



DOCTORS FOR SEXUAL ABUSE CARE

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NATIONAL NEWSLETTER

EDITORS: SANDRA RHIND & CAROLINE CORKILL

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Manager's Report - Hayley Samuel

A brief Sexual Abuse Assessment and Treatment Service (SAATS) update...

The implementation of the SAATS is now well underway. To date both the Auckland District Health Board (on behalf of Counties Manukau DHB and Waitemata DHB) and Canterbury DHB have signed up to the contract, which is being run as an 18 month trial. The trial process will allow for data collection and any necessary enhancements to be made on completion.

New ACC Sensitive Claims reporting forms have been developed and are being used by the SAATS vendors/providers. It is expected that these forms will be phased in to replace the "DSAC Forms" as the DSAC/ACC contract is phased out. In time, these will be made available electronically via the Sensitive Claims Provider site on the ACC website. Meanwhile, ACC will be contacting all doctors who have signed a DSAC/ACC contract to advise them that once their local DHB has signed up to the SAATS contract, the DSAC/ACC contract will be terminated. It is hoped that all doctors currently working under the DSAC/ACC contract will want to continue to provide these services under the new SAATS agreement via their DHBs.

The NZ Police are stepping up to provide solutions to front-load funding for "workforce creation". It is thought by the SAATS funders that the SAATS contract funding model has sufficient funding within it to enable ongoing workforce development costs, but it does not include a start-up fund for areas requiring a new workforce. The NZ Police and

DSAC are currently exploring this workforce development plan. The Police will be providing funding from both the national budget and local district budgets. This is because the existing Police district sexual assault budgets are to remain in place with the SAATS funding being **additional** to this.

These discussions with NZ Police have highlighted the importance of Local Level Agreements. These agreements will need to be drafted up by the DHBs, in conjunction with their local Police, alongside the SAATS contract in order to ensure that any workforce development concerns are addressed within this document.

Meanwhile I invite any clinicians engaging in this process with their DHBs or ACC to contact me for further information. It is essential that you, as the key service providers, are involved throughout this process with your DHBs as, in many cases, only you will know how the service specifications will be able to be implemented in your area and the funding that will be required to enable this to happen. It is recommended that a lead clinician is established to work with the DHB to develop services that meet the service specification and local need. The lead clinician should be remunerated for their time committed to service development. ACC will fund 10 hours of clinician time (for non-DHB employees) to the DHB to support this role.

Best wishes to you all!

Hayley Samuel
DSAC Manager



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With special thanks to

Image Centre,

34 Westmoreland Road West, Grey Lynn, Auckland

(09) 360 5700



Wellington City Police Adult Sexual Assault (ASA) Interviewing Project and Impact on Victim Examinations by Sexual Assault Doctors - Mike Arnerich

In July 2006 Wellington City CIB commenced an improved interviewing approach for ASA victims. Initially it involved a conceptual change to Free Recall interviewing and this was further improved to Enhanced Cognitive Interviewing in July 2007.

It follows a 3 step process:

1. A Scoping interview at the time of reporting by the victim to establish initial information. Questions used by Police are limited to establish what, where, when and who and the interview technique used is the free recall model using questions based on T.E.D.S. - Tell, Explain, Describe and Show rather than direct or leading questions that are often used.

2. Medical examination. The doctor is to be provided with all the information from the scoping interview for recording on the Assault Medical Protocol Form. This reduces the number of times the victim is questioned about the incident, thereby reducing trauma for the victim and the possibility of inconsistencies that are used by defence counsel to attack victims credibility.

3. A formal interview using the Enhanced Cognitive Interviewing technique that is considered more victim orientated. Because the victim's memory has had a reduced amount of disturbance using this process, more quantity and quality of information is obtained during the formal interview.

In conducting this interviewing style, Wellington CIB has asked local sexual assault doctors to be mindful of the technique when the necessity arises to question victims before or during the medical examination. Doctors will always have the health, safety and wellbeing of the victim as a priority and naturally will ask any questions required to facilitate that purpose.

Wellington CIB have requested that when local doctors ask a victim questions, to where possible reduce the amount of questions to those necessary, and to ask the questions in the T.E.D.S. format. This will aid the process of minimising the disturbance to the victim's memory prior to the formal interview.

*Mike Arnerich
Detective Inspector
O/C Wellington CIB*

Addressing the Impact of Sexual Assault on Sexuality and Sexual Functioning - Sex Therapy New Zealand (STNZ)

STNZ is a national network of specialised sex therapists, trained to deal with all sexual dysfunction (including sexual "addiction" or out of control sexual behaviour, any concerns about sexuality or sexual orientation and any intimate relationship concerns). Referrals are received from GPs and other medical or counselling/psychological professionals, self referrals and ACC.

While sexual assault will not necessarily result in sexual problems, it certainly can do. There are many counsellors approved by ACC to help survivors of sexual assault to work through their experiences and resolve any resulting psychological trauma from the assault. STNZ provides something separate from general sexual abuse (sensitive issues) counselling.

In the case of sexual assault (childhood or recent adult) usually sex therapy takes place near or at the end of the resolution of trauma work when sexual concerns remain. It may involve the partner attending treatment which would not of course be appropriate with the individual sexual abuse counsellor who already has established a therapeutic relationship with the assault survivor.

STNZ is approved by ACC to provide the treatment of sexual dysfunction arising from a covered injury. (This could be a physical injury or a sexual assault). Any referrals wanting ACC

funding need to state clearly this connection in order to best facilitate treatment approval.

How to refer: either you or your patient simply phone 0800 SEX THERAPY (0800 739 843) or email admin@sextherapy.co.nz and an appointment with the closest accredited STNZ therapist will be arranged.

Costs: vary according to region and whether ACC funding is utilised or not. Average unfunded fee is \$125 per hour session.

Who are STNZ therapists?

- Skilled professionals with a comprehensive background training and experience as a psychologist, counsellor or psychotherapist.
- Completed advanced training in sex therapy.
- Have a good understanding of relationship dynamics.
- Have the personal attributes to be approachable to deal with issues of sexuality.
- Accreditation is maintained by meeting ongoing professional development criteria.

For a list, or if you would like to meet STNZ therapists in your region, contact Hannah on 0800 SEX THERAPY (0800 730 843) or admin@sextherapy.co.nz

www.sextherapy.co.nz

The Challenges of Drug-Facilitated Sexual Assault

ESR sponsored a workshop on the investigation of Drug Facilitated Sexual Assault (DFSA) on Thursday March 14th 2008 at ESR Mt Albert Science Centre.

The programme included:

- Sexual Assault Toxicology: The NZ Experience. Ms Diana Kappatos, Forensic Toxicologist, ESR.
- The Challenges of Drug Facilitated Sexual Assault Investigations. Guest speaker: Dr Marc Le Beau, PhD, Chemistry Unit Chief, FBI Laboratory, Quantico VA.
- The Pharmacology of Drugs Used to Facilitate Sexual Assaults. Dr Marc Le Beau.
- The Overview of Current ESR Research Projects for the Toxicological Investigation of DFSA Cases. Dr Paul Fitzmaurice, Science Leader, Forensic Toxicology, ESR.



L-R Dr Paul Fitzmaurice, Science Leader Forensic Toxicology, ESR; Ms Diana Kappatos, Forensic Toxicologist, ESR; Dr Marc Le Beau, Chemistry Unit Chief, FBI Laboratory Quantico VA

Clinicians, crisis support counsellors, police and prosecutors, were among the many who attended this useful and relevant seminar held at the ESR facility in Auckland. The programme began with Diana Kappatos, forensic toxicologist with ESR, giving a succinct summary of New Zealand ESR data on sexual assault toxicology. This was followed by Dr Marc Le Beau, Chemistry Unit Chief, FBI Laboratory, Quantico, Vancouver, giving an informative summary of the challenges we face with drug-facilitated sexual assault. The last speaker was Dr Paul Fitzmaurice, Science Leader Forensic Toxicology, ESR.

Diana Kappatos' talk focused on ESR New Zealand toxicology data from 2002-2008. 538 toxicology specimens were received at ESR. 94% of these were from female complainants and the predominant age group was 16-20 years old. Alcohol was detected in 260 specimens and cannabis in 147. Over that period there were no GHB positive results. Of the stimulants the most common was "P" (29), followed by party pills (28) then MDMA (10). Of the CNS depressants benzodiazepines or Zopiclone were present in 28 specimens.

The alarming data regarded alcohol levels. When "back titrations" are done, it was calculated that over 90% of cases had alcohol levels above 80mg% (adult legal limit for driving) at the time of the alleged assault. Of the cases where specimens were collected eight hours or less after the alleged assault, by far the commonest drug was alcohol. In the 12 to 15 year-old age range, 28 out of 65 had an alcohol level between 26 and 331mg% with an average of 129mg% (the legal limit for driving in a 15 year old is 30mg %). The average in the 16 to 20 year-old age group was 153mg%. There were some proven cases of drink and food spiking: one with Diazepam, 4 with Zopiclone, one with Doxepin and one with Viagra (this was detected in spaghetti!).

Dr Le Beau then took the floor and affirmed our NZ experience that DFSA is NOT predominantly a drink-spiking scenario, ("Mickey Finn") but more commonly situations involving voluntary alcohol and drug use, including the mixing of alcohol with prescription, OTC or recreational drugs. The historical origin of the term Mickey Finn comes from the eponymous bartender/owner of the Lone Star Saloon and Palm Garden Restaurant, located in the "Whiskey Row" section of old Chicago around 1900. He would slip chloral hydrate into patron's drinks and then rob them. The bar was closed down in 1903.

Dr Le Beau summarised the multiple challenges for the victims, medical professionals, laboratories and investigators involved in DFSA crimes.

When drugs are used to spike drinks they generally are strong-acting CNS depressants whose effects include euphoria, relaxation, decreased inhibitions, amnesia, impaired perceptions, impaired consciousness and possible death. The candidates are the ones we know about: ethanol,

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L-R Chrissie Sygrove (Nurse, Pohutukawa Clinic), Dr Min Lo, Hayley Samuel (DSAC Manager), Dr Kristen Sorrenson

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benzodiazepines, Zopiclone, GHB and its pre-cursors, ketamine, opiates, anti-histamines, hallucinogens, sedative anti-depressants, chloral hydrate, muscle relaxants, scopolamine etc. He emphasized that it is highly unlikely that one can determine the drug used in a DFSA case simply by symptoms alone. There can sometimes be clues e.g. if GHB is not mixed with alcohol intoxication the effects are rapid in both onset and recovery such that when the person “comes to”, they will generally feel normal and not have any hangover effects. The rapid elimination of GHB however, means that it is seldom detected in toxicology samples. Dr Le Beau commented that it is almost certainly being used much more than we realise or can detect. He has also noted an increasing use of the “Z” drugs (e.g. Zopiclone) and antihistamines.

Challenges surrounding the reporting of the crime include the typical delay in reporting and the understandable reluctance for complainants to report honestly about their voluntary drug use. Challenges for the laboratory include the fact that there is no one analytical test that will detect all potential drugs used. Tests have detection limits and cut-off limits below which low titres may be missed. This is particularly true of GHB because it is a naturally occurring substance in the body.

The key messages for victims of DFSA are in Table 1 and include early action, collecting their urine and seeking help as soon as possible.

Table 1: RECOMMENDATIONS FOR VICTIMS

- Collect the first urine –in any clean jar or container and refrigerate
- If not seeing a doctor or Police within a few hours, place this urine in the freezer
- Call police
- Get medical attention and toxicology specimens as soon as possible
- Be truthful about alcohol and drug use
- Call a rape crisis centre for information and support

Advice for medical professionals includes collecting urine as soon as possible, up to 4 days post-assault and less importantly, also blood, if presentation is within 24 hours. Ask about the time of and the number of urinations since the estimated time of the assault. See Table 2.

Table 2: RECOMMENDATIONS FOR MEDICAL PROFESSIONALS

- Prioritise URINE collection with the Police at initial triage
- GET URINE if reported within 96 hours
 - 100mls if available
- GET BLOOD if reported within 24 hours
 - 10mls blood
 - Collect additional blood for other forensic tests (DNA reference etc)
- REFRIGERATE specimens
 - Ensure Police store and transport toxicology specimens correctly
 - FREEZING specimens is good also if there is likely to be delays, or specimens are not in preservative (Toxicology Kits urine jar does have preservative. Freezing does not affect toxicology testing)
- DOCUMENT
 - When drug/alcohol ingested and the actual size of the drinks
 - # of urinations since
 - Drugs taken/used, including medications used by victim
 - All symptoms
- USE appropriate forensic toxicology lab (ESR)

- SELF COLLECTED URINE* specimens
 - Document time collected by the patient, and how urine stored
 - Transfer urine to a toxicology kit, documenting time of transfer
 - Retain the original container and send to Toxicology as well
 - Collect another urine at time of exam

* Deliberate contamination of a self collected specimen is easily detected by the laboratory and lack of original chain of evidence should not be a deterrent.

Recommendations for investigators, included an appeal to not disregard bizarre stories and to ensure a thorough history is obtained around the timing of and type of substances (including type of alcohol and size of the drinks) consumed leading up to the alleged event. And of course OBTAIN A URINE SAMPLE in all cases as soon as possible, and prioritise the medical assessment.

The use of hair samples in DFSA is an emerging field. It is available in NZ. Individual cases should be discussed with a toxicologist prior to sampling. The cost is equivalent to other toxicology tests and should not be a barrier to proceeding. Problems include the fact that all drugs do not go into hair and that it is theoretically possible for external hair exposure to account for positive results, especially with smoked drugs. GHB is still not reliably able to be tested for, partly because of the naturally occurring GHB. The recommendation for hair sampling is that you wait a month. See Table 3.

Table 3: HAIR IN DFSA CASES

- Discuss with ESR
- Typically head hair is used
- Need pencil thickness sample of hair
- Wait one month after exposure before collection
- Hair grows approximately ½ inch (1 cm) per month
- Difficulties with hair:
 - One off exposures may be difficult to detect
 - Negative results may be misleading
 - It doesn't always prove "ingestion"
 - Can't readily screen for multiple drugs
 - Should be done by laboratory with newer technology and experience with hair (ESR is developing this experience)
 - Hair treatments can affect
 - Washing hair slowly washes the drug out
- ESR scientists can use other drugs given near the time of the drugging to act as "markers"- so please note if gave ECP or antibiotics at the time of the forensic examination

Dr Paul Fitzmaurice discussed research projects at ESR which include:

- Benzodiazepines and illicit drugs in hair samples
- Investigation of self reporting of recreational drug use in DFSA
- Pilot study to develop best practice protocols for toxicology investigation of DFSA
- Stable Isotope Mass Spectrometry (IRMS) of GHB (to help separate out endogenous GHB from exogenous).

Planned future projects at ESR include:

- The possible use of identifying drugs on hair samples by looking for co-located drugs, such as ECP or/and antibiotic, given at the time or soon after the sexual assault. So if taking hair samples, PLEASE give ESR info re what drugs were given at the time of the forensic.
- Looking at GHB glucuronide which is a metabolite of GHB (extends the time frame of detection)
- Correlating alcohol consumption and alcohol metabolite profiles, which may enable an extension of the detection time frame.

ESR welcomes our ideas and feedback on how best they can assist in the investigation of suspected DFSA crimes.

Dr Le Beau is co-author of a textbook on DFSA: Drug-Facilitated Sexual Assault, A Forensic Handbook, Edited by Marc Le Beau and Ashraf Mozayani. This is available via Elsevier online at books.elsevier.com/forensics.

All proceeds of sales of this book go to Rape Crisis charities.

Dr Kristen Sorrenson
Auckland



L-R Hayley Samuel, Diana Kappatos, Dr Marc Le Beau, Dr Kristen Sorrenson, Dr Min Lo, Dr Paul Fitzmaurice

DSAC Manual Excerpt:

Section A 11 HIV Post-Exposure Prophylaxis

11.1 INTRODUCTION

The following points may be useful when considering HIV Post-Exposure Prophylaxis (PEP) in Sexual Assault.

- PEP should be given as soon as possible (preferably within 24 hours) and no later than 72 hours (3 days) after exposure. If > 72 hours no PEP.
- We have a duty of care to at least discuss HIV PEP when there has been semen to mucosal contact presenting within 72 hours, especially in cases involving anal assault or vaginal assault with injury.
- At the present time, routine prophylaxis for HIV is a matter of considerable controversy and not a universally accepted standard of practice.
- The overall risk of acquiring HIV infection through sexual assault is low.
- The risk factors for acquiring HIV from a sexual assault will determine whether or not PEP should be offered to a patient.

- Doctors should refer to local protocols dealing with PEP and consult with an HIV Specialist.
- The patient and doctor must evaluate the risks and benefits of post-exposure prophylactic (PEP) treatment and decide together the best option for the patient.
- In situations where reaching a definite decision is not possible (eg in the middle of the night or if unable to access HIV Specialist advice); and the doctor considers PEP might be indicated, consider providing a starter pack or 2-3 days of treatment to allow time for a specialist review decision.
- A baseline HIV test is mandatory prior to commencing PEP.
- The patient needs to be fully informed of the following:
 - the limited data regarding the efficacy of PEP
 - possible side effects of the medications
 - the need for strict compliance when taking the medications
 - length of treatment
 - importance of follow-up
 - the need to begin treatment immediately for maximal effect of medications



A recent case in Auckland involved an adult female who was allegedly sexually assaulted by a 'just met' male. The victim presented to police about 6 hours following the incident. The alleged offender had previous convictions and according to the police file was HIV positive. This was unable to be confirmed. This information including his name and details was duly given to the DSAC doctor. The victim was seen in the early hours of the morning and at that time was informed of the potential risk and started on a starter pack of HIV PEP [combivir i bd for 2 days]. She was also given the appropriate counselling and work up before being seen by the Infectious Diseases doctor for follow up the next day when she made a decision to continue with the treatment.

This case demonstrates a clear indication for starting HIV PEP. There were however, other interesting issues that arose surrounding the offender's right to privacy and confidentiality. When does the doctor's Duty of Care to the victim override the offender's right to privacy? Stay tuned to the next issue of DSAC newsletter...

*Dr Min Lo
Auckland*



Azithromycin

Remember that supplies of Azithromycin (Zithromax) are available for STI prophylaxis for any patient who is at risk of infection as a result of a sexual assault. The regime is absolutely simple
1G. stat. (2 x 500mg tabs)

PHARMAC is fully subsidizing this drug through DSAC and supplies are available from:
DSAC National Office, PO Box 90723, AUCKLAND

To order your supplies for the next 6-12 months you can either write, email: dsac@ihug.co.nz or
fax: 09 376 0790



THE MEDICAL MANAGEMENT OF SEXUAL ASSAULT SIXTH EDITION 2006

The DSAC training manual is a resource for medical health professionals who provide medical care for victims of sexual assault. It is a supplement to the DSAC training courses in medical management of sexual assault and represents a collation of current thinking in this field of medicine, from both local and international sources.

The 6th edition is significantly different from the 5th edition and has been reorganised into 3 main sections. Not all subsections have been fully updated for this edition and these will be added to the online manual as they emerge. Until all sections have been updated, some cross referencing will be inaccurate.

Section A contains practical guidelines for forensic examination and medical care of adult victims of sexual assault. For ease of use, references have been kept to a minimum. Forms and templates that can be used in your clinical situation are marked with a printer icon.

Section B contains guidelines for children and adolescents.

Section C contains important reference material.

Note that previous appendices are now included in the main body of each individual section.

The technology of the Web will allow DSAC to regularly up-date sections in response to new knowledge. Users can browse and download in print individual chapters as they wish.

Visit **www.dsac.org.nz**

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DSAC Diary of Events 2008

DSAC is a RNZCGP CME Registered Special Interest Group

For all events apply to: DSAC National Office PO Box 90723, AUCKLAND, 5/4 Warnock St, Grey Lynn,
AUCKLAND Tel: (09) 376 1422 Fax (09) 376 0790 email: dsac@ihug.co.nz website: www.dsac.org.nz

OVERSEAS SPEAKER

Dr Marylene Cloitre

*“Psychotherapy for the Interrupted
Life: Treating Adult Survivors of
Childhood Abuse”*

Auckland - Monday 20th October 2008
Wellington - Wednesday 22nd October 2008
Christchurch - Friday 24th October 2008

MEDICAL/FORENSIC MANAGEMENT OF ADULT SEXUAL ASSAULT TRAINING WEEKEND

Dates: 16-18 May 2008
Venue: Marion Davis Library
Auckland Hospital



Advanced Paediatric Training Course

Christchurch
1st - 3rd August 2008
Venue: To Be Advised

Special Guest Speaker
Lori Frasier MD



Dr. Lori Frasier attended the University Of Utah College Of Medicine and completed a pediatric residency at the University of Washington. She was fellow at the Harborview Sexual Assault Center under Dr. Carole Jenny, from 1988-90. Dr Frasier was on faculty of the Department of Pediatrics at the University of Iowa, from 1990-1995 establishing the sexual abuse evaluation clinic there, and participating in evaluations of physical abuse and neglect. From 1995-2002 she was on the faculty of the Department of Child Health at the University of Missouri-Columbia, Director of the Child Protection program there, and from 1994-2002 was the Medical Director of the Missouri SAFE-CARE Network a network of medical providers trained to provide medical evaluations to abused and neglected children. She is currently the Medical Director of the Medical Assessment Team at the Center for Safe and Healthy Families, Primary Children's Medical Center, Salt Lake City, Utah, and a Professor in the Dept. of Pediatrics at the University Of Utah School Of Medicine. She has published many articles and chapters in the field of child abuse and has lectured locally and nationally. She is the immediate past Chairman of the Executive Committee for the Section on Child Abuse and Neglect of the American Academy of Pediatrics and on the board of Directors of the American Professional Society on the Abuse of Children (APSAC). Dr. Frasier has been appointed to the American Board of Pediatrics, first sub board in Child Abuse Pediatrics.

LETTERS TO THE EDITORS

Letters to the Editors can be submitted, although publication, editing and abbreviation are at the Editors' discretion. While the principle of 'right of reply' to articles and letters published in the Newsletter is accepted, this right is not automatically granted and is subject to Editorial discretion and the limitations of space - DSAC news and information have priority. All letters submitted must include appropriate contact details and email submissions are preferable so as to reduce the possibility of error in transcription.

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