UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault 2011

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Clinical Effectiveness Group: British Association for Sexual Health and HIV

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What's new in these Guidelines? These guidelines update and replace the 2001 BASHH guidelines on the management of adult victims of sexual assault. Updated areas include:

- Updated advice on prophylaxis of sexually transmitted infections - new treatment for gonorrhoea (updated June 2012) based on the *2011 Management of Gonorrhoea* BASHH guidelines(49)
- Issues of consent, confidentiality and disclosure of medical records
- Legal frameworks on sexual offences
- Sexual Assault Referral Centres
- Forensic aspects of sexual assault
- Aftercare following sexual assault
- Self-harm risk identification
- Prophylaxis of pregnancy and some sexually transmitted infections (STIs)
- Psychological consequences of sexual assault
- Vulnerable groups
- Psychosocial support

NHS Evidence has accredited the process used by the British Association for Sexual Health & HIV (BASHH) to produce UK national guidelines. Accreditation is valid for 3 years from January 2011 and is retrospectively applicable to guidance produced using the processes described in the BASHH Framework for Guideline Development and Assessment dated September 2010. More information on accreditation can be viewed at www.evidence.nhs.uk

Note: Drug treatment regimens and screening and testing guidance for sexually transmitted infections are rapidly changing areas. Advice given in this document was correct at the time of publication; however the reader is advised to check the most up-to-date guidance from BASHH at

www.bashh.org/guidelines

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2. Introduction and methodology

Scope and purpose

The main objective of this guideline is to provide information on the initial assessment and aftercare (including psychosocial support) of those who disclose a history of sexual assault to healthcare professionals in the setting of Genitourinary Medicine (GUM) / Sexual Health clinics in the United Kingdom. It may also be useful for other health professionals who find themselves managing complainants of sexual assault.

These guidelines must be interpreted with a degree of flexibility dependent upon the assessment of the emotional and physical state of the presenting person, as well as the risk of infection. A pragmatic and compassionate approach is needed for someone who may be desperately trying to regain control after the assault. The benefit of any investigation must be weighed up against the risk of exacerbating or prolonging distress.

This guideline is aimed at managing sexually assaulted adults of both sexes but the forensic aspects can also be applied to adolescents. For the specific management of STIs in adolescents, refer to the current BASHH guidelines and to the Royal College of Paediatrics and Child Health handbook (1, 2, 3).

Rigour of development

Evidence was sought from Medline, Cochrane library and Google search as well as websites such as the UK Department of Health. Searches were made from 1980 to 2009 using key words: Sexual Assault, Rape, Sexually Transmitted Infections, post exposure prophylaxis, HIV infection, Hepatitis B infection, Adult, Adolescent, Male, Client care, PTSD, Psychological, Domestic violence. Additional papers identified by searches were also reviewed.

Stakeholder involvement: methods, piloting and feedback

The following provided input into the original draft document : senior physicians in genitourinary medicine, clinical nurse specialists, a health advisor/counsellor, clinical psychologists, clinical directors of UK sexual assault referral centres, members of the Faculty of Forensic and Legal Medicine, a senior police officer from the specialist Sapphire Unit in the Metropolitan Police, SARC development project manager in the Department of Health, Victim Support (an independent UK charity) and a service user who has chosen to remain anonymous to protect her confidentiality. The draft document subsequently underwent consultation with the GU Medicine specialty and the public via the BASHH website for 3 months. Comments and feedback were taken into account in producing the final document.

3. Service availability and staffing

It is considered good practice to:

- Respect the client's wishes as far as possible
- Offer a suitable appointment such as a fast-tracked or booked appointment to anyone identified as a complainant of sexual assault, with a minimum waiting time

- Offer an experienced doctor or a nurse, with a choice of female or male gender where possible
- Offer a non-judgmental, supportive and safe environment
- Maintain training in communication skills amongst all staff groups
- Encourage all staff dealing with sexual assault to have the knowledge of forensic timeframes and aftercare aspects of sexual assault, as well as child protection, domestic violence and self-harm risk identification issues
- Ensure local police are aware of the clinic and that staff have contact information for local Sexual Assault Referral Centres (SARCs), police stations and specialist sexual offences police units, as well as social services, child protection agencies, local mental health departments, general practitioners and voluntary organisations such as Victim Support, Rape Crisis Centres, Survivors UK, Respond and others (see Appendix 1: list of national helplines).

4. Documentation

Careful documentation in clinical notes is essential. The notes may form a part of the evidence in the criminal justice process, with the clinician later being requested to provide a statement and disclose notes. Clinical notes can be requested for disclosure by the Police, the Crown Prosecution Service (CPS), barristers acting for the Defence in criminal proceedings or lawyers acting on behalf of clients in civil proceedings.

Healthcare professionals seeing the complainant may be asked to write a medical report at a later date for legal or compensation purposes. A copy of the original notes may be requested for disclosure if there is a court case and minor discrepancies between records may be used by the Defence barrister to discredit the complainant. Thus, the examination should be conducted and the findings documented very carefully. Some centres use a specific pro-forma. It is good practice to record sentences verbatim where appropriate, e.g. the assailant had said: 'I will hurt you, if you scream'.

A brief history of the assault should be recorded in the GUM clinical notes concentrating on what happened, when, where and by whom. This will help in understanding the scenario and will assist in deciding about sites for STI swabs as well as the possible need for psychosocial support.

5. Consent, confidentiality and disclosure of notes

Assess Gillick competence in all under-16 year olds (1, 4, 5). Obtain consent for examination and give information about confidentiality and disclosure of recorded information, documenting the discussion in the notes (6, 7, 8). If the assault is subsequently reported to the police, they may request disclosure of information divulged during the consultation (9). In particular, disclosure of counselling or psychology notes for court purposes may generate anxiety about the potential impact they may have on criminal proceedings, due to the very personal nature of such consultations. It is important to balance protecting the client's confidentiality with assisting the criminal justice system. The information provided may be useful to the Crown Prosecution Service

(CPS) in preparation of the case for court. It is better for vulnerabilities to be highlighted at an early stage. This will enable the CPS to present the case to court in an appropriate manner, minimizing the chances of the complainant being discredited by the Defence. Appendix 3 summarises the request for disclosure of information. If in doubt:

- follow your local Trust's disclosure policy

- seek advice from experienced colleagues, the Trust's legal department, the GMC or your defence union

6. Needs following sexual assault

The client's needs following a sexual assault depend on the time of presentation and can be classified as: immediate, medium and longer term.

Appendix 4 summarises pathways depending on the presentation and type of referral for any setting where complainants of sexual assault may present soon after an assault. Readers are encouraged to adapt it for local use.

Immediate needs (disclosure within 7 days of assault)
Consider the following, although not all will be applicable to (or accepted by) the client

- Immediate safety
- Treatment of injuries
- Offer of baseline screening for STIs and/or prophylaxis for bacterial STIs

  - follow-up schedule is adapted accordingly. See appendix 6
- Baseline HIV test or save serum sample
- HIV post-exposure prophylaxis post-sexual assault (PEPSE) (within 72 hours)
- Hepatitis B vaccination (and Hepatitis B immunoglobulin if assailant likely or known to be surface antigen carrier)
- Prevention of pregnancy
- Consider referral for forensic medical examination (FME) in a local SARC to gather DNA evidence and document any injuries
- Be aware of any child and vulnerable adult protection issues
- Carry out self-harm risk identification (Appendix 5: forms 1 & 2)

Medium term needs (disclosure after 7 days of assault)

- Screening for STI's at baseline and/or 2 weeks after the assault

- Hepatitis B vaccination as appropriate
- Pregnancy testing as appropriate
- Assessment of coping abilities
- Identify symptoms of Post Traumatic Stress Disorder (PTSD) (10, 11, 12, 13, 14)
- Practical and psychosocial support

Long term needs (disclosure after 1 year post-assault)

Sexual Health clinic staff may be told of an historical assault. STI screening may be offered. Psychological problems are best dealt with the involvement of the client's GP and appropriate referrals made for counselling or psychological treatment. A detailed assessment and management of the psychological consequences of sexual assault is not expected in the general genitourinary setting, however awareness of symptoms and knowledge of referral and treatment options will be beneficial.

• With PTSD Those with severe post-traumatic symptoms, or with severe PTSD in the first month after the traumatic event, can benefit from Cognitive and Behavioural Therapy (CBT) or Eye Movement Desensitisation and Reprocessing (EMDR) (15). Anti-depressant medication may also be prescribed, but should not be used as a routine first-line treatment for adults in preference to a trauma-focused psychological therapy.

• Without PTSD Counselling, psychotherapy or psychological therapy can be offered to clients who do not have PTSD but are having ongoing psychological difficulties following the assault. It should be remembered that only some psychological interventions are allowed in cases awaiting a trial, in order to prevent their impact on the proceedings.

7. Basic changes to the law on sexual offences

An awareness of the basic law on sexual offences is helpful when discussing with the client the reporting of the assault to the police and the need for a forensic medical examination. The Sexual Offences Act 2003 (England & Wales) (16), Sexual Offences Order (Northern Ireland) 2008 (17) and Sexual Offences Act (Scotland) 2009 (18) all provide a statutory framework for sexual offences in the United Kingdom.

Key changes in the law on sexual offences include the following:

- Inclusion of oral penile penetration in the definition of "rape"
- Recognition of an assault by penetration with an object such as a finger
- The definition of consent is defined as "free agreement"

- Sexual behaviour towards children is addressed by maintaining the age of consent at 16 years of age
- Sexual activity of any kind between adults and children under the age of 16 is deemed unlawful
- Separate 'protective' offences are provided for, in respect of sexual activity with young children (under the age of 13) and older children (from age 13 to age 15)
- Sexual intercourse and oral sex between under-16 s remains unlawful and it is an offence for a person in a position of trust over a child under the age of 18, or a person with a mental disorder, to engage in sexual activity with that child or person.

8. Aspects of Forensic Medical Examination (FME)

Carrying out an FME is outside the scope of these guidelines and would not be expected to be undertaken in a general GUM setting by physicians not trained in the forensic aspects of sexual assault (19). Not everyone who has been sexually assaulted will want to report the assault to the police or have forensic evidence gathered.

An increasing number of Sexual Assault Referral Centres (SARCs) has been set up in the United Kingdom (see Appendix 2). These are specialist units where complainants of sexual assault can have forensic evidence gathered, injuries documented and immediate medical aftercare and psychosocial support facilitated. There are different models of SARCs, not all of which offer STI screening, which is usually carried out in a local GUM clinic (20).

If an FME is required, it can be arranged by suggesting the reporting of the assault to the Police who will facilitate it, or by contacting the nearest SARC who may be able to offer an FME without police involvement (see Appendix 2) (21).

8.1 FME with police involvement

- Those who wish to report the assault to the police immediately should be encouraged to do so
- Have the contact numbers of the local police station readily available.
- Specialist police officers trained in the management of complainants of sexual assault will take a brief first account of the incident and arrange an FME.
- The officers may use an early evidence kit (see below) and arrange an FME in a SARC or a non-SARC setting, depending upon local arrangements.

8.2 FME without police involvement

The wishes of those who disclose recent sexual assault but do not wish to report the offence to the police should be respected.

Some SARC's offer an FME with collection of DNA and other evidence, without police involvement. This gives clients the opportunity to consider their options and report the assault at a later date.

Options for non-police referrals include:

- testing of anonymous forensic samples
- storage of anonymous forensic samples without testing
- release of police intelligence information with the samples
- release of police intelligence information without samples
- independent trained police officer advice
- revisiting decisions regarding testing and/or reporting

8.3 Forensic timescales

Knowledge of forensic timescales (Table 1) and the choices that are available in a SARC setting can help the GU physician give appropriate advice and facilitate an appropriate referral (22, 23, 24). DNA can be gathered for up to 7 days after vaginal penetration, up to 2 days in oral penetration and for up to 3 days in anal/penile penetration irrespective of washing or bathing.

Table 1 Forensic timescales (persistence of DNA)

Type of assault	Female	Male
Kissing, licking, biting	48 hours or longer	48 hours or longer
Oral penetration	48 hours (2 days)	48 hours (2 days)
Vaginal penetration	7 days	n/a
Digital penetration	12 hours	12 hours
Anal penetration	72 hours (3 days)	72 hour (3 days)

Be aware of the short detection times of substances which may be used in Drug Facilitated Sexual Assaults (DFSA). Blood and urine samples should be collected within 3 and 4 days respectively (25, 26, 27, 28).

In delayed presentation in cases suspected of DFSA, it is possible to carry out hair analysis seeking a single dosage of drugs after one month of ingestion; however this is not done routinely and is considered on an individual case-by-case basis.

Advise clients about preserving forensic evidence if possible by avoiding bathing, washing clothes, brushing teeth or drinking liquids prior to an FME, as well as the preservation of sanitary pads, tampons and clothes (particularly underwear) worn at the time of the assault and immediately after the assault. If DFSA is suspected, advise not to dye hair as this interferes with toxicology results in hair.

8.4 Early Evidence Kits (EEKs) which contain a urine sample pot, mouth swab and mouth rinse, are now available in many police forces, allowing early collection of DNA evidence and toxicology. Having an EEK in the GUM setting may assist in the early collection of forensic evidence in those who present in this setting, within the first few days following an assault. When gathering EEK samples, Chain of Evidence should be demonstrated (see below).

8.5 Forensic significance of positive STI results

The identification of an STI rarely assumes evidential importance, as prior acquisition would have to be excluded. In 1993 Ledray expressed concern that the presentation of positive STI findings in court may hurt rather than help a victim's case (29) by presenting him/her as "promiscuous". The presence of an STI may assume evidential importance when diagnosed in a child, the elderly and a sexually inexperienced orifice in an adult (for example ano-rectal gonorrhoea in a heterosexual male who has been sexually assaulted). (30) It may occasionally be used to link the perpetrator with the victim in sexually experienced individuals. Under such circumstances, it is advisable to demonstrate a Chain of Evidence of the custody of the samples. This refers to the chronological documentation from collection, transfer and analysis, of all the samples taken from the client (2, 31,). The Royal College of Pathologists has published guidelines on handling medico legal specimens and preserving the chain of evidence (31). All GUM/Sexual Health clinics should consider the need to have policies and procedures in place for chain of evidence, but it is acknowledged that not all GU services can offer such provision. In cases where criminal proceedings may be anticipated, liaison with local Police or SARC services will help with appropriate management. Medico-legal protocols ought to be agreed with the laboratory (e.g. isolates of gonorrhoea can be stored and typed and NAATs retested using different platform). Finding an STI may influence the level of criminal injuries compensation awarded to the client. Applying for compensation before the criminal trial is not advisable due to the potential for it to be used against the client.

9.0 Aftercare following sexual assault

Those presenting within forensic timescales for DNA collection who opt not to have an FME and those presenting beyond forensic timescales, should be offered aftercare appropriate to the time of presentation, type of exposure and risk factors, with emergency contraception, the offer of prophylaxis against certain STIs, risk assessment and safety, being a priority.

9.1 History taking

This should be especially sensitive and unhurried, respecting the wishes of the client

A brief history of the assault including: date, time, location, number of perpetrators, perpetrator characteristics (stranger, partner, ex-partner, acquaintance), physical violence, presence of

injuries (new and old), sexual acts (vaginal, oral, anal, penile/digital penetration), ejaculation and condom use (21). Some will not disclose forced oral or anal penetration without being directly asked, due to embarrassment.

- Pre- and post-assault sexual history
- Presenting symptoms Eg: vaginal/anal pain or bleeding
- Risk of viral infections (HIV, Hepatitis B and C) in the perpetrator, if known
- Past medical, surgical, gynaecological, obstetric history and mental health history
- Menstrual and contraceptive history
- Prescription and non-prescription medication and allergies

9.2 Examination

- Examination should be carried out with privacy in an unhurried and sensitive manner with good documentation of the findings
- If the assault is recent, ask about any injuries and refer to A&E if they require treatment
- Genital examination may be a reminder of the assault and some clients may be reluctant to have it done. Respect their wishes.
- In historical cases where an adolescent girl discloses a past history of vaginal penetration by a penis or another object such as finger, interpretation of hymenal findings may be useful evidentially and knowledge of how to examine and describe hymenal findings is beneficial (1, 32). Referral to the local SARC or a community paediatrician for photo-documentation of genital findings using a colposcope should be considered (33)
- In females, carry out an internal vaginal examination using Cusco's speculum, inspecting for injuries and possible signs of infection
- In males, examine the genitalia and peri-anal area, looking for injuries and possible signs of infection
- In both sexes with a history of oral penetration inspect the oral cavity for the presence of injuries mainly, as STIs at this site are usually asymptomatic
- Consider proctoscopy in cases with a history of anal penetration, noting any recent or old ano-rectal trauma and signs of infection.

10. Investigations for STIs - see also the latest testing guidelines from BASHH (49)

In those without symptoms or those who do not wish to have a speculum examination, offer non-invasive tests such as self-taken or physician-taken vulvo-vaginal swabs or urine tests (34, 35, 36 37). Anal internal examinations and swabs are sometimes refused or delayed by both females and males who have been anally penetrated. Proceed at their pace and allow them to be in control over this process.

If the client presents within 2 weeks of the assault, consider STI screening at baseline using Nucleic Acid Amplification Tests (NAATs) if appropriate and repeat tests 2 weeks after exposure

(38, 39). Be aware that there is a high rate of default from subsequent appointments, so a pragmatic approach to management may have to be taken.

Currently, NAATs are recommended for the diagnosis of Chlamydia trachomatis as they show superior sensitivity and specificity to other tests (39). Every positive Chlamydia result should be confirmed using another NAAT, preferably of equal sensitivity but with a different target. NAATs are the tests of choice for urethral, cervical, vaginal (self-taken or physician-taken), rectal and pharyngeal infections and first catch urine specimens in men. At the time of writing, the BASHH Chlamydia Testing guidelines are being updated; the reader is advised to refer to these guidelines in due course for more up-to-date advice (see BASHH website).

Clinicians should be aware of the potential for false-positive results regardless of the site tested, particularly when using the test in a low prevalence population. When the test result is equivocal, arrangements should be made to re-test the original sample and request a further sample. Where possible this sample should be tested using a NAAT assay of equal sensitivity but with a different target.

10.1 Asymptomatic screening

- Cultures for Neisseria gonorrhoea and dual Nucleic Acid Amplification Techniques (NAAT) tests for Chlamydia trachomatis from any site of penetration or attempted penetration (vagina: urethra, cervix; rectum or throat) (39). The sensitivity of testing urine using a NAAT to identify gonococcal infection in women is lower than testing an endocervical specimen (37).

10.2 Symptomatic screening

- Vaginal wet slides for microscopy for yeasts, bacterial vaginosis and *Trichomonas vaginalis* (TV). If available, culture for TV (37)
- Gram stained slides for microscopy for gram negative diplococci from site(s) of penetration or attempted penetration (37) excluding pharynx where culture for gonorrhoea should be taken.
- Cultures for Neisseria gonorrhoea and dual Nucleic Acid Amplification Techniques (NAAT) tests for Chlamydia trachomatis from any site of penetration or attempted penetration (vagina: urethra, cervix; rectum, throat) (39)

10.3 Baseline bloods

Presentation within 3 months:

- Syphilis serology
- Hepatitis B and C serology
- HIV serology

There may be pre-existing infections (40, 41, 42). Serum samples saved immediately, or soon after the disclosure of sexual assault, can be tested after 3 months if any of the above mentioned blood tests are positive, as negative saved serum may indicate an association between the alleged assault and the acquisition of infection.

Presentation over 3 months:

- Syphilis serology
- Hepatitis B and C serology
- HIV serology

When HIV PEPSE is prescribed at commencement of treatment (41)

(NB: Recommendations may change - please see the latest BASHH guidelines on PEPSE)

- Baseline HIV serology
- Syphilis serology
- Hepatitis B and C serology
- Full blood count (FBC)
- Liver function tests (LFTs)
- Urea and electrolytes (U&E)
- Glucose
- Lipids
- Amylase

11. Prophylaxis of bacterial STI's

Gonorrhoea, Chlamydia and Trichomoniasis are the infections most frequently identified in women who present with a history of sexual assault (43, 44, 45). The peak age for sexual assault is similar to that of many STIs, so their presence does not necessarily indicate acquisition as a result of the assault.

Prophylaxis against STIs can be offered as part of immediate medical aftercare post sexual assault. Using bacterial prophylaxis may reduce the need for tests, decrease the chances of detecting a bacterial STI and lessen the chance of missing an infection in cases of default from follow up. The advantages of bacterial prophylaxis have to be weighed against the disadvantages. These include unnecessary treatment, reinforcing belief that there was a high risk of infection (which in itself may raise levels of anxiety) and missing out on partner notification, if the source of infection was someone other than the assailant, leading to the possibility of re-infection by a regular or known sexual partner (46). In situations where the client may default, is unable to tolerate the distress of a repeat examination or requires an IUD for emergency contraception, prophylactic treatments with antibiotics which cover gonorrhoea and Chlamydia and trichomoniasis may be offered (Table 3). Weigh up the advantages of giving Metronidazole in a stat 2 g oral dose against its potential for causing vomiting (and thus a potential reduction of the efficacy of any emergency oral contraception).

Table 3. Recommended Regimens (adult doses) (IV, C - UK National Guidelines- BASHH Clinical Effectiveness Group). NB: See the latest appropriate BASHH guidelines for up-to-date advice on treatment options.

Gonorrhoea	Ceftriaxone 500 mg IM as a single stat dose + Azithromycin 1g PO stat
Chlamydia	Azithromycin 1 g PO single stat dose (not needed if Azithromycin is given with Ceftriaxone as above)
TV	Metronidazole 2 g PO single stat dose

Treatment of uncomplicated Gonorrhoea and Chlamydia in Pregnancy or Breastfeeding

- Due to the emergence of resistance of gonorrhoea to Cefixime, Ceftriaxone 500 mg as a single intramuscular injection plus Azithromycin 1g po stat are recommended as the first line treatment (49). The safety of Azithromycin in pregnancy and breastfeeding has not been fully studied however it is regarded as safe and can be used as first line treatment (47, 48). If the patient refuses injectable treatment or is needle phobic, Cefixime 400 mg stat orally can be given as an alternative to the Ceftriaxone.

Treatment of Gonorrhoea in allergy to Penicillin (49)

- Ciprofloxacin 500mg orally as a single stat dose if the organism is known to be sensitive and the patient is not pregnant or breastfeeding. Alternatively, Spectinomycin 2 g intramuscularly as a single stat dose or Azithromycin 2g orally stat can be used.

Treatment of uncomplicated Pharyngeal and Rectal Gonorrhoea (49)

- Ceftriaxone 500 mg intramuscularly stat plus Azithromycin 1g po stat, or Ciprofloxacin 500 mg orally as a stat dose, or Ofloxacin 400 mg orally as a stat dose.

Epidemiological treatment of gonorrhoea in a Sexual Assault Referral Centre setting with low gonorrhoea prevalence

- In view of the emergence of resistance of gonorrhoea to Cefixime it is preferable to refer patients for testing and treatment (with injectable Ceftriaxone) to a local sexual health clinic.
- If the patient does not wish to go for testing and treatment or is more likely to default from follow up, the most sensible option is Cefixime 400mg orally stat plus Azithromycin

1g orally stat. Do not use ciprofloxacin, unless there is a history of cephalosporin allergy or severe penicillin allergy.

Those who have accepted prophylaxis should be offered full STI screening after treatment to exclude the possibility of treatment failure or re-infection if the source of infection was a regular partner.

Evidence for the efficacy of antibacterial prophylaxis is limited. Avoidance of unprotected sexual intercourse until they have had STI screening and, in the case of a positive STI diagnosis, partner notification, should be advised. Those aged less than 18 years of age should be particularly encouraged to attend for follow up to offer screening for STI's, assess risks (child protection and self-harm) and consider contraceptive advice and sexual health promotion (1).

12. Prophylaxis of viral STIs

The assailant is known to the complainant in the majority of cases (50) and the anxieties of a woman assaulted by a known sexual partner, particularly with regard to HIV, may be very different to that of a woman assaulted by a stranger.

12.1 HIV post exposure prophylaxis after sexual exposure (HIV PEPSE)

HIV PEPSE should be discussed, documented and offered depending on the risk assessment as soon as possible after unprotected exposure but no later than 72 hours post assault (41).GUM clinics should work closely with their local SARCs in immediate HIV PEPSE provision and/or follow up.

Advice should be given concerning the lack of conclusive data about the efficacy and long-term toxicity of HIV PEPSE, as well as possible side effects, length of treatment, importance of adherence and frequency of follow up as well as baseline blood tests including HIV.

Carry out HIV risk-assessment (40, 41, 51, 52) - see Tables 4 to 9 below. The risk of transmission and prevalence tables are awaiting an update. For more up to date information refer to the most recent BASHH/BHIVA guidelines.

Table 4. HIV Risk factors

- Assailant from high risk group
- Background local prevalence of HIV in the community
- HIV status of the assailant (if known)
- The assailant is thought to come from a high prevalence area
- Type of assault (vaginal, oral or anal penetration)
- "Stranger" versus "known" assailant
- Presence of other STIs in the assaulted individual
- Genital injuries
- Multiple assailants
- Multiple risk factors

Table 5. Risk of HIV transmission from a known HIV positive source (41)

Receptive anal sex	0.1-3.0%
Insertive anal sex	0.06%
Receptive vaginal intercourse	0.1 – 0.2%
Insertive vaginal intercourse	0.03 - 0.09%
Receptive oral sex (fellatio)	0-0.04%
Mucous membrane exposure	0.09%
Needle-stick injury	0.30%

Risk of HIV transmission = Assailant's risk of HIV x Risk of exposure

Table 6. Risk that the source is HIV positive (41)

Community group	HIV seroprevalence
Homosexual men* London Scotland Elsewhere	15% 2.5% 2.3%
Heterosexuals UK Sub Saharan Africa SE Asia Caribbean Latin America Eastern Europe and Central Asia	0.1% 0.1-39% <0.1-2.7% 1.2-6.1% 0.1-2.7% <0.1-1%
Injecting drug users* London Elsewhere in the UK	4.7% 0.23%

*HPA data 2004. Contemporaneous prevalence can be obtained from estimates available from www.hpa.org.uk/infections/topics_az/hivanddsti

Table 7 Indications for HIV PEPSE if source individual is known to be HIV positive (41)

Exposure	PEP
Receptive anal sex	Recommended
Insertive anal sex	Recommended
Receptive vaginal sex	Recommended
Insertive vaginal sex	Recommended
Fellatio with ejaculation	Considered
Splash of semen into eye	Considered
Fellatio without ejaculation	Not recommended

Table 8. Indications for HIV PEPSE if source is from a group or area of high HIV prevalence (>10%) (41)

Exposure	PEP
Receptive anal sex	Recommended
Insertive anal sex	Considered
Receptive vaginal sex	Considered
Insertive vaginal sex	Considered
Fellatio with ejaculation	Considered
Fellatio without ejaculation	Not recommended

Table 9. Indications for HIV PEPSE if source is not from a group or area of high HIV prevalence (41)

Receptive anal sex	Considered	
Insertive anal sex	}	Not recommended unless
Receptive vaginal sex	}	aggravating factors such
Insertive vaginal sex	}	trauma and bleeding
Fellatio	Not recommended	

NB: the risk for male rape is often especially high – see examples below

- High risk body fluids (in the context of sexual assault) include: blood, semen, saliva (if blood stained) and vaginal secretions.
- Low risk body fluids: faeces, saliva, urine, vomit

HIV PEPSE combinations (table 10)

HIV PEPSE in adults generally comprises 2 x Nucleoside Reverse Transcriptase Inhibitors and 1 x Protease Inhibitor (boosted) for 28 days. The antiretrovirals used are unlicensed for PEPSE. The cost of a 28 day course is about £650. Starter packs usually contain a few days worth of medication (52). For the most up to date combinations of antiretrovirals used as HIV PEPSE, refer to the latest BASHH guidelines.

Table 10. HIV PEPSE regimens as per DH/EAGA PEP guidelines (53).

Drug	Constituents	Dose	Duration
Truvada®	Tenofovir & Emtricitabine	ONE tablet ONCE a day with or without food	28 days
Kaletra®	Lopinavir & Ritonavir	TWO tablets TWICE a day with or without food	28 days

Treatment of side effects:
Side effects include nausea, vomiting and diarrhoea. Supportive therapies should be provided (Table 11)

Table 11. Supportive treatment in HIV PEPSE

Domperidone	10 mg tablet	ONE (1) tablet THREE times a day when needed for nausea or vomiting Maximum of 8 tablets in 24 hours	Pack of 30
Loperamide	2 mg tablet	TWO (2) tablets at the first sign of diarrhoea then ONE (1) tablet when needed thereafter. Maximum of 8 tablets in 24 hours	Pack of 30

• Drug interactions

Kaletra® (Lopinavir and Ritonavir) reduces the effect of the contraceptive pill through induction of hepatic enzyme activity (54). Additional barrier contraception such as condoms should be advised to those on the combined oral contraceptive pill, patch, an implant (Implanon®) or a progesterone only pill. The dose of a combined oral contraceptive pill should be adjusted to provide 50 micrograms or more of ethinylestradiol.

• HIV PEPSE for children and low weight adults

Advice should be sought from an HIV specialist / Paediatrician from a local HIV network. The guidance from the Children's HIV Association (51) is that the management of children with HIV in the UK should be according to the current version of the PENTA (Paediatric European Network for the Treatment of AIDS) guidelines (see www.pentatrials.org). Currently this is a 2009 document. Adults who weigh ≤ 40 kilograms will need to have their dosage calculated with advice from an HIV physician / pharmacist (51, 55).

• HIV PEPSE in pregnancy

Pregnancy does not preclude the use of HIV PEPSE however drugs used as PEP are not licensed for use in pregnancy. Once again, it is good practice to seek advice from an HIV specialist.

12.2 Hepatitis B

Acquisition of Hepatitis B following sexual assault in the UK is very rare. BASHH guidelines recommend that Hepatitis B vaccine may be considered in those who give a history of a sexual assault up to 6 weeks previously, in particular when there was high risk exposure (56, 57) See table 12.

Table 12. Risk factors for hepatitis B and indications for hepatitis B vaccine

- Assailant known to be a Hepatitis B carrier
- Assailant has risk factors (IVDU, men having sex with men, high prevalence area)
- Anal rape
- Trauma and bleeding
- Multiple assailants
- Client wishes to be vaccinated
- Client not known to be immune to Hepatitis B following vaccination

Prophylaxis of Hepatitis B infection

• Previous vaccination Increasing numbers of people have now been vaccinated for occupational or other reasons; if there is a good history of at least three vaccinations having been given, and ideally of a subsequent check for immunity, then vaccine need not be given but a blood sample is recommended to check for immunity (anti-HBs). If there is any doubt about completion of or time elapsed since previous vaccination, offer a booster.

• Immunoglobulin

Immunoglobulin should be considered within 48 hours and no later than 7 days after a known infectious contact and may be given to a non-immune contact after a single unprotected sexual exposure, if the assailant is known or strongly suspected to have Hepatitis B (58).

• Hepatitis B vaccination

There is a theoretical possibility that a very rapid course of Hepatitis B vaccination given within 6 weeks of sexual exposure, apart from offering long term protection, will prevent the development of Hepatitis B infection in those at risk (58, 59). Hepatitis B vaccination may not be appropriate in clients assaulted by a long-term partner; they should be offered screening instead.

Hepatitis B	Immunoglobulin 500 i.u. IM (best within 48 hours) no later than 7 days of an known infectious or strongly suspected contact to non-Hepatitis B immune individuals Hepatitis B vaccination 1 ml IM in adults and adolescents > 13 yrs of age within 6 weeks of exposure (Engerix B 3 x 20 mcg; HBvaxPro 3 x 10 mcg)

Hepatitis B vaccine schedules

Very rapid course of Hepatitis B vaccination given at 0, 7 and 21 days post exposure or an accelerated course at baseline, 1 month and 2 months post exposure followed by a booster at one year, is recommended.

Very rapid schedule (Super accelerated)	At 0, 7, 21 days post exposure with a booster at 12 months
Accelerated schedule	At 0, 1, 2 months post exposure with a booster at 12 months

13. Follow up after sexual assault (see also appendix 6)

- Offer first HIV PEPSE follow-up appointment before starter pack finishes (usually 3-5 days) and carry out baseline bloods if not already done, review the wish to continue, side effects and compliance followed by weekly (if problems) or two weekly (if no problems) follow up appointments until completion of the course (41, 52)
- Offer STI screening at baseline and/or 2 weeks after the alleged assault.
- Do baseline bloods for syphilis, hepatitis B and C depending on risk assessment at first follow up appointment
- Offer hepatitis B vaccination within 6 weeks of assault (45, 57, 58, 59) and complete within the timeframe dictated by chosen schedule
- Carry out risk identification (child protection, self-harm, domestic violence)
- Carry out pregnancy testing where and when applicable
- Review psychosocial needs and coping

- Use of 4th generation HIV tests (for both HIV antibodies and p24 antigen) is recommended
- Offer HIV test at 3 months post assault (or 3 months post completion of HIV PEPSE if given) (60)
- Consider HIV test 1 months post high-risk exposure if 4th generation HIV tests are used (60)
- Offer serological tests for hepatitis B, C and syphilis at 3 months post assault. Consider repeating tests at 6 months for Hepatitis B and HIV as late seroconversion has been documented (61, 62).

13.1 Pregnancy prevention

Rape carries a 5% risk of pregnancy (63)

• Copper intrauterine contraceptive device (CuIUD)

A copper IUD, due its low failure rate and its potential for use as an ongoing method of contraception, ought to be discussed with all women presenting within 5 days after an episode of unprotected sexual exposure (64). The CuIUD can be fitted at any time in the menstrual cycle, provided the assault is the only unprotected sex that has occurred since the last menstrual period and was within 5 days. If unprotected sexual activity had taken place more than once since the last period then an emergency CuIUD can be fitted up to day 19 of a 28 day menstrual cycle.

There may be logistical difficulties with providing CuIUD as emergency contraception in some GU clinics; local referral pathways for emergency CuIUDs should be in place. If the victim chooses not to have a coil, or is too distressed, hormonal methods should be offered.

• Hormonal emergency contraception

Levonelle 1500® as a single dose (ie: 1.5 mg) may be given up to 5 days after the assault (it is licensed for up to 72 hours but it may be still effective for up to 120 hours after sexual exposure). The dose of Levonelle should be doubled (ie: 3 mg) for those taking liver enzyme-inducing drugs (65). Those starting HIV PEPSE at the same time should use condoms. The issue of emergency contraception and simultaneous administration HIV PEPSE raises questions about efficacy and toxicity. Some clinicians would choose to use a double dose of emergency contraception in case Ritonavir reduces levels. Whilst this may not be necessary, there does not appear to be any increase in toxicity.

A new emergency contraceptive, Ellaone® containing 30 mg of Ulipristal, a selective progesterone receptor modulator, can be given for up to 120 hours after unprotected sexual exposure (65). It should not be given in pregnancy and a pregnancy test is recommended prior to administration.

13.2 Pregnancy following sexual assault

If a pregnancy test is positive, discuss options which include:

- Continuing with the pregnancy
- Termination of pregnancy
- Paternity testing
- Using products of conception as evidence

If the client continues with a pregnancy, make a referral to a GP or an Antenatal Clinic and share relevant information about the assault, with the client's consent. If the client wishes to terminate the pregnancy, the foetus can be used as DNA evidence. Arrangements should be made for the collection of products of conception by the investigating police officer, demonstrating chain of evidence. If there is uncertainty about who the father is, the assailant or a partner, paternity testing using chorionic villous biopsy can assist in making decision about whether to keep or terminate the pregnancy (66). The procedure should be arranged via a local gynaecology department (there may be funding issues to consider).

14. Partner notification (Contact tracing)

Arrangements should be in place for the management and treatment of all sexual partners of clients found to have an STI. Clients and partners should abstain from sexual intercourse until treatment has been completed. Contact tracing of perpetrators is a complex issue which should be addressed if possible with the help of a Health Advisor who can arrange provider referral if appropriate. This will require discussion with the client about our duty of care towards the client, the assailant and respective partners/sexual contacts. Contact tracing can be arranged via the investigating police officer bearing in mind that positive STI may have evidential potential and will require demonstrating a chain of evidence.

15. Men and sexual assault

There is limited evidence that men are at higher risk of acquiring HIV and other STI's following a sexual assault, but often they do not engage with medical care (67). Male sexual assault has been persistently under-reported due to embarrassment, male rape being a taboo and men expected to be emotionally "strong" (69, 70, 71). Setting up a sensitive service with a choice of a gender of the examining healthcare professional, may encourage men to disclose their assault. Sexually assaulted men often prefer to see and be examined by female staff (71); however a choice of a male or female health care professional should be available to them if possible.

16. Vulnerable groups

Groups vulnerable to sexual violence include the young and elderly, those with mental health problems, learning difficulties/disability, victims of domestic violence, ethnic minorities, trafficked women/ commercial sex workers and those misusing alcohol and/or recreational drugs. Enquiries about such vulnerabilities will help to identify those in need of additional support and help to facilitate appropriate referrals to mental health services, general practitioners and support agencies. Access to interpreter and advocacy services may be helpful.

16. 1. Young people and sexual assault

Rape amongst young people has been publicised by the media (72, 73). Sexually assaulted young people typically have vulnerabilities, including mental health problems (74, 75).

Consider consent issues and assess Gillick competence in everyone who is under 16 years of age or under 18 with learning difficulties. If not Gillick competent, seek consent to examine the child from a person with parental responsibility or legal guardian.

In children with learning difficulties/disabilities, seek paediatric advice.

Liaison with community Child and Adolescent Mental Health Services (CAMHS), Child and Family Consultation Services (CFCS) and Social Services, may be necessary in order for effective child protection to occur in line with 'Working Together to Safeguard Children' (76, 77).

16.2. Child protection

Consider child protection issues and refer to Social Services when dealing with particularly vulnerable under-16 year olds (and those 17-18 year olds where there is a vulnerability concern or learning difficulties) who have disclosed a history of sexual assault or are children who have witnessed domestic or sexual violence (1,2). Under-13 year olds should be followed up by Community Paediatricians. Have available a contact lists of Designated Doctor's for Child Protection in your area who will accept such referrals.

16.3 Domestic Violence and sexual assault

Domestic violence is strongly linked to rape (78, 79). Almost 85% of violence against women crimes are domestic violence; 5% are rape and 11% sexual offences. Over 144,000 defendants were prosecuted for violence against women offences in the two years ending in March 2008 (80).

A client-centred and multi-agency approach is often needed in handling such cases, with care taken to build trust and offer support when needed. The issue of child protection for children witnessing such abuse should not be ignored and appropriate risk assessment and referrals to agencies such as Social Services or the likes of a Multi-Agency Risk Assessment Conference (MARAC - a forum where multiple agencies provide a coordinated response) (79) or Coordinated Action Against Domestic Abuse (CAADA - a national charity) should be made (80,81). See appendix 1

16.4 Ethnic minorities and sexual assault

Rape amongst ethnic minorities is underreported and stigmatized (82). The maintenance of virginity may be an issue and the opportunity to marry after a rape may be affected. This is complicated by language barriers (a family member should never be used to interpret for a client; they should be seen on their own or with an impartial interpreter), cultural issues, social isolation and family pressures. An understanding of local ethnic minority populations in your GUM/Sexual Health clinic catchment area is useful, as is access to language services and/or interpreters as well as having leaflets in other languages. The language barrier may be an issue in communication. Use an independent, professional interpreter whenever possible.

16.5 Female Genital Mutilation (FGM)

FGM refers to procedures which involve partial or total removal of the external female genitalia, or injury to the female genital organs for cultural or other non-therapeutic reasons. FGM is practiced in some African countries such as Egypt, Somalia, Ethiopia and Sudan (83). It is deemed a child protection issue as well as a criminal offence, a serious public health hazard and a

human rights issue (84). Up to 24,000 young girls in the UK are at risk of FGM (85). It is illegal in the UK to subject a child to FGM or to take a child abroad to undergo the procedure. Females in the UK who have undergone FGM may be British citizens born to parents from FGM practicing communities, or they may be females living in Britain who are originally from those communities e.g. women who are refugees, asylum seekers, overseas students or the wives of overseas students. FGM is safeguarding issue; inter-agency collaboration and communication is vital. Suspicion should be raised in cases of behavioural changes in a child, such as prolonged toilet visits (due to urinary symptoms) or sudden holidays abroad (for the FGM procedure). Where practitioners believe that an adult has undergone FGM they should also consider the risks to any children or young people who may be related to, or living with the woman. Whenever there is concern that a girl or young woman is at risk of harm through FGM, steps must be taken to safeguard them, following national and local guidelines. If a girl or young woman has already had the procedure performed and there are other female siblings in the family, a child-in-need referral may need to be made, following the steps outlined in 'What to do if you are worried a child is being abused' (86, 87).

17. Safety issues

Consider safety issues, particularly in cases of domestic violence, stranger or known assailant sexual assault, where there is fear of the assailant (or their friends and family) knowing the client's address and threatening or intimidating the client. Under these circumstances, advise the client to seek help from a local Community Safety Unit at the police station, who will offer advice on what to do, or install safety measures such as alarms at their home.

18. Psychological consequences of sexual assault

Anxiety and depression after sexual assault appear early and are common. The majority recover whilst a minority will go on to develop Post Traumatic Stress Disorder (PTSD) (10, 11, 12, 13, 14, 88). It is a diagnosable disorder (APA; DSM-IV, 1994) and occurs when a person has experienced, witnessed or has been confronted with an event that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others. The person's response involved intense fear, helplessness and horror. Symptoms can include persistent re-experiencing of trauma (such as thoughts and images) , avoidance of stimuli associated with the trauma (such as talking or thinking about what happened) and numbing of general responsiveness, as well as persistent symptoms of increased arousal (such as concentration and memory problems, irritability, being easily startled and hyper vigilance to threat). Individuals with PTSD may also experience a range of other difficulties such as sleep and appetite disturbance, relationship difficulties, sexual dysfunction, low-mood, feelings of guilt, shame and self-blame, suicidal ideation and self-harm.

In one study, 20% of those who reported that they had been sexually assaulted gave a history of mental health problems (12). Factors that make individuals more vulnerable to developing PTSD include a previous history of sexual victimisation, a history of mental health difficulties including self-harm, lack of social support, a sense and/or evidence of ongoing threat e.g. domestic violence and post-trauma life events. People who have been raped or sexually assaulted are much more susceptible to develop PTSD than any other trauma (89, 90).

19. Psychosocial support

Assessment of the psychosocial needs and coping can be done by any healthcare professional dealing with the client within a local GUM/Sexual Health clinic. Carrying out self-harm risk identification will help to establish the degree of risk and facilitate appropriate referrals (appendix 5). Those not coping, or who have vulnerabilities, should be referred to a health advisor, counselor, psychologist or general practitioner for support, depending upon their needs (8). An acute referral to mental health services may be necessary in those at high risk of suicide. Some SARC's have Crisis Workers or Young Persons Support Workers who offer advice and support, others are Independent Sexual Violence Advisors (ISVA's) or Child and Young People Sexual Violence Advisor who offer practical support (91). Rape Crisis (Appendix 1) offers emotional support to anyone who has been sexually assaulted.

20. Follow-up in the Community

Communication with the client's General Practitioner (GP) - with consent - to assure continuity of care, should be encouraged. Enquire the reasons for any client declining a GP referral/notification and explain why such a referral may be beneficial e.g. added support in the community if risk of self-harm has been identified or completion of Hepatitis B vaccination, if unwilling or unable to attend for follow up in the clinic.

21. Voluntary organisations

Information about local victim support organisations such as: Rape Crisis Centres, The Samaritans, Survivors and Victim Support should be present to facilitate referral, if needed (appendix 1)

22. Criminal Injuries Compensation Authority

The Criminal Injuries Compensation Authority is a government body responsible for administering the UK Criminal Injuries Compensation Scheme. It provides a free service to victims of violent crime who may be interested in applying for financial compensation. See www.cica.gov.uk

23. Auditable Outcome Measures

There are several auditable outcome measures, consistent with management
spanning multiple areas of Sexual Health practice

- Documentation of the following essential historical elements important for statement writing: When: date and time of assault. Where: location of assault. Who: assailant number and type, including stranger, acquaintance, partner, any known risk factors (including injecting drug use, ethnic group, local or non-local) What: type of assault (vaginal, anal, oral, non-penile penetration), condom use, ejaculation, violence, any bleeding. Standard 100%
- Documentation of any physical injuries. Standard 100%
- Documentation of whether or not further assessment of any physical injury in an Accident and Emergency Department was needed. Standard 100%

- Documentation of an HIV risk assessment. Standard 100%
- Documentation of the offer of post-exposure prophylaxis against HIV infection if this was indicated by an HIV risk assessment. Standard 100%
- Provision of post-exposure prophylaxis against HIV infection, when indicated by an HIV risk assessment and when accepted by the victim and within one hour of the start of the clinical assessment by a service managing a victim of sexual assault. Standard 100%
- Documentation of a self-harm risk assessment. Standard 100%
- Documentation of the offer of a Forensic Medical Examination if applicable (either police or non-police referral). Standard 100%
- Documentation of the offer of emergency contraception, including the specific offer of a copper intrauterine device when there was a risk of pregnancy resulting from a sexual assault, and where this was appropriate. Standard 100%
- Documentation of the offer of prophylactic treatment with antibiotics against Chlamydial, gonorrhoeal and trichomonal genital tract infections. Standard 100%
- Documentation of the offer, at the first visit, of baseline testing for genital Chlamydial, gonorrhoeal and trichomonal infections and blood borne syphilis, HIV, hepatitis B and hepatitis C infections. Standard 100%
- Documentation of a plan for repeat testing for Chlamydial, gonorrhoeal , trichomonal, syphilis, HIV, hepatitis B, and hepatitis C infections. Standard 100%
- Documentation of the offer of active vaccination against hepatitis B infection, at the first visit, if the victim was not known to have immunity against hepatitis B infection. Standard 100%
- Documentation of an assessment of child protection needs, if the age of the victim was eighteen years or less. Standard 100%.

Editorial independence:

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Dr Jan Welch has received occasional editorial fees for work with the British Medical Journal electronic guidelines on sexual assault. She is also a member of the UK Dept of Health Violence against women and children Implantation Group. No other declarations of interest were declared by the other principle authors.

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28. Abbreviations:

CAMHS - Community Adolescent Mental Health Services

CPS - Crown Prosecution Service

EEK -Early Evidence Kit

FGM - Female Genital Mutilation

FME - Forensic Medical Examination

HIV - Human Immunodeficiency Virus

HIV PEPSE - HIV Post Exposure Prophylaxis after Sexual Exposure

MARAC – Multiagency Risk Assessment Conference

NAAT - Nucleic Acid Amplification Techniques

PTSD - Post Traumatic Stress Disorder

PII - Public Interest Immunity

SARC- Sexual Assault Referral Centre

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30. Appendices

1 - National Helplines and useful websites

2 - Locations of SARCs

3 - Disclosure pathways

4 - Sexual Assault Referral Pathways

5 - Mental Health Risk Assessments

6 - Follow up after sexual assault schedules

Appendix 1

National Helplines

There are a number of UK organisations that specialise in providing support (often via helplines) to people who have experienced sexual violence. A selection of these is listed below:

Bristol Crisis Service for Women

National helpline supporting women of any age in emotional distress, offering a range of resources about self-injury PO Box 654 Bristol BS 1119 0117 925 1119

WWW.USERS.ZENET.CO.UK/BCSW

Childline

Free 24 –hour helpline for children and young people with any problems including child sexual violence 0800 1111

www.childline.org.uk

The National Association for People Abused in Childhood (NAPAC)

National telephone helpline and postal information for adults who experienced childhood violence or abuse of any kind : NAPAC 42 Curtain Road London EC2A 3NH 0800 085 3330

www.napac.org.uk

Survivors UK

National helpline for men who have experienced sexual violence and childhood sexual violence 0845 122 1201

www.survivors.org

Rape Crisis

Help and advice for the general public and healthcare professionals 0808 802 9999

www.rapecrisis.org.uk

Other sources of support

Sexual violence can be part of another problem, or cause many other problems for its victims. A selection of agencies which may be able to help with some of these problems is detailed below:

London Centre for Personal Safety (LCPS)

Specialised self-defence and personal safety training and consultancy service. Operates a sliding-fee scale, with a limited number of free sessions. This is available nationally and internationally PO Box 38883 London W12 PXP 0208 743 7827/0208 740 1114

www.londoncentreforpersonalsafety.org

National Domestic Violence Helpline

Free 24-hour helpline offering support and advice to women experiencing domestic violence, including referrals to refuges and outreach services. This service is available nationally 0808 200 246

www.womensaid.org.uk/www.refuge.oeg.uk

Coordinated Action against Domestic Abuse (CAADA)

CAADA is a national charity supporting a multi-agency response to domestic abuse. They provide practical tools, training, guidance, quality assurance, policy and data insight to support professionals and organisations working with domestic abuse victims.

www.caada.org.uk

The Samaritans

24-hour helpline and email service, offering emotional support for any distressed people.
0845 790 9090 (helpline)
jo@samaritans.org (helpline)
www.samaritans.org.uk

Victim Support

Victim Support is an independent charity providing free and confidential support and information to help victims of crime, including sexual violence. Victim Support also runs the Witness Service, which supports witnesses in courts in England and Wales. 0845 303 0900

www.victimsupport.org

Respond

Respond supports people with learning disabilities who have been affected by trauma and abuse. It also provides support for families, carers and professionals. 3rd Floor 24-32 Stephenson Way, London, NW1 2HD Tel: 020 7383 0700 Fax: 020 7387 1222 Helpline: 0808 808 0700

http://www.respond.org.uk/

Useful websites

www.bashh.org	www.forensic.gov.uk
www.homeoffice.gov.uk	www.met.police.uk/sapphire
www.fflm.ac.uk	www.rsm.ac.uk
www.thehavens.org.uk	www.crimestatistics.org.uk
www.stmaryscentre.org	www.ukafn.org
www.fsrh.org	www.dh.gov.uk/en/index.htm
www.survivorstrust.org	

Appendix 2

Sexual Assault Referral Centre (SARC) locations

An up to date list of SARCs is available from :

http://www.homeoffice.gov.uk/crime-victims/reducing-crime/sexual-offences/sexual-assaultreferral-centres/referral-centre-locations/?version=9

Avon and Somerset

The Bridge 2nd Floor Central Health Clinic Tower Hill Bristol BS2 0JD Telephone Number: 0117 3426999 Fax: 0117 342 6890 Web: http://www.turntothebridge.org

Cambridge

The Oasis@Rivergate Rivergate Primary Care Centre Viersen Platz Peterborough Cambridgeshire PE1 1ES Telephone Number: 0845 089 6262 Web: www.oasiscentre.org

Carmarthen, Dyfed, West Wales

Elm Tree House West Wales General Hospital Carmarthen Dyfed West Wales S431 2AF Tel: 01267 235 464 Fax: 01267 231349 Website: www.newpathways.co.uk

Cardiff, South Wales

Safe Island Cardiff Royal Infirmary Newport Road Cardiff CF24 0SZ Tel: 02920 335 795 Fax: 02920 335 796

Codnor, Derbyshire

Millfield House PO Box 6960 Ripley Derbyshire DE5 4AF Tel: 01773 573 840/1 24hr Helpline: 0845 129 0111 Website: www.drconline.org.uk

Dartford, Kent

Renton Clinic Darent Valley Hospital Dartford Kent DA2 8DA Tel: 01322 428 740

Durham

The Meadows John Street North Meadowfield Co Durham DH7 8RS Tel: 0191 301 8554

Gwent

Laburnum House Tredegar Street Risca Gwent NP11 4YA Tel: 01495 233 972 Website: www.newpathways.co.uk

Hampshire, Portsmouth, Isle of Wight

The Treetops Centre Northern Road Cosham Portsmouth PO6 3EP Tel: 02392 210 352 Website: www.treetopscentre.co.uk

Humberside

CASA Suite Sexual Assault Referral Centre 810a Hessle Road Hull HU4 6RD Tel: 01482 305 037 Fax: 01482 305 033

Leicester

Juniper Lodge Sexual Assault Response Centre Lodge One Leicestershire General Hospital, Gwendolen Road Leicester LE5 4PW Tel: 0116 273 5461 24 hour helpline: 0116 273 3330 Email: juniperlodge@ukonline.co.uk

London

Haven - Camberwell King's College Hospital 13-14 Caldecot Road Denmark Hill London SE5 9RS Tel: 020 3299 1599 (9am - 5pm Monday to Friday) or 020 3299 9000 at all other times Fax: 020 3299 1598

Haven - Paddington

St Marys Hospital Praed Street London W2 1NY Tel: 020 7886 1101 (9am - 5pm Monday to Friday) or 020 7886 6666 at all other times.

Haven - Whitechapel

The Royal London Hospital 9 Brady Street London E1 5DG Tel: 020 7247 4787 Website for all: www.thehavens.org.uk

Manchester

St. Mary's Centre St. Mary's Hospital Hathersage Road Manchester M13 0JH 24hr Helpline: 0161 276 6515 Fax no. 0161 276 6691 Website: www.stmaryscentre.org Email: stmarys.sarc@cmmc.nhs.uk

Merseyside

SAFE Place – Merseyside 6th Floor Citrus House 40-46 Dale Street Liverpool L2 5SF Tel: 0151 295 3550 Fax: 0151 295 3551

Merthyr Tydfil, South Wales

New Pathways Willow House 11 Church Street Merthyr Tydfil CF47 0BS Tel: 01685 379 310 Website: www.newpathways.co.uk Email: enquiries@newpathways.co.uk

Newcastle

REACH - Rhona Cross Centre 18 Jesmond Road West Newcastle NE2 4PQ Tel: 0191 212 1551 Website: www.reachcentres.co.uk Email: info@reachcentre.org.uk

Nottingham

The Topaz Centre

P.O. Box No. 9262 North Nottingham Nottinghamshire NG5 0DW Tel: 0115 844 5024 Helpline: 0845 600 1588 Website: www.topazcentre.org.uk Email: support@topazcentre.org.uk

Preston, Lancashire

The Lancashire SAFE Centre Royal Preston Hospital Sharoe Green Lane Fulwood Preston PR2 9HT Tel: 01772 523 344 Fax: 01772 523436 Email: safe@lthtr.nhs.uk

South Yorkshire

The ISIS The Rotherham NHS Foundation Trust Moorgate Road Rotherham South Yorkshire S60 2UD

Sunderland

REACH -Ellis Fraser Centre Sunderland Royal Hospital Kayll Road Sunderland SR4 7TP Tel: 0191 565 3725

Website: www.reachcentres.co.uk Email: info@reachcentre.org.uk

Sussex

The Saturn Centre (SARC) Crawley Hospital West Green Drive Crawley West Sussex RH11 7DH Tel. No: 01293 600469 (9am-5pm, out of hours answerphone) Fax No.: 01293 600466 Website: www.saturncentre.org Email: info@saturncentre.org

Swansea, South Wales

Beech Tree Centre Emily Phipps House Hendrefoelan Student Village Killay Swansea SA2 8NB Tel: 01792 206885

Swindon, Wiltshire

The New Swindon Sanctuary Sexual Assault Referral Centre The Gables Shrivenham Road South Marston Swindon, SN3 4RB Tel: 01793 507 811 Helpline 24hr (freephone): 08081680024 Email: info@swindonsanctuary.co.uk

Cleveland

Helen Britton House 13 Trinity Mews North Ormesby Health Village North Ormesby Middlesbrough TS3 6AL Tel: 01642 516888 Website: www.helenbrittonhouse.co.uk

West Midlands

The Rowan Centre 2 Ida Road Walsall West Midlands WS2 9SR Tel: 01922 644 329 (8.30 - 5.30 Monday to Friday) 24 hour emergency line: 0800 73 111 62 Website: www.crisispoint.org.uk (new window)

The Rowan Centre Castlevale Primary Care Medical Centre 70 Tangmere Drive Castlevale, Birmingham, B35 7QX

Plymouth, Devon

Twelves Company Metropolitan House 37 The Millfields Plymouth Devon PL1 3JB Tel No: 01752 220400

Gloucester

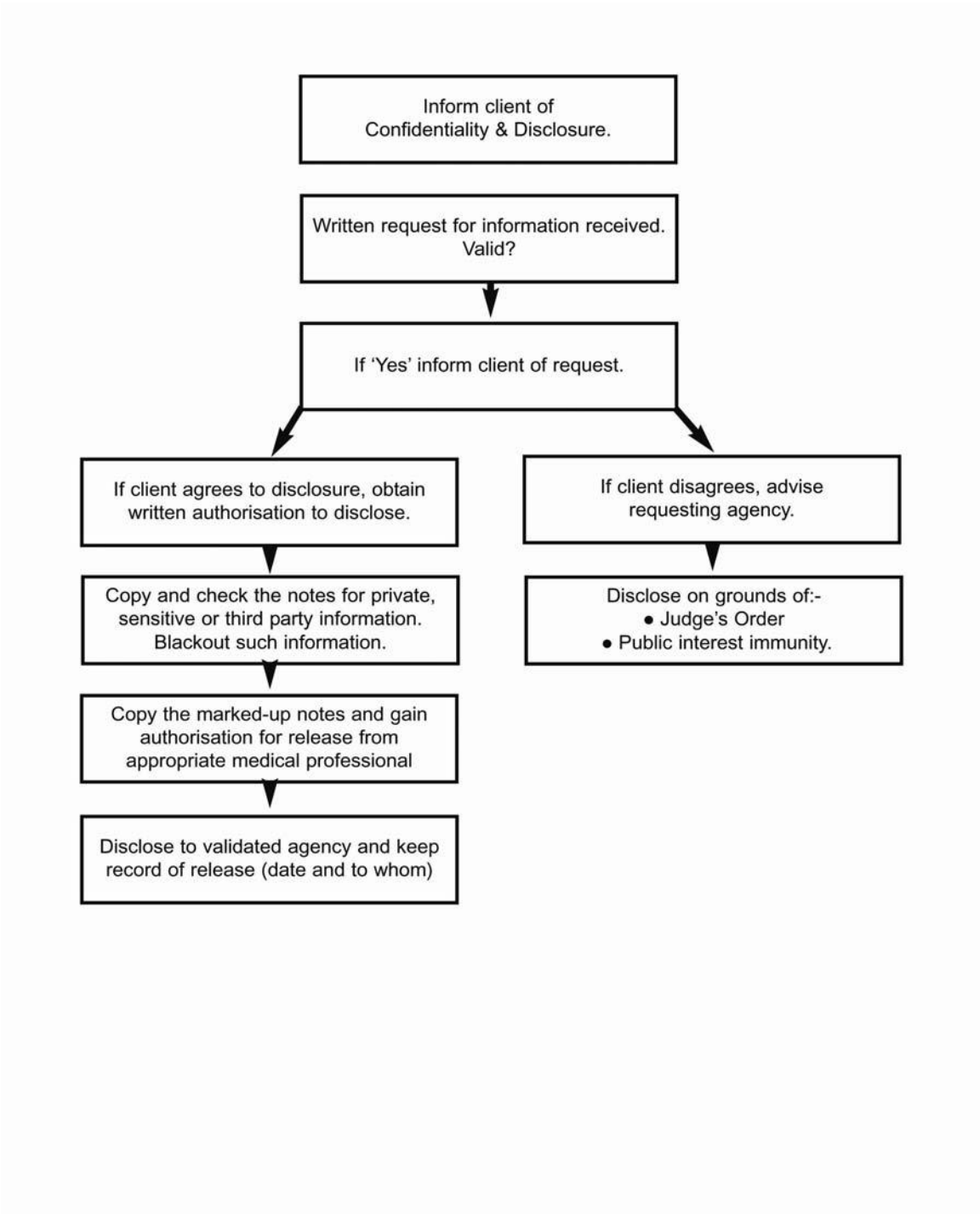
Hope House SARC Gloucestershire Royal Hospital Great Western Rd Gloucester GL1 3NN

Glasgow

Archway 2-6 Sandyford Place Glasgow G3 7NB Tel 0141 211 8175 (24 hrs 7days a week)

Appendix 3

Disclosure of information algorithm (Author: Dr B Cybulska) Consider also your local Trust's policy



Disclosure of information

With Consent

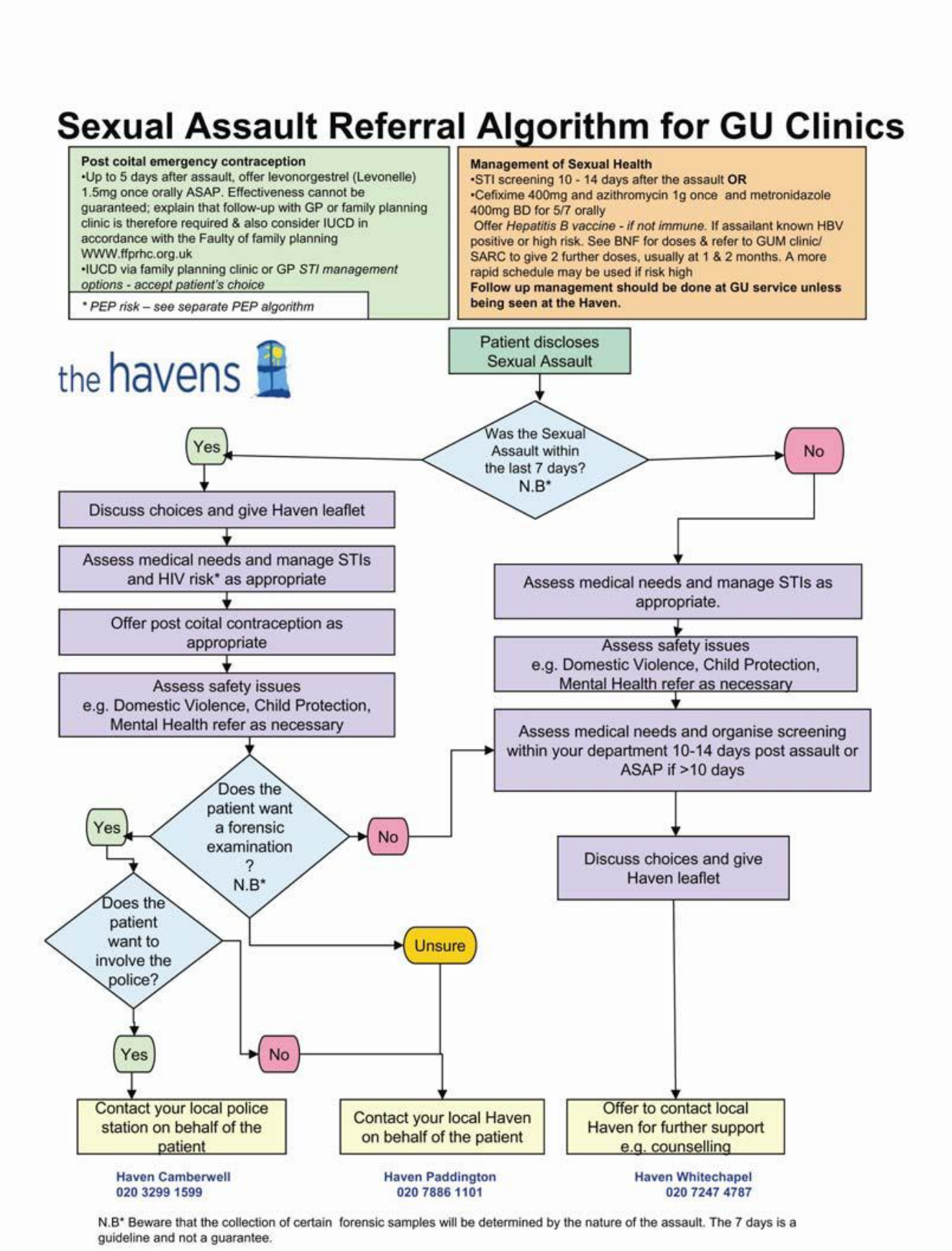
- Requests for release of information should be made in writing clearly stating the reason for the request, to whom, about whom, and by whom (27)
- Document the date of request and date of release of information in the notes
- Inform the client of the request for disclosure and the content of the recorded information and obtain:
    - verbal consent (telephone discussion documented in the notes) or
    - written consent after arranging an appointment to view the content of the released notes (28, 29)
- Check the notes for any sensitive, private or third party information, black it out, copy the notes and release the second copy
- Telephone before sending a fax using a fax cover page and request confirmation of receipt by the person or a named person in the organisation to whom it is being sent
- Post confidential information using recorded delivery
- Minimise the risk to client confidentiality through means of communication such as: telephone, email, fax or letter. Information sent from @nhs.net to @nhs.net account or to a small number of government agencies which can be found of the nhs.net website is a secure way to email confidential information.

Without Consent

- Court Order/Judge's Summons or
- Public Interest where the benefits to an individual or to society, of the disclosure, outweigh the public and the client's interest in keeping the information confidential. Client's consent ought to still be thought of (6, 25, 27)

Appendix 4

Sexual Assault Referral Pathways (produced by The Havens and used with permission)



NB : Since this algorithm was produced, STI treatments have now been updated - see main text

Appendix 5

Self harm risk identification Form RI 1 (Produced by The Havens and used with permission)

Appendix 5 RI1

the havens

RISK IDENTIFICATION - RI 1

Haven no: _____ Date___/___/___ Staff member _____

1. MENTAL STATE EXAMINATION

Appearance: kempt / unkempt
Behaviour: withdrawn / no eye contact / agitation/motor retardation/other _____
Mood: normal / low / flat / hyper (manic) / anxious / other _____
Speech: normal / pressured / slow / incoherent/ other _____
Cognition: normal / abnormal If delusions: specify_____
Perception: normal / hallucinations (*visual/ auditory /tactile*) specify _____
Other (specify) _____

2. PSYCHIATRIC HISTORY

Prior to the sexual assault did the patient have a history of:
Anxiety / Depression / Schizophrenia / Alcohol misuse / Drug misuse / NIL
Other mental health problems _____

ANY contact with other mental health services?
Counselling / Psychology / Psychiatry / NIL
Details _____
Is the patient currently receiving treatment from this service? Y / N
Has the patient ever been a psychiatric in-patient? Y / N
If YES, number of admissions _____

Date/place of last admission _____

3. SELF HARM AND SUICIDAL IDEATION

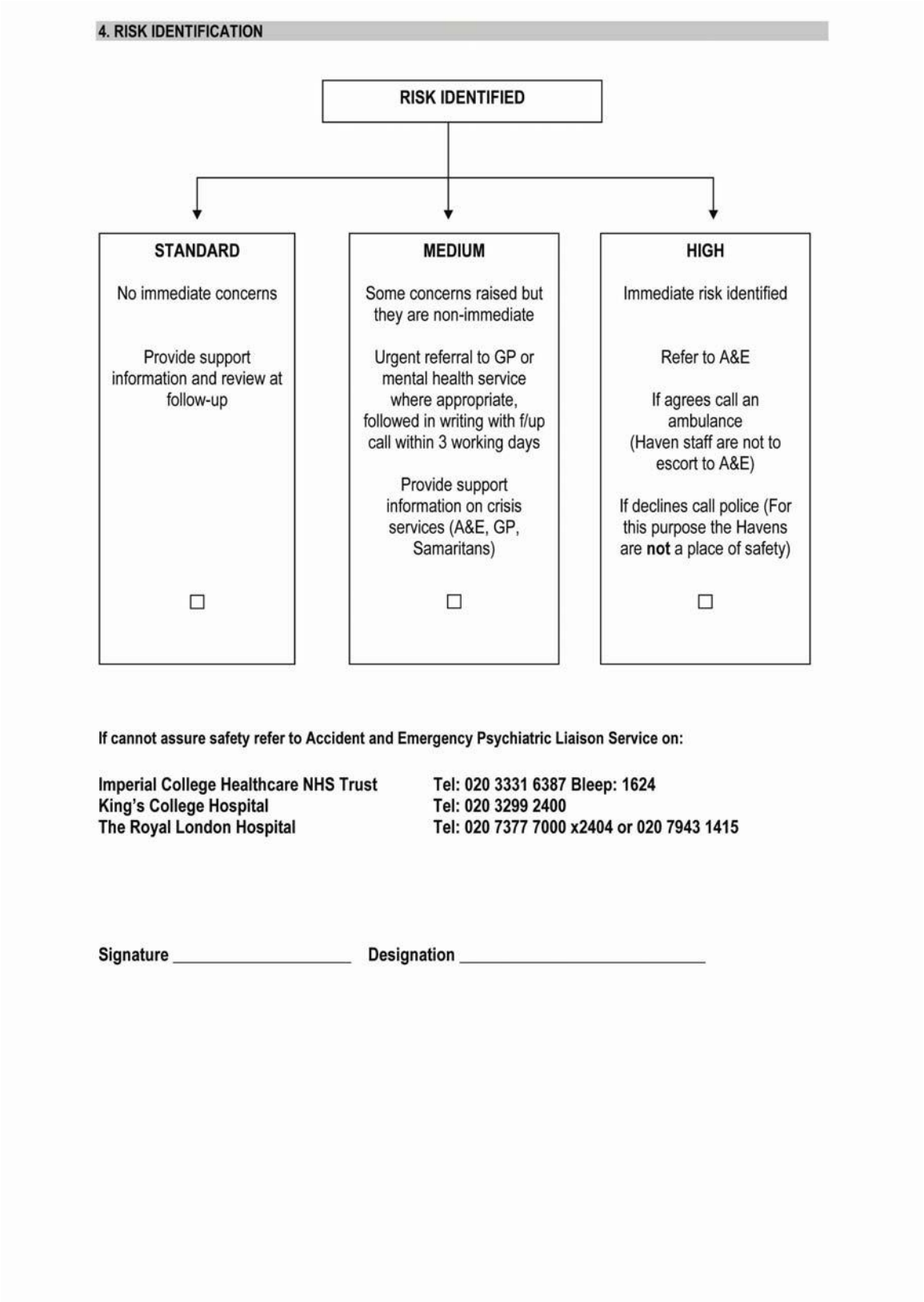
Has the patient ever self-harmed? Y / N Approx no. of incidents _____
Method(s) used: Overdose / Cutting / Burning / Multiple / Other _____
When did this last occur: _____ After this sexual assault? Y / N
Intention: Hurt self / Ease emotional pain / Die / Other _____
Was medical attention necessary? Y / N If so, was medical attention sought? Y / N
Does patient think they are likely to self-harm before next visit? Y / N

Has this been so bad that patient has felt like killing self? Y / N
If YES
Suicidal ideas only / frequent or persistent thoughts / vague plans / specific plans
Hopelessness (e.g. no plans for future/pessimism about future) Y / N

If suicidal:
Proposed means _____
Are these readily available Y / N

Anything to stop an attempt? Children / Family / Religious beliefs / Other _____

Form RI 1 (continued) Self harm risk identification Form RI 2



4. RISK IDENTIFICATION

RISK IDENTIFIED

STANDARD	**MEDIUM**	**HIGH**
No immediate concerns Provide support information and review at follow-up ☐	Some concerns raised but they are non-immediate Urgent referral to GP or mental health service where appropriate, followed in writing with f/up call within 3 working days Provide support information on crisis services (A&E, GP, Samaritans) ☐	Immediate risk identified Refer to A&E If agrees call an ambulance (Haven staff are not to escort to A&E) If declines call police (For this purpose the Havens are **not** a place of safety) ☐

If cannot assure safety refer to Accident and Emergency Psychiatric Liaison Service on:

Imperial College Healthcare NHS Trust	**Tel: 020 3331 6387 Bleep: 1624**
King's College Hospital	**Tel: 020 3299 2400**
The Royal London Hospital	**Tel: 020 7377 7000 x2404 or 020 7943 1415**

Signature _____ **Designation** _____

(Produced by The Havens and used with permission)

Appendix 5 RI2

the havens

FOLLOW-UP RISK IDENTIFICATION – RI 2

Patient no: _____ Date___/___/___ Staff member _____

1. COPING AND SOCIAL SUPPORT

How does the patient feel they are coping? (Circle) V. Well / Well / OK / Struggling / Not coping

If STRUGGLING or NOT COPING, please describe the areas of difficulty (e.g. work, difficulties being outdoors, relationship problems etc.)

_____

_____

In education / employed? _____

Attending Y / N If NO, reasons? _____

Living arrangements_____

Who have they disclosed to and what was their reaction_____

2. PSYCHOLOGICAL SYMPTOMS

Does the patient currently report any of the following? (Circle / specify where appropriate)

NONE
Change in eating habits _____
Poor Sleep _____
Flashbacks / Intrusive thoughts _____
Guilt / Depression / Anxiety / Self-Blame _____
Irritability / Anger _____
Emotional Numbing / Avoidance _____
Sexual Difficulties _____
Other (please specify) _____

Since last here have these generally:
Improved Worsened Stayed about the same
Please comment on any changes:

_____

_____

If **NOT COPING** or things have **WORSENED**, has the client sought help? Y / N
If YES, what and who from?

_____

_____

Is the patient using drug or alcohol in a problematic way? Y / N
If YES, what, how much and how often?
Alcohol Amount:_____ Frequency:_____
Has this increased? Y / N
Drugs Type(s):_____ Amount/Frequency:_____
_____ _____
Has this increased? Y / N

Form RI2 (continued)

3. SELF HARM AND SUICIDE RISK

SELF-HARM

Has client self-harmed or made a suicide attempt since the sexual assault, or thought about attempting to do this? Y / N
If **YES**:
When_____

Method(s) used to self-harm?
Overdose / Cutting / Burning / Other _____

What was the intention in doing this?
To hurt self / Ease emotional pain / To die / Other _____

Did they have to seek medical attention? Y / N _____

Was this life-threatening? Y / N _____

SUICIDE RISK

Since the last appointment, has the client at any point felt SUICIDAL? Y / N
If YES has this been:
Fleeting thoughts/ Persistent thoughts / vague plans / Specific plans

If SPECIFIC PLANS, what are these? _____

Does the client have the means to carry these out? Y / N

Is there anything that would stop them from acting on these thoughts? Y / N
If YES what? _____ _____

4. FURTHER ACTION

CAN assure safety → Discuss at the Haven psychosocial meeting re: internal follow-up or need for referral on where appropriate

CANNOT assure safety → Refer to A & E Duty Psychiatrist

Imperial College Healthcare NHS Trust	**Tel: 020 3331 6387 Bleep: 1624**
King's College Hospital	**Tel: 020 3299 2400**
The Royal London Hospital	**Tel: 020 7377 7000 x2404 or 020 7943 1415**

Signature _____ **Designation** _____

Appendix 6

Suggested follow-up schedules after sexual assault

NB:

- Not all will be applicable - the client's wishes must be taken into account
- PEPSE follow-up recommendations may change and the reader is advised to check the latest PEPSE guidelines from BASHH

At presentation

- Baseline HIV, hepatitis B, C and syphilis serology
- HIV PEPSE baseline bloods such as: FBC, U&E's LFT'S, Glucose, Amylase
- 1st Hepatitis B vaccination or booster dose if previously vaccinated
- STI screening if symptomatic
- Consider prophylactic antibiotic treatment if that is what the client wishes
- Self-harm risk identification with referral to mental health if risk high, or GP if low to medium risk
- Assessment of safety, practical needs and child protection
- Counsellor makes contact to arrange follow up appointment

2 weeks post assault

- STI screening
- 2nd Hepatitis B vaccination (if accelerated schedule)
- HIV PEPSE Review
- Self harm risk identification if risk medium to high (or not assessed at 1st follow up visit) with referral to mental health if risk high, or GP if low to medium risk
- Assessment of coping, safety, practical needs and child protection issues
- Counsellor review if necessary or if client wishes

3 weeks post assault

- 3rd Hepatitis B vaccination
- HIV PEPSE review if necessary
- Pregnancy test if indicated

- Self harm risk identification if risk medium to high (or not assessed at 2nd follow up visit) with referral to mental health if risk high, or GP if low to medium risk
- Assessment of coping, safety, practical needs and child protection issues
- Counsellor review if necessary of if client wishes

4 weeks post assault

- HIV serology if high risk exposure, using 4th generation HIV test if HIV PEPSE was not given
- HIV PEPSE final follow up bloods such as FBC, LFTs, Lipids and glucose
- Syphilis serology
- Self harm risk identification if risk medium to high (or not assessed at 3rd follow up visit) with referral to mental health if risk high, or GP if low to medium risk
- Assessment of coping, practical needs as well as safety and child protection issues
- Counsellor review if necessary or if client wishes

6 weeks post assault

- Syphilis serology
- Screening for Chlamydia if bacterial prophylaxis given post assault
- Self harm risk identification if risk medium to high (or not assessed at 4th follow up visit) with referral to mental health if risk high, or GP if low to medium risk
- Assessment of coping, practical needs as well as safety and child protection issues
- Counsellor review if necessary or if client wishes

3 months post assault

- HIV, hepatitis B, C, syphilis serology
- Self harm risk identification with referral to mental health if risk high, or GP if low to medium risk
- Assessment of coping, practical needs as well as safety and child protection issues
- Counsellor review if necessary

4 months post assault

- HIV serology if HIV PEPSE was taken
- 6 months post assault

- HIV test if 4 th generation HIV tests not available
- Hepatitis B, C and syphilis serology