CONSULTATION

Clinical Pathway for Children and Young People who have disclosed sexual abuse (2019)

RAPE CRISIS SCOTLAND

Response ID ANON-BKEV-64SZ-Y

Submitted to **Clinical Pathway for Children and Young People who have disclosed sexual abuse**
Submitted on **2019-08-01 17:22:48**

Section 1: Introduction

1 Do you believe the pathway would improve and standardise services for children who have disclosed sexual abuse and their families?

No

If not, what improvements would you suggest? :
Whilst we are very supportive of the intention, and have been part of both the Task Force and the Clinical Pathways group what is missing from this pathway in its current format is the clear outline of the importance of support & advocacy which should be made available to the child &/or family throughout their engagement to enable them to make informed choices, to be able to access the support they need following disclosure and to enable recovery. Whilst the Barnahus model is referenced, what is missing from the body of the text is the importance of and need for young person centred support. This is clearly articulated in the adult pathway but missing from here. What was clearly demonstrated in the NSPCC research 'Right to Recover' into the experiences of children and young people who disclose https://learning.nspcc.org.uk/media/1128/right-to-recover-sexual-abuse-west-scotland.pdf was that for many there was little support provided once any immediate child protection concerns were addressed. This document will do little to clarify that this needs to change. On page 17 paragraph 2 for example it references having a child's plan and says 'The Child's Plan (GIRFEC) may include access to ongoing therapeutic support for the child and their family members / carers post examination, but also in the months and years following disclosure of Child Sexual Abuse (CSA). In many parts of Scotland this is just not available and this needs to change. This should be stressed as something which is fundamental. Earlier in the document there are references to ACES and the impact of trauma on children, and on their parents, but without looking at the support needs as something which is not optional this will not change.

2 Are there any key areas of research missing, or any general amendments you would suggest?

Are there any key areas of research missing, or any general amendments you would suggest?:
The term child sexual abuse is used throughout this document.
Generally this term is used where abuse has been over a period of time and is by an adult/older person. This term would not generally be used for example if we were talking about the rape of a 14 year old by her boyfriend. We would reconsider whether the sexual assault of a child or young person is a better fit if we are looking to improve the responses across the board, and to acknowledge within the text the differing nature of how children and young people might experience sexual violence and the differences in service responses and design. What was really clear in earlier workshops RCS have been at re responses was that children are not a homogenous group and that the needs of young children and teenagers are quite different in service delivery. This we believe needs acknowledged here. It may be referenced in some of the linked documents but it requires a more central focus.
Non contact sexual abuse such as Image based sexual abuse is not mentioned. Whilst the driver for this work has been forensic provision if the aim is to look holistically at best practice in responding to sexual violence disclosures, including non contact abuse, then the law and context around image based and cyber enabled crime should be included. See recent research on the impact with recommendations
https://www.dur.ac.uk/resources/law/ShatteringLivesandMythsFINALJuly2019.pdf

3 Do you have any further general comments on the pathway document?

3. Do you have any further general comments on the pathway document? :

Section 2: Context

1 Do you agree with the context given in the pathway document?

Yes

If not, which key areas or research you would like to be added, amended or removed?:
Page 11 the paper states: " The dynamics of child sexual abuse differ from those of adult sexual abuse." We are not clear what is meant by this? The paper goes on to say "It is more likely for a child to experience sexual abuse at the hands of a family member or another supposedly trustworthy adult." This is the same for adults. For both it is about power and control, it is about silencing and blaming and putting barriers in the way of disclosure, whether internal within the person e.g. by making them feel responsible and to blame, or externally by threatening and isolating. With both, workers need to be aware of their own power, and work to build trust, utilising the trauma informed principles. Also the term 'adult sexual abuse' is referenced, what does this mean? We consider that people would read that as sexual abuse of a vulnerable adult. We consider this to be vague and unhelpful. If what the paper is trying to convey is it is important to consider the context of how children are abused and assaulted then this needs to be spelled out explicitly with practical considerations for practice. This phrase is used again later in the document on page 12, with the same feedback.
On Page 11 the paper states: With childhood sexual abuse children are often too young to know how to express what is happening and seek out help. Again the use of CSA limits what kind of sexual assault this might be seen to apply to. This might not be the key barrier with older children, but with both there are significant barriers such as fear of not being believed, fear of being blamed, judged or of getting themselves or others into trouble.
Also in this section the paper describes child sexual abuse of a child. We feel it is important to also highlight sexual assault of older children by peers/older children and to recognise coercion and the peer pressure at play which might be not about age but gender and status. In terms of health care responses it is important that this is given consideration and weight re training and staff responses. It would be useful to use the terms children and young people throughout the document and not just in the title to emphasise this.

Section 3: Clinical Pathway

1 Do you agree with the aims of the pathway?

Yes

If not, why not? :

2 Do you agree with the layout and content of the pathway process?

Not Answered

If not, what improvements would you suggest? :
The layout is accessible, albeit much of the key information needed is in the attached links.

Re content see below for specific comments:
Page 2. Paragraph 8.
Throughout the document the term child sexual abuse is used. This should be changed.
p.8 you reference stats from England around prevalence and say “The Crime Survey for England & Wales (2016) reported that 10.5% of women and 2.6% of men had experienced any form of abuse; 3.4% of women and 0.6% of men had experience of penetrative offences.” When you reference ‘abuse’ do you mean all kinds of abuse eg emotional and physical abuse or is this shorthand for sexual abuse? Important to be clear.
On page 8 the paper also references the increase in reports of sexual crime reporting by young people and state “There is an increasing trend of police recordings over the past 5 years, but the reasons for that trend cannot be identified with certainty.” Whilst this is true I think 2 issues are important to include here. Firstly (which is mentioned elsewhere) that the vast majority of reports are historic and outside the forensic window, and that even where forensics or child protection are not concerns that there should still be an onus to consider the wider and longer term mental and physical health needs of the person disclosing. It is also important to include the number of young people where cyber enabled sexual crime is an issue – the threatening and/or sharing of intimate images. This is often minimised and young people blamed but image based abuse can have significant impacts on the wellbeing of the young person as evidenced in this new research https://www.dur.ac.uk/resources/law/ShatteringLivesandMythsFINALJuly2019.pdf For this reason the legislation for this should be included in the document about legal content.
On page 9 you use the term ‘allegedly’ here: “ Cases are counted in the year that the case was concluded rather than when the crime was (allegedly) committed. “ I would suggest this term should not be used anywhere as it implies dubiety of the veracity of the disclosures, which is not the role of health. Not being believed is one of the biggest barriers to disclosure and modelling the best practice in language we can for all health professionals is what this document should aspire to. Police Scotland have moved away from this terminology and instead talk of the far more neutral ‘reports. You could say something else like: Cases are counted in the year that the case was concluded rather than when the crime was reported to have taken place.
On page 12 you reference the NHE Education Opening Doors trauma informed practice resource. It would be worth including the Sowing the Seeds one which is about trauma informed practice with children & young people https://vimeo.com/334642616
On page 13 you talk about checking whether under age sexual activity is truly consensual and “ to ascertain if this activity is truly consensual and ensure the child is not a victim of exploitation or grooming.” It would be helpful if coercion could be added in there. Again I think that the adolescent experience might be missed as grooming and exploitation implies more of an age/power dynamic than some of the more subtle coercive behaviour which could be missed in a more peer to peer abusive situation.
On page 14 Do all disclosures need an IRD? What about a 15 year old who was raped on holiday, who has a supportive family, and who doesn’t want to report to the Police. What role would social work and the Police have? It would be appropriate to consider support needs by the health care professional eg Look at sexual health and/or referral to rape crisis, but what actions would statutory services take? Whilst this is high level and would apply to many cases if this is too black and white it risks services providing support to young people having no confidentiality and having to disregard the young person’s choice, for the 13-15 age group, when specialist agencies will be risk assessing and reviewing child protection and risk constantly. Compared with the much more holistic and collaborative adult pathway this seems like a poor sister. The term “Management of health care needs” for example, unlike the assessment and referral protocols and pathways around psycho social physical and mental health care needs for adults.
On Page 15 again the term allegation is used in paragraph 4 which is unhelpful and has a hint of disbelief, which would be picked up by survivors & family members if used by professionals. This would be better replaced with the neutral term disclosure in this context.
On page 15 the list re presenting symptoms, the last one is not the same format, eg a perpetrator of abuse.
Page 15 When referring to child protection the paper highlights assessing: “ Immediate safety of child and any other children living within the house.” I would suggest removing ‘in the house’ and say ‘who may be at risk’. The existing phrasing limits the risk and setting to the family home and the risks may be outwith that, eg in the wider family, care setting, a school etc.
Page 16. Paragraph 2, also names the household : “The IRD aims to share information and identify the risks to the child (and other children in the household) so that immediate safeguarding measures can be taken.” Again I would suggest that ‘in the household’ is removed so that this is considered beyond a single family setting.
Page 17. As highlighted earlier re the Child’s Plan you state “The Child’s Plan (GIRFEC) may include access to ongoing therapeutic support for the child and their family members / carers post examination, but also in the months and years following disclosure of Child Sexual Abuse (CSA).” This is one of the key areas for improvement in the current system. This should be much more of a feature. There is reference to work in the taskforce considering this but the intention should be clear. I would suggest this should be changed to something along the lines of: “The Child’s Plan (GIRFEC) SHOULD ALWAYS CONSIDER THE NEED FOR access to ongoing therapeutic support for the child and their family members / carers post examination, but also in the months and years following disclosure of Child Sexual Abuse (CSA).” This cannot be overstated.

Section 4: Medical Examination

1 Do you agree with the medical examination section of the pathway?

Yes

If not, why not? :
We agree with much of the content with the following comments:

Page 18. Re medical examinations the paper states: “In cases of non-acute sexual abuse that is outside the forensic capture window, a medical examination will still be required for the child. How quickly a non-acute case needs to be seen may vary according to clinical need. It is envisaged that such cases would be seen for paediatric assessment within two weeks of a decision being made that such an assessment is required.” The language here is a concern re the choice and control of the patient (the use of will rather than may). It assumes we are talking about a much younger child, and again links to the earlier point about the differences in children and adolescents who can make some decisions about their own healthcare needs and wishes. Trauma informed practice emphasises safety, trust, collaboration, choice and empowerment. If a 15 year old discloses to her GP that she was coerced into sex by her previous boyfriend this guidance reads like a medical examination will be required of her and she will have no choice. This is not what would happen in practice so we consider this needs some qualification in the main text. In this scenario the young woman does not need to engage with the Police if she chooses not to. Support & advocacy should be offered, as it would be for adults, to enable her to make an informed choice, but she and the pathway should be clear that this is her choice.
Page 21, paragraph 9. The pathway states: “Follow up for other needs, for example referral to Children’s Reporter or other agencies, should be arranged and documented.” No mention is made of who these might be. Rape Crisis services across Scotland support young people aged 13+ with support and advocacy navigating the justice system, enabling them to make informed choices and supporting them and their families through what can be traumatic and confusing. Clinicians need clear information about 1) the need for support & advocacy and 2) where to access this locally. As the Right to Recovery Research highlights, in many areas these services do not exist, especially for children of primary school age and below, and their families. This gap needs to be addressed if we are to mitigate the impact of trauma in the longer term.

2 Do you have any further comments or suggested amendments to the medical examination section of the pathway document?

Do you have any further comments or suggested amendments to the medical examination section of the pathway document?:

Section 5: Appendices

1 Do you have any comments on the appendices of the pathway document?

Do you have any comments on the appendices of the pathway document?:

About you

What is your name?

Name:
Sandie Barton

What is your email address?

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Are you responding as an individual or an organisation?

Organisation

What is your organisation?

Organisation:
Rape Crisis Scotland

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

Publish response with name

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Yes

Evaluation

Please help us improve our consultations by answering the questions below. (Responses to the evaluation will not be published.)

Matrix 1 - How satisfied were you with this consultation?:
Slightly satisfied

Please enter comments here.:
Some of the Yes/No questions were too black and white so these have been left blank. It would be preferable to have a Yes/No, with reservations/comments or a likert scale rather than comments only being linked to where a No answer was suggested.
Good that it can be saved and also that it is available as a word document to work from/share.

Matrix 1 - How would you rate your satisfaction with using this platform (Citizen Space) to respond to this consultation?:
Very satisfied

Please enter comments here.: