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Is there a role for paediatric Sexual Assault Nurse Examiners in the management of child sexual assault in Australia?

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ABSTRACT

In Australia, paediatricians and Child Protection Specialists provide the medical and forensic examinations of child victims of sexual assault. There are workforce challenges in the recruitment and retention of doctors to undertake child sexual assault (CSA) work particularly in remote and rural areas. Pediatric Sexual Assault Nurse Examiner (PSANE) programs have existed in the USA and the UK for many years. Using Rapid Evidence Assessment (REA) methodology, a systematic search of the literature was performed to ascertain what is known about SANE programs, to evaluate the evidence for their effectiveness across a number of domains (accessibility, health and legal outcomes and cost effectiveness) and to inform policy on models of care and elements of best practice which may be appropriate for local implementation in Australia. This review showed that despite the limited evidence available and significant gaps in the evidence, SANEs provide a high standard of medical care and are not detrimental to the legal process. By providing recommendations regarding the potential value, effectiveness and feasibility of establishing a PSANE program in Australia, this article may be of interest to other high income countries facing similar workforce challenges in meeting the needs of children with alleged sexual assault.

Child sexual assault (CSA) is a global problem. The World Health Organisation reports that worldwide, 1 in 5 women and 1 in 13 men report having been sexually abused as a child (WHO, 2014). A recent meta-analysis examining the global prevalence of child sexual abuse gave an overall prevalence rate of 11.8%, with rates in girls of 18% and boys 7.6% (Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kraneburg, 2011). In the United States, a recent study found the lifetime experience with sexual abuse and assault at the hands of adult perpetrators in 17 year old females was 11.2% (Finkelhor, Shattuck, Turner, & Hamby, 2014).

In Australia, there is no single data source detailing rates of child sexual abuse and assault, however the best national population prevalence estimate of women experiencing sexual assault before the age of 15 years is 12% (Tarczon & Quadara, 2012). There are also no national data on population-specific rates of reported sexual assault in Australia (Australian Institute of Family Studies [AIFS], 2004; Australian Law Reform Commission [ALRC], 2010), but estimates using police data in various jurisdictions and population density suggest the prevalence of CSA in some remote, rural and regional areas of Australia is

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up to four times the average of metropolitan regions (AIFS, 2004). Further challenges exist in Aboriginal communities where data indicate over-representation of Aboriginal and Torres Strait Islander children among victims of sexual assault (ALRC, 2010; Tarczon & Quadara, 2012).

Victims of sexual assault have extensive medical needs, including injury detection and treatment, forensic examination, screening and treatment for sexually transmitted infections, pregnancy testing and emergency contraception if required (Campbell et al., 2006). They also have ongoing emotional and psychological needs (Patel et al., 2013). All these should be addressed in a timely and sensitive manner with documentation that can withstand the scrutiny of the justice system. The management of child victims of sexual assault has an additional level of complexity as children need to be managed within the context of their family and their developmental capacity (Campbell, Greeson, & Fehler-Cabral, 2013).

In Australia, adult victims of sexual assault are cared for by medical practitioners, forensic physicians and, since 2005, Sexual Assault Nurse Examiners (SANEs). SANE programs were introduced in the United States in 1976, in the UK in 2001 and in Canada in 2002. There has since been rapid growth of this model of care (Ledray, 1999; Littel, 2001) with the literature reporting the widespread adoption of SANEs as part of the sexual assault workforce across the US and, to a lesser extent, the UK and Canada.

SANEs were introduced in Australia to complement the service already provided by medical practitioners, respond to the needs of victims of sexual assault in a timely manner, particularly in rural settings, and reduce the need for victims to travel excessive distances for forensic examinations (NSW Department of Health [NSWDOH], 2005). However they provide care only to victims of sexual assault aged over 16 years and where appropriate, to post pubertal adolescents aged over 14 years.

Child victims of SA in Australia are usually cared for by paediatricians and Child Protection Specialists who perform the medical and forensic examinations. Child Protection Specialists are available in the tertiary referral Child Protection Units, typically located in urban Children's Hospitals, but provide tertiary level expertise, case review, consultation, training and advice for paediatricians providing this service in other parts of the country. In regional and rural areas, limited availability of suitably qualified medical practitioners and difficulties in their recruitment and retention is considered a significant barrier to increasing the rate of sexual assault reporting (NSW Ombudsman, 2012; Wood, 2008) and the provision of optimal care.

SANE programs are currently most prevalent in the US, where 50% of SANE programs see children in addition to adults and adolescents. The training requirements and standards as overseen by the International Association of Forensic Nurses (IAFN) and the breadth of their clinical and judiciary roles are well described (Azzopardi & Au, 2010; Campbell et al., 2014; Cole & Logan, 2008; IAFN, 2013).

The aims of this review were to:

1) review the international literature and evaluate the evidence for the effectiveness of SANEs across a number of domains (accessibility, health and legal outcomes and cost effectiveness) to inform policy on the introduction of a Paediatric Sexual Assault Nurse Examiner program in Australia;
2) determine a model of care and elements of best practice which may be appropriate for local implementation in Australia and other similar settings with consideration given to the specific challenges in rural and remote areas of the country.

1. Methods

Rapid Evidence Assessment (REA) methodology was used which applies similar methods to a systematic review with rigorous methods for locating, appraising and synthesising the evidence, but with concessions made to the breadth and depth of the process to complete within a short timeframe. The REA can synthesise and rank the evidence in a relatively short space of time, although it is not necessarily as exhaustive as a well-constructed systematic review or meta-analysis (Khangura, Konnyu, Cushman, Grimshaw, & Moher, 2012).

1.1. Search strategy

A systematic search of the literature was undertaken including studies of SANE programs (either paediatric specific or combined adult/paediatric) addressing child victims of sexual assault aged under 16 years, with data on the outcomes of interest (models of care, key elements of best practice, factors that contribute to or hinder implementation, and features of regional/rural/remote programs). Studies addressing evidence of effectiveness in terms of accessibility, health outcomes, legal outcomes and cost effectiveness, were limited to systematic reviews, rapid reviews and any more recent studies with NHMRC evidence level III-3 and above (NHMRC, 2009).

The following databases were searched up until June 2015: Cochrane library, PubMed, Ovid MEDLINE, EMBASE, PsycInfo, Nursing@Ovid, Campbell Collaboration, Google Scholar, DARE and PROSPERO. All study types were included in the search, with the selection of studies limited to within the last 10 years, and to published, peer-reviewed, English language studies. Grey literature was sourced using online searches to provide specific details as required. No hand searches were conducted.

The study titles, abstracts and full papers of "potentially relevant articles" were reviewed independently by two authors (SW and DN). Disagreements about inclusion were resolved through consensus and discussion with a third author (KZ). Study characteristics, SANE program descriptions, elements of best practice and evidence of effectiveness were extracted (by DN).