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Ontario Paediatric Sexual Assault /Abuse

**SickKids®**

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**Training Manual**



## **Contributors**

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The Suspected Child Abuse & Neglect Program and the Ontario Network of Sexual Assault and Domestic Violence Treatment Centres would like to gratefully acknowledge the following individuals for their contributions to the production of this manual.

**Corry Azzopardi, MSW, RSW**

Social Worker  
Suspected Child Abuse & Neglect Program  
The Hospital for Sick Children

**Nancy Horan, RN, BScN, SANE-A, SANE-P**

Coordinator DV/SA, Treatment Program  
Sexual Assault & Domestic Violence Treatment Centre  
HRSRH, Sudbury

**Amelia Sloan, RN, BScN, MN(c), SADVNE**

Sexual Assault Nurse Examiner  
Suspected Child Abuse & Neglect Program  
The Hospital for Sick Children

**Tanya Smith, RN, BScN, MN, NP-P, SANE**

Nurse Practitioner & Sexual Assault Nurse Examiner  
Suspected Child Abuse & Neglect Program  
The Hospital for Sick Children

**Judy Waldman, RN, BScN, MN, SANE-A, SANE-P**

Sexual Assault Nurse Examiner  
Suspected Child Abuse & Neglect Program  
The Hospital for Sick Children

**Karla Wentzel, RN, BScN, MN, NP-P, SANE**

Nurse Practitioner & Sexual Assault Nurse Examiner  
Suspected Child Abuse & Neglect Program  
The Hospital for Sick Children

## **Editors**

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**Corry Azzopardi, MSW, RSW**

Social Worker  
Suspected Child Abuse & Neglect Program  
The Hospital for Sick Children

**Hosanna Au, MD, FRCPC**

Staff Physician  
Suspected Child Abuse & Neglect Program  
The Hospital for Sick Children

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## Purpose of Manual

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The purpose of this manual is to provide standard guidelines on the medical evaluation of children and adolescents who may have experienced sexual abuse or assault.

This manual has incorporated Canadian content and is based on a review of current guidelines, clinical and empirical literature and expert clinical consultation. A full reference list is provided at the end of the manual.

These guidelines can be incorporated within existing community based protocols.

Many communities have protocols for joint investigations and this manual can be incorporated when considering the medical evaluation for sexual abuse and assault cases.

Development and publication of this manual was funded by the Early Years Initiative through the Ontario Ministry of Health and Long-Term Care.

## The Suspected Child Abuse and Neglect Program

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The Suspected Child Abuse and Neglect (SCAN) Program is an interprofessional child maltreatment program at The Hospital for Sick Children (SickKids) in Toronto, Canada. SCAN is comprised of a team of healthcare professionals who offer a range of medical and psychosocial services to children and adolescents, under 18 years of age, who may have been maltreated, and their families. The SCAN Program provides a link between SickKids, community doctors and hospitals, Children's Aid Societies, police, schools and other community agencies.

SCAN is an interprofessional team that consists of:

- Social workers
- Paediatricians
- Nurse practitioners
- Sexual Assault Nurse Examiners
- Psychologists

Anyone may initiate a referral and/or consult with SCAN:

- Healthcare providers within SickKids or from the community
- Schools
- Children's Aid Societies
- Mental health professionals
- Police
- Family members/general public
- Lawyers

SCAN provides the following services:

- General medical and psychosocial consultation – 24 hours/7 days a week
- Medical review and evaluation of suspected physical abuse, sexual abuse and neglect
- Medical neglect and/or non-adherence consultation
- Inpatient psychosocial assessments:
  - Psychosocial Injury Assessment
  - Empirically Based Clinical Decision Making Interview
- Case management and liaison role with CAS and/or police and healthcare team
- Crisis intervention, supportive counseling and psycho-education for the non-offending caregiver
- Complex trauma assessment and treatment
- Sexual Abuse Forensic Evaluation Program
- High risk sexual behaviours assessments
- Child & Youth Internet Sexual Exploitation Program

SCAN is also involved in the following activities:

- Preparation of medicolegal reports
- Expert court testimony
- Teaching
- Research

# The Ontario Network of SA/DV Treatment Centres

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## **Network**

Sexual Assault and Domestic Violence Care and Treatment Centres (SA/DVCTC) provide care to women, men and children who have recently experienced sexual assault or domestic violence.

There are 34 hospital-based programs in Ontario. Services include: emergency medical and nursing care, crisis intervention, forensic evidence collection, medical follow-up and counselling.

## **History**

Responding to the concerns expressed by community-based women's organizations, the Ministry of Health and Long-Term Care opened the first of 34 hospital based Sexual Assault Care Centres (SACC) beginning in 1984. These Centres, located across Ontario, provide regional access and emergency care to women, men and children who have been recently sexually assaulted. In November 1999, the Network expanded the mandate to include domestic violence (SA/DVCTC) to provide services to survivors of intimate partner violence.

## **Why We Need a SA/DVCTC**

Many survivors of sexual assault and/or domestic violence have immediate medical, emotional and safety issues. Health concerns such as injuries, pregnancy and sexually transmitted infections can be addressed and treated by the nurses and physicians at the centres. If the client chooses to involve the police, forensic evidence can be collected at the hospital. When a client is at risk of further violence, immediate referrals to shelters can be made. Any safety concerns, as well as safety planning can be discussed with the SA/DVCTC nurse.

The centres are accessible 24 hours a day, seven days a week. They are staffed by an on-call team of nurses and/or physicians who provide prompt and specialized care through the emergency department.

## **Mandate**

The Sexual Assault and Domestic Violence Care and Treatment Centres provide emergency care to women, men and children who present to a hospital emergency department following a sexual assault or an intimate partner violence incident. The centres work collaboratively with community agencies to provide a continuum of care accessible to survivors, recognizing that the effects of sexual and domestic violence are complex and cannot be met by any one agency. In addition to emergency care, the centres provide a follow-up service for clients, which includes medical care and counselling. The follow-up service varies from centre to centre depending how they have been funded.

Education and outreach are important components of every centre. While service provision remains the primary focus, staff use every opportunity to educate the community and other professionals about their services and issues related sexual assault and intimate partner violence.

As health care professionals, we are legally obligated to report suspected abuse of children and adolescents under the age of 16 years to the appropriate child protection agency.

## **Values**

Sexual and domestic assaults are crimes that are often rooted in power and control.

Our care revolves around the following principles:

- Victims and survivors are provided with unconditional support
- During an assault, personal control and self-determination are usurped. Care is given in a non-judgmental manner and assists clients in reclaiming their autonomy by encouraging them to make decisions about their own care
- The assailant/abuser is deemed responsible for the violent behaviour
- Domestic violence and sexual assault are critical global issues that must be addressed by the health care, legal, social and political systems. On-going education for change is required throughout these systems.
- Continuous improvement in accessibility for all persons is necessary

We help people to:

- Receive care in privacy
- Recognize their self-worth
- Obtain information about their options
- Take their time to process information about what has happened to them.

The Ontario Network of Sexual Assault and Domestic Violence Treatment Centres

[www.satontario.com](http://www.satontario.com)

# The Ontario Network of SA/DV Centres Paediatric Initiative

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## **Paediatric Initiative**

The Ontario Ministry of Health and Long-Term Care supports the enhancement of services within Ontario Sexual Assault/Domestic Violence Care and Treatment Centers (SA/DVCTC) for the care of children who have been sexually abused and/or assaulted, through the Early Years Initiative. Since 2001/02 the Ministry has provided annual one-time funding for all SA/DVCTCs to plan and develop 24-hour emergency medical care, forensic documentation, crisis counselling and safety planning for children, adolescents, and their families. In order to ensure permanent paediatric services at all SA/DVCTCs, the Ministry approved base funds for all Centres in 2004/05.

These enhancement funds have allowed for the development of an infrastructure to support many paediatric sexual abuse and assault initiatives. This infrastructure consists of a paediatric leader and a paediatric committee consisting of coordinators and Registered Nurses from six regional paediatric sites. These six Paediatric Regional Sites will provide leadership in practice and education in each of the regions of Ontario. These regional sites include: Sudbury, Ottawa, Toronto, London, Hamilton and Thunder Bay.

## **Identified Need**

One of the goals of the paediatric initiative is to ensure that children are cared for within their own communities by qualified clinicians. There may be a reluctance or hesitancy among some clinicians to be involved in the medical and psychosocial evaluation of children who have been sexually abused and/or assaulted. This may be due to a lack of:

- Training and skill development
- Opportunities for ongoing education and professional development and
- Access to supervision and peer review/expert consultation.

As a result, children and adolescents are often referred to tertiary hospitals for care rather than being seen in their local communities. Consequently, many children, adolescents, and their families are required to travel long distances to receive services. This disconnect may increase the likelihood of inconsistent medical and psychosocial follow-up care.

Since the inception of funding in 2001, many centres have begun to develop community-based clinical services for children, adolescents and their families when both acute and non-acute medical or psychosocial sexual abuse/assault concerns have arisen.

The SA/DVCTC model for paediatric services is a comprehensive continuum of care for children who have been recently sexually abused/assaulted. In cases where the assault occurred within 24 – 72 hours and the child is brought to the hospital emergency department, the on-call team of nurses and/or physicians will respond. Beyond the acute phase of 72 hours, if there is sufficient reason to examine a child, a scheduled appointment during office hours is arranged. If required, psychosocial services are provided to children, adolescents, and their families.

Within this model of care, there is an expectation that centres work closely with the police, the judicial system, the child welfare authorities, and community mental health services to ensure an integrated system response for children, adolescents, and their families.

## Expert Consultant List for Clinicians

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As the paediatric initiative has developed across the province, many issues have been identified from a practice and knowledge perspective. While some centres have historically provided services to children, many centres have not and therefore initial training and continuing education programs have been developed. These programs are designed for both nurses and physicians who are providing direct service to children and/or adolescents. A peer review program has also been implemented with centers across the province to for quality assurance and continuing education through the ongoing review of cases by clinicians. Given the medico-legal nature of paediatric sexual abuse and assault cases, it is imperative that all clinicians involved in these cases receive adequate training, continuing education, peer review and access to consultation.

In order to provide all clinicians across the province with easy access to consultation, a group of **expert consultants** has been developed. These experts are available to provide a second opinion on both acute and non-acute cases when requested. The Network Paediatric Committee has defined “expert”, as outlined by Joyce Adams MD and colleagues as a clinician who has conducted a minimum of 1,000 exams, participates regularly in peer review, attends advanced sexual abuse training every 2 years and has qualified as an expert in the provincial and/or federal court. It is recognized that the volume of sexual abuse patients is much lower in Canada than in the U.S. and as such conducting 1,000 exams is not likely to be achieved by clinicians in smaller communities.

The Network Paediatric Committee has identified the following individuals as expert consultants (see page 11) based on their experience, knowledge and ability to meet the above criteria outlined in the definition of “expert”.

The majority of paediatric sexual abuse and assault examination findings are normal or non-specific. Therefore, when abnormal or concerning findings arise, it is strongly suggested that one review these findings with an expert. Given the medico-legal and child protection implications that may follow an abnormal finding, a second opinion is a critical step in the medical evaluation.

When contacted, the expert consultant will be able to do the following:

- Review the case and images if available
- Provide an opinion, both verbal and in writing, in a timely manner
- Testify in court
- Educate and mentor the referring clinician on the findings.

Depending on what is requested to be reviewed, a variety of tools can be used to facilitate the review. The Telehealth videoconferencing system and web-based conferencing system can be utilized. Once you contact the expert, they can advise you on which system will work best.

It is suggested that the consultant in your particular geographical region be contacted. This is to prevent clinicians having to travel far from their community if their opinion is requested in court.

## Expert Consultant List

### CENTRAL WEST, SOUTH WEST & CENTRAL REGION

#### **Burke Baird, MD**

e-mail: burkebaird@gmail.com

#### **Anne Niec, MD**

Email: nieca@mcmaster.ca

phone: 905-521-2100 ext.73268

call paging 905-521-5030 pager 2637

#### **Michelle Shouldice, MD**

e-mail: michelle.shouldice@sickkids.ca

phone: 416-813-5660

fax: 416-813-5846

page: through switchboard 416-813-7500

#### **Tanya Smith, RN, MN, NP-P**

e-mail: tanya.smith@sickkids.ca

phone: 416-813-6178

fax: 416-813-5846

page: through switchboard 416-813-7500

#### **Karla Wentzel, RN, MN, NP-P**

e-mail: karla.wentzel@sickkids.ca

phone: 416-813-6797

fax: 416-813-5846

page: through switchboard 416-813-7500

#### **Judy Waldman, RN, MN, SANE-A, SANE-P**

email: judy.waldman@sickkids.ca

phone: 416-813-4955

fax: 416-813-5846

page: through switchboard 416-813-7500

### EASTERN REGION

#### **Richard VanWylick, MD**

Email: richard.vanwylick@queensu.ca

Fax: 613-544-3559 (secure office fax)

Phone: 613-544-3400 ext 3359 (answered 9 – 12, M – F)

Page 613-548-3232 (hospital switch board)\*\*

\*\* Ask for Dr. VanWylick to be paged. Need to inform operator that it is related to sexual assault in order for them to put the person through 24/7, whether he is on-call or not.

## Definitions

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### **Child Maltreatment**

The World Health Organization (WHO) defines child maltreatment as “all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power” (2002).

### **Sexual Abuse**

World Health Organization (WHO)

“Involvement of a child in sexual activity that he/she does not comprehend, is unable to give informed consent, is not developmentally prepared for or violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult (or another child who by age or development) who is in a relationship of responsibility, trust or power. The activity being intended is to satisfy the needs of the other person” (1999).

In addition sexual abuse may involve;

- an alleged offender who is known to the child and in a position of trust and/or authority over the child.
- a spectrum of activities with varying levels of intrusiveness: acts of exposure; sexual touching; oral, anal, or vaginal penetration,
- exploitative use of child in prostitution or other unlawful sexual practices,
- exploitative use of children in pornographic performances and materials,
- the use of threats, bribes, force, misrepresentation, or other forms of coercion,
- an ongoing pattern of progressively intrusive acts.

American Association of Pediatrics

“A child is engaged in sexual activities that the child cannot comprehend, for which the child is developmentally unprepared and cannot give consent, and/or that violate the law or social taboos of society” (1999).

### **Sexual Assault**

Involves the same sexual activities, exploitation, coercion, and intrusiveness as sexual abuse, however, the alleged offender may be **unknown** and/or not in a position of trust or authority over the victim. Sexual assault is not limited to a certain age.

## Incidence and Prevalence of Child Sexual Abuse

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It is difficult to get an accurate picture of child sexual abuse statistics due to the significant problem of under reporting. Child abuse is rarely reported at the time that the abuse occurred and many cases are never reported. Most prevalence data come from surveying adults about their past experiences.

A survey of 4,549 children in the United States found that 61% of the participants had experienced at least one direct, or witnessed victimization in the previous year (Finkelhor, Turner, Ormrod & Hamby, 2009). The same study found that 6.1% of children in the sample had experienced sexual victimization.

International studies have reported rates of sexual abuse between 7% and 36% for girls and between 3% and 29% for boys (WHO, 2003). In 2006, the WHO reported that globally, the reported rates for child sexual abuse are 20% for girls and 5% to 10% for boys. There is a high degree of variability in statistics for sexual abuse due to variations in definitions, cultural meaning, levels of surveillance, and awareness in the countries that provide data.

The trafficking of women and children for prostitution is becoming one of the fastest growing areas of international criminal activity. Annually, between one and two million women and children are trafficked worldwide for such purposes according to official estimates (WHO, 2003).

The **Canadian Incidence Study of Reported Child Abuse and Neglect (CIS)** is a national survey of data from child welfare agencies on the reported and investigated cases of child maltreatment in Canada. The CIS provides an analysis of the occurrence of all forms of child maltreatment in Canada, including the circumstances of the children and their families, as well as the services provided by child welfare agencies in response to the reported maltreatment.

The CIS (2003) is the second national study conducted. It is to be updated every five years. It is important to consider this When interpreting the statistics, it is important to consider that the data includes only cases reported to and investigated by child welfare agencies. Many cases of child maltreatment are not reported and therefore the data may capture only a small proportion of the child abuse occurring in Canada.

## **Canadian Incidence Study Findings**

In 2003, an estimated 217,319 child welfare investigations were conducted in Canada, excluding Quebec. Forty seven percent of those cases were substantiated, 13% were found to have insufficient evidence to substantiate but remained suspected and 40% were unsubstantiated. Unsubstantiated should not be interpreted as abuse not having occurred, but rather that sufficient evidence was lacking. Within the substantiated cases of child maltreatment, neglect was the most common form, followed by exposure to domestic violence, physical abuse and emotional maltreatment. Sexual abuse represented 3% of substantiated cases of child maltreatment.

The CIS reported on eight forms of sexual abuse:

- 1) **Penetration:** penile, digital or object penetration of vagina or anus.
- 2) **Attempted Penetration:** attempted penile, digital or object penetration of vagina or anus.
- 3) **Oral Sex:** oral contact with genitals by either perpetrator or by the child.
- 4) **Fondling:** touching or fondling of genitals for sexual purpose.
- 5) **Sex Talk:** verbal or written proposition, encouragement, or suggestion of a sexual nature (included face to face, phone, written and internet contact, as well as exposing the child to pornographic material).
- 6) **Voyeurism:** included activities where the alleged perpetrator observes the child for the perpetrator's sexual gratification.
- 7) **Exhibitionism:** included activities where the perpetrator is alleged to have exhibited himself/herself for his/her own sexual gratification.
- 8) **Exploitation:** included situations where an adult sexually exploits a child for purposes of financial gain or other profit, including pornography and prostitution.

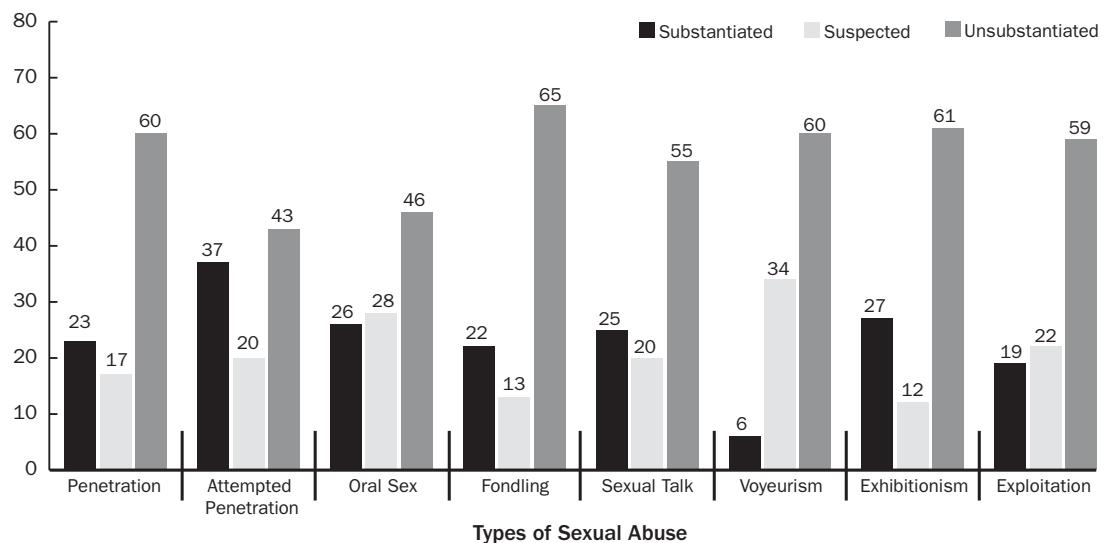
In 2003 an estimated 15,277 investigations of child maltreatment involved sexual abuse as the primary or secondary reason for investigation. Twenty-one percent of those investigations were substantiated, 15% remained suspected and 64% were unsubstantiated. Allegations of sexual abuse that do not involve a caregiver are typically investigated only by police and not child welfare authorities, unless there are concerns regarding the parent(s) ability to protect the child. Therefore the estimates do not include sexual abuse/assaults investigated by police only.

## Further Prevalence Data

In a study using data from the Ontario Health Supplement, a large province wide survey of adults, 12.8% of females and 4.3% of males self reported some form of sexual abuse as a child (MacMillan et al 1997).

Although neither source of data accurately depicts the prevalence of child sexual abuse, this retrospective self report study may be more reflective of the true numbers of sexual abuse.

**Figure 1: Sexual Abuse by Level of Substantiation**



MacMillan, H.L., Fleming, J.E., Trocmé, N., Boyle, M.H., Wong M., Racine Y.A., Bedardslee, WR & Offord, DR (1997).

Prevalence of child physical and sexual abuse in the community. Results from the Ontario Health Supplement. *JAMA*, 278(2):131–135.

World Health Organization (2003). Guidelines for medico-legal care for victims of sexual violence. Gender and Women's Health, Family and Community Health. Injuries and Violence Prevention, Noncommunicable Diseases and Mental Health. Geneva, Switzerland.

Trocmé, N., Fallon, B., MacLaurin, B., Daciuk, J., Felstiner, C., Black, T., Tonmyr, L., Blackstock, C., Barter, K., Turcotte, D. & Cloutier, R. (2005). *Canadian Incidence Study of Reported Child Abuse and Neglect – 2003: Major Findings*. Minister of Public Works and Government Services Canada, 2005.

Finkelhor D, Turner, H, Ormrod, R. and Hamby, S. (2009). Violence, Abuse and Crime Exposure in a National Sample of Children and Youth. *Pediatrics*, 124(1411-1423).

## Child Sexual Abuse Disclosure

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Child sexual abuse often occurs within the context of coercion, secrecy, and shame. Nondisclosure of child sexual abuse is very common. Studies show that the majority of children who have been sexually abused do not disclose in childhood. Victims of child sexual abuse often delay disclosure, deny or minimize abuse even when questioned, and provide disclosures in a tentative or incremental manner over time (Lyon, 2007). Some children who disclose being abused subsequently recant their disclosure.

Nondisclosure of child sexual abuse may be attributed to a number of factors, including:

- feelings of embarrassment or shame
- assumed responsibility or self-blame
- lack of full appreciation for/understanding of what happened
- limited language ability
- protection of the offender or family members
- use of threats, manipulation, or coercion by the offender
- compliance with requests for secrecy from the offender or family members
- anticipated disbelieving/unsupportive response
- fear of negative consequences (real or imagined) for themselves or family members.

Lyon, T.D. (2007). False denials: Overcoming methodological biases in abuse disclosure research. In M.E. Pipe, M.E. Lamb, Y. Orbach, and A.C. Cederborg (Eds.), *Child Sexual Abuse: Disclosure, delay and denial*. Mahwah, NJ: Lawrence Erlbaum Associates.

## **Indicators of Sexual Abuse**

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Current literature suggests that approximately one-third of victims do not show signs of abuse, even when abuse is disclosed (Van Tongeren-Harvey & Edwards Dauns, 2001; Coulborn Faller, 2003). An even smaller percentage have genital findings that confirm the allegation of sexual abuse (refer to chapter 5, interpretations of findings) (Adams, 2004; Adams, Harper, Knudson, & Revilla, 1994; Heger, Tiscon, Velasquez, & Bernier, 2002; Hornor, 2009; White & McLean, 2006).

The signs of sexual abuse and exploitation may vary based on factors such as the victim's age and developmental stage, gender, their experience of abuse, family functioning and community support.

Those who have been sexually abused in any form may show the following signs:

(Van Tongeren-Harvey & Edwards Dauns, 2001):

- Express sexual statements or demonstrate sexual behaviours that are inappropriate for their developmental level
  - For example, when they have not received sex education, are unlikely to have peers who have exposed them to sexual materials, and/or are unlikely to be sexually active (Coulborn Faller, 2003).
- Express sexual aggression towards younger or more naïve children
- Make verbal or behavioral sexual advances towards older individuals
- Engage in promiscuous behaviour as a consequence of their victimization
  - For example, one may have low-self esteem and perceive sex as a way to gain acceptance and acquire relationships (Coulborn Faller, 2003).

### **Non-specific Indicators**

Children and youth who are sexually abused may also show a range of non-sexual signs. However, it is important to note that these signs are not unique to sexual abuse and many of these signs are also attributed to additional types of abuse and/or other medical or mental health conditions. These include but are not limited to:

#### **Physical signs**

- sleeping problems such as insomnia, nightmares or over sleeping
- eating problems such as anorexia bulimia
- bowel and bladder problems, such as wetting the bed, losing control of bowel functions
- trauma to their oral, genital and/or anal areas.

### **Emotional signs**

- becomes quiet and depressed
- isolation
- appears preoccupied
- increased hyperactivity
- increased anxiety

### **Behavioural problems**

- physical aggression
- running away
- suicidal behaviour
- substance abuse

### **Developmental signs**

- lags in cognitive development
- decrease in school performance and grades

Adams, J. (2004). Medical evaluation of suspected child sexual abuse. *Journal of Pediatric and Adolescent Gynecology*, 17(3), 191-197.

Adams, J., Harper, K., & Knudson, S., & Revilla, J. (1994). Examination findings in legally confirmed child sexual abuse: It's normal to be normal. *Pediatrics*, 94(3), 310-317.

Coulbourn Faller, K. (2003). Understanding and Assessing Child Sexual Mistreatment. Thousand Oaks, California: Sage Publications.

Heger, A., Tiscon, L., Velasquez, O., & Bernier, R. (2002). Children referred for possible sexual abuse: Medical findings in 2384 children. *Child Abuse & Neglect*, 26(6-7), 645-659.

Honor, G. (2009). A normal ano-genital exam: sexual abuse or not? *Journal of Pediatric Care*, 23(5), 283-288.

Van Tongeren Harvey, W., & Edwards Dauns, P. (2001). Sexual Offences Against Children and the Criminal Process (2nd ed.). Toronto, Butterworths Canada Ltd.



# Consent

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There are a number of matters related to consent that clinicians must be aware of when evaluating children and adolescents for sexual abuse or assault.

## Consent to Treatment

- Every patient, no matter what age, has the right to informed consent prior to any medical, procedural or forensic treatment.
- The **Ontario Health Care Consent Act (HCCA)** provides the legislative framework for decisions related to consent to treatment.
- The **Ontario HCCA does not set a minimum age** at which a person, including a child, who is capable, can consent to his/her treatment.
- The capacity to exercise independent judgment for health care decisions varies according to the individual and the complexity of the decision being made.
- A person (including children) cannot consent to a proposed treatment unless he/she is capable with respect to that specific treatment.
- A health care professional must determine that a patient is capable of giving consent and must obtain consent from a patient before providing treatment.

The clinician proposing the treatment is responsible for determining if the patient has the capacity to consent to the treatment. If the health care professional determines that the child is incapable with respect to the treatment, then he/she must identify an appropriate **substitute decision maker** (parent/guardian) who can either consent or not consent to the treatment on behalf of the child.

Any patient who is capable of providing consent is also capable of withdrawing consent to the treatment at any time. Ontario HCCA 1996, c. 2, Sched. A, s. 10 (1)

## Capacity

The assessment of mental capacity should not consider chronological age alone. The individual must be able to understand the information relevant to making a decision about the treatment and must be able to appreciate the reasonably foreseeable consequences of a decision. The practitioner must consider maturity and the presence of developmental delay or cognitive disability.

Capacity does not remain static. It can change over time depending on the nature and complexity of the specific treatment decision. What is being determined is whether the patient has the ability to understand the nature and effect of the treatment being proposed, not the overall capacity of the person. Therefore a child may have the capacity to make some treatment decisions but not all. Capacity must be determined for each intervention or treatment. For example, a child may be capable of consenting to some parts of the forensic assessment but not capable of understanding and consenting to other parts that may be more complex.

An individual may have the capacity during an assessment but on another occasion may not exhibit the same capacity. Capacity must be determined for each subsequent presentation for treatment.

A clinician may have both parent and child sign consent as it may offer both a sense of control.

### **Elements of consent**

The following elements are required for consent to treatment:

- the consent must relate to the treatment.
- the consent must be informed.
- the consent must be given voluntarily.
- the consent must not be obtained through misrepresentation or fraud.

Ontario HCCA 1996, c. 2, Sched. A, s. 11 (1)

### **Informed consent**

Informed consent with respect to a treatment requires that:

- the person received the information about the matters that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
- the person received responses to his or her requests for additional information about those matters.

Ontario HCCA 1996, c. 2, Sched. A, s. 11 (2)

The matters referred to in subsection (2) are:

- the nature of the treatment.
- the expected benefits of the treatment.
- the material risks of the treatment.
- the material side effects of the treatment.
- alternative courses of action.
- the likely consequences of not having the treatment.

Ontario HCCA 1996, c. 2, Sched. A, s. 11 (3)

Health care practitioners have no authority to make treatment decisions on behalf of clients, except in an emergency when no authorized person is available to make the decisions.

An emergency is considered to be an experience of or risk of severe suffering or sustaining serious bodily harm if treatment is not administered immediately.

An exam or diagnostic procedure that is a treatment may be conducted without consent if it is reasonably necessary to determine if there is an emergency.

## **Legal Age of Consent for Sexual Activity**

In 2008, an amendment to the Criminal Code of Canada (s. 151) raised the age of consent for non-exploitative sexual activity from 14 years to 16 years (see Chapter 8).

These amendments have included close in age exceptions to the consent defense.

- if the complainant is between 12 and 14 years-old and the accused is:
  - between 12 and 16 years-old and
  - less than 2 years older than the complainant
  - not in a position of authority
- If the complainant is 14 or 15 years-old and the accused is:
  - less than 5 years older than the complainant and
  - not in a position of authority or a caregiver or in an exploitative relationship with the complainant

Further exceptions:

- Marriage exception: 14 to 15 year-old who is married
- Common-Law/Family Exception: 14 to 15 year-old in a common-law relationship

The age of consent for exploitative activity remains the same at 18 years. This means that in order to engage in prostitution or pornography, one must not be under the age of 18 years.

## Confidentiality

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### Release of Personal Health Information

Under the provincial privacy legislation, the Ontario **Personal Health Information Privacy Act** (PHIPA) and the **Personal Information Protection and Electronic Documents Act** (PIPEDA), all patient information is confidential. In order to release any personal health information, a patient or parent must sign consent to release the particular information.

- There may be times when health care practitioners must breach confidentiality due to **mandatory reporting laws** (See Further Mandatory Reporting, Chapter 3, p.28). It is important to explain any limitations of confidentiality at the start of an assessment. Health care professionals must maintain confidentiality unless a mandatory reporting law obligation exists.
- Even under the circumstance of mandatory reporting there are limits to the medical information that can be revealed. Only relevant health care information directly related to the suspicions of abuse may be reported to a child protection agency.
- Consent is not required for providing information to the worker within the child protection agency if the child or adolescent is in their custody.
- Clients have the right to consent to whether information is released to police (unless documents are subpoenaed).
- Adolescents have a right to confidential treatment. This means you may not discuss information with parents or legal guardians unless the adolescent provides consent.
- Adolescents may consent or decline consent to release of their own personal health information.

### Reporting of Communicable Diseases

#### HIV

The Supreme Court of Canada ruled that all people living with HIV have a legal duty to disclose their HIV status before engaging in behaviours that put another person at **significant risk of serious bodily harm**. The Court clearly states that the risk of HIV infection is one of serious bodily harm (Public Health Agency of Canada).

#### Sexually Transmitted Infections

According to the Health Protection and Promotion Act (HPPA), physicians or practitioners must report to the local health unit the suspicion of or confirmation of the following sexually transmitted communicable diseases, in order to monitor the health of the community and to provide the basis for preventive action:

- Chlamydia Trachomatis
- Chancroid
- Gonorrhea
- Hepatitis B & C
- Syphilis

# Reporting Child Abuse and Neglect

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## Child and Family Services Act

In Ontario the criteria for reporting child abuse and/or neglect are governed by the Child and Family Services Act (CDSA).

### Purpose of the Act

The Child and Family Services Act of Ontario provides a range of services for families and children, including children (**under the age of 16**) who may be victims of child abuse or neglect: “The paramount purpose of this Act is to promote the best interests, protection and well being of children,” (CDSA 1990 sec. 1.1). The Act recognizes that we all have a responsibility for the welfare of children.

The CDSA provides a “legislative framework allowing earlier and more decisive intervention into the lives of children where there are **reasonable grounds to suspect** that a child **has suffered** or there is a **risk** that a child is likely to suffer, abuse or neglect” (CDSA 1990 sec. 1.1).

### Child in Need of Protection

A child is considered “in need of protection” if he/she falls into one of the matters under subsection 37(2) of the CDSA.

### Duty to Report

According to the CDSA, “despite the provisions of any other Act, if a person, including a person who performs professional or official duties with respect to children, has **reasonable grounds to suspect** (a child is in need of protection) the person shall forthwith report the suspicion and the information on which it is based to a society” (CDSA, 1990 sec 72(1)).

Reasonable grounds is interpreted as what an average person, given his or her training, background and experience, exercising normal and honest judgment, would have reason to suspect.

Therefore a report of child abuse or neglect need only be suspected. You do not have to know or have proof that abuse has taken place. If you are unsure about whether or not a concern should be reported, it is best to consult with your local child welfare agency or local experts (ie SCAN).

The CDSA, under subsection 72(1), sets out 13 categories, mirroring those of a child in need of protection’ that require a report of the suspicion and the information upon which it is based.

## **Ongoing Duty to Report**

There is also an ongoing duty to report. Despite having previously made a report, if a person has additional reasonable grounds to suspect any of the matters under subsection 72(1), that person must make a further report to the child welfare agency (CDSA, 1990, sec 72(2)).

Although an individual may have made an initial report to the child welfare agency, if further concerning information is known, this must be reported. Many cases of child abuse and neglect are not substantiated. It may be necessary for the investigating agency to compile further evidence.

According to the CDSA **Section 37.2 (c)**, with respect to sexual abuse a child in need of protection is defined as: “the child has been sexually molested or sexually exploited, including by child pornography, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child.”

A report should be made to a child welfare agency when:

- there is a suspicion of sexual abuse of a child under 16 years of age,
- a sexual assault has occurred and there are concerns that the caregiver is not supportive and protective,
- a sexual assault has occurred and there are concerns that the lack of caregiver supervision placed the victim at risk of assault,
- a sexual assault has occurred and the alleged offender is in a caregiving role with other children under 16 years of age.

## **Report Promptly and Directly**

Any person who has a duty to report a suspicion of a child in need of protection must make that report **immediately, without delay** and **directly** to the child welfare agency (CDSA, 1990, Sec 72(3)). A report should not be put off until the next business day. You can contact child welfare agencies 24 hours a day, seven days a week to report suspicions.

## **Failure to Report**

Failing to report a suspicion of a child in need of protection for persons who perform professional or official duties with respect to children may result in conviction of an offence, fine of not more than \$1,000 or reprimand from the professional governing body.

## How to Report Child Abuse and/or Neglect

In Ontario, child welfare agencies may be known by names other than the Children's Aid Society, such as Child and Family Services. Some communities (such as Toronto and Hamilton) have child protection agencies specific to religion and/or culture.

When making a report, determine the geographic location and religion of the child. The appropriate agency will be that which is located where the child lives. If you are uncertain about which agency to report to, contact any child welfare agency for direction.

Once you have contacted the appropriate agency, have the demographic information of the family available. You may want to consider contacting the child welfare agency while the family remains in your care.

Provide only **objective** information related to the child protection suspicions. Personal health information unrelated to the child protection concern remains protected by the PHIPA.

Take direction from the child welfare agency regarding whether or not to advise the family of the referral prior to an investigation commencing. In some circumstances the child welfare agency will not want the family to be aware of the report.

Although a report to the child welfare agency may be made anonymously, as a health care professional you should provide you name and contact information. In many cases the worker may need to contact the referral source for further information or planning.

Remember that child welfare agency workers are not medically trained and therefore you should provide medical information in a clear and concise manner.

## Reporting to Police

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Health care providers must obtain consent to involve police in order to collect forensic evidence (such as the Sexual Assault Evidence Kit) and to release such evidence to the police.

In addition, health care practitioners must receive consent from the client or from the legal guardian to release personal health information to police, **unless** a warrant is obtained or records are subpoenaed.

Release of information requires written documentation of consent (for police, lawyers and non-health professional). This can be provided on a standard 'Release of Information' form.

If it is believed that the circumstances are a violation of a criminal law or statute, it is the responsibility of the child welfare agency to report to the relevant police service. A health care practitioner does not have the authority to make a report to the police without consent of the child and/or family.

A report may be made to police on behalf of the child or adolescent provided they have given informed consent. Clinicians may help facilitate police reporting by explaining the importance of early reporting, assisting in contacting the authorities and providing a private space to do so.

A report to police would be made to the local division/detachment in which the alleged offence took place.

## **Further Mandatory Reporting**

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There are several other circumstances in which clinicians may be obligated to report a concern to the appropriate governing body. It is important for the clinician to inform the child/family of these limitations to confidentiality at the beginning of the evaluation.

### **Interpersonal Violence (CDSA)**

There is evidence that exposure to violence in the family often co-occurs. Exposure to domestic violence may have a severe negative impact on children and is considered a form of emotional maltreatment (Tower 1996, Edleson 2000). The estimated overlap between domestic violence and child physical or sexual abuse ranges from **30 – 60%** (Appel & Holden 1998, Edleson 1999).

\*Exposure to domestic violence is reportable under the CDSA as a form of emotional abuse.

### **Mental Health (Ontario Mental Health Act)**

In some circumstances, it may be necessary to breach confidentiality when there is a concern that a child, adolescent, or parent may be in danger of harming themselves or another person. The Ontario Mental Health Act (MHA) provides a framework under which these concerns may be addressed.

The main purpose of this law is to regulate the involuntary admission of people into a psychiatric facility. The MHA allows for a physician to require that a patient attend a psychiatric facility for assessment under application of a Form 1.

### **Application for psychiatric assessment (Form 1)**

Where a physician examines a person and has reasonable cause to believe that the person, as a result of a mental disorder:

- (a) has threatened/attempted or is threatening/attempting to cause bodily harm to themselves
- (b) has behaved/is behaving violently towards another person or has caused/is causing another person to fear bodily harm from him or her; or
- (c) has shown/is showing a lack of competence to care for himself or herself.

### **Ontario Mandatory Gunshot Wounds Reporting Act**

A health care professional has a legal obligation to report the circumstance of a gunshot wound to the police:

“Every facility that treats a person for a gunshot wound shall disclose to the local municipal or regional police force or the local Ontario Provincial Police detachment the fact that a person is being treated for a gunshot wound, the person’s name, if known, and the name and location of the facility.” (Mandatory Gunshot Wounds Reporting Act 2005).

- Appel, A.E. & Holden, G.W. (1998). The co-occurrence of spouse and physical child abuse. *Journal of Family Psychology*, 12:578-599.
- Edleson, J.L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women*, 5:134-154.
- Edleson, J.L. (2001). Should childhood exposure to adult domestic violence be defined as child maltreatment under the law? Retrieved August 20, 2010 from Minnesota Center Against Violence and Abuse Website;  
<http://www.mincava.umn.edu/link/documents/shouldch/shouldch.shtml>
- Health Care Consent Act:[www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_96h02\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm)
- Criminal Code of Canada: <http://laws.justice.gc.ca/en/C-46/>
- Personal Health Information Privacy Act: [www.elaws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_04p03\\_e.htm](http://www.elaws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm)
- Personal Information Protection and Electronic Documents Act: [www.priv.gc.ca/legislation/02\\_06\\_01\\_e.cfm](http://www.priv.gc.ca/legislation/02_06_01_e.cfm)
- Public Health Agency of Canada: [www.phac-aspc.gc.ca/publicat/ccdr-rmtc/index-eng.php](http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/index-eng.php)
- Child and Family Services Act, R.S.O., 1990, c.11, as amended CFSA s. 71(1): [www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_90c11\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c11_e.htm)
- Children's Aid Society of Toronto: [www.TorontoCAS.ca](http://www.TorontoCAS.ca)
- Ministry of Children and Youth Services: [www.cfcs.gov.on.ca](http://www.cfcs.gov.on.ca)
- Mental Health Act, 1990: [www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_90m07\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm)
- Ontario Hospital Association (2000). Identifying and Managing Child Abuse and Neglect. A Manual for Ontario Hospitals. Ottawa, OHA.
- Mandatory Gunshot Wounds Reporting Act, 2005: [www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_05m09\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_05m09_e.htm)

## Role of the Clinician

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Many clinical service delivery models exist in paediatric sexual abuse/assault. Regardless of whom the clinician is, it is vital that they have appropriate training and continuing education in order to examine, interpret findings, diagnose and treat.

Clinicians providing opinions in paediatric sexual abuse/assault cases should be a:

1. Nurse Practitioner
2. Physician
3. Sexual Assault Nurse Examiner (SANE) with Physician or NP backup/support

These clinicians should:

- have completed comprehensive training in paediatric sexual abuse/assault
- participate in ongoing yearly continuing education
- participate in ongoing review of the literature in the field and be current with new and up to date findings
- have a system to review findings, seek out expert consultation and peer review cases
- collaborate with multi-disciplinary team members
- be available to testify in court
- participate in quality assurance activities.

(Adams et al 2007)

Expert consultants may provide secondary consultations to all clinicians on cases which require

support (see Chapter 1). It is strongly recommended that a secondary consultation be obtained by all clinicians if a “Finding Diagnostic of Trauma and/or Sexual Contact” is found. This is especially important if this finding directly impacts a child protection and/or criminal offence.

Adams, J., Kaplan, RA, Starling, SP, Mehta, NH, Finkel, MA, Botash, AS, Kellogg ND, and Shapiro, RA. (2007) Guidelines for Medical care of children who may have been sexually abused. *Journal of Pediatric and Adolescent Gynecology*, 20(3), 163-172.

## **Sexual Assault Nurse Examiner (SANE)**

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A Sexual Assault Nurse Examiner (SANE) is a registered nurse that has obtained specialized training to provide care for patients who have been sexually assaulted. The training provides the SANE with the skills to conduct an examination for sexual trauma and collection of forensic evidence while also being able to attend to the patients' unique emotional response (Lynch, 2006). SANE training consists of a 40-hour didactic course and a clinical practice component. SANEs must have further specialized training in order provide examination and treatment for the paediatric population.

The **International Association of Forensic Nurses (IAFN)**, through the Forensic Nurse Certification Board, offers the only international certification examination for Sexual Assault Nurse Examiners; SANE-Adult/Adolescent (SANE-A). The SANE-Pediatric (SANE-P) credential is currently offered as a professional certification for sexual assault nurse examiners that care for the paediatric population. SANE certification recognizes that the highest standards of forensic nursing have been achieved. You can become certified by successfully completing the SANE-P examination.

Lynch, V.A. (2006). Concepts and theory of forensic nursing. In: Lynch, V., *Forensic Nursing* (pp. 19-29). St Louis, MO: Elsevier Mosby.

International Association of Forensic Nurses. <http://www.iafn.org/index.cfm>

## Referral Sources

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A suspicion of sexual abuse may be based on:

- Concerns expressed by child's caregiver
- Child's physical symptoms
- Concerning behaviours demonstrated by the child
- Child's disclosure

Unlike adult victims, many children do not present as a medical emergency. Child victims of sexual abuse are brought to the attention of the health care professional through a variety of avenues or circumstances:

- A family may bring a child to hospital for examination and/or treatment
- A physician may refer a child for examination based on concerns raised by the family or based on a disclosure.
- A physician or nurse practitioner may request a further evaluation based on physical examination findings.
- Other professionals (social worker, teacher) may request the evaluation based on behavioural or physical concerns or disclosure.
- A child protection worker or police officer may request an examination when there has been an allegation or report of abuse.

## Community Response Protocols

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Many communities will have developed protocols for investigations of child sexual abuse/assault. These protocols highlight interagency collaboration and commitment and outline the steps to a joint investigation and subsequent referrals to other agencies. It is strongly encouraged that all communities work with necessary stakeholders to develop these protocols. The following is a list of stakeholders/partners that typically participate in these protocols:

- Child Protection Agencies
- Law enforcement
- Medical practitioners
- Mental Health practitioners
- School Boards
- Child victim witness
- Crown attorneys
- Prevention agencies
- Treatment agencies

The City of Toronto Protocol:

Protocol for Joint investigations of Child Physical and Sexual Abuse:

Guidelines and Procedures for a Coordinated Response to Child Abuse in the City of Toronto ©.

Fourth Edition May 2006.

Copies of this document may be requested through BOOST Child Abuse Prevention and Intervention

890 Yonge St., 11th Floor

Toronto, ON M4W 3P4

Tel: 416-515-1100

Fax: 416-515-1227

E-mail: [info@boostforkids.org](mailto:info@boostforkids.org)

## Role of Other Multidisciplinary Team Members

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### Law Enforcement

The police conduct investigations into the allegations of sexual abuse/assault as they pertain to the Criminal Code of Canada. Investigations may be conducted jointly with Child Protection Agencies.

### Child Protection Agencies

Agencies work with service partners and communities to ensure the safety, well-being and stability of children and youth. Community partners such as hospitals, schools, community service agencies and police services, work together with Ontario's Children's Aid Societies to prevent abuse and neglect, improve child safety, maintain children's health and wellness and support and strengthen families to better care for children ([www.oacas.org](http://www.oacas.org)).

### Crown Prosecutor

The Crown prosecutor is a lawyer representing the state. The role of a prosecutor is to bring all of the facts of a case into evidence, not only presenting evidence against the accused. The goal is to get to the truth, not just to prove that a person is guilty.

### Children's Mental Health/Assessment and Treatment Providers

There are many agencies that provide mental health services related to the sexual abuse. Please see Chapter 7 regarding best practices in relation to mental health and assessment and treatment.

### Ontario Victim Services Secretariat

**Victim/Witness Assistance Program:** Provides services for emotional support, preparation for court and referrals to community resources. Clients are referred by police or prosecutor if charges have been laid.

**Victim Crisis Assistance and Referral Service:** Provides immediate crisis support.

Note: Both programs also provide assistance with financial need.

[www.attorneygeneral.jus.gov.on.ca/english/ovss/faqs.asp](http://www.attorneygeneral.jus.gov.on.ca/english/ovss/faqs.asp)



# Sexual Abuse Medical Protocol

## 1. History Taking

- Build rapport
- Use open ended questions
- Explain role to child and family
- Get information from police/child welfare as necessary
- Document all information verbatim as soon as possible
- This is NOT an interview

## 2. Timing Considerations

### & Need for Examination

- Determine need for exam
- Determine need for evidence collection (medicolegal exam)
- Obtain consent for exam and consent for forensics
- Keep in mind that the majority of exams are normal
- SAEK within 72 hours & within 24 hours for the paediatric population

## 3. Physical Examination

- Ensure privacy
- Explain all procedures
- Head to toe
- Genital exam, including hymen

## 4. Forensic Evidence Collection

Conduct according to forensic evidence collection protocol

## 5. STI testing & treatment

- Prophylaxis for STIs, HIV and/or Hepatitis B
- Pregnancy prevention

## 6. Explain Results to Family

Ensure to explain the forensic limitations of examination to families. **Normal or non-specific examination does not mean that something did not happen.**

## 7. Documentation

- Document:
- Date and approximate time of assault
- Who is involved
- Nature of assault
- Injuries present
- Symptoms – physical & psychological
- Interventions done
- Plans
- Discharge

## 8. Reporting & Follow-up

- Re-examination
- Psychological support

## 1. History Taking

**Children should not be interviewed:** Ideally, forensic interviews should be done prior to the medical assessment and/or forensic evidence collection by specially trained investigators such as child welfare workers and/or police.

It is important for medical clinicians to understand the difference between a medical history, taken prior to performing an examination, and a forensic interview.

The purpose of a specialized forensic interview is:

- to establish the child's ability to accurately relate a history
- to enhance communication while reducing suggestibility
- to obtain a detailed description of events (who, when, what, where, how, how many times)
- to avoid unnecessary multiple interviews of the child

The purpose of a medical history taking is:

- to determine the likelihood that a child's signs/symptoms are consistent with sexual abuse
- to establish the type of physical findings that may be present
- to ascertain if a child needs treatment
- to provide information to law enforcement officers, investigative social workers, deputy district attorneys, defense attorneys, and judges about the history and how it relates to the case findings.

### Medical History

Document who provided the history and the following:

- Weight and height
- Significant medical history – conditions, hospitalizations, surgeries
- Current medications – Rx, OTC & herbal
- Known drug allergies
- Immunizations up to date – particularly hepatitis B
- Menstrual history – menarche, FDLMP, regular or irregular, contraception
- Pregnancy history – if relevant
  - Para/gravida, date of birth, normal/abnormal delivery
- Current symptoms – specifically genital/anal pain, bleeding, discharge
  - Behaviour noted by parents – sleep, eating, sexualized behaviour, mood
  - Psychological difficulties – depression, suicidality, etc.
- History of abuse/assault (make all attempts possible not to interview, especially young children if CAS/police have not yet interviewed)
  - Date & time of abuse/assault
  - Pattern (one time vs. repeated over time)
  - Alleged perpetrator

- Anything known about perpetrator risks (STIs, drug user, high risk sexual activity, HIV endemic country)
  - Nature of abuse/assault (fondling, genital to genital contact, oral, vaginal, anal, penetration)
  - Symptoms at time of abuse/assault and since
  - Bathing since abuse/assault

## 2. Timing and Need for Examination

Many referred cases of child sexual abuse do not require a medical evaluation on an emergent basis. In most cases the preferred environment for a child sexual abuse evaluation is in the outpatient clinic setting. This provides a more comfortable environment for both the child and family and allows the involvement of psychosocial clinicians as well as allowing the opportunity to work directly with child protection workers and/or referral sources.

Decisions regarding whether to see a child acutely should be triaged based on the following criteria:

- age of child
- suspected perpetrator (i.e. in caregiving role or not)
- time of alleged assault and of last contact with suspected perpetrator
- type of contact; genital to genital, vaginal and or anal penetration, body fluid exchange
- physical symptoms; bleeding, discharge, pain
- likelihood of evidence collection; within 24 hours of abuse/assault for prepubertal children or within 72 hours for adolescents
- caregiver and/or patient distress level
- ability of caregiver to be supportive/protective

When triaging referrals it is important to speak directly to the person with the most information; this may be police, child welfare worker and/or parent.

## Triage

### Emergent Cases

Should be seen within the same day in emergency department (ED) or clinic:

- child with acute injury or symptoms
  - such as bleeding or pain
- client that may not return next day for medical care
  - such as adolescent with no caregiver present
- need for crisis intervention
  - such as suicidal ideation or attempt, very high level of caregiver stress, etc.

- within approximately 24 – 72 hours of assault if next day will be too late for the following:
  - if CAS/police need information for decision-making
  - forensic evidence collection within 24 hours in prepubertal children, 72 hours in adolescents
  - emergency contraception up to 96 hours since assault
  - HIV PEP up to 72 hours

### **Urgent Cases**

Should be seen within the next business day:

- presence of psychosocial risks
  - high level of caregiver distress
- vaginal discharge
- active investigation with need for urgent examination
  - i.e. other children at risk due to concerns
- for consideration of forensic evidence collection
  - up to 48 hours for paediatric cases
  - up to 72 hours for adolescent population
- for medical treatment
  - emergency contraception up to 96 hours since assault but should be administered as soon as possible
  - HIV PEP up to 72 hours but should be administered soon as possible

### **Elective Cases**

May be seen at next available clinic day:

- No symptoms
- No urgent need for medical evaluation
- No urgent need for psychosocial intervention

\*\*Interview by child protection agency and/or police should occur prior to exam

### **Referral Cases**

Refer to family MD or paediatrician when:

- No clear allegation
- CAS/police not involved
- No investigation underway
- Family needs reassurance

If the child is not seen emergently, team members must speak directly with the caregiver to ensure they understand the reason for the plan, where to come and how to respond to the child in the interim (refer to psychosocial crisis intervention guidelines in Chapter 7).

In all cases, documentation must be provided for the patient chart regarding the interaction with family, police, etc, and the outcome even if the child is not seen emergently.

### 3. Physical Examination

#### **Acute Injury and Trauma Care**

1. First respond to acute injury and trauma care needs. After initial evaluation, management, and stabilization of acute problems, perform the forensic medical examination.
2. Be supportive and empathetic in your approach. Sensitive medical care can:
  - Reduce acute psychological trauma and its aftereffects
  - Support existing and emerging coping skills
  - Set the tone for resumption of normal functioning.

#### **Examiners Approach to Patients**

##### **Upon arrival**

- Provide privacy for patients promptly upon arrival and during all aspects of care.
- Contact the local rape crisis center for a victim advocate to provide immediate and follow-up support for the patient.
- Conduct the examination as soon as possible to reduce fear and trauma and to prevent loss of evidence.
- Provide an explanation to alleviate stress caused by waiting if delays occur.

##### **Prior to the examination**

- Introduce yourself to patients and apprise them of your role.
- Ask patients how they want to be addressed and refer to them by that name.
- Establish a positive examiner-patient relationship.
  - For **male examiners**: consider having a female nurse or female rape crisis center advocate in the exam room for patient reassurance.
- Privately inquire of patients if the presence of a friend, relative, victims advocate, or social worker is desired or not. Let them know in advance that highly personal, sensitive information will be discussed.
- Patients may not fully disclose sexual acts if another person is present (especially with family members)
  - Adolescents, in particular, may want to privately describe the sexual acts and discuss past history without having a parent present.

- Approach and respond to patients in a supportive, nonjudgmental manner.
- Provide supportive interventions that assist patients to regain feelings of safety, control, trust, and positive self-regard.
- Avoid slang terms and inappropriate references.

**A physical exam should never be forced upon a child:** Sedation or anaesthetic should only be used if medically indicated by symptoms such as bleeding or trauma. Consider swab collection and forensic evidence collection prior to the examination. With young children a practitioner may have only one opportunity to collect swabs, therefore preparation is essential.

#### During the examination

- Explain what is being done and why, as well as the reasons for questions asked.
- Inform patients of findings regarding their physical condition as the examination is conducted.
- Ask only what is necessary to collect evidence and to complete a thorough examination.
- Build rapport and lead gradually to sensitive questions.
- Use terminology understood by patients when referring to sexual acts and parts of the body.
- Avoid the appearance of prurient interest or questions about a patient's reasons or motivation such as "Why did you do that?"
- Accept each patient's response as an individual adaptation to a personal crisis.  
Reactions vary from outward calm to strong emotional expression.
- Encourage patients to express feelings, concerns, and needs related to the assault.
- Explicitly acknowledge the sexual assault and its traumatic nature.
- Be patient and allow the patient to set the pace. Never pressure or interrogate the patient.
- Involve patients of appropriate age in decision-making regarding treatment, follow-up care, and notification of family members or others.
- Provide patients with age-appropriate information regarding physical and psychological sequelae to sexual assault.

#### After the examination

- Provide a change of clothing, if needed.
- Explain the examination findings, interpretation and limitations (see Section 6)
- Provide reassurance and support.
- Allow for an opportunity for patient/family to ask any questions.

## **Ensuring Quality of Forensic Medical Examinations**

### **During the examination**

- Ensure that the forensic medical examination is conducted promptly.
- Ensure that the protocol is followed according to the standards set forth in this document.
- Ensure that the reporting requirements to child protection and/or law enforcement agencies are followed (see Chapter 3).
- Explain to patients the steps of the protocol and the reasons for the procedures.
- Ensure that patients receive psychological support during the forensic medical examination.
- Notify and serve as liaison with families and friends, and provide supportive intervention to reduce their stress.

### **Following the examination**

- Arrange follow-up care for treatment of injuries, sexually transmitted infections, pregnancy, forensic follow-up medical examinations and photographs, etc.
- Provide information about crime victim compensation for reimbursement of out-of-pocket medical expenses, lost wages, psychological counseling, and job retraining and rehabilitation services.
- Provide referrals to local rape crisis centers, child sexual abuse treatment programs, local victim/witness assistance centers, available psychological counseling resources, and other needed services.
- Arrange transportation for patients when needed.
- Monitor civil and criminal court subpoenas to ensure patient privacy rights are not violated.

### **Peer Review**

Peer review of photodocumented images of the genital examination including the medical finding/opinion for that examination allows for an objective assessment by another expert clinician.

The main purpose of peer review is to provide a method of quality assurance to build consensus. Peer review also provides the opportunity for knowledge and skill development of sexual abuse examination. All clinicians should develop partnerships with an expert(s) to participate in a peer review program. In the recent *Guidelines for Care of Children Who May Have Been Abused* by Adams, 2007, photodocumentation and regular peer review is strongly recommended.

## Anogenital Examination

For both female and male patients, all parts of the external and internal genitalia should be described. Injury or findings should be noted for type, appearance, location and measurement. If no injury is observed the examiner should document such.

### Clock Face Orientation

When describing the location of injury on the hymen or genital structures, use the clock face orientation as a means of position reference. The location of a finding is designated using the superimposed numerals on the face of the clock. The 12 o'clock position is always pointed up (toward the urethra) and the 6 o'clock position is always pointed down. If the position of the child is reversed the clock face should follow. The position of the patient must be documented when using this description.

### Female

- External genitalia, including public hair and presence of trauma
- Labia majora
- Labia minora
- Urethral opening
- Posterior fourchette
- Fossa navicularis
- Hymenal orifice (vaginal opening)
- Hymenal membrane – configuration, appearance, presence of estrogen, edges & rim
- Perineum
- Anus

Measurement of the size of the hymenal opening should not be performed for forensic examination. Studies have demonstrated that hymenal opening measurements have limited value as measurements vary with anatomy, positioning, state of relaxation or techniques used (Berenson, et al., 2002).

### Male

- Penis – foreskin (circumcized or not), glans, frenulum, corona
- Scrotum
- Testes – descended bilaterally or not
- Urethral meatus
- Perineum
- Anus

## **Examination Considerations**

**Preparing for the anogenital examination:**

- Genital examination should be put into the context of a full head to toe physical examination.
- The examiner should ask the child about their understanding of the reason for the visit/examination.

**Never restrain or force a child to conduct the forensic examination.**

If the child is in distress the exam should be deferred to a later time. The child should be allowed to have as much control over as many aspects of the exam as possible, such as who they would like with them, what toys they want with them, positioning and pace of exam.

Genital examination may be re-traumatizing to a child or adolescent. The exam may be uncomfortable, frightening and reminiscent of the abuse or assault. It is important to prepare the child and family. Examiners should provide a detailed explanation of the procedures and what the child/adolescent may experience as well as accurate information about the reasons for examination. Providing education and information has been found to decrease the child's distress during the examination (Waibel Duncan & Sanger, 1999 & 2004). Using distraction techniques and planning or problem solving to allow the child to control some aspects of the examination has also been found to decrease distress (Waibel Duncan & Sanger, 2004).

**The child/adolescent should be informed that they are allowed to have the examiner stop at any time.**

Waibel-Duncan, M.K. & Sanger, M. (1999). Understanding and reacting to the genital exam: Implications for patient preparation. *Child Abuse and Neglect*, 23(3):281-286.

Waibel-Duncan, M.K. & Sanger, M. (2004). Coping With the Pediatric Anogenital Exam. *Journal of Child and Adolescent Psychiatric Nursing*, 17(3):126-135

## **Positioning for the Genital Examination**

Female genital exam positions:

- Supine frog-leg
- Supine frog-leg in caregiver's lap (as needed to assist in comfort)
- Prone knee-chest
- Lithotomy (for adolescents or larger children)

Anal exam positions:

- Supine
- Prone knee-chest
- Lateral recumbant

Ensure to always document the exam position used and avoid positions that may be reminiscent of abuse. Any abnormal findings noted in the supine frog-leg position should be evaluated and confirmed in the prone knee-chest position.

## **Examination Techniques:**

- **Labial separation**

Gentle separation of the labia

- **Labial traction**

Allows for visualization of the hymen and internal structures

Gently grasp and retract the labia between the thumb and index finger of each hand

Pull the labia downward and outward until hymen is visualized

- **Labial traction – prone knee-chest**

Allows for visualization of the posterior hymen

Gently pull the lower labia majora upward and outward

(not recommended for adolescent patients)

## **Examination with a moistened swab**

A moistened cotton swab can be used on the estrogenized hymen to examine the edges of the hymen. This should not be performed on prepubertal children due to the sensitivity of the hymen.

### **Internal speculum examination**

Internal speculum exams should **never** be done on prepubertal children either in the emergency department or clinic setting. Few adolescents have ever had a speculum exam. The clinician must consider whether initiating an internal speculum exam after a sexual assault is appropriate (i.e. need to test for STI).

### **Examination under anaesthesia**

Consider sedation or general anaesthetic only when medical signs and symptoms indicate the need for exam/treatment and an external exam is not possible or adequate to assess concerns:

- Ongoing bleeding (no external source)
- Suspected foreign body
- Suspected STI when swabs necessary but not able to do speculum exam
- Need for surgical intervention

### **Colposcope**

A colposcope is a binocular instrument used to visualize anogenital structures during sexual abuse evaluations. Each colposcope offers a light source and varying magnification capability, and may also attach to a camera in order to photograph genital injuries.

A colposcope is not necessary to use in the ED setting. A colposcope does not typically provide any additional forensic information. Any abnormal findings can be visualized with the naked eye provided a good light source is used.

Benefit of colposcopy:

- Allows the opportunity for peer review
- Provides research that can be reviewed and replicated
- Attached to camera and video
- Most importantly prevents repeated examinations of victims of sexual abuse or assault

### **Other specialized techniques**

The value of several specialized techniques is debated in the literature. An examiner should assess the benefit of using versus the potential trauma to the child/adolescent by using these techniques.

- Toluidine blue staining
- Foley catheter balloon technique
- Woods lamp

## **Sexual Maturity Rating**

Sexual maturity rating (SMR) is widely used to assess adolescents' physical development during puberty in five stages (from preadolescent to adult). Also known as Tanner stage, SMR is a way of assessing the degree of maturation of secondary sexual characteristics. The developmental stages of the adolescent's sexual characteristics should be rated separately (i.e. one stage for pubic hair and one for breasts in females, one stage for pubic hair and one for genitals in males), because these characteristics may differ in their degree of maturation. Tanner J M. Growth at Adolescents. 2nd edition. Oxford : Blackwell Scientific Publication. 1962, p. 32-38.

### **Males**

#### **SMR      Pubic Hair**

Stage 1	Preadolescent
Stage 2	Scanty, long, slightly pigmented, primarily at base of penis
Stage 3	Darker, coarser, starts to curl, small amount
Stage 4	Coarse, curly; resembles adult type but covers smaller area
Stage 5	Adult quantity and distribution, spread to medial surface of thighs

#### **SMR      Genitals**

	Penis	Testes
Stage 1	Preadolescent	Preadolescent
Stage 2	Slight or no enlargement	Beginning enlargement of testes and scrotum; scrotal skin reddened, texture altered
Stage 3	Longer	Further enlargement of testes and scrotum
Stage 4	Larger in breadth, glans penis develops	Testes and scrotum nearly adult
Stage 5	Adult	Adult

### **Females**

#### **SMR      Pubic Hair**

Stage 1	Preadolescent
Stage 2	Sparse, slightly pigmented, straight, at medial border of labia
Stage 3	Darker, beginning to curl, increased amount
Stage 4	Coarse, curly, abundant, but amount less than in adult
Stage 5	Adult feminine triangle, spread to medial surface of thighs

#### **SMR      Breasts**

Stage 1	Preadolescent; elevation of papilla only
Stage 2	Breast and papilla elevated as small mound; areola diameter increased
Stage 3	Breast and areola enlarged with no separation of their contours
Stage 4	Projection of areola and papilla to form secondary mound above the level of the breast
Stage 5	Mature; projection of papilla only, areola has recessed to the general contour of the breast

## The Hymen

The hymen is a mucous membrane that surrounds the opening of the vagina. The hymen is inset in the vagina and is a collar or partial collar of tissue that provides an anatomic separation between the outer genital structures and the vaginal canal. All female children are born with a hymen. There is a common misconception that the hymen is a covering of the vagina and that it breaks with the first sexual intercourse during adolescence (often referred to as losing virginity). The hymen is not a covering and therefore is not “broken,” neither from intercourse nor from tampons, masturbation, horseback riding, etc. In reality the hymen is a circular (or semi-circular) membrane that always has a central opening except in rare circumstances. Therefore, clinicians should avoid using terminology referring to the hymen as “intact.” It is important to explain this to families early on in the assessment.

The hymen should be examined for any signs of trauma either acute or healed. Examination of the hymen should include an assessment of the configuration, the smoothness of the edges and the width of the rim. Particular attention should be paid to the posterior edge of the hymen from the 3 o’clock to 9 o’clock position.

## Configuration

- **Annular:** Circumferential hymenal membrane tissue that extends completely around the circumference of the vaginal orifice
- **Crescentic:** Hymen with attachments at approximately 11 and 1 o’clock positions without tissue present between the attachments
- **Fimbriated:** Hymen with multiple projections and indentations along the edge, creating a ruffled appearance
- **Septate:** Appearance of the hymenal orifice when it is bisected by a band of hymenal tissue
- **Cribiform:** Hymen with multiple small openings
- **Microperforate:** A hymenal membrane with one small opening
- **Imperforate:** A hymenal membrane with no opening.
- **Redundant:** Abundant hymenal tissue that tends to fold back on itself or protrude.

For pictures, please refer to: [www.healthystrokes.com/hymengallery.html](http://www.healthystrokes.com/hymengallery.html).

### **Effects of Estrogen on the Hymen**

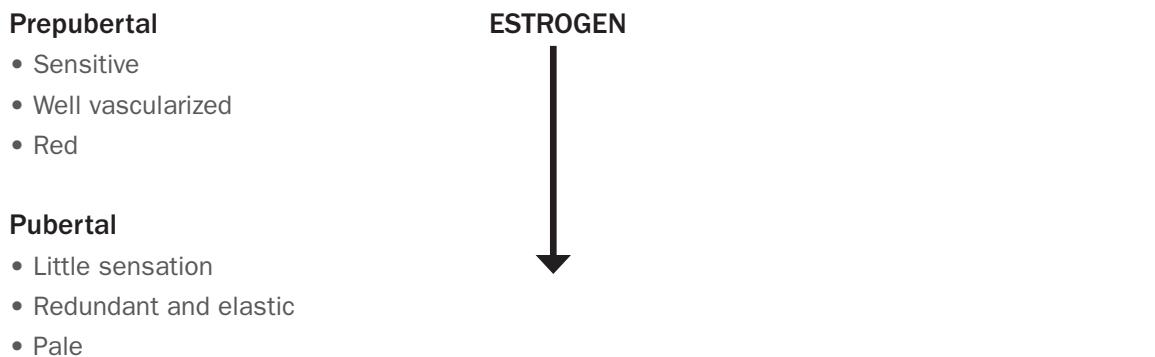
At birth the female infant genitalia is influenced by maternal estrogen. The labia majora will appear full and puffy; the labia minora are significantly thickened and enlarged. The clitoris is often disproportionately enlarged, and the urethral meatus is difficult to visualize. The hymen is thickened and redundant. Hymenal shape in newborns begins as annular and as the estrogen levels decrease, the anterior rim diminishes creating a crescentic shaped hymen (Heger & Emans, 1992).

Estrogen levels continue to decrease; from about the age of 3 until 8 or 9 years the estrogen levels are at their lowest. Lower levels of estrogen create an atrophic effect on the genital tissues. The clitoral hood and the clitoris are less prominent. The urethral meatus may vary in size but is often quite small. The labia majora appear as normal skin and the labia minora become thin. These structures do not provide the same coverage for the vaginal opening as in pubescent females. The vestibular sulcus may appear very erythematous, due to the density of capillaries that surround this area. The thick, redundant hymen now becomes thin and translucent and varies in shape. The pH of the vagina is alkaline and consists primarily of columnar epithelium.

With the onset of puberty the ovaries begin to secrete increasing amounts of estrogen. This causes breast development and enlargement and maturation of the genital organs. Estrogen stimulates the lining of the uterus to thicken. The hymen becomes redundant, elastic and thickened with physiological discharge.

## **Estrogen Changes and the Appearance of the Hymen**

For pictures, please refer to: Lahoti, S., McClain, N., Girardet, R., McNeese, M., & Cheung, K. (2001). Evaluating the Child for Sexual Abuse. *American Family Physician*, 65(5):883-892.



## **Hymenal Development Across the Lifespan**

	Birth	Pre-pubescent	Pubescent	Menopausal
<b>Estrogen</b>	Present	Not present	Present	Minimal
<b>Hymenal Density</b>	Thickened with some translucency	Thin and translucent	Very thick	Thickened
<b>Vaginal secretions</b>	None: Fluid seen may be urine	Slight: Crusted along labial folds	Physiological discharge	Physiological discharge – slight
<b>Vascular</b>	50 – 75% of surface covered from base toward vaginal lumen	Entire surface of the hymen	Less than 25% covered forming corona at attachment (base)	25 – 50% of surface covered from base toward vaginal lumen
<b>Movement</b>	Slightly mobile	None	Fully mobile; redundant, protrudes towards the vestibule	Elastic, not resistant, floppy, folds indicate redundancy
<b>Sensitivity</b>	Variable – touch likely to elicit pain with palpation	Elicits pain with palpation	No pain	Variable – unlikely to elicit pain with palpation

Speck P.,(2003). Pediatric Forensic Nurse Training Guide. Forensic Nurse Examiners. St Mary's Hospital: Richmond Virginia.  
Heger, A., Emans, S., & Muram, D. (2000). Evaluation of the Sexually Abused Child: A Medical Textbook and Photographic Atlas. New York: Oxford University Press.

Rene- Harris, K., (1998). The effect that the following hormones (testosterone, Estrogen and progesterone) have on the human body. Yale-New Haven Teachers Institute. [www.yale.edu/ynhti/curriculum/units/1988/5/88.05.04.x.html](http://www.yale.edu/ynhti/curriculum/units/1988/5/88.05.04.x.html)

Medscape, (2003). Normal Genital Findings. Seminars in Reproductive Medicine, 21(4):329-338.

Lahoti, S., McClain, N., Girardet, R., McNeese, M. & Cheung, K. (2001). Evaluating the Child for Sexual Abuse. *American Family Physician*, 63(5):885.

## 4. Forensic Evidence Collection

Forensic evidence is collected through the use of a **Sexual Assault Evidence Kit** (SAEK). This is typically initiated and collected by a SANE on behalf of the police. Decisions to collect forensic evidence should be based on the case history of the assault/abuse and the age of the victim. Forensic evidence collection may depend upon the time interval between the assault and presentation to a medical facility as well as certain factors that may reduce the likelihood of findings. The SAEK is transferred to the police and submitted to the local Centre of Forensic Sciences Laboratory.

### Timing

The timeframe for the collection of forensic evidence is significantly lower for the prepubertal paediatric population.

- Prepubertal: Up to 24 – 48 (max) hours for all relevant swabs
- Adolescent: Follows the guidelines of the adult SAEK – typically 72 hours.

### Consent

- SAEK is NOT considered a medical treatment
- SAEK does not fall under the HCCA
- No age of consent for the SAEK
- Forensic examination requires consent
- Release of SAEK to police requires consent
- Capability must be assessed

### Differences between adult and paediatric SAEK

- Timing: 48 hrs (max) – prepubertal
- No speculum exam – no internal collection of evidence
- Bloodwork for alcohol not needed
- Prepubertal diagram
- Based on history

### Collection

The possibility of recovering evidence decreases quickly and is unlikely after 24 hours for prepubescent children and after 72 hours for adolescents (Adams, 2008; Christian et al, 2000; Young et al, 2006; Palusci, 2006).

The SAEK is an intrusive undertaking for children so clinicians must consider the likelihood of yielding findings. Swabbing genitals of a recently traumatized child is uncomfortable and should be

avoided if the suspected positive yield is low, as the potential emotional harm to the child by evidence collection may be greater than the likelihood of the benefit.

The Christian et. al. (2000) study found that all of the positive forensic findings in prepubertal victims were collected within 44 hours of the sexual abuse. In addition, after 24 hours, evidence (except one hair) was found only on clothing and/or linen. Given this information, it is important to collect clothing and linen and/or to ensure that the police collect it from the home. The Young et. al. (2006) study supported the findings of Christian and colleagues, reporting that for all positive forensic findings the subject presented within 24 hours.

**A speculum or internal examination should never be performed on prepubertal children in the ED or clinic setting for the purposes of evidence collection.** If there is evidence of vaginal or rectal bleeding, or a suspected foreign body, the exam should be performed under sedation in the operating room. Invasive procedures such as bloodwork should be avoided unless medically or forensically necessary.

### **Procedures**

- Allow the child to have as much control over the procedures as possible.  
Explain each procedure in a manner the child will understand.
- Explain that if at any time they are uncomfortable they may tell the clinician to STOP.
- You may have only a brief window of opportunity to collect evidence.  
Prepare the SAEK prior to examination.
- A clinician should have a systematic routine for evidence collection and follow this routine as much as possible. This allows the clinician to maintain continuity of practice and may serve useful when testifying in court.
- Typically clinicians work head to toe, inward to outwards, with the genital and anal exam conducted last in order to make the client feel as comfortable as possible.

Adams, J. (2008). Guidelines for medical care of children evaluated for suspected sexual abuse: an update for 2008.

*Current Opinion in Obstetrics and Gynecology*. 20: 435-441.

Christian, C., Lavelle, J., DeJong, A., Loiselle, J., Brenner, L. & Joffe, M. (2000). Forensic Evidence Findings in Prepubertal Victims of Sexual Assault. *Pediatrics*, 106(1):100-104.

Palusci, V.J., Cox, E.O., Shatz, E.M. & Schultze, J.M. (2006). Urgent medical assessment after child sexual abuse. *Child Abuse and Neglect*, 30:367-380.

Young, L., Jones, J., Worthington, T., Simpson, P. & Casey, P. (2006). *Archives of Pediatric and Adolescent Medicine*, 160:585-588.

## 5. Sexually Transmitted Infections

Information in the following section is based on the recommended guidelines at the time of publication by the Center for Disease Control (CDC). Please ensure that you remain up to date, as information with regards to sexually transmitted infections is ever evolving. The current Canadian Guidelines on Sexually Transmitted Infections are also a good source for information\*.

Organism	Incubation Period	Transmission	Recommended Treatment (Always refer to CDC Treatment Guidelines)	Approach to interpreting physical & laboratory findings in suspected child sexual abuse**
Gonorrhea	2–7 days	Sexually transmitted Perinatal transmission can be seen in children 0 – 6 months of age	≤45 kg: cefixime 8 mg/kg PO in a single dose (max 400 mg PO) >45 kg: cefixime 400 mg PO single dose	Confirms mucosal contact with infected and infective bodily secretions, contact most likely to have been sexual in nature
Chlamydia	1 – 3 weeks but up to 6 weeks	Sexually transmitted Perinatal transmission can be seen in children up to 3 years of age	≤45 kg: azithromycin 15 mg/kg PO in a single dose (max 1g) >45 kg: azithromycin 1g PO in a single dose	Confirms mucosal contact with infected and infective bodily secretions, contact most likely to have been sexual in nature
Herpes Simplex Virus	2 – 14 days	Sexual & non-sexual transmission must be considered Perinatal transmission can be seen in children up to 3 months old	Refer to current STI guidelines	Indeterminate finding
Trichomoniasis	1 – 4 weeks	Sexually transmitted Perinatal transmission can be seen in children 0 – 6 months of age	Refer to current STI guidelines	Confirms mucosal contact with infected and infective bodily secretions, contact most likely to have been sexual in nature
Human Papilloma Virus	>1 month	Sexual & non-sexual transmission must be considered Perinatal transmission can be seen in children up to 2 – 3 years old	Refer to current STI guidelines	Indeterminate Finding
Syphilis	Up to 90 days	Primarily sexually transmitted Mother-to-child transmission must be excluded	Refer to current STI guidelines	Confirms mucosal contact with infected and infective bodily secretions, contact most likely to have been sexual in nature
Hepatitis B	Up to 3 months	Sexual & non-sexual transmission Mother-to-child transmission must be excluded	3 dose course of hepatitis B vaccine at 0, 1 & 6 mths following exposure HBIG 0.06 ml/kg IM up to 14 days post-exposure depending on immune status and risk	Confirms mucosal contact with infected and infective bodily secretions, contact most likely to have been sexual in nature
Human Immunodeficiency Virus	Up to 6 months, but majority seroconvert within 4 – 12 weeks	Sexual & non-sexual transmission Mother-to-child transmission must be excluded	HIV post-exposure prophylaxis may be considered on a case-by case basis. Consult local expert (and See HIV PEP protocol)	Confirms mucosal contact with infected and infective bodily secretions, contact most likely to have been sexual in nature

\* adapted from the revised version of the Canadian Guidelines on Sexually Transmitted Infections.

Public Health Agency of Canada, 2006 edition.

\*\* Adams, J., Kaplan, RA, Starling, SP, Mehta, NH, Finkel, MA, Botash, AS, Kellogg ND, and Shapiro, RA. (2007)

Guidelines for Medical care of children who may have been sexually abused. *Journal of Pediatric and Adolescent Gynecology*, 20(3), 163-172.

## Relationship of STI to Possibility of Abuse and Reporting Considerations in the Prepubescent Child

STI confirmed	Evidence for sexual abuse	Suggested action (perinatal r/o)
Gonorrhea*	Diagnostic	Report
Syphilis*	Diagnostic	Report
HIV**	Diagnostic	Report
Chlamydia*	Diagnostic	Report
Trichomonas	Suspicious	Report
Condyloma*	Suspicious	Report
Genital herpes	Suspicious	Report***
Bacterial Vaginosis	Inclusive	Medical f/u

\*If not perinatally acquired and rare nonsexual vertical transmission excluded

\*\*If not perinatally acquired or by transfusion

\*\*\*Unless there is a clear history of autoinoculation

Adapted from AAP, Committee on Child Abuse and Neglect. The evaluation of sexual abuse in children. *Pediatrics*. 2005; 116:506-512.

### Sexually Transmitted Infection Testing

Each child should be assessed individually with regards to testing for sexually transmitted infections (STIs). The following situations put the child at higher risk for STI and are indications for testing:

- The child has symptoms or signs of an STI
  - vaginal discharge or pain, genital itching or odour, urinary symptoms, genital ulcers or lesions
- The suspected assailant is known to have an STI or to be at risk for an STI
- Another child or adult in the household is known to have an STI
- The prevalence of STIs in the community is high
- There is evidence of genital, oral or anal penetration

Testing should wait until outside the window of the incubation period (NAATs may be the exception). Prophylaxis may be considered. Do not provide prophylaxis if doing testing.

If testing indicated based on history and timing of visit, perform the following:

### **Gonorrhea (GC) & Chlamydia**

- Cultures have been the preferred method for medico-legal purposes, but Nucleic acid amplification tests (NAATs) may be acceptable if positive results are confirmed by a second set of primers or, in some cases a second test sent to another laboratory
- If both culture & NAAT available do both
- Consider vaginal/cervical, urethral, pharyngeal and rectal sites for testing
- In post-pubescent females cervical specimens should be obtained
- NAATs (depending on specific test) approved for use with the following specimens:  
urine, vaginal/cervical, urethral

### **Herpes Simplex Virus**

- Culture of unroofed vesicles
- PCR (not widely available)

### **Bacterial Vaginosis & Candidiasis**

- Gram stain

### **Trichomoniasis**

- Wet mount and/or culture

### **Syphilis, Hep B, Hep C & HIV**

- Serology
- If testing indicated, ideally, baseline testing done and then repeat testing at 3 – 6 months
- Transmission of Hepatitis C is low via sexual contact
- No need to retest for Hep B if baseline HBsAb  $\geq 10$  IU/L

### **HIV Post Exposure Prophylaxis (PEP) Clinical Guideline for Child/Adolescent Sexual Assault Victims**

The SickKids HIV Post Exposure Prophylaxis (PEP) protocol was developed based on the Ontario HIV PEP study recommendations (Loutfy et al 2005). Infectious Disease and Pharmacy experts were consulted to adapt the protocol to the unique needs of the paediatric population.

The decision to initiate HIV PEP needs to be made in consultation with the patient, family and clinician. HIV PEP should be initiated as soon as possible after an exposure – no later than 72 hours – and continued for 28 days (Havens & Committee on Pediatric AIDS 2003). The patient must have careful follow up for reinforcement of medication adherence, assessment of side effects and monitoring of toxic effects, psychological support and follow up HIV testing.

The strategy used to approach decision making is that of “universal offering” for those who may be at risk. HIV PEP should be offered for any known risk, high or low, or any unknown risk.

### **Counselling**

It is important that clients/parents are provided adequate counselling as ultimately they must make the decision whether to take the prophylactic medication. The following elements should be included in HIV PEP counseling.

- Risk of transmission
- Timing
- Medications – dosing and schedule
- Bloodwork
- Efficacy
- Potential side effects and management
- Potential adverse effects (toxicity)
- Adherence
- Follow-up
- Serial testing

### **HIV Testing**

Baseline HIV testing is required for initiation of HIV PEP as well as subsequent follow up testing. HIV testing requires informed consent. Ensure to follow the policy in the local setting for documentation of consent.

### **Assessment of Risk of HIV Transmission**

The risk of HIV transmission should be discussed with all sexual assault patients based on the known history of assault/abuse. It is important that the patient have a clear understanding of the risk of transmission as it is ultimately the patients/families decision.

Risk assessment is based on two contributing factors:

- the risk that the offender is HIV positive
- the risk of the exposure

#### **High Risk: Strongly Recommend HIV PEP**

HIGH RISK EXPOSURE (anal/vaginal/oral\* penetration\*\*, unknown)

**+**

**HIGH RISK ASSAILANT** (known HIV+ or high risk)

\*victim performed on assailant

\*\*attempted, partial, completed penetration or ejaculation and with or without condom

#### **Unknown Risk: Recommend HIV PEP**

HIGH RISK EXPOSURE (anal/vaginal/oral\* penetration\*\*, unknown)

**+**

**UNKNOWN RISK ASSAILANT** (unknown assailant or unknown HIV status)

\*victim performed on assailant

\*\*attempted, partial, completed penetration or ejaculation and with or without condom

#### **No Risk: Do not offer/recommend HIV PEP**

NO RISK EXPOSURE (no penetration)

**+**

**ANY ASSAILANT**

**Adolescent patient:** HIV PEP offered in the following situations:

- when patient presents within 72 hours (between 72 hours and one week may be considered for high risk situations with appropriate counseling)
- history of anal or vaginal contact with perpetrator's genitalia or body fluids
- possible vaginal or anal penetration with perpetrator with increased risk factors for HIV
- acute genital, anal or oral injuries on examination

**Pre-pubescent patient:** HIV PEP offered in the following situations (must discuss with local HIV (paediatric if possible) expert):

- when patient presents within 72 hours (between 72 hours and one week may be considered for high risk situations with appropriate counseling\*)
- acute genital injuries on examination consistent with penetration
- **clear** history of anal or vaginal contact with perpetrator's genitalia or body fluids
- alleged perpetrator has a reliable history which indicates significant risk of HIV (known to be positive, known to be IV drug user, etc.)

\*If HIV PEP is offered after the 72-hour period patients must be counselled that the efficacy is unknown and that there is no existing evidence to suggest that this will be effective. The more time that passes between the assault and the initiation of HIV PEP, the less likely it is to be effective. According to the CDC, available data does not indicate absolute time of effectiveness nor does it rule out complete ineffectiveness after 72 hours. Decisions to initiate HIV PEP should be made on a case by case basis. A clinician must use their judgement to consider whether the diminished potential benefit outweighs the potential risk of adverse events.

### **Medication**

This protocol uses the combination of Kaletra (Lopinavir/Ritonavir) and Combivir (Zidovudine (Retrovir/AZT)/3TC (Lamivudine). There is no evidence regarding what the optimal medication or combination of medication is for use as HIV PEP (CDC). The standard medications were selected on the basis of adherence, tolerance, toxicity and cost. Alternate anti-retroviral medications may be used in other settings or circumstances.

## **Consultation**

Consultation with a local HIV expert when considering using these medications in the paediatric population is strongly recommended. The use of HIV PEP in this population requires careful consideration, knowledge about the medications and close follow-up.

## **Adherence**

Adherence to the dosing and schedule of HIV PEP is important to ensure the efficacy of the regimen. Many young children may have difficulty swallowing the tablets. Both Kaletra and Combivir are available in a suspension. It is important to note that the Kaletra suspension has a very bad taste and the Combivir suspension is a large amount of liquid. Both may be equally difficult to administer to children.

### **Tips for managing adherence**

- Kaletra is currently available in smaller paediatric tablets.
- Combivir may be crushed and added to food
- OTC medication may be used (i.e. Gravol)

Adherence to the prescribed medications will depend on the involvement of, and support provided to patients and parents or guardians by clinicians.

## **Bill 105: Health Protection and Promotion Act Amendment, 2001**

“An Act to amend the Health Protection and Promotion Act to require the taking of blood samples to protect victims of crime, emergency service workers, good Samaritans and other persons.”

Bill 105 provides the ability to force a person to undergo HIV, HBV, or HCV testing. The law indicates that if “exposure has occurred, and the status of the source person is unknown, non-consensual testing is justified because it will result in peace of mind for the exposed person and allow for timelier and better decisions about post-exposure prophylactic treatment.”

In some circumstances the possibility of testing the offender may impact whether prophylaxis is continued. This can be considered if the offender is known, available for testing (custody/bail) and consents. If the person does not consent, an application may be made to the Medical Officer of Health.

- Loutfy, M., Macdonald, S., Myhr, T., Husson, H., DuMont, J., Balla, S., Antoniou, T., & Rachlis, A. (2008). A prospective cohort study of HIV post-exposure prophylaxis for sexual assault survivors. *Antiviral Therapy*, 13(1), 87-95.
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## HIV Post Exposure Prophylaxis (PEP) Protocol\*\*

### **Initial visit**

- Offer HIV PEP if appropriate based on assessment of risk of transmission.
- HIV PEP medications and side effects discussed.
- Determine whether patient/family wish to proceed with HIV PEP. If yes, continue.
- Clinician to discuss HIV PEP decision with HIV expert.
- Recommendation of medications and doses to clinician.
- Order for inpatient pharmacy to dispense five days medication to child/adolescent.
- Clinician to phone pharmacy and indicate need for meds to be dispensed within one hour.
- Pharmacy to dispense meds as soon as possible.
- On-call phone number and medication information (pamphlet) provided to patient in case of side effects or questions regarding medications.
- Baseline Bloodwork:
  - Urine Beta-HCG (if Tanner 3+)
  - HIV, Hep B&C, VDRL (baseline)
  - CBC & differential, electrolytes, blood sugar, creatinine, urea, AST, ALT ALP, bilirubin, CK, amylase
- Follow up appointment in clinic in 48 hours or next business day arranged.
- Message left for SCAN NP/RN with patient info to ensure follow up.

### **Follow-up**

Follow up in clinic. Joint follow up with local HIV expert should be considered, especially in children under 12 years of age receiving HIV PEP.

#### Rapid HIV Testing of Alleged Perpetrator:

Discuss possibility of this with the police (police/crown to contact alleged perpetrator's legal counsel). Testing of the alleged perpetrator may impact whether prophylaxis is initiated or continued, depending on the situation. Typically, the prophylaxis is started, but may be discontinued if perpetrator tests negative.

Should be considered with each case if the alleged perpetrator:

- is known
- is available for testing (in custody or out on bail)
- consents to have bloodwork done
- If perpetrator does not consent, an application can be made by the victim under Bill 105 for mandatory testing (within 1 week of sexual assault). Please see: [www.health.gov.on.ca/english/providers/legislation/bill\\_105/105\\_phys.html](http://www.health.gov.on.ca/english/providers/legislation/bill_105/105_phys.html)

Procedure for rapid HIV testing:

- 1 clotted sample (in a red top tube) must be obtained.
- The sample should be sent through the provincial public health lab
- A plan for accessing results should be established (consent signed)

### **48 Hour Follow-up**

- Follow up in clinic
- Assess side effects
- Physical exam as appropriate
- Intervention as appropriate
- Prescription/meds provided for nine days
- 2 week follow-up appointment booked

### **1 Week Follow-up (phone)**

- Follow up by clinician
- Assess side effects
- Intervention as appropriate

### **2 Week Follow-up**

- Follow up in clinic
- Assess side effects
- Intervention as appropriate
- Repeat bloodwork: CBC & differential, electrolytes, blood sugar, creatinine, urea, AST, ALT ALP, bilirubin, CK, amylase
- Prescription provided for 1 week supply of medication

### **3 Week Follow-up**

- Follow up in clinic
- Assess side effects
- Intervention as appropriate
- Advise patient to have follow up HIV testing at 3 – 6 months

### **3 – 6 month Follow-up**

- Patient contacted
- Follow-up testing arranged for HIV, Hep B & C, VDRL

\*\*See Appendix A for full protocol

## **6. Explaining Results to Patient/Families**

It is always important to ensure that the results of the examination are explained to the child/youth and their caregiver/family. Ensure that you have received consent from the child/youth about sharing details about the examination with their caregiver/family. While the purpose of the examination is to ensure the overall health and well being of the child and youth, caregivers may have additional questions regarding injury, sexually transmitted infections and long term physical effects.

If the examination results are normal or non-specific it is important to explain to caregivers that these results do not confirm or rule out the sexual abuse concerns that have been raised. Many caregivers may feel that if there are no physical findings then the abuse may not have happened. Discuss why the results are normal or non-specific and address any immediate concerns they may have. It may be helpful to use a diagram of the genital area to explain anatomical structures, especially the hymenal and anal area. It is also important to ensure that further questioning of the abuse should not occur and that direction around questioning the child/youth further should be gathered from CAS/police.

It is important that all caregivers link with a psychosocial clinician to address any immediate emotional concerns. See Chapter 7 for further information.

## **7. Documentation**

The following is a guideline for information and data that should be included in documentation for cases of paediatric sexual abuse. Each individual agency may have a different format, process or tool used for documentation.

### **Demographic Data**

- Name
- Age and DOB
- Gender
- Address and telephone number – is it okay to leave a message?
- Date and time of arrival, examination and discharge
- Who accompanied child
- Family composition – parents, custody or siblings (children of offender?)
- Referral information
- Names of police and/or child protection workers and agencies
- Did you meet alone with the child/adolescent
- Was an interpreter used
- Document consents obtained verbally

In many cases the clinician will be gathering information from child welfare workers and/or police as well as from the family. It is important to document who provided what pieces of information.

### **History of Assault/Abuse**

- Type of abuse/assault
  - touching, fondling, genital to genital, digital/anal/vaginal penetration, oral contact
  - ejaculation and condom use
- Physical symptoms – present now or at time of abuse
  - pain, bleeding, discharge
- Psychological symptoms
- Offender – known, age, risk factors
- Previous contact – single or multiple contact
- Last contact with offender – date, time
- Photos taken, met on internet

### **Disclosure**

- To whom
- When
- How (Context)
- Questions asked
- Verbatim, including questions asked

### **Medical History and Physical Exam**

- Significant medical and/or mental health history
- Immunizations (HepB)
- Allergies
- Medications
- Menstrual history – menarche, LMP, regularity
- Sexual history, when relevant
- Routine physical exam, body maps

### **Genital Examination**

- Positioning
- Techniques, tools, equipment used
- Outside to inside
- Hymen – configuration, estrogen, redundancy
- Penis – circumcision
- Testes – descended
- Anus
- Superimposed face of clock for findings
- Diagrams

### **Treatment, Presentation and Plans**

- Medications/diagnostic procedures
- BetaHCG
- SAEK
- Behaviour/mental health status
- Follow up/recommendations
- Referrals
- Child protection issues, safety issues
- Reports to child protection – agency, worker, recommendations
- Discharge

### **Impression Statements**

- Be careful when writing impression statements or giving opinions
- Should be supported by research/literature
- If writing opinions, one must be up to date on the literature and able to substantiate opinion
- Do not provide if not an expert and cannot back up your opinion

## **Reports**

- Language understandable to the child protection/justice system
- Explain medical terminology
- Provide all possible explanations
- Who was consulted with
- Support with evidenced based research
- References

## **Paediatric Documentation Tool**

- Please see tool developed by The Sexual Assault & Domestic Violence Treatment Program, Hôpital Régional de Sudbury Regional Hospital (Appendix D).

## **Documentation Tips**

- Write clearly and legibly
- Document exactly what information is provided –preferably verbatim
- If a child makes any spontaneous remarks or disclosures document those verbatim
- Document any subsequent responses to the child and the child's exact response
- Avoid misleading terminology (ie ‘alleged’ abuse, ‘refused’ exam, ‘intact’ hymen)

## **Photodocumentation**

Documentation of visual findings is an important component of child abuse evaluation. Apart from careful examination and written documentation, photographs are useful adjuncts to preserve visual findings. These photographs assist clinicians in recalling or re-confirming findings, or in discovering previously undetected results; should a second opinion be required, high quality photographs can be reviewed in lieu of re-examination, thus sparing the child unnecessary trauma.

Further, clinicians may use photographs to illustrate and further clarify their testimony when serving as expert witnesses in court.

Finally, photographs facilitate technical peer review. By obtaining the opinion of experts on difficult-to-evaluate cases, child protection specialists improve their knowledge and skills, benefiting from the experience and expertise of others.

Although colposcopic photography is used primarily to document abnormal findings, it may also be prudent to photograph cases with normal findings for comparative value if the patient is later re-examined.

## **Photodocumentation Guidelines**

These guidelines are developed to outline a suggested standardized approach for the collection, use, disclosure and safe storage of images.

### **Purpose**

- May serve as an adjunct to medical examination.
- Photographs are considered the clearest form of documentation of genital examination findings.
- Photodocumentation may prevent the need for re-examination of the child.
- Review of photos can occur to ensure proper interpretation of findings.
- Photodocumentation is a standard of practice and it is recommended that photos be done of every examination.
- Digital photography (still or video) is currently preferred because of the rapidity of the development of images, and copies of images, and the ability to check the quality of photodocumentation at the time of the patient visit. If the digital photography system is unavailable or inoperable, the backup 35 mm system may be utilized.
- The images create a baseline for comparison if the child is examined at a later time.
- Photos can be used to reassure the child/adolescent and parent(s) regarding physical findings.
- Quality photographs can benefit legal proceedings by helping the medical provider explain the anatomy and physical findings.

### **Consent**

- Photographic images are considered Personal Health Information (PHI) under the Personal Health and Information Protection Act 2004 (PHIPA).
- Consent is required for the collection, use and disclosure of personal health information. Every reasonable effort should be made to obtain consent when possible.
- Children/youth and caregivers always have the right to refuse photos.

### **Taking Photos**

- Clear description of the equipment should be described to the child/youth & caregiver.
- Photos should be done simultaneous to the genital examination to avoid multiple exams.
- External photos should include a minimum of: one photo with labial separation in supine position, one photo with traction in knee chest position and one photo of the anal area.
- If findings are present, more photos at different magnifications may be necessary.
- Compose the picture the way you normally look at the area.
- To avoid distortion, take photographs head-on so that the surface to be photographed is perpendicular to the camera and at the same level.
- Use an uncluttered, neutral-coloured background. Skin is best photographed against a blue background.

- Use a color wheel for color comparisons of the injury when possible. Take a photograph with the color wheel in the photo.
- Photograph transfer evidence that may be present on the body or clothing, such as dirt, gravel or vegetation.
- Ultraviolet light may be helpful for photographing injuries.

### **Storage**

- Collaboration with the hospital health records department should occur to decide where the photos should be stored and how access is obtained.
- All photos taken with a digital camera should be downloaded onto a password secured server or a password protected CD ROM.
- All CD ROMS should be locked in a cabinet.
- Photos should be downloaded after each patient and recorded in a log.
- No photos should be deleted, including blurry or poor quality photos.
- Files should be identified with child's name or medical record number and the date on which the photos were taken.

### **Access**

- An access log should be attached to the photos to document who has accessed the photos at all times (to ensure continuity of evidence).
- Never send original photos, always ensure a copy is taken.
- Permission from family should be obtained before sending out the photos.
- If photos are requested in court it is strongly recommended that photos be accompanied by a clinician who can interpret the findings.

Request for photos may be made by the following:

- MD consultant for a second opinion
- Law enforcement and crown attorneys with a subpoena

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## **8. Reporting and Follow-up**

Ensure all reporting obligations are addressed. See Chapter 3 for reporting considerations.

Follow up phone contact with the client or family is recommended. This follow up should include assessment of any further symptoms, assessment of psychological impact such as trauma symptoms, family functioning, need for counseling services or other services as well as provision of support.

A child or adolescent should be referred for a follow up appointment for re-examination when injuries or a finding that requires reassessment were present on the initial examination.

Clients taking HIV PEP should have follow up as outlined in the HIV PEP Protocol. In the case of children and adolescents taking HIV PEP, families may require extra support through phone contact to ensure continued adherence.

Families or clients who may need further psychosocial support should be offered follow up for social work assistance.

## Growth and Development Fundamentals

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### Infant, Toddlers and Preschoolers

Age	Gross Motor	Fine Motor	Social	Language	Self-Help
2 mo	Head sustained in plane of body on ventral suspension; holds head steady when held sitting; head lags on pull to sit position	Holds objects put in hand; hand regard; follows moving object 180°	Recognizes mother/primary caregiver, listens to voice and coos	Makes sounds "ah", "eh", "ugh"; laughs	Reacts to sight of bottle or breast
6 mo	Rolls over from back to stomach	Transfers objects from one hand to another	Reaches for familiar persons	Babbles, responds to name; truns and looks	Looks for objects after disappears from sight
12 mo	Climbs up on chairs or other furniture; walks with one hand held; "cruises"	Turns pages of a book a few at a time	Imitates simple acts. i.e. hugging or loving doll; plays simple ball game;	Says one word clearly; points in response to word	Removes socks
18 mo	Sits on a small chair; walks up stairs with one hand held; kicks a ball – good balance and coordination; explores drawers and waste baskets; moves toys into and out of container	Builds tower of four or more blocks; scribbles, imitates vertical stroke; dumps small object from bottle	Sometimes says "no" when interfered with; kisses parent with pucker;	Uses five or more words as names of things (ie. Water, cookie, clock); follows a few simple instructions; identifies one or more aprts of body; follows two-step command	Feeds self; eats with a fork; seeks help when in trouble;
24 mo	Runs well; walks up and down stairs, one step at a time; opens doors; climbs on furniture; throws ball; kicks ball	Builds tower of six cubes; performs circular scribbling; imitates horizontal stroke;	Often tells immediate experiences; listens to stories with pictures	Puts three word together (subject, verb object); knows "I"; points to appropriate picture when someone says "show me the dog"; has expressive vocabulary of 50-250 words	Handles spoon well; helps to undress
36 mo	Goes up stairs alternating feet; rides tricycle; stands momentarily on one foot	Builds tower of nine cubes; copies circle, imitates cross	Plays simple games (in "parallel" with other children)	Knows age and sex; counts three objects correctly; repeats three numbers or sentence of six syllables; expressive vocabulary of over 1,000 words; remembers some recent past events	Toilet trained; helps in dressing; washes hands
48 mo	Hops on one foot; throws a ball overhand; uses scissors to cut out pictures; climbs well	Imitates construction of "gate" of five cubes; copies cross and square; draws person with two to four parts besides head;	Plays with several children – beginning of social interaction and role-playing	Counts four pennies accurately; tells story; asks many questions; uses four-to-five word sentences; uses plurals; can repeat three or four numbers; knows four colours	Uses toilet alone
60 mo	Skips	Draws triangle from copy; can name heavier of two weights	Asks questions about meaning of words; participates in domestic role-playing	Repeats sentence of ten syllables; counts ten pennies correctly; follows three-part instructions; 80-90% of what he or she says is understood by people outside of family, uses I, me, you, he, she, her, & him properly	Dresses and undresses

## School-Aged Children

Age	Gross Motor	Fine Motor	Language (receptive and expressive)
5 years	Balance on one foot for 10 seconds or longer and skip, alternating their feet	Hold a pencil in a mature tripod pencil grasp and cut along a line fairly accurately	Defines words by use (ie. Ball, lake, hat) ("What is a ball?" "You throw it"); Indicates understanding of concepts by pointing to appropriate pictures or lining up blocks to indicate knowledge of centre, widest, nearest, forward, first, beginning
6 years	Able to do a smooth forward heel-toe gait easily		Sentence structure is usually grammatically correct; few if any articulation errors; defines words by use, category, composition (ie. Orange, envelope, puddle); knows right from left; understands yesterday vs. tomorrow, more vs. less, several vs. few, most vs. least; can state differences (ie. between dog and a bird)
7 years			Defines words: football, tiger. Can state similarities and differences
8 years			Defines words such as eyelash, tap, roars, Mars; recites days of the week in order; states similarities and differences
9 years			Understands absurdities in sentences ("The mans feet are so big he has to pull his pants over his head")
10 years			Understand the meaning of words such as curiosity, grief, surprise

## Adolescents

Task	Characteristics	Health Care Needs
<b>10 – 14 year olds</b>		
Puberty	Wide variation in rapid physical changes, self-consciousness	Confidentiality, privacy
Independence	Ambivalence	Support for growing autonomy
Identity	Am I normal?; peer group	Reassurance and positive attitude
Thinking	Concrete operational; egocentric; imaginary audience; focus on present	Emphasis on immediate consequences of actions
<b>15 – 17 year olds</b>		
Puberty	Females ahead of males; chronic illness may delay puberty	Emotional support for adolescents who may vary from "normal"
Independence	Limit testing; non-compliance; "experimental" behaviours; dating	Consistency; limit setting
Identity	Who am I?; introspection; global issues	Non-judgmental acceptance; gentle reality testing
Thinking	Concrete → formal operational; personal fable; experiments with ideas	Problem solving; decision making; education
<b>18 – 21 year olds</b>		
Puberty	Adult appearance; slow change	Minimal needs except in chronic illness
Independence	Ambivalence about real independence, separation/individuation from family	Support
Identity	Who am I with respect to others, sexuality, education, job?	Encouragement of identity allowing maximal growth
Thinking	Formal operational; contemplation of future; introspection; commitments	Approach as adult, but recognize that adolescent still changing

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## **Developmental Considerations in Building Rapport**

### **Infants**

#### **Challenges**

- Communication
  - unable to provide history
  - crying
- Limited comprehension
  - unable to understand examination and follow instructions
- Squirmly
  - unlikely to lie still
- Stranger anxiety, 6 – 12 months
  - reluctant to have exam

#### **Tips**

- Warm the stethoscope and your hands
- Keep a hand on infant at all times in order to prevent falls!
- Leave intrusive parts of the exam until the end i.e. ears, mouth

### **Toddlers**

#### **Challenges**

- Communication
  - unable to get clear history
- Active and explorative
  - likely to protest remaining still for examination
- Wary of strangers (that's you) and separation from parents
  - likely to be reluctant to be examined
- Noncooperative!

#### **Tips**

- Develop rapport
  - join in an activity child is engaged in
  - comment on clothing or toys
  - stickers
- Get down to child's level – sit or kneel
- May need to examine in parent's lap
- Allow exploration
  - stethoscope, lights, etc.
- Least intrusive parts of exam first

## Preschoolers

### Challenges

- More communicative
  - can articulate displeasure with exam

### Tips

- Develop rapport
  - comment on clothing or toy
- Let child see medical equipment
- Offer choices i.e. "which ear should I examine first"
- Explain as you go
- Demonstrate on parent, doll etc.

## School age

### Challenges

- Shyness
  - more concerned about privacy
  - new experience
  - understand gender difference

### Tips

- Develop rapport
  - ask about friends, school, activities
- Explain examination clearly
- Respect privacy
  - draping
  - changing alone
- Be aware of who child wants in room

### General Tips

- Narration during examination, what you are doing, if everything looks normal
- Explain results and ask for questions
- Discuss common concerns, even if question wasn't asked
- Identify yourself, and explain that you are here to help
- Ask the child the reason for coming to the hospital
- Establish rapport with the child
- If you need to ask questions, use open ended, not leading questions

## Adolescents

### Developmental milestones

- Embarrassment
  - may not voice concerns
- Common concerns:
  - body image – can anyone tell what happened?
  - being different
  - infection/pregnancy
- Struggle for autonomy:
  - Privacy important, confidentiality issues

## Challenges

- Privacy and confidentiality
- Recent trauma
- May have preference for gender of examiner
- Sexual maturity
- Questioning sexuality
- Involvement with gangs
- Substance use
- Conflict with family
  - move from family to peers for socialization and support

## Tips

- Separate from parent/caregiver
- Develop rapport
  - explain examination and your role
  - identify yourself and explain that you are here to help
  - discuss confidentiality and its constraints
  - obtain consent
- Narration during examination
  - what you are doing and whether everything looks normal
- Explain results and ask for questions
- Discuss common concerns, even if question wasn't asked
- Ask the teen their reason for coming to the hospital
- If you need to ask questions, use open ended, not leading questions
- Do not treat them as a child
- Respect decisions of the adolescent

## Special Considerations

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### Drug Facilitated Sexual Assault

Drug facilitated sexual assault (DFSA) refers to any circumstance in which a sexual assault is facilitated by taking advantage of someone who is incapacitated by drugs and/or alcohol.

DFSA can occur by:

- Intentional drugging of a victim (often referred to as “date rape”) unknown to the victim
- Providing a victim with excessive amounts of alcohol or drugs
- Self-induced intoxication by consuming too much alcohol and/or drugs

Regardless of the method of intoxication (self-induced vs drugging), a person that is intoxicated cannot consent to sexual activity.

Tolerance varies: what may be too much alcohol/drugs for one person may not be the same for another. Therefore, assess on an individual and case-by-case basis.

#### Prevalence:

- Approximately 21% of women report that drugs were a factor in a sexual assault  
(DuMont, McDonald et al 2009)
- The most common “date-rape” drug is alcohol.

It is believed that the majority of DFSA cases are not reported to police. Possible reasons include:

- The drugs used cause memory loss and victims may be uncertain as to whether they were assaulted.
- A concern that police will not believe them or blame them.
- Some victims want to forget it occurred and put the situation behind them.
- Feelings of self-blame, fear and shame.

### Drugs Used In DFSA

#### Depressants

- Alcohol\*\* & GHB\*\*

#### Stimulants

- Ketamine, MDMA (ecstasy), Cocaine\*\*, Amphetamines

#### Hallucinogens

- Cannabis\*\*, PCP, Crystal Method, LSD, Benadryl, Gravol/Dramamine

#### Barbiturates (sedatives)

- Phenobarbital

## **Analgesics**

- ASA, Tylenol and Advil, Morphine

## **Psychotropic Meds**

- Benzodiazepines\*\* (Rohypnol, Clonazepam and alprazolam), Tricyclic antidepressants

\*\* Most common drugs used in DFSA

## **Options for Care**

### **Medical Care**

- Head to toe physical exam including oral, vaginal and anal exam to look for injury
- Hospital toxicology to detect potential drugs that remain in the system (48 hour time limit for blood and 72 hours for urine)
- Document details of DFSA
- Prophylactic medications

### **Forensic Care**

- SAEK that collects blood up to 48 hours and urine up to 72 hours, as well as any forensic evidence relevant to the case history that can be released to police

### **Relevance to Practice**

These cases are often challenging for clinicians as clients typically expect the clinician to provide them with information as to what happened to them and if drugs were used. Many drugs have short half-lives and are cleared from the system before an opportunity to collect a sample for toxicology testing. Therefore, clients may leave with questions unanswered. In light of this concern, particular attention should be paid to the need for accurate documentation of what the client reports, symptoms and mental state, speech, gait and ability to recall. Finding injuries on the body or genitals may add evidence to their suspicions but a clinician may not be able to conclude whether a sexual assault has occurred.

### **Toxicology Testing**

If DFSA is suspected, urine and blood for toxicology should be obtained as soon as possible. Drugs used to facilitate sexual assault metabolize quickly. Urine samples detect metabolites and can be used beyond the time frame for blood samples. Substances used in DFSA are typically not detected after 8 – 12 hours. Rohypnol is rarely detected beyond 24 hours and GHB is only detectable within 6 – 12 hours. (Hornfeldt, Lothridge & Upshaw-Downs, 2002). Tests include:

- Broad spectrum drug screen
- Sensitive drug screen (sensitive benzodiazepines, Rohypnol, GHB)

Many facilities outside of major urban centres do not have the facilities to test for substances used in DFSA. Very few labs have the facilities for sensitive drug screening. Please contact your local lab and inquire about the process for toxicology testing.

### **Unconsciousness**

If a client presents as unconscious as a result of intoxication, any emergent medical intervention may be addressed but forensic assessment and collection of evidence must be deferred to a time when the victim is able to provide informed consent for those procedures (see Chapter 3).

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## **Internet Sexual Exploitation**

The existence of child sexual abuse images/videos is an additional form of victimization that children who have experienced sexual abuse may face. The Internet has become a vehicle in which child sexual abuse images are made and distributed across the world. As medical practitioners, inquiry into the possible creation of images or use of images for purposes of grooming is important. This should be done in collaboration with law enforcement. In all sexual abuse cases, questions related to the use of cameras, computers, cell-phones, exposure to pornography or online contact with alleged offender should be explored. If sexual abuse images of a child have been found, it is important to work with law enforcement to determine the type of contact seen on the images as this will influence the medical examination.

In addition, children and youth may have been sexually assaulted by individuals who have lured them online. Inquiry into how they met the alleged offender would be critical for a police investigation. Always work collaboratively with police to address these issues.

Cybertip: [www.cybertip.ca](http://www.cybertip.ca)

Media Awareness: [www.media-awareness.ca](http://www.media-awareness.ca)

## Psychosocial Considerations

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### Impact of Child Sexual Abuse

Sexual abuse may interfere with a child's normal developmental trajectory. Child sexual abuse has been associated with adverse short-term and long-term outcomes in cognitive, behavioural, affective, physical, and interpersonal domains (Kendall-Tackett, Meyer-Williams, & Finkelhor, 1993; Putnam, 2003). There is no one symptom or cluster of symptoms that characterize the majority of child sexual abuse victims. There is considerable variation in the frequency, intensity, and duration of symptom presentation. Most symptoms are non-specific for sexual abuse and may also be related to other forms of trauma.

Possible impact of child sexual abuse includes:

- sadness/depression
- fear/anxiety
- anger/aggression
- affect dysregulation
- disruption to sleeping/eating patterns
- nightmares
- irrational beliefs/cognitive distortions (e.g. self-blame, overestimation of danger, mistrust)
- sexualized behaviour
- regressive behaviour (e.g. enuresis, temper tantrums, difficulty separating/clingy)
- oppositional behaviour
- low self-esteem/negative self image
- self-destructive behaviour (e.g. self-injury, substance use)
- suicidality
- poor social skills
- school difficulties

Post-traumatic stress reactions include:

- re-experiencing (e.g. recurrent, intrusive thoughts/dreams, intense physiological/psychological distress upon exposure to internal or external reminders)
- avoidance (e.g. emotional numbing, avoidance of thoughts, feelings, conversations, people, places, situations that remind of traumatic event, lack of interest/participation in activities, detachment from others, restricted range of affect, dissociation)
- hyperarousal (e.g. difficulty falling/staying asleep, irritability/angry outbursts, difficulty concentrating, hypervigilance, heightened startle response, night terrors, separation anxiety)

Not all children who are victimized are traumatized. A significant proportion of children demonstrate highly resilient responses. The impact of child sexual abuse may be mediated by a number of overlapping variables, including:

- abuse-related factors (e.g., severity, duration, age of onset, use of force, relation to offender)

- child-related factors (e.g., attributions, coping style, cognitive functioning)
- environment-related factors (e.g., family response/functioning, system response, elapsed time, treatment)

## Supporting the Non-Offending Caregiver

The disclosure or discovery of child sexual abuse is often experienced as a crisis impacting many aspects of a family's life. The implications for the child's non-offending caregiver(s) are significant. They may experience a range of emotions, including shock, disbelief, confusion, anger, sadness, worry, shame, and guilt. Possible consequences for non-offending caregivers include:

- loss of financial resources, employment, residence, family/social support, relationship with the offender
- symptoms of post-traumatic stress, depression, anxiety, general psychological distress

The post-disclosure response of a non-offending caregiver exists on a continuum of belief, support, and protection, which are overlapping constructs (Alaggia, 2002; Bolen, 2002). There is an extensive body of theoretical, clinical, and empirical literature that suggests a child's adjustment following sexual abuse is strongly associated with their caregiver's response and the support received (Elliott & Carnes, 2001). A supportive non-offending caregiver response has been associated with more positive child outcomes, including:

- fewer symptoms of general distress
- decreased depression
- decreased anxiety
- increased self-esteem
- decreased aggression
- fewer behavioural problems
- increased social competence
- better school performance
- more positive treatment outcomes
- decreased likelihood of recantation
- increased likelihood of prosecution
- decreased likelihood of apprehension/out of home placement

Interventions targeting non-offending caregivers in the aftermath of child sexual abuse are critical. Caregivers who receive support are shown to be:

- less distressed and more supportive of their child
- less likely to have their child placed in foster care
- less likely to exhibit parental dissatisfaction
- more likely to have their child benefit from treatment (decreased symptoms in child)

The following information may be helpful for non-offending caregivers:

- role of child welfare, police, healthcare, legal system/court process
- prevalence and dynamics of child sexual abuse
- children's disclosure patterns
- short-term and long-term impact of sexual abuse on the child and mediating variables
- how to recognize and respond to trauma symptoms in the child
- importance of a supportive post-disclosure caregiver response to a child's recovery
- effective caregiver response strategies and common stress reactions
- adaptive coping mechanisms
- sexual abuse prevention education
- community resources

## Trauma Assessment/Treatment

While not all children who have experienced sexual abuse will require intensive therapy, a comprehensive and careful trauma assessment by a mental health professional is critical to identifying treatment needs and optimal treatment planning. Evidence-based trauma-focused therapy with a structured, phase-oriented approach has been reported to be the most appropriate type of treatment for children who have been sexually abused. According to the *Child Physical and Sexual Abuse: Guidelines for Treatment* (Saunders, Berliner, & Hanson, 2004), Trauma-Focused Cognitive Behavioural Therapy is among the intervention protocols with the greatest level of theoretical, clinical, and empirical support and emerged as clear best practices in the field of child abuse treatment. Involvement of caregivers in the treatment process is essential.

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## Mental Health Assessment and Crisis Intervention

### Psychological Crisis

Psychological crisis is defined as a condition where the person experiences a level of psychological pain that exceeds their ability to cope/adapt effectively. This imbalance between psychological pain and coping skills is often referred to as **disequilibrium**.

The immediate response to a crisis is highly variable, often difficult to assess and may not be recognized by the client. A clinician may observe this psychological pain as behavior and/or affect changes. It is important for clinicians to assess the impact or seriousness of the psychological pain in relation to the degree of a client's disequilibrium. This assessment forms the basis for **risk assessment**. Risk assessment involves assessment of the impact of disequilibrium through assessment of a client's coping/adaptation mechanisms. It is critical for a clinician to recognize when a psychological crisis may become a **psychological emergency** (where there is an imminent risk of harm).

### Coping/Adaptation Mechanisms

**Internal coping mechanisms:** are everyday behaviours, under normal circumstances that one uses to relieve stress. Assessment involves knowledge of a client's general psychological disposition and developmental age.

**External coping mechanisms:** are those that depend on supporting relationships with others. For many clients this will include parents, family and friends however may also include other caregivers, counsellors, clergy, teachers. This type of coping mechanism is particularly important to the developmentally young.

Remember:

- Individual in supportive relationship to the client may also be in state of crisis
- May contribute to the psychological pain of the client
- **Active** – directs their own symptoms at the client (anxiety, agitation, depression)
- **Passive** – their own crisis interferes with their ability to act effectively

Supports:

- Family (parent-child relationship, parent functioning, communication styles, sibling support, boundaries)
- Society (friends, school, church, community groups, CPS, LE, HCP, cultural differences)
- Supportive person may not always be a family member... peer, cousin, teacher etc.

#### Protective Factors:

- Presence of a supportive, positive relationship with a non-abusive parent or sibling
- Stable living environment
- Socioeconomic status

(DuMont, Spatz, Widom & Czaja 2007)

#### Crisis Intervention Strategies:

- Rapport building
- Effective communication
- Active listening
- Remaining calm
- Support
- Correct cognitive distortions
  - self blame
  - overestimation of danger
  - differentiation from caregivers own sexual abuse
- Provide information/education
  - systems/investigative process
  - impact of sexual abuse
  - caregiver response strategies
  - resources
- Follow up

#### Effects of Crisis Intervention

- Implementing social supports and safety can reduce long lasting effects of trauma.
- Sharing thoughts and feelings with others can reduce trauma symptoms.
- Professional help to confront memories can reduce the frequency and severity of trauma symptoms

#### Tips:

- Reassure them that it is not their fault!
- Make them feel **SAFE!**
- Be supportive
- Be nonjudgmental (verbal & nonverbal)
- Be accepting
- Most important step is to return control to the patient
- Do not avoid embarrassing subjects
- Reassure the child that you believe him/her and are proud of them

DuMont, K. A., Spatz-Widom, C., & Czaja, S. J. (2007). Predictors of resilience in abused and neglected children grown-up: the role of individual and neighborhood characteristics. *Child Abuse & Neglect*, 31, 255-274.

## **Common Adolescent Issues**

There are several unique challenges encountered by adolescents as a result of sexual victimization.

Many adolescents are concerned about the reaction of their parents to a disclosure of a sexual assault. Common concerns involve, anger, disbelief, blame and religious or cultural beliefs. Although not every adolescent will express these concerns, it is important for a clinician to assess for their presence.

### **Blame/anger**

In many cases a caregiver may express anger attribute blame toward an adolescent for having put themselves in a high risk situation however the adolescent may attribute this anger toward themselves. Clinicians should address these cognitive distortions and involve parents in discussions about attributing responsibility to the offender.

### **Virginity**

A common concern for many cultures is that of virginity. A clinician should assess for the value and meaning of this state for a given culture. Providing education about anatomy and physiology can mitigate this issue.

### **Stigma/Fear of retribution**

Adolescents may have been assaulted by peers whom they know and/or peers may be aware of the assault. A common concern for adolescents involves the stigma of returning to school or a neighbourhood where peers will be. Clinicians should address this concern through education and support. It is important to remember that many clients may fear retaliation as a result of reporting. This may be a real fear for many youth and should be respected by clinicians.

### **Self harm**

There are many reasons why adolescents may engage in self injurious behaviours:

- Provides temporary relief from intense negative feelings. Pain reduces level of emotional and physiological arousal
- Relieves anger unable to express outwardly
- Expression of emotional pain
- Validates emotional pain
- Continues abusive patterns
- Means of punishing oneself
- Exertion of control over their body
- Avoids suicide and escapes numbness
- Obtain a euphoric feeling
- Grounding in reality (dissociation, depersonalization)

### **Assessment**

- Understand why individual self harms, what it does and what it means to them
- Self-injurious behaviours may occur on a recurring or even chronic basis
- May or may not be associated with intent of suicide
- Understand the context in which thoughts occurred
- Assess each act in context of the current situation

### **Intervention**

- Help to replace this behaviour with safer coping strategies
- Harm reduction
- Access to non-judgmental medical care
- Offer referrals or crisis lines

### **Resources**

- **S.A.F.E.** (Self Abuse Finally Ends) in Canada 519-857-7259
- **Kids Help Phone** 1-800-668-6868

### **Suicide**

- Suicide is the second leading cause of death among youth aged 14 years to 24 years of age.  
On average, almost 300 youth die from suicide each year in Canada and many more attempt suicide (CMHA).
- Aboriginal and gay/lesbian youth are at particularly high risk.
- Stressful events often precede suicide attempts (loss of relationship, family difficulty, trouble with the law, academic/school issues, sexual victimization).
- Suicidal thoughts are common in adolescents and are not always associated with psychopathology or intent.

### **Intervention**

- If a clinician suspects a concern of suicidal thoughts or behaviours, a suicide risk assessment must be performed. Many centres may have access to a psychiatric consultation service. If this service is not available and the clinician is not comfortable in assessing a client's risk of suicide they should be referred to a mental health institution or local Emergency Department.

### **Risk Assessment**

- Impossible to predict with certainty.
- Although suicidal ideation and attempts are associated with increased suicide risk, most individuals with suicidal thoughts or attempts will never die by suicide.

Evaluation of the suicidal thoughts/behaviour:

- Ideation
- behaviours
- intent
- plan
- access
- lethality
- safety

#### History

- Suicidal or self-harming thoughts, plans, behaviours and intent
- Nature, frequency, depth, timing, and persistence of suicidal ideation
- Presence or absence of specific plans for suicide, including any steps taken to enact plans or prepare for death
- Previous attempts or gestures
- Methods considered and availability of means (firearms, lethal medication)
- Psychiatric and family history
- Acute psychosocial stressors
- Evidence of hopelessness, impulsiveness, anhedonia, panic attacks, or anxiety
- Collateral information (from parents, school, counsellors)

#### High Risk/Red Flags

- History of self harm or prior suicide attempts
- Persisting desire to die or frequency of thoughts
- Family pathology and/or history of suicide in the family
- Presence of a recent significant loss
- Presence of alcohol or drug use/abuse
- Lack of significant social support
- Social isolation
- Hopelessness
- Recent distress in interpersonal relationships
- Poor impulse control

### **Protective factors**

- Intact social supports
- Supportive family/caregiver
- Access to medical and mental health resources
- Reasons for living and plans for the future
- Proven impulse control
- Problem solving and coping skills
- Religious or cultural affiliation

### **Further Assessment**

- Collateral information (parents, friends)
- Consultation, psychiatry assessment and referrals

### **Safety Plan**

- What will they do if they have suicidal thoughts?
- Who will they call, tell or go to?
- Safety proofing the home (supervision, access to means)

Canadian Mental Health Association

Registered Nurses' Association of Ontario. (2008) Assessment and Care of Adults at Risk for suicidal Ideation and Behaviour. Toronto, Canada.



# Canadian Criminal Justice System Overview

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## Canadian Criminal Law

Canadian Criminal Law is based on the Common Law System which descended from the British legal system.

- **Common Law** – traditional unwritten legal precedents derived from customary English social practices, supported by judicial decisions. Judges have the authority and duty to decide what the law is when there is no specific written law. Common Law places great weight on previous court decisions. These are considered law, as are statutes.
- **Statutory Law** – written legal codes enacted by government (“on the books”)
- **Case Law** – body of historical judicial precedents set by the courts based on legal reasoning and interpretation of the statutory laws
- The Canadian Constitution gives the authority to the Canadian government to enact criminal laws. Criminal law is exclusively under the jurisdiction of the Federal government.
- The Provincial governments however, have the power to administer the justice system, to enforce and prosecute laws. Most written criminal law in Canada is found in the **Criminal Code, R.S.C. 1985, c. C-46.**
- Criminal court determines the guilt or innocence of an individual accused of an offence under the Criminal Code.

## Offences:

- 1) **Summary conviction** – minor or petty offences typically tried without an indictment, that is, without a jury trial, called misdemeanor in USA
  - 2) **Indictable offence** – more serious offences in which the defendant is entitled to a trial by jury, can only be tried on an indictment after a preliminary inquiry to determine whether there is enough evidence to support a case (*prima facie*), called felony in USA
  - 3) **Hybrid offences** – special class that allows the prosecutor to decide whether to prosecute the offence as either indictable or summary, treated as indictable until Crown decides
- **Preferred indictment** – special circumstances which allow the Crown to skip the preliminary inquiry and go straight to trial in cases of high profile or overwhelming evidence

## Canadian Court System

- **Adversarial System** – both sides are allowed to argue their cases before a fair and impartial arbiter
- **Family Court** – determines whether a child is in need of protection and determination of custody/placement
  - parties include CAS represented by a lawyer and family represented by one or more lawyers (may be one per caregiver)
  - threshold is the preponderance of the evidence

- **Provincial and Territorial Courts** – local trial courts of limited jurisdiction called ‘lower’ or ‘inferior’ court that involve less serious crimes. These courts are restricted to statutes. They may have judges or justices of the peace presiding.
- **Superior Court** has unlimited jurisdiction but typically involve more serious crimes and also may hear appeals from lower courts.
- The **Court of Appeals** – both Provincial/Territorial and Federal courts hear appeals from lower courts. This is the highest provincial court in most jurisdictions.
- The **Supreme Court of Canada** – the highest court in Canada and the final court of appeal. Its decisions are binding for all lower courts.

## The Courtroom

### Judge

- publicly appointed official who presides over the court of law, authorized to conduct trials, hear and sometimes decide cases
- has ultimate authority on ruling matters of law, admissibility of evidence, weighing objections and disciplining challenges to court order
- sentences offenders and may decide guilt or innocence in absence of a jury

### Jury

- a 12-member panel of peers of the accused
- selected prior to the trial
- the accused under an indictable offence may choose to have their case heard by either a judge or a judge and jury

### Crown Prosecutor

- represents the province, to get to the truth and not just prove a person guilty
- role is to bring all the facts of a case into evidence, not just presenting evidence against the accused

### Prosecutorial Discretion

- the decision making power of the prosecutors with respect to laying charges, accepting plea bargains, handling of defendants and scheduling trials

### Defence Counsel

- represents the accused; ensures the rights of the defendant are not violated, tests the strength of the prosecutor’s case, negotiates plea bargains and prepares a defense for trial
- may be a private lawyer, public defender or legal aid lawyer (**Judicare model** where government subsidizes non-profit society for legal services)

The accused in Canada is presumed **innocent until proven guilty**. It is up to the court to prove guilt. The judge or jury must be convinced **beyond a reasonable doubt** that the accused is guilty.

### Evidence

- **Rules of Evidence** govern the admissibility of evidence. These are found in the Canada Evidence Act.
- **Real evidence** – proves the facts and does not rely on inference
- **Circumstantial evidence** – establishes intermediate facts that allow an inference
- **Hearsay** – any statements made outside of the court
  - typically a statement made by one who is not present to testify as to the truth of the statement; inadmissible unless falls under an exception
- **Hearsay evidence rule** – prohibits use of hearsay evidence (many exceptions to the rule)

### Criminal Court Process

- **Arrest** – based on reasonable and probable grounds
- **Bail Hearing** – accused released on own recognizance, released on bail or kept in custody; may be released with bail conditions
- **Remand** – court proceeding to accept plea and set trial date or adjourn/postpone for a later date
- **Arraignment** – the accused makes a plea of guilty or not guilty
- **Preliminary hearing** – indictable offense may have a preliminary inquiry prior to the trial
  - purpose is to decide if the prosecution has enough evidence to go to trial
  - not mandatory and may be requested by either the defense or the prosecution
- **Trial** – if the accused pleads not guilty trial proceedings begin
- **Sentencing** – hearing to decide on sentencing following a conviction
- **Appeal** – either party may appeal the decision of the court
- **Alternatives** – there may be a process for alternate dispute resolution (i.e. diversion)

### Young Offenders

- Criminal matters dealing with youth between the ages of 12 – 17 fall under the **Youth Criminal Justice Act**.
- Offenders under the age of 12 may not be prosecuted.

Schmallegger et al.(2000). Canadian Criminal Justice Today: An Introductory Text for the Twenty-First Century.  
Prentice Hall:Scarborough.

Chayko, G.M. (1999). Forensic Evidence in Canada. Canada Law Book: Aurora.

Criminal Code of Canada R.S., 1985, c. C-46: <http://laws.justice.gc.ca/en/C-46/index.html>

## Expert Witness Testimony

### Fact/Lay Witness

- Anyone who may be called upon to testify to facts of a case that is not considered an expert.
- A witness may testify as to what was heard or seen but their testimony must be limited to only facts and they may not draw conclusions or express opinions.
- In sexual abuse cases a clinician may be asked to testify to physical findings, patient presentation and processes and procedures used to gather evidence.
- A fact witness cannot testify as to what was said to them (**hearsay**).

### Expert Witness

- A person with special knowledge or skills in an established profession or technical area that is recognized by the court as relevant to determining guilt or innocence or facts of a case.
- May express opinions or draw conclusions, which is an exception to the hearsay rule
- A clinician may be called to testify by either the Crown or the Defence.
- **An expert is not an advocate for either side; testimony must remain objective.**
- May be qualified based on sufficient relevant education, training or experience but there are no minimum requirements, each case is decided individually.
- Must have specialized knowledge and experience beyond that of the courts that will be of assistance to the trier of fact in deciding an issue in a case.
- May only testify to matters within their area of expertise and a factual foundation must be established for the opinion.
- Must be prepared to refer to recent and relevant literature to support opinion and these articles referred to in testimony must be brought for the court.
- A clinician must be qualified at each court appearance; Clinicians should record the times they have been qualified, including which courts and in which capacity.
- Expert reports or intention to call an expert must be disclosed to the opposing side with 30 days notice.
- A clinician qualified as an expert may be entitled to a fee and this fee should be discussed with the individual program; may be asked to discuss this fee in testimony.

### **Voir dire**

- A small trial within the trial (without jurors present) in which a witness is qualified as a expert.
- Qualifications of the witness will be reviewed based on their curriculum vitae (CV).
- The opposing counsel will have the opportunity to challenge the qualifications of the proposed expert or the admissibility of the evidence.
- The admissibility of expert evidence is based on reliability and validity. The requirement for scientific validity is based on case precedent.

In order for expert witness evidence to be admissible it must meet 4 requirements:

- 1) evidence must be relevant
- 2) expert must be qualified
- 3) evidence must be necessary in assisting the trier of fact in forming proper conclusions
- 4) there is no exclusionary rule prohibiting the use of the evidence

(R. v Mohan (1994), 89 CCC (3d) 402)

Canada uses a similar approach to the USA, following *Frye vs United States*, 293 F. 1013 (D.C. Cir. 1923) and *Daubert vs Merrill Dow Pharmaceuticals Inc.*, 509 U.S. 579. The Supreme Court of Canada established this in R. v J.-L.J. (2002) 2 S.C.R. 600: A particular technique or theory must have gained general acceptance within the relevant scientific community, must be validated by scientific method, subjected to peer review, able to be tested and have controlled standards.

## **Curriculum Vitae**

A CV should include the following

- academic qualifications – education, degrees
- relevant employment history
- courses specifically relevant to area of expertise
- awards or recognition in the field
- experience as an instructor or lecturer
- presentations
- membership in professional societies/organizations
- attendance at professional conferences or meetings
- relevant publications
- history of previous court qualifications (number and levels of court)

Note: If you have previously testified, the attorney may want to obtain a transcript of your testimony.

## **Qualities of a Good Expert**

- Most important requirement is ability to communicate effectively
- Ability to speak on level of lay person (juror) avoiding medical/technical jargon
- Ability to speak clearly and slowly
- Non-verbal communication i.e. eye contact, etc
- Peer reviewed work

## **Responding to a Subpoena**

- A subpoena is a court issued order requiring a person to appear in court along with all relevant documentation and give testimony.
- It may be delivered directly to the clinician or through the program.
- A clinician must respond to a subpoena by contacting the Liaison Officer noted on the subpoena. This officer will provide you with the victim's name as it will not appear on the subpoena, and the name of the Crown Prosecutor.
- Contact and arrange a time to discuss the case or meet with the Crown prior to the trial.
- Find out when the Crown wishes you to testify and whether they intend to qualify you as an expert.

## **Preparing for Court**

Meeting with the Crown- At this time the clinician and lawyer should discuss what is within or outside of the expert's scope of expertise. This discussion should include:

- types of questions you will be asked to establish your credentials and expertise
- boundaries/limitations of your testimony
- types of questions you will be asked by the prosecutor
- questions to be avoided (outside expert scope)
- hypothetical scenarios that may be posed
- how to prepare for cross-examination
- questions to expect from opposing counsel

The expert may also provide relevant literature to the Crown.

- Once you have been subpoenaed, you should read the documentation and review any other materials relevant to case such as photos. It may be months to years from when the case was seen. Review the relevant research and literature.

### **Privacy and Confidentiality**

- Records accessed through court ordered subpoena overrides confidentiality but there are some exceptions (privilege and rape shield law)
  - No privilege in RN-client relationship
- Health Care Professionals cannot supply medical records
  - Crown or Police must access records prior to trial from Medical Records
  - Client can sign Release of Information
- All evidence that the Crown has must be provided to the defence (disclosure). Therefore any documentation you bring to the trial must have been provided prior to your testimony.
- If you do have evidence that the defence is not aware of, the trial may be adjourned for the defence to have the time to review the evidence.

### **Testifying**

- Ensure you know the date and time you are required and arrive early.
- Dress comfortably and conservatively.
- Have your documentation with you.
- Wait outside the courtroom
  - Witnesses are not allowed in the courtroom while other witnesses are testifying.
- You will be invited into the courtroom when it is your turn to testify.
- You will be shown to the witness stand where you will be sworn in; an oath to tell the truth.
- There may be a judge/justice of the peace, and/or a jury. If there is a jury, your testimony should be addressed toward them.
- If you will be qualified as an expert, the **voir dire** will take place first, with the jury excused.
- The next step is **direct examination** by the lawyer who called you as a witness. Following is **cross examination** where the opposing lawyer(s) have the opportunity to ask questions
  - Can be stressful as the lawyer may use tactics to discredit, confuse or attempt to have you speak outside your expertise.
- Finally, a **redirect** examination by the lawyer who called the expert has the opportunity to address any testimony that came up during the cross examination.
  - The lawyer may not ask any new questions not previously addressed.
- You must leave the courtroom after your testimony. You will not be allowed to hear other witness testimony even after you have testified in case there may be a reason to recall you for further testimony.

### **Tips for testifying**

- Listen to the whole question before answering.
- Listen carefully and clarify if you do not understand the question.
- Take the time and think before answering.
- Stick to the questions being asked.
- Answer truthfully and objectively.
- If you do not know or do not remember say so, **do not guess**.
- Speak clearly and in lay language understandable to the jury.

### **Tips for cross examination**

- Be calm and respond politely.
- Don't be defensive or argumentative.
- Avoid testimony outside of the scope of expertise.
- If you are not qualified as an expert, do not provide an opinion even if asked.
- If asked several questions at once, have the lawyer ask one question at a time.
- Allow the time for an "objection" (watch the Prosecutor) and wait for the judge to reply.

Walsh, J.T. (1999). Keeping the Gate: The evolving role of the judiciary in admitting scientific evidence. *Judicature*. 83(30).

Gagnon, S.W. & Mitchell, M.R. (2000). Daubert, its Progeny and Their Effect on Family Law Litigation in State Courts.

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Daubert v. Merrill Dow Pharmaceuticals, Inc., 509 U.S. 579, 595 (1993)

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## Appendix A

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### Resource and Reference List

#### Journals

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## Websites

American Professional Society of the Abuse of Children: [www.apsac.org](http://www.apsac.org)

Association of Sites Advocating Child Protection (ASACP): [www.asaco.org](http://www.asaco.org)

BOOST, Child Abuse Prevention & Intervention: [www.boostforkids.org/](http://www.boostforkids.org/)

Community Legal Education in Ontario (CLEO): [www.cleonet.ca/](http://www.cleonet.ca/)

International Society for Prevention of Child Abuse and Neglect (ISPCAN): [www.ISPCAN.org](http://www.ISPCAN.org)

Kids Help Phone: <http://org.kidshelpphone.ca/en> or 1-800-668-6868

National Child Traumatic Stress Network: [www.nctsnet.org](http://www.nctsnet.org)

National Clinicians' Post Exposure Prophylaxis Hotline: 888-448-4911 or [www.ucsf.edu/hivcntr](http://www.ucsf.edu/hivcntr)

Ontario Association of Child Welfare Agencies: [www.oacas.org/](http://www.oacas.org/)

SAFE-T Program, Sexual Abuse, Family Education and Treatment: [www.irvingstudios.com/child\\_abuse\\_survivor\\_monument/Social.htm](http://www.irvingstudios.com/child_abuse_survivor_monument/Social.htm)

S.A.F.E. in Canada: [www.safeincanada.org/index.htm](http://www.safeincanada.org/index.htm)

Sexuality and U, Your Link To Sexual Well-Being:  
[www.sexualityandu.ca](http://www.sexualityandu.ca)

Spiderbytes: A New Spin on Sexual Health for Teens:  
[www.spiderbytes.ca](http://www.spiderbytes.ca)

The California Evidence-Based  
Clearinghouse for Child Welfare:  
[www.cachildwelfareclearinghouse.org](http://www.cachildwelfareclearinghouse.org)

The Gatehouse, Child Abuse Investigation & Support:  
[www.thegatehouse.org](http://www.thegatehouse.org)

The National Child Traumatic Stress Network:  
[www.nctsnet.org](http://www.nctsnet.org)

The Ontario Network of Sexual Assault  
& Domestic Violence Treatment Centers:  
[www.satontario.com](http://www.satontario.com)

The Suspected Child Abuse and Neglect Centre:  
[www.sickkids.ca/scan/](http://www.sickkids.ca/scan/)

Trauma Focused-Cognitive Behavioural Treatment:  
[www.musc.edu/tfcbt](http://www.musc.edu/tfcbt)

### **HIV PEP Resources**

National Clinicians' Post Exposure Prophylaxis Hotline:  
1-888-448 448-4911 or [www.ucsf.edu/hivcntr](http://www.ucsf.edu/hivcntr)

United States Department of Health  
and Human Services HIV Guidelines:  
[aidsinfo.nih.gov](http://aidsinfo.nih.gov)

The Center for Disease Control HIV,  
STDs and TB information:  
[www.cdc.gov](http://www.cdc.gov)

US Food and Drug Administration HIV:  
[www.fda.gov/oashi/aids/hiv.html](http://www.fda.gov/oashi/aids/hiv.html)

Individual medication websites:  
[www.Kaletra.com](http://www.Kaletra.com)

AIDS Meds:  
[www.aidsmeds.com](http://www.aidsmeds.com)

The Body:  
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## Books

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## Appendix B

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### Terminology

The following is a partial list of frequently used terms and definitions in describing a sexual assault examination. This list is based on the American Professional Society on the Abuse of Children, where a complete list can be found through APSAC at [www.apsac.org](http://www.apsac.org). Information was also obtained from the Pediatric Forensic Nurse Training Study Guide created by the Forensic Nurse Examiners at St Mary's Hospital in Richmond Virginia.

### Anatomical Structures

**Anal Sphincter (external):** A spindle shaped ring of striated muscular fibres surrounding the anus, attached posteriorly to the coccyx

**Anterior commissure:** The joining of the two labia minor anteriorly

**Anus:** Lower opening of the digestive tract, lying in the folds between the buttocks

**Bartholin's Gland:** Lies within the labia minora and is connected to ducts that open onto the inner surface of the labia next to the vaginal opening. Located at 5 and 7 o'clock outside the hymen

**Clitoris:** A small cylindrical, erectile body situated at the anterior portion of the vulva

**Cervix:** The narrow lower portion of the uterus that protrudes into the vaginal vault

**Cervical Os:** Opening in the center of the cervix

**Diastasis Ani:** A congenital smooth midline depression which may be wedge shaped, located either anteriorly or posteriorly to the anus; It is due to failure of fusion of the underlying corrugator external anal sphincter muscle

**Fossa Navicularis/Posterior Fossa:** Concavity on the lower part of the vestibule, posterior and inferior to the vaginal orifice and extending into the posterior forchette

**Glans Penis:** The head of the penis which is covered by a mucous membrane sheathed by the foreskin (prepuce) in uncircumcised males

**Hymen:** A membrane that surrounds the vaginal orifice, located at the junction of the vestibule floor and the vaginal canal. It may vary in size, shape and thickness

**Labia Majora:** Rounded folds of skin that form the outer boundaries of the vulva. The majora is covered by numerous sweat glands, oil glands and nerve endings

**Labia Minora:** Inner thin folds of spongy tissue enclosed within the labia majora

**Median Raphe:** The ridge or furrow that marks the line of union of the two halves of the perineum

**Mons Pubis:** Rounded, fleshy prominence that lies over the symphysis pubis of the female

**Pectinate/Dentate line:** The saw toothed demarcation between the distal portion of the anal valves and the pectin. It is a smooth zone of stratified epithelium which extends to the anal opening

**Penis:** Male sex organ composed of erectile tissue through which the urethra passes

**Perianal folds:** Folds within the anal opening radiating from the anus which are created by contraction of the external anal sphincter

**Perineum:** Part of the genitalia located in females between the vulva and the anus and in males from the scrotum to the anus

**Posterior Commissure:** The union of the two labia majora posteriorly

**Posterior Forchette:** The junction of the two labia minora posteriorly. This area is referred to as the posterior commissure in prepubertal female

**Prostate:** Located directly below the bladder and surrounds the urethra. It consists of muscular and glandular tissue. It produces about 30% of the seminal fluid. The remaining 70% is produced by the seminal vesicles

**Rectum:** It is the portion of the large intestine that is continuous with the descending sigmoid colon, proximal to the ending in the anal canal

**Scrotum:** The pouch which contains the testicles and their accessory organs

**Spermatozoa:** A mature male germ cell

**Testes:** The male sex organs; has two functions, hormone and sperm production

**Uterus:** The hollow muscular organ shaped like an inverted pear. It is made up of three layers, the endometrium, (inner lining) the myometrium (muscular lining) and the perimetrium (outer cover)

**Urethra:** The tube extending from the bladder to the exterior

**Urethral Orifice:** External opening of the canal from the bladder

**Vagina:** Internal structure that extends from the uterine cervix to the inner aspect of the hymen

**Vas Deferens:** A tube that connects the epididymis to the urethra in males. These tubes are cut and sutured off during a vasectomy

**Vestibule:** anatomical cavity containing the opening of the vagina, the urethra and ducts of Bartholin's glands. Bordered anteriorly by the clitoris, laterally by the labia, and posteriorly by the commissure. It encompasses the fossa navicularis immediately posterior to the vaginal introitus.

**Vulva:** The external genitalia of the female. Includes the clitoris, labia majora and minora, vestibule, urethral opening, vaginal orifice, hymen and posterior commissure.

## Descriptive Terminology

**Abrasion:** an area of the body surface denuded of the skin or mucous membrane

**Acute Laceration:** A tear through the full thickness of the skin or other tissue

**Attenuated Hymen:** The term has been used to describe area where the hymen is narrowed

**Cleft:** An angular V shaped indentation on the edge of the hymenal membrane

**Ecchymosis:** A hemorrhagic area on the skin due to extravasation of blood in to the skin or mucous membrane

**Erythema:** a redness of the skin or mucous membrane produced by congestion of the capillaries

**Friability:** A term used to describe tissue that bleeds easily

**Hyperpigmentation:** increase in melanin pigment in tissue

**Labial separation:** The labia minora are gently separated in a lateral and downward direction, exposing the vestibule

**Labial traction:** The labia majora are grasped between the thumbs and index fingers and gently pulled towards the examiner

**Labial agglutination/adhesion/fusion:** The result of adherence of the adjacent, outermost mucosal surfaces of the posterior portion of the vestibule walls

**Linea vestibularis:** A vertical, pale/avascular line across the posterior forchette and or fossa

**Lichen sclerosus:** A chronic atrophic skin disease characterized by homogeneous hypopigmented areas

**Mound/bump:** A solid, localized rounded and thickened area of tissue on the edge of the hymen

**O'clock destination:** A method by which the location of genital structure or findings can be designated by using the face of a clock

**Perineal groove:** Developmental anomaly also known as “failure of midline fusion” This skin and mucosal defect may be located anywhere from the fossa to the anus

**Petechiae:** A small pinhead sized haemorrhaged caused by leaking capillaries

**Scar:** Fibrous tissue which replaces normal tissue after the healing of a wound

**Sulcus:** Crease between two structures or tissues

**Tag:** Elongated projection of tissue arising from any location commonly found midline in the genitalia

**Transection:** A tear or laceration through the entire width of the hymenal membrane extending from its edge to the vaginal wall attachment

**Urethral Prolapse:** Circular protrusion of the distal urethra through the meatus

**Vascularity:** Dilatation of existing superficial blood vessels

**Venous engorgement/pooling:** pooling of the venous blood in the perianal tissues creating a purplish blue bulging of the tissues

**Vulvovaginitis:** Inflammation and irritation of the labia and vestibule

## Appendix C

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### SickKids HIV Post Exposure Prophylaxis (PEP) Clinical Guideline for Child/Adolescent Sexual Assault Victims

This clinical guideline refers to medications provided to prevent HIV infection in sexual assault victims. Our current procedure is to discuss the risk of HIV infection with all children and adolescents who have experienced a sexual assault and offer HIV PEP to those children and adolescents considered at risk for HIV infection. The medication course consists of 3 medications provided daily for 28 days. This protocol describes the process and medications involved in HIV PEP. SCAN nurses, nurse practitioners and staff paediatricians are all familiar with this protocol.

#### **Step 1: Child/adolescent with suspected sexual assault identified:**

- in the emergency department by SCAN nurse on-call with SCAN and emerg MD
- in SCAN clinic by SCAN nurse/nurse practitioner and/or SCAN MD

#### **Step 2: Assessment of Risk of HIV Transmission:**

Risk of HIV transmission discussed by SCAN staff with all sexual assault patients based on history provided

#### **Adolescent patient:** HIV PEP offered in the following situations:

- when patient presents within 72 hours (between 72 hours and one week can be considered for high risk situations\*)
- history of anal or vaginal contact with perpetrator's genitalia or body fluids
- possible vaginal or anal penetration with perpetrator risk factors for HIV
- acute genital, anal, or oral injuries on examination

#### **Pre-pubescent patient:** HIV PEP offered in the following situations (discuss with SCAN MD):

- when patient presents within 72 hours (between 72 hours and one week can be considered for high risk situations\*)
- acute genital injuries on examination consistent with penetration
- **clear** history anal or vaginal contact with perpetrator's genitalia or body fluids
- alleged perpetrator has a reliable history which indicates significant risk of HIV (known to be positive, known to be IV drug user, etc.)

\*If HIV PEP is offered after the 72 hour period the patient should be counseled that the efficacy is unknown and that there is no evidence existing to suggest that this will be effective. The more time that passes between the assault and the initiation of HIV PEP, the less likely it is to be effective.

### **Step 3: HIV PEP Protocol**

#### **Initial visit**

- Offer HIV PEP if appropriate based on assessment of risk of transmission.
- HIV PEP medications and side effects discussed.
- Determine whether patient/family wish to proceed with HIV PEP. If yes, continue
  - In order to increase efficacy HIV PEP should be initiated as soon as possible post sexual assault, if the patient/family is having difficulty with the decision the practitioner may offer to initiate HIV PEP with the possibility of discontinuing at a later time.
- SCAN nurse/nurse practitioner to discuss HIV PEP decision with SCAN MD.
- SCAN MD recommends medications and doses to SCAN nurse/nurse practitioner or emergency MD.
- Order for inpatient pharmacy to dispense five days medication to child/adolescent, signed by SCAN or emergency MD.
- MD or nurse to phone pharmacy (x6473) to indicate need for meds to be dispensed within one hour.
- Pharmacy to dispense meds to emergency or SCAN clinic.
- SCAN on-call phone number and medication information provided to patient in case of side effects or questions regarding medications.
- Baseline bloodwork:
  - Urine Beta-HCG (if Tanner 3+)
  - HIV, Hep B&C, VDRL
  - CBC & differential, electrolytes, blood sugar, creatinine, urea, AST, ALT ALP, bilirubin, CK, amylase
- Follow up appointment in SCAN clinic in 48 hours or next business day will be arranged by SCAN and the patient/family contacted.
- Message left for SCAN NP/RN with patient info to ensure follow up.

#### **Follow-up**

Follow up in SCAN clinic. Joint follow up by SCAN and ID of any children under 12 years of age receiving HIV PEP.

#### **Rapid HIV Testing of Alleged Perpetrator:**

- Discuss possibility of this with the police.
- Testing of the alleged perpetrator may impact whether prophylaxis continued, depending on the situation. Typically, the prophylaxis is started, but may be discontinued if perpetrator tests negative.

Should be considered with each case if the alleged perpetrator:

- is known
- is available for testing (in custody or out on bail)
- consents to having bloodwork done
- does not consent – an application can be made by the victim under Bill 105 for mandatory testing (within 1 week of sexual assault)
  - [http://www.health.gov.on.ca/english/providers/legislation/bill\\_105/105\\_phys.html](http://www.health.gov.on.ca/english/providers/legislation/bill_105/105_phys.html)

Procedure for rapid HIV testing:

One clotted sample (in a red top tube) must be obtained.

- The sample may be sent through our lab or through another hospital to the provincial lab.
- If the sample cannot go to the lab immediately the sample should be stored locked in the SCAN fridge.

If the testing is needed urgently on the weekend, contact the provincial lab duty officer about the sample (it could be run either Saturday am or in exceptional circumstances on Sunday):

- Provincial Lab Duty Officer # is 416-605-3113
- The contact person at Toronto Public Health that helps answer the questions regarding blood collection for HIV from incarcerated individuals is Paul Di Battista, Toronto Public Health, Control of Infectious Diseases and Infection Control South Region.

277 Victoria Street, 8th Floor Toronto, Ontario, M52 1W2

Telephone: 416-338-7896

Fax: 416-338-8787

Funding of medication:

The first five days of medication will be supplied by the inpatient pharmacy (x6473).

Remainder of medication to be dispensed by SickKids' Shopper's Drugmart (x6700) with a prescription.

Enquire whether family has a drug plan which will cover the medication.

- Combivir DIN-00636576
- Kaletra DIN-02243643

If drug plan will cover medication but usually reimburses family after payment, explore with SickKids' Shopper's Drugmart possibility of family not paying up front. Medication will be covered by provincial funding (allocated to SCAN for this purpose) if family is not insured.

If CAS has apprehended the patient or is involved with the family, explore contribution toward medication

#### **48-Hour Follow-up**

Follow up in SCAN clinic

Assess side effects.

Physical exam as appropriate.

Intervention as appropriate – discuss with ID (Dr. Read) if necessary.

Prescription provided for 9 day supply of medication.

2 week follow-up appointment booked.

#### **1 Week Follow-up (phone)**

Follow up by SCAN NP/RN

Assess side effects

Intervention as appropriate

#### **2 Week Follow-up**

Follow up in SCAN clinic

Assess side effects

Intervention as appropriate

Repeat bloodwork: CBC & differential, electrolytes, blood sugar, creatinine, urea, AST, ALT ALP, bilirubin, CK, amylase

Prescription provided for remaining medication

#### **3 Week Follow-up (phone/clinic)**

Follow up by SCAN NP/RN

Assess side effects

Intervention as appropriate

Advise patient to have follow up HIV testing at 3 – 6 months

- Follow up schedule assessed on a case by case basis, considering; risk of transmission, sexual activity, reliability for follow up

#### **3 to 6 Month Follow-up**

Patient called to set up follow up testing

If patient cannot be reached, letter sent

## ORAL ANTIRETROVIRAL AGENTS

### Medications

Adult ( $\geq 50$  kg) = Combivir (AZT & 3TC combined) + Kaletra (LPV/RTV)

Paediatric ( $< 50$  kg) = AZT + 3TC + Kaletra (LPV/RTV)

- See table for dosing
- All medications available in both pill/capsule and liquid forms

$$\text{Formula for Body Surface Area (m}^2\text{)}: \quad \frac{\text{The square root of}}{\text{Ht (cm)} \times \text{Wt (kg)}} \quad \frac{3600}{}$$

	NNRTIs		Protease Inhibitor Combinations
	Lamivudine	Zidovudine	Lopinavir/Ritonavir
<b>SHORT FORM</b>	3TC	AZT, ZDV	LPV/RTV
<b>PAEDIATRIC DOSE</b>	4 mg/kg/dose po bid	PO:180 mg/m <sup>2</sup> /dose po bid	6 months-12 years: 230/57.5 mg/m <sup>2</sup> /dose po bid
<b>TRADE NAME</b>	3TC <sup>®</sup> , Heptovir♦	Retrovir♦	Kaletra <sup>®</sup>
<b>ADOL./ADULT DOSE</b>	$\geq 50$ kg: 150 mg po bid	$\geq 50$ kg: 300 mg po bid	400 mg/100 mg po bid (2 tablets or 5 mL po BID)
<b>AVAIL.FORMS/ STORAGE</b>	Tablet: 150mg white film-coated tablet, (not scored – may cut in half)  Oral Solution: 10 mg/mL (strawberry banana flavoured, room temp.)  (Combivir <sup>®</sup> 150 mg 3TC + 300 mg AZT film-coated tab)  *3TC – tablets – can be crushed in food	Capsule: 100 mg Oral Solution: 10 mg/mL (strawberry flavoured, room temp)  (Combivir <sup>®</sup> 150 mg 3TC + 300 mg AZT film-coated tab)  *AZT – tablets – can be crushed in food	Tablets: 200 mg lopinavir/50 mg ritonavir Oral solution: 80 mg lopinavir + 20 mg ritonavir/mL (tastes bad; cotton candy flavoured; contains 42.4% alcohol) “Paediatric” tablets (smaller) available  *Kaletra – “paediatric” tablets cannot be crushed
<b>MAIN PRECAUTION</b>	Pancreatitis	Myelosuppression, severe anemia	Rash, drug interactions
<b>TOXICITY</b>	Most frequent: headache 10%, fatigue 8%, nausea, diarrhea 8%, rash, abdominal pain 10%  Unusual (more severe):  Pancreatitis 14% (seen in paediatric advanced HIV on multiple medications), paresthesia/peripheral neuropathy 13%, ↓ wbc (neutrophils), ↑ LFTs  ADRs for NRTI class: Lactic acidosis & severe hepatomegaly – rare in adults, but may be fatal. Discontinue all NRTIs if ↑↑ LFTs	Most frequent: hematologic toxicity, headache, N & V  Unusual (more severe): Myopathy, myositis, liver toxicity  Bone marrow suppression: (neutropenia ± anemia) ↓WBC: mean onset 6 weeks Tx: G-CSF ↓Hgb: dose related – mean onset 4-6 weeks, as early as 2 weeks. Tx: EPO ADRs for NRTI class: lactic acidosis & severe hepatomegaly – rare in adults, but may be fatal. D/C all NRTIs if ↑↑ LFTs	Most frequent: diarrhea, nausea and stomach upset, skin rash, intestinal gas and bloating, headache  Unusual (more severe): pancreatitis, liver inflammation (hepatitis)

	Lamivudine	Zidovudine	NNRTIs Protease Inhibitor Combinations
<b>MONITORING (blood tests)</b>	CBC, ALT, amylase	CBC (retic count, MCV), ALT, amylase	CBC, PT, ALT, glucose, TRIG, CHOL, bilirubin, amylase
<b>DRUG INTERACTIONS</b>	- Cotrimoxazole may ↑3TC levels	- acyclovir, ganciclovir, interferon - rifampin, rifabutin - clarithromycin - fluconazole, methadone, atovaquone, valproic acid, phenytoin, probenecid - stavudine (d4T)	Many check each new drug - cisapride - midazolam, triazolam - lovastatin, simvastatin - pimozide - ergot derivative anti-migraine medications - carbamazepine - several anti-histamines - erythromycin, rifampin - flecainide, propafenone - sildenafil - St. John's wort - OCP (decreases effectiveness)
<b>MEALS</b>	Take with or without food	Take with or without food	Take with food
<b>SPECIAL INSTRUCTIONS</b>	If 3TC upsets the stomach, take with food  Safety has not been established in pregnancy or breastfeeding  Assess kidney, liver, or hematological conditions	Manufacturer recommends 30 minutes before meals or 1 hour after  If ZDV upsets the stomach, take with food  May open capsule & give in small portion of food or 5-10 mL cool tap water  - Safety has not been established in pregnancy or breastfeeding	- Absorption enhanced with high fat meal - Safety has not been established in pregnancy or breastfeeding - Assess diabetes, liver conditions or hemophilia - Administer repeat dose in patients who vomit within 1½ hours of dose

Follow up (2 – 5 days)

Date:	Phone <input type="checkbox"/>	Clinic <input type="checkbox"/>
<input type="checkbox"/>	Reviewed risk of HIV infection, HIV PEP medication regimen, HIV PEP side effect and any other concerns	
<input type="checkbox"/>	Review of side effects: Cough Shortness of breath Nausea Vomiting Constipation Diarrhea Mood Muscle weakness Painful neuropathy (pain, numbness, or tingling in fingers, toes, hands and/or feet) Fever (oral without infection, >12 hours) Headache Fatigue Allergic reaction Rash Other	
<input type="checkbox"/>	Exam (if appropriate)	
<input type="checkbox"/>	Review baseline blood work	
<input type="checkbox"/>	If patient to continue on HIV PEP: Prescription provided Follow-up appointment given _____	

## Follow up (1 week)

**Date:** \_\_\_\_\_ **Phone**  **Clinic**

<input type="checkbox"/>	Reviewed risk of HIV infection, HIV PEP medication regimen, HIV PEP side effect and any other concerns
<input type="checkbox"/>	Review of side effects: Cough Shortness of breath Nausea Vomiting Constipation Diarrhea Mood Muscle weakness Painful neuropathy (pain, numbness, or tingling in fingers, toes, hands and/or feet) Fever (oral without infection, >12 hours) Headache Fatigue Allergic reaction Rash Other
<input type="checkbox"/>	Remind of follow-up appointment _____

## Follow up (2 weeks)

Date:	Phone <input type="checkbox"/>	Clinic <input type="checkbox"/>
<input type="checkbox"/>	Review of side effects: Cough Shortness of breath Nausea Vomiting Constipation Diarrhea Mood Muscle weakness Painful neuropathy (pain, numbness, or tingling in fingers, toes, hands and/or feet) Fever (oral without infection, >12 hours) Headache Fatigue Allergic reaction Rash Other	
<input type="checkbox"/>	Exam (if appropriate)	
<input type="checkbox"/>	Blood work: CBC & differential, Electrolytes, Glucose, Creatinine, Urea, AST, ALT, Alk Phos, Bilirubin, CK, Amylase	
<input type="checkbox"/>	If patient to continue on HIV PEP: Prescription provided	
<input type="checkbox"/>	Discuss follow up testing of HIV, Hep B (if appropriate), Hep C & VDRL in 3 months	
<input type="checkbox"/>	Bloodwork reviewed for signs of toxicity	

## Follow up (3 weeks)

Date:                      Phone               Clinic

<input type="checkbox"/>	Reviewed risk of HIV infection, HIV PEP medication regimen, HIV PEP side effect and any other concerns
<input type="checkbox"/>	Review of side effects: Cough Shortness of breath Nausea Vomiting Constipation Diarrhea Mood Muscle weakness Painful neuropathy (pain, numbness, or tingling in fingers, toes, hands and/or feet) Fever (oral without infection, >12 hours) Headache Fatigue Allergic reaction Rash Other

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