Response ID ANON-BKEV-64SH-D

Submitted to **Clinical Pathway for Children and Young People who have disclosed sexual abuse**
Submitted on **2019-08-05 10:01:00**

Section 1: Introduction

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

Not Answered

If not, what improvements would you suggest? :
The pathway as drafted would, if fully implemented, improve standards and services for children who have disclosed sexual abuse and their families. However, we believe that the focus on children who have disclosed sexual abuse is too narrow, and restricts the impact that this pathway could have. We believe that the document should cover clinical pathways for all children and young people who have or may have experienced sexual abuse.

In focussing on children who have disclosed child sexual abuse, this document potentially misses an important opportunity to engage medical professionals in wider discussions about child sexual abuse; increasing their understanding of this type of abuse, their ability to identify signs and indicators, and therefore their ability to engage child protection processes at an earlier stage. This will impact on the support and protection the child or young person will receive.

In our experience, very few children and young people will independently make a verbal disclosure of sexual abuse. Some are unable to do so due to age, developmental stage or disability; others do not feel able to disclose due to fear, shame or not recognising what they are experiencing as abuse. Recent research from the University of Bedfordshire (https://www.beds.ac.uk/ic/recently-completed-projects/making-noise) also identifies a number of situations where children and young people think they have made a disclosure, but this is not picked up as such by those around them. By limiting the focus to young people who disclose, many victims will be missed.

At present, the pathway puts the onus onto the child by focussing on disclosure. The Scottish Government's wider child protection work encourages us to see child protection as everyone's business, while the current focus of this pathway relies on children to protect themselves by focussing on disclosure.

The document does detail (in Section 5.1) a range of ways in which sexual abuse in children may present. We believe that this should be highlighted much earlier in the document, with medical professionals encouraged to look out for and identify these signs in all the children and young people they work with.

This approach is particularly important as this pathway is for use by a broad spectrum of medical professionals. While those conducting a forensic examination, for example, may not be in a position to spot indicators of potential sexual abuse, others who have more regular or ongoing contact with children and young people such as GPs, health visitors, school nurses and LAC nurses, would be well placed to identify patterns and possible indicators. These might include recurrent STIs/UTIs, multiple pregnancies, terminations and use of emergency contraception, missed medical appointments or children regularly being under the influence of alcohol.

They are also well placed to support the child before, during and after any eventual disclosure or child protection response. This document could be used to increase their understanding of the background risks and indicators for child sexual abuse.

To best support medical practitioners through situations where they have reason to believe that a child or young person they work with may have experienced or be experiencing sexual abuse, we recommend that three pathways should be developed alongside one another to support medical practitioners:
• One for children/young people who are experiencing abuse currently (and therefore require an immediate response);
• another for children who have reported abuse that is not current or non-recent;
• and a final pathway where there is suspicion or concern of abuse.

We do not believe that one pathway for those who have experienced child sexual abuse is sufficient, as this does not take sufficient cognisance of different experiences and the different situations children and young people may be in. In some circumstances, the pathway could and should be used as a basis for discussion between the medical practitioner and the child about what will happen next, and what the child should expect at different points in the process. It is therefore important that the pathway accurately reflects the different processes in different situations, to avoid children being given inaccurate information. It is also important that the response is based on the need of the child/young person and their individual circumstances; one response will not fit for all children and young people.

Within the pathways for children currently experiencing abuse, or where there are concerns this is the case, distinctions in the pathway should be drawn where a child is at immediate risk and where there is ongoing but less immediate risk. For example, while a child who is being abused when visiting relatives every other weekend may require a Child Protection response, a child returning home from the medical appointment with the perpetrator of their abuse may also require a response from emergency services.

We do not believe that all sections of the pathway as drafted would be required or appropriate for a child/young person who has disclosed non-recent or non-current sexual abuse, and therefore recommend that a parallel pathway is developed for this situation.

Coordinating pathways should therefore be developed for children and young people who have disclosed ongoing abuse; children and young people who have disclosed non-current abuse; and children and young people where sexual abuse is suspected.

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?:
We believe that this pathway should apply to all children and young people under 18. We believe this for the following reasons:

• At present, the guidance includes 16 and 17 year olds who have a particular vulnerability. We would argue that having experienced child sexual abuse is in itself a vulnerability and it is therefore logical that all under-18s are responded to via this pathway.
• All victims deserve access to a compassionate, trauma-informed, person-centred pathway; in our experience, young people aged 16 and 17 struggle to receive this through adult services and often feel unable to engage with adult processes.
• The UNCRC, which will shortly be incorporated in Scotland, defines a child as under 18 years old.
• Legislation and guidance that has recently been developed in this area, of which we are aware, is moving to a definition of a child as under 18. This includes: the Scottish Government definition of Child Sexual Exploitation and the Human Trafficking and Exploitation (Scotland) Act 2015.
• We understand that the current review of the National Guidance on Child Protection (2014) is likely to recommend amending the definition of a child to all those under 18. Bringing the pathway into line with this would help to future-proof it, and prevent guidance having to be changed in future to keep pace with these developments.
• We cannot identify any unintended consequences of including all 16/17 year olds in the pathway, but can think of many 16/17 year olds we have worked with who would have benefited enormously from a more child/young person-friendly process.

In order to incorporate a range of learning styles, alongside the existing reports referenced in the document, links could be included to the following videos:
• Tyler's Story, a short film by Seen and Heard documenting a young man's journey to and through disclosure within a health care setting (https://www.seenandheard.org.uk/)
• Making Noise, a short animation sharing the voices of children and young people who have experienced sexual abuse and their experience of disclosure and service provision (https://www.beds.ac.uk/ic/recently-completed-projects/making-noise)

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

3. Do you have any further general comments on the pathway document? :
Throughout our response we have noted specific suggestions on improving the structure and clarity of the document, but overall we have a concern that the pathway document is not easy to follow, and at times the information presented seems so complex that we are concerned this may cause readers to disengage.

In particular, we note that while the document is not intended to be read from cover to cover, separate sections can be difficult to understand without reference to other content. The structural device of hyperlinking to different documents within the text also gives the impression that further reading is necessary to fully understand the issues.

Medical professionals working with children and young people are likely to come into contact with those who have experienced or are experiencing sexual abuse. It is therefore vital that the information in the pathway is presented in an accessible way, which empowers professionals to take a proactive, supporting and responsive role.

We believe that the document would be improved by child sexual abuse being presented as an issue with which medical professionals will routinely engage, rather than as a complex legal issue. We believe that this could be achieved by ensuring that throughout the document the focus is on the child, and what the medical practitioner can/should do alongside the child to support them through this pathway.

The document could be strengthened throughout by increasing the focus on the child/young person's own agency and rights within this process. The list of other documents in Section 1.5 could usefully include information on children's rights, and in Section 1.7 it would be helpful to mention what work, if any, has been done with children and young people as part of the process of developing the pathway.

Section 2: Context

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

Not Answered

If not, which key areas or research you would like to be added, amended or removed?:
In relation to the Crime Survey for England and Wales (2016), we assume that the wording should be clarified to explain that the percentages relate to any form of sexual abuse, not any form of abuse as currently drafted.

It is important that the context given in this section reflects both contact and non-contact offences. The definitions of child sexual abuse explored later show that not all abuse involves physical contact with the child or young person (for example, online grooming), and it is vital that medical professionals both identify and respond to situations where any form of sexual abuse is taking place.

The language in relation to the CSA Centre for Expertise paper could be simplified and clarified by referring to abuse by "adults and other children/young people" rather than adults and peers. The word 'peer' suggests someone of a similar age, when in reality abuse by another child or young person can encompass this, but can also include children/young people of different ages, and relationships between children/young people of the same age where a power imbalance creates an abusive context.

Section 3: Clinical Pathway

1 Do you agree with the aims of the pathway?

Not Answered

If not, why not? :
We would add safeguarding to the aims of the clinical pathway. This could be achieved using the following wording: "services for the child or young person and

those who care for them are able to promote health, wellbeing and recovery, and maintain a focus on safeguarding."

The wording of the fourth bullet point in Section 3 ("Balance confidentiality with the need to share information to safeguard the child or young person, or other children and young people at risk of harm") suggests an inherent conflict between confidentiality and information sharing, and may unconsciously act as a barrier to clinicians sharing information and intelligence.

In our experience of working with a range of statutory partners, while confidentiality must of course be balanced with the sharing of information relating to a particular individual, agencies also hold a range of 'softer' intelligence, which can more readily be shared, and can be invaluable in working together to tackle child sexual abuse. For example, information on individuals of concern and places of concern can be shared.

This document should leave practitioners feeling empowered to share information, rather than discouraged from or fearful of doing so. It should also be noted that where there is a child protection concern, information should be shared in order to help safeguard the child/young person, and pathways should detail whom this information should be shared with.

The final bullet point in this section ("Ensure that the examination meets the forensic standards required to support any future criminal justice process including the requirement that facilities used for forensic medical examination are appropriately maintained and comply with the agreed forensic decontamination processes and procedures") is extremely clinical/legal, and clearly places the focus on collection of evidence. There is very welcome reference in Section 6 to the fact that the primary purpose of medical examinations is to support the health and wellbeing of the child, and that the collection of forensic evidence is a secondary purpose, but that important nuance does not come across in this final bullet point.

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

No

If not, what improvements would you suggest? :
As noted in Section 1, Question 1, we believe that coordinating pathways should be developed for children and young people who have disclosed ongoing abuse; children and young people who have disclosed non-recent or non-current abuse; and children and young people where sexual abuse is suspected.

We also believe that the pathway should apply to all children and young people under 18. If it is the case that the guidance remains for those under 16 (or up to 18 for young people with vulnerabilities and additional support needs), it is essential that the guidance signposts to support for 16/17 year olds. Simply treating young people who have been through this experience as adult abuse victims is not sufficient.

The pathway would be strengthened by focussing more on support for the child/young person. At present, support for the child is not included until the very end of the pathway at Section 5.5, but we believe that it should be a consideration from the outset.

One important element of this is that the pathway must include a step between disclosure and IRD where the medical practitioner considers whether or not the child/young person is currently safe (for example whether they are leaving the appointment with the perpetrator), and if not, supports the practitioner to know how to take steps to help to secure the child/young person's welfare.

In order to ensure that medical staff are equipped to provide support, additional guidance on how to respond to a disclosure (expanding on the useful 'listen and believe' message) could be included in this document. It should also further detail (prior to IRD) who professionals should contact in the first instance, how arrangements for an IRD are made, and any relevant timescales for doing so.

It would also be useful for the pathway to include consideration of what role the medical practitioner is able to play in providing ongoing support to the child or young person. If the child or young person has chosen to disclose to a medical professional, this could be because they feel they can trust them, or feel a connection with them, so in some cases an ongoing supportive relationship could be extremely beneficial. While this is more likely to be appropriate/possible in some contexts than others (for example, school nurses), all medical professional should be encouraged to consider a follow-up appointment.

As noted in Section 1 above, we believe that the pathway could be strengthened by considering how children and young people can be more involved in the process. The language and processes in Section 5.2 could be revised to assist with this. For example, seeking the child/young person's views on, and consent to, a medical examination should come before decisions about the type or location of the examination.

We welcome mention in the pathway of support for those around the child, and would be pleased to see this section expanded and strengthened with the outcomes of the work being taken forward by the Taskforce. Making support available to non-abusive carers and family members to better respond to their child's needs was found to be a key component of a child's recovery by the NSPCC's 'Right to Recover' work in 2017 (https://learning.nspcc.org.uk/research-resources/2017/right-to-recover-sexual-abuse-west-scotland/)

Barnardo's colleagues in England recently conducted research into the needs of young victims and witnesses involved in criminal justice processes relating to CSA and the practical and operational considerations of undertaking this kind of work within a multi-agency environment. Five elements were identified as being central to helping children and young people to cope with the emotional stress and turmoil they can experience, and help set them on a pathway to recovery. These were: sense of self and control; relationships and support networks; emotional and physical health; practical support; and safety and safeguarding. This may be a useful framework from which to promote a holistic, child-centred response from medical practitioners. (https://www.barnardos.org.uk/journey_to_justice_summary_paper.pdf)

Section 4: Medical Examination

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

Not Answered

If not, why not? :

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?:
We welcome the clarification in the pathway document that the primary purpose of a medical examination is to address the health and wellbeing of the child or young person in a holistic manner. With this in mind, it is particularly important for this document to recognise the potential for medical examination to contribute to the trauma experienced by the child or young person, and the importance of taking all possible steps to avoid this.

The issue of consent should be expanded within this section, to ensure that children's rights are fully considered in each situation. If consent is not being sought from a child (for example, where parental consent is sought) or there is use of anaesthetic, then this should be made clear to the child while supporting them through the process – both before and after the examination. Discussion of the interplay between consent from children/young people and parental consent would also be useful in this document.

It should be highlighted that a child can withdraw their consent for the examination at any time, and this should be explored with a child/young person prior to undertaking any examination, as well as discussions with children/young people about what to expect. Areas for expansion should include how examiners check in with young people and obtain consent throughout the process.

It should be explicitly stated that if consent is withdrawn during the examination it must be stopped immediately. The document should support medical practitioners to recognise the interplay between the child having power within this situation and their power having been removed in a sexual abuse situation, in an effort to avoid further traumatisation.

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?:
In relation to Appendix B on the legal context, we believe there is value in extending this to children and young people who have been sexually abused, rather than only those who have disclosed, including legal context on grooming and prevention. The two documents below are suggested additions.

• Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005 which, among other useful information, refers to Risk of Sexual Harm Orders

• Human Trafficking and Exploitation (Scotland) Act 2015 which highlights the issue of children and young people being recruited for the purpose of sexual exploitation.

Section 6: Final comments

1 Do you have any comments or additions on topics which are not covered in previous sections? Please be specific in your reasons and include any resources or references we should consider.

Do you have any comments or additions on topics which are not covered in previous sections? Please be specific in your reasons and include any resources or references we should consider.:
We believe that section 4 of the document, on which no consultation questions are asked, is key to ensuring that medical practitioners have an up-to-date, relevant understanding of CSA, which enables them to identify CSA and act in the best interests of those who have or may have experienced it. We would suggest the following amendments:

4.1
As noted above, we believe that the clinical pathway should be applicable to all children and young people up to the age of 18.

4.2
We believe that a simple, accessible definition of child sexual abuse would be most useful here. The WHO definition used does not offer a great deal of clarity and is not widely used in policy and practice around CSA in Scotland. It is very important for the definition to extend to subtypes of child sexual abuse, including child sexual exploitation, online child sexual abuse, grooming, and contact/non-contact abuse.

Alternative definitions include:

• Guidance for Child Protection (2014) (currently under review: "Sexual abuse is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of indecent images or in watching sexual activities, using sexual language towards a child or encouraging children to behave in sexually inappropriate ways (see also section on child sexual exploitation)."
• NSPCC definition (available in full at: https://learning.nspcc.org.uk/child-abuse-and-neglect/child-sexual-abuse/) which has been widely cited by other medical bodies (cf. https://www.rcoa.ac.uk/safeguarding/child-protection/child-sexual-abuse)

It may be useful for this section to draw a distinction between children and young people, highlighting the differences in the most common forms of abuse within different age groups.

The list of ways in which CSA may present (currently at Section 5.1) should be moved to 4.2, and retraction of a disclosure should be added. To avoid referring to children as perpetrators, the final bullet point should be rephrased to say "a child exhibiting unexpected, problematic or harmful sexual behaviour may have

exhibit this behaviour due to their own experience of sexual abuse”

We do not believe that the paragraph suggesting that the dynamics of child sexual abuse differ from adult sexual abuse is helpful or necessary.

The information on the Sexual Offences Act should be included in Section 4.5 rather than 4.2.

4.3 and 4.4
Sections 4.3 and 4.4 should be amalgamated.

The information in section 4.4, on the possible impact of ACES, should be rewritten to be clear that child sexual abuse is an established Adverse Childhood Experience, and that experiences of trauma can impact negatively on brain development, behaviours and mental health, whilst acknowledging that impact is very dependent on the individual circumstance of the child and crucially, the support they have around them.

This should precede the information on trauma-informed services in 4.3, making explicit that the reason services must be trauma informed is to take cognisance of this possible effect, and to avoid anything which could be re-traumatising for the child/young person and create a space for recovery.

4.5
This section is titled ‘legal context’, but it may be more useful to frame this section explicitly in terms of what a medical practitioner is legally required to do in different situations, with the focus on practitioners’ actions rather than the full complexity of the law (references could of course be provided for those who wish to have a fuller legal understanding).

The language in this section could be simplified and clarified: the term non-consensual activity should be replaced with sexual abuse to avoid undue complication for medical practitioners around the complexity of consent. So, for example, the second paragraph should read that information must be passed to police about any child or young person under 13 who has been engaged in any sexual activity, any child or young person who has disclosed any form of sexual abuse (including sexual exploitation), or where there is suspicion or concern that this child/young person may be experiencing abuse.

Where a child/young person discloses any sexual activity with an adult, Child Protection processes should be followed. It is important to note that due to the grooming process, children and young people can be made to believe they have consented or are to blame for their abuse, or have been deceived into believing that it is not abuse. Professionals are still required to respond to instances where there has been an adult involved as a child protection concern, regardless of whether the child/young person can currently understand the situation as abusive or not.

In cases where there has been reported or suspected sexual activity with another child/young person over 12, practitioners should exercise professional curiosity in terms of gauging children/young people’s understanding of consent and ‘free agreement’, and the circumstances surrounding the relationship between the young people. If it is disclosed or suspected that this relationship may be abusive, professionals should again use a child protection response. Where a child over 12 is disclosing consensual sexual activity with another child over 12, this should be closely monitored and appropriate supports offered.

About you

What is your name?

Name:
Kirsten Hogg

What is your email address?

Email:
kirsten.hogg@barnardos.org.uk

Are you responding as an individual or an organisation?

Organisation

What is your organisation?

Organisation:
Barnardo's Scotland

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

Publish response only (without 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.:

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

Please enter comments here.: