GUIDELINE

Sexual assault

| Scope (Staff): | School Health |
| Scope (Area):  | CACH, WACHS |

This document should be read in conjunction with this DISCLAIMER

Background

Sexual assault is “...any unwanted sexual act or behaviour which is threatening, violent, forced or coercive and to which the person has not given or was not able to give consent.”¹ This can be considered sexual abuse when the assault occurs in the context of a power imbalance and a person uses their ‘authority’ to take advantage of a person’s trust, such as sexual assault of a child by an adult.

The Australian 2012 data indicated that almost half of the victims of sexual assault where aged between 10 and 19 years, and females in this age group had the highest victimisation rate, which was more than four times the rate of all females.² These results are consistent with previous years which indicated that young people (particularly young females) where more vulnerable to sexual assault than older people.³ It is difficult to ascertain the true nature and extent of sexual assault prevalence in society as there are numerous barriers to disclosure, low reporting rates and varying definitions of sexual assault. Nevertheless, the statistics provide an overview of the trends and characteristics of sexual assault.

Sexual assault can have diverse and long-lasting physical and mental health consequences. Immediate difficulties in managing emotions (fear, anger, guilt and shame) can occur. Longer term problems associated with sexual assault include Post-traumatic Stress Disorder, depression, suicide ideation, and increased risky behaviours, such as impulsivity, disruptive behaviour and substance abuse. These emotional and behavioural difficulties can have significant effects on normal adolescent development and negatively impact future adult mental health.⁴

Sexual assaults on young people are usually committed by someone they know, such as a family member, person of authority or a peer. Therefore it is not surprising that this acts as a significant barrier to disclosing and/or reporting the incident. It is especially difficult for young men to report abuse because of increased fear of being labelled as ‘weak’ or homosexual. Other barriers to disclosure pertinent to young people include; fear of cultural repercussions, fear of being blamed or not believed, uncertainty of whether it was an assault, and expectations to conform to ‘normal’ relationships.⁵

Children and adolescents with physical and/or mental disabilities, such as blindness or intellectual impairment, are considered to be at higher risk for sexual assault than other young people.⁶⁷ Some studies have reported that 83% of people with a disability have experienced an incident of sexual assault; either as children or adults,⁸ and a United States study of 55 000 children found that those with an intellectual disability are four times more likely to be sexually abused.⁹
Homeless youth are considered to be an at risk population for sexual assault. Often the reasons for leaving home are related to physical and sexual abuse within the familial environment. Unfortunately, once a young person is homeless the risk of ongoing sexual assault is increased. Furthermore, homeless youth are difficult to reach as they are less likely to have contact with school and health services.10

**General principles**

**Address immediate priorities**

In the first instance the young person’s safety from immediate harm should be ascertained. This can include safety from the alleged perpetrator or others, as well as self-harm or suicidal ideation.

Secondly, the young person should be assisted with immediate health concerns which have arisen as a result of the assault such as injury, emergency contraception, and STI testing.

The young person should be given information and supported in the decision-making about accessing further help such as if and how to let a parent know, accessing medical assistance and further counselling. It is helpful to explain as soon as possible the requirement for all nurses and doctors – as well as teachers and police officers - to make a mandatory report of child sexual abuse to the Department of Child Protection (DCP) when they have formed a ‘reasonable belief’ that a person under 18 years has been sexually abused. Ensuring the young person is fully informed of this requirement and what might be likely to happen as a consequence of this report can increase their sense of control over what happens next.

**Supporting the young person to access help**

Counselling is important in supporting recovery. It helps with the immediate impact of the assault and any ongoing issues which may arise.

It is important to listen and to acknowledge the young person’s experience and reactions by encouraging them to talk. It is also important to be non-judgemental. The victim should be enabled to have a sense of control over what happens after the assault. They will have a strong need to feel safe, and to have their right to be fully consulted in what happens next to be assured. Most young people who experience sexual assault form the opinion that it was somehow their fault, so it is important to ensure that any interaction they have with the health worker counters, rather than confirms this belief.

Sexual Assault Resource Centres (SARC) provide a range of (free) services in the metropolitan area for males or females over the age of 13 years. These services include a medical/forensic and counselling crisis service for people who have alleged a sexual assault within the previous two weeks. For young people 13 to 15 years, parental or guardian consent is needed for forensic tests to be conducted.

This is also required for 16-17 year olds for forensic examination when the police are already involved. Clients can request a male or female counsellor, and Aboriginal workers are available for support if requested.

SARC also operates a state-wide crisis counselling line which can be accessed 24 hours, 7 days a week. SARC offers free, short-term counselling to people who have experienced sexual assault or child sexual abuse, either recently or in the past. This counselling is available in business hours at various locations throughout the metropolitan area.
In regional centres, sexual assault counselling services are available in some sites only, and most medical and forensic services are offered through regional hospital emergency departments. Local GP’s can also provide appropriate services where SARC services are not available.

SARC can provide 24 hour medical advice and support for community health nurses who are working with clients, via the SARC crisis line.

Mandatory reporting of child sexual abuse by doctors and nurses

Since January 1st 2009 medical, midwifery and nursing staff (as well as teachers and police) are legally required to make a written report to the Department for Child Protection and Family Support (DCPFS) when they have formed a belief based on reasonable grounds through the course of their work that child sexual abuse is occurring or has occurred – post the date of the Act (January 1st 2009), under the Children and Community Services Act 2008. Reporters do not need to have evidence that a child is being sexually abused in order to make a report, only a belief formed on reasonable grounds. DCPFS are also obliged to pass a copy of all mandatory reports received on to WA Police.

In most cases of sexual assault of a minor, it is highly likely that a community health nurse would be required to make a mandatory report to DCPFS. Forms can be accessed via the WA Health website www.health.wa.gov.au/mandatoryreport or directly from the Department www.mandatoryreporting.dcp.wa.gov.au.

It is important to note that the legislation is not intended to capture cases of informed, consensual sex between two teenagers of similar age that is not exploitative, even when the involved children are under the legal age of consent.

When working with mature minors in particular, it is crucial that they feel as much a part of the decision-making process as possible. Therefore, whilst the reporting of (suspected) sexual abuse is mandatory for all doctors and nurses, fully informing the child of this requirement and spending time talking through with them any concerns and worries they may have regarding this, can alleviate fears and reduce feelings of powerlessness and lack of choice. Professional judgement should be relied upon in instances where it may be felt that openly discussing this action could further jeopardise the safety of the young person and/or the reporter.

If you are unsure, you should clarify your concerns by discussing them with your colleagues, line manager or the Department for Child Protection Mandatory Reporting Service (1800 708 704 – 24 hours), PMH Child Protection Unit (9340 8646) and/or staff at the WA Health State-wide Protection of Children Coordination (SPOCC) unit. This can be done without identifying the child about whom you are concerned.

Not all reports will result in an investigation or contact with the family. The action taken by DCPFS and/or the WA Police will depend on the unique circumstances of each report and the information provided.

Making a mandatory report should not interfere with any ongoing support, referral or medical/nursing assistance that you would usually offer to the child.

For further information refer to the Health Department mandatory reporting website www.health.wa.gov.au/mandatoryreport.
Reporting to Police

If a mandatory report has been made, the Police will receive this report from DCPFS. Any action they take following the receipt will depend on the individual circumstances of each case. If a mandatory report has not been made; because the health professional providing the service to the child is NOT a doctor, nurse or midwife, there is no mandatory obligation to report the crime to Police. Victims can choose to talk anonymously and informally to Police in the first instance. Police officers, as mandatory reporters, will also be obliged to make a formal report to DCPFS and follow processes as indicated by the individual circumstances.

Details of the processes undertaken in a Police investigation and subsequent court proceedings are outlined in the SARC document Information about sexual assault and sexual abuse. www.wchs.health.wa.gov.au/services/sarc

In instances which indicate that immediate police action is required to guarantee the safety of a young person it is highly recommended that the health worker consult immediately with the Child Protection Unit at PMH (9340 8646) for advice, support and accurate information regarding processes and procedures.

Work within the law

Community health nurses should refer to Working with Youth – a legal resource for community based health workers, to ensure familiarity with relevant common law and legislation.

Any decisions and actions should be well documented in order to provide quality information to other parties such as the Police or DCPFS.

Health professionals are expected to monitor the care and protection of any minor under their care whom they know is engaging in underage (<16 year) sex. If there is any concern about the young person’s wellbeing, the professional should respond as per Guidelines for Responding to Child Abuse, Neglect and the impact of Family and Domestic Violence, DOH.

Role of community health staff

Considerations when working with sexual health issues in the school setting

The following points should be considered when working with students experiencing sexual health issues:

In general

- Do you have competence in dealing with sexual health issues?
- Do you have competence in providing youth health care?
- Can you provide a non-judgemental and impartial approach in dealing with young people and sexual health issues?
- Have you organised your open times and appointment times so students have a regular, known ‘drop-in’ time with the option of coming back for a longer more in-depth appointment?
- Is your service highly accessible to your clients, especially those who are most disadvantaged and vulnerable?
- Do you have a thorough knowledge of the youth-friendly local services to which you can refer students for sexual health issues, including for the purchase of condoms?
Have you considered the duty of care and duty of confidentiality you owe to students? Have you considered scenarios when the duties may conflict, and how you might deal with them?
  
  o Examples are included in *Working with Youth – A legal resource for community based health workers*.

Do you have a working knowledge of the law in relation to dealing with minors, their rights and your responsibilities?

What happens when a situation arises outside of your scope of practice? Do you have access to clinical supervision in relation to sexual health issues?

Are you aware that when discussing a case with another health professional or any other third party, you should do so in a manner which does not identify the client?

Note: If you have answered ‘no’ to any of the questions above, discuss with your line manager.

**When working with individual students**

- In the best interests of the young person, who else should be involved in care?
- Do you need to inform parents? If yes, when?
- Have you maintained good documentation in relation to the student and the care provided?
Sexual assault disclosures

2. Ask questions to understand the young person and their situation
   - Explore recent sexual activity.
   - Explore whether sexual intercourse was consensual.

2a. Non-consensual
   - Explore context of the alleged non-consensual sexual assault to the extent necessary to guide immediate support.
   - Do not ask any leading/specific questions that could compromise any police investigation.

2b. Consensual
   - Provide care pathway as appropriate.
   - See other sexual health guidelines.

3. Identify immediate health issues and prioritise
   - Injury
   - Safety
   - Pregnancy
   - STIs
   - Psychological effects

4. Treatment required for injury
   - Reassure.
   - Ensure immediate and short term safety.
   - Identify any physical injuries.
   - Talk to young person about family support and likely reactions.
   - Assist client to contact parent or support person.
   - Inform young person of any mandatory reporting obligation and actively seek their thoughts, feelings, fears and desires around this with the aim of them accepting and agreeing with the necessity for this.

5. Refer to SARC, hospital ED or GP

5. Assertively follow-up

Documentation

- CHS 410 – High School Health Record (must be ordered from SmartDirect Online Ordering)
- CHS 412 – Progress Notes
- CHS 421- A – HEADSS Psychosocial Assessment form – Initial
- CHS 421- B – HEADSS Psychosocial Assessment Form – Plan & Follow up
- CHS 0663 – Referral from Community Health (must be ordered from SmartDirect Online Ordering)
Related professional development

- **Sexual Health Foundations (FPWA)** [www.fpwa.org.au](http://www.fpwa.org.au)
  A comprehensive 5 day course designed for nurses and other professionals wishing to develop a sound understanding of core sexual health and reproductive health issues, and skills to work effectively with young people and other individuals to promote sexual health.

- **Nuts and Bolts of Sexual Health (FPWA).** [www.fpwa.org.au](http://www.fpwa.org.au)
  A 3-4 day core sexual health training program, appropriate for community workers in areas such as youth, health, education, drugs and alcohol; people working with Aboriginal communities; and peer educators.

- **MOODITJ Leaders training (FPWA)** [www.fpwa.org.au](http://www.fpwa.org.au)
  A 3-4 day facilitators training program focussing on positive lifestyles and sexual health for Aboriginal youth 10-14 years of age. Includes topics on identity, puberty and caring for your body, understanding your emotions and how to express them well, relationships sexual issues and sexual rights, parenting, identifying goals and dreams.

- **ABC of the Birds and Bees (Child and Adolescent Community Health)**
  A 2 day course for community health nurses working in primary and secondary schools. The course provides fundamental information necessary to expand the knowledge, skills and confidence of those dealing with sexual health issues in schools and the community. Covers values and sexuality, contraception and managing unplanned pregnancy and STI's. (Available in metropolitan areas only.)

- **Tools of the Trade (FPWA)** [www.fpwa.org.au](http://www.fpwa.org.au)
  This 3 day course is designed to build on the foundation acquired in Nuts and Bolts to develop competence and confidence as a sexual health educator. This course aims to increase your understanding of sexual health promotion and behaviour change theory, develop skills to plan education sessions to promote knowledge, attitudes, skills and behaviours needed for sexual health and analyse a variety of facilitation techniques and creative group work strategies. Must have prior experience and be comfortable talking to small groups about sexual health information.

### Related internal policies, procedures and guidelines

<table>
<thead>
<tr>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Health Guidelines Identifying sexual healthy issues – how to ask the right questions.</td>
</tr>
<tr>
<td>Working with Youth – A legal resource for community based health workers, Department of Health WA. Available from HealthInfo 1300 135 030</td>
</tr>
<tr>
<td>Information Circular IC 0164/13 - Patient Confidentiality, Department of Health WA</td>
</tr>
<tr>
<td>Operational Circular – OP 1548/02 New Western Australian Public Sector Code of Ethics, Department of Health WA</td>
</tr>
<tr>
<td>Consent to Treatment Policy for the Western Australian Health System, Information Series No. 9 (2006). Office of Safety and Quality in Health Care</td>
</tr>
<tr>
<td>Guideline – Decision Making Framework, AHPRA Nursing and Midwifery Board</td>
</tr>
<tr>
<td>Code of Ethics, AHPRA Nursing and Midwifery Board</td>
</tr>
</tbody>
</table>
References


Useful resources

PASH Manual www.fpwa.org.au

Promoting Adolescent Sexual Health (PASH) is a manual used for the training program providing participants with the knowledge and skills to run PASH groups. PASH with a Twist is a peer education program that gives older adolescents an opportunity to explore a variety of issues related to sexuality and sexual health in a safe, informal and fun environment. It includes issues such as drugs, alcohol and sex, social and emotional wellbeing. The manual can be used to run groups and FPWA educators are available to provide consultancy in planning and /or delivering a PASH. The manual is available for purchase at FPWA website or 9227 6177.

Puberty and Relationships Series - Three booklets for school children

Produced by the Sexual Health and Blood-borne Virus Program, Communicable Disease Directorate, Department of Health WA. Available from HealthInfo 1300 135 030

Interviewing Adolescents. A training DVD which covers generic concepts relevant for any
health professional working with adolescents. It is a self-paced teaching tool for taking a complete psychosocial history from an adolescent. Phone CACH Workforce Development on 9224 1657.

**Let’s Talk about Sex.** A DVD story of teenage Perth-based Aboriginal couple negotiating their relationship. Includes STI information. Contact Jo Rees - Youth Coordinator, South Metro Population Health Unit. Phone 9431 0200 or email jo.rees@health.wa.gov.au

**Quarry Health Centre** supports young people across Perth to look after their sexual health. They provide education, counselling and clinic services. Ph 9227 1444

**Talk Soon. Talk Often.** A guide for parents talking to their kids about sex. This free resource has been developed to help parents initiate regular and relaxed conversations with their children about sexuality and relationships.

**All About Growing Up - Me, Myself and I** toolkit was designed to provide standardised, research-informed materials for community school health nurses to use when working with groups of students in schools. The toolkit contains lesson plans, powerpoints and activities on health, puberty, growth, development and relationship issues created to teach students (school years 5-7) about the changes occurring during adolescence.

### Appendix A

**When communicating with an individual child/young person who is disclosing sexual assault.**

- Find a quiet place to talk.
- Explain the limits of confidentiality. **Do not** promise confidentiality.
- Listen to the child/young person and let them tell their story, at their own pace and in their own words.
- Comfort the child/young person if they are very distressed, without making any promises.
- Always believe the child/young person and convey that belief through your words and actions.
- Reassure the child/young person that telling you was the right thing to do
- Maintain a calm and accepting manner
- Do not ask leading or specific questions.
- Do not interview or investigate, this is the role of the Department for Child Protection and/or Western Australia Police.
- Write down what the child/young person has told you and your observations.
- Tell the child/young person what you will do next
- Explain that this will almost always include involving others; as this tends to work best in keeping the child/young person safe.
- Avoid making the child/young person repeat their story/disclosure to another person in your department/agency.
Sexual assault

- Do not confront the person alleged by the child/young person to be responsible for abuse.

*If the disclosure is about sexual abuse and you are a Mandatory Reporter (doctor, nurse or midwife):*

- You have no discretion in the sharing or withholding of information; after you have formed a ‘reasonable belief’ of child sexual abuse you *must* report this to Department of Community Development which must then pass this information on to WA Police.

- To maximise the possibility of maintaining a good working relationship with your client, it is advisable to make every attempt to let the child/young person know of your legal obligation. Attempt to gain the agreement of the child/young person and/or parent for you to submit the mandatory report unless you believe that to do so would have the potential to put the child/young person, other family members or yourself, at risk of (further) harm.

This document can be made available in alternative formats on request for a person with a disability.