West of Scotland Guideline *Approved September 2022*

THE MANAGEMENT OF SEXUAL ASSAULT IN SEXUAL HEALTH SERVICES

What's New?

- **A pathway summarising the management of the 5 common scenarios following disclosure of sexual violence either face to face or in a telephone consultation.**
- **A link to support awareness of safety issues when using remote consultations**
  Gender Based Violence Poster | Turas | Learn (nhs.scot)
- **Information on referral to SARCS that allows eligible people the opportunity to access forensic medical services and consider forensic examination and storage of potential evidential samples for up to 26 months without the requirement for immediate police involvement.**
- **Ensuring the following 5 trauma informed principles are embedded into patient management;**

  Safety
  Trust
  Collaboration
  Empowerment
  Choice

- **A review of the options for police engagement with a suggested 'intelligence only' reporting form (ie no police investigation) for those who do not wish police contact although wish to share some details of the perpetrator.**
- **Link to BASHH UK, Scottish Government and Rape Crisis patient information leaflets.**
- **Acknowledgement that sexual violence includes all forms of abuse including coercive control and does not necessarily include physical harm.**
- **Link to** National Trauma Training Programme within references / resources **https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-training-programme/**

Contents

Scope and Purpose

This guidance summarises the BASHH guidance 2022 for health care workers in sexual health settings who manage sexual violence disclosures. Many individuals do not disclose sexual assault or rape. The guidance aims to provide guidance to support appropriate management when they do.

Sexual Violence can take on many different forms; it is not limited to acts of non-consensual penetration nor does it require the use of physical force. It involves a wide range of behaviours, including attempts to obtain a sexual act, sexual harassment, coercion, trafficking for sexual exploitation and Female Genital Mutilation. Sexual assault is an act motivated by power and control and although presents more frequently in females, affects all genders.

The role of sexual health clinics

Sexual Health Services are a key area where first disclosures about a sexual violence may be made. Disclosures can be complex in nature and part of wider organised crime. There are also strong links between sexual abuse and other forms of gender based violence including domestic abuse and forced marriage.

Clinicians working within sexual health services should be able to identify concerns about sexual violence, have an understanding of the relevant medico-legal aspects and be familiar with local support services in order to respond to disclosures of sexual assault appropriately (GPP).

Disclosure of rape & sexual abuse is always difficult and patients should be assisted as much as possible with this process. The structure of the service both in terms of clinic environment and administrative processes should be considerate to the needs of patients disclosing sexual violence. Staff should be confident in informing patients of the choices available to them.

Reference to the current updated guidance on clinical and forensic issues by the British Association of Sexual Health and HIV (BASHH), The Faculty of Sexual and Reproductive Healthcare (FSRH) and The Faculty of Forensic and Legal Medicine (FFLM) is recommended.

All sexual health clinicians should:

- Take sexual health histories that allow recognition of gender based/intimate partner violence.
- When a disclosure is made, ascertain and acknowledge the patient's priorities in the provision of care.
- Embed Trauma Informed Principles of Safety, Choice, Collaboration, Empowerment and Trust into management.
- Be aware of the impact and potential consequences of sexual violence and avoid potential physical or emotional triggers.
- Identify and appropriately respond to any safeguarding issues.

- Explain the options available regarding police involvement and referral for forensic medical examination for the collection of potential DNA and other evidence if within the window of opportunity for forensic capture. Remember, if a patient has chosen to be referred to a SARC for a forensic medical examination, as a self-referral or with police engagement, a genital examination is generally unnecessary in a sexual health setting and prior examination may compromise the forensic evidence.
- Undertake pregnancy and infection risk assessments and offer testing depending on details of the assault, the time since the incident and incubation periods. If attending a SARC, this will be within 7 days of the assault and still within incubation periods.
- Assess psychological state and onward safety risk, and enquire about the use of harmful coping strategies and any pre-existing or ongoing domestic abuse. Acknowledge and encourage positive coping mechanisms.
- Acknowledge the risk of re-traumatisation when disclosures are made. Minimise the number of times the patient has to do this by offering to share appropriate information on their behalf with other health care staff or agencies involved in their aftercare and recovery for example a summary letter to their GP.

General Approach

- Listen
- Be Sensitive
- Accept their account in a non-judgemental way. It is not within your role to decide if a crime has been committed.

Acknowledge how they are feeling, this may sometimes include misplaced self blame. Reassure them that they are in a safe place and re-enforce the patient's courage in speaking out.

- Try to empower the patient by supporting them to make choices about reporting.
- Provide risk assessments for STIs and pregnancy as appropriate and facilitate access to support services
- Try to avoid typing and looking at computer monitor while patient is speaking; if you do please reassure the patient that you are still listening
- Offer information on available options, resources and appropriately supported onward referrals

Take into account the impact sexual violence may have had on the patient and offer a dynamic different to the one experienced during the assault. Ensure that their experience is not repeated or triggered in the consultation. Offering choices avoids inadvertently taking away control. Every interaction provides an opportunity to support recovery.

- Maintain the **trust** that has been established when someone has felt safe enough to make a disclosure by explaining confidentiality limitations early to avoid any perceptions of false promises

- Explain clearly the **options** available to the patient in response to the recognition of their priorities and your clinical assessment.
- Provide realistic expectations to avoid loss of trust.

- Provide an environment that allows adequate time and avoids interruptions during the consultation to promote feelings of **safety.**
- Enquire about pre-existing harmful coping strategies or domestic abuse to ensure about onward **safety** when leaving the clinic
- **Collaborate** to make a management plan that acknowledges their priorities and concerns.
- **Involve** and collaborate with the patient in the management plan, **empowering them to make informed choices** and acknowledging their priorities and concerns. Enquire about what they are expecting from the consultation and perhaps more importantly, what they don't want to happen, including any proposed multi-agency involvement.

A useful, short animation on understanding how victims of sexual assault may respond is available at:
http://www.nhslanarkshire.org.uk/SERVICES/EVA%20SERVICES/Pages/trauma-and-the-brain.aspx

Take into account the impact this may have on you and seek appropriate onward support for yourself if adversely affected by managing the situation.

There are five main scenarios where Sexual assault presents spontaneously or following routine enquiry in sexual health;

1. **Assault took place less than 7 days ago and patient wishes police engagement**
    a. **Disclosure during face to face consultation**
    b. **Disclosure on the phone, patient having called for advice**
2. **Assault took place less than 7 days ago and patient undecided about immediate police engagement**
3. **Patient discloses sexual violence and does not want to involve police regardless of the timing of the assault**
4. **Those attending for aftercare following previous attendance at a Sexual Assault Referral Centre**
5. **Assault took place over 7 days ago, beyond the time for forensic capture, and patient wishes to inform police**

1. Assault took place less than 7 days ago and patient wishes police engagement

i. Patient is face to face in clinic:

Call 101 and ask to speak to a sexual offences liaison officer. If patient is attending a Sandyford/ Lanarkshire or Ayrshire & Arran Service there is also the option of the clinician contacting Archway 0141 211 8175 if seeking further advice.

If the patient opts to be referred for a forensic examination do not examine unnecessarily prior to a forensic exam (unless concerned about serious injury that needs emergency treatment).

Forensic samples looking for suspect DNA or samples for toxicology must be taken in a forensic setting to ensure they are admissible in court. Do not take evidential samples in sexual health services as they are not forensically secure.

ii. Patient is on the phone having called for advice:

Advise to contact police directly on 101 or attend a police office.

Staff can offer to contact police on patient's behalf by phoning 101 to initiate arrangements for police to make contact with patient.

2. Assault took place less than 7 days ago and patient undecided about immediate police engagement

Explain within 7 days the options available for forensic capture of evidence are either

- Police involvement
- Self-referral to a sexual assault response coordination centre (SARC). From 1st April 2022 each Health board in Scotland has self-referral access where a forensic medical examination (FME) is carried out by a healthcare professional with the aim of collecting evidence that can be used to help identify the person who carried out the assault, if the patient decides to report to the police at a later date.

It may help to direct the patient to

- Rape Crisis Scotland video guides to the criminal justice system
    - The long video can be found here: https://youtu.be/MeFAoxFJWWU
    - The short overview can be found here: https://youtu.be/N249emeYVz0
- NHS Inform for more information about the sexual assault self-referral service https://www.nhsinform.scot/turn-to-sarcs

Advise patient to call NHS Scotland self-referral phone service on 0800 148 8888 if they decide on this option. Patients who are undecided should also be encouraged to contact the NHS Scotland self-referral phone service since this will provide an opportunity for the patient to speak in due course with a clinician working in the SARC.

Although SARCS retain evidence for 26 months there is no time limit on disclosing to police. People, including those who did not attend a SARC, can opt to make a disclosure at any time by walking into any Police station or alternatively phoning 101 and asking to speak to a sexual offences trained officer.

For scenario (1) and (2) to preserve potential evidence in patients presenting within 7 days, do not examine unnecessarily prior to a forensic exam (unless concerned about serious injury that needs emergency treatment) and advise to avoid

- Eating, drinking or brushing teeth
- Washing, showering or bathing
- Disposal of sanitary wear and suggest they set aside in a plastic bag
- Laundering clothes and to set aside individual items in bags (even if laundered)
- Passing urine (especially if drug facilitated assault is suspected) and retain tissue used to wipe if they need to urinate

3. Patient discloses sexual violence and does not want to involve police regardless of the timing of the assault.

Assess for safeguarding issues and any requirements to share information.
Assess and manage clinical risks and psychosocial wellbeing- refer to flow chart

Management by Sexual Health Staff of Sexual Violence

- Document history and any examination carefully and fully – it could be cited as evidence if the patient does subsequently report the crime.
- Consider offering the option of **Intelligence sharing** with Police Scotland.
- Offer advice or refer to local support services.
- Archway support is available for patients presenting within 7 days in GG&C, A&A and Lanarkshire.

4. Assault took place over 7 days ago, beyond the time for forensic capture, and patient wishes to inform police

Advise to contact police directly on 101 or attend a police office.

The patient is beyond the opportunity for forensic capture. Offer the patient an examination to check for injuries and offer appropriate clinical interventions such as STI and pregnancy testing. Provide information on support services. Refer to flow chart

Management by Sexual Health Staff of Sexual Violence Disclosure

Always ensure patient safety when undertaking remote consultations. The following link leads to a poster to remind staff of assessing and reducing risks whilst supporting disclosures; Gender Based Violence Poster | Turas | Learn (nhs.scot). The poster although described as a helpful visual to assist with information on Gender Based Violence and Coronavirus, its content remains relevant post pandemic.

5. Those attending for aftercare following previous attendance at a SARC

Patients who have attended a SARC in Scotland will have a summary of their clinical management scanned into NaSH to support aftercare. In addition, there will be a clinical note outlining the follow up requirements in sexual health. This will minimise the details that are required to be sought directly from the patient to reduce re-traumatisation and inform staff to STI screen involved sites appropriately.

Irrespective of where in Scotland a patient attended a SARC generally follow up is in their health board of residence. Where relevant consent should be sought to allow the resident Health board to access details of attendance and follow up plan.

There may be exceptions where the patient has expressed a preference to be followed up in a health board in which they are not normally resident.

Patients who have attended a SARC outwith Scotland will not have details of the attendance documented in NaSH unless there has been direct communication from the SARC concerned with the sexual health service where follow up is likely to be taking place.

Follow up care may include STI and BBV and syphilis testing, completion of vaccinations, pregnancy testing or advice on ongoing contraception.

Occasionally, following liaison with a SARC, STI screening samples may be advised to be taken along with an appropriate chain of evidence form – see STI testing. .

Patient's attending SARC in Lanarkshire, AA and GG&C who have consented to follow up with a support worker will have been already referred so no need to re refer. If unsure check with Archway on 0141 211 8175.

Management of Sexual Violence Disclosure To Sexual Health Staff Flow Chart

Patient discloses sexual assault

- Assess immediate and onward safety including routine enquiry on Domestic Abuse
- Assess and treat life threatening or serious injuries

Does patient want police involvement?

Yes

Did it take place within the last 7 days?

Yes

Patient on phone call

Give advice to preserve potential evidence (see page 6)

Advise patient to contact police directly on 101 or attend a police office.

Staff can offer to contact police on patient's behalf by phoning 101 to initiate arrangements for police to make contact with patient.

Patient face to face

Avoid intimate examination

Call 101 on the patients's behalf and ask to speak with a sexual offences liaison officer.

If patient attending a Sandyford. Lanarkshire or an A&A service is seeking more info prior to making this decision contact Archway on 0141 211 8175

No

Advise to contact police directly on 101 or attend a police office

AND

No or Unsure

Did it take place within the last 7 days?

No

Yes

Does patient want to 'self refer' for Forensic examination with up to 26 months storage of potential evidence samples until wishes to involve

No

Yes

Patient face to face

Patient on phone call

Give advice to preserve potential evidence (see page 6)

Avoid intimate examination

Advice patients to call NHS Scotland self-referral phone service on 0800 148 8888 if they decide on this option.

For those not considering police involvement consider information sharing option of "INTELLIGENCE ONLY" reporting to Police Scotland following local protocols and see Appendix 1

For all patients where it is anticipated they will not choose or not be eligible (ie those where the assault was > 7 days previously) to attend a SARC consider the following as part of a Clinical Risk Assessment:

- **Offering examination of exposed sites if symptoms or injuries**
- **Hepatitis B vaccination**
- **HIV PEPSE assessment (<72hrs)**
- **Emergency Contraception**
- **Emotional support needs and offer support referral**
  If resident D&G and Forth Valley refer to local support services which may include Rape Crisis
  If patient resident in GC&C, A&A and Lanarkshire
    - **< 7 days offer "support only" referral to Archway 0141 211 8175**
    - **> 7 days refer to local support services which may include Rape Crisis**
- **Child Protection / Vulnerable Adult concerns**
- **Risk of self-harm and coping strategies (+/- GP or mental health referral)**
- **Suicide risk assessment**
- **STI screening (starting 14 days after incident)**
- **Testing for HIV, syphilis, hepatitis B and C (after window period)**
- **Pregnancy testing**
- **Consider referral to "My Body Back" if cytology due and sexual violence more than 12 months previously**

***Consider timeframes for DNA collection**

Kissing, Licking, Biting	**2 days (up** to 7 days if unwashed)
Penile Oral Penetration	2 days
Penile Anal Penetration	Up to 3 days
Penile Vaginal Penetration	Up to 7 days

Initial Consultation in a Sexual Health Setting

Assess for any serious injuries that need urgent medical attention or referral – the management of these should always take priority

Limits of Confidentiality
The limits of confidentiality should be made clear early in the consultation. When an individual is deemed to have capacity, information may be shared in the absence of consent only if there is concern for the safety or wellbeing of a child, other vulnerable individuals or is in the public interest, or required by law. This acknowledges one of the cornerstones of medical ethics in respecting an individual's autonomy and right to make their own decisions regardless of the view of the professional.

Young person (13, 14 and 15 years of age and young people looked after or accommodated age 16 and 17)
Disclosure by a young person of sexual violence should follow local safeguarding procedures. Please carry out a young person's risk assessment, discuss any immediate concerns with senior clinician or safeguarding / child protection lead within your service.

Self referral for a FME is not available for any young person (13, 14, 15 and those who are looked after / accommodated 16 and 17). Evidence can only be gathered through the Police Referral route.

All cases involving a young person should be discussed with both senior clinician and safeguarding / child protection lead within your service. It would be normal practice to also discuss with local Child Protection services since there may be previous or existing concerns over the welfare of the young person or other family members. Following local procedures information may need to be shared with social services or police.

If a young person who does not wish Police Involvement it would not be normal practice for the Sexual Health Service to contact the Police directly unless there were serious / immediate concerns over safety of young person or another person. It would be normal practice to be engaging with social work and the local Child Protection Services.

Sexual activity (recent or historic) which took place under age of 13 should always be discussed with senior clinician or safeguarding / child protection lead within your service.

See Appendix 2 of BASHH UK Sexual Violence Guidelines 2022 (pending publication) for more information on Confidentiality and Information sharing in young people

Adults at risk
Adults may be unable to protect themselves from harm because of a learning disability, mental ill-health, substance use or a physical disability. If an adult discloses sexual violence and there are any concerns about their capacity to protect themselves from harm, then information may need to be shared with social care or the police.
Professionals should be aware of the possibility of coercive control influences the level of duress which, in the context of current or escalating sexual violence, may impede the individual's ability to make a decision freely.

Gender based violence disclosures should be discussed within the multi-disciplinary team (MDT) and may include a medical defence organisation. Clearly document the subsequent decision-making processes.
Please discuss any immediate concerns with senior clinician.
For ongoing input / advice, please refer patient to the local adult protection team.

See Appendix 2 of BASHH UK Sexual Violence Guidelines 2022 (pending publication) for more information on Confidentiality and Information sharing in adults.

The following details should be taken during the consultation:

- Date, Time and Location of the assault
- Ascertain whether the patient wishes referral to the police and sensitively enquire about the reason for their reservation.
- Assailant details including gender, number of assailants, whether known to the patient, any known risk factors that may increase blood borne virus transmission, additional details such as ethnicity is helpful if wishing to share information with police.
- Nature of the assault – specifically ask which anatomical sites were involved in the assault including oral, vaginal, anal and use of objects and physical violence. Also ask whether a condom was used and if ejaculation occurred.
- Last Menstrual Period, contraceptive use and last consensual sexual intercourse
- Medical and drug history including allergies
- Ask if they are injured and any symptoms since the assault being mindful that it is more common to have an absence of genital injuries following sexual assault. They may have non genital injuries or no physical injuries at all.

Documentation
Accurate and timely documentation is essential. Clinical notes may form a part of the evidence in the criminal justice process should the patient choose to involve the police at a later stage, particularly if you are one of the first people to be informed about the assault. Keep the history clear and concise without abbreviations, as inconsistencies between your history and the patient‘s statement could discredit their account of events. As potentially one of the first people to become aware of the incident you may be asked about what they said to you during the disclosure if they later involve police. The account should be documented verbatim using punctuation for the patient’s own words with clarification of any slang or colloquial terms used.

Clinical considerations

- Urgent medical care always comes before forensic capture e.g. refer to the Emergency Department if head injury
- Assess risk of pregnancy/ and offer emergency contraception as appropriate
- Medical history
- Allergies
- Assess for PEPSE if within 72 hours
- Previous hepatitis B vaccination –offer if within 1 week
- Current use of PrEP
- Past and recent mental health
- Current and previous suicide attempts and self harm

Genital Examination (Good Practice Point)

If the patient has chosen to be referred for a forensic medical examination (FME), in order to preserve DNA evidence, a physical examination should not be performed in the sexual health clinic unless there is an urgent indication for examination e.g. serious injury/ bleeding etc. Collaborate with patient on balancing their priorities and medical emergencies against forensic capture. If the patient prioritises reduction of pregnancy risk via insertion of a copper IUD as emergency contraception over forensic capture, then their informed decision should be respected.

Patient's not referred for a FME who present with injuries or genital symptoms should be offered a genital examination. Those without injuries or symptoms, with consideration of incubation periods, can be offered an examination or self-taken sampling for STIs. Offer a chaperone, offer gender choice of both examiner and chaperone, explain every step of the examination process before the patient undresses, and advise that they may withdraw their consent to examination at any point. Agreeing beforehand how the individual will tell you or indicate if they want to stop can help individuals feel safe and empowered. Asking the patient if there are any specific actions that could remind them of the assault and offering them alternatives may help minimise the risk of re-traumatisation. Triggers might include being touched in a particular place on their body, or with a particular pressure, or using particular words or phrases, for example the phrase, "Just relax".

During the examination the examiner and chaperone should carefully observe the patient looking for any signs of hyper or hypo stimulation, for example distress or dissociation. Dissociation is a sense of being disconnected from the here and now and can occur after traumatic events. If there are any signs of distress or re-traumatisation, address any identified triggers and re-affirm consent to continue with the examination, asking for permission to continue and terminating the examination if requested. Grounding techniques such as use of their name and affirmation of current safety may be more effective at reassuring safety at that moment than distraction and detachment from the examination.

If female genital mutilation (FGM) is identified, discuss with patient when and where this occurred and discuss with senior clinician since it may require reporting.

Observation of injuries: In those not attending or declining SARC involvement, if asymptomatic, offer a full SHS with self taken swabs after appropriate incubation periods. If symptomatic, carry out focussed examination.

> Remember, if a patient has chosen to be referred to a SARC for a forensic medical examination as a self-referral or with police engagement, genital examination is unnecessary in a sexual health setting.

Safety concerns

Consider immediate safety issues particularly in cases of domestic violence or sexual assault where the assailant (or their family & friends) may know the patient's address or if threatening/ intimidating behaviour. Consider completing risk indicator checklist (RIC) to identify high risk domestic violence and establish if a Multi-Agency Risk Assessment Conference (MARAC) is required, available via the following link;
http://safelives.org.uk/sites/default/files/resources/Dash%20without%20guidance.pdf.

Police Involvement - Information sharing options

A patient may report a sexual assault **at any time** to the police regardless of when the assault took place although forensic evidence is best collected as soon as possible.

If the patient does not want to report the assault sensitively ask why – you may be able to give them the support they need to report the crime.

If an individual discloses sexual violence, the options available to them on information sharing with other organisations, including police should be discussed. Once the health care professional has excluded any immediate or ongoing adult or child protection concerns, the patient's decision should be respected. The options are:

i. Police Engagement
ii. Third Party Reporting
iii. Intelligence Reporting
iv. No information sharing (See Section 5 of BASHH UK Sexual Violence Guidelines 2022 (pending publication).

In the sexual health setting at Sandyford the first three options may require liaison with Archway. Elsewhere discuss with senior colleagues.

i. Police engagement

An individual may report to police directly to initiate a full investigation. There is no time limit between the incident and the opportunity to report sexual crime to the police. However, physical evidence, closed circuit television (CCTV) availability and witness accounts may lessen with the passage of time. It is recognised that victims of sexual crime are often unwilling to reveal or talk about their experiences for some time. The Crown Prosecution Service (CPS) or Crown Office and Procurator Fiscal Service (COPFS) (in Scotland) will decide on the appropriateness of progressing investigations in the public interest whatever the time frame between the incident and the crime being reported.

ii. Third party reporting

Third party reporting involves an agency / organisation reporting an incident on behalf of the patient with the knowledge that **there will be a policing response and an investigation initiated**. The reporting agency can be the conduit for police contact with the victim of the crime with the knowledge that **police will require to speak to the patient**.
See Appendix 1 for suggested proforma for recording details for 3rd party reporting.

iii. Information Sharing - Intelligence only reporting

This option is available **if a patient is NOT wishing to formally report the crime although wishes to share intelligence with the police.**
Intelligence sharing must be carefully considered by the health care professional to ensure that the information provided does not inadvertently allow identification of the patient. It is of equal importance to take care to avoid information sharing that would essentially be deemed as a report of a crime resulting in a police requirement to investigate and make contact with the patient.

The patient's expectations of this process should be explored.

Health professionals may provide information to the police using this method without including the patient's details. This can include perpetrator details. The information sharing is with the explicit consent of the individual and only for intelligence purposes. **There will be no police contact or investigation based on an 'intelligence only' report** if local police guidance for partner intelligence sharing is followed to ensure only appropriate information is disclosed.

The process allows police to focus on a background check of any named suspects rather than the incident itself. No approach will be made to suspects without a formal report to police and no investigation can be initiated.

The value of this process for police is when several reports note the same perpetrator. Police would always support patients who later opt to involve police.
Early disclosure to police will lessen the risk of loss of potential evidence.

Ask if the patient wishes to;
- share the details of the perpetrator
  and secondly if they wish to
- share the circumstances of the incident.

To retain anonymity be mindful and considerate about including details of dates and times that may inadvertently identify the patient.

Complete local proformas such as that in appendix one and follow local protocols as to who will upload / share with the police on your behalf.

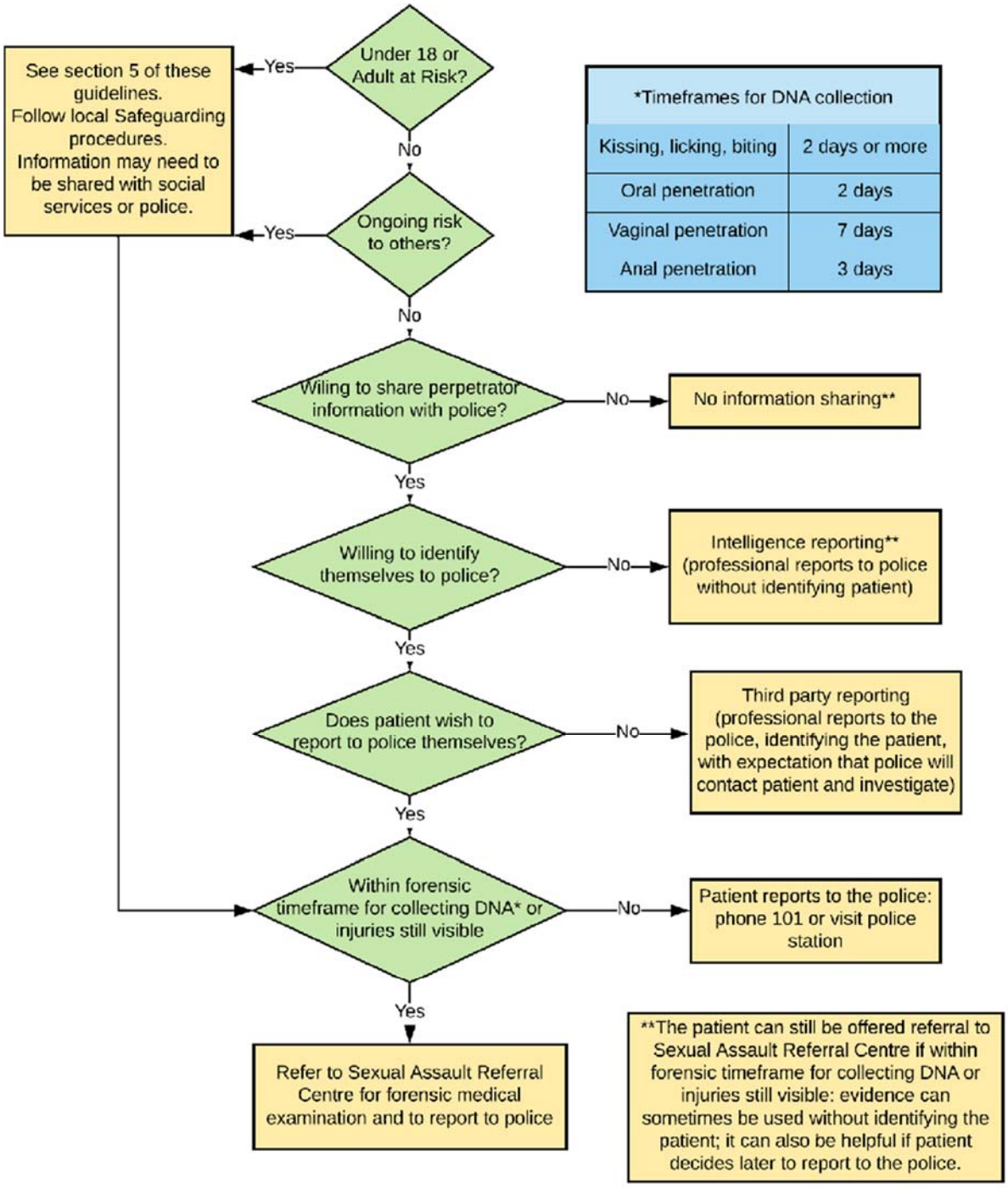
iv. Information sharing declined

The individual may decline any option of information sharing. Provided there are no immediate or ongoing adult or child protection concerns, this should be respected. It is not a requirement to inform the police of all reports of sexual violence.

If there are concerns by the professional of wider risk to the public from the patient's disclosure of perceived risk of reprisals by the perpetrator – discuss with senior staff member regarding onward sharing in the public interest and document the outcome of the discussion. Onward information sharing is preferably with the patient's consent however information may sometimes be required to be shared in the absence of consent.

Domestic Violence and Abuse Disclosure Schemes
Domestic Violence and Abuse Disclosure Schemes (also known as Clare's Law) are available in all England and Wales, Scotland and N Ireland and let a person (over the age of 16 years) make enquiries to police where they are concerned that their partner or the partner of someone they know (such as a friend or relative) has a history of abusive behaviour. Informing patient's of this option may be of value in enabling individuals to make informed choices about information sharing that supports them staying safe.

The following chart is taken from the 2022 BASHH guidelines (pending publication) on Management of sexual violence disclosures in sexual health settings. Section 5 of the BASHH UK guiidance explains and describes the limits of confidentiality.



*Timeframes for DNA collection

Kissing, licking, biting	2 days or more
Oral penetration	2 days
Vaginal penetration	7 days
Anal penetration	3 days

Sexual Health Assessment Following Sexual Violence

Post exposure Prophylaxis for HIV

If the patient presents within 72 hours of sexual assault, then a risk assessment for acquisition of HIV should be performed. Please see PEPSE guidelines. *Signposting: BASHH UK Guideline for the use of HIV post-exposure Prophylaxis (PEPSE) 2021*

Clinicians should bear in mind that transmission of HIV is likely to be increased by physical genital injury, current STI, presence of bleeding or by multiple assailants or repeated assaults.

If the patient is taking PrEP, an assessment of need for PEPSE will be based on correct dosing around the time of the assault, in particular for patient's on event based dosing. Where less than 3 daily doses in the last week, more than 7 days since the last dose or if not covered by event based dosing of PrEP, a switch to PEPSE may be indicated.

Hepatitis vaccination guidance post sexual assault

Hepatitis B

Hepatitis B vaccine should be offered early, preferably within 24 hours of a sexual assault or rape. As post-exposure prophylaxis, there is little evidence to support its effectiveness beyond 7 days. There are various different vaccination regimes for hepatitis B vaccination.
All three schedules are likely to have similar effectiveness as post exposure prophylaxis. The accelerated schedule 0, 1, and 2 months is preferred local guidance because of higher completion rates in addition to rapid development of immunity in those at ongoing risk and where compliance is an issue. An additional booster dose is recommended at 12 months in those with an ongoing risk of exposure.

Adolescent cases; Vaccination schedules in under 16s:

The adult dose (20mcg /1ml) is licensed for use in patients 16 years or over.

A lower paediatric dose (10mcg / 0.5ml) of Engerix® is licensed for use in children aged 15 years and younger on a three-dose regimen.

Adolescents aged 11-15 who are not likely to attend for three doses and are at low immediate risk can be offered a two-dose regimen using the adult 20 mcg preparation.

This two-dose schedule of a vaccine containing adult strength hepatitis B at zero and six months provides similar protection to three doses of the childhood hepatitis B vaccines.

Adult and adolescent vaccination regimes:

	1st	2nd	3rd	Booster	Additional points
ROUTINE	0	1 month	6 months	Not required	
ACCCELERATED	0	1 month	2 months	Only required at 12 months if ongoing risk of exposure	Preferred post exposure regimen
SUPERACCELERATED	0	7-10 days	3 weeks	12 months	
Adolescent 2 DOSE SCHEDULE OPTION adult dosage if ongoing risk and unlikely to return	0	6 months			

Adolescent preparation options:

Engerix B	16 years +	20mcg	1.0ml
Engerix B	0-15 years	10mcg	0.5 mls

High risk exposures:

In the unusual situation of high risk case of likely exposure where Hepatitis B Immunoglobulin (HBIG) is indicated this should be given as soon as possible, ideally at the same time or within 24 hours of the first dose of vaccine.

Missed Vaccine Doses or attends partially vaccinated

- Missed doses are common. One or two doses of vaccine may provide immunity in 40% and over 90% of immunocompetent patients respectively.
- If a patient attends having started but not completed a course of immunisation: simply resume so that it is completed rather than restart the entire programme. (DH green book)
- If two doses have already been administered, give the third.
- If only one dose has been administered, give the remaining two at least 4 weeks apart.

Hepatitis A

Post exposure vaccination for Hepatitis A following sexual assault would only be recommend if the patient was a contact of a confirmed case and within 2 weeks prior or 1 week after onset of jaundice in the index case.

If rapid protection against hepatitis A is required for adults, for example following exposure or during outbreaks, then a single dose of monovalent vaccine is recommended. In children under 16 years, a single dose of Ambirix® may also be used for rapid protection against hepatitis A. Both vaccines contain the higher amount of hepatitis A antigen and will therefore provide hepatitis A protection more quickly than Twinrix.

Opportunistic vaccination and the use of combined vaccines

Some patient groups attending Sexual health services for routine care would normally be offered combined hepatitis A and B vaccination (for example Twinrix).

Unlike Engerix, Twinrix does not have a license for post exposure prophylaxis. However in some patient's for example ongoing risk from both hepatitis A & B is thought to be greater than any previous risk from hepatitis B it may be preferable to offer combined hepatitis A &B vaccination

All MSM (and transgender women who have anal sex) attending WoS sexual assault services reporting previous Hepatitis B vaccination should be opportunistically offered a single dose of adult monovalent hepatitis A vaccine, where available, unless they have documented evidence of two doses of hepatitis A vaccination or of previous hepatitis A illness and measures put in place to offer a second dose 6 months later.

There may be other groups who have previously been vaccinated for hepatitis B but not Hepatitis A and they should also be offered hepatitis A vaccination. For example, people who inject drugs (PWID) and people with chronic hepatitis C infection should be offered Hepatitis A vaccination. Likewise patients with chronic hepatitis B infection may also be in need of hepatitis A vaccination.

HPV vaccination in adults post sexual violence

HPV vaccination is not routinely given post sexual assault to those disclosing sexual violence in the acute post sexual violence setting .

We would recommend instead that all survivors are questioned with respect to their HPV vaccination history and all those who are currently eligible for the HPV vaccination as per current UK guidelines are advised and signposted to commence (or complete any incomplete) HPV vaccination courses.

Emergency contraception

If no ongoing contraception in place, offer emergency contraception if indicated. If an IUD is recommended as per Emergency contraception Guideline ideally wait until after the forensic exam and offer an emergency hormonal method in the interim.

Also offer emergency contraception as a precautionary measure if there are concerns about bodily fluids when assault was by penetration by an object or a digit.

A pregnancy test (PT) will be positive at 3 weeks post risk (and sometimes earlier than this)

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 patient continues with a pregnancy, contact their GP or Antenatal Clinic and share relevant information about the assault, with the patient's consent (Good Practice Point). This may include discussion on the option of obtaining a DNA profile from the baby at some time following delivery.

If the patient does not wish to continue the pregnancy, refer to local abortion services. Products of conception may be used as DNA evidence. If this is consented to, abortion services will liaise with Police Scotland on the available options.

STI Testing

Patients should be offered opportunities to test at the end of the incubation period for each STI. Offer screening in all cases where there is a risk of infection, including assault by penetration by an object or a digit if there is any possible risk STI transmission This includes NAAT for CT/GC, bloods for HIV/syphilis/Hep B and Hep C. If the sexual assault was oral/anal penetration, consider also doing NAATs from these sites.

Type of penetration	Offer STI screen	Offer Emergency Contraception
Penile vaginal	Yes	Yes
Penile anal	Yes	Yes
Digital Vaginal	*	*
Digital anal	*	*
Oral vaginal	Yes	No
Oral anal	Yes	No

*Consider as a precautionary measure if there is concern about bodily fluids on penetrating digit or object

If a site is sexually naive, please consider sending a chain of evidence form if patient has reported or is considering reporting and seek advice from colleagues at a SARC as to how this should be handled.

The additional complication of contact tracing suspects is introduced when a patient tests positive for an STI. Undertaking this public health responsibility, whilst retaining patient confidentiality can be complicated and require documentation of discussion with senior colleagues.

	HIV	Hepatitis B	Hepatitis C	Syphilis	pre-PEP
At presentation	4th generation HIV serology test	Hep B core Antibody	Hep C testing	EIA	renal function ALT
Follow up	45 days after assault; 3 months after commencement of PEP: 4th generation HIV serology test	3 months after assault: The incubation period for hepatitis B infection can be up to 160 days. The majority of patients test positive by 3 months. Retest at 6 month if the opportunity arises.	3 months after assault: Hep C PCR or Ab If Ab used at 3 months then repeat at 6 months if high risk.	3 months after assault: EIA	repeat tests not necessary if normal at baseline, and no side effects of PEP

Prophylaxis against Bacterial Sexual Transmitted Infections

Prophylactic antibiotics for STI risk would not normally be indicated. A pragmatic approach may have to be taken whilst balancing against unnecessary antibiotic prescribing if there is a possibility of not re-attending.

Offering testing after incubation would be the preferred recommendation

Consider the use of prophylactic antibiotics if patient presents within the 2 week incubation period and is unlikely to re-attend or if patient is symptomatic of a bacterial STI and Emergency Contraception copper coil insertion is being carried out.

At the time of writing, the recommended first line regimens for adults are:

- Chlamydia: Doxycycline 100mg twice daily for 7 days
- Gonorrhoea: Ceftriaxone 1g intramuscular single dose
- Trichomonas: Metronidazole 400mg twice daily for 7 days (or metronidazole 2g oral single dose in non-pregnant women)

SUMMARY POINTS

- Forensic Examinations including swabs for potential DNA or semen analysis should only take place in facilities that are forensically secure e.g. local sexual assault referral centre (SARC).

- There is extensive detailed information within the appendices on Confidentiality and Information Sharing in the BASHH UK Management of Sexual Violence Disclosures in Sexual Health Settings 2022.

- It is not correct that all rape /abuse disclosed to healthcare providers MUST be reported to the Police.

- When an individual is deemed to have capacity, information may be shared in the absence of consent only if there is concern for the safety or well-being of another, or in the public interest, or if it is required by law. This would include the rare occasion of the suspect being a potential serial offender. Please discuss such concerns with senior colleagues.

- Information sharing options between police and health should be discussed to allow the patient to make a fully informed decision. In the absence of immediate child protection or adult support and protection concerns a patient in a sexual health setting may opt **not** to make any form of disclosure beyond health. The health care worker should usually respect a decision to decline information sharing when an adult with capacity (or a child with legal capacity) chooses this option.

- We encourage efficient and effective information sharing and collaborative multi-agency working to support the decisions made by the patient.

- Information shared for the benefit of the patient, ideally with their engagement, acknowledges the importance of a trusted relationship.

- Where a patient defers or declines police involvement, but is willing to share some details with police anonymously, a health professional can report information in the absence of patient's details. Such intelligence reporting will not lead to police contact or investigation. The intelligence may however, support existing or subsequent police intelligence that may determine a police response and during that subsequent investigation the patient may inadvertently become identifiable.

- Domestic Violence and Abuse Disclosure schemes are available in all UK jurisdictions and let a person (over the age of 16 years) make enquiries to police where they are concerned that their partner or the partner of someone they know (such as a friend or relative) has a history of abusive behaviour.

- Asylum status should not deter effective management. Identified or suspected victims of human trafficking should be afforded all the necessary medical, forensic and police interventions, as outlined in these sexual assault guidelines without incurring any delay.

- Contact Archway for help and advice if seeking advice on disclosure of sexual violence abroad.

Support Services

Scottish Women's Aid
Charity working to end domestic abuse against women and children with branches across Scotland
☎ 0800 027 1234
https://womensaid.scot/

Glasgow Women's Aid
☎ 0141 553 2022
https://glasgowwomensaid.org.uk/

Scotland's Domestic Abuse and Forced Marriage Helpline
☎0800 027 1234 (24 hours a day, 7 days a week)
www.sdafmh.org.uk

Rape Crisis Scotland Helpline
☎08088 010302 5pm to midnight 7 nights a week
Text 07537410027
https://www.rapecrisisscotland.org.uk/
Email support@rapecrisisscotland.org.uk

Lifelink
☎0141 552 4434
https://www.lifelink.org.uk/

Samaritans
☎116 123 (free from any phone)
https://www.samaritans.org/scotland/branches/glasgow/

Breathing Space
☎0800 83 85 87 Mon – Thur 6pm to 2am and Fri 6pm to Mon 6am
https://breathingspace.scot/

Routes out
https://www.encompassnetwork.info/routes-out.html

Childline
☎0800 1111 (24 hours a day, 7 days a week)
www.childline.org.uk

LBT Global
support if raped whilst abroad.
https://www.lbt.global/

Police Scotland
In an emergency ☎ 999 Non emergencies ☎ 101
www.scotland.police.uk

Victim Support Scotland
☎0800 160 1985 (Mon to Fri 8am to 8pm)
www.victimsupportsco.org.uk

Patient Information Leaflets

BASHH

BASHH UK pending publication

BASHH PIL Draft.doc

NHS Scotland
Don't Know Where To Turn If You've Been Raped Or Sexually Assaulted? Turn to SARCS (www.gov.scot)

Rape Crisis Scotland
Information after rape or sexual assault
https://www.rapecrisisscotland.org.uk/resources/1648722358_RCS-booklet---web-version-24032022-final-1.pdf
(link needs to be cut and pasted)

NHS Inform
https://www.nhsinform.scot/sarcs

References:

BASHH Guidelines on management of sexual violence in sexual health settings 2022 (pending publication)

Forensic Medical Services (Victims of Sexual Offences) (Scotland) Act 2021
https://www.legislation.gov.uk/asp/2021/3/contents/enacted

Resources:
National Trauma Training Programme
https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-training-programme/

Appendix 1

EXAMPLE OF A PARTNERS INTELLIGENCE SHARING FORM

'Intelligence only' reporting form

For those NOT WISHING POLICE CONTACT although agreeable to sharing intelligence .

ORGANISATION INFORMATION

Name of staff submitting form First Name:	
Last name:	
Telephone:	
Email address:	
Organisation Location:	

INTELLIGENCE ONLY

Part 1 Intelligence on suspect

ON THE UNDERSTANDING THAT INFORMATION MAY INADVERTENTLY RESULT IN IDENTIFICATION OF THE PATIENT, DOES THE PATIENT WISH TO SHARE DETAILS OF THE PERPETRATOR WITH POLICE?

Suspect's First Name: (If known)	
Suspect's Surname: (If Known)	
Suspect's Age: (DOB / Approx. age / Unknown)	
Alias / Nickname:	
House number or name:	
Street:	
Town / City:	
County:	
Country:	

Post Code:	
Telephone Number:	
Email address:	
Social Media Tags or Aliases:	
Physical Description: (please complete as fully as able) **Consider:** **Accent** **Ethnicity** **Build** **Hair Colour** **Hair Length** **Eyes** **Glasses** **Tattoos** **Scars** **How is Suspect known to the person?** **Where met? (Social Media apps)** **Suspect Traits** **Suspect Behaviours** **Suspect Phrases used**	

Part 2 Incident details

DOES THE PATIENT WISH TO SHARE CIRCUMSTANCES OF THE INCIDENT WITH POLICE?

Points to consider:
Dates and times may inadvertently result in patient becoming identifiable.
Consider carefully the free text content
Leave blank if patient wishes to avoid or minimise the possibility of becoming identifiable.

Date of incident: **(DD / MM / YYYY)**	
Intelligence obtained: **(DD / MM / YYYY)**	
Any concerns for Intelligence being shared? **(Any risks if Police Scotland share with other partner organisations)** **(Yes / No / Don't know)**	
Is there any risk to any person if Police Scotland investigate information provided? **(Yes / No)**	