MRC/CSO Social and Public Health Sciences Unit Consultation Response

Title of consultation
Healthcare and forensic medical services for people who have experienced rape, sexual assault or child sexual abuse: children, young people and adults - Draft Indicators

Name of the consulting body
Healthcare Improvement Scotland

Link to consultation

Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?
Healthcare Improvement Scotland (Rachel Hewitt) invited the unit to participate in this consultation (email to Gillian Bell) – based on their knowledge that we were working on a whole-school approach to gender violence alongside some of their partners (including Rape Crisis).

Our consultation response

Indicator 1: Gender of forensic examiner

Indicator 1.1 Proportion of people who were offered a choice of gender of forensic examiner

Indicator 1.2 Proportion of people who were examined by the gender of examiner that they requested

Rationale
In their research into sexual assault referral centres, Lovett et al noted that adult service users, regardless of gender, expressed a strong preference for female forensic examiners and they recommended that this should be the norm.

The Victims and Witnesses (Scotland) Act 2014 states that an individual must be given the opportunity to request the gender of the examiner.

Corresponding Healthcare Improvement Scotland (2017) Standard:

2.10 People have the opportunity to request the gender of the forensic examiner who will be involved in their care. Children and young people are given the opportunity to request the gender of their paediatrician.

1. Do you agree with the indicator heading?
No. In addition to the forensic examiner, we would suggest adding a reference to the gender of the pediatrician as per standards. This would ensure taking into account all age groups. The indicator could be as follows: ‘Gender of forensic examiner/pediatrician’.

2. Do you have any comments on the indicator or measures?
We note the importance of monitoring the gender of the forensic examiner. We would also add the mention of the pediatrician to the indicator measure 1.1 and 1.2.

We also observe that there is no indicator or measure monitoring the profile of the forensic examiner beyond their gender, such as their skills-set and training related to person-informed and trauma-informed care. We do understand that the full training requirements are presented under another standard (standard 4: Educational, training and clinical requirements) – and that this consultation does not encompass these criteria. However, it seems it could be relevant to add certain skills related measures under this indicator, such as the presence of paediatricians with child protection experience and skills – in specific cases that require child protection (which is an aspect included under standard 2).

We also note that measure 1.1. provides some information on whether a choice of gender was offered, but it seems there are no guidelines in the standards on how this choice will be presented to ensure the person feels comfortable in stating her/his preference. It seems important this choice can be made through a mechanism that would enable the person to decide without influence and without having to request it first.

3. Do you agree with the rationale?
We perceive a discrepancy between the rationale and the indicator. The paper by Lovett et al (2004) concludes that the default/standard forensic examiner should be female: “Service users, both female and male, expressed a strong preference for female examiners: this should be the default position” (p. xi). However, the indicator and measures suggest a different approach – where people are asked about their preference from a ‘blank slate’. This inconsistency could be further explained, as to why the default gender is not female.

An evaluation of the current system in Scotland seems necessary to ensure such standards are based on evidence and therefore on views of children, adolescents, and adults who have gone through forensic examinations.

Indicator 2: Timing of forensic examination

Indicator 2.1 Proportion of forensic examinations commenced within 3 hours of the person consenting to the forensic medical examination

Rationale

Good practice notes that the principles of trauma-informed care should be applied throughout the process of a person’s care, including in any communications with or about them. This will enable the individual to have as much sense of choice and collaboration about the examination and their subsequent care as possible and enhancing their sense of safety and trust.

The timing of the forensic medical examination should be person centred and trauma informed. It should be performed following discussions with the person, the forensic examiner, and others as appropriate (for example a paediatrician if the person is under 16 years of age). The forensic medical examination should commence within 3 hours of the individual consenting.

Corresponding Healthcare Improvement Scotland (2017) Standard:

2.11 The timing of the forensic medical examination:
a) is person-centred and trauma-informed, and  
b) follows discussions with the person, the forensic examiner and others as appropriate, for example a paediatrician if the person is under 16 years of age.

2.12 For young people and adults, the forensic examination is undertaken within three hours of request. Exceptions to this timeframe may be necessary:

- to reflect a person’s choice or decision about the timing of the forensic examination, and  
- in remote and island communities where significant travel is involved.

In either of these situations, the forensic examiner provides the person and the police with an indication of when the examination will take place, and the reasons for this are recorded and shared appropriately.

1. Do you agree with the indicator heading?  
   Yes.

2. Do you have any comments on the indicator or measures?  
   None.

3. Do you agree with the rationale?  
   Although we understand the challenges of delivering forensic examinations within a small timeframe of 3 hours of the person consenting to the procedure, we are concerned about the mention of exceptions that are out of the person’s control. This comment refers to people living in remote and island communities where significant travel is involved. Such a provision is understandable on a practical level but is also cause for concern in further exacerbating inequalities in access to services – especially services as important as these. We would suggest adding more information on what would constitute a valid exception, and how best these occurrences could be mitigated. An evaluation of the management of such cases could support better quality interventions in future.

Indicator 3: Chaperone support

Indicator 3.1 Proportion of people examined by a sole forensic examiner who were offered a suitably trained, impartial chaperone  

Indicator 3.2 Proportion of people who were supported by a suitably trained, impartial chaperone  

Rationale

In line with the General Medical Council’s guidance on intimate examinations and chaperones, a patient should be offered the option of having an impartial observer (a chaperone) present wherever possible. For forensic examinations, an offer of the presence of an impartial and trained observer should be made where a sole clinician is undertaking the forensic examination.

Corresponding Healthcare Improvement Scotland (2017) Standard:

2.13 A suitably trained, impartial chaperone is offered for all forensic examinations where there is a sole clinician present.

1. Do you agree with the indicator heading?  
   No. We think it would be of value to add a mention of translators, in addition to the chaperones. The standards mention that when it is required, a translator should be present (2.14). The translator should not be a family member or friend, and their gender should also be based on the preference of the person undergoing the examination.
2. **Do you have any comments on the indicator or measures?**
As mentioned above, we would suggest adding the mention of a translator as an additional measure. It seems critical that a person that does not have the sufficient English language skills would be supported by a suitably trained translator.

With regards to the chaperone profile, it would be important to define what is meant by ‘suitably trained and impartial’. For instance, would this include chaperones trained in communicating with people with autism, learning disability?

3. **Do you agree with the rationale?**
As per comments above, we would add a rationale as to why a translator should be present during the forensic examination.

**Indicator 4: Assessed support needs**

**Indicator 4.1 Proportion of people who had their support needs assessed and documented**

**Rationale**

Person-centred care involves people and services working collaboratively and in genuine partnership. Care provision that focuses on personal goals, preferences and needs, results in more effective care with better outcomes and a better experience for people who use services.

Decker et al (2009) noted that individuals who have experienced rape or sexual assault are at high risk for suicide and self-harm. Individuals can be immediately assessed using non-intervention methods such as psychological first aid (PFA) and suicide prevention methods.

Campbell et al noted that reactions to and recovery from rape, sexual assault and child sexual abuse are highly individualised and dependent on a number of factors. Good practice in trauma-informed care emphasises the importance of individuals identifying their own immediate needs. This enables individuals to regain a sense of control over their environment and ongoing recovery.

**Corresponding Healthcare Improvement Scotland (2017) Standard:**

2.6 Individualised support needs are assessed, documented and actioned as appropriate.

1. **Do you agree with the indicator heading?**
Yes.

2. **Do you have any comments on the indicator or measures?**

As mentioned in the rationale, person-centred care involves people and services working collaboratively and in genuine partnership. Although the idea of a ‘multi professional, multi-agency and coordinated response’ seems to be implied by the indicator and measure, we would argue it would be important to have another measure about the quality of collaboration and referral links.

In addition, measure 4.1 focuses on whether the needs were assessed and documented, and not whether these were actioned. This seems to be gap. We also note that it could be interesting to add services mentioned under standard 2.7 and 2.8.

3. **Do you agree with the rationale?**

The rationale could be further strengthened by adding more detail of what is meant by ‘support needs’. 
The rationale needs to define what assessments should take place, when, where, by whom, using which tools, and how this differs between adults, young people, and children. Failure to specify what constitutes appropriate assessment may have the unintended adverse effect of validating unacceptable variation in practice. The two references provided report findings for adults only. Any extrapolation from adults to children should be justified.

Decker and Naugle (2009) specifically recommend that assessments of adult women should involve (1) assessment of immediate safety, (2) assessment of and response to suicidality, and (3) assessment of access to social support. The rationale should be clarified if this is the form of assessment of support needs which the indicator will measure. If psychological first aid is being recommended here as an assessment method, an evidence base for this should be cited.

The statement in the rationale regarding the findings of Campbell et al. (2009) suggests that responses and recovery are "highly individualised and dependent on a number of factors". This statement emphasises individual-level characteristics as shaping the response, which is not an accurate representation of Campbell et al.'s findings (which included mixed findings on the impact of individual characteristics) and could be misinterpreted as victim blaming. A more accurate statement based on Campbell et al. would be that recovery is "dependent on a number of individual and system-related factors, including provider reactions, sociocultural beliefs, cumulative trauma and revictimisation over the life-course".

The rationale is silent on the assessment of children who have been sexually abused, or of adults who have been abused as children. Although beyond the scope of this response, a review of relevant research and guidelines seems necessary so that the rationale encompasses more than the two cited studies, both of which refer to adult women in America.

**Indicator 5: Access to immediate sexual health care**

Indicator 5.1 Proportion of people who were offered immediate referrals to sexual health services for:

a) emergency contraception  
b) post-exposure prophylaxis for HIV  
c) post-exposure prophylaxis for hepatitis B, and  
d) sexually transmitted infection screening.

Indicator 5.2 Proportion of people who were referred to sexual health services for:

a) emergency contraception  
b) post-exposure prophylaxis for HIV  
c) post-exposure prophylaxis hepatitis B, and  
d) sexually transmitted infection screening.

Indicator 5.3 Proportion of people who attended sexual health services for:

a) emergency contraception  
b) post-exposure prophylaxis for HIV  
c) post-exposure prophylaxis for hepatitis B, and  
d) sexually transmitted infection screening.

**Rationale**

Rape and sexual assault may result in sexually transmitted infections, including human
immunodeficiency virus (HIV) and hepatitis B and unwanted pregnancy. People who have experienced rape and sexual assault should be offered appropriate interventions, including emergency contraception.

International studies suggest that the risk for pregnancy after rape is approximately 5-7%, with adolescents most at risk.

Evidence from the United States notes that the literature cannot provide reliable estimate data on the risk for transmission of herpes, hepatitis B or HIV infection from sexual assault. The frequency and type of sexually transmitted infections acquired from sexual assault depend on local prevalence and the nature of the assault. However, it is noted that chlamydia and gonorrhoea are the most common sexually transmitted infections.

Although the risk of HIV infection from a sexual assault or rape appears to be low, it is typically of grave concern for people who have experienced sexual assault or rape.

**Corresponding Healthcare Improvement Scotland (2017) Standard:**

2.8 Support is provided to enable people to access:

a) immediate and follow-up healthcare
b) trauma care, including evidence-based psychological therapies
c) mental health services, including safety planning
d) sexual health services
e) support services, and
f) independent advocacy.

1. **Do you agree with the indicator heading?**
   Yes.

2. **Do you have any comments on the indicator or measures?**
   We find the sexual health indicators relevant. We do note that there is no mention of pregnancy testing under this indicator as it is likely included under the forensic examination standard. However, it seems it could be important to mention abortion related services (as appropriate). If it were to come under standard 2.8d, this should be included here.

   We also notice that there are no indicators measuring support and referral for non-medical services (standard 2.8 e,f), including child protection services and domestic violence services.

   For the post-exposure prophylaxis for HIV and emergency contraception, a timeframe (i.e. 72-120 hours) could be important to include in these measures, between the time of the sexual assault/rape/sexual abuse, the referral and service use.

3. **Do you agree with the rationale?**
   Yes.

**Indicator 6: Access to follow-up mental health services and aftercare**

Indicator 6.1 Proportion of people identified as requiring:

a) psychological therapies, and
b) mental health services.

Indicator 6.2 Proportion of people who were referred to:

a) psychological therapies, and
b) mental health services.

Indicator 6.3 Proportion of people who attended:

a) psychological therapies, and
b) mental health services.

Rationale

Support should be provided to enable people to access appropriate ongoing care, relative to their needs. One third of people who experience rape, sexual assault or child sexual abuse develop long-term psychological conditions such as post-traumatic stress disorder (PTSD).

Uptake of follow-up services for people who have experienced rape or sexual assault is low. Rather than referring immediately to psychological therapies, best practice recommends proactive support to enable individuals to access mental health or other services months or years after disclosure. Research notes that in many cases, service users for Rape Crisis Centers in the United States preferred immediate practical and non-interventionist support, highlighting the success of psychological first aid.

Availability of social support networks and other factors may determine the level and type of service offered to an individual at a later stage.

While Seña et al (2015) noted there are no new data on the prevalence of hepatitis B among sexual assault patients, they report that survivors are at risk for hepatitis B virus infection.

Corresponding Healthcare Improvement Scotland (2017) Standard:

2.8 Support is provided to enable people to access:

a) immediate and follow-up healthcare
b) trauma care, including evidence-based psychological therapies
c) mental health services, including safety planning
d) sexual health services
e) support services, and
f) independent advocacy.

1. Do you agree with the indicator heading?
Yes.

2. Do you have any comments on the indicator or measures?

We notice a difference between the wording in the standards and in the indicators. Standard 2.8c mentions “mental health services including safety planning”, whereas the indicator only refers to mental health services.

As mentioned under indicator 5, there is an absence of indicators relating to services mentioned under standards 2.8 e and f (support services and independent advocacy).

Given the extensive evidence that follow-up support will be required for years after the assault or abuse, it is important to specify the timeframe covered by the measures. If the indicator only refers to the very short term and specific circumstances of assault, this should be clarified.

3. Do you agree with the rationale?

No. The first paragraph of the rationale understates the psychological impact of sexual assault and child sexual abuse, which translates into a potential underestimate of the requirement for access to
follow-up mental health services and aftercare and of the proportion likely to represent acceptable performance.

See for example the WHO guidelines, “Responding to Children and Adolescents who have been sexually abused” (2017, p.33ff) and “Responding to Intimate Partner Violence and Violence Against Women” (2013); the ScotPHN report “Polishing the Diamonds: Addressing Adverse Childhood Experiences in Scotland” (2016); and UK evidence on the mental health support requirements of adolescents following sexual assault (Khadr et al., Lancet Child & Adolescent Health 2018, https://www.thelancet.com/journals/lancah/article/PIIS2352-4642(18)30202-5/fulltext).

Indicator 7: Examination setting

Indicator 7.1 Proportion of examinations that took place in a healthcare setting

Indicator 7.2 Proportion of examinations that took place in a social care setting

Rationale

Her Majesty’s Inspectorate of Constabulary in Scotland’s 2017 report states that it is not acceptable for forensic examinations of people who have experienced rape, sexual assault or child sexual abuse to take place in police stations.

Corresponding Healthcare Improvement Scotland (2017) Standard:

3.1 All forensic examinations take place in facilities that are:

a) located in health or

b) designated multi-agency settings with health and social care facilities

1. Do you agree with the indicator heading?

Yes

2. Do you have any comments on the indicator or measures?

We note a discrepancy between the standard and the indicators. Criteria 3.1 mentions two options for settings: a health setting, or a multi-agency setting. However, measure 7.2 refers only to a social care setting.

We also note the absence of an indicator to monitor whether these examinations took place in a setting other than the ones mentioned in the standards, such as police stations. It would likely be difficult to collect data on this, but it seems an indicator is missing on monitoring forensic examinations that took place outside of a health/multi agency setting. This type of data would likely require a separate evaluation that would collect evidence from other sources than health service data.

3. Do you agree with the rationale?

The rationale presented in the document is rather brief. We would suggest adding the content from the Standards document which presents a more comprehensive background to the indicators.

Indicator 8: Facilities decontamination

Indicator 8.1 Proportion of forensic medical examinations undertaken in facilities that have been forensically decontaminated to national standards
Rationale

All facilities for forensic examinations should be safe, effective and person centred.

All facilities and equipment used for forensic medical examinations should comply with relevant national standards, specifications and guidelines.

Corresponding Healthcare Improvement Scotland (2017) Standard:

3.2 All facilities and equipment used for forensic medical examinations comply with relevant national standards, specifications and guidelines

1. Do you agree with the indicator heading?
Yes.

2. Do you have any comments on the indicator or measures?
It seems that measure 8.1 could be divided into two measures. As it is presented now, it would collect two types of information: a) whether the facilities have been forensically decontaminated to national standards, and b) whether forensic medical examinations have taken place in these facilities. To ensure data can be collected on this measure, we would suggest dividing this measure as follows:

Indicator 8.1 Proportion of facilities that have been forensically decontaminated to national standards
Indicator 8.2 Proportion of forensic medical examinations undertaken in facilities that have been forensically decontaminated to national standards

3. Do you agree with the rationale?
Yes.

Indicator 9: Colposcope

Indicator 9.1 Proportion of forensic medical examination facilities that have a digital storage facility for colposcopes

Indicator 9.2 Proportion of forensic medical examinations that used a colposcope that had been stored in a digital facility

Rationale

National sampling kits and any other relevant equipment used, including a digital storage facility for colposcopes, are available, monitored, maintained, up to date and comply with national specifications.

Corresponding Healthcare Improvement Scotland (2017) Standard:

3.3 National sampling kits and any other relevant equipment provided, including colposcopes, are available, monitored, maintained, up to date and comply with national specifications

1. Do you agree with the indicator heading?
Yes.

2. Do you have any comments on the indicator or measures?
N/A

3. Do you agree with the rationale?
To ensure people without a clinical background can have a good understanding of this indicator, it would be useful to add a definition for colposcopes, as well as for digital storage facilities.

**Indicator 10: National forensic documentation**

Indicator 10.1 Proportion of national forensic documentation that was completed with investigators within 4 weeks of the examination

Indicator 10.2 Proportion of national forensic documentation that was shared with investigators within 4 weeks of the examination

**Rationale**

Consistent documentation (electronic or paper) and data collection for forensic reporting will ensure a high quality, consistent national approach and minimise unwarranted variation and error.

All information shared is subject to relevant professional confidentiality guidance, legal requirements and national and local data sharing protocols, policies and procedures.

**Corresponding Healthcare Improvement Scotland (2017) Standard:**

5.3 Following each forensic examination, relevant standardised documentation is:

a) completed by the forensic examiner (and paediatrician for children and young people) to inform investigators, court practitioners and jurors, and

b) shared and stored appropriately.

1. **Do you agree with the indicator heading?**
   Yes.

2. **Do you have any comments on the indicator or measures?**
   The importance of consent and confidentiality of information seems to be missing from these measures, although the standards put an emphasis on these matters.

3. **Do you agree with the rationale?**
   The timeframe of 4 weeks, does not seem to be present in the standards document, and could benefit from being further explained in the rationale section.

**Other general comments:**

We understand that this consultation only covers indicators for standards 2, 3, and 5. We note however a lack of focus on indicators relating to people’s perspectives and experiences with the quality of care provided across the multi-agency services – We realise this aspect is mentioned under Standard 1 – Leadership and governance, and we would like emphasize the importance of collecting people’s feedback for quality improvement of services. Under standard 1, there is mention of the importance of ongoing quality improvement (including offering people the opportunity to feedback on their experience) through anonymised systems.

Specifics regarding different age groups, learning disabilities and English language skills seem to be lacking across indicators for standard 2, but we assume this will be further detailed in the next stage of the indicators’ development.

In general, the indicators would benefit from clarification as to whether and how they can be applied consistently to the various types of clinical presentation and patient groups covered.
For example, will data be collected on adult survivors of child abuse, and from what services? Do the indicators assume acute presentation only following an assault or do they apply to people who present or re-present months or years following a sexual assault?

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