25 September 2015

CoramBAAF response to the Home Office
Consultation on statutory multi-agency guidance on Female genital mutilation

This response is being submitted on behalf of the CoramBAAF Health Group, which is also a special interest group of the Royal College of Paediatrics and Child Health (RCPCH). The Health Group was formed to support health professionals working with children in the care system, through training, the provision of practice guidance and lobbying to promote the health of these children. With over 500 members UK-wide, an elected Health Group Advisory Committee with representation from community paediatricians working as medical advisers for looked after children and adoption panels, specialist nurses for looked after children, psychologists and psychiatrists, the Health Group has considerable expertise and a wide sphere of influence.

Our area of concern is the particularly vulnerable group comprised of looked after and adopted children and young people.

Summary of Consultation Questions

Q1. Do you agree that the draft statutory guidance provides **frontline professionals** with the information they need on the **prevalence of FGM and the issues** around it? If not, where and how could the guidance be changed?

Our members welcomed the background information and principles set out in the guidance, and particularly stating explicitly that FGM is illegal in the UK and a form of child abuse. The statement that "Professionals should not let fears of being branded 'racist' or 'discriminatory' weaken the protection and support required by vulnerable girls and women" is helpful in decreasing anxiety and supporting practitioners to carry out their safeguarding roles.

Similarly health practitioners welcome the guidance on safeguarding duties and mandatory reporting in section 4.1.

The advice in section 4.3 about how to talk about FGM is helpful to practitioners and the emphasis on the sensitivities around provision of an appropriate interpreter is particularly welcome. However in the experience of our members it is often difficult to access any interpreter services, and this needs to be a addressed by commissioners and providers of services.

Q2. Do you agree that the draft statutory guidance provides **service delivery** organisations with the information they need on the **prevalence** of FGM and the issues around it? If not, where and how could the guidance be changed?

It is helpful that the measures in 2.4 have been made explicit.

We welcome section 2.11 which highlights the impact of FGM on mental health and the need to provide mental health support for affected girls and women. There appears to be an assumption in section 6.3 that existing mental health services will be able to meet the mental health needs of this group of girls and women. However this is a specialised area of practice which in many areas likely cannot be met by existing services. The guidance would be strengthened by addressing the need to develop capacity, both in terms of training to develop specialist expertise and to increase the number and geographical distribution of the workforce with this expertise.

It is helpful that section 6.6 of the guidance highlights the need for training of health professionals, which commissioners and providers of services need to address. However, E-learning and watching videos may not sufficiently meet the training needs; wider training in diversity issues and skill building sessions may also be needed. The acknowledgement of professional learning needs in section 10.2 is welcome although these needs are not addressed in detail.

Q3. Do you agree that the draft statutory guidance adequately captures FGM **risk** factors?

The risk factors are clear, however it would be helpful to specifically mention the risk to children who may be separated from their birth families, where there may be less information known about the family and community. This group includes children in private fostering arrangements, looked after children from black and minority ethnic communities, and unaccompanied asylum seeking refugee children.

Q4. Do you agree that the draft statutory guidance captures the full range of **legal tools** and interventions to enable professionals and public sector organisations to safeguard and protect women and girls at risk of FGM?

The provisions in section 5 and particularly the examples in section 5.2 of the types of orders the court might make are helpful.

Q5. Do you agree that the draft statutory guidance promotes an **individual-centred** approach, ensuring that a woman or girl's individual circumstances drive the decision making process at all times? If not, what additions do you consider could be made to the guidance?

Yes. The examples of situations which would need to be individually assessed are helpful.

Q6. Do you agree that the draft statutory guidance provides sufficient - and clear information for a) health care providers b) police c) children's social care and d) schools and colleges?

The main messages and steps to take are generally clear.

Q7. Do you agree that the draft statutory guidance captures how professionals and public sector organisations can work with **communities** to prevent FGM?

No. Section 10.3 acknowledges the need to address this but only in the broadest terms. Effecting change in long-standing cultural practices is a challenge which will require a variety of approaches by a range of disciplines over a period of time, and will require resourcing, which is not addressed here.

Q8. Do you agree that the draft statutory guidance describes a **multi-disciplinary** approach which will allow for the voice of the child to be heard and respected whilst working to protect and support her? If not, where and how could it be improved?

Yes, although achieving truly joined up working is very challenging in practice, and particularly in cases where diversity and cultural sensitivity must always be considered.

Submitted by:

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