Caroline, N. (2010). Traumatic Brain Injuries. *Nancy Caroline's Emergency in the Streets* (6th edition, pp.29-30). Electronic version of chapter retrieved from <https://intranet.bcas.ca/areas/medicalprograms/education/resources/eCaroline/pdf/9781449640521-ch21.pdf>
3. Department of Justice Canada. (2017). Victimization of Indigenous Women and Girls. Electronic version retrieved from: <https://www.justice.gc.ca/eng/rp-pr/jr/jf-pf/2017/july05.html>
4. Dumont, J., Kosa, D., Macdonald, S., Benoit, A., & Forte, T. (2017). A Comparison of Indigenous and Non-Indigenous Survivors of Sexual Assault and Their Receipt of and Satisfaction with Specialized Health Care Services. *PLOS ONE*, 12(11). Electronic version retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5690475/>
5. Ending Violence Association of BC. (2016). Paramedic Practice Tips. *Responding to a Sexual Assault Disclosure*. Electronic version retrieved from: http://endingviolence.org/wp-content/uploads/2016/05/EVA_PracticeTips_Paramedics_vF.pdf
6. Family Justice Centre. (2018). "Do you need a paramedic?" The Role of Emergency Medical Services in Non-Fatal Strangulation Cases. Electronic version retrieved from: <https://www.familyjusticecenter.org/wp-content/uploads/2018/03/Do-You-Need-a-Paramedic-The-Role-of-Emergency-Medical-Services-in-Non-Fatal-Strangulation-Cases-2018.pdf>
7. Fehler-Cabral, G., Campbell, R., Patterson, D. (2011). Adult Survivors' Experiences with Sexual Assault Nurse Examiners (SANEs). *Journal of Interpersonal Violence*, 26(18), 3618-3639. Electronic version retrieved from <https://journals-sagepub-com.libproxy.jibc.ca/doi/pdf/10.1177/0886260511403761>
8. Fraser Health Authority (n.d.) Introduction to Indigenous Health. Electronic version retrieved from: <https://learninghub.phsa.ca/Courses/16926/introduction-to-indigenous-health>
9. Fraser Health Authority (2016) Human Trafficking- Help Don't Hinder. Electronic version retrieved from: <https://learninghub.phsa.ca/Courses/6427/human-trafficking-help-dont-hinder>
10. Hawley, D., McClane, G., & Strack, G. (2001) A Review of 300 Attempted Strangulation Cases. *Journal of*

- Emergency Medicine*, 21(3), 317-322. Electronic version retrieved from: <https://www.deepdyve.com/lp/elsevier/a-review-of-300-attempted-strangulation-cases-part-iii-injuries-in-r0UjWsIYnO?key=elsevier>
11. International Association of Forensic Nurses (n.d.) Non-Fatal Strangulation Documentation Tool Kit. Electronic version retrieved from: <https://www.forensicnurses.org/page/STAssessment>
 12. Kimerling, R., & Calhoun, K. S. (1994). Somatic symptoms, social support, and treatment seeking among sexual assault victims. *Journal of Consulting and Clinical Psychology*, 62(2), 333-340. Electronic version retrieved from: <http://web.b.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=4&sid=6388cdb6-08ef-4e51-9191-0b22c884fa28%40sessionmgr101>
 13. Lifshitz, J., Crabtree-Nelson, S., Kozlowski, D. (2019). Traumatic Brain Injury in Victims of Domestic Violence. *Journal of Aggression, Maltreatment & Trauma*, 28(6), 655-659. Electronic version retrieved from: <http://dx.doi.org/10.1080/10926771.2019.1644693>
 14. McGregor, M., Le, G., Marion, S., & Wiebe, E. (1999). Examination for Sexual Assault: Is The Documentation of Physical Injury Associated with the Laying of Charges? A retrospective cohort study. Electronic version retrieved from: <https://www.cmaj.ca/content/cmaj/160/11/1565.full.pdf>
 15. Ministry of Health. (2013) Trauma-Informed Practice Guide. Electronic version retrieved from http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
 16. National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). On January 19, We March Again. Electronic version retrieved from: https://www.mmiwg-ffada.ca/wp-content/uploads/2019/01/2019-01-19-Womens-March_EN.pdf
 17. Ontario Human Rights Commission. (2006). Policy on Female Genital Mutilation. Retrieved from: <http://www.ohrc.on.ca/en/policy-female-genital-mutilation-fgm/4-fgm-canada>
 18. Pearce, M., Blair, A., Teegee, M., Pan, S., Thomas, V., Zhang, H., Schechter, M., & Spittal, P. (2015). The Cedar Project: Historical Trauma and Vulnerability to Sexual Assault Among Young Aboriginal Women Who Use Illicit Drugs in Two Canadian Cities. Electronic version retrieved from: <https://journals.sagepub.com/doi/abs/10.1177/1077801214568356>
 19. Perron, L., Senikas, V., Burnett, M., & Davis, V. (2013). Female Genital Cutting. *Journal of Obstetrics and Gynaecology Canada*, 35 (11), pp. 1028-1045. Electronic version retrieved from: [https://www.jogc.com/article/S1701-2163\(15\)30792-1/fulltext#s0030](https://www.jogc.com/article/S1701-2163(15)30792-1/fulltext#s0030)
 20. Province of British Columbia Ministry of Justice. (2014). Human Trafficking: Canada is not immune. Electronic version retrieved from: <https://www2.gov.bc.ca/gov/content/justice/criminal-justice/victims-of-crime/human-trafficking/human-trafficking-training>
 21. Province of British Columbia Ministry of Justice. (2015). Creating a Safety Plan. Electronic version retrieved from: <https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/victims-of-crime/vs-info-for-professionals/training/creating-safety-plan.pdf>
 22. Public Health Agency of Canada. (2012). Aboriginal Women and Family Violence- Detailed Findings. Electronic version retrieved from: <https://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/prevention-resource-centre/aboriginal-women/aboriginal-women-family-violence.html>
 23. Rozzi and Riviello. (2019). How to Evaluate Strangulation, *American College of Emergency Physicians NOW*. Electronic version retrieved from: <https://www.acepnw.com/article/how-to-evaluate-strangulation/>
 24. United Nation Population Fund. (2019). Top 5 Things You Didn't Know About Female Genital Mutilation. Electronic version retrieved from: <https://www.unfpa.org/news/top-5-things-you-didnt-know-about-female-genital-mutilation>
 25. Valera, E., & (2003). Brain Injury in Battered Women. *Journal of Consulting and Clinical Psychology*, 71(4), 797-804. Electronic version retrieved from: https://www.researchgate.net/publication/6250765_Brain_injury_in_battered_women
 26. World Health Organization. (2018). Female Genital Mutilation. Electronic version retrieved from: <https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>
 1. World Health Organization. (2010) Global Strategy to Stop Health Care Providers from Performing Female Genital Mutilation. Electronic version retrieved from: https://apps.who.int/iris/bitstream/handle/10665/70264/WHO_RHR_10.9_eng.pdf?sequence=1
 1. World Health Organization. (2013) Responding to Intimate Partner Violence and Sexual Violence Against Women- WHO Clinical and Policy Guidelines. Electronic version retrieved from http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

