THE MANAGEMENT OF SEXUAL ASSAULT IN SEXUAL HEALTH SERVICES

What's New?

- A pathway summarising the management by Sandyford sexual health staff 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 local pathways and signposting following the enactment of the Forensic Medical Services Act (April 2022) 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.
- Highlighted text in the Hepatitis vaccination section to aid access to commonly asked questions.
- 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 an amended '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 and Scottish Government patient information leaflets.
- Acknowledgement that sexual violence includes all forms of abuse including coercive control and does not necessarily include physical harm.
- Link to Police Scotland PIP training video

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 client's courage in speaking out.

- Try to empower the client by supporting them to make choices about reporting, Provide risk assessments for STI's and pregnancy as appropriate and facilitate access to support services
- Try to avoid typing and looking at PC monitor while client 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.

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

There are 5 main scenarios where Sexual assault presents spontaneously or following routine enquiry in sexual health in NHS GGC;

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

Patient is face to face in clinic:

Contact Archway 0141 211 8175 to assist with arranging police contact, this will preferably be a trained sexual offences liaison officer (SOLO) if available.
OR Call 101 and ask to speak to a sexual offences trained officer

If the assault took place within the last **seven** days and patient is **undecided about police engagement**, a forensic exam may be appropriate as a self referral. Contact Archway 211 8175 for advice on how to proceed.
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. Only take STI samples with a chain of evidence form following advice from Archway.

Patient is on the phone having called for advice:

Always ensure patient safety when undertaking remote consultations. The following link leads to a poster to reminds staff of assessing and reducing risks whilst supporting disclosures: Gender Based Violence Poster | Turas | Learn (nhs.scot)

Preserving potential evidence.
Advise, if possible, 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

Advise to contact Archway or contact police directly on 101 or by attending a police office if they decide to engage.

Assess for other clinical risks including pregnancy, STI risks, onward safety and manage appropriately.

People can access **emotional support from Archway Support Worker** with or without having had a forensic examination **if within 7 days of assault.**

2. Assault took place less that 7 days ago and client undecided about police engagement

Options:

- From 1st April 2022 people in Scotland can self refer to sexual assault referral centres within 7 days of an assault. Each Health board in Scotland has self referral access.
- For Sandyford patients who are NHS GG&C residents call Archway, Glasgow 0141 211 8175 for advice on self referring.
- For patients who are residents of other health boards advise them to call 0800 148 8888 for local self referral information.
- People can access emotional support from Archway Support Worker with or without having had a forensic examination if within 7 days of assault.

- There is no time limit on disclosing to police. People can opt to make a disclosure by walking into any Police station or alternatively phoning 101 and asking to speak to a sexual offences trained officer.

Police will make arrangements for forensic examination following discussion if appropriate.

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.
Document your 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 support services in Sandyford.
Archway support worker is only available for those presenting within 7 days of an assault.

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

If 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 screening or pregnancy testing.

Provide information on support services.

5. Those attending for aftercare following previous attendance at Archway.

Patients who have attended Archway if requiring follow up care, 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.

Patient follow up will be in their health board of residence.

Consent is sought to allow their resident Health board to access details of their attendance and follow up plan.

There may be exceptions. ONLY if the patient has expressed a preference to be followed up in NHS GGC. Sandyford will then accommodate these requests.

Archway patients resident in NHS GGC are usually attending for asymptomatic screening and may choose to opt for grab kits, face to face or postal testing as/when this becomes available.

Occasionally, following liaison with Archway, STI screening samples may be advised to be taken along with an appropriate chain of evidence form and transported to the lab by courier.

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

If a patient has attended Archway they will have been offered referral to the Archway support worker. PLEASE DO NOT RE-REFER TO SUPPORT SERVICES IN SANDYFORD OR ELSEWHERE. CHECK WITH ARCHWAY IF UNSURE.0141 211 8175

Management of Sexual Violence Disclosure by Sexual Health Staff

Key:
--- Incident more than 7 days ago
--- Incident within the last 7 days

*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

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

Avoid showering or bathing

Patient face to face

Avoid intimate examination

Advise of options for contacting Police Scotland

Patient can:
- **Call 101 and ask to speak to a specially trained sexual offences liaison officer (SOLO)**
- **Walk into any police station**

Staff can:
- **Offer to contact police on patient's behalf (ie as a 3rd party) by phoning 101 to initiate arrangements for police to make contact with patient.**

No

Patient on phone call

Is the patient a NHS GGC resident?

No

Advise to call 0800 148 8888 for advice from local services

Yes

Arrange for patient to speak with Archway staff on 0141 211 8175

Arrange private room for onsite patients

Opts to attend Archway

Declines examination at SARC

No or Unsure

Did it take place within the last 7 days?

Yes

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

Yes

Patient face to face

Avoid intimate examination

No

Offer information sharing option of "INTELLIGENCE ONLY" reporting to Police Scotland (Appendix 1)

Yes

Complete form and forward to: gail.cairns@ggc.scot.nhs.uk for upload to Police Intelligence Portal

No

Clinical Risk Assessment: consider:-
- **Offering examination of exposed sites if symptoms or injuries**
- **Hepatitis B vaccination**
- **HIV PEPSE assessment (<72hrs)**
- **Offer "support only" referral to Archway(0141 211 8175) if within 7 days**

- **Emergency Contraception**
- **Child Protection / Vulnerable Adult concerns**
- **Risk of self-harm and coping strategies (+/- GP or mental health referral)**
- **Suicide risk assessment**
- **STI screening from all involved sites (if 10 – 14 days after incident). Consider use of Chain of evidence form (Appendix 2) if from a sexually naïve site or not sexually active for > 5 yrs.**
- **BBV screening and syphilis serology (after window period)**
- **Pregnancy testing**
- **Emotional support needs and offer support referral**
- **Referral to SCASS or Rape Crisis ONLY if > 7 days**
- **Opportunistic cervical cytology if due or referral to "My Body Back"**

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.

Children (under age 18)

Disclosure of sexual violence by a child should follow local safeguarding procedures. Please carry out a young persons risk assessment, discuss any immediate concerns with the GUM/SRH consultant and refer patient to the young people's team for any further input/specialist advice.

See Appendix 2 of Bashh UK of Bashh UK Sexual Violence Guidelines 2022 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 the GUM/SRH consultant covering that day. For ongoing input / advice, please refer patient to the Sandyford inclusion team.

Please note that this information is correct at the time of publication (April 2022) and legislative changes can occur

See Appendix 2 of Bashh UK Sexual Violence Guidelines 2022 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 client 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 patients' 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 clients' own words with clarification of any slang or colloquial terms used.

Clinical considerations

- Urgent medical care always comes before forensic capture e.g. refer A&E 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 (GPP)

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 patients 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.

Patients 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 SRH/GUM consultant if 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:

- **Police engagement**
- **Third party reporting**
- **Intelligence reporting**
- **No information sharing** (see section 5 of BASHH guidelines; Limits of confidentiality)

In the sexual health setting at Sandyford the first three options may require liaison with Archway, Glasgow.

- **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.

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 the form below to obtain details for 3rd party reporting.
See Appendix 1

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.**

Police Scotland 17.5.22 PIP Training.mp4

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 'third party crime report' that would result 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. Local police guidance for partner intelligence sharing should be followed to ensure only appropriate information is disclosed. **There will be no police contact or investigation based on an 'intelligence only' report.**
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.**

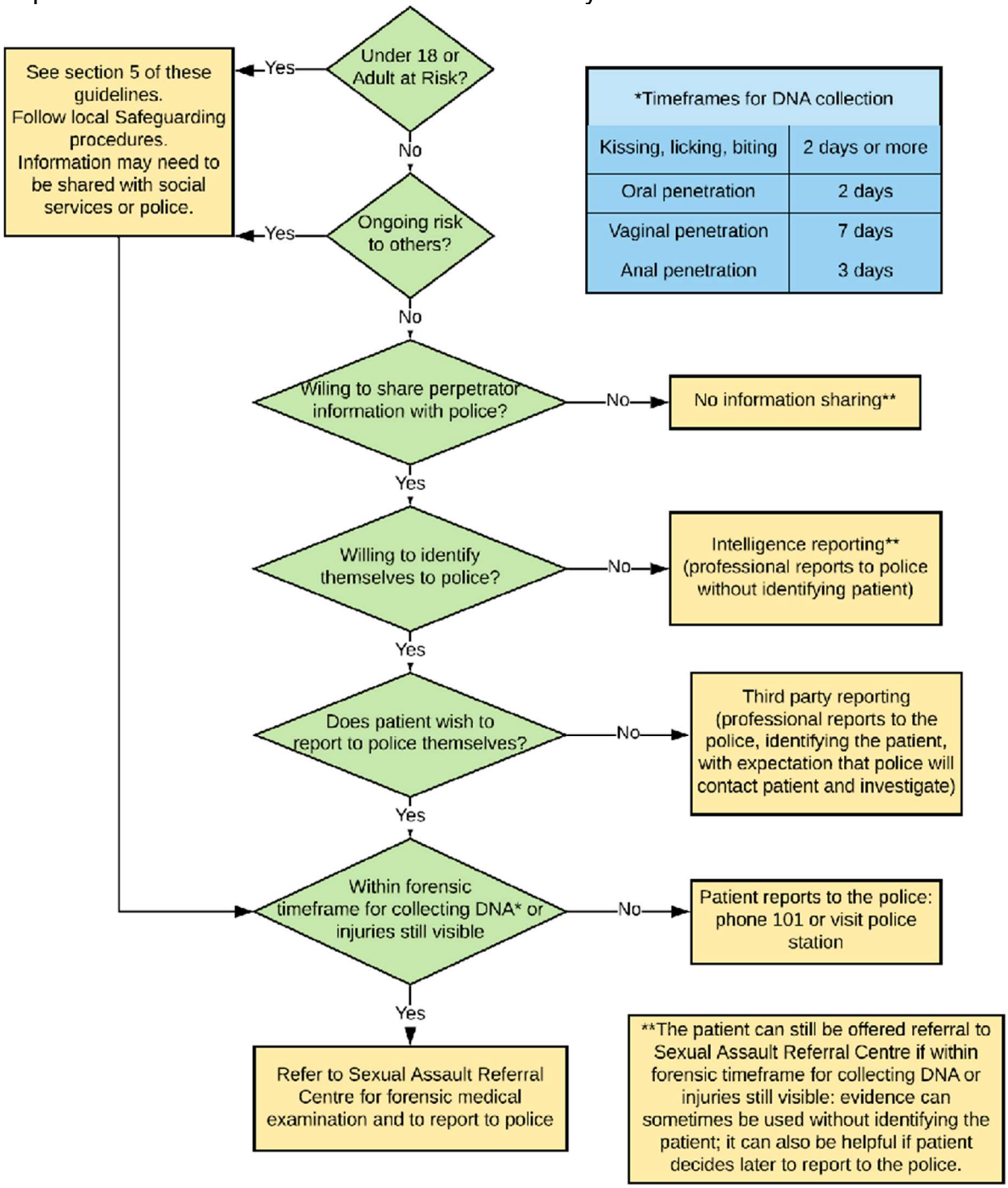
To retain anonymity be mindful and considerate about including details of dates and times that may inadvertently identify the patient.

Complete the form in Appendix 1 and pass to the named staff member who will upload this on your behalf to the police intelligence portal
This is currently Kathryn.mcgrory@ggc.scot.nhs.uk

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 patients 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 on Management of sexual violence disclosures in sexual health settings. Section 5 of the BASHH UK guidance explains and describes the limits of confidentiality.



Sexual health assessment following sexual violence

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 patients 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 PEP. 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 clients 16 years or over.

A lower paediatric dose (10mcg / 0.5ml) of Engerix® (or combined in Twinrix®)

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.

If in doubt about appropriate dosing, then seek advice.

Take care to check the syringe – usual dosing option;
1ml for adults aged 16 years and over,
0.5 ml for 15 years and under.

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
Twinrix Paediatric®	0-15 years	HAV 360 ELISA units HBV:101gHB	1.0ml

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.

There is no routine recall for clients who may have missed vaccine doses.

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

Twinrix is available for use in those being provided both Hepatitis A and B vaccines where the risk of exposure is not as high or ongoing risk where pre exposure vaccination would be routinely recommended.

Twinrix	16 years+	20mcg	1.0ml
Twinrix paediatric	1-15 years	10mcg	0.5 mls

People with ongoing risk factors including people who inject drugs (PWID) and people with chronic hepatitis B and C infection should be offered Hepatitis A 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.

HPV vaccination in adults post sexual violence

HPV vaccination is not routinely given post sexual assault to those disclosing sexual violence (SV) in the acute, post SV 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 quadrivalent vaccination courses.

Emergency contraception

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

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 to a GP or an Antenatal Clinic and share relevant information about the assault, with the patient's consent (GPP). 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 TOPAR. Products of conception may be used as DNA evidence. If this is consented to, TOPAR will liaise with Police Scotland on the available options

STI screening

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 STI transmission or pregnancy risk. 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 NAAT's 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. 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 PCR	EIA	renal function liver function urinalysis (+/-)
Follow up	45 days after assault; 3 months after commencement of PEP: 4th generation HIV serology test	3-6 months after assault: Hep B core Antibody	3-6 months after assault: Hep C PCR	3 months after assault: EIA	repeat tests not necessary if normal at baseline, and no side effects of PEP

Prophylaxis against Bacterial STIs

Signposting: BASHH UK guidelines for specific 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 EC copper coil insertion is being carried out.

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

- Chlamydia: Doxycycline 100mg bd PO 7/7
- Gonorrhoea: Ceftriaxone 1g IM stat
- Trichomonas: Metronidazole 400mg bd PO 5/7 (or Metronidazole 2g stat 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 Archway staff / inclusion team /consultant on call.

- Information sharing options between police and health should be discussed to allow the patient to make a fully informed decision. A summary diagram is included. 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

Glasgow Women's Aid
http://www.glasgowwomensaid.org.uk/get-support-now.html
Phone number: 0141 553 2022

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

Glasgow and Clyde Rape Crisis
https://www.glasgowclyderapecrisis.org.uk/
Freephone:
- 08088 00 00 14 (Glasgow & Clyde Rape Crisis helpline)
- 08088 01 03 02 (National rape & sexual assault helpline)

Rape Crisis Scotland Helpline
(5pm – midnight, every night)
Email: support@rapecrisisscotland.org.uk
- www.rapecrisisscotland.org.uk
- Call: 08088 010302 Text: 07537 410 027

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

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

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

Hemat gryffe
https://www.hematgryffe.org.uk

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

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

LBT Global (formerly Lucie Blackman Trust)
https://www.lbt.global/
-support if raped whilst abroad.

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

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

Patient Information Leaflets
Information and Help after Rape and Sexual Assault.

BASHH UK
PIL leaflet

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

1648722358_RCS-booklet---web-version-24032022-final-1.pdf (rapecrisisscotland.org.uk)

NHS Inform www.nhsinform.scot/sarcs

References:

BASHH Guidelines on management of sexual violence in sexual health settings 2022

Sandyford
Sexual Health Services for Greater Glasgow & Clyde

Appendix 1

PARTNERS INTELLIGENCE PORTAL FORM (PIP)

'Intelligence only' reporting form

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

ORGANISATION INFORMATION

Name of Sandyford staff submitting form First Name:	
Last name:	
Telephone:	
Email address:	
Organisation Location: (Sandyford Sexual Health include which site)	

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** **500 CHARACTER LIMIT** **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)**	

Appendix 2

WoS Sexual Assault Service

LABORATORY 'CHAIN OF EVIDENCE' FORM (LCOEF)

Please complete a separate form for EACH specimen & staple LCOEF to request form

- Details must be documented of any person examining the sample or authorising the report.
- The original request, completed LCOEF and any authorised result generated for each sample should be retained by West of Scotland Specialist Virology Centre.

Date Taken:	Time Taken:	Doctor's Name (block capitals):
Patient's Details (NaSH Label):		Doctor's Signature:
		Nurse's Name (block capitals):
		Nurse's Signature

Specimen Type: Please circle/state	Vulvovaginal	Urine	Rectal	Oral	Other (please state): _____
Test(s) requested: Please circle/state	NAAT Testing	HSV PCR	Bacterial culture	Microscopy	Serology (please state type): _____

ALL NAMES MUST BE ACCOMPANIED BY A SIGNATURE

Procedure	Name (caps)	Signature	Date	Time
Specimen obtained by				
Specimen delivered to laboratory by				
Received by BMS				
Other				

Details of any other staff handling sample
ALL NAMES MUST BE ACCOMPANIED BY A SIGNATURE

Procedure	Name	Signature	Date	Time
BMS check on completion				
Consultant Scientist check on completion				