Child/Adolescents 2022

Ohio Protocol for Sexual Assault

Medical Forensic Examinations

Ohio Department of Health

ACKNOWLEDGMENTS

The first Ohio Protocol for Sexual Assault Medical Forensic Examinations: Child/Adolescents was written in 2000. It was authored by the Ohio Chapter - American Academy of Pediatrics in collaboration with the Ohio Department of Health and the Ohio Attorney General's Office.

The Child/Adolescents protocol was first updated in 2009, and this third edition is intended for:(1) healthcare providers who conduct sexual abuse medical forensic examinations of children and adolescents; and (2) other professionals and agencies/facilities involved in the initial community response to child sexual abuse, in coordination with healthcare providers, to facilitate medical forensic care.

This comprehensive response to child sexual abuse/assault, including intervention and treatment, has improved greatly, providing children with equitable, victim centered, and trauma informed services.

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GOALS

Goals of the Ohio Protocol for Sexual Assault Medical Forensic Examinations

The main goals of a pediatric sexual abuse medical forensic examination, as described in this protocol, are to:

- Address the healthcare needs of children and adolescents who disclose sexual abuse or for whom sexual abuse is suspected.
- Promote their healing.
- Gather forensic evidence for potential use in the criminal justice and/or child protection systems.

It is also essential during the exam process to address concerns regarding children's safety, as well as to offer emotional and mental health support, crisis intervention, education, and advocacy to children and their caregivers as needed.

When there is a concern of child sexual abuse/assault, it is highly recommended that, when possible, children be taken to facilities best equipped to provide the full array of comprehensive and multidisciplinary services and with the greatest medical expertise to address the needs of children and adolescents. These facilities will often be a Child Advocacy Center (CAC), a children's hospital, or a child abuse clinic for sexual abuse/assault evaluations. Communities that lack or are unable to provide reasonable access to such a facility are encouraged to establish a pediatric forensic program with linkages to a CAC or a child sexual abuse medical expert. Collaboration with members of multidisciplinary teams (MDTs) helps provide adherence to established evidence collection procedures and establishes a means for an effective referral network. The protocol promotes multidisciplinary response teams and partnerships with CACs, where available, as tools to foster coordination and communication in these cases across disciplines and agencies/facilities, both in a community and across jurisdictions as needed.

Although the protocol's focus is on the exam process, it also speaks to the initial community response to child sexual abuse, as it is a gateway for patients to access medical forensics care. The protocol also acknowledges the necessity of a comprehensive, coordinated community response to fully address the needs of children specific to their individual circumstances. Planning at the conclusion of the examination can help connect children and their families to resources and prepare them for next steps in the community response.

INTRODUCTION

Children experience sexual abuse across multiple settings within the home, community, and broader society. Children who have experienced child sexual abuse are at greater risk for a wide range of adverse psychological and somatic problems into adulthood in contrast to those who were not sexually abused (Shrivastava, Karia, & Sonavane, 2017). Specifically, child sexual abuse refers to the involvement of a child in a sexual activity that the child does not fully comprehend and is unable to give informed consent, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society (Mathews & Collin-Vézina, 2017). Sexual abuse can occur between a child and a person or persons of any age or relationship to the child.

There are many reasons why children and youth may not disclose a sexual assault or sexual abuse. These include their dependence on caregivers, the ability of perpetrators to manipulate and silence them, and children's lack of "rights" as minors. This is especially true when the perpetrators are family members or other adults trusted by, or with power over, children. Very young children and children with disabilities who have increased dependence on caregivers are particularly at risk (Centers for Disease Control and Prevention, 2019). Children and youth may present with problematic behaviors and adults may not understand the cause. In these instances, children and youth are often seen as being problematic, labeled "at risk" rather than having problems and being in dangerous situations that adults can remedy. Sexual abuse may be a single encounter, but often it is ongoing over many weeks, months, or even years due to perpetrators' unfettered access to and control over their victims. Intermittent sexual abuse may become more aggressive over time as perpetrators gradually groom and manipulate their relationship with their victims. Sexual abuse is a hidden crime, unwitnessed by others, and often leaves no physical signs on a child's body.

Providing services to individuals who have been victims of sexual abuse requires special sensitivity. Social, cultural, ethnic and religious backgrounds must be considered and may be a cause of additional stress for sexual abuse patients. Emotional and/or psychological trauma may not always be apparent when the patient arrives at the hospital or clinic. Psychological trauma may be evidenced in many different forms, from unusual calm to heightened anxiety, extreme tearfulness to laughter, anger to withdrawal. As such, when the child/adolescent and family first presents, it is important to provide sensitive care using a tailored approach that offers continued support through the evaluation.

With appropriate support and resources, children can heal from sexual abuse. From a health perspective, the medical forensic exam process provides a proactive vehicle for communities to:

1. Build rapport with the child. This is essential for the comfort of the child and the effectiveness of the exam process, but also in reinforcing for children that there are adults who are safe and can be trusted (U.S. Department of Justice, Office on Violence Against Women, 2016).
2. Assess sexually abused children's health status and identify health concerns of children and their caregivers.
3. Provide emotional support and education for children and their caregivers so they are aware of their options and available resources for treatment and healing.
4. Coordinate treatment for physical, psychological, and behavioral issues.
5. Develop a plan to promote healing that minimizes and mitigates the negative health outcomes for children over time.

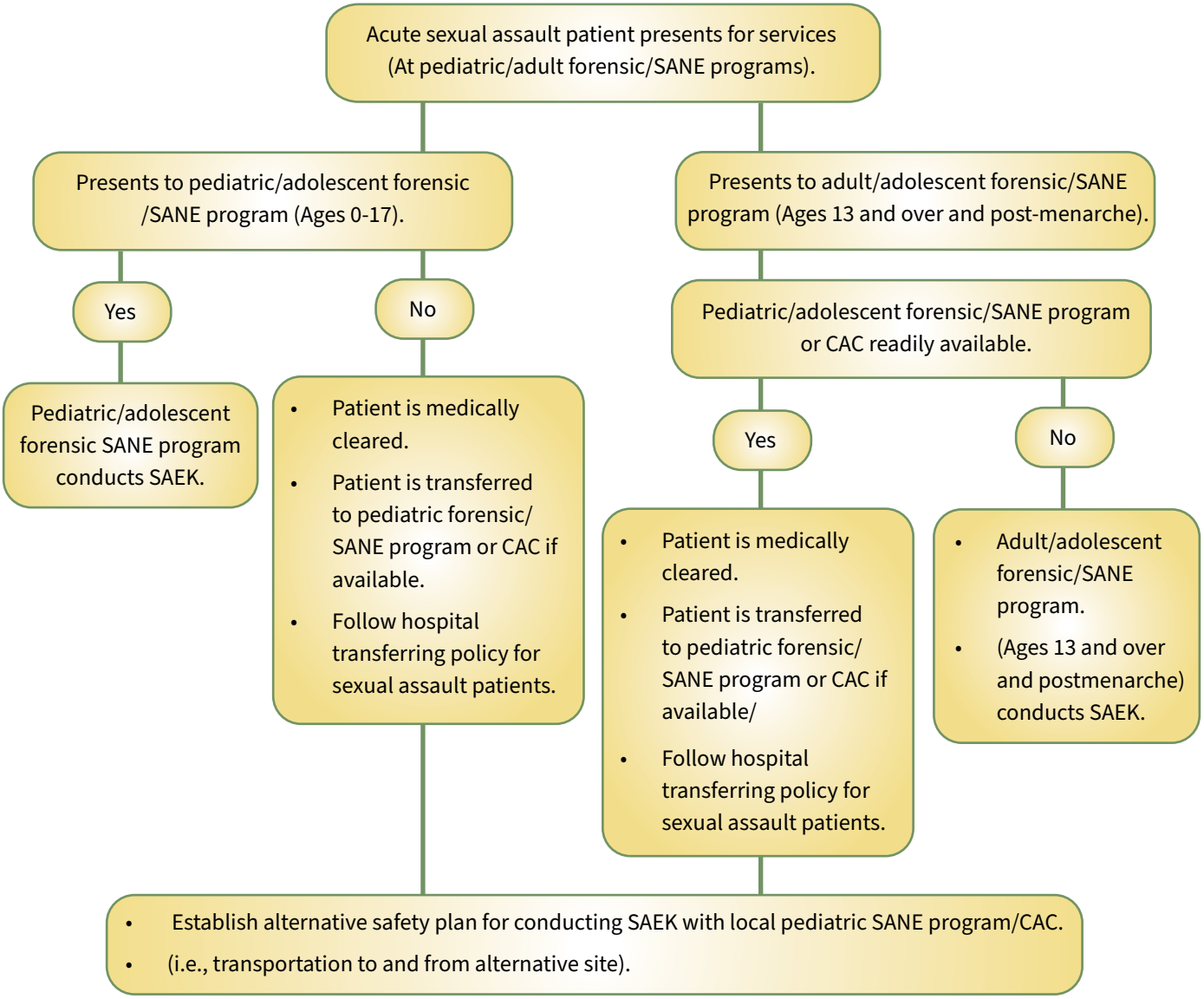
For more information about child sexual abuse, please go to:

- ORC: § 2919.22, http://codes.ohio.gov/orc/2919.22v1
- www.safeta.org
- pediatrics.aappublications.org/content/132/2/e558.full
- www.childwelfare.gov/pubPDFs/whatiscan.pdf

Pediatric medical-forensic exams should be performed by healthcare professionals trained in identifying, interpreting injuries and the scope of injuries or findings specific to pediatric patients.

Pediatric Algorithm for Sexual Assault Patients

Ages: 0-17



SAEK=Sexual Assault Evaluation Kit
CAC=Child Advocacy Center equipped to conduct acute SAEK
*Chart created by Kathleen Hackett, MSN, N, SANE-P

SECTION A OVERARCHING ISSUES

This section presents issues that impact all or most of the sexual assault medical forensic exam process. The following chapters are included:

1. Multidisciplinary Teams (MDTs)

This protocol promotes multidisciplinary coordination during the exam process, within a community and/or across jurisdictions as applicable in a case. A coordinated, multidisciplinary approach facilitates efficient interagency communication and information sharing, ongoing involvement of key individuals, and support for children and families. Each agency gains the benefit of a broadened knowledge base from which decisions are made, thorough and shared information, and improved and timely evidence gathering. Multidisciplinary interventions are associated with less anxiety, fewer interviews, and more appropriate and timely referrals for needed services. Coordination and communication among initial responders can also enhance documentation and evidence collected during medical forensic care as well as information gathered during forensic interviews. This can aid law enforcement and child protective services investigating these cases in keeping children safe and support prosecutors in holding perpetrators accountable for their behavior.

This protocol encourages the development and/or use of children's advocacy centers (CACs) tofacilitate coordination of multidisciplinary response teams. CACs have been established in many jurisdictions to facilitate team coordination in child abuse and neglect cases, with goals of child safety, trauma-informed care, justice, and healing.

It is the responsibility of all multidisciplinary members to tailor their responses to meet the developmental level and cultural and linguistic needs of the child and caregiver. This can include arranging for language assistance and other accommodations as needed. Interventions should be child-focused, victim-centered and trauma-informed.

- Child-Focused: An approach to care that is developmentally, linguistically, and culturally appropriate for children; designed with their needs, abilities, and best interests in mind; and intended to reduce potentially traumatic effects of the exam process.
- Victim-Centered: An approach to care that is grounded in an awareness of and commitment to addressing the needs of patients of sexual abuse during the exam process. This approach recognizes that patients deserve timely, compassionate, and appropriate care to promote their healing and information to support their decision making. This encourages choice for patients whenever possible, as fitting their developmental level and applicable laws.
- Trauma-Informed: Trauma-informed response seeks to support the healing and safety of children who experience sexual abuse, while avoiding re-traumatization. A trauma-informed response considers and evaluates all interventions in light of a basic understanding of the role violence plays in the lives of patients and integrates an understanding of the child's history and the context of their experience. It recognizes the effects trauma can have on children's behavior, coping strategies, relationships, and ability to interact with responders.

Examples of Common Developmentally Appropriate Sexual Behaviors Among Children

(Note these behaviors may not constitute sexual abuse and are distinguished from inappropriate/problem sexual behaviors.)

Developmental Stage/Age	Common Sexual Behaviors
Preschool	• Exploring, touching, and/or rubbing private parts, in public and in private.
	• Showing private parts to others.
	• Trying to touch mother's or other women's breasts.
	• Removing clothes and wanting to be naked.
	• Attempting to see other people when they are naked or undressing.
	• Asking questions about their own bodies and others' bodies and bodily functions.
	• Talking to children their own age about bodily functions such as "poop" and "pee."
Young Children	• Purposefully touching private parts, occasionally in the presence of others.
	• Attempting to see other people when they are naked or undressing.
	• Mimicking dating behavior (such as kissing or holding hands).
	• Talking about private parts and using "naughty" words, even when they do not understand the meaning.
	• Exploring private parts with children their own age (such as "playing doctor," "I'll show you mine, if you show me yours," etc.).
School-Aged	• Purposefully touching private parts (masturbation), usually in private.
	• Playing games with children their own age that involve sexual behavior (such as "truth or dare," playing "family" or "boyfriend/girlfriend").

U.S. Department of Justice, Office on Violence Against Women. (April 2016). A National Protocol for Sexual Abuse Medical Forensic Examinations Pediatric, (page 10), https://www.justice.gov/ovw/file/846856/download.

The Role of the Child Sexual Abuse Medical Expert

Every community should have access to trained, competent pediatric examiners who can provide medical forensic care to children who disclose sexual abuse or are suspected of being sexually abused. There are ranges of healthcare providers who have completed training requirements to perform this examination for a pediatric population:

- Physicians.
- Advanced Practice Nurses.
- Physician Assistants.
- Forensic Nurse Examiners (FNEs)/Sexual Assault Nurse Examiners (SANEs).

Key Roles and Responsibilities on an MDT

Medical:

- Assess the child for acute medical needs, stabilize, and treat.
- Determine the urgency of care needed and arrange for acute/nonacute medical forensic care.
- Obtain/document the medical history.
- Perform the physical and anogenital examination and document findings.
- Collect, dry, package, label, seal, and securely handle forensic specimens.
- Evaluate for STIs and HIV, and provide care.
- Collect samples for toxicology analysis.
- Plan for discharge and follow-up care.
- Mandatory reporting of the abuse as per jurisdictional law and facility policy.
- If the child has urgent safety needs at the healthcare facility, immediately involve law enforcement and/or child protective services.
- Testify in court as requested.
- Recognize the examination is an opportunity to facilitate healing by treating children holistically, taking into consideration the unique needs of each child and family unit.
- Actively participate in all necessary and appropriate MDT/CAC collaborations, consultations, and case reviews, and provide medical expertise and insight as needed. If the community does not have an existing MDT or CAC, actively collaborate with and provide needed medical expertise and insight to other agencies and disciplines as would benefit the child patient/victim.

Victim Advocacy:

- Offer crisis intervention, support, information, and safety planning to the child and the family.
- Explain victim rights to the child and family, review community response procedures and options, answer questions, and provide referrals.
- Support the child and caregiver in voicing their concerns, and act as a liaison or facilitate communication with other partners as needed, provide information about Constitutional Victims' Rights in Ohio including Victim's Compensation and application assistance, and provide relevant information about system processes and expectations.
- Advocate for the child's self-identified needs to be addressed with a coordinated, developmentally, culturally, and linguistically appropriate response.
- Accompany the child/caregiver during the examination, to criminal court, or any other appropriate appointments or related matters.
- Mandatory reporting of the abuse per jurisdictional law.
- Explain longer-term advocacy services available to aid in addressing child and family needs related to the abuse.
- Make referrals for needed services, including ensuring the child has access to trauma focused mental health treatment, basic needs, caregiver services, and other relevant needs as stated or assessed.
- Engage in trauma responsive approaches for intervention alongside MDT/CAC partners and service providers.
- Actively participate in all necessary and appropriate MDT/CAC collaborations, consultations, and case reviews, and provide advocacy expertise and insight as needed. If the community does not have an existing MDT or CAC, actively collaborate with and provide needed advocacy expertise and insight to other agencies and disciplines as would benefit the child patient/victim.

Law Enforcement:

- Respond to referrals of child sex abuse.
- Determine basic facts of the reported incident, if the child is in imminent danger, need for immediate medical attention, and case jurisdiction.
- Work with child protective services as needed to provide child protection.
- Facilitate access to an initial medical assessment and medical forensic examination.
- Coordinate crime scene processing.
- When contacted by the exam site to pick up forensic evidence, retrieve evidence and deliver to designated labs/law enforcement storage facility.
- Conduct/arrange the preliminary child/forensic interview, preferably by someone trained to interview child sex assault patients, either before or after the medical forensic examination, in conjunction with child protective services as applicable to the case.
- Actively participate in all necessary and appropriate MDT/CAC collaborations, consultations, and case reviews, and provide law enforcement expertise and insight as needed. If the community does not have an existing MDT or CAC, actively collaborate with and provide needed law enforcement expertise and insight to other agencies and disciplines as would benefit the child patient/victim.

Child Protective Services:

- Assess the child's immediate safety, and institute necessary steps to ensure immediate and ongoing child safety.
- Make referrals to the appropriate law enforcement agency and coordinate multi-agency response based on circumstances of report and initial assessment of child's safety.
- Facilitate access to an initial medical assessment and medical forensic examination.
- Conduct or arrange the preliminary interview. Best practice for preliminary interviews is to use a trained interviewer skilled in interviewing child sexual assault patients. The preliminary interview can be conducted either before the medical forensic examination, in conjunction with law enforcement as applicable to the case. An example of an appropriate training for this skillset is *Finding Words Ohio: A ChildFirst Course on Interviewing and Preparing Children for Court* provided by the Ohio Attorney General's office, https://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Trainings-for-Victim- Service-Providers/Finding-Words-Ohio-Registration.
- Actively participate in all necessary and appropriate MDT/CAC collaborations, consultations, and case reviews, and provide child welfare expertise and insight as needed. If the community does not have an existing MDT or CAC, actively collaborate with and provide needed child welfare expertise and insight to other agencies and disciplines as would benefit the child patient/victim.

Prosecution:

- Be available to consult with first responders to answer questions that arise and to request additional information as necessary to aide in the case prosecution.
- Focus is potential prosecution and upholding law in fair manner.
- Actively participate in all necessary and appropriate MDT/CAC collaborations, consultations, and case reviews, and provide child welfare expertise and insight as needed. If the community does not have an existing MDT or CAC, actively collaborate with and provide needed child welfare expertise and insight to other agencies and disciplines as would benefit the child patient/victim.

Mental Health Providers:

- Access cases for mental health services using evidence based and peer reviewed assessment tools and treatment modalities.
- Receive referrals and provide trauma responsive and culturally relevant services to child sex abuse patients and their families.
- Provide access to crisis intervention services for children and families as needed.
- Collaborate with the multidisciplinary team to reduce long-term negative impact on the child and the child's family.
- Actively participate in all necessary and appropriate MDT/CAC collaborations, consultations, and case reviews, and provide mental and behavioral health expertise and insight as needed. If the community does not have an existing MDT or CAC, actively collaborate with and provide needed mental and behavioral health expertise and insight to other agencies and disciplines as would benefit the child patient/victim.

Child Advocacy Center:

- Coordinates the MDT response to ensure the child and family are receiving non-duplicative and trauma responsive services.
- Provides a child focused setting where trained professionals conduct forensic interviews, provide advocacy and caregiver support, and other needed services.
- Actively coordinates in all necessary and appropriate MDT/CAC collaborations, consultations, and case reviews, and provides MDT guidance and child abuse expertise as needed.

Clarity of core responders' roles can help increase their collaboration in individual cases and reduce conflicts surrounding issues such as reporting, victim protection, healthcare, safety planning, victim services, and investigation. Note that "MDT response" does not mean all responders will be involved in every case; rather, they may be called to respond, depending upon case needs.

MDT Case Review

Case review is the formal process that enables the MDT to monitor and assess its independent and collective effectiveness to ensure the safety and well-being of children and families. Case review serves multiple purposes:

- Experience and expertise of multidisciplinary members is shared and discussed.
- Collaborative efforts are fostered.
- Formal and informal communications are promoted.
- Mutual support is provided.
- Informed, collective decisions are made.

The process encourages mutual accountability and helps assure children's needs are met sensitively, effectively, and in a timely manner. Case review is intended to plan and monitor cases and not intended as a retrospective case study. Representatives from each discipline in the MDT section should attend case review.

Sexual Abuse Medical Expert

Sexual abuse medical experts should provide input regarding child sexual abuse exams and findings at case review.

Ongoing education of pediatric examiners, as well accessing experts in the child sexual abuse field is encouraged. Access to experts and ongoing education has been shown to increase examiner competence and improve the quality of examinations, documentation, and interpretation of findings over time (["KIDSta protocol section A2," n.d.](#)). In addition, examiner participation in multidisciplinary training opportunities and case review can help evaluate and improve team response and interventions.

Medical Peer Review

A peer review process is encouraged for all sexual abuse medical experts. In peer review, medical experts in child sexual abuse across disciplines have the opportunity to review written and photographic documentation of a child's examination. Peer review has been demonstrated to improve professional practice patterns (U.S. Department of Justice, Office on Violence Against Women, 2016).

It can help improve diagnostic accuracy, assist with confirmation and verification of exam findings, and establish a consensus in the data and interpretation (U.S. Department of Justice, Office on Violence Against Women, 2016USDOJviolenceAgainstWomen). Because often no residual visible injury is seen in child sexual abuse cases, the use of peer review can be particularly helpful in strengthening examiners' skills to not overcall a normal variant finding as consistent with sexual abuse (Adams et al., 2016), (Mathews, & Collin-Vézina, 2017).

2. Patient Special Considerations

Individualized Services

Care should be adapted to each child's needs and circumstances. Understanding the child's circumstances includes looking at obvious factors such as the child's developmental level, the nature of the sexual abuse experienced, the child's reactions to it, and additional factors. The goal is for the provider to acknowledge and appreciate the whole child and be sensitive and inclusive during interactions with each child.

Assess these fundamental communication issues early in the exam process in each case:

- Evaluate children's developmental level so that appropriate language is used. Developmental level and language skills and preferences must be factored into responders' decisions regarding how to build rapport with children, as well as the scope of information that is communicated to and sought from them. Literacy of children must be considered when offering material (e.g., pictures may be more appropriate than words for younger patients).
- Identify if there is a need for language assistance or other accommodations to allow a child and/or caregiver to clearly and fully communicate with responders during the exam process.

It is impossible to know all cultural and linguistic barriers that may impact the care of any individual child. Providers should take measures to promote culturally and linguistically responsive care during all aspects of the exam process. Key actions are recommended below to develop a holistic approach to services.

- Recognize that personal biases can negatively impact the ability to provide high quality care for children and need to be addressed.
- Consider how historical oppression (racism, sexism, ableism, audism, classism, homophobia, religious persecution, etc.) can impact care provided and identify approaches to create conditions that are more just for all children served. (U.S. Department of Justice Office on Violence Against Women. 2016, April). *A national protocol for sexual abuse medical forensic examinations pediatric.)*
    - Audism is the notion that a person is superior based on the ability to hear or to behave in the manner of one who hears (Humphries, 1977).
- Understand each person is multicultural, bringing a blend of cultural and linguistic considerations. View multicultural identity of children and family members in these cases as a potential strength.
- Recognize evidence-informed care is only as good as the diversity of populations sampled for research and needs to be balanced with child-focused, victim-centered, and trauma-informed principles of care.
- Regularly seek to learn about different populations and community settings.

During the exam process, do not press children or caregivers for information beyond what is essential for providing medical forensic care. It is more important to be guided by what children and caregivers self-identify, as well as what is observed.

Children/Adolescents With Special Health and Social Considerations

This section was partially adapted from "A National Protocol for Sexual Assault Medical Forensic Examinations" 2nd Ed April 2013 (Shrivastava, Karia, & Sonavane, 2017).

Children and adolescents with special health or social considerations present with unique needs during their evaluations. These special considerations may include developmental disabilities, cultural factors, gender or sexual identity, and language barriers. Addressing these in a comprehensive and sensitive manner involves recognizing and understanding these issues and is an important part of a complete and effective evaluation (Shrivastava, Karia, & Sonavane, 2017).

Although the special considerations noted in this section may affect the experiences of a patient during an evaluation, it is up to the patients to decide whether and to what extent any personal information is shared. While language barriers and overt disabilities may be clear during the evaluation, some cultural considerations, gender/sexual identity, and subtle disabilities may not be obvious. It is generally unnecessary to question the patients about certain data, such as sexual orientation and gender identity, immigration status, or religious or spiritual beliefs, beyond certain information needed for appropriate care. However, it is important to gain a basic understanding of potential issues and concerns facing sexual assault patients if these considerations become apparent.

Developmental Disabilities

Developmental disabilities are a group of conditions due to an impairment in physical, learning, language, or behavior areas. These conditions begin during the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime. (Rubin and Crocker 1989) Vera Institute of Justice reports that children with disabilities are 2.9 times more likely than children without disabilities to be sexually abused (Vera Institute of Justice, 2012). Children with intellectual and mental health disabilities are the most at risk, with 4.6 times the risk of sexual abuse as their peers without disabilities (Smith & Harrell, 2013). Many of these children have decreased contact with other individuals, thereby limiting the child's opportunity to disclose the abuse (Smith & Harrell, 2013). Children with multiple caregivers may be at increased risk of all types of abuse, including sexual abuse, due to increased opportunity, and are often victimized repeatedly by the same offender. Many children with disabilities have limited access to information about personal safety and sexual abuse prevention. They may be accustomed to having their bodies touched by adults due to increased dependency for their physical needs. Children with cognitive delays may have difficulty understanding the experience as abuse, and any communication impairment may limit the ability to disclose abuse. Finally, children with disabilities may have unique fears related to disclosure of abuse, including potential loss of caregivers who they rely on for daily living assistance (Murphy & Ellis, 2006)

The evaluation of suspected sexual abuse in children with disabilities should consist of an explanation of the interview and exam process at a developmentally appropriate level. Consultation with a developmental pediatrician or other expert in children with disabilities can be helpful in guiding this process. It is important to remember that children with disabilities may require additional time for both the interview and exam, and they may require additional assistance, such as service animals, communication devices, or the presence of a non-offending caretaker during the examination.

Further considerations are listed below:

- Caretakers, family members, or friends may be responsible for the sexual assault. In such cases, offenders may bring patients to the exam site, and jurisdictional and facility policies should be in place to provide guidance on how staff should screen for and handle situations that are threatening to patients or facility personnel.

- Respect patients' wishes to have or not to have caretakers, family members, or friends present during the exam. Although these individuals may be accustomed to speaking on behalf of persons with disabilities, it is critical that they not influence the statements of patients during the exam process. If assistance is required (e.g., from a language interpreter or mental health professional), those providing it should not be associated with the patient.
- Speak directly to patients with disabilities, even when interpreters, intermediaries, or guardians are present. Be exact when explaining what will happen during the exam process and reduce distractions by limiting bright lights and loud noises.
- Many children with chronic health conditions have undergone painful procedures prior to coming for the medical examination and may be wary of medical professionals. Careful demonstration of the medical examination with additional time for questions is essential.
- During the ano-genital exam, individuals with motor disabilities may require special positioning due to contractures or other joint mobility limitations. They may need assistance to get on and off the exam table or to assume positions necessary for the exam or may need an alternative to the standard table.
- Ano-genital exams are generally normal. A high index of suspicion is needed in this vulnerable population, particularly when communication or barriers prevent a detailed disclosure that abuse has occurred.
- An optimal healthcare setting for an adult with developmental disabilities depends on the severity of the disability. A pediatric facility should be considered for these individuals if it is felt to better meet their needs (Hibbard et al., 2007).

Assistive or augmentative tools used by children may be considered as forensic evidence. It is important to ask the child before touching these items and obtaining swabs and photos of the devices with the child's consent. They should not be taken from the child (U.S. Department of Justice, Office on Violence Against Women, 2016).

Cultural Factors

The term *culture* refers to a body of learned beliefs, traditions, and guides for behaving and interpreting behavior that may be shared among members of a particular group (Centers for Disease Control and Prevention, 2014). Aspects of a culture include its values, beliefs, customs, communication styles, behaviors, practices, and institutions (Centers for Disease Control and Prevention, 2014), (Gervin et al., 2014). The American Academy of Pediatrics (2013), as cited by the World Health Organization, defines culturally effective healthcare as the delivery of care within the context of appropriate knowledge, understanding, and appreciation of all cultural distinctions, leading to optimal health outcomes. For sexual assault/abuse patients, an immediate response should sensitively and appropriately address related cultural needs and concerns. Hospital and clinic staff are encouraged to seek out reliable information and training on practices and beliefs specific to people from culturally diverse backgrounds who may utilize the services of the hospital or clinic.

Developing culturally competent care begins with an awareness about and sensitivity to the ways that culture can impact a person's experience in the immediate aftermath of sexual assault and across the lifespan. Be aware and responsive to the ways in which cultural identities may influence a person's experience during the exam process as well. The knowledge and understanding of providers and other child healthcare professionals about the cultures of their patients and their families will increase their ability to provide care in a manner that is responsive to the individual needs of each patient. (American Academy of Pediatrics, 2013).

Building understanding of the perspectives of a specific population may help increase the likelihood that the actions and demeanor of responders will mitigate the patient's trauma. Further considerations are listed below:

- Understand that culture can influence beliefs about sexual assault, its victims, and its offenders. It can affect healthcare beliefs and practices related to the assault as well as emotional healing from an assault. In addition, it can impact beliefs and practices regarding justice in the aftermath of a sexual assault, the response of the criminal justice system, and the willingness of patients to be involved in the system.
- Some patients and their families may benefit from responders of the same background or with an understanding of their culture due to apprehension, fear, or mistrust of responders from ethnic or racial backgrounds different from their own. Conversely, in smaller ethnic and racial communities, patients may be more likely to know the responder and doubt the responder's ability to maintain confidentiality.
- Be aware that cultural beliefs may preclude a member of the opposite sex from being present when patients disrobe. Also, it may be uncomfortable for patients from some cultures to speak about the assault with members of the opposite sex.
- Understand that patients may not report or discuss the assault because the stigma associated with it is so overwhelmingly negative. For example, the loss of virginity prior to marriage may be devastating in their culture, or the discussion of an assault or sexual terms may be linked with intense embarrassment and shame.
- Recognize when a hospital chaplain may be of assistance in discussing culturally specific religious or spiritual healing with a patient and/or family.
- Consider establishing regular trainings and/or in-services at multidisciplinary team (MDT) meetings focusing on the unique cultural make-up of your service area.

Help patients obtain culturally specific assistance and/or provide referrals where they exist. Additional resources may be obtained by contacting the Sexual Assault and Domestic Violence Prevention Program at the Ohio Department of Health (614) 466-2144 or email HealthyOhio@odh.ohio.gov

LGBTQ Youth

The term *LGBTQ* stands for lesbian, gay, bisexual, transgender, and questioning, but is used more broadly to encompass a variety of sexual and gender identities (Human Rights Campaign Foundation) (Shrivastava, Karia, & Sonavane, 2017). Sexual orientation refers to an inherent enduring emotional, romantic or sexual attraction to other people, and can be primarily directed to the same gender, the opposite gender, both genders, or a person may not have sexual attractions to any gender. Gender identity refers to a person's innermost concept of self as male, female, a blend of both or neither; this may be the same or different from their natal sex (female/male sex assigned at birth). Gender expression includes the external appearance of one's gender identity, usually expressed through behavior, clothing, haircut or voice, and may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine. The term *transgender* is an umbrella term for people whose gender identity and/or expression is different from cultural expectations based on their natal sex; being transgender does not imply any specific sexual orientation or gender expression. Transgender youth may or may not have chosen to socially transition (dress or use names/pronouns that are socially recognized as their preferred gender) or physically transition through medical interventions.

Data from the National Intimate Partner and Sexual Violence Survey suggests that individuals who self-identify as lesbian, gay, and bisexual (LGB) experience an equal or greater likelihood of experiencing sexual violence, stalking, and intimate partner violence as compared with self-identified heterosexuals (Smith, et al., 2017). Additional data from the Youth Risk Behavior Surveys ("national intimate partner and sexual violence survey 2010 findings on victimization by sexual orientation

national center," 2010) shows that 19% to 29% of gay and lesbian students and 18% to 28% of bisexual students experienced dating violence in the prior year, and 14% to 31% of gay and lesbian students and 17% to 32% of bisexual students had been forced to have sexual intercourse at some point in their lives (The Human Rights Campaign Foundation, 2018). It is important that responders are aware of differences in sexual and gender identity, and are equipped to communicate in a sensitive manner, while understanding the unique medical and social needs of this population (Mathews, & Collin-Vézina, 2017). Further considerations are listed below:

- Intake forms and other documents that ask about gender or sex should allow patients to write in a response or include transgender and intersex options. Make sure questions appropriately distinguish between sexual orientation, gender identity, and natal sex.
- Forms used during the intake process and discussions with patients should be framed in a way that does not assume they are of a specific gender identity or gender expression. (e.g., nongendered body maps, if available, for transgender patients).
- Always refer to patients by their preferred name and pronoun, even when speaking to others. If unsure of what to call the person or what pronoun to use, ask.
- Treat the knowledge that the person is LGBTQ as protected medical information subject to all confidentiality and privacy rules. Be aware that companions of LGBTQ patients may not know their gender identity or sexual orientation.
- Be aware of your internal and external responses when you are told or discover that a person is transgender; our body language and immediate responses should be nonjudgmental and supportive.
- Understand that transgender people have typically been subject to others' curiosity, prejudice, and violence. Keep in mind that transgender patients may be reluctant to report the crime or consent to the exam for fear of being exposed to inappropriate questions or abuse. If the patient does consent to an exam, be especially careful to explain what you want to do and why before each step and respect the patient's right to decline any part of the exam.
- Be aware that transgender individuals may have increased shame or dissociation from their body. Some use nonstandard labels for body parts, and others are unable to discuss sex-related body parts at all. Reflect the patient's language when possible and use alternative means of communication if necessary.
- If a patient has undergone some level of medical transitioning, be aware that vaginas that have been exposed to testosterone or created surgically are more fragile than vaginas of most non-transgender women and may sustain more damage in an assault. There may be additional layers of psychological trauma for patients with a male identity or a constructed vagina when they have been vaginally assaulted.
- Transgender male individuals who still have ovaries and a uterus can become pregnant even when they were using testosterone and/or had not been menstruating.
- Some transgender patients may want to talk about their perceptions of the role their gender identity might have played in making them vulnerable to an assault. Because of their implication in possible prosecutions under hate crime laws, document any anti- transgender statements the patient says were made during the assault.
- Ensure that all referrals given to a transgender patient have been trained on or have significant experience with the special needs of transgender survivors of sexual assault.
- Include opportunities for LGBTQ individuals to influence the development of sensitive responses for patients of sexual assault.

Language Barriers

Language barriers can affect all aspects of the evaluation of a patient following sexual assault/abuse, and may contribute to discomfort, lack of complete disclosure, misunderstandings, and even medical errors. The American Academy of Pediatrics recognized in a 2013 Policy Statement that immigrant children represent the fastest growing segment of the U.S. population, and one in every four children in the U.S., approximately 18.4 million children, live in an immigrant family (Chilton et al., 2013). These children are particularly vulnerable, and may face a variety of challenges, including poverty, lack of health insurance, low educational attainment, and language barriers. In addition to immigrant children, providing language assistance services for other children with limited English proficiency, deaf and hard-of-hearing individuals, and those with sensory or communication disabilities is imperative for an effective and comprehensive assessment. Further considerations are listed below:

- Use certified and qualified interpreters and translators (U.S. Department of Justice, Office on Violence Against Women, 2016). Certification usually indicates that a person has met the minimal requirements of an accrediting body (usually a state or national organization) for providing interpretation and/or translation services in a specific language (Centers for Disease Control and Prevention, 2019).
- Responders should identify what languages are spoken by the patients and families they are serving and be aware of how to access interpreters for any language needed. Take the patient's country of origin, acculturation level, and dialect into account when responding or arranging interpretation. Use qualified interpreters when possible and not patients' families or friends.
- Be patient and understanding toward patients' language skills and barriers, which may worsen with the crisis of sexual assault.
- Let the individual specify the preferred method of communication. Be aware that patients with sensory disabilities may prefer communicating through an intermediary who is familiar with their patterns of speech.
- Not all individuals who are Deaf or hard-of-hearing understand sign language or can read lips. Not all blind persons can read Braille. Communication equipment that may be beneficial to patients with sensory disabilities include TTY machines, word boards, speech synthesizers, anatomically correct dolls, materials in alternative formats, and access to interpreter services. Responders should familiarize themselves with the basics of communicating with an individual using such devices.
- If using an interpreter, speak directly to patients. Consider the patient's need for modesty and privacy when determining where interpreters should be located in the exam room.
- Understand immigrant patients may fear that assisting law enforcement could identify them to immigration authorities for deportation.

VocaLink: Provides Interpreting, Translation, and Localization Services 877-492-7754

Human Trafficking

Background

Human trafficking is a global health issue and humanitarian crisis and is illegal under United States and international law.

As defined by the United States' Trafficking Victims Protection Act (TVPA) ("Victims of trafficking and violence protection act of 2000," 2000), trafficking in persons is defined as:

1. Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or
2. The recruitment, harboring, transportation, provision or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery ("Victims of trafficking and violence protection act of 2000," 2000).

TVPA states that sex trafficking of any person less than 18 years of age does NOT have to involve force or coercion, and transportation of a victim regardless of age is likewise NOT required to qualify as human trafficking ("Victims of trafficking and violence protection act of 2000," 2000).

Human trafficking is often referred to as modern-day slavery. Cases of human trafficking have been identified in at least 124 countries and in all fifty states (Polaris, 2019). Human trafficking involves women, men, and children from diverse backgrounds and educational and socioeconomic levels. Victims include both documented and undocumented citizens.

As of 2015, the U.S. State Department estimated there are approximately 27 million victims of human trafficking globally. Annually, about 900,000 persons are trafficked across international borders, with about 20,000 of these persons entering the United States. Half of all victims are younger than 18 years of age (Polaris, 2019).

Multiple types of human trafficking are recognized, including forced labor, bonded labor, debt bondage, involuntary domestic servitude, forced child labor, child soldiers, sex trafficking, and commercial sexual exploitation of children. As of 2014, the International Labour Organization estimates that forced labor and human trafficking is a $150 billion industry worldwide, with two-thirds, or an estimated $99 billion, resulting directly from commercial sexual exploitation (Polaris, 2019).

Several unique characteristics make Ohio particularly vulnerable to human trafficking, including intersection of major highway systems, relatively high minority and immigrant populations, easy border access to Canada and close proximity to major metropolitan cities, and a large number of truck stops.

While the scope of human trafficking is vast, for purposes of this protocol, content will focus on individuals involved in commercial sexual exploitation.

Commercial sexual exploitation of children (CSEC) is defined as "crimes of a sexual nature committed against juvenile victims for financial or other economic reasons. These crimes include trafficking for sexual purposes, prostitution, sex tourism, mail-order-bride trade and early marriage, pornography, stripping, and performing in sexual venues such as peep shows or clubs." (The National Academies of Sciences, Engineering, and Medicine, 2013). In the United States, the average age of entry into the commercial sex industry has been estimated at 12 to 14 years for females, and 11 to 13 years for males and transgender youth. According to the National Center for Missing and Exploited Children, approximately 100,000 children in the United States are at risk of being commercial sexually exploited annually (National Center for Missing and Exploited Children, 2019).

Risk Factors

As shown in Table 1, many potential risk factors for human trafficking exist. While some individuals demonstrate multiple risks, others may have no readily identifiable risk factors.

Table 1: Risk Factors for Human Trafficking, child or adult (not all inclusive)

Individual/Family

- History of welfare involvement.
- History of abuse/neglect (including sexual abuse).
- History of familial trafficking.
- History of drug addicted parent.
- History of foster care placement.
- Prior juvenile justice involvement.
- Adult prostitution in the home.
- Problems with parental supervision.
- Frequent runaway behavior.
- Pre-existing mental health problems.
- Poor academic performance and/or attendance.
- Learning disabilities.
- Poverty, homelessness.
- Substance abuse history.
- Gang membership.
- Parent with substance abuse history.
- Refugee fleeing conflict.
- Immigrant status (esp. undocumented).
- Member of socially marginalized group.
- Frequent "thrown away" episodes.*

Community

- Individual lives in or near area with transient male population (military bases, international airports, convention centers, truck stops, etc.).
- Adult prostitution in community.
- Perception of victim as a criminal.
- Community tolerance of child-adult sexual relationships.
- Poverty in community relationships.

Societal

- Over sexualization of girls.
- Glorification of "pimp culture."
- Countries with high rates of poverty, crime, corruption.

*Thrown away episode: "A child is asked or told to leave home by a parent or other household adult, no adequate alternative care is arranged for the child by a household adult, and the child is out of the household overnight; OR a child who is away from home, is prevented from returning home by a parent or other household adult, no adequate alternative care is arranged for the child by a household adult, and the child is out of the household overnight (Hammer, Finkelhor, & Sedlack, 2002).

Table 1 reprinted/used with permission from American Professional Society on the Abuse of Children. APSAC Practice Guidelines. The Commercial Sexual Exploitation of Children: The Medical Provider's Role in Identification, Assessment and Treatment. (Greenbaum et al., 2013).

Certain risk factors demonstrate significant association with commercial sexual exploitation of children and should be noted during patient discussion by the sexual abuse medical expert. One in three "runaway" children and adolescents become involved in the commercial sex industry at some point (National Council of Juvenile and Family Court Judges, 2015). Many of these children and adolescents engage in sexual acts to secure basic needs such as food, clothing, or shelter ("survival sex") or for other personal reasons. Estimates also indicate that 70% of all teens involved in the sex industry report a history of childhood sexual abuse (Greenbaum et al., 2013).

Victim Recruitment

Traffickers target potential victims with one or more vulnerabilities. In countries facing extreme economic challenges, the false promise of new opportunity and a better life — safe job, education or a secure marriage — may be enough for a family to allow a child to be given unknowingly to a trafficker.

Sex trafficking of minors in the United States occurs in diverse venues, such as shopping malls, truck stops, bus stations, schools, and via varied social media sources. Traffickers employ various tactics to lure children and adolescents including bribes of money and gifts, seeming fulfillment of personal needs, or other untrue promises. Potential victims may also be recruited by current victims working for the trafficker.

Presentation

Individuals at risk for or actively involved in being trafficked rarely self-identify as being trafficked when presenting for medical care. However, at some point while being trafficked, many victims interact with the healthcare system. This provides a critical opportunity for intervention by sexual abuse medical experts.

Numerous inherent challenges impede victim self-identification including cultural "glamorization" of certain lifestyles portrayed in media; emotional control and psychological abuse exerted by traffickers over victims; traffickers' threats regarding arrest and/or deportation; isolation tactics resulting in total dependency on a trafficker for survival; victim use (often forced by trafficker) of substances such as alcohol and/or illicit drugs, which creates additional dependency on trafficker; victim lack of knowledge regarding how to access help; and in some cases, victims who are involved in familial sex trafficking by a primary caretaker.

Victims may present with a variety of potential indicators of trafficking as noted in Table 2. Sexual abuse medical experts must be vigilant for potential concerns and seek opportunities to intervene.

Table 2. Possible Indicators of Human Trafficking

- History of multiple sexual partners in short period.
- Shows distrust of adults or the accompanying person.
- Has signs of lacking healthcare, and or malnutrition.
- Has history of multiple STIs, or pregnancy/abortion.
- Patient provides information that appears to be recited.
- Patient has tattoos, evidence of branding gang insignia.
- Reports "boyfriend" who is significantly older than the patient.
- History of involvement with child protective services, abuse/neglect.
- Signs that patient is being controlled (domineering person accompanying child or adult).
- Patient has history of living outside of home, with "friends."
- Has signs of substance use/abuse.
- Has signs of physical abuse.
- Fearful, withdrawn, depressed or submissive.
- Patient has hotel room keys.
- Patient has poor school attendance.
- History of running away from home (esp. more than three times in past year).
- Patient gives false or changing demographic information.
- Patient has large amounts of cash, or expensive items (jewelry, electronics, clothing).

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Preparing for the Medical History

Special preparation is required when eliciting medical history from individuals presenting with possible indicators of human trafficking. When speaking with patients to obtain such history, it is mandatory to do so *without* the person(s) accompanying the patient present. As the person presenting with the patient could be a trafficker or someone affiliated with a trafficker, eliciting private medical history from the patient is critical.

In order to facilitate this process, begin by explaining to the patient and any companion(s) that it is standard practice for the sexual abuse medical expert and/or social worker to *obtain history from the patient alone*. Then ask the patient's companion(s) to wait outside of the exam room in a location that is a distance away (i.e., waiting room). It is important that the history be obtained in a private exam room location while assuring the exam room door remains closed.

Ask the patient about any immediate personal safety concerns. Example questions may include: "*Is it safe for you to talk to me?*" or "*Is there a problem if we talk alone awhile?*" In some cases, the child or adolescent patient may fear the trafficker will retaliate if a discussion is held without the trafficker present. If the patient appears fearful, declines to reply, or indicates that they are not safe, consider further follow-up questions. Depending on the particular situation, potential questions may include: *"Are you able to say what makes you feel unsafe talking to me alone?* or "*Is there something we can do so you can feel safe talking to me?*" Continue to be aware of the time spent alone with patients in this situation and ask if they are feeling differently about their safety during the course of the conversation.

Prior to the start of the medical history, it is mandatory to discuss with the patient the limits of confidentiality, mandated reporting of abuse and neglect concerns, and the purpose for the medical history. Offering an explanation about why the sexual abuse medical expert will ask a detailed history, including multiple personal questions, in order to provide the patient with the best possible medical care provides a reassuring environment, and may encourage the patient to engage in more open dialogue. The patient should be reminded that they may refuse to answer any question, are to ask for clarification of questions asked, and may stop the discussion at any time.

Use of Interpreters

In select cases, an interpreter may be necessary to collect patient history. Given the highly sensitive and potential significant safety risks posed with cases of human trafficking, every effort must be made to ensure accurate communication between possible minor patients and medical staff as well as interpreters.

The person(s) accompanying the patient should NOT be used as an interpreter under any circumstances.

Interpreter services may be secured by local sexual abuse medical expert s in various ways. In all cases, a professional interpreter who does not know the patient, the person(s) accompanying the patient to the medical site, or the patient's family is required.

Sexual abuse medical experts in the state of Ohio may access a professional *over-the-phone* interpreter by contacting **Vocalink Global** at **877-492-7754**. The service is available 24 hours daily. An account must be established by the sexual abuse medical expert either prior to or at the time of service. A fee will be charged to the medical site using the service. In addition, with 48 hours advanced notice, an *in-person* interpreter may be scheduled by phoning Vocalink Global. A fee will likewise be charged to the medical site using in-person interpreter services.

Medical staff using an interpreter should privately prepare the interpreter prior to the patient interview by reviewing the following:

1. Importance of translating child's and sexual abuse medical expert's words as closely and completely as possible.
2. Potential that child will be fearful of disclosing information.
3. Potential challenging behaviors of child during interview (e.g., hostile, distrusting, withdrawn).
4. Need to tell provider if interpreter identifies signs that the child is in distress.
5. Importance of maintaining nonjudgmental, open, supportive attitude, and not showing anger, horror, pity, etc.
6. Commonly used street terms.

Medical History

It is important to establish initially the reason why the individual is seeking medical care. This allows the patient to recognize the provider's interest in the patient's well-being, permits assessment and care of any emergent concerns, and provides the patient with a feeling of control over the visit. It is vital for every sexual abuse medical expert to approach each patient with a sensitive and nonjudgmental attitude, regardless of any perceived "motivation" for the patient's potential engagement in sexual activity.

Setting an appropriate "tone" during patient interaction is often the key to assuring a comfortable and thorough medical evaluation for a patient. Table 3 offers ways to supportively approach and appropriately interact with patients during a medical interview when suspected human trafficking.

Tips for Interviewing Commercial Sexual Exploitation of Child Patients

- Show your interest; listen actively, carefully, and responsively.
- Consider any preconceptions and prejudices you may have.
- Remain open-minded and nonjudgmental.
- Maintain professionalism while treating persons with respect and compassion.
- Ensure child feels in control of own body and communications.
- Inform child of the right to a forensic medical exam and report.
- Reassure child they are not to blame.
- Establish rapport.
- Allow enough time.
- Gauge how much information is needed and what patient is able to provide.
- Accept the individual without trying to alter views/plans/actions.
- Treat the individual as someone who needs services, not as a criminal offender.
- Control your own emotions. Avoid showing anger, frustration.
- Maintain neutral posture and expression.
- Ask open-ended questions when possible.
- Look for nonverbal information (clues to maturity level, intoxication, stress reactions) .
- **Avoid:**
    - Leading questions.
    - Assumptions and interruptions.
    - Acting like surrogate parent or buddy.
    - Power struggles.
    - Continuous direct questions (interrogation).

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Screening Questions for Possible Child Commercial Sexual Exploitation/Sex Trafficking

- The following questions are suggested to the sexual abuse medical expert to ask when speaking privately with a patient.
- Questions should be individualized for each patient's presenting situation and developmental/emotional status.
- If a question elicits a "yes" response from the patient, the sexual abuse medical expert should follow up with additional statements and questions for clarification as the patient is willing to share.
- The patient should NOT be forced to disclose any information they are not comfortable to report. (Greenbaum et al., 2013).

1) Sometimes people say things happen that make them feel scared or not safe. Has anyone ever threatened you or your family in any ways?
2) Can you leave your home whenever you want?
3) Some people get hurt. Have you ever broken any bones, had any cuts that required stitches, or been knocked unconscious? Has anyone ever hurt you physically?
4) Some people have a hard time living at home and feel that they need to run away or leave. Have you ever left home?
5) People often use drugs or drink alcohol, and different kids use different drugs. Have you ever used drugs or alcohol?
6) Sometimes people have been involved with the police. Maybe for running away, for breaking curfew, or for shoplifting. There can be lots of different reasons. Have you ever had any problems with the police?
7) Some kids have sex. Have you ever had any kind of sex (explore oral, vaginal, or anal contact with age-appropriate terms)?

   If "Yes" response, then ask: Has anyone ever done something to your body or made you have any kind of sex that was forced or not your choice?
8) Have you ever had or been worried that you may have a sexually transmitted infection, like herpes, gonorrhea, chlamydia, or trichomonas? (For Females): Have you ever been pregnant, or been worried you were pregnant?
9) Has a boyfriend, a girlfriend, or anyone else ever asked you or forced you to do something sexual with *another* person (including oral sex, vaginal sex, or anal sex with someone else)?
10) Sometimes people are in a position where they really need money, drugs, food, or a place to stay. Have you ever traded sex for money, drugs, a place to stay, a cell phone, or something else?
11) Has anyone ever asked or forced you to do some sexual act in public, like dance at a bar or a strip club, or post your picture on the internet? (Greenbaum et al., 2013).

What If Screening Questions Indicate Concern for Human Trafficking?

1) Remain calm, professional, and nonjudgmental.
2) Do *NOT* refer to patient as a "victim."
3) Reassure patient generally about the information that was shared.
4) Remind patient that they have a right to be safe and healthy.
5) Do *NOT* confront suspected trafficker and do *NOT* share any of patient's disclosed information with person(s) accompanying the patient.
6) Inform patient of physical exam, testing, and treatment options as indicated and complete such with patient agreement.
7) Report suspected concerns to appropriate legal authorities.
8) Address patient's follow-up care.

Physical Examination, Forensic Evidence Collection, and Testing

The sexual abuse medical expert should obtain the adult's consent and the minor's assent prior to completion of the physical exam, testing, and treatment. Refer to the physical examination, forensic evidence collection, and testing section for sexual assault patients. See Section 3 for additional details about adult consent.

Emotional Outcome of Human Trafficking

Patients of trafficking endure various forms of emotional trauma and may experience differing short- and long-term negative psychological effects. Feelings of worthlessness and guilt, memory loss, depression, anxiety, panic attacks, post-traumatic stress, and substance use/abuse are common, and suicidal ideation and attempt may also occur. Aside from thorough medical assessment and care of physical conditions and concerns, sexual abuse medical experts must also address the complex psychological issues of patients to assist with securing both acute and nonacute mental health services.

Reporting

In Ohio, all medical staff are mandated reporters of child abuse and neglect. Commercial sexual exploitation of children is considered a form of child abuse. Disclose your status as a mandated reporter and explain limits to confidentiality (i.e., safety). If appropriate, educate the patient on what human trafficking means and call attention to red flags.

For all children and adolescents younger than 18 years of age, the following referrals are recommended in any case of suspected abuse or neglect, including possible commercial sexual exploitation of children (CSEC):

1) Ohio Department of Job and Family Services.
   a. Report to the county children services agency in which the child resides.
   b. (855)-OH-CHILD (855-642-4453) is a toll free, automated directory to link callers directly to a child welfare/child protective services agency in any Ohio county.
2) Law enforcement.
   a. Police or sheriff – report to the jurisdiction in which trafficking/exploitation occurred (if known).
   b. Federal Bureau of Investigation (FBI):
      - Cincinnati office: 513-421-4310
      - Cleveland office: 216-522-1400
      - Columbus office: 614-224-1183
      - Dayton office: 937-222-7485
   c. If your region has a human trafficking task force, consider establishing a regional protocol for response to human trafficking.
3) For transnational victims, contact U.S. Immigration and Customs Enforcement: (866-872-4973) for victim support and legal advocacy.

If patient is older than 18 years of age, sex trafficking is likewise a crime, though does not require a mandated report to authorities. However, IF an adult patient agrees, the sexual abuse medical expert may contact law enforcement. Whether a report is filed or not, adult patients should be offered support services.

Follow-Up Care

Sexual abuse medical experts should recommend appropriate follow-up as indicated. Assistance from medical social workers and local children services agency should be sought as necessary to ensure follow-up is secured.

1. Mental health evaluation for acute safety concerns (suicidal ideation, self-harm).
2. Referral for appropriate outpatient counseling services.
3. Follow-up examination and testing with a physician specializing in child abuse pediatrics.
4. Referral to OB-GYN.
5. Subspecialist for additional medical issues identified.
6. Dental care.

Additional Resources

1) Human Trafficking National Hotline: 888-373-7888. Victim assistance and support services
2) Polaris Project: https://polarisproject.org/

3. Informed Consent

Consent for Medical Treatment

The minor patient may come in "with" or "not with" their custodial person (parent or guardian). Ideally, the parent or guardian is present and able to follow usual procedure for parental consent for treatment of a minor. The standard consent to treat is sufficient in sexual abuse cases. If the parent or guardian is not already present, it is recommended that a custodial person (parent or guardian) be notified at the time of the hospital visit, by the minor, whenever possible, unless the parent or guardian is alleged to be the perpetrator.

A minor who is a victim of sexual abuse or assault does not need to have the written consent of a parent or legal guardian before proceeding with the forensic examination. A minor may consent to a forensic exam, and this consent is not subject to disaffirmance because the patient is a minor. The consent of the parent(s) or legal guardian of the patient is not required for an exam. However, according to the Ohio Revised Code (ORC) 2907.29, the parent(s) or guardian must be notified in writing after the exam. In cases of child sexual abuse, safety issues for the child patient need to be considered before notifying a parent, guardian or caregiver.

Hospital personnel must advise the minor patient about the written requirement to notify a parent or guardian concerning the treatment. If the alleged perpetrator is also the parent or guardian and will receive the written notification, the local children's services agency, the law enforcement agency involved, and the minor child shall all be advised of the nature of the notification letter and the approximate date when the notification will be mailed.

For situations in which the requirement to notify a parent/guardian is likely to endanger or cause harm to the child, coordination with the local children services agency must be done to ensure the safety of the child. Ohio Administrative Code (OAC) Rule 5101:2-36-03 requires the children services agency to interview and advise the alleged perpetrator of the allegations and to assess/investigate the allegations and determine the safety of the child. Medical personnel should also consult with their agency's legal counsel with regard to the notification requirement.

- If an unwilling minor is brought in for a sexual abuse exam by a parent or guardian, the minor must agree to submit to the exam after discussion with the physician, nurse, social worker, or other healthcare provider, without the necessity of restraints or sedation. If the patient does not consent to the examination, force should not be used. In addition, if the patient is incoherent/intoxicated, the exam should be postponed and completed as soon as the patient is able to give consent.

Under Ohio law Ohio Revised Code Section 3701.242. a minor (regardless of age) may consent without the authorization of a parent or legal guardian to:

- Diagnosis or treatment of any sexually transmitted infection by a licensed physician.
- Being given an HIV test.

In addition, a minor may give consent to diagnosis or treatment of any condition that is reasonably believed to be caused by drug or alcohol abuse Ohio Revised Code Section 3719.012.

Note:

- The minor patient may consent to such diagnoses and treatment *without* the consent of a parent or legal guardian. Thus, a minor may independently seek testing and treatment for sexually transmitted infections. This statute is *not* limited by the age of the minor.
- In a situation in which a minor has independently sought diagnosis or treatment for sexually transmitted infections, the minor controls the disclosure of such health information. In the case of a positive test result under these circumstances, the parent or legal guardian does not need to be notified of the positive test result under Ohio law. However, section 2907.29 of the Ohio Revised Code, (https://codes.ohio.gov/ohio-revised-code/chapter-2907) does require written notification to the parent or legal guardian when a sexual assault examination has occurred.
- Patients should be informed *prior* to the beginning of a physical exam and/or testing of the specific information that legally must be shared with a parent/legal guardian and/or with the children services agency and law enforcement.
- Sexual abuse medical experts should ideally speak in detail with all minor patients independently seeking testing and treatment for STIs, and exercise reasonable clinical judgment. If feasible and appropriate, medical staff should encourage such patients to share medical concerns, testing, and treatment decisions with a parent/legal guardian, *unless* doing so may jeopardize a patient's safety or willingness to obtain medical care. Sexual abuse medical experts should offer patients assistance with discussing medical testing and treatment plans with their respective parent and/or legal guardian to provide additional patient support.
- Under Ohio law, section 2907.29 of the Ohio Revised Code (https://codes.ohio.gov/ohio- revised-code/chapter-2907) each patient reporting a sexual assault *must* be informed of available testing for sexually transmitted infections, pregnancy, and other medical and psychiatric services.

Sample Notification Letter

Hospitals/facilities can send the following notification letter after examining a minor without parental consent.

Date

Patient/ Caregiver
Address
City, State, ZIP code

Minor Patient's Name
Date of Examination
Dear Parent/Guardian or Caregiver:

On the date indicated above, your child was treated in the emergency department of our facility. This examination is not your financial responsibility.

If you have any questions, please call (*Name of Contact Person*), at (*Phone Number of Contact Person*).

Sincerely,

Signature
Typed Name
Title

c: Minor Patient

4. Guidelines for Reporting

The Ohio Revised Code section 2151.421 (https://codes.ohio.gov/ohio-revised-code/section- 2151.421) mandates that medical staff are required to make a report to child protective services or law enforcement if they suspect that abuse is taking place. The law requires that you make a report if you believe that a reasonable person would also suspect abuse or neglect, given the same circumstances. You do not have to provide proof when making a report of abuse. It is not your responsibility to conduct an investigation. In fact, questioning too many individuals regarding your concerns may interfere with a formal investigation.

You should report abuse or neglect even if someone tells you that it has already been reported. You may have additional information that was not previously reported to the child protective services agency.

When making a report, you should try to include the following information:

- The name and address of the patient you suspect is being abused/neglected.
- The age of the patient.
- The name and address of the parent(s), guardian, or caregiver.
- The name of the person you suspect is abusing or neglecting the patient and the address, if available.
- The reason you suspect the patient is being abused/neglected.
- Any other information that may be helpful to the investigation.

It is the responsibility of medical personnel to inform the patient and/or patient's legal guardian that law enforcement and/or child protective services will be notified, unless concern exists that informing the patient and/or patient's legal guardian may pose a safety risk to the patient.

Reporting Suspected Sexual Abuse/Assault

- Under Ohio law (ORC 2151.421) (https://codes.ohio.gov/ohio-revised-code/section-2151.421) all medical staff are mandated to report stated or suspected sexual abuse of a patient younger than 18 years of age (or an older child with significant developmental delays), regardless of whether the patient and/or legal guardian/caregiver agree to speak with investigating agencies.
    - Physical proof or other forms of validation are not required.

- The name of a minor (younger than 18 years of age) sexual abuse patient must be reported to the legally mandated authorities even when the patient or patient's family wishes not to report.

It is a misdemeanor criminal offense for mandated reporters to fail to report suspicions of child abuse or neglect. Failure to report could jeopardize your licensure. If you make a report in good faith, you are immune from civil or criminal liability if complaints about you intentionally providing false information are unfounded.

The child protective services agency to which the report should be made is determined by where the parent(s) or guardian resides. The law enforcement jurisdiction is determined by where the alleged abuse took place.

Age 12 or younger

All children under age 13 who report any form of sexual activity must be screened by child protective services for sexual abuse. Cases may be reviewed with law enforcement in the incident occurred to determine if the incident rises to the level of a crime.

Ages 13, 14, 15 years

File a report of sexual abuse with the local child protective services agency and/or law enforcement agency if any of the following are noted:

- The sexual partner is more than four years older.
- The sexual partner used force or coercion.
- The sexual partner misused their authority (i.e., authority figure).
- There was a significant difference in maturity levels between the patient and sexual partner (i.e., patient is cognitively or developmentally delayed).
- There was impairment (i.e., developmental delay, intoxication) rendering the person unable to consent.
- There are protective issues (i.e., the child lives on the street, is a runaway, or there is a significant lack of supervision, which puts the child at risk for abuse, injury, etc.).

Consider filing if the sexual partner is over the age of 18 but less than four years older than the minor patient. In this situation, law enforcement might charge the partner with the corruption of a minor.

The guidelines above may not prove applicable in all situations. Professional judgment must be used. In 13, 14 and 15-year old children, abuse may be present even when the age difference between partners is four years or less. The professional must carefully assess the situation and should seek consultation with social work, child protective services, or the relevant police jurisdiction.

Age 16 or Older

Generally, 16 years of age is the age of consent in Ohio.

However, if the patient is 16 years of age and reports having “consensual” sexual activity with a partner who is 18 years or older, the patient’s legal guardian may opt to contact the local police agency to file charges. In this situation, the medical staff would not file a child abuse report.

A report of sexual abuse should be made when any of the following issues are present:

- The sexual partner used force or coercion.
- The sexual partner misused their authority (i.e., authority figure).
- There was a significant difference in maturity levels between the patient and sexual partner (i.e., patient is cognitively or developmentally delayed).
- There was impairment (i.e., developmental delay, intoxication) rendering the person unable to consent.
- There are protective issues (i.e., the child lives on the street, is a runaway, or there is a significant lack of supervision, which puts the child at risk for abuse, injury, etc.)
- A human trafficking situation is suspected. Under federal law, it is illegal for 16- and 17-year- olds to be trafficked and should be reported to law enforcement.

Mandatory Reporting and Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The HIPAA privacy rule and its implementing regulations (45 CFR Part 160 and Subparts A and E of Part 164) established national standards for the protection of certain individually identifiable health information created or held by health plans, certain healthcare providers, and health clearinghouses. Healthcare facilities and medical personnel involved in caring for child sexual abuse patients should be instructed that (1) mandated child abuse and neglect reporting laws fit under exceptions to HIPAA and require the release of information as allowable by applicable laws when reporting is triggered (Gudeman, & Monasterio, 2014); and (2) they may disclose only information that is necessary to satisfy a jurisdiction's mandatory reporting requirements.

SECTION B OPERATIONAL ISSUES

This section presents operational issues. The following chapters are included:

1. Sexual Assault Forensic Examiners (page 39)
2. The Medical Evaluation (page 42)
3. Evidence Collection (page 43)

1. Sexual Assault Forensic Examiners

Caring For Yourself/Vicarious Trauma

How to define it

Those who care for children experiencing trauma, including sexual abuse, are at risk of developing what is known as vicarious trauma (VT). Vicarious trauma is also known as secondary trauma or compassion fatigue. The emotional responses that professionals experience while empathically working with abused children are normal. However, repeated exposure to traumatic histories can lead to vicarious traumatization. VT can impact the professional's sense of self and interpersonal relationships. VT has also been associated with depression, anxiety, substance abuse, and burnout. Other signs of VT include social withdrawal, feeling alienated from friends and partners, and the inability to enjoy things that were enjoyable in the past (Department of Health and Human Services, 2018).

Who experiences it?

VT has been studied among physicians, social workers, therapists, and nurses in various roles of patient care. Every individual experiences trauma differently. The response the caregiver has depends on current circumstances, early experiences, and personal history of trauma. Sexual assault nurse examiners (SANEs) have been shown to experience higher levels of VT than other women's health nurses (Townsend, & Campbell, 2009).

Prevention techniques

Having the support of supervisors who are aware of and recognize the role of VT in personal and professional lives is a factor that supports resiliency. It is important that hospitals, clinics, and SANE programs provide a support network for those caring for abused children to discuss their reactions to their work. Maintaining a healthy personal life, self-care, and higher job satisfaction are also protective factors against developing VT (Townsend, & Campbell, 2009).

For more information:

www.nctsn.org/resources/topics/secondary-traumatic-stress.

Examiner Court Appearances

Note: *The author wrote about service as an expert witness in Narang, SK; Melville, JD. "Legal issues in child maltreatment." Pediatric Clinics of North America (2014); 61:1049- 1058. This section is based on that prior work. (Narang, & Melville, 2014).*

Testifying as an Expert Witness

When a legal controversy involves specialized or technical information, the courts frequently turn to expert witnesses. The Federal Rules of Evidence (Medical Legal Publishing, 2019) define an expert as someone with "scientific, technical, or other specialized knowledge" who would assist the judge or jury in deciding the case. While many sexual abuse medical experts may hesitate to serve as an "expert" in child abuse, most healthcare professionals possess the required level of expertise. A witness does not need to have a specific specialization or emphasis in child abuse to testify as an expert. Providers who are unsure about their qualification as an expert can consult with more experienced providers, such as a physician specializing in child abuse pediatrics (Narang, & Melville, 2014).

A provider will typically become aware of an impending trial by receiving a subpoena. A subpoena might require testimony (subpoena ad testificandum), the production of documents (subpoena duces tecum), or both. Thus, it is important to read the subpoena carefully to ascertain what disclosures are required, and therefore allowed, by the subpoena (Narang, & Melville, 2014).

A subpoena ad testificandum may require testimony at a trial or a deposition. A deposition is a recorded statement made under oath but without a judge or jury present. If a sexual abuse medical expert receives a subpoena duces tecum for a document that the sexual abuse medical expert did not create, the sexual abuse medical expert should notify the issuing attorney of the proper "custodian of records" who would be responsible for producing the record (Narang, & Melville, 2014).

A subpoena does not require a witness to speak to either attorney prior to the trial or deposition. Generally, however, the best practice is to call the attorney who issued the subpoena. The attorney may be able to accommodate the witness' schedule or accept documents without an appearance. An attorney will frequently need to receive the witness' curriculum vitae prior to trial.

An attorney should discuss the witness' anticipated testimony. The witness should point out important facts or opinions that the attorney may choose to emphasize. Sometimes the attorney may be able to predict the opposing attorney's questions on cross examination. If the opposing party has retained an expert, the attorney should share the opposing expert's report (Narang, & Melville, 2014).

A medical expert must be completely familiar with the facts of the case, and especially facts regarding the patient's medical care. Most courts will permit a witness to refer to notes during testimony, but the witness should be prepared to discuss much of the case from memory. Witnesses should also be aware that any notes used during testimony may be taken and examined by either party. The witness should be familiar with the entire chart, not just the parts pertaining to abuse or neglect.

Expert testimony begins with "qualification" of the witness. The witness will describe education, training, research, teaching, and other qualifications to suggest that the expert has "specialized knowledge" that would be relevant to the court. The judge decides whether or not to allow the witness to testify as an expert. Testifying as an expert allows the witness to offer opinions in court (American Medical Association, 2019). Nonexpert, or fact, witnesses may only testify to specific facts that the witness personally observed.

The witness will then be asked questions about the matter before the court. Direct examination, or questions from the attorney who called the witness, precedes cross examination by the opposing attorney. For all questions, the best answers are clear and succinct, but scrupulously correct. A witness may consider himself or herself to be teaching the court about the topics discussed. Avoid the appearance of bias by providing clear and respectful responses to all parties.

Various legal rules may limit what a witness is permitted to discuss. These need not concern the witness because it is the attorney's job to ask questions that elicit admissible testimony. An attorney who fears one of these rules may be broken can object to a question or response. The witness should sit quietly and allow the court to handle the objection.

Inexperienced witnesses sometimes feel pressure to "prove" or "win" the case when the responsibility to prove the case actually lies with the attorney. The expert should recall that they are not the only witness, and may not be the best or even a permissible witness to a given fact. At times, certain facts must be introduced first to "lay a foundation" for other facts. An expert witness appears biased when they force favorable facts into the answer to a question that does not call for them.

Sometimes the correct response to a question, especially a question on cross examination, will give an incorrect impression. The attorney who called the witness will have another opportunity, called re- direct, to ask questions after the cross-examination. If a question on cross-examination requires clarification, the attorney can ask another question.

A small minority of experts who give irresponsible testimony harms the legal system (Chadwick, & Krous, 1997). Irresponsible testimony includes testimony beyond the expert's actual expertise or testimony based upon idiosyncratic theories that do not enjoy wide acceptance in the medical community. The American Medical Association Code of Medical Ethics (2019) requires that physicians testifying based upon "a theory not widely accepted in the profession" must "characterize the theory as such."

For more information:
pediatrics.aappublications.org/content/early/2017/02/16/peds.2016-3862.

2. The Medical Evaluation

Consent for Care

Be aware of which healthcare procedures require consent during the exam process. (See Section A3.) Consent sought by healthcare providers related to the examination generally should cover the following, as applicable/indicated in a specific case:

- Initial healthcare assessment.
- The medical forensic examination.
- Testing and treatment (e.g., STIs, including HIV, and toxicology).
- Forensic sample collection.
- Photo documentation of the exam findings.
- Permission to contact the child and caregiver for medical follow-up purposes.

The healthcare provider needs to identify the person(s) responsible for providing permission for the child's care (e.g., the parent/guardian). The provider also needs to know the mechanism in place at their facility to obtain consent for care if abuse or neglect of the child by the parent/guardian is suspected or if a parent/guardian refuses to consent or is absent. (In such instances, child protective services and/or law enforcement should be consulted immediately, as a court order may be needed to take the child into protective custody. In some instances, parental/guardian consent is not needed.1 Be aware that consent can be withdrawn at any time during the exam process.

In addition to seeking consent, seek children's assent for care throughout the exam process. Assent is the expressed willingness of an individual to participate in an activity. Assent should be sought from children who are, by jurisdictional definition, too young to grant informed consent for care but old enough and/or developmentally able to understand and agree to participate in that care.

Tailor the process of seeking assent and consent so it is developmentally and linguistically appropriate for children and parents/guardians.

Do not proceed with an examination without the cooperation of the child, even if the child's parent/guardian gives consent (with exception in instances of serious medical injury, pain, or trauma to be evaluated/treated).

3. Evidence Collection

Basic evidence collection is built on the understanding that where contact between two objects exists, there also exists the possibility of material transfer (Lynch, & Duval, 2011). Any contact between a perpetrator, child, and the crime scene itself may hold corroborating evidence. Seek as much forensic evidence as possible, guided by the medical history, information from investigative agencies, examination findings, and the child's assent to procedures. This evidence may be trace materials and/or body fluids from the perpetrator. During medical forensic care, forensic samples should be taken from areas of the child's body where evidence may exist. Clothing, especially underwear, and linens are the most likely positive sites for evidentiary DNA in prepubescent children (U.S. Department of Justice Office on Violence Against Women, 2016). Investigating agencies may also look for evidence on other items from the child's home and scene of abuse. Information derived from analysis of biological and trace evidence may help determine if sexual contact occurred, provide data regarding the circumstances of the incident, and be compared with reference samples collected from children and suspects for identification purposes. Follow facility policies for drying, packaging, labeling, sealing, and storing forensic specimens, as well as maintaining the chain of custody of forensic evidence until released to the appropriate law enforcement agency. Contact law enforcement, prosecution, and/or the crime lab with any questions. Proper management of forensic evidence is critical to avoid loss or alteration of evidence and to allow for its admissibility during a trial.

It is imperative that evidence be properly collected, preserved, and analyzed so that, should the assailant be prosecuted, effective evidence will be available to law enforcement officials. Proper collection and handling of evidence is vital. Legal protocol dictates a "chain of custody" wherein each individual handling the evidence documents receipt and delivery of the specimens. This procedure helps rule out possible improper handling of evidence. Should prosecution occur, proper collection of evidence increases the probability of conviction.

When collection of trace forensic evidence is indicated:

- Carefully follow all directions provided in the Ohio Sexual Assault/Abuse Evidence Collection Kit and maintain the chain of evidence. See the Ohio Protocol for Sexual Assault Medical Forensic Examinations for Adults/Adolescents Section C6. Refer to the "Detailed Instructions for Ohio Department of Health Sexual Assault/Abuse Evidence Collection Kit" for detailed specimen collection instructions. All specimen collection envelopes should be labeled with patient identifiers regardless of whether they are used. If not used, state the reason for exclusion on the envelope and include it with the rest of the specimen collection envelopes in the evidence collection box.
- **An ultraviolet (UV) lamp exam, such as Blue Max or similar UV frequency lamp (NOT a Wood's lamp)**, should be performed in a dark room, checking all skin areas likely to be stained by semen or saliva. Other substances will fluoresce besides semen and saliva. A fluorescent stain is NOT evidence of semen or saliva, but these stains should be collected for analysis by the crime lab.
- The law enforcement agency may ask for additional tests and/or specimens. These requests should be honored if medically and forensically indicated. Tests related to the medical work- up should be done at the discretion of the treating physician or healthcare provider.
- Patients have a right to decline evidence collection at any point during the exam and choose portions of the exam they do not want.
    - If a patient is reluctant to go through an exam at the parent/guardian's request, discuss with patient to ascertain why they do not want it, answer patient questions, and adjust care accordingly.
    - Patient has the right to decline the medical forensic exam or any part of the exam even if the guardian is requesting.
- Patients who disclose a history of digital-genital contact should still have evidence collection performed.
- A prepubescent female must not have speculum exam unless there is associated trauma requiring sedation and surgical intervention (U.S. Department of Justice, Office on Violence Against Women, 2016).
- Parents/legal guardians cannot refuse evidence collection. (Refer to Informed Consent information on page 32.
- Obtaining an assault history, including the patient narrative, is vital to determine the best areas to swab outside of genital contact. Swab any areas where there was significant contact such as licking of body parts, strangulation, restraining with hands, squeezing of breasts or rubbing of an area with hands because evidence of perpetrator body fluid, such as saliva, might be present.

SECTION C
THE EXAMINATION PROCESS

This section focuses on the various medical and forensic components of the exam process, from the initial contact with victims to court testimony by examiners on exam findings.

The following chapters are included:

1. Timing of the Evaluation

The timing of a medical evaluation can be prioritized as indicated in the table below. Guidelines for conducting the evaluation are outlined in the sections that follow.

	Timing of Evaluation	Medical Indications
Indications for emergency evaluation	Evaluation scheduled without delay.	Medical, psychological, or safety concerns such as acute pain or bleeding, suicidal ideation, or suspected human trafficking. Reported assault that may have occurred within the previous 72 hours (or 96 hours for pubertal patients) necessitating collection of trace evidence for later forensic analysis. Emergency contraception and STI prophylaxis can be provided up to 120 hours after exposure. Non-occupational post- exposure prophylaxis (nPEP) needs to be within 72 hours of exposure to prevent human immunodeficiency Virus (HIV). (www.cdc.gov/std/treatment-guidelines/sexual-assault-children.htm)
Indications for urgent evaluation	Evaluation scheduled as soon as possible with qualified provider.	Suspected or reported sexual contact occurring within the previous two weeks, without emergency medical, psychological, or safety needs identified.
Indications for non-urgent evaluation	Evaluation scheduled at convenience of family and provider but ideally within one to two weeks.	Disclosure of abuse by child, sexualized behaviors, sexual abuse suspected by MDT, or family concern for sexual abuse, but contact occurred more than two weeks prior, without emergency medical, psychological, or safety needs identified.
Indications for follow-up evaluation	As determined by qualified provider.	Findings on the initial examination are unclear or questionable necessitating re-evaluation. Need for further testing for STIs not identified or treated during the initial examination. Documentation of healing/resolution of acute findings. Confirmation of initial examination findings, when initial examination was performed by an examiner who had conducted fewer than 100 such evaluations.

Adams, J. A., Kellogg, N. D., Farst, K., Harper, N., Palusci, V. J., Fraiser, L. D., Levitt, C. J. (2016). Updated guidelines for the medical assessment and care of children who may have been sexually abused. Retrieved from https://www.sciencedirect.com/science/article/pii/S1083318815000303.

2. Medical History

Recognize that the medical history is a critical component of medical forensic care, both acute and nonacute. The pediatric examiner, prior to the examination, should seek information regarding the child's health and symptoms, including the specific circumstances of sexual abuse. The process of taking medical history as part of medical forensic care is similar to any other medical history taking; chief complaints/history of present illness; review of systems; and medical, family, and psychosocial history. Sexual abuse is the presenting medical issue about which the examiner needs information to provide care. The history subsequently guides the examination, formulation of a diagnosis, treatment and other healthcare interventions, and discharge planning, and helps determine if and which forensic evidence collection procedures are necessary (Adams et al., 2016).

Recognize that a forensic interview is different from the medical history. A forensic interview is a structured conversation with a child intended to elicit detailed information about a possible event(s) that the child may have experienced or witnessed. The purposes of the forensic interview are:

1. To obtain information from a child that may be helpful in a criminal investigation.
2. To assess the safety of the child's living arrangements.
3. To obtain information that will either corroborate or refute allegations or suspicions of abuse or neglect.
4. To assess the need for medical treatment and psychological care.

Be familiar with the key parts of history taking. At the start of history taking, examiners should make clear to the child and caregiver that their role is to obtain a medical history for the purpose of diagnosis and treatment, and that the medical history is not an investigative interview. After building rapport and assessing the child's circumstance and developmental level, examiners can explain that questions will focus on the sexual abuse event(s), the child's medical condition, and the child's family and psychosocial history. Examiners should be careful to avoid the use of leading questions.

There are four main areas of medical history:

1. Getting started: Obtain the child's name and age. Explain what your job is; ascertain if the child knows why they are there to see you, review the child's knowledge of body parts.
2. Event history – chief complaint.
3. Past and current medical history.
4. Family and psychosocial history.

3. Examination and Documentation

One of the most invaluable benefits of the medical forensic examination is its power to promote children's healing. In many situations, children leave the exam room feeling empowered, having learned information about their bodies and been reassured that they are healthy. The vast majority of children who experience sexual abuse have normal examinations. When findings are abnormal, medical forensic care can facilitate the treatment needed to allow children to regain their health. The exam process also provides the opportunity to begin to address children's needs related to safety, justice, and support. It is important that examiners educate the multidisciplinary response team about the positive impact that medical forensic care can have on children and their families. This knowledge allows team members to address misconceptions that children, caregivers, or others may have about the examination and to explain its benefits.

Preparation

- Prior to the examination, explain the overall examination to the child and caregiver, as well as specific procedures during the examination.
- Clarify who can be in the exam room beyond the child, examiner, and chaperone. A chaperone is necessary during the medical forensic examination as a safeguard for children, due to their vulnerability to abuse. The chaperone may be a caregiver, a healthcare provider other than the examiner, or another supportive person not suspected of involvement in the abuse.
- Allow the patient to change into an exam gown privately.
- Do not bribe a patient to undergo the examination.

Exam Techniques

- Complete a head-to-toe examination. The examination should proceed in a way that affords as much dignity, privacy, and comfort to the child as possible. Limit exposure of the body to the area being examined (e.g., when observing the breast, only expose that particular area). Note that an alternate light source (ALS), if available, can aid in examining the body, hair, and clothing.
- The examination is typically painless, and not traumatic to the child. For the prepubertal child, a speculum will not be used. If there is injury that requires repair, foreign object, or anogenital bleeding, sedation or surgical involvement may be required.
- Explain and obtain consent and assent for photographic images of patient to include anogenital images.
- Recognize that the child must consent and, if not legally able to consent, must assent to what happens during the examination (U.S. Department of Justice, Office on Violence Against Women, 2016).
- Explain to the patient what you are doing during the examination (e.g., I am now going to use a swab on your skin, etc.).

Genital/Anal Examination for Males and Females

Genital Examination of Females:

In females, assess the following external genital structures for injury or disease process: mons pubis, labia majora and minora, clitoral hood and clitoris, urethra and periurethral tissues, perineum, posterior fourchette, fossa navicularis, hymen and vaginal vestibule.

- Visualize the external female genitalia, including the hymen, by using gentle labial separation and traction with gloved hands while the child is in supine frog-leg position, supine knee- chest position and prone knee-chest position. Abnormalities noted to hymen should be confirmed in prone knee-chest position (U.S. Department of Justice, Office on Violence Against Women, 2016).
- **Instrumentation or use of a speculum should not be attempted for pre-pubertal examinations.**
    - Suspected intravaginal trauma or foreign body must be evaluated using proper anesthesia.
    - The adolescent female genital exam may optionally include a speculum exam.

Document the genital structure assessment and findings using the clock face analogy. Examiners assign the 12 o'clock position to the urethra, causing the clock positions to remain the same when the position of the patient changes, and always document the position of the child when describing a finding. Each examiner should choose the method that best suits their practice and adhere to that method for each examination. The examiner superimposes the clock face and uses the appropriate time to document what is observed. Note the type of injury; size, if possible; structure upon which the injury is observed; color of injury; discharge; foreign bodies; and/or blood.

Note the hymen of prepubescent females is sensitive and will cause the child pain if touched (U.S. Department of Justice Office on Violence Against Women, 2016). Techniques used in post pubertal females for hymenal assessment, such as the cotton-tipped swab to examine edges of the hymen or the urethral (Foley) balloon catheter technique, should not be used with prepubescent females

For more information:
www.safeta.org/page/KIDSSectionB7 .
www.safeta.org/page/KidsAppendix2.

Genital Examination of Males:

Include the following structures and tissues in the genital examination of males, checking for signs of injury or disease process: prepuce of the glans, glans penis and frenulum, urethral meatus, penile shaft, scrotum, testes, inguinal region, perineum.

Anal examination of Females and Males:

Use either the supine or prone knee-chest positions to examine the anus of children. In either position, apply gentle traction to the buttocks. Inspect the following tissues and structures during the anal examination, looking for signs of injury or disease process: perianal area, paying particular attention to the perianal folds; anal verge/margin; anorectal canal; anus; and gluteal cleft.

A digital examination should only be performed by a qualified healthcare provider, and where laxity of the sphincter is observed. Anoscopy is not routinely used, unless there is concern of bleeding, obvious trauma, and/or a mass or foreign body. If there are such concerns, anoscopy should be done under sedation or anesthesia and performed by a qualified healthcare provider.

Documentation

Ensure completion of all documentation. Examiners are responsible for documenting the medical forensic details of the examination in the child's medical record. All aspects of care should be documented: consent, the medical history, the examination (including written descriptions, diagram/body map rendering, and interpretation of findings), consultant reports (if done), forensic samples collected (if done), testing and/or treatment rendered and results as available, descriptions of photographic images taken, a discharge plan, and follow-up care scheduled and referrals given.

The following items should be included in the documentation:

- General appearance of the patient (including description of clothing e.g., torn, dirty, bloody, etc.).
- During the general exam, use anatomical drawings to indicate location, size, and shape, and obtain photographic documentation.
- External genitalia
  - Pubertal sexual maturation status and general appearance.
  - Female patients.
- Include findings of the perineum, peri-urethral area, urethra, peri-anal area, anus, rectum, labia majora, labia minora, clitoris, vestibule, posterior fourchette, fossa navicularis, vagina, vaginal discharge, hymen, and cervix (if visualized).
- An internal vaginal examination/use of speculum is not needed and should not be done in the pre-pubertal patient unless internal bleeding/trauma is present. Internal visualization typically will require deep sedation or general anesthesia.
  - Male patients.
- Include findings of the glans penis, foreskin, shaft, testicles, discharge from penis, peri-anal area, anus, and rectum.

Atraumatic exams are common following sexual abuse. Reasons for atraumatic exams following child sexual abuse include: many forms of sexual contact result in no permanent injury, the hymenal tissue and anal tissue are distensible, anogenital tissues heal rapidly following injury and often there is a delay in the time from when sexual abuse occurs and when a child reports abuse, allowing injuries to heal before the examination.

Telemedicine

Telemedicine is a form of telecommunication that allows the exchange of medical data between sexual abuse medical experts for consultation, collaboration, supervision, continuing education, and peer review. Telemedicine uses the technologies of teleconferencing, email, or other internet methods to transmit the medical data. The use of any of these methods allows telemedicine to be used in the evaluation of child victims of sexual abuse and allows for the collaboration or supervision of a health professional, such as an SANE-P, resident, or fellow, by a physician or APN expert in the evaluation of pediatric sexual assault patients (Rose, 2015).

There are several important caveats that need to be included for telemedicine to be fully utilized. First, the information shared must contain all of the elements that are gathered in the face-to-face encounter with the patient. The history given by the patient must be shared. This can be in the form of a verbal or written summary of the patient interview or the audio or video recording of the patient interview. Second, the elements of the physical examination are shared using high resolution digital imaging and must be of diagnostic quality. Third, the elements of the diagnostic laboratory results and radiological imaging should be provided (Rose, 2015).

There are two systems of telemedicine, asynchronous/store-and-forward and synchronous. Store- and-forward system uses a data storage system through which the patient's data is downloaded for future review. The synchronous system allows for a real-time patient encounter with the sexual abuse medical expert using a telecommunication connection (Rose, 2015).

The "gold standard" for patient evaluation remains a sexual abuse medical expert in a face-to-face encounter with the patient. Telemedicine should be used when this type of encounter is problematic. When considering a telemedicine system for collaboration or supervision, it must be realized that telemedicine has some limitations. The most notable limitation is to make a medical diagnosis for a patient who may present with genital symptoms and no clear history or a confusing history of sexual abuse. In such instances a medical diagnosis other than sexual abuse may be the etiology for the genital symptoms and the lack of a face-to-face evaluation presents a significant disadvantage.

Telemedicine does not allow for palpation by the remote expert. There is no way to directly assess tenderness. There are clear limits to assessing the anatomy in all three dimensions and inflammatory changes are difficult to interpret. Changes in color, pallor, the hues of the resolving ecchymosis, and the color of vaginal or urethral discharge may vary from monitor to monitor.

Another disadvantage, especially with the use of a store-and-forward system, is the conclusion that additional images are needed to complete the evaluation. This is often realized by the expert medical consultant after the patient has been discharged from the clinic, necessitating that the patient return for another exam. Consideration that the additional exam be done face-to-face with the consultant is appropriate (Rose, 2015).

A successful telemedicine program requires a strong commitment by professionals on both ends of the equipment. It requires a great deal of attention to detail by the professional at the patient's bedside and a great deal of instruction and patience by the expert medical consultant. This is a tool that can be used in a specific context to facilitate and enhance the patient's medical evaluation; it does not eliminate the "gold standard" of the face-to-face encounter with a sexual abuse medical expert (Rose, 2015).

4. Photography

Photographic documentation of the genital/anal examination has become the standard of care in the medical forensic evaluation of child sexual abuse. In every case, examiners should take diagnostic quality images of detected injuries as well as normal, apparently uninjured anatomy. Documentation should be of sufficient quality to allow for peer and expert review. Copies of these photos can be made available to the mandated law enforcement and/or social service agency with the written consent of the patient, by court order, or by subpoena per facility and jurisdictional procedures.

Explain medical photography procedures to children and caregivers. The explanation should be developmentally and linguistically appropriate for children and caregivers. Taking photographic images of children in the aftermath of sexual abuse can be traumatizing, especially if photography was a component of the abuse. In these cases, children might not be able to discern the difference between photography used in the sexual abuse and forensic photography. To help avoid traumatization and facilitate decision making, examiners should explain to children and caregivers: the purpose of the photography during medical forensic care; the extent to which photographs will be taken and the procedures that will be used; how photographs will be securely stored at the healthcare facility and to whom they can be released; potential uses of photographs during investigation and prosecution (especially anogenital images); and the possible need to obtain additional photographs following the examination. Explaining the process and welcoming questions helps to reduce reluctance to photo documentation during the examination. In addition to being comfortable explaining this information to children and caregivers, examiners also should also be comfortable discussing sexual abuse that included still- and video-imaging, if that issue arises during the medical history or in the course of the examination.

Photo documentation is considered standard of care for pediatric sexual abuse. Reimbursement by the Ohio Sexual Assault Forensic Examination (SAFE) program does not require photo documentation.

Photo documentation should also be obtained of any trauma found on examination. Close-up photographs of lacerations, bruises, scratches, burns, etc. should be obtained with and without a measuring tool, such as ABFO No. 2, in the photographic frame. A separate wide field photo may be necessary to demonstrate the lesion's location on the body. A measuring tool is not needed when documenting genital or anal trauma.

The photos should include two acceptable patient identifiers such as name, medical record number, or birthdate. Digital images should be considered part of the medical record maintained securely by the healthcare facility (U.S. Department of Justice, Office on Violence Against Women, 2016).

Establish healthcare facility policies for storage, retention, and controlled release of photo documentation in these cases. Retention policies for photo documentation and other medical records should reflect the statute of limitation for criminal and civil proceedings (U.S. Department of Justice, Office on Violence Against Women, 2016).

5. STI Evaluation and Care

Testing for the Pre-Pubescent Patient

Pregnancy Testing

- Urine pregnancy testing is recommended for female patients Tanner Stage 2 (www.safeta.org/page/KIDSAppendix1) or greater.
- Baseline pregnancy testing should be completed before emergency contraception. (See next section.)

Sexually Transmitted Infections Evaluation and Care

Integrate the evaluation and care of sexually transmitted infections (STIs) into the medical forensic examination of children who disclose sexual abuse or for whom sexual abuse is suspected. Contracting an STI from a perpetrator during sexual abuse is a risk that must be considered for this population. Medical forensic care should include evaluation for STIs for two purposes: (1) to determine if an STI is present, so it can be treated; and (2) to acquire evidence for potential use in legal investigations. Mechanisms should also be in place in any setting where children are examined for STIs to ensure continuity of care, including timely review of test results, and to monitor compliance with and adverse reactions to any therapeutic or prophylactic regimens (Centers for Disease Control and Prevention, 2019).

Recognize that the diagnosis of an STI in a prepubescent child may be evidence that the child has experienced sexual abuse.

In any case that a child presents with an STI, conduct an investigation into the risk factors and contacts, obtain a medical and social history, and evaluate for sexual abuse (Centers for Disease Control and Prevention, 2019). Examiners should be aware of which types of STIs in children need to be reported to law enforcement or child protective services, if the case is not already being investigated as suspected abuse (The Royal College of Pediatrics and Child Health, 2018; Centers for Disease Control and Prevention, 2019).

Provide STI information to children and caregivers (in a manner that is developmentally appropriate for the child and linguistically appropriate for the child and caregiver).

On an individual case-by-case basis, consider the need for STI testing. In each sexual abuse case, children should be evaluated for STI risk. They may or may not require diagnostic testing based on their presentation, the examination, and assessment of risk (from sexual abuse and additional exposure that might have occurred since the abuse).

Factors that indicate the need for STI testing for children, regardless of whether the case is acute (<72 hours) or nonacute (> 72 hours).

Sexually Transmitted Infection Testing

Genital-genital contact. Unexplained genital injury. Genital discharge.	Urine or vaginal DNA amplification for chlamydia/ gonorrhea/trichomonas.* HIV/RPR/Hep C antibody/Hep B surface antigen. Urine HCG if pubescent female.
Anal-genital contact. Unexplained anal injury. Anal discharge. Anal discharge.	Anal DNA amplification for chlamydia/GC. HIV/RPR/Hep C antibody/Hep B surface antigen.
Oral-genital contact. Victim to perpetrator's genital or anus.	Oral DNA amplification for chlamydia/GC.
Oral-genital contact. Perpetrator to victim's genitals.	Urine or vaginal DNA amplification for chlamydia/GC.*
Oral-genital contact. Perpetrator to victim's anus.	Anal DNA amplification for chlamydia/GC.

* See the most recent CDC recommendations: https://www.cdc.gov/std/treatment-guidelines/ sexual-assault-children.htm.

Interpretation of Positive STI Result

Gonorrhea (genital/anal/oral.) Chlamydia (genital/anal). Trichomonas (genital).	Transmitted by sexual contact, unless there is evidence of perinatal transmission or clearly documented but rare nonsexual transmission.
Syphilis	Transmitted by sexual contact, unless there is evidence of perinatal transmission or clearly documented but rare nonsexual transmission.
HIV	Transmitted by sexual contact if perinatal or blood transfusion transmission has been ruled out.
Ano-genital warts	May be sexually transmitted.
Ano-genital herpes	May be sexually transmitted.

Consider STI testing at the initial exam and follow-up testing two weeks later. Decisions regarding which tests should be performed must be made on an individual basis. In circumstances where the transmission of syphilis, HIV, hepatitis B, hepatitis C, or HPV is a concern – but baseline tests for syphilis, HIV, and hepatitis B were negative and examination for genital warts was negative – follow- up serologic testing and an examination approximately six weeks and three months after the last sexual exposure is recommended to allow time for antibodies to develop and signs of infection to appear.
Refer to: https://www.cdc.gov/std/treatment-guidelines/sexual-assault-children.htm.

The risk of the child acquiring HIV as a result of sexual abuse must be considered during medical forensic care. There is a short timeline to start nonoccupational postexposure prophylaxis (nPEP) – no later than 72 hours post-exposure.

Understand that the decision to recommend HIV testing, as well as initiating HIV nPEP, depends on local epidemiology, a case-by-case assessment of risk factors of the perpetrator, and details of the contact. The risk for an individual patient is extremely low, since details about the perpetrator's risk factors and HIV status are usually unknown. Other exposure characteristics might also influence risk, such as the following: penile, anal, or oral penetration; site of exposure to ejaculate; viral load in ejaculate; multiple perpetrators; and the presence of an STI or genital lesions in perpetrators or children.

Provide discharge instructions to the patient and/or non-offending caregiver documenting the STI testing that was completed, the medications given (see next section) and recommendations made for follow-up care, including follow-up of STI and pregnancy testing (see section on follow-up).

Treatment

Emergency Contraception

Hospital/clinic personnel must discuss and offer options for post-coital emergency contraception with the female adolescent patient when indicated.

- Should an institution or physician be precluded from providing post-coital emergency contraception for religious reasons, referral to another physician, healthcare institution or agency must be made and information about this option must be provided to the patient and/or family without delay.
- Post-coital emergency contraception treatment should be offered when female pubertal or peri-pubertal patients present within 120 hours of sexual abuse that could potentially lead to pregnancy. Discussion of efficacy of prophylaxis (especially when the patient presents 72-96 hours from the abuse) should be discussed.
- Hospital/clinic personnel should inform the patient that some medications might lessen the effectiveness of post-coital emergency contraception and determine if the patient is taking such medication.
- Baseline pregnancy testing should be completed before prophylactic treatment.

Prophylaxis for Gonorrhea, Chlamydia, and Trichomonas

Pre-Pubertal Patients:
Prophylactic treatment for gonorrhea, chlamydia, and trichomonas should not be prescribed.

- 1% to 4% of sexually abused pre-pubertal children contract a STI from abuse.
- False positive tests are not uncommon.
- Accurate diagnosis is paramount because of the legal implications of an STI diagnosis and typically requires confirmatory testing before treatment.
- Ascending infection or complications from untreated infection is rare in this age group.
- Delay in treatment is therefore warranted until confirmatory testing can be obtained.

Adolescent Patients:
Prophylactic treatment for gonorrhea, chlamydia, and trichomonas should be prescribed.

- Treatment is at the discretion of the treating physician with the permission of the patient. Prophylactic treatment should be based on current guidelines from the Centers for Disease Control and Prevention.

For latest treatment guidelines and doses, refer to:
https://www.cdc.gov/std/treatment- guidelines/sexual-assault-children.htm.

HIV Post-Exposure Prophylaxis

- The use of HIV non-occupational post-exposure prophylaxis (nPEP) after acute sexual assault is based on the efficacy demonstrated in non-occupational exposures. To provide effective prophylaxis, patients need to be promptly evaluated and assessed for the risk of HIV transmission. HIV nPEP is most effective if given as soon as possible after the sexual assault and is not effective if given after 72 hours. Therefore, HIV nPEP is typically recommended only for acute cases presented within 72 hours post-assault and when other indications are met.
- Determination to begin HIV nPEP depends on the HIV status and risk factors of the alleged perpetrator, timing of the assault, and type of contact involved in the assault. While HIV seroconversion has occurred as a result of sexual assault, the frequency of this occurrence is quite low. In consensual sex, the risk for HIV transmission per act from vaginal intercourse is 0.1% to 0.2% and from receptive anal intercourse is 0.5% to 3%. The risk of HIV transmission per act from oral sex is lower (Centers for Disease Control and Prevention, 2019). Due to the traumatic nature of sexual assault, HIV transmission may be higher in cases with vaginal, anal, or oral penetration. Risk factors that may increase the rate of transmission include multiple perpetrators, unknown perpetrator, multiple episodes of intercourse, no barrier contraception, or mucosal injuries. A flow chart is included below with recommendations for initiation of HIV nPEP.
- An important consideration before initiating HIV nPEP should include the patient's ability to adhere to the medication regimen. Incomplete nPEP treatment presents a theoretical risk of increased resistance and thus making the HIV more difficult to treat should the patient become HIV positive.
- HIV nPEP consists of two or three antiretroviral medications given for 28 days. The regimen typically includes two reverse transcriptase inhibitors. A third antiretroviral medication, typically a protease inhibitor, may be added. Common side effects of antiretroviral medications include nausea, vomiting, and headache. Check with local HIV experts to determine the best HIV nPEP to offer patients in your geographic area.
- If HIV nPEP is to be prescribed, the patient should receive baseline HIV testing. Laboratory evaluations also recommended at this time include pregnancy testing, hepatitis B and C serology, and syphilis screening. Depending on the antiretroviral medications used, additional baseline testing may be recommended and includes a CBC with differential, liver profile, and a renal profile. Patients should have follow-up HIV testing at six weeks and in three months post- exposure. This should include HIV antibody testing, STI screen as indicated, syphilis screen, and hepatitis B and C serology.

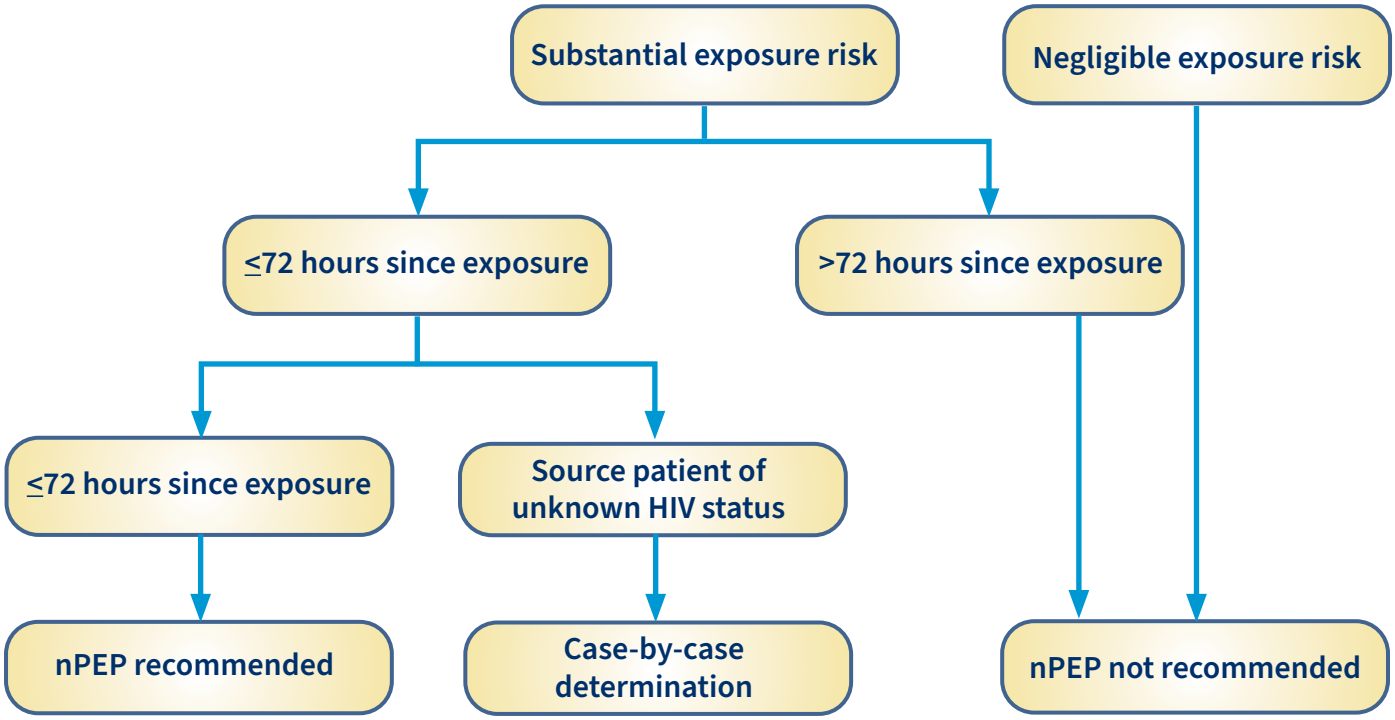
*Refer to chart on (page 57) for timelines.

Tips Regarding Prescribing HIV nPEP

- HIV nPEP is expensive, and not all insurance carriers provide coverage. Some strategies to help defray costs include working with your institution's pharmacy to provide three- to five-day starter packs in the emergency department, as well as referring families to your institution's financial services office.
- The Ohio Attorney General's Office (OAG) has implemented reimbursement for HIV PEP as part of the SAFE Program.
- Determine the availability of the particular HIV nPEP medications within your community pharmacies. It is also helpful to determine if they carry a liquid preparation in stock.
- Follow-up should be arranged for the patient within two or three days of starting HIV nPEP to monitor for side effects and assess compliance. Follow-up can be done through your local advocacy center or through the local HIV clinic.
- **For details regarding the OAG reimbursement program, see:** www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Sexual-Assault-Forensic- Examination-%28SAFE%29-Program.

Additional information on this topic may be found on the Centers for Disease Control and Prevention website at www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm.

Recommendations for Initiation of HIV nPEP



Substantial Risk for HIV Acquisition:

Exposure of
vagina, rectum, eye, mouth, or other mucous membrane, nonintact skin or percutaneous contact.

With
blood, semen, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood.

When
the source is known to be HIV-positive.

Negligible Risk for HIV Acquisition:

Exposure of
vagina, rectum, eye, mouth, or other mucous membrane, nonintact skin or percutaneous contact.

With
urine, nasal secretions, saliva, sweat, or tears if not visibly contaminated with blood.

Regardless
of the known or suspected HIV status of the source.

Follow-Up Testing and Care

It is important to ensure follow-up care. Follow-up examinations after medical forensic care, either with the child's primary care provider, the exam facility, or another specialist, provide opportunities to:

- Detect new infections acquired during or after the abuse.
- Complete hepatitis B and HPV vaccinations, if indicated.
- Discuss test results, complete repeat testing as indicated, and start treatment for other STIs indicated.
- Discuss HIV testing results and monitor side effects and adherence to post-exposure prophylactic medications, if prescribed.

Repeat Examinations

- Clarify findings on initial examination.
- Document healing if injury noted on initial examination.
- Evaluate for development of signs or symptoms of sexually transmitted infections.
- Confirm initial examination findings, when initial examination was performed by an examiner who had conducted fewer than 100 such evaluations.

HIV Non-Occupational Post-Exposure Prophylaxis (nPEP)

Since it is often difficult to prescribe all 28 days of medication, many hospitals and other institutions have developed plans to distribute a few days of medication. The remaining medication must be prescribed and a follow-up process developed to ensure the patient is able to obtain the remaining required medications for the HIV nPEP regimen. In addition, a follow-up appointment by a specialist must be arranged for the patient within two weeks of starting the HIV nPEP regimen to monitor for side effects, assess compliance, and prescribe the remaining medication.

Follow-up care should then occur at a CAC and/or by a child abuse pediatrician or a provider with experience and expertise with child sexual abuse or through the local HIV clinic.

Follow-up arrangements should be established prior to discharging the patient who was prescribed HIV nPEP.

Sexually Transmitted Infections Follow-Up Testing

- Acute testing can be done at presentation but will not be a true indicator of the patient's infection status or future seroconversion.
- See CDC Sexually Transmitted Infections Treatment Guidelines 2021 – Follow-Up.

HPV Vaccination

- Vaccination beginning at age 9 is recommended for children.
  - According to the CDC, "sexual abuse and assault raise the risk of HPV infection attributable to the abuse itself, potential future victimization, and subsequent engagement in at-risk behaviors."

For more information: www.cdc.gov/hpv/hcp/know-facts.html.

Mental Health Needs

- All patients and families should be provided information/referral for trauma informed therapies such as child and family traumatic stress intervention, cognitive behavioral therapy and parent-child interaction therapy. These evidence-based, trauma informed therapies have an emphasis on intervention and coping skills.

For more information: www.nctsn.org/sites/default/files/assets/pdfs/CFTSI_General_Information_Fact_Sheet.pdf.

6. Discharge and Follow-Up

SAFE Discharge

Recognize that pediatric examiners have critical tasks to accomplish prior to discharging a child, after completing all other components of sexual abuse medical forensic care. They can create a discharge plan with the child and caregiver, in conjunction with other responders in a case, for individualized community "wrap-around" services that address the child's post-exam needs. In recognition of the long-term health impact of child sexual abuse, particularly mental health consequences and the risk of acquiring HIV and other STIs, all responders should stress the importance of trauma-informed counseling and other supportive services as essential components of follow-up interventions, including the need for follow-up medical testing and care.

Prior to discharge, the primary nurse or sexual assault nurse examiner checks all forms for completeness of information and signatures. Also, the designated person should confer with the medical team about treatment and follow-up. Procedures for handling the paperwork should follow each hospital's/clinic's own policies.

Examiners should coordinate with other responders of the MDT, if available, during discharge planning. The child must be discharged to a physically and emotionally safe environment.

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RESOURCES

AIDS Education Training Center
aidsetc.org/npep

National Domestic Violence Hotline
1 (800) 799-7233
www.thehotline.org

National Organization for Victim Assistance
1 (800) 879-6682
www.trynova.org

Nation Sexual Violence Resource Center
1 (877) 739-3895
www.nsvrc.org

National Center for Victims of Crime
1 (855) 484-2846
victimsofcrime.org

Rape, Abuse, & Incest National Network (RAINN) Hotline
1 (800) 656-4673
www.rainn.org

Sexual Assault Forensic Examiner Technical Assistance
www.safeta.org

Ohio

Action Ohio: Coalition for Battered Women
614-825-0551
www.actionohio.org

Forensic Nursing Network, Inc.
740-602-3008
www.ForensicNursingNetwork.org

Ohio Crime Victim Justice Center
614-848-8500
www.ocvjc.org

International Association for Forensic Nurses, Ohio Chapter
ohioiafn.nursingnetwork.com

Ohio Alliance to End Sexual Violence
216-658-1381
888-886-8388
www.oaesv.org

Ohio Attorney General's Office
SAFE Program 614-466-4797
www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Sexual-Assault-Forensic- Examination-(SAFE)-Program

Ohio Department of Health
Sexual Assault and Domestic Violence Prevention Program
614-466-2144
odh.ohio.gov/wps/portal/gov/odh

Ohio Domestic Violence Network
800-934-9840
www.odvn.org

Appendix A

Patient Booklet:

Information for survivors and their families after a sexual assault.

Patient Booklet:

Information for survivors and their families after a sexual assault

Ohio Department of Health

Caring for yourself: a note to survivors

Survivors of sexual assault may feel:

Confused, tired, scared, or angry

Like shutting themselves away.

As if they cannot trust anyone.

Unable to sleep or focus.

Physically unwell, including stomachaches or headaches.

They need to hurt themselves.

Very emotional.

You may have some of these feelings. Talking to someone about what has happened may help you feel better. The Ohio Sexual Violence Helpline has trained support people available to listen. Call 1-844-OHIO-HELP or visit www.ohiosexualviolencehelpline.com.

Ohio Sexual Violence Helpline: 844-644-6435
A confidential resource for survivors of sexual assault

Information you should know as a survivor

What is sexual assault?

Sexual assault is a **crime** and it is **NEVER you fault**. It happens when someone is forced to do something sexual they not want to do. Doing something sexual to anyone can also be sexual assault even if no force is used. Examples of sexual assault may include someone:

- Touching your body or private parts in a sexual way.
- Forcing you to touch them in a sexual way.
- Making you take off your clothes and show parts of your body.
- Tricking you into doing something sexual when you don't want to.
- Touching your body or private parts when you are drunk, passed out or asleep.
- Showing you pictures of naked people.

Ohio Sexual Violence Helpline: 844-644-6435
A confidential resource for survivors of sexual assault

Now that you are here, what's next?

- You can choose to have a sexual assault forensic and medical exam (SAFE).
- A police officer may ask you questions about what happened. You have the option to decline or wait until later to talk to the police officer. A support person can be with you when you speak with police.
- If you do not want evidence collected, it is still important to seek other medical care. You can choose to take an HIV and/or a pregnancy test.
- You have the right to have a support person with you during your visit and exam. This may be a family member, a friend, or a local rape crisis advocate.
- You will be asked questions about your medical history.
- A nurse or doctor will perform a head-to-toe physical exam, which may include your private parts.
- Medicine may be offered to prevent sexually transmitted infections or pregnancy.
- You will be given telephone numbers for local services such as counseling and medical follow up.

What happens during the exam?

You will be examined for injuries. Evidence will be collected for the police to use during the investigation. You have the right to refuse any steps of the exam.

Ohio Sexual Violence Helpline: 844-644-6435
A confidential resource for survivors of sexual assault

Evidence collection includes:

- Asking what happened. These questions help the doctor or nurse provide the best medical care for you.
- Collecting the clothing worn to the hospital.
- Documenting injuries and photographing visible injuries.
- Swabbing various parts of your body, including private parts. The nurse or doctor will explain each step.
- Collecting evidence including blood, urine, or vomit. The evidence collection kit will be given to police.

Who will pay for the exam?

Neither you nor your insurance should be billed for any costs associated with the sexual assault evidence collection.

There may be charges for treatment of injuries. If your health insurance does not cover this, you may be eligible for a reimbursement through the Victims of Crime Compensation Program. If you are billed for this exam or you need more information and about crime victim compensation, call the Sexual Abuse Forensic Examination (SAFE) program of the Ohio Attorney General at 800-682-2877 or 614-466-5610.

Ohio Sexual Violence Helpline: 844-644-6435
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Talking to the Police

- When a sexual assault is disclosed. Ohio law requires medical providers to tell the police the general date, time, and location of the assault.
- You have the option to decline or wait until later to talk to the police officer. A support person can be with you when speaking with the police.
- If you are reporting anonymously, your name will not be given to police.

If you are under 18 years of age

- Unless there is a safety reason not to, a letter will be sent informing your parents or guardian that you were seen at the emergency room.
- Children's services and/or law enforcement will be contacted.
- You may not report anonymously.

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Ideas for taking care of yourself:

- When scared or anxious , you may stop normal breathing. Breathe deeply or count how many times you breathe in and out.
- Understand your triggers. Triggers are things that remind you of the assault or abuse. They could be a smell, a sound, a thing, a place, or a person.
- Value yourself and your strength for having survived.
- Be patient with yourself. It takes time to heal.
- Don't be afraid to ask for help! Look for people who can guide, support, and coach your healing. Call the Ohio Sexual Violence Helpline to find out about resources.

Follow-up medical care

Follow-up medical care is important. It is another way to take care of yourself. Please make sure to follow the instructions you were given during the exam.

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Resources to learn more about sexually transmitted infections

- Centers for Disease Control and Prevention fact sheets in English and Spanish: www.cdc.gov/std/healthcomm/fact_sheets.htm
- Ohio HIV/STI Hotline **800-332-2437**
  (voice) **800-332-3889**
- (TTY for the deaf and hearing impaired)
- www.ohiv.org
- ohiohotline@equitashealth.com.

Resources for survivors

The Ohio Sexual Violence Helpline aims to ensure that no matter where in Ohio survivors are located, they will have 24-hour access to sexual violence advocacy and links to resources and options in their local communities. Interpreters and referrals to support members in a wide range of specific communities are available.

- Rape, Abuse & Incest National Network (RAINN) National hotline for survivors. The hotline connects callers to the nearest rape crisis canter that can provide emotional support and referral information. **800-656-HOPE** or www.rainn.org.
- Ohio Crime Victim Justice Center provides tree legal assistance to crime victims if their rights are violated. Get more information at OCVJC.org or **614-545-8500** or access the Crime Victim's Rights Toolkit: A Self-Help Resource for Crime Victims at victimsrightstoolkit.org.
- Find the nearest Rape Crisis Center at Ohio Alliance to End Sexual Violence. OAESV.org

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Please seek immediate assistance if you have feelings of wanting to hurt others or yourself.

- National Sucicde Prevention Lifeline: **800-273-8255.**
- U.S. Crisis Text Line Text **"HOME"** to **741741**.
- The Trevor Project Suicide Hotline for LGTBQ youth: **866-488-7386.**

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Important contacts

Sexual Assault Nurse Examiner, Nurse, or Doctor	
Advocate	
Police Officer	
Medical Follow-Up Appointment	

Other Notes:

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Helping Your Child:
A Note to Caregivers and Parents

Reactions you may experience as a parent or guardian of a sexual assault survivor:

- Disbelief, guilt, shame, confusion.
- Blaming your child for speaking up.
- Anger that someone would do this to your child.
- Wanting to harm the abuser.

Learning your child has been sexually assaulted can be very traumatic. More than 90% of abusers are people children know, love, and trust.[1] Worrying about the accused person may be an issue when they are someone close and trusted. These feelings are normal. Talking to a trained support person about what happened is an important step.

[1]From "Child Abuse Statistics by Indiana Center for Prevention of Youth Abuse and Suicide, 2018. https:www.indianaprevention.org/child-abuse-statistics.

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Some common feelings and reactions of children after sexual assault

- Sad, afraid, confused, angry, guilty, numb, or ashamed.
- Withdrawing from friends and activities.
- Acting young such as clinging, bedwetting, or thumb-sucking.
- Nausea, stomach aches, headaches, or tiredness.
- Sleeping problems, nightmares, or being afraid of the dark.
- Changes in appetite, sudden weight gain, or weight loss.
- Trying to act like a perfect child, or trying to take care of everyone.
- A drop in school grades, or difficulty concentrating.
- Getting into trouble at school — fighting, lying, stealing, using alcohol or drugs, taking dangerous risks, or getting into trouble with the law.
- Acting out in a sexual way.
- Thoughts of harming others, self-harm, or thoughts of suicide.

Seek immediate assistance if your child expresses feelings about wanting to hurt others or hurt themselves.

Your child is not responsible for the sexual assault.

National Suicide Prevention Lifeline.
800-273-8255.

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Things you can do for your child

- Be calm and patient. Listen to what they need. Be honest and explain what is happening.
- Allow them to see your feelings, reinforcing that you are not upset with them but rather the person who did this.
- Respect their feelings and reactions. Follow their lead when it comes to touch and hugs.

Things you can say

- I believe you. Thank you for telling me. I am proud of you.
- This is not your fault. You are not to blame.
- I will work hard to help you.
- I am sorry that you are feeling ... angry, upset, or ashamed.
- We will get through this together.
- What you are feeling is normal and it is okay to feel this way.
- I am not angry with you. I am angry with who did this to you.
- What would make you feel better? What can we do together to feel better?

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Resources for parents

It is important that you and your child have a strong support system to help with expressing and dealing with your feelings.

Caring for your child and family can be exhausting and overwhelming. You shouldn't expect your child to deal with this alone, so do not expect this of yourself. Do not be afraid to talk with someone about your feelings and experiences.

- Stewards of Children "When a Child Tells You about Abuse" www.d2l.org/get-help/being-the-safe-adult.
- Find the nearest Ohio Child Advocacy Center www.oncac.org.

Please seek immediate assistance if your child has feelings of wanting to hurt others or themselves.

- National Suicide Prevention Lifeline: **800-273-8255.**
- U.S. Crisis Text Line: Text **"HOME"** to **741741.**
- The Trevor Project Suicide Hotline for Young LGTBQ lives: **866-488-7366.**

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Sexual Assault Advisory Board of Ohio — Convening Organizations:

- Ohio Department of Health
- Ohio Department of Public Safety
- Office of the Attorney General

Sexual Assault Advisory Board of Ohio
Participant Organizations:

American Academy of Pediatrics, Ohio Chapter; Buckeye State Sheriffs' Association; Equitas Health; Forensic Nursing Network; Ohio Alliance to End Sexual Violence; Ohio Association of Chiefs of Police; Ohio Chapter of the American College of Emergency Physicians; Ohio Chapter of the Internal Association of Forensic Nurses; Ohio Children's Hospitals Association; Ohio College Health Association; Ohio Department of Developmental Disabilities, Ohio Department of Higher Education; Ohio Department of Mental Health and Addiction Services, Ohio Department of Rehabilitation and Correction; Ohio Department of Youth Services; Ohio Hospital Association; Ohio Network of Children's Advocacy Center; Ohio Nurse's Association; Ohio Organization for Nursing Executives.

Patient's Bar Code Here

Department of Health