**Review Article**

**Standardizing Discharge Educational Materials for Persons Who Have Been Sexually Assaulted**

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**Abstract**

How to properly take care of persons who have been sexually assaulted in the emergency room is well described but what information to include in discharge education is less well-known. The purpose of this literature review is to provide information that should be included in discharge documents for persons who have been sexually assaulted who present to the Emergency Department (ED) so that discharge education is consistent and standardized. A review of the literature was conducted using CINAHL Plus and OVID Databases. Thirty-five articles were identified. The dates of the literature identified for this review ranged from 1994 to 2008 and 2010 to 2020, with a 2-year gap in publications. The literature suggests that discharge materials be presented in a clear and brief manner using a language that the reader can understand. Discharge education should be written between a grade 6 and 7 readability level. Information on follow-up, including with a physician, mental health counselor, or rape crisis advocate should be given along with information regarding STDs (i.e., chlamydia, gonorrhea, HIV), pregnancy, and medication prophylaxis.

**Keywords:** Discharge education; Discharge instructions; Follow-up; Health literacy; Mental health; Patient education; Readability; Sexual assault; Sexual assault nurse examiner

**Introduction**

Sexual assault is an underestimated public health problem. Sexual assault refers to sexual contact that occurs without consent of the person and includes attempted rape, fondling or unwanted sexual touching, forcing someone to perform sexual acts, or penetration of the person’s body [1]. Sexual assault also includes any other acts a person may describe as sexual assault [2]. In a national survey of adults, nearly 1 in 3 women (33.3%) and 1 in 4 men (25%) reported experiencing sexual violence at some point in their life [3]. The risk for sexual assault increases 10 times for men in the military [4]. Most persons who have been sexually assaulted experienced the assault before the age of 25, with 33.3% of females and 25% of males reporting rape between the ages of 11-17, and 12.5% of females and 25% of males reporting rape when they were 10 years old or younger [3].

Following sexual assault, most women who seek medical care do so in EDs, which tend to be best equipped to handle such situations [5-7]. Persons who have been sexually assaulted encounter immediate and chronic psychological consequences including denial, fear, confusion, anxiety, distrust of others, and symptoms of post-traumatic stress disorder [8]. Many long-term physical and psychological consequences can occur including Post-Traumatic Stress Disorder (PTSD), depression, anxiety, eating disorders, attempting suicide, and/or drug and alcohol abuse [9,10]. Ninety-four percent of females who have been sexually assaulted report symptoms of PTSD [1]. Persons who have been sexually assaulted who develop PTSD are 13 times more likely to have alcohol-related problems and 26 times more likely to have two or more serious drug abuse problems compared to persons who have encountered non-sexual assaults [9]. Persons who have been sexually assaulted are 3.4 times more likely to use marijuana, 6 times more likely to use cocaine, and 10 times more likely to use other major illicit drugs than the general public [1]. Moreover, persons who have been sexually assaulted experience an increased number of physician and ED visits for up to three years after the assault [9]. Unfortunately, the economic burden of sexual violence is challenging to quantify due to limited data; however, the existing research suggests that the costs are substantial [11]. Rape is the costliest of all violent crimes, with a total estimated cost of $127 billion a year (excluding the cost of child sexual abuse) [11]. The estimated cost of sexual violence per victim is $122,461 [3].

An incidental finding by a Sexual Assault Nurse Examiner (SANE) Coordinator at an Illinois hospital noted that persons who had been sexually assaulted were returning to the ED within 1 month for complaints associated with their assault. Of those persons who returned, 6 of the 40 randomly selected persons (15%) returned to the ED for mental health or substance abuse complaints, ranging from depression, alcohol intoxication, and suicidality. Similar findings were found in a study by O’Connor & Chadwick [12], who found that 7 of 359 selected persons who had been sexually assaulted (2%) returned to the ED with suicidality within 72 hours of their assault. Discharge instructions are given to persons who have been sexually assaulted, but information provided is not standardized and teaching is not uniform, potentially being delivered in a variety of ways. Unfortunately, current evidence-based literature regarding what should be included in discharge materials for persons who have been sexually assaulted is minimal and vague. Thus, the purpose of this literature review is to provide information that should be included in discharge documents for persons who have been sexually assaulted who present to the ED so that discharge education is consistent and standardized nationwide.

**SANE Nursing**

Registered Nurses (RNs) who wish to become a SANE must complete an educational course consisting of a minimum of 40 classroom hours [5,13,14]. Following mastery of classroom knowledge, clinical components, including simulated clinical experiences, are completed in addition to the didactic coursework [14]. The SANE functions without assistants while performing the history and examination, obtaining evidence, taking photographs, drawing blood, and administering medications [6,13]. The SANE nurse also provides discharge education.

**Literature Review**

A review of the literature was conducted using CINAHL Plus and OVID Databases. CINAHL Plus database covers over 2400 journals and publications in nursing and allied health, searching publications written between 1982 and the present [15]. OVID Databases cover more than 6,000 ebooks, over 1,400 journals, and over 100 bibliographic and full-text databases [16]. OVID Databases search PsychInfo entries between 1806 and the present and Medline entries between 1946 and the present. Thirty-five articles were identified by searching the following keywords: sexual assault, sexual assault nurse examiner, mental health, discharge instructions, discharge education, patient education, follow-up, health literacy, and readability. The dates of the literature identified for this review ranged from 1994 to 2008 and 2010 to 2020, with a 2-year gap in publications.

As stated, the current evidence-based practice for sexual assault discharge education and follow-up is minimal and vague. Recommendations in the literature for follow-up after a sexual assault exist; however, different articles have dissimilar recommendations. Current evidence-based literature describes various treatments to be performed after a sexual assault but is not specific in terms of treatment methods, including when or how to begin them [17]. This is a problem, as the person who has been sexually assaulted may not receive sufficient, appropriate and evidence-based treatment [17]. Studies have estimated that 60% of post-discharge unfavorable outcomes are avertable [18]. While the goal of client discharge is a safe hospital-to-home transition, mechanisms to prevent post-discharge complications are multifaceted and not well understood [18]. However, a lack of understanding in regard to discharge education can contribute to unfavorable outcomes [18,19].

Persons who have been sexually assaulted visit EDs or physician offices more than other clients for up to three years post assault [9]. Roughly 3% of all ED patients return to the ED within 48 to 72 hours of their initial visit, and of these returns, it is estimated that 20 to 50% of these return visits may have been avoided with appropriate communication [19]. Multiple studies show a high percentage (40-78%) of clients having deficits in at least one standard discharge domain (diagnosis, medications, follow-up instructions, and return precautions) [20]. It is estimated that there are 110 visits to the ED annually in the United States, and close to half (45%) are referred for outpatient follow-up with only 26-56% following through [21]. Increased compliance with follow-up may result in better health outcomes, less return visits to the ED, and decreased malpractice risk [21]. It is important that discharge instructions are consistent, uniform, and given in a clear manner to enhance understanding to reduce the number of ED return visits.

**Educational Materials and Health Literacy**

Clients, and prospective clients, use written information for a variety of different reasons, including how to find a doctor’s office, interpreting lab results, reading a prescription or over-the-counter drug labels, and following hospital discharge instructions [22]. Clients need good print or web-based information to manage their health in order to process what they have heard, as they are only with their healthcare providers for a fraction of the time they are dealing with their health conditions [22]. Having appropriate evidence-based handouts will provide the client with supplemental information at home, as well as provide the caregivers with information they rely on to support their loved ones [22,23].

Discharge instructions, including follow-up instructions and appointments, should be given to the client during the initial exam in both written and verbal forms [9,24]. The State of Illinois provides a discharge instruction sheet in their forensic evidence collection kit; it is mandatory that the SANE give this discharge instruction sheet to the person who has been sexually assaulted. The State of Illinois discharge instruction sheet is two pages long, uses medical/scientific terminology, and has numerous words on the page. The pages appear crowded and the countless information is crammed into a small amount of space. Current evidence-based literature suggests the opposite of the State of Illinois form, stating that having all discharge information on one page would be a mistake and possibly the start of a complication for the reader [25]. The literature also makes the following suggestions regarding printed health information: short sentences, not exceeding 15 words in length, should be used because they are easier to comprehend [25]; medical/scientific terminology should not be used, as it hinders the understanding of the learner [23,25]; simple one- or two-syllable words should be used whenever possible [25]; and text should be direct, brief, and use language that the learners use in their everyday lives [23,25]. Written materials should be available in different languages and cater to the primary languages spoken in the hospital’s community [22]. Topic headings and pictures can be useful if they correlate with the information given [25].

If discharge instructions are more than one page long, the first page should let the client know the document is for them, grab the reader’s attention, and should indicate the contents [25]. The most important information should be delivered as quickly as possible, focusing only on the things that the reader needs to know and remember, keeping in mind that most people will only remember three to five ideas when they read [22,25]. When going over the discharge information orally, the nurse should repeat the important information more than once because the more the information is repeated and heard, the more likely the person will remember [26]. Written materials are the least costly methods for client education, and most effective; however, they are often written at a literacy level greater than that of clients. Therefore, clients do not have the ability to read them and consequently cannot properly understand the information [27]. Research conducted by Arian, et al. [27] found that the average level of literacy among 500 clients in two training hospitals was at grades six and seven, while most pamphlets were at a college level of literacy based on readability indexes.

To test a document for readability, the literature suggests the Flesch-Kincaid Grade Level Formula [27]. The Flesch-Kincaid Grade Level Formula selects three samples of 100-word passages randomly from the initial, middle, and final sections of the document, counting the number of sentences and syllables. The average sentence length (ASL) and average syllables per word (ASW) for the three 100-word passages are then put into the following formula: 0.39(ASL) + 11.8(ASW) - 15.59. The result is the Flesch-Kincaid Grade Level of the document. Future study recommendations include applying the knowledge of the Flesch-Kincaid Grade Level to various discharge materials related to sexual assault.

**Physician Follow-up**

All persons who have been sexually assaulted should be referred for physician follow-up [28,29]. However, only about 20% of persons are seen for a follow-up appointment [30]. There is no difference in age, race, or perpetrator factors that correlate with the use of follow-up services; however, the care the clients receive during their initial visit may affect their decision to pursue a follow-up visit [2]. Follow-up resources and follow-up appointments should be provided during the initial visit verbally and in writing [9]. Physician follow-up is very important for repeat STD, pregnancy, and HIV testing. Persons who have been sexually assaulted should be tested for HIV and pregnancy during their initial ED visit. Testing for STDs is not uniform nationally; some EDs test during the initial visit and some do not. In both cases, follow-up for repeat testing is recommended. In addition, it is recommended that Human Papillomavirus (HPV) education be provided, and in one study, 86% of nurses supported change to written discharge education that would include HPV vaccination recommendations [31]. Integrating information about HPV into forensic nursing care spotlights the importance of HPV as a public health burden, sets a precedent for vaccination with the understanding that not all sexual activity is consensual, and adds to efforts to educate clients about the risk of cancer associated with the virus [31].

**Medications**

Post sexual assault care is time sensitive, as medication administration for STD prophylaxis and unwanted pregnancy must be addressed within days to weeks after the assault [32]. Medications offered to the female include emergency contraception, STD prophylaxis, and immunizations [2]. A urine pregnancy test is performed before administration of emergency contraception and antibiotics. Every ED should have established guidelines to provide consistent and proper treatment of all STDs and provision of pregnancy [28]. Only one-third of persons who have been sexually assaulted receive information about the risk of STDs and HIV from an assault [33]. Sexually active teenagers, young adults, and African Americans have the highest rates of reported infection [34].

**Rape Crisis Advocate**

The partnership of a SANE and Rape Crisis Advocate is beneficial to the person who has been sexually assaulted [26]. This partnership provides the person with trained, medical personnel who have expertise in rape trauma and who can assist in caring for the person’s emotional needs [6,26]. Persons who have been sexually assaulted who work with an advocate during their ED visit receive more medical services, report significantly fewer negative interpersonal interactions with medical system personnel, report less distress from their medical contact experiences, are more likely to have police reports taken, and are less likely to be treated negatively by police officers [33]. Campbell [33] found that persons who did not have the assistance of an advocate were more likely to report feeling guilty or depressed. The advocate’s primary purpose is to provide support, ensure rights are preserved, and prevent additional distress [26]. Advocates provide numerous services to persons who have been sexually assaulted, including crisis intervention, medical and legal advocacy, and counseling [4,33,35].

A person who was sexually assaulted, presented to the ED, and was discharged home may feel lonely or isolated, and therefore, may be at risk for PTSD [26]. Advocates should let the persons know that they will remain in contact with them through the Rape Crisis Center so that they are not left alone without the resources that were discussed during their initial visit [26,36]. The advocate should provide the person with a follow-up phone call, if accepted, within 7 to 10 working days following the assault [26]. If a rape crisis advocate is not available, or if the person who has been sexually assaulted declines the rape crisis advocate, it is recommended that the SANE nurse continue to be a life line for the client, providing contact information and checking in on a regular basis [9]. Persons who have been sexually assaulted should be provided with multiple resources, including referrals to counselors, mental health specialists, crisis centers, support groups, and medical subspecialists as appropriate [2,4,7,9,10,28,29]. Counseling and mental health follow-up should occur 3 days after the original event, with additional follow-up at 30, 45, 90, and 180 days after the assault [37]. Healthcare providers should provide written information on coping strategies for dealing with severe stress [11]. Immediate psychological care directly impacts the well-being of the person and contributes to the beginning stages of recovery [26,29,32].

Roughly 70% of persons who have been sexually assaulted experience moderate to severe distress, which is a larger percentage than for any other violent crime [1]. Persons who have been sexually assaulted are at risk for Posttraumatic Stress Disorder (PTSD), rape trauma syndrome, depression, substance abuse, and/or suicidality [2,17,32,38,39]. Persons who have been sexually assaulted are 13 times more likely to experience suicidality [38]. Thirty-three percent of females who have been sexually assaulted have contemplated suicide, with 13% of those females attempting suicide [1]. Clients at any risk of suicidality would benefit from clear discharge education, including available community mental health resources [38]. Persons who have been sexually assaulted who present with a history of nightmares, avoid intimate relationships, or have trouble concentrating should be referred for evaluation and management of PTSD [2]. The literature suggests that a social worker may contact the person a few days after the ED visit and recommend the person acquire emotional support individually and in groups [13]. The social worker should assess risk threats, monitor for rape trauma syndrome and monitor the potential for PTSD [13].

**Law Enforcement**

It is likely that less than 25%, potentially as few as 10%, of sexual assault cases ever come to the attention of law enforcement [7]. The perpetrator may experience more legal ramifications if the person who has been sexually assaulted is motivated to report the assault and is provided the means to do so [7]. The literature suggests that if the person declines involving law enforcement, the SANE should educate the person about the need for law enforcement if desiring to press charges against the perpetrator using the forensic evidence collected during the ED visit [40] If the person continues to decline law enforcement involvement, the client will not be seen or interviewed by law enforcement, due to the Health Insurance Portability and Accountability Act (HIPAA) but may still have the forensic evidence kit collected, pregnancy prophylaxis, STD prophylaxis, HIV post-exposure prophylaxis, and medical follow-up provided [40]. Recommended information to include in standardized discharge educational materials regarding law enforcement is included in (Table 1).

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| Content Topic | Recommended Information |
| Physician Follow-up | Person should make a follow-up appoint with a physician within 1-2 weeks after ED discharge [41,42]. |
| Rape Crisis Advocate | The National Rape Crisis Center provides ongoing counseling services, 24-hours a day, 7-days a week [26]. The number is 1-800-656-4673. |
| Counseling and Mental Health | Counseling and mental health follow-up should occur 3 days after the original event, with additional follow-up at 30, 45, 90, and 180 days after the assault.  Coping strategies include avoiding drugs and alcohol, finding support, connecting socially, self-care (i.e., eating healthy, regular exercise, getting plenty of sleep, taking a break when feeling stressed, maintaining a normal routine), and staying active [8]. |
| Sexually Transmitted Diseases: Chlamydia | Chlamydia is one of the most common STDs present after a sexual assault [2].  Chlamydia is a STD that can be present for months without symptoms.  Follow-up testing to chlamydia should be done at 3- and 12-months post assault/ED treatment [43]. The client should return for reevaluation if symptoms recur or new symptoms develop.  There is an increased risk of pelvic inflammatory disease (PID) with untreated chlamydia and about 20-40% of women infected with chlamydia will develop it [43].  Signs and symptoms of PID include vaginal discharge, dysuria, pelvic pain, and irregular bleeding [43].  Other complications include ectopic pregnancy or infertility [43].  Azithromycin (Zithromax) 1 gram orally in a single dose is used to treat chlamydia. The client will need to be abstinent from sexual intercourse for 7 days from the start of treatment, including a single-dose regimen [43].  Young African American women, between the ages of 15 and 24, are at the highest risk for chlamydia [43]. |
| Sexually Transmitted Diseases: Gonorrhea | Gonorrhea is one of the most common STDs present after a sexual assault [2]. Symptoms may appear 3 to 10 days after sexual contact and are often mistaken for a bladder or vaginal infection [34]. Initial signs and symptoms include dysuria, vaginal discharge, and irregular bleeding [34,43]. It is recommended that gonorrhea be treated with 2 medications, ceftriaxone (Rocephin) 250 mg intramuscular in a single dose and Azithromycin (Zithromax) 1 gram orally in a single dose [44]. Both medications should be administered on the same day. If left untreated, gonorrhea can cause pelvic inflammatory disease, leading to internal abscess or chronic pelvic pain [34]. Pelvic inflammatory disease can also cause infertility or increase the risk of ectopic pregnancy [34]. |
| Sexually Transmitted Diseases: HIV | The risk of HIV being transmitted during a sexual assault is less than 1% [2]. HIV testing is performed during the initial ED examination for a baseline reading. Repeat testing for HIV should be performed at 6 weeks and at 3- and 6-months after the assault [2,7]. It is important that the client understands that anytime over the course of the next 6 months, they could become HIV positive and it is recommended that they have protected safe sex. The need for post-exposure HIV prophylaxis should be determined based on a case-by-case basis. Some factors to consider when discussing HIV transmission with a client are the types of sexual intercourse that were performed (oral, anal, or vaginal), if trauma occurred to any of these areas, the viral load in ejaculate, the site of exposure to ejaculate, and STD presence [2]. If clients choose to receive prophylactic treatment for HIV prevention, they should be given a combination of bictegravir, tenofovir alafenamide, and emtricitabine [45]. |
| Sexually Transmitted Diseases: HPV | The FDA in 2006 approved a vaccine (Gardisil) to prevent the four significant strains of HPV (16, 18, 6, and 11) in women, and in 2010, this vaccine was approved for men [31].  CDC recommends routine HPV vaccination at age 11 or 12 years of age.  CDC’s Advisory Committee on Immunization Practices (ACIP) recommends the HPV vaccination for everyone through age 26, if not adequately vaccinated previously.  Vaccination is not recommended for everyone older than 26 years. However, some adults ages 27 through 45 may decide to get the HPV vaccination based on discussion with their clinician [46].  Vaccination represents a significant step toward the reduction of the HPV public health burden if widespread uptake occurs [31]. |
| Pregnancy Prophylaxis | The risk of pregnancy from unprotected intercourse for one occurrence is between 3.1-5% [1].  Emergency contraception can be administered up to 72 hours after an assault. |
| Immunizations | If a person who has been sexually assaulted has not received childhood immunizations, hepatitis B transmission may be prevented by the post-exposure vaccination at the initial ED visit [2].  The hepatitis B series will need to be continued at 1-2 months and 4-6 months after the initial injection [2].  In sexual assault trauma cases, tetanus prophylaxis should be offered [2]. |
| Law Enforcement | Without law enforcement involvement, forensic kit will not be sent or examined by state crime lab.  Forensic evidence kit sent to crime lab when client decides to press charges against perpetrator  Case number used to link collected forensic kit with unidentified client.  Keep case number in safe place |

**Table 1:** Recommended Information to be Included in Standardized Discharge Education for Persons Who Have Been Sexually Assaulted.

**Technology-Based Follow-Up**

SANE programs may find it difficult to maintain contact with persons who have been sexually abused over time [36]. Only 23% of persons who had been sexually assaulted, who were treated by a SANE, could be reached on the telephone 3 months after their assault, and no persons who have been sexually assaulted responded to mailed letters [36]. Technology-based interventions may be a solution to aid in client follow-up. About three-fourths of all U.S. adults use the Internet, and more than half of them have looked on the Internet for health or medical information [47]. According to Kalmakis and Banning [32], current methods of follow-up with persons who has been sexually assaulted are unsuccessful and nurses should utilize technology as an alternative method of communication. This technological communication can provide accurate and prompt information in an easily acceptable place [32].

Kalmakis and Banning’s [32] research also showed that most people have access to computers and would access health information via the Internet, if available. However, they state in their research summary that the next step would be to trial a website for persons who have been sexually assaulted [32]. Currently, no website like this exists. A national website, www.RAINN.org, has been established to provide information to persons who have experienced acts of violence, including persons who have been sexually assaulted. This website provides important information to assist persons who have been sexually assaulted, but it lacks crucial information about follow-up ED recommendations regarding medications and medical care after a hospital forensic exam [32]. Research suggests that persons who have been sexually assaulted would be interested in mobile device interventions, such as text messaging [36]. Currently, there is a text messaging program, I Care that can be used to provide people with information and reminders over a course of 4 weeks [36]. Persons who have been sexually assaulted believed information received via text message on their mobile devices was more confidential [36,39], promoted independent decision-making, and was personalized to the client [36]. Persons who have been sexually assaulted also showed satisfaction with mobile device text messaging reminders for medication adherence and STD testing follow-up [36]. Technological interventions have great potential given how easily they can be distributed [17].

**Cultural Considerations**

While sexual assault can occur to individuals of any age, gender, ethnicity, and socioeconomic status, a study revealed that more than half of persons who had been sexually assaulted were young African Americans (average age 26 years), with half of those individuals completing a high school education [30]. Not only are African Americans experiencing a high number of sexual assaults; but, young African American women have the greatest risk for chlamydia [43] and sexually active teenagers, young adults, and African Americans have the highest rates of reported gonorrhea infection [34]. In general, African Americans are less likely to seek treatment; however, this has not been explored in the sexual assault literature [17]. One reason that African Americans may not seek treatment is a lack of resources to obtain services [17]. Alvidrez, et al. [48] offered services (case management, psychotherapy, and medications) within 3 weeks of a person’s assault, free of charge, and overall use was high, however, African Americans with prior trauma history were less probable to seek treatment [17]. A recommendation for a future study includes African American persons who have been sexually assaulted and their use of follow-up services.

**Conclusion**

Persons who have been sexually assaulted require a multidisciplinary team approach consisting of the SANE, rape crisis advocate, and emergency physician in order to provide repetition, consistency, and reliability of education [26]. Further research is needed to examine the factors of continued involvement in clinical care, given that avoidance is a common symptom of post-sexual assault distress [17]. Standardized discharge information is recommended to verify that each person who has been sexually assaulted receives appropriate resources. Although what needs to be included in discharge education instructions for persons who have been sexually assaulted has not been explored, using the above literature search can help guide evidence-based research regarding the topic.

**Conflict of Interests**

No Conflicts of Interest and Source of Funding declared.

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