The Paediatric Society of New Zealand
Te Kāhui Mātai Arotamariki o Aotearoa

NZCYCN
New Zealand Child & Youth Clinical Network

Multidisciplinary care for tamariki experiencing sexual abuse in Aotearoa New Zealand

Child Protection Clinical Reference Group, Paediatric Society of New Zealand

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Who are we?
The Child Protection Clinical Reference Group of Te Kahui Mātai Arotamariki o Aotearoa, The Paediatric Society of New Zealand includes most DHB-based clinicians working in child protection in Aotearoa. We are a multidisciplinary group including allied health staff, nursing, midwives and paediatricians with a membership of over 100, representing most DHBs, from the largest (Auckland DHB) to the smallest (Wairarapa DHB). Most of our members have been practising in child protection for several years.

Sexual abuse in childhood is common
Sexual assault in childhood is common. Well-conducted international surveys estimate that 20-30% of girls and 10-15% of boys experience unwanted sexual contact by someone at least five years older then them during their childhood. In the Otago Women's Health Survey 32% of women reported one or more unwanted sexual experiences before the age of 16 years, and 20% genital contact or more severe sexual assault before 16 years. Of these 16% were before the age of 12 years. Wahine Māori are twice as likely to experience sexual assault as children than NZ European.

Services for children experiencing sexual assault in Aotearoa New Zealand

<u>Services are variable, because there has been no plan</u>
In the absence of a national plan for child protection services in district health boards generally, and child sexual assault (CSA) specifically, services around New Zealand for children and adolescents who have been sexually assaulted are at best patchy. Historically in each region CSA services have been established and maintained by clinicians passionate in this area. The services offered have depended on available resources, including buildings, equipment and nurses and doctors trained in CSA assessments. This has led to a wide range of services provided, some with advantages, and all with disadvantages, to children experiencing CSA and their families.

In children, sexual assault is rarely the only type of abuse that the child will have experienced it is therefore vital that clinicians working in this area are competent at assessing children for all types of abuse.

<u>There are examples of high-quality, multidisciplinary care, but none provide comprehensive services under one roof</u>

Te Puaruruhau Multi-Agency Centre, Starship Children's Hospital, Auckland District Health Board
Te Puaruruhau, based at Auckland's Starship Children's Hospital, provides a 24/7 service for all children experiencing abuse and neglect in the Greater Auckland region, including CSA. Auckland District Health Board (ADHB) are contracted to provide out of hours CSA care to children from the other two DHBs in the Auckland area (Waitemata and Counties Manukau). During normal working hours Counties Manakau provide some clinical assessments for children who present with historic sexual abuse only. All children from Waitamata DHB are seen at Te Puaruruhau (both in and out of hours) and those that are historical and cannot be seen at Counties Manukau along with all acute (recent sexual assault) are seen at Te Puaruruhau.

Te Puaruruhau is the only centre in New Zealand set up to look after children regardless of the type of abuse they have experienced, in a purpose-built facility. Children are assessed by a multidisciplinary team, which can include nurses, doctors, social workers and a psychologist.

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These staff work mainly or solely in the area of child abuse, and are therefore extremely competent and experienced in this area. Police are co-located in the same facility, along with the evidential interviewing staff (Central Auckland Video Unit). Te Puaruruhau therefore provides a wrap-around service for the *assessment* of children who have alleged abuse. However, wrap around *care* is not available. Children and their families who need counselling have to be referred on for this. If parents disclose their own history of abuse they also need to be referred to other agencies. Any child who needs ongoing medical assessment will need to be referred to other paediatricians.

Christchurch, Wellington and Hamilton
In Christchurch children historically were seen in the Cambridge Clinic, by GPs trained in sexual assault who had an interest in children. In more recent years, prepubertal children who have been sexually assaulted have been seen in Child and Family Safety Service - Tiaki Whanau, based at the hospital. This multi-disciplinary team can also assess older children who present with other forms of abuse. The Cambridge Clinic continues to assess adolescents and adults who have alleged sexual assault. Again, they cannot offer counselling services, and need to refer parents with their own history of abuse to other agencies. However if medical concerns are identified the same doctor can arrange to see the child again.

Wellington and Hamilton have similar set ups to Christchurch. In all three centres the teams are small and very dependent on a few doctors who are passionate about this work. The services risk collapsing if one or two key people leave.

Tautoko Mai Charitable Trust, Bay of Plenty
In the Bay of Plenty services are set up markedly different from others in the country for historical reasons. The DHB do not run this service and instead contract to a charity, Tautoko Mai. Tautoko Mai provide a cradle to grave service for all people affected by sexual abuse. Within this service are doctors, nurses, social workers, and counsellors. Children seen by Tautoko Mai are able to access both crisis and long-term ACC counselling in the same building as the medical assessments. Tautoko Mai work closely with other NGO such as Good Neighbour, so that families in need can also access food packages and other supports. Paediatricians assess sexual assault in Tautoko Mai, but assess physical assault and other types of abuse at the hospital. The service is dependent on excellent links between the hospital and Tautoko Mai, mainly provided by the clinicians working in this area.

Rest of New Zealand
Around the rest of the country paediatricians who look after children who have alleged sexual assault do this as part of their general paediatric workload. For some this will be a reasonable amount of their workload, for others a small fraction, and maintaining skills is challenging.

In smaller centres services range from one or two paediatricians with an interest in this area seeing children, often as isolated practitioners, to no services being provided at all. In some regional centres, acute forensic examinations are performed by adult providers with paediatrician presence to ensure that they are age appropriate. In parts of the South Island some children and their whanau need to travel four hours in order to have an assessment following a sexual assault. In small centres doctors may be working independently, without the support of nurses or social workers. Children may be referred for counselling, but in small towns there may be no counsellors, meaning families having to travel for this, or the family may personally know the counsellor, which makes it inappropriate for the child to become a client.

Services for adolescent victims of sexual assault are also variable
All the services mentioned above also provide some services for adolescents. In Bay of Plenty the services provided are seamless and the age of the victim is irrelevant. However, around the country there are different age cut offs for adolescents. In Auckland for example forensic examinations are performed by the adult team for young people > 18 years. Te Puaruruhau sees all children and young people up to the age of 18 years. In the other main centres young people > 13 are usually seen exclusively in adult-based centres. Although clinicians who work in this area have the necessary forensic skills they do not always have the necessary skill set to work with adolescents.

Training in CSA and maintaining skills is challenging, especially in smaller centres

The skills required to perform CSA assessments are complex

Training clinicians to assess children following a sexual assault and then maintaining these skills is challenging. Skills required include:

- Cultural competence
- Assess the child in a developmental context e.g. sexualised behaviour
- Forensic examination including differential diagnosis – paediatric gynaecology, genital injuries
- Assess for developmental or behavioural concerns
- Risk assessment and safety planning
- Write a report of concern and communicate with Oranga Tamariki
- Write a medical report for every child
- Write a Formal Statement and present this in Court.

(Dr Jenny Corban, 2015 with amendments from Dr Russell Wills, 2021)

In smaller centres each clinician may only see one child with CSA a year. In order to maintain skills ideally every clinician needs to see at least 4 children per year. Providing a 24/7 service, when each service may be referred a handful of children per year is not cost effective and is difficult to maintain. In a 2020 survey of paediatricians by Dr Amy Neels et al only 29% of paediatricians agreed they had sufficient training in child protection and sexual assault was the area of practice they had least confidence in.

General paediatricians are often poorly-prepared to work in CSA

Dr Jenny Corban (paediatrician, HBDHB, Doctors for Sexual Abuse Care board member) summarised the issues in training and recruitment of paediatricians for CSA assessment and ongoing care in 2015. Key points included:

- General paediatricians in many areas were poorly prepared for CSA assessments during their training, CSA assessment was a very small part of their clinical workload, were therefore reluctant to perform these assessments and in may areas 'opted out' of performing CSA assessments, leaving CSA victims with no CSA roster and, effectively, little or no service for victims of acute CSA
- CSA assessment was not a core training requirement for general paediatricians to gain fellowship of the Royal Australasian College of Physicians, which reduced both trainees' interest and hospitals' incentive to provide that training
- General paediatricians were time-poor and had to prioritise their acute on-call and professional development time to issues they saw commonly
- Professional support for paediatricians seeing CSA cases was generally available from colleagues in tertiary centres but their time was also becoming increasingly stretched
- In contrast,
    - most general paediatricians saw other aspects of child protection as central to their role and
    - some areas had well-resourced, expert services
    - services for children and young people with historical CSA, provided in-hours, were better-developed
- Maintaining competence and accreditation was challenging due to the small numbers of referrals and aspects of the accreditation process, which was focused on adult victims – this has since been addressed - and
- Dr Corban noted the excellent training in CSA provided annually by Dr Patrick Kelly and his team at Te Puaruruhau.

Cultural competence of the workforce is a priority

The majority of victims of sexual assault are Māori tamariki and rangatahi. We agree that they should be seen in a service that meets all their needs, physically, mentally, spiritually and culturally, with care provided by Māori clinicians. Although services try their best to be culturally sensitive, all services need to develop further in this area. There are very few Māori paediatricians working in Aotearoa, and most of these do not work in child protection. Medical

and nursing schools have worked hard to increase their number of Māori but these clinicians will take time to flow through. The Paediatric Society of New Zealand, including this Clinical Reference Group, has worked hard to promote and support young Māori leaders into positions of influence and to ensure their perspectives inform and direct our work.

The way forward for services for children and young people experiencing sexual assault

The varying size of centres and nature of their populations means that there is no one model of care that will meet the needs of children in New Zealand affected by sexual abuse. However, our experience suggests there are common principles that should inform the Family and Sexual Violence Strategy, where it discusses service provision for child and adolescent victims of sexual abuse:

Properly-resourced, multidisciplinary, comprehensive care leads to better-coordinated and more accurate, reliable and helpful assessments and care, and better outcomes for victims and whānau

The Auckland model works well for children in an urban area. In regional centres, where multidisciplinary teams of clinicians work mostly in the area of child abuse, clinical confidence and competence are improved, skills maintained, and excellent training can be provided to junior doctors and nurses. Maintaining rosters is more easily achieved, and experience and training can contribute to building a sustainable workforce to continue this work. Work needs to be done to improve the comprehensiveness of care, e.g., counselling for victims and families.

The Tautoko Mai Bay of Plenty model works well in providing wrap-around care, with children and their families being able to access medical care as well as counselling. However Tautoko Mai only provides support to those children who have been sexually abused, and if they experience other types of abuse referral to the hospital is required.

A 'Hub and Spoke' model could provide better support for clinicians working in smaller centres, and could be developed within existing regional tertiary paediatric centres

Clinicians are clear that they need more training and support in CSA and, without that support, gaps appear in services. Whanau are clear that travelling to another centre for assessment is burdensome and adds to the trauma of the assault.

A 'hub and spoke' model already exists for most of paediatric care, with regional general paediatricians referring to and receiving outreach support from tertiary centres. It should be straightforward to resource the existing paediatric regional centres' CSA services to provide the same outreach support for CSA already provided for other tertiary paediatric services. This would however require proper resourcing as there is little spare capacity in any regional centre for this role currently.

Meantime, our view is that the Royal Australasian College of Paediatrics should mandate training in child protection, including sexual assault examination, as "core training" in general paediatrics and for accreditation of overseas-trained general paediatricians and re-certification for practising general paediatricians. Ongoing maintenance of standards can be supported by participation in MEDSAC accreditation, which has been reviewed to ensure it is appropriate for regional general paediatricians. It is important not to separate sexual abuse as a single form of abuse in children, young people, tamariki and rangatahi, when often the alleged abuse is linked to other forms of trauma and abuse.