Comments on Hidden Crimes, Secret Pain

Consultation Response Questionnaire

I am responding on behalf of an organisation.
Consultant in Sexual and Reproductive Health Care, and Honorary Secretary of the Faculty of Family Planning and Reproductive Health Care (FFPRHC) of the Royal College of Obstetricians and Gynaecologists.
27 Sussex Place
Regents Park
London NW1 4RG
E mail : cosec@ffprhc.org.uk

The FFPRHC welcomes the opportunity to comment on this document. The aims of the Faculty are to promote training and standards in all matters related to the provision of contraception and reproductive health, often including diagnosis and management of sexually transmitted infections. Our members offer services through a network of largely community-based services and general practice, and large numbers of men and women are seen; awareness of child sexual exploitation, inappropriate sexual behaviour and risk taking are part of our every day work. It is often here that disclosures are made in what are perceived to be safe, non-judgemental and confidential environments, through return visits after 'testing' us out for our attitudes and skills. The comments below relate to the parts of the consultation document which are within our sphere of experience.

Part 1 –introduction:
The regional strategy will use the term sexual violence, which is defined as 'Any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent.
1.2.1 The legal age of consent differs from that in England and Wales, but the principles are the same.
Q1 –yes agree with terminology of sexual violence and its definition.

Part 2-prevention:
Q6: should the governmanet give a clear message ahead of public opinion, to stem the tide of normalising sexual violence in society
–yes

Q7 –what steps could the media take to support the process of increasing public understanding and awareness of the realities of sexual violence?
The doctors and nurses working in sexual and reproductive health often observe the – aftermath of sexual violence (psychosexual distress, post traumatic stress) and these could be highlighted in story lines of popular soaps and dramas, which should include examples of how to tell in safety, how to say no without losing cred with peers, and spotlighting the responsibilities of professionals and public in disclosing for safety of victim.

2.1.4-PSE: good to include issues 4-16 years

Q8: What key messages should be promoted in relation to how healthy relationship and respect can help to prevent sexual violence?
It is never ok to keep secret if feeling uncomfortable; role of police, school nurses, gps etc in helping (difficulty if will feel confidence will be broken by policies that keep people away from fp clinics)

q9: In addition to the education and training sector, what other sectoral groups and influencers have a role in delivering relevant messages?
Outreach via sexual and reproductive health services to youth settings such as Connexions, with good links to the clinical and training expertise of experts working in the health sector.

q10: what could the government do to promote the importance of healthy relationships in society?
The FFPRHC is aware that ensuring viability of choice for people to access sexual and reproductive health advice, support and provision of contraception via community clinics is key in helping people to be aware of their options in starting and maintaining sexual health in its widest sense. The Government should ensure that this choice is a real one for men and women.

q13: what practical measures could be developed to promote personal safety, generally, and to protect those most at risk, in particular?
Ensure access to ongoing sources of advice –voluntary sector eg Barnardos working with adult victims of child sexual abuse. Increase capacity of social services to act on those with lower thresholds of concern to prevent escalation of situations.

2.54 -?mandatory phse (not clear in sections above if includes sexual elements
q14:a: How can we stop sexual violence happening to children?
More work with people who have themselves suffered sexual violence so cycles are not perpetuated.

Q14c-what role can the media play in bringing this about?
Increase awareness of other than stranger rape scenarios. More story lines on picking up on distress at school/changed behaviour/falling academic standards.

Q16: How do we ensure that the legal system is better able to provide children with protection and justice when they have experienced sexual assault?
Witness protection, special arrangements for giving evidence. ??when mentally disabled or communication difficulties –advocates etc. (see 3.51)

2.59 –age of consent in NI is 17, or 16 if married.

Q18: How can awareness be raised among children and young people about sexual exploitation?
Awareness raising via schools, youth clubs, YOT, NICE one to one interventions when sexual matters being discussed including to vulnerable groups at health and other

settings, ensuring that any existing or proposed sexual activity is fully consensual in a relationship not affected by a power/age/dependency inbalance. This takes time and skill, and should be available via a choice and range of providers.

2.60-early interventions for victims and those recognising they are starting to perpetrate (see above)

2.65 Professionals in sexual and reproductive health care settings are also key –people who are concerned about what is happening to them within relationships expect to talk about sex when coming to these settings, and need to meet with well trained staff who understand their duties to keep children safe when disclosures are made. It may be easier for children to address these matters here than within general practice, where they perceive that their information may not be treated in the same confidential way.
The staff are also in a good position to assess children engaging in unsafe sexual behaviour, who may present for emergency contraception or help with diagnosis of pregnancy, with opportunities to discuss whether they are under duress to agree to this activity.

3.39 Terminology: not morning after pill but 'emergency contraception'. It is not considered best practice that not all FMEs are able to prescribe this as the treatment is more effective when used promptly, and victims should not be inconvenienced by having to seek out other sources of supply.

Section 4 (page 107 onwards) deals with services and SARCs
4.4 –future psychosexual distress if abuse not well dealt with initially–highlight rather than just mental health problems.

Q24 : what will be the most effective way to identify necessary support services and models for resourcing and delivering them?
Prospectively gathering comments from victims currently going through the services would be a good starting points about what they would have found most helpful and in what way the services could be delivered. A local network approach with client pathways needs to be developed from a template of good practice.(as in 4.43).
Ideally SARC should be staffed by medial and nursing practitioners who have expertise in sexual and reproductive health since the care pathway should include (where appropriate) provision of emergency contraception, sexual health advice, prophylaxis against STIs, post-exposure prophylaxis against HIV, immunisation against Hepatitis B and /or tetanus, psychosocial support and follow up. Once a victim has been referred (or self-referred) to a SARC, s/he prefers to receive care from the team at the SARC and should not be referred on to multiple agencies with the inevitable need to repeat his/her evidence of the assault to many different professionals.

Q25: what key services would contribute most to victim/survivor care and support?
Services include contraceptive clinics, GUM clinics, termination of pregnancy services, school drop in services, Connexions, health staff giving sexual and reproductive health talks within youth settings.

Q26:Is there a need to develop different services for different cohorts of victim/survivors , for example due to gender, age or sexual orientation?
Services for young people, those with learning disabilities, sensory impairments, speakers of other languages, cultural and religious diversity, straight and gay men and women need not necessarily be different, but good training should be available to cover specific needs of these groups. Same or different sex examiners and police officers should be available on request.

Q28 : which organisations could benefit victims/survivors by having clear protocols for joint working?
Social services, health and education plus voluntary sector.

Q31: what will be the most effective ways of increasing awareness about services that are available?
Distribute directories ideally at multi-agency training events. Ensure updating happens and subsequent distribution is timely.

Q32: to which services should regional standards apply and how should standards be monitored?
Services as in answer to q28. Monitoring of application of standards via case review with lessons learned disseminated to improve compliance.

Q33: what skills and training and support do people working directly with victims/survivors of sexual violence need?
Ability to listen in non-judgemental way, ability to separate and prioritise the multi-faceted needs being presented (eg forensic, contraceptive, STI). Ability to hear any unspoken cries for help, eg presentations for repeated emergency contraception or help with unplanned pregnancy, and sexually acquired infections.
Training and updating required –statutory child and vulnerable adult plus domestic violence training, basic first line interventions training as per the Haven DVD where people present distant from SARCs.
Support required –access to safeguarding children advisors, vulnerable adult advisors, supervision/debriefing for front line workers.

Q35: should training about the nature, incidence, impact and response to sexual violence be incorporated into pre-qualification training for relevant health professionals?
Yes; the FFPRHC develops standards and training for post qualification doctors and nurses, but its members are often involved in training those prior to qualification.