GUIDELINE	
Sexual assault	
Scope (Staff):	School health
Scope (Area):	CACH, WACHS

This document should be read in conjunction with this DISCLAIMER

Aim

This guideline aims to support nurses working in schools to provide primary health care for young people who have experienced sexual assault.

Risk

Inappropriate support and information from a health professional at the time when a young person needs advice regarding sexual health may have long term influences on their health and wellbeing. Sexual assault may have long-term impact on young people's physical and mental health, and requires an empathetic and supportive approach.

Background

Sexual assault can be a violent, unexpected, traumatic and sometimes life threatening event or series of events. 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] See Appendix A for more information on Consent.

Sexual assault and sexual abuse are terms that are often used interchangeably. Typically people tend to think of sexual abuse occurring to a younger child and/or perpetrated by someone within the close family circle of the young person who has experienced the abuse. For the purposes of this document the term sexual assault will be used to represent both sexual abuse and sexual assault.

Nurses, as mandatory reporters of child sexual abuse, must consider sexual assault as sexual abuse and follow appropriate actions if they form a belief in relation to their mandatory reporting obligations. Further information on **Mandatory reporting** is provided in **Appendix B** and information on **Mature minors** is in **Appendix C**.

In Australia, almost half of those who experience sexual assault are aged between 15 and 19 years. Females in this age group are seven times more likely to experience sexual assault than the overall population.[2] It is difficult to ascertain the true prevalence of sexual assault in society as there are numerous barriers to disclosure, low reporting rates and varying definitions of sexual assault.[3] Nevertheless, the statistics provide an overview of the trends and characteristics of sexual assault.

Exposure to sexual assault or intimate partner violence can have diverse and long-lasting physical and mental health consequences. Immediate difficulties in managing emotions (fear, anger, guilt and shame) can occur.[3] Sexual assault impacts health and well-being resulting in long term emotional and interpersonal difficulties [4, 5]which can manifest as disordered eating behaviours, reduced self-esteem, increased risk for internalising and

externalising behaviours, increased levels of fear and anxiety and suicidality.[4] Teen dating violence is reported to affect up to forty percent of young people.[4] These emotional and behavioural difficulties can have significant effects on normal adolescent development and negatively impact future adult mental health.[6]

Sexual assaults are usually committed by someone who is known to the young person, such as a family member, person of authority or a peer, and most assaults occur in a residential location.[4] It is especially difficult for young men to report assault because of increased fear of being labelled as 'weak' or homosexual. Other barriers to disclosure for young people include: fear of cultural repercussions; feelings of shame; fear of blame or being judged negatively and/or threats by the perpetrator. [3, 7]

Children and young people with physical and/or mental disabilities, including intellectual impairment, are considered to be at higher risk for sexual assault than other young people. [3, 6, 8] Some studies have reported that 83% of people with a disability have experienced an incident of sexual assault in childhood or adulthood.[8]

Homeless youth are considered to be an at risk population for sexual assault.[9] 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.[9]

Another group at greater risk of experiencing sexual assault are Lesbian, Gay, Bisexual, or Transgender or Questioning or Queer (LGBTIQ+) young people.[10] In a 2008 survey of 390 LGBTIQ+ young people, approximately 12% reported having experienced sexual assault.[10]

The collection of forensic evidence may be considered following a sexual assault in accordance of the wishes of the client and the broader medical and psychosocial needs.[11] The timeframe for collecting specimens is short. Evidence may be collected for up to two weeks following sexual assault, however, the optimal period for collecting forensic evidence is within 72 hours.[12] The nurse will not be involved in the collection of specimens, however should be able to explain the purpose of avoiding showering, changing clothes, going to the toilet and eating or drinking prior to a forensic medical examination if required.

Key Points

- Nurses must work within their scope of practice.
- 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.
- 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.
- SARC can provide 24 hour medical advice and support for CHNs who are working with clients, via the SARC crisis line.
- The Perth Children's Hospital (PCH) Child Protection Unit offers a free service to children up to 16 years of age, and their families, where there is a concern of abuse or neglect.

- Refer to: *Working with Youth- A legal resource for community based health workers* for information about legal matters including duty of care, sharing information with third parties, consent and mature minors.
- Be aware of Western Australian laws in relation to age of consent and Mandatory Reporting of Child Sexual Abuse. Refer to: *Guidelines for protecting children.*

Process

Steps	Additional Information
1. Build rapport • Discuss confidentiality and ensure privacy. • Thank the young person for telling you. • Believe the disclosure. • Raise issues gently, be kind, and remain calm and confident. • Adopt a supportive, interested, non-judgemental approach in both spoken and body language. • Reassure the young person that help and support is available.	• Early in the consultation, explain privacy, confidentiality, and the limits of confidentiality. Check understanding by the individual. • Reassure the young person. Be careful not to promise safety or other supports that you cannot guarantee. • Whether conducting a full HEADSS assessment or responding to a student-initiated conversation, it is useful to spend time building a rapport before asking probing questions.
2. Assess risks • Assess the young person's safety from immediate harm. This can include safety from the alleged perpetrator or others, as well as, self-harm or suicidal ideation. • In instances where immediate action is required to address the safety of a young person, liaise with the Student Services Team to consult with Crisis Care, the PCH Child Protection Unit and/or the WA Police Force. • Notify Nurse Manager to provide nurse with support.	• Refer to *HEADSS assessment guideline* and *HEADSS Handbook for nurses working in secondary schools* for guidance on how to develop rapport and ask sensitive questions. • Most rural hospitals provide services by staff who are trained and networked with SARC. • Rural and Aboriginal people can access local services with SARC input. • Aboriginal Community Controlled Health Services (ACCHS) – there are 22 ACCHS in WA run by local Aboriginal people and their communities to manage their own health and well-being.
3. Support the young person • Reassure the young person that they are not to blame for what has happened and that you believe them. • Find out if the individual has previously disclosed to anyone and if medical	• Consult the young person at each stage of the process. • If not requiring mandatory reporting of child sexual abuse, reassure the young person about their ability to choose who is informed and how.

Steps	Additional Information
and/or counselling support has already been accessed. • Encourage and support the young person to seek medical attention to address issues such as sexually transmitted infections, unwanted pregnancy or injuries. • Reassure the young person that they are an important part of the decision making process.	• Following a disclosure of sexual assault, an individual needs to be supported to maintain a sense of control and choice. • If the assault occurred at school or during a school-related activity, inform the school principal as soon as practical. For self-directed information and services for young people: • Get the Facts – access to accurate and objective information about sex, relationships, body art and STIs. It includes an online game *Quiz Quest*. • Could I have it? - STI facts, testing advice and clinic locations.
4. Reporting • As per Mandatory reporting guidelines, make a report. See **Appendix B.** • Consider if the assault may reflect other abuse that needs to be reported to CPFS.	• Information and online forms for mandatory reporting can be found on the Mandatory Reporting website.
5. Gather support • Support the individual to contact a parent or trusted relative to assist in accessing medical attention. • Inform the young person and parent/carer about the services provided by Sexual Assault Resource Centre (SARC).	• Nurses should be aware of youth friendly doctors in their area. The Australian Medical Association provides details of medical practitioners who have undertaken specific Youth Friendly Doctor training by the AMA, though they may not be available in all areas. • headspace – Youth friendly GP and sexual health clinics. Free, confidential and no Medicare card required. • If appropriate assist the young person to identify other suitable support people within the school setting and in their community. • Sexual Health Quarters – Drop-in STI testing clinics, with low fee of $10.
6. Refer • Provide information and links to support organisations in the short and longer	For self-directed information and services for young people: • SARC also operates a state-wide crisis counselling line which can be accessed

Steps	Additional Information
term. • Sexual Assault Resource Centre (SARC) – 08 6458 1828 or 1800 199 888 - 24 hour, 7 day per week emergency line (free call from landlines). Free medical/ forensic and counselling crisis service for people who have alleged a sexual assault in the previous two weeks, aged 13 years and over. Parental or guardian consent is required for those under 18 years of age for forensic examination. SARC are available in some regional areas. For more information call the number above. • The Child Protection Unit at PCH takes referrals from parents, community members and professionals - 9340 8646. A Duty Social Worker - 9340 8222 - is available each week day 8.30am - 5pm. After hours support is available. • Local hospital emergency department for immediate medical attention for injuries and access to specialist support for sexual assault. • General Practitioner – medical services for referral to counselling services. Emergency contraception, STI testing.	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. • ReachOut – Online mental health organisation provides practical support and links to emergency counselling. • Nurses should be aware of youth friendly doctors in their area. The Australian Medical Association provides details of medical practitioners who have undertaken specific Youth Friendly Doctor training by the AMA, though they may not be available in all areas. • 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.
7. Follow-up • Maintain contact with the young person to ensure ongoing psychological wellbeing.	• Counselling is important in supporting recovery. It helps with the immediate impact of the assault and any ongoing issues that may arise. See the Sexual Assault Resource Centre (SARC) website for information.
8. Professional support • Following consultation with adolescents, seek to debrief, as required.	• Staff should discuss the availability of professional support and debriefing strategies with their line manager.

Documentation

Nurses will document according to local processes.

Related internal policies, procedures and guidelines
The following documents can be accessed in the Community Health Manual: HealthPoint or Internet
HEADSS adolescent psychosocial assessment procedure
School-aged health services
School-aged health services - secondary
Sexual health in adolescence
The following documents can be accessed in the CAHS Policy Manual
Clinical Incident Management
Critical Incident Impact Management (Debrief)

The following documents can be accessed in School Health Resources: HealthPoint
HEADSS Assessment: Handbook for nurses working in secondary schools
Health Promoting Schools Framework Toolkit – Secondary School – Mental Health and Resilience
Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning + (young people) fact sheet
Medicare for young people , in WA Youth Health Policy 2018–2023 Toolkit Department of Health, Government of Western Australia
Working with Youth– A legal resource for community-based health workers. Perth: Department of Health Western Australia; 2007. (Revised 2013.)

Additional Department of Health, Government of Western Australia resources:
Consent to treatment Perth: Department of Health Western Australia;2016
Guidelines for Protecting Children 2015 Department of Health, Government of Western Australia
Mandatory Reporting of Child Sexual Abuse in Western Australia. A guide for mandatory reporters.

Useful resources
Australia Medical Association (WA) youth friendly GPs list.
Child Protection Unit (PCH) offers a free service to children up to 16 years of age, and their families, where there is a concern of abuse or neglect.
Consent is as simple as tea – a YouTube video which explains the concept of consent.
Get the facts. Australian Government. Department of Health. [Internet] Australian Government. Department of Health. [n.d.]
Growing and developing healthy relationships curriculum materials for teachers. [Internet] Western Australia Department of Health. (2016)
Kids Helpline 1800 55 1800
MOODITJ leaders training (Sexual Health Quarters). A 3-4 day facilitators training program focussing on positive lifestyles and sexual health for Aboriginal youth 10-14 years of age.
Nuts and bolts of sexual health (Sexual Health Quarters) A 3- day SHQ course relevant for people working in the community including youth workers, health workers, drug and alcohol workers, health promotion officers, nurses, teachers and peer educators.
Sexual assault resource centre (SARC) provides a 24-hour emergency service in metropolitan Perth. This involves medical care, a forensic examination and counselling support to people who have been sexually assaulted within the previous 14 days.
Sexual Health Quarters offers counselling, contraception, STI testing and treatment and unplanned pregnancy support at low or no cost.
Talk soon. Talk often. A guide for parents talking to their kids about sex. Assists parents initiate regular and relaxed conversations with their children about sexuality and relationships.
Yarning quiet ways. A guide for Aboriginal parents talking to their kids about sex. For orders email the Sexual Health and Blood-Borne Virus Program.

Appendix A: Consent

Consent means agreeing to sexual relations without fear, coercion, force or intimidation. Giving consent is active, not passive: it means freely choosing to say 'yes' and also being free to change your mind at any time.[13]

There are two different contexts for consent depending on the legislation (law) that is describing consent; either Criminal law, or according to the *Children and Community Services Act 2004 (CCSA).*

According to Criminal Law in WA, legal consent to sexual activity can only occur when both parties are 16 and over. Consensual sex is when all parties:

- are of legal age [13]
- agree to engage in intercourse by choice [13]
- have the freedom and capacity to make that choice [13]
- understanding what is being proposed without confusion (not being tricked or fooled) [12]
- having an awareness of possible consequences such as punishment, pain, pregnancy or disease [12]
- having respect for agreement or disagreement without repercussion [12]
- having the competence to consent (being intellectually and physically able and unaffected by intoxication).[12]

The *Children and Community Services Act 2004 (CCSA)* includes information about mandatory reporting of child sexual abuse requirements, and describes child sexual abuse as occurring to a child (i.e., aged under 18) and includes sexual behaviour in circumstances where:

- the child is the subject of bribery, coercion, a threat, exploitation or violence; and/or
- the child has less power than another person involved in the behaviour; *and/or*
- there is significant disparity in the developmental function or maturity of the child and another person involved in the behaviour.

The CCSA does not define an age or age difference between partner/s that, of itself, requires a mandatory report. Therefore children over 16, who are over the age of consent, but where the sexual activity is non-consensual (using the CCSA criteria above), can be described as being sexually abused.

Appendix B: Mandatory Reporting of Child Sexual Abuse: Legal Requirements

In accordance with the *Children and Community Services Act 2004*, doctors, midwives and nurses (as well as teachers, police and boarding supervisors) are **legally** required to make a written report to the Department of Communities Child Protection and Family Support (CPFS) Mandatory Reporting Service when they have formed a **belief based on reasonable grounds** through the course of their paid or unpaid work that **child sexual abuse** is occurring or has occurred after 1 January 2009. The mandatory reporting requirement applies to children who are still aged under 18 at the time the belief is formed.

The essential requirement to make a mandatory report of child sexual abuse is that the reporter has **formed a belief,** based on reasonable grounds that the child is, or has been, sexually abused.[14] Reporters **do not need to have evidence** that a child is being sexually abused in order to make a report. CPFS are also obliged to pass a copy of all mandatory reports to the WA Police Force (WAPOL). Forms and fact sheets can be accessed via the WA Health website www.health.wa.gov.au/mandatoryreport or directly from CPFS www.mandatoryreporting.dcp.wa.gov.au.

Nurses need to consider how they will manage this mandatory obligation, in the context of any concerns the young person may have about their information being provided to others. Informing the young person 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.[14] Professional judgement should be used 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. Young people should be made aware of the limits of confidentiality at every occasion of service. This can be facilitated by making sure the boundaries of confidentiality are discussed, particularly when first working with a young person, and displaying posters or pamphlets which highlight occasions when confidential information must be shared, even against the wishes of the young person.

Not all reports will result in an investigation or contact with the family.[15] The action taken by CPFS and/or the WAPOL will depend on the unique circumstances of each report, the information provided and other information known to CPFS and WAPOL.

Making a mandatory report should not interfere with any ongoing support, referral or medical/nursing assistance that you would usually offer to the young person.[12]

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 WAPOL or CPFS.

For further information refer to CPFS mandatory reporting or CAHS Identifying Abuse and Neglect.

Appendix C: Mature Minors

This information is intended as a guide only. For more information please refer to the School-aged health services guideline or the Working With Youth resource.

Assessing a young person as a 'mature minor' should be based on the individual's emotional maturity, intellectual intelligence and their lived experience rather than their chronological age. Each young person must be assessed on a case-by-case basis within their context as these factors develop at differing rates for each individual.

Some of the factors that may be assessed include (but not limited to):

- Age of the young person.
- Nature of the clinical or other problem.
- Ability of the young person to explain the clinical or other problem by providing an appropriate history.
- Nature and purpose of the proposed health care or other action.
- Ability of the young person to understand the gravity and complexity of the proposed health care or other action.
- Ability of the young person to understand and rationalise health care or other relevant options.
- Consequences of the proposed health care (including side-effects of proposed treatment) or other action.
- Ability of the young person to understand fully the nature, consequences, risks and implications of the proposed health care or other action and of non-action.
- Emotional impact on the young person of either accepting or rejecting the proposed health care or other action.
- Young person's general maturity of expression.
- Young person's level of functioning in other aspects of his or her life.
- Young person's level of schooling.
- Young person's level of independence from parental care.
- Any moral and family issues involved.
- Health worker's prior knowledge of the young person.
- Reason the young person came to see the health worker about the clinical or other problem without parental involvement.
- Whether the young person is acting freely in attending the health worker and making his or her decision.[16]

Nurses should ensure that the process, and factors relied upon in assessing a young person's competence, are carefully documented in the young person's medical record. If at any stage the nurse is unsure of the maturity of the young person or the process, they should consult their line manager.

References

1. Sexual Assault Resource Centre, Government of Western Australia. What is sexual assault and sexual abuse? [Internet]: Sexual Assault Resource Centre; 2017 [2017 September 1]. Available from: http://www.kemh.health.wa.gov.au/services/sarc/.

2. Australian Bureau of Statistics. Reports of sexual assault reach a six-year high. Internet: Australian Bureau of Statistics; 2015 updated 2016 Jul 13 [Available from: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4510.0~2015~Media%20Release~Reports%20of%20sexual%20assault%20reach%20six-year%20high%20(Media%20Release)~19.

3. Tarczon C, Quadara A. The nature and extent of sexual assault and abuse in Australia: Australian Institute of Family Studies; 2012.

4. Collibee C, Furman W. Impact of sexual coercion on romantic experiences of adolescents and young adults. Arch Sex Behav. 2014;43(7):1431-41.

5. Webber R, Moors R. Engaging in cyberspace: seeking help for sexual assault. Child Fam Soc Work. 2015;20(1):40-9.

6. McCauley JL, Zajac K, Begle AM. Adolescent sexual assault: prevalence, risk associates, outcomes, and intervention. Handbook of adolescent health psychology: Springer; 2013. p. 175-90.

7. Münzer A, Fegert JM, Ganser HG, Loos S, Witt A, Goldbeck L. Please tell! Barriers to disclosing sexual victimization and subsequent social support perceived by children and adolescents. J Interpers Violence. 2016;31(2):355-77.

8. Quadara A. Responding to young people disclosing sexual assault: A resource for schools: Australian Institute of Family Studies; 2008.

9. Morrison Z, Australian Institute of Family Studies. Homelessness and sexual assault 2009 [Available from: https://aifs.gov.au/publications/homelessness-and-sexual-assault/homelessness-solutions-sexual-assault-perspective.

10. Fileborn B. Sexual violence and gay, lesbian, bisexual, trans, intersex, and queer communities 2012 [Available from: https://aifs.gov.au/publications/sexual-violence-and-gay-lesbian-bisexual-trans-intersex-and-queer-communiti.

11. Department of Health. Responding to an allegation of sexual assault disclosed within a public mental health service. Perth2012.

12. Department of Health. Guidelines for protecting children 2015. In: Statewide Protection of ChildrenCoordination Unit, Child and Adolescent Community Health, editors. Perth 2015.

13. Department of Health. Consent to sexual activity [n.d.] [Available from: http://healthywa.wa.gov.au/Articles/A_E/Consent-to-sexual-activity.

14. Australian Institute of Family Studies. Mandatory reporting of child abuse and neglect 2017 [Available from: https://aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect.

15. Department for Child Protection. Mandatory reporting of child sexual abuse in Western Australia: A guide for mandatory reporters. In: Department for Child Protection, editor. Perth2008.

16. Department of Health Western Australia. Working with Youth – A legal resource for community-based health workers. Perth: Department of Health Western Australia; 2007 (Revised 2013).

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

Document Owner:	Director of Clinical Services Community Health		
Reviewer / Team:	Clinical Nursing Policy Team		
Date First Issued:	2009	Scheduled Review Date:	27 Nov 2020 (extended to 30 June 2021)
Last Reviewed:	Nov 2013		
Approved by:	CACH/WACHS Community Health Clinical Nursing Policy Governance Group		
Endorsed by:	Executive Director CACH	Date:	27 Nov 2017
Standards Applicable:	NSQHS Standards: 1.7, 1.8		
Printed or personally saved electronic copies of this document are considered uncontrolled			