Response to Scottish Government's Consultation on the Clinical Pathway for Children and Young People who have disclosed sexual abuse

July 2019

We welcome the opportunity to submit our views in response to the Scottish Government's consultation on the Clinical Pathway for Children and Young People who have disclosed sexual abuse (the Clinical Pathway), which has been developed in the context of the work of the ongoing Chief Medical Officer (CMO) Taskforce to improve medical and healthcare service provision for all victims of sexual crime. We strongly support the intention to align the recommendations of the CMO Taskforce, and specifically the guidance provided by the Clinical Pathway, with the Barnahus concept.[1] Such alignment will help to ensure that the responses children and young people receive from all services are child-centred, trauma-informed, and enable recovery.

Key messages

- Improvements can be made to responses to child sexual abuse through trauma informed practice, close multiagency working, and utilising concepts from the Barnahus approach.
- Barnahus concepts should be more clearly integrated and embedded throughout the Clinical Pathway.
- The Clinical Pathway should recognise the vulnerability and uphold the rights of all children up to the age of 18 (and up to age 26 for young people to whom the state has duties and responsibilities as a corporate parent).
- Greater clarity is required about how the Clinical Pathway is integrated within the wider multi-agency child protection system.

Background

At CELCIS, we undertake a range of systemic, evidence-informed approaches to drive sustainable and positive change in systems, services and practices for children in need of care and protection and their families. Our work includes a Protecting Children Programme, which supports delivery of the national Child Protection Improvement Programme (CPIP), launched by the Scottish Government in 2016. CPIP aims to ensure that Scotland's child protection system puts children's wellbeing first, and keeps them safe from neglect and abuse. Official statistics indicate that there are 2,688 children on the child

[1] Scottish Government (2019) *Clinical Pathway for Children and Young People who have disclosed sexual abuse: Consultation document. Version 1.0*. Edinburgh: Scottish Government, Para 1.7

protection register in Scotland, and for 163 of these children, case conferences identified concerns relating to sexual abuse.[2] The true extent of child sexual abuse in Scotland is not known, and is difficult to estimate, as often sexual abuse is not disclosed or discovered for many years. The NSPCC estimate that as many as 7 out of every 8 children who experience sexual abuse do not come to the attention of services.[3]

The Scottish Government is committed to incorporating the United Nations Convention on the Rights of the Child (UNCRC) into our domestic law in Scotland, and is currently consulting on the best mechanisms through which to do this.[4] Article 39 of the UNCRC sets out the right to recovery for children who are victims of any form of exploitation or abuse, and states that such recovery shall take place within an environment which fosters the health, self-respect and dignity of the child. Improving the way in which Scotland responds to children and young people who have experienced sexual abuse (and other serious and traumatic crimes) is a priority for the Scottish Government. Specific commitments are enshrined in the 2018-2019 Programme for Government to take forward work to consider how the Barnahus approach for trauma-informed support to child victims can operate within the Scottish context, and a scoping report on the development of standards to introduce this approach has recently been published by Healthcare Improvement Scotland and the Care Inspectorate.[5] The Barnahus approach is a multi-agency, child-focused response for victims and witnesses of violence, involving intensive and ongoing support in a child-friendly setting and a single forensic interview which avoids the child or young person being required to attend court as a witness.

Our current response to child sexual abuse requires improvement, and the development of the Clinical Pathway is in the context of this complex work. It is important to consider how the Clinical Pathway is integrated into the whole system response to child sexual abuse and the roles of multiagency partners, within the framework of Scotland's national approach to improving outcomes and supporting children's wellbeing, Getting It Right For Every Child (Girfec).

Section 1: Introduction

1. Do you believe the pathway would improve and standardise services for children who have disclosed sexual abuse and their families? If not, what improvements would you suggest?

The introduction of the Clinical Pathway has the potential to improve and standardise the services and supports children and their families receive where

[2] Scottish Government (2018) *Children's social work statistics 2017-2018.* Table 4.5 – Additional Tables. Edinburgh: Scottish Government

[3] Galloway, S., Love, R. & Wales, A (2017) *The Right to Recover: Therapeutic services for children & young people following sexual abuse - An overview of provision in the West of Scotland*. NSPCC

[4] Scottish Government (2019) *Children's Rights: Consultation on incorporating the United Nations Convention on the Rights of the Child into our domestic law in Scotland*. Edinburgh: Scottish Government

[5] Healthcare Improvement Scotland, Care Inspectorate & Scottish Government (2019) *Barnahus Standards Scoping Workshop Report*. Edinburgh: Healthcare Improvement Scotland

medical examinations are required due to experience of sexual abuse. In order for the potential of these improvements to be fully realised, further development of some areas of the Clinical Pathway is required. In particular, improvements could be made by:

- **Clearly integrating and embedding the Barnahus concepts throughout the Clinical Pathway,** in particular, the three core principles of placing the best interests of the child at the centre of practice and decision-making; ensuring children's right to be heard and to receive adequate information at all times; and avoiding delay in protection, assistance and justice processes[6]. Currently, beyond the initial mention of Barnahus on page 7, there is little evidence of how the approach and concepts are reflected in the Clinical Pathway, and what this means for the way practitioners should operate.
- **Reflecting clear recognition of the vulnerability of all children, and their rights and entitlements to sensitive, trauma informed and holistic responses when receiving services as part of the Clinical Pathway.** Regardless of the inconsistency in some areas of the Scottish legal system concerning the definition of a child, the UNCRC (which the Scottish Government is committed to incorporating into domestic law) is clear that anyone under the age of 18 is a child, and is entitled to have their rights upheld as such. This is also reflected in Girfec, which is in place for all children up to the age of 18. Furthermore, in recognition of the additional needs and vulnerabilities faced by children and young people with care experience, and the responsibility of the state to safeguard their rights and promote their wellbeing, Part 9: Corporate Parenting of the Children and Young People (Scotland) Act 2014, requires Scottish Ministers, NHS health boards, and a range of other public sector bodies to pay particular attention to meeting the needs and listening to the views of these children and young people in all areas of their services. Young people to whom the state is a corporate parent are entitled to additional support up to the age of 26. Their needs, and how these are taken into account in the Clinical Pathway, requires explicit clarification.
- **Providing greater clarity about how the Clinical Pathway is integrated within the wider multi-agency child protection system**, in line with the Girfec approach. This is largely missing from the Clinical Pathway currently, and the shared responsibilities of all practitioners in responding to child sexual abuse, and the mechanisms through which partners work together, requires significant attention.

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

To strengthen the Clinical Pathway, the following additions are recommended:

[6] Hall, H (2018) *Trauma-Free Justice, Care and Protection for Scotland's Children: Learning from the Barnahus approach.* Edinburgh: Children 1st

- To reflect the commitment to taking a rights-based approach, include reference to the UNCRC in Section 1.5
- The inclusion of the Additional Notes for Practitioners: Protecting Disabled Children from Abuse and Neglect supplementary document to the National Guidance for Child Protection in Scotland is a necessary addition to Section 1.5. Research suggests that children affected by disability are 3 to 4 times more likely to be abused than non-disabled children, and that children with communication impairments, learning disabilities and sensory impairments are particularly vulnerable.[7]
- In terms of Section 2, the difficulty in estimating the prevalence of child sexual abuse is recognised. Useful additions to the data referenced include:
    - The NSPCC estimate that 7 of every 8 children who experience sexual abuse do not come to the attention of statutory services.[8]
    - Reference to increased prevalence for children affected by disabilities, as noted above.
    - Findings from the 2015 survey by FRA, the European Union Agency for Fundamental Rights, reports that 18% of women in the UK said that they experienced sexual violence before the age of 15, by adult perpetrators.[9]

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

In order to be as useful as possible to practitioners, the Clinical Pathway document may benefit from clarifying the purpose of document, and that the stated purpose fully aligns with the contents of the document. The statement of purpose in Section 1.1 is noted as '*a resource to outline the process for the healthcare response to disclosures by children and young people of sexual abuse of any kind*'. However, this is not clearly reflected in the document. Rather than guidance about responding to disclosures, the document provides a detailed account of the process for undertaking medical examinations of children, where such examination is required under child protection procedures. Throughout the document, introductory or summary information is provided on a range of areas related to the purpose of the document (such as disclosures, indicators of sexual abuse, adverse childhood experiences, as well as legislation, policy and procedures), however this information appears cursory, and its place and purpose in the document is unclear. If the document is partly intended as a signposting document to more detailed information, this should be clear, and the expected practice implications of such signposting for those using the Clinical Pathway must be identified.

[7] Scottish Government (2014) *National Guidance for Child Protection in Scotland. Additional Notes for Practitioners: Protecting Disabled Children from Abuse and Neglect*. Edinburgh: Scottish Government
[8] Galloway, S., Love, R. & Wales, A (2017) *The Right to Recover: Therapeutic services for children & young people following sexual abuse - An overview of provision in the West of Scotland*. NSPCC
[9] FRA (2015) *Violence against women: and EU-wide survey. Main results*. Luxembourg: European Union

Section 2: Context

1. Do you agree with the context given in the pathway document? If not, which key areas or research would you like to be added, amended or removed?

The issues in the context section are all important and relevant, however the concern identified in our answer to Section 1.3 applies. Much of the information in sections 4.1-4.5 is brief, introductory, and disconnected from the stated aims and purpose of the document. If the issues cannot be covered comprehensively within the document, it may be more beneficial to signpost to the National Guidance for Child Protection in Scotland (2014). This guidance is currently being reviewed, and utmost care should be taken to ensure the content of the Clinical Pathway document is aligned with the reviewed guidance to avoid the document quickly becoming out-of-date.

Suggested specific amendments include:

- **4.1 'Who is a Child'** –
    - Whilst we recognise the complex legal landscape in relation to defining the age of a age, to align with the Scottish Government's commitment to the UNCRC, the Clinical Pathway should apply to all those under 18. This recognises the right of these individuals' to a child-centred responsive approach, which takes into account their additional vulnerabilities as children and young people. Furthermore, extending the application of the Clinical Pathways to care experienced people up to the age of 26 should be considered, in line with corporate parenting duties and responsibilities.
- **4.2 'Sexual Abuse'** –
    - Consistency with the definition of sexual abuse generally used in Scotland, taken from the National Guidance for Child Protection in Scotland (2014), is recommended.
    - Relocate references to the legal context to section 4.5.
- **4.3 'Trauma-Informed Services'** –
    - We strongly support a focus on trauma-informed services for children who have experienced sexual abuse. However, this section itself is brief, and a trauma-informed approach is not integrated into the document. The Clinical Pathway would be significantly strengthened by explicitly detailing the role of health practitioners in ensuring trauma-informed responses, in the multi-agency context, at every stage of the child's journey, including future planning and recovery.
    - Replace 'sexual violence' with 'sexual abuse' in the opening sentence of this section. All experiences of sexual abuse require a trauma-informed response, not only experiences of sexual violence.
- **4.4 'Adverse Childhood Experiences'** –
    - This section could be strengthened, it currently contains very limited detail.

- The language used in this section is highly clinical, emphasising the diagnosable disorders which can result when child sexual abuse is not 'treated'. This could be improved by taking a more holistic view of the child, the need to be trauma-informed, and attend to their overall wellbeing in responses to child sexual abuse.

- **4.5 'Legal Context' –**
  - The focus of this section, particularly on responding to disclosures of sexual abuse by children, is potentially confusing. Firstly, there is not enough information to constitute comprehensive guidance. Secondly, the Clinical Pathway appears aimed at practitioners undertaking medical examinations, which will occur after disclosures have been made.
  - The lack of clear references to relevant law in this section is confusing. The statement that additional context is provided in Appendix B is noted, however this appendix is simply a list of Acts (plus a paragraph outlining some aspects of the Children and Young People's (Scotland) Act 2014 which have not yet commenced) and as such the legal context is largely unexplained.

Section 3: Clinical Pathway

1. Do you agree with the aims of the pathway? If not, why not?
We agree with the aims stated in Section 3. We strongly support the attention in the opening paragraph to the importance of partnership working, and ensuring children (and those who care for them) are supported in a manner which promotes health, wellbeing and recovery. The references to holistic support and trauma-informed practice are also particularly positive.

To improve the aims still further, consideration should be given to explicitly stating the aim of being rights-based in responses to disclosures of child sexual abuse. Additionally, explicit recognition should be given to the aim that services will be responsive, and practitioners will enable children (however they communicate) to communicate their views and needs, rather than any onus or pressure being on the child to make themselves understood.

Whilst the 'aims' section of the document is strong, we are concerned that the stated aims and approaches are not coherently integrated into the Clinical Pathway, and therefore into practice. It is thus difficult to see how these aims will be realised.

2. Do you agree with the layout and content of the pathway process? If not, what improvements would you suggest?
Whilst it is sometimes useful to use diagrams/flowcharts to represent complex systems and processes, in this case the process diagram fails to capture important aspects of the multiagency response to child sexual abuse. For instance, rather than a disclosure simply triggering an interagency referral discussion, importantly it should trigger support to the child and their family, in

line with the Barnahus approach. Additionally, the sense of multiagency working is limited, where what is required is an emphasis on the way in which practitioners will work together to ensure children's needs are planned for and met.

Similar to other sections, the purpose of this section of the Clinical Pathway document is somewhat confusing, again giving some limited introductory information on topics such as Joint Investigative Interviewing and Interagency Referral Discussions, without constituting usable guidance. If the purpose is to place the medical examination in context, this could be better achieved with greater emphasis on matters such as interagency collaboration and support to children and their families.

Therapeutic support helps rebuild children's lives by helping them to understand and move on from difficult experiences. The response of non-abusing parents and carers is critical to children's recovery, and this must be reflected in the planning and provision of support from multiagency partners.[10] In relation to the detail of the stages outlined in the diagram, it is concerning that the 'Management of Healthcare Needs' stage receives limited attention. This is an important and complex stage of the process, where multiagency plans to meet assessed need should be made and implemented, in line with the Girfec approach. The reader is referred to Section 6 for more information on 'follow up' from the medical examination, however the content of section 6 which relates to 'follow up' is very limited, focuses on processes, and fails to reflect any sense of the trauma-informed, child-centred approach the Clinical Pathway sets out to aim for.

Section 5.2 refers to Interagency Referral Discussions (IRD). Whilst the document sets out an overview of the IRD process, it is important to note that there is significant variance in IRD practice across Scotland. The current National Guidance for Child Protection in Scotland (2014) does not contain guidance on IRDs, however this will be encompassed in the reviewed guidance, to be published in 2020.

Section 4: Medical examination

1. Do you agree with the medical examination section of the pathway? If not, why not?

To some extent. Whilst this section comprehensively details the medical examination process, it does so in an entirely procedural manner, which fails to reflect the child-centred intentions expressed elsewhere in the document.

Despite the opening paragraph of this section reflecting the primary purpose of the medical examination as identifying needs and planning to address the child's

[10] Galloway, S., Love, R. & Wales, A (2017) *The Right to Recover: Therapeutic services for children & young people following sexual abuse - An overview of provision in the West of Scotland*. NSPCC

needs in a holistic manner, the stated secondary purpose of collecting forensic evidence for formal police and court proceedings appears to be the main focus. Clearer reflection of the Barnahus principles and approach could redress this imbalance.

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

A medical examination is likely to be an intrusive and frightening experience for any child, and particularly so for those who have experienced sexual abuse. This section could be significantly improved by acknowledging this, and integrating examples of the ways in which a trauma-informed approach to practice can be embedded. For example, setting out whose role it is to explain, in developmentally appropriate language, the process to the child; ensure the child has the opportunity to look at the room in which the examination will happen; talk the child through the process whilst it is going on; comfort the child; ask their permission; and support the parent or carer. This includes meeting the needs of the child and their family after the examination, in terms of any ongoing dialogue.

Other specific amendments to this section include:

- 6.1.2 – Complexities involving arrangements for written consent from an individual with parental rights should be made explicit. Such as, what arrangements are in place if the individual with such rights is potentially responsible for the abuse. Additionally, what arrangements are in place in the example of a child who is looked after away from home, whose parent cannot be contacted within the required timescales.
- 6.1.3.b – Reference to neglect and emotional abuse is confusing in this heading. Additionally, rather than referrals being 'assessed according to clinical need and requirements of the child protection process', they should be assessed according to the child's needs and best interests.

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.

Throughout the document, there are references to underage sexual activity and sexually harmful behaviour displayed by young people. As with other aspects of this guidance, neither of these issues receive sufficient attention for the reader to fully understand the context of these complex matters (which are not necessarily equivalent to child sexual abuse) and there is a danger that their inclusion serves to undermine the focus on child sexual abuse.

About CELCIS

CELCIS is a leading improvement and innovation centre in Scotland. We improve children's lives by supporting people and organisations to drive long-lasting

change in the services they need, and the practices used by people responsible for their care.

Thank you for providing us with this opportunity to respond. We hope the feedback is helpful; we would be happy to discuss any aspect in further detail.

Contacts:

Jillian Ingram
Child Protection Consultant
jillian.ingram@strath.ac.uk
0141 4448559

Lizzie Morton
Policy Associate
lizzie.morton@strath.ac.uk
0141 4448504