

The Rape Clause

How Health and Social Care Professionals Administer
the 'Non-Consensual Conception Exception' to the Two-Child Limit

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If you have been the victim of sexual assault, you've conceived a child as a result of that.... you've made that decision that you're going to continue with that pregnancy, and raise that child... a lot of women in that situation would be, they would want to get on with their life... But what this policy is asking somebody to do is for that information to continue to be a part of this child's childhood...

And it's a terrible thought that somebody would be re-traumatised, every time a letter comes through, or every time you have to provide more information, or you have to confirm your details again, and again, and again.

Social Worker

Foreword

Across the UK, thousands of women are now in receipt of a 'rape clause' exception to the two-child limit. For too many, this has meant filling out a form with their child's name and asking a third-party professional to confirm that child was conceived in circumstances consistent with sexual violence, just so they can put food on the table.

Since the two-child limit was first mooted in George Osborne's Budget in 2015, questions have persisted about the morality and practicality of the policy. Since then, it has driven up child poverty rates and caused severe hardship to many during the cost-of-living crisis. One of the most alarming aspects of this policy, which limits the child element of universal credit to the first two children in a family, was the "non-consensual conception exception", better known as the "rape clause".

This research shines a light upon the workings of a policy that from its inception was poorly thought through. While there has been significant research on the impact of the two-child limit on larger households and child poverty, the operation of the specific rape clause exemption has had very little scrutiny. This has been made more challenging by the frustratingly scant data provided by the DWP; Dr Hewer's insightful research is therefore all the more valuable.

Even after seven years of operation, Dr Hewer identifies ongoing uncertainties among the very professionals upon whom this cruel and stigmatising system relies. It brings voice to those on the frontline, the nurses, health visitors, sexual violence support workers, GPs and social workers who could be called upon by a woman to give credence to her claim of non-consensual conception, in the eyes of the Department of Work and Pensions. It also reveals the dearth of guidance available to those professionals, who may not have either the expertise or time to offer appropriate support to women reliving a traumatic time in their lives.

Despite the recent election bringing a change in the UK Government, the two-child limit and the rape clause have remained shamefully on the statute books. In the wider context of the Scottish Government's stated intention to remove the two-child limit, Dr Hewer's timely research adds further weight to the wider civil society calls to scrap the policy completely across the UK.

It is clear that the two-child limit and the associated rape clause cannot be made just or fair and represents an unjustifiable intrusion into the lives of women and their children.

Alison Thewliss
Former Member of Parliament of the United Kingdom

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Executive Summary

In 2017, the UK government created a series of exceptions to its 'two-child limit' on 'Universal Credit'. The most controversial of these exceptions exempts claimants from the limit if they can demonstrate – to the satisfaction of the Secretary of State – that their third or subsequent child was conceived non-consensually. Many critics – including numerous civil society organisations – expressed outrage at this 'rape clause', arguing that it was unacceptable for the state to coerce survivors of sexual violence into reliving their traumatic experiences, simply to claim subsistence level benefits.¹

It has been eight years since the two-child limit and its exceptions came into effect, and while controversy surrounding the two-child limit continues to make headlines², the rape clause has faded from view. Moreover, whilst government data indicates that over 3,100 rape clause exceptions have been granted since 2017,³ a lack of research into the implementation of this measure means we know next to nothing about *how* it works in practice. Given the stakes of the rape clause, this gap in our knowledge and awareness is significant.

This report begins to address this gap by providing crucial insights into how health and social care practitioners who have been awarded 'approved third-party status' by the Secretary of the State, and who are tasked with 'evidencing' rape clause eligibility, might ascertain and certify such eligibility in practice. It presents original findings from interviews conducted with a cross-section of health and social care professionals working in Scotland's central belt, and raises *significant concerns* regarding the frontline administration of this policy. Specifically, it identifies a series of knowledge deficits, access challenges, and legislative ambiguities that substantially increase the chances that 'rape clause' cases will be mishandled. Ultimately, this report diagnoses serious shortcomings in the design and rollout of the state's 'rape clause'.

1. HM Government, "Consultation Response - Exceptions to the Limiting of the Individual Child Element of Child Tax Credit and the Child Element of Universal Credit to a Maximum of Two Children," 2017, <https://assets.publishing.service.gov.uk/media/5a7ffacde-5274a2e87db722e/government-response-to-universal-credit-and-child-tax-credit-exceptions-to-the-2-child-limit-consultation.pdf>.

2. For instance, see Isabella McRae, "Scrap Two-Child Benefit Cap to Prove You're Serious about Child Poverty, Labour Told," *Big Issue* (blog), February 27, 2025, <https://www.bigissue.com/news/social-justice/two-child-benefit-cap-cuts-poverty-labour/>.

3. "Universal Credit and Child Tax Credit Claimants: Statistics Related to the Policy to Provide Support for a Maximum of Two Children, April 2024," GOV.UK, accessed October 2, 2024, <https://www.gov.uk/government/statistics/universal-credit-and-child-tax-credit-claimants-statistics-related-to-the-policy-to-provide-support-for-a-maximum-of-2-children-april-2024/universal-credit-and-child-tax-credit-claimants-statistics-related-to-the-policy-to-provide-support-for-a-maximum-of-two-children-april-2024>.

Key Findings

- Practitioners have **very limited knowledge** of the rape clause or the demands made of them as approved third-parties. This undermines appropriately sensitive and effective case handling.
- Practitioners **need time and tailored resources** to prepare to certify rape clause eligibility. There are very few tailored resources available, and the health and social care sector is stretched to capacity.
- Whilst, in theory, all claimants should have access to an approved third-party (due to 'universal service' involvement) many will encounter **foreseeable obstacles to access**, e.g., waiting lists, non-clinical triage, and restrictive service eligibility criteria.
- **The state has failed to identify a clear standard of, or threshold for, 'non-consensuality'**, for the purposes of rape clause administration. They have left this complex and challenging task to the discretion of individual practitioners.
- Most practitioners say they would take **a light touch approach** to certifying rape clause eligibility, assuming high levels of survivor credibility and defining sexual violence in accordance with a survivor's subjective experience. **This calls into question the necessity and politics of a third-party evidence model.**
- Practitioners **lack confidence in their ability to contradict a survivor's account of sexual violence** and do not, therefore, feel qualified to deny certification of rape clause eligibility.
- Practitioner reflections on how they would contradict a survivor's account – if they felt obliged to do so - reveal **scope for mishandled cases and inequitable provision**, largely due to confusion about what constitutes rape, alongside rape myth acceptance, and the failure of the state to provide a threshold definition of non-consensuality.
- **Practitioners feel ill-equipped to perform the historic capacity assessments** necessary to certify that a survivor lacked capacity to consent to a sexual encounter over 9 months prior.
- A large subset of practitioners, working for statutory agencies **would feel duty bound to take action with respect to adult and child safeguarding if they heard a disclosure of sexual violence**, which would likely necessitate invasive enquiries and, in some circumstances, unwanted interventions.
- Practitioners would be more comfortable certifying rape clause eligibility if they were already aware that a service user had experienced a non-consensual conception or long-term intimate partner violence. Practitioners **are concerned about the relational challenges and therapeutic implications of certifying rape clause eligibility for a new service user**, or a service user who has not previously disclosed an experience of sexual violence.

Evidence-Based Recommendations

- Given the demonstrable unworkability of the rape clause, this report recommends the **repeal of the two-child limit**.

In the interim (if repeal of the two-child limit is delayed)

- Given that practitioners either credential (rather than verify) survivor's disclosures of sexual violence or run the risk of using contested and variable definitions of rape to deny certification, this report strongly recommends that the state move away from using a third-party evidence model to demonstrate rape clause eligibility and towards a self-certification model.

In the interim (if a self-certification model is not adopted)

- Given recurrent access challenges related to current approved third parties, and the importance of allowing survivors to choose whom they confide in, this report recommends that the Secretary of State immediately increase the kind of professionals with approved third-party status.
- Given that knowledge and understanding of the rape clause appears to be low, and that this may frustrate sensitive and effective case handling, this report recommends that the state **build rape clause knowledge and capacity among approved third-party professionals**.

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1. Introduction

In 2017, former leader of the Scottish Conservatives, Ruth Davidson, sparked outrage when she declared that applying for the UK government's 'rape clause' would be a straightforward bureaucratic exercise. Eligible claimants, she suggested, were simply required to 'tick a box' on a form and 'put their name on it'. Critics argued that this characterisation of the rape clause downplayed the fact that claimants had to *evidence* their eligibility.⁴ Indeed, shortly before Davidson made her controversial comments, the *Equality and Human Rights Commission* had criticised the UK government for failing "to fully consider the impact of the implementation of this exemption, including the potentially traumatic process for having eligibility assessed and the risk of re-traumatisation upon survivors of rape."⁵

Eight years on, however, we know next to nothing about how the rape clause is actually implemented *in practice*. To date, no empirical research has examined how those responsible for certifying survivor eligibility would approach this task, and with what impact. This report begins to address this gap in our knowledge by critically interrogating how health and social care practitioners, working in Scotland's 'central belt', would ascertain and certify eligibility for the UK Government's rape clause, if asked.

For clarity, the rape clause exempts claimants from the 'two-child limit' on the 'child element' of 'Universal Credit' (worth £3455 pa) if their third or subsequent child is born of non-consensual conception, and if they can demonstrate this to the satisfaction of the Secretary of State. In practice, the latter requirement can be satisfied by a criminal conviction, a criminal injuries compensation award, or the 'evidence' of an *approved third-party*.

At the time of writing, a range of general and specialist health and social care practitioners, working across statutory agencies and third sector organisations, has been granted approved third-party status. In practice, these practitioners act as *the* primary gatekeepers for the benefit entitlement offered by the rape clause.

This report presents original findings from interviews with a range of approved third-party practitioners, including GPs, health visitors, social workers, and sexual violence support workers. In turn, it raises evidence-based concerns regarding the frontline administration of the rape clause. Specifically, this report identifies a series of knowledge deficits, access challenges, and legislative ambiguities that increase the chances that rape clause cases will be mishandled. Importantly, these deficiencies and challenges exist *despite* a broad intention among practitioners to take a victim-centred, non-invasive, and compassionate approach to certification. They therefore indicate serious flaws in the design and rollout of the policy.

In concluding, this report joins a chorus of academic and civil society research by recommending the urgent repeal of the two-child limit.⁶ The wellbeing of sexual violence survivors can only be secured by ensuring that they can, *at the very least*, access subsistence level benefits with ease. The two-child limit and the rape clause clearly undermine this objective. In the event that, against recommendation, repeal is delayed, this report recommends interim measures: significant amendments to the form and function of the rape clause.

4. Jenny Davidson, "Ruth Davidson: Rape Clause Just Involves Ticking a Box," *Holyrood*, October 4, 2019, https://www.holyrood.com/news/view,ruth-davidson-rape-clause-just-involves-ticking-a-box_13490.htm.

5. Rebecca Hilsenrath, "Child Tax Credit (Amendment) Regulations 2017," 2017, <https://www.equalityhumanrights.com/sites/default/files/letter-to-damian-hinds-child-tax-credits-rape-clause-21-april-2017.pdf>.

6. For example, Ruth Patrick and Kate Andersen, "The Two-Child Limit and Fertility Decision Making: When Policy Narratives and Lived Experiences Collide," *Social Policy & Administration* 57, no. 5 (2023), <https://doi.org/10.1111/spol.12877>; The Church of England et al., "All Kids Count: The Impact of the Two-Child Limit after Two Years," 2019.

1.1 Who Should Read This Report

This report will be of interest to:

- Policy-actors (broadly construed) who are engaged in policy discussions about the two-child limit and rape clause.
- Health and social care practitioners tasked with administering the rape clause.
- Anyone who is concerned about UK welfare reform and/or gender-based violence, particularly intimate partner and sexual violence.
 - This may include survivors of sexual violence, and those potentially eligible for a rape clause exception.

1.2 Background and Context

What is the two-child limit?

In 2017, pursuant to the *Welfare Reform and Work Act 2016*, the UK government limited the number of children for whom a low-income family could claim the 'child element' of 'Universal Credit' to two. This measure, which applies to children born after 6th April 2017, is commonly referred to as the 'two-child limit'. The then Conservative government justified this limit by suggesting that it was necessary to safeguard the economic health of the nation, ensure a benefit system that was fair to tax-payers, and ensure "those on benefits face the same financial choices around the number of children they can afford as those supporting themselves through work."⁷ In reality, of course, many families eligible for the child element of Universal Credit are in work and do pay taxes. At the time of writing, the child element of Universal Credit is worth up to £3455 per annum. A figure which, the *Institute for Fiscal Studies* has demonstrated, could constitute a substantial portion of a poor, large family's overall income.⁸

Also in 2017, the UK government created a handful of exceptions to the two-child limit, via statutory instrument. They claimed that these exceptions were designed to support families unable to make the same kind of 'choice' regarding their family's size. In brief, these exceptions allow families to claim the 'child element' of Universal Credit for a third or subsequent child if they can demonstrate that said child was: part of a multiple birth (i.e., twins or triplets); living in kinship care; or born following non-consensual conception. The final exception – colloquially termed the rape clause – is the focus of this report.

In recent months, the Scottish Government have announced plans to 'scrap' the two-child limit by 2026. In practice, because welfare reform is not fully devolved, this will mean *mitigating* the impact of the policy, rather than abolishing it per se. The Scottish Government has therefore requested data from the UK government on how the two-child limit impacts claimants in Scotland, and is (at the time of writing) consulting on how best to proceed.⁹ How the Scottish Government intends to tackle claimants in receipt of an exception remains unclear.

7. Her Majesty's Treasury and Department of Work and Pensions, "Welfare Reform and Work Bill: Impact Assessment of Tax Credits and Universal Credit, Changes to Child Element and Family Element," 2015, <https://www.parliament.uk/globalassets/documents/impact-assessments/IA15-006E.pdf>.

8. Eddin Latimer and Tom Waters, "The Two-Child Limit: Poverty, Incentives and Cost" (Institute for Fiscal Studies, June 17, 2024), <https://ifs.org.uk/articles/two-child-limit-poverty-incentives-and-cost>.

9. Scottish Government, "Universal Credit - Mitigation of the Two-Child Limit: Consultation," 2025, <https://www.gov.scot/publications/mitigation-two-child-limit/pages/6/>.

What do we know about how the two-child limit impacts families?

Almost 8 years after its enactment, the full impact of the two-child limit is clear. Government data¹⁰ indicates that, as of April 2024, 450,000 households (caring for around 1.3 million children) have been affected, overall. Moreover, 59% of impacted claimants are in work, and 52% are in lone parent households. In total, 24,000 households are in receipt of an exception. Research indicates that, on a population level, the two-child limit has had minimal impact on fertility rates¹¹, and no measurable impact on workforce participation (despite the state's insistence that the measure incentivises work).¹² Instead, the primary impact of the two-child limit is to make poor families poorer and to push many households – housing many children – into poverty.

What is the rape clause?

In broad terms, the rape clause – created by the *Social Security (Restrictions on Amounts for Children and Qualifying Young Persons) Amendment Regulations 2017/376* – exempts a claimant from the two-child limit if they can demonstrate, to the satisfaction of the Secretary of State, that their third or subsequent child was conceived non-consensually. Put differently, it creates a benefit entitlement for some individuals who conceive following non-consensual sex, subject to the 'availability' of appropriate 'evidence'. Notably, survivors whose first and/or second child were conceived non-consensually – and third and/or subsequent children were not – are not eligible for the rape clause exception, though the legality of this 'ordering rule' is currently subject to litigation.¹³

Schedule 12, s5(1)(b) of the aforementioned regulations, states that a claimant is eligible for a non-consensual conception exception if their third or subsequent child was:

"...conceived as a result of sexual intercourse to which [they] did not agree by choice, or did not have the freedom and capacity to agree by choice"

Further clarifying these eligibility criteria, s5(2)(b) states that a claimant's lack of 'freedom and capacity to agree by choice' may result from a context of coercive control. Significantly, the regulations do not further clarify what is meant by 'sexual intercourse to which a claimant did not agree by choice'.

The regulations also specify that the claimant cannot be living at the same address 'as the other party of that intercourse' (e.g., their attacker) and that evidence of non-consensual conception can be derived from a criminal conviction, a criminal compensation award, or 'evidence from an approved person'. In turn, it states that an 'approved person' means "a person of a description specified on a list approved by the Secretary of State". The current version of that list is available online, and can be **found here**.

10. DWP and HM Revenue and Customs, "Universal Credit and Child Tax Credit Claimants: Statistics Related to the Policy to Provide Support for a Maximum of Two Children, April 2023," GOV.UK, 2023, <https://www.gov.uk/government/statistics/universal-credit-and-child-tax-credit-claimants-statistics-related-to-the-policy-to-provide-support-for-a-maximum-of-2-children-april-2023/universal-credit-and-child-tax-credit-claimants-statistics-related-to-the-policy-to-provide-support-for-a-maximum-of-two-children-april-2023>.

11. Mary Reader, Jonathan Portes, and Ruth Patrick, "Does Cutting Child Benefits Reduce Fertility in Larger Families? Evidence from the UK's Two-Child Limit," *IDEAS Working Paper Series from RePEc*, 2022, 39.

12. Mary Reader et al., "Making Work Pay? The Labour Market Effects of Capping Child Benefits in Larger Families" (Centre for Analysis of Social Exclusion, LSE, 2023).

13. Aine Fox, "Mothers in High Court Challenge over Two-Child Limit 'Rape Clause,'" *The Independent*, November 4, 2024, sec. News, <https://www.independent.co.uk/news/uk/crime/mothers-child-poverty-action-group-one-high-court-department-for-work-and-pensions-b2640700.html>.

In brief, at the time of writing, 'approved persons', also referred to as 'approved third-party professionals', are:

- healthcare workers;
- social workers;
- a specialist worker employed by Refuge;
- a specialist worker employed by a Survivor's Trust Organisation; or
- a specialist worker employed by a range of local organisations further specified by the Secretary of State.

The latter category of approved third-parties, includes (amongst others) specialist workers employed by *Rape Crisis England and Wales* and a range of local *Women's Aid* branches. Curiously, and of particular salience to this research given its Scottish focus, *Rape Crisis Scotland* and *Scottish Women's Aid* both received and rejected the approval of the Secretary of State, explaining that:

*"Acting as third-party verifiers would fundamentally change the relationship our services have with women. We trust women. We trust what they tell us, we recognise their experience and we support them to come to terms with their trauma in whatever way we can. To serve as 'verifiers' for women to be able to receive financial support would compromise this stance, and that is something we are not willing to do"*¹⁴

As a consequence, they no longer have approved third-party status. Indeed, at the time of writing, no additional Scottish organisations have received approved third-party status.

In practice, approved third-party professionals are required to complete the latter half of the "support for a child conceived without your consent form (NCC1)" which can be [accessed here](#). They must provide their professional details and address, and declare that the claimant seeking certification has described 'circumstances' 'consistent' with non-consensual exception by ticking the most appropriate box.

Professionals are primarily aided in this work by 3 pages of guidance, [available here](#). The majority of this guidance is dedicated to explaining the two-child limit and its exceptions, explaining the NCC1 form, and explaining coercive control. Moreover, it clearly states that potential claimants are eligible to apply for a non-conceptual conception exception if the circumstances they describe are consistent with coercive control, incapacity to choose, or *rape*. In explicitly mentioning rape the guidance appears to clarify, perhaps even narrow, the regulation's vaguer reference to 'sexual intercourse not agreed to by choice'. Curiously, no attempt is made to define rape or describe what circumstances 'consistent' with rape might look like in practice. Rather, rape is treated as self-evident.

Also worthy of note is that the guidance provides next to no instructions to guide the evidence gathering process. Beyond specifying that a potential claimant's affect should not be used to evaluate a claim, the guidance offers no clarity on *how* practitioners should elicit information, or the level of detail required. Given that disclosures of sexual violence can – if poorly handled – cause survivors very significant distress, this is a striking omission.

14. Scottish Women's Aid and Rape Crisis Scotland, "Joint Briefing – 25/04/2017," 2017, <https://womensaid.scot/wp-content/uploads/2017/09/FamilyCapRapeClause.pdf>.

With that said, a handful of high-profile members of the Conservative government did make public claims regarding the third-party evidence gathering process, in the years following the implementation of the two-child limit and its exceptions. Most notably, in 2018, former Work and Pensions Secretary, Esther McVey told Scotland's Social Security Committee that "there will be no invasive or delving questions asked".¹⁵

What do we know about how the rape clause plays out in practice?

We know vanishingly little about how the rape clause plays out in practice. Government data¹⁶ indicates that, as of April 2024, approximately 3,100 households were in receipt of a 'non-consensual conception exception', approximately 200 of which were in Scotland. Given that it is difficult to accurately estimate how many third or subsequent children in low-income families are conceived non-consensually, it is difficult to evaluate uptake. Since, however, non-consensual conception is taken to include conception in the context of coercive control, it seems plausible that uptake is low.

We also know that there are women who would find, or who do find, the obstacles to realising their benefit entitlement, pursuant to the rape clause, insurmountable. Research published by the *Church of England, Child Poverty Action Group, and others*¹⁷, indicates that shame regarding disclosures, and a lack of easily accessible benefit-related support, may undermine a claimant's ability and/or willingness to claim the non-consensual conception exception.

Beyond this, our understanding of how health and social care professionals, and claimants, implement and experience the rape clause is poor. Certainly, there has been much helpful and insightful educated speculation about the administration of the rape clause¹⁸, and considerable resistance to it, but little in the way of robust empirical research. We do not know, for instance, which health and social care professionals are most frequently asked to certify eligibility (the government collects relevant data via the NCC1 form, but does not aggregate it), nor do we know how these professionals would go about performing this task, if at all (there is no legal mandate to complete the form).

This gap in our policy knowledge is significant, and undermines meaningful evaluation of the efficacy and effect of the rape clause. For whom does the rape clause 'work', how does it work, and under what conditions? Given the lack of strong guidance, and legislative ambiguity regarding the meaning of non-consensuality, approved third-parties arguably have considerable discretion when it comes to the receipt and assessment of claimant disclosures. How do they exercise this discretion, and in whose interests? Is the approach taken consistent across approved third-parties or does it vary? If there is variation, what is the potential impact?

These latter questions are particularly salient given the significant power approved third-parties wield in this context. Whilst medical practitioners are often asked to provide evidence for the assessment of benefit eligibility (e.g., Personal Independence Payment) that evidence generally forms part of a broader evaluation undertaken by the *Department of Work and Pensions*. In the case of the rape clause, however, the Secretary of State's discretion is functionally delegated to the third-party professionals, whose certification decision becomes highly, if not entirely, determinative. What is more, there is no right of appeal if an approved third-party refuses to certify eligibility (though potential claimants may be able to 'try again' with a different approved third-party, if one is available).

This research report constitutes a first step towards answering some, but not all, of these questions.

15. *Social Security Committee*, 2018, <http://www.scottishparliament.tv/meeting/social-security-committee-april-16-2018>.

16. DWP and HM Revenue and Customs, "Universal Credit and Child Tax Credit Claimants."

17. The Church of England et al., "All Kids Count: The Impact of the Two-Child Limit after Two Years."

18. see Richard Machin, "The Professional and Ethical Dilemmas of the Two-Child Limit for Child Tax Credit and Universal Credit," *Ethics and Social Welfare* 11, no. 4 (October 2, 2017): 404–11, <https://doi.org/10.1080/17496535.2017.1386227>; Rebecca Wilson, "Mother Knows Best?: Critical Maternal Ethics and the Rape Clause," in *Troubling Motherhood*, by Rebecca Wilson (Oxford University Press, 2020), 122–38, <https://doi.org/10.1093/oso/9780190939182.003.0008>

2. Research Approach and Limitations

This report is based on data collected during 13 in-depth interviews “conducted with health and social care practitioners, working in Scotland’s central belt, who are, at the time of writing, ‘approved third-parties’ per the Secretary of State’s list. Specifically, it draws on interviews with:

- 4 general practitioners (GPs)
- 1 nurse
- 2 health visitors
- 3 social workers, and
- 3 specialist workers employed by an eligible organisation.

This report also draws on insights generated via two ‘resonance seminars’ and one informal ‘research discussion’ during which seven of the above participants, and one additional health visitor, were introduced to and asked to reflect on emergent findings. These insights played a vital role in the concluding stages of this research.

Given the tens of thousands of professionals in Scotland with ‘approved third-party’ status, relative to the number of Scottish households in receipt of a rape clause exception (200), recruiting participants with experience of certifying rape clause eligibility was not a feasible research strategy. Instead, I asked participants who had not yet certified eligibility to draw on their practice-based experiences in order to think through how they *would* go about assessing eligibility for the rape clause, if asked, and if at all. In addition, I asked them to speculate on what kind of professional and ethical challenges and opportunities might subsequently arise.

Interviewing participants who did not yet have experience of certifying rape clause eligibility not only made this research feasible, it generated potent insights into, e.g., how prepared practitioners were to undertake certification, prior to doing so. However, insofar as participants were hypothesising about what they *would do*, rather than reflecting on the messy process of *actually doing*, it is possible they presented *idealised* narratives of their probable professional conduct. With that said, and as the report’s findings attest, many participants were frank about the potential for (and their concerns about) non-ideal scenarios.

By design, a majority of recruited participants had experience of working with multiply marginalised women, including women living on a low income who had survived sexual violence. For instance, all but one of the interviewed GPs, and both of the interviewed health visitors, worked in areas of wide-spread deprivation. This approach to recruitment was fruitful, as participants were able to offer practice-based reflections on how common issues specific to multiply marginalised communities might shape service delivery vis-à-vis the rape clause.

It is important to note, however, that rape clause eligible claimants may approach practitioners who *do* not have significant experience of working with marginalised populations (e.g., healthcare professionals serving affluent communities containing pockets of deprivation). As such, this research is less likely to capture the perspectives of a group implicated in rape clause administration, who may – by virtue of their practice-based experience (or lack thereof) – be less equipped to do it well.

Notably, all of the practitioners who participated in this research were white cis-gender women. This gender and ethnicity skew does not reflect an intentional approach to recruitment. Rather, it reflects the gendered demographics of the health and social care sector (which is dominated by women), a self-selection bias, and the small sample size. Given that practitioner race and gender *can* shape understandings of sexual violence, and experiences of disclosure, this research should be read with this limitation in mind¹⁹. Most notably, research suggests that men are more likely to entertain 'rape myths' than women.²⁰

Given its small sample size and locality the representativeness of this research needs to be considered carefully. It is particularly notable that this research was conducted in Scotland, and its applicability to other UK jurisdictions should be carefully considered. The Scottish Parliament and NHS Scotland have been avowed in their disdain for the rape clause, and this may have shaped, e.g., the availability of service specific guidance on how to certify eligibility, if at all. However, this report will sensitize readers across Scotland, and in other UK jurisdictions, to possible trends, weak points in policy design, and areas of particular concern requiring further scrutiny.

This research received ethical approval from the *School of Social and Political Science, University of Edinburgh* on 15th May 2023.

19. For e.g. see Jennifer M. Milone et al., "The Effect of Lecture and a Standardized Patient Encounter on Medical Student Rape Myth Acceptance and Attitudes Toward Screening Patients for a History of Sexual Assault," *Teaching and Learning in Medicine* 22, no. 1 (January 5, 2010): 37–44, <https://doi.org/10.1080/10401330903446321>. Attitudes Toward Screening Patients for a History of Sexual Assault," *Teaching and Learning in Medicine* 22, no. 1 (January 5, 2010): 37–44, <https://doi.org/10.1080/10401330903446321>.

20. Barbara E. Johnson, Douglas L. Kuck, and Patricia R. Schander, "Rape Myth Acceptance and Sociodemographic Characteristics: A Multi-dimensional Analysis," *Sex Roles* 36, no. 11 (June 1, 1997): 693–707, <https://doi.org/10.1023/A:1025671021697>.

3. Research Findings

In Part 3, key themes arising from this research are discussed in full.

- **Section 3.1** discusses what practitioners knew about the rape clause prior to research involvement, and explores the potential consequences of a demonstrable knowledge deficit.
- **Section 3.2** discusses access routes to approved third-parties and highlights notable access challenges.
- **Section 3.3** discusses how practitioners would prepare themselves to certify eligibility for the rape clause, if required to do so.
- **Section 3.4** explores the approach practitioners imagined they would take if asked to certify rape clause eligibility.
 - This section highlights a general willingness, among practitioners, to assist claimants in evidencing non-consensual conception, and a broadly victim-centred approach to evaluating disclosures.
 - It also raises a number of significant evidence-based concerns about the potential for case mishandling.
- **Section 3.5** addresses the realities of safeguarding, and the associated likelihood that claimants who disclose sexual violence to a health or social care practitioner will face probing and potentially consequential questions regarding their safety and the safety of their children.
- **Section 3.6** briefly points to possible inequities in the administration of the rape clause.

3.1 Knowledge of the Rape Clause

Prior to their involvement in this research project, *none* of the practitioners I interviewed felt they clearly understood what the rape clause was, how it was meant to function, or what role they were meant to play in administering it. Moreover, no practitioner could recall any official notification of their approved third-party status.

"I've never come across this process before... I remember it in the news, yeah, but I don't remember anything coming out that was professional guidance through the Colleges or the BMA or, you know, how this would be approached in practice. Now that's not to say it definitely didn't happen, but I don't have any memory of it being discussed."

General Practitioner

Health Visitor: So, it's something...I'd seen it in my media but not, like, super recently, it's something I'd, like, was aware of, the term, rape clause. But I've not had any communication from formal channels about it through my work, it's something I've seen, like, popular media or whatever but I've not been aware of it through work.

Researcher: And do you have any sense of what your responsibilities are?

Health Visitor: No.

I was aware of the legislation and aware of the, kind of, resistance to it, in my personal life. But workwise, I mean, there's been nothing. So, you know, professionally we haven't been informed that we would be potentially an identified person. There's no policy in place that I'm aware of.

Social Worker

Although there is some guidance available to practitioners online, this knowledge deficit is significant. Broadly, it indicates that health and social care professionals in Scotland are poorly prepared to undertake certification of the rape clause. And while the majority of practitioners said they would try to rectify this lack of preparedness if required to do so (discussed below), it is clear that such preparatory activities would delay the certification process. What is more, a failure to immediately appreciate the needs of a survivor *could* undermine the provision of informed care at the point of disclosure, and could increase the likelihood of a mishandled case. To illustrate, one practitioner reported that their service had, in fact, been approached by a woman asking for help with the rape clause, and that they had turned her away because they had not been informed, and were not aware, that this was a task they had the authority to perform. What is more, the significance of this error did not dawn on them until I approached them to participate in this research.

Moreover, this knowledge deficit suggests that potentially eligible claimants are less likely to receive proactive guidance and support from their care providers vis-à-vis the rape clause. This is notable because a number of practitioners indicated that - if they were able to develop sufficient knowledge of the clause, and their role in administering it - they would pre-emptively broach the topic with women they believed could benefit.

So yeah, I frequently am looking for ways, and ways to try and get women emotionally and financially secure, without having to rely...because that's often what happens, once a woman draws a line and leaves [an abusive partner], then finance, anything that these perpetrators can use to try and get control, to try and assert themselves is often used, and women can end up quite isolated and unsure.

General Practitioner

So I think if you'd gone away, like, spoken to family, think they're a good candidate and then you look at it and it, yeah, I think they would be a good candidate, then I would probably be comfortable offering it to somebody if I thought that it was appropriate, you know... you know, if somebody's in a place that it feels appropriate, you should always make sure that they've got access to the benefits that they are entitled to because so many people don't know what they're entitled to.

Health Visitor

3.2 Accessing an Approved Third-Party

Survivors eligible for a non-consensual conception exception can technically seek help from a range of approved third-party practitioners. Accessing their preferred practitioner may not always be entirely straightforward, however. Some approved third-parties, most notably social workers, work in services that are only accessible to service users who meet particular eligibility criteria and are not, therefore, open to everyone who might require rape-clause support. Moreover, services with broader or 'universal' remits often create intentional obstacles to access designed to manage demand. For instance, some services offer non-critical care to service users and therefore manage demand via waiting lists.

I think our waiting list is around about the 80 days.... so, we've got active clients, we've got 173 active clients in the organisation at the moment. We work with them fortnightly. We have a waiting list, there's 64 people on the waiting list. Average waiting time, 84 days.

Sexual Violence Support Worker

Others, most notably healthcare centres, use care coordination and non-clinical triage to manage demand for access to clinical staff (e.g., GPs). Whilst these processes are unlikely to significantly delay access to a practitioner, they may require – or be experienced as requiring – a sexual violence survivor to make more than one sensitive disclosure. For instance, one general practitioner suggested that – in the context of a knowledge deficit about the rape clause – the most straightforward route to certification would be as follows:

....as long as somebody, sort of, explained on the phone what it was they were doing, the receptionist would probably signpost that directly to the practice manager, who would then clarify exactly what needed to be done, and then that would be sent to one of the partners. And we'd probably be saying, look, we can do this, but we might need, like, it needs to go into specific set aside admin time, so it maybe is going to need....be in a week or two.

General Practitioner

In this hypothetical scenario, details of a survivor's possible rape clause eligibility are shared with three people (a receptionist, a practice manager, and a general practitioner) and the survivor themselves is required to disclose to at least one gatekeeper without approved third-party status. Some survivors would be untroubled by this, others might find it a deeply painful and shameful experience, exposing themselves, their children, and even a former partner, to unwanted scrutiny.

Relatedly, a number of GPs said that their service would treat the provision of evidence for a welfare benefit claim as an administrative exercise, triggering a specific 'administrative' (rather than clinical) pathway. In practice, this could mean that a patient who broadly implied they required assistance with welfare benefits would *not* be given an appointment to see a GP, but would rather be asked to provide required documentation to a receptionist. Given that the documentation needed to claim the non-consensual conception exception is titled the 'Support for a child conceived without your consent form', it is very possible that handing in necessary documentation would constitute – or could be felt to constitute – a form of disclosure unto itself. Put differently, administrative pathways designed to expedite the provision of evidence for welfare benefits generally, may not be entirely fit for purpose when it comes to certifying eligibility for the rape clause.

Of course, potential claimants can refuse to disclose their needs to anyone but their doctor if they so choose, but this kind of refusal creates its own challenges. For instance, one GP told me that a service user who was unwilling to share the reason they wanted to see a doctor might be given an appointment scheduled for weeks in the future (possibly delaying benefit receipt) whilst another suggested that the service user's encounter with the service could become 'confrontational'.



If it was a very personal issue, understandably a lot of people would say, I don't want to talk to you about this, I want to talk to my GP, or, this is something that's really personal and I'd rather not discuss it. You know, so sometimes that would go quite well and it would be understood and articulated well and there would be an agreement or an understanding that this is a personal issue and it just needs to go straight through to one of the clinicians. Or sometimes if people struggle to articulate their frustration or their needs or their, kind of, lack of confidence in the system it might end up in a bit of a confrontation, which is never good for anybody.

General Practitioner

Clearly, struggling to schedule an appointment with one's GP, or feeling discomfort about personal disclosures to non-clinical staff, is not an issue specific to the rape clause. However, it is an issue which takes on particular meaning when we consider the sensitivity of rape disclosures, the effect of ongoing poverty on large families, and the vulnerabilities of women who have experienced the compound impacts of financial hardship, potentially recent childbirth, and sexual violence. Put differently, accessing health and social care may be challenging for everyone, but the weight and impact of those challenges are likely to differ depending on a person's context and needs.

Arguably the most accessible practitioners implicated in rape clause certification are health visitors, insofar as they are a universal service for families with pre-school children, and insofar as they seek out contact with, and can be highly responsive to the needs of, mothers.

Every family has a universal pathway, so every family gets about 11 visits, and they're home visits, before a child goes to school. And the idea is that they will then get to know their health visitor... If we feel that it's an issue with a child maybe not developing or the family are having particular issues, we will change their health plan indicator. So instead of being a core family, they'll become additional because they might have parental needs, there might be child protection. So, in that case, we will put in more than the universal pathway, we will actually visit in between. And that will be totally up to us as to... so I might go out to a mum that's very, very depressed and suicidal and I think, right, I can't leave her very long, I'll go in a few days and just check up on her.... And because the family will get to know their health visitor, they'll always have our number and they can ring at any point. And even if their health visitor is on holiday, another one will pick it up. If someone's sounding desperate, someone will go out and see them. So, at any point, a family can phone in to request something.

Health Visitor

It is important to note, however, that health visitors are not available to families whose children have aged out of their service. They are therefore inaccessible to parents who might wish to claim a non-consensual conception exception more than 5 years after a relevant child's birth. Mothers might experience this kind of delay if they are ineligible for Universal Credit in the first few years of their third or subsequent child's life (e.g., due to employment status), if they are living with their sexually abusive partner (disqualifying them from rape clause eligibility), or if they feel unable to make necessary disclosures in the aftermath of rape or coercive control.

3.3 Preparing to Certify

The vast majority of practitioners interviewed for this research indicated that they would be prepared to certify eligibility for a non-consensual conception exception, if asked. However, no practitioner felt they would be able to do so immediately. Rather, all willing practitioners felt that they would need time to prepare to certify, beyond reading the government's guidance. For instance, a number of practitioners said that they would require training to certify rape clause eligibility with confidence.

Is there a manual of the questions I would need to ask, is there...no? I think I would need to go through some form of training to see what exactly I'm expected to be....

Nurse

But I actually, kind of, feel especially as this is a very official piece of documentation. I feel, like, well you're asking me to do this and there's no training. You know, you're being clear about what it is. You know, it's in this document here, but I don't really understand the premise of this and there's nothing in our organisation that prepares therapists for this being the case.

Sexual Violence Support Worker

It is not clear, however, what (if any) training is available. One practitioner indicated that they would seek out their NHS Trust's 'standing operating procedure' before confirming that no such procedure was in place. Beyond this, practitioners routinely indicated that they would want to seek advice from their unions, colleagues, legal teams, or senior management, before certifying eligibility. For the most part, practitioners felt this would be necessary to ensure a high standard of care. Many also had concerns about personal and organisational liability and political controversy.

We do have a legal team, who are available to answer questions around these things. And I certainly, because it's not been something that we've had, well I've not had it at all, I would absolutely want to check with the legal team. But we would involve the senior management team as well, to ask them, is this something we can crack on with, or are we taking a stance as a Council.

Social Worker

I think for me to sign the form there and then, not knowing, you know, not being really clued up on the full consequences, I think I'd want to check it out.... I would probably, kind of, be looking for, you know, is there a detrimental consequence for the client and is there some sort of consequence for our organisation that we would be expected to do anything else in the future?

Sexual Violence Support Worker

During the resonance seminars, several practitioners voiced concern that seeking advice vis-à-vis the rape clause could (inadvertently) compromise good practice with respect to data sharing. While these practitioners said they would take every precaution to protect confidentiality (e.g., via strict anonymisation) they nonetheless felt that widely discussing any aspect of a rape clause case might increase the risk of, e.g., data breaches or privacy violations. Clearly, data management challenges like this would be compounded if a survivor was required to make disclosures to workers without approved third-party status (e.g., gatekeepers) in order to access to support.

This issue is further exacerbated by the fact that not all practitioners were confident they would know where, or from whom, to seek advice. Many felt they would need to cast a wide net.

I could easily phone multiple people and nobody know. I probably wouldn't know where to start. I think I would phone MDDUS [Medical and Dental Defence Union of Scotland] first. I'd ask my other partners first and hope that some of the older partners might know, but I don't think they do. I briefly said today, I'm going home to do this interview, and everyone was like, what's that, what's that, so I really don't think they would know. I mean, it's not even like child protection stuff, is it, so paediatrics wouldn't know it. The obstetric team probably wouldn't know it. Midwives probably wouldn't know it.

General Practitioner

The need to seek support from others prior to rape clause certification, as well as a lack of rape-clause specific informational literacy, or readily available training, should be understood in the context of broader resource and capacity issues in health and social care. Most of the practitioners interviewed for this research felt their service was suffering due to underinvestment and/or the high needs of their service users, and that these struggles had been exacerbated by the pandemic, the cost-of-living crisis, and persistent over-delegation to frontline health and social care practitioners.

Yes, We're, kind of, on our knees at the moment a little bit. It's been pretty... I mean, social work is always, kind of, on its knees but increasingly so. I think that we are now seeing the real reality of the bite of austerity and we see it in the women that we work alongside too. You know, that things are just really desperate.

Social Worker

So, we are seeing a lot more mental health issues, a lot more things like children not being toilet trained, not speaking very well, very shy. So that is definitely impacting on the service because we're having to put more input in to try and get these children back up where they would have been before COVID... And poverty is always...it's families that are under immense stress because they can't even get food on the table, can't get heating, they don't have anything in their house, they don't even have proper furniture, you know, children without proper beds.

Health Visitor

Well, we have been dumping things on General Practice for a while and if you want fewer GPs to come in and stay as they are haemorrhaging out, either going into specialties or leaving and going to New Zealand and Australia, [the rape clause] is something else that is going to make it happen.

General Practitioner

In other words, many practitioners lack the time or resources required to convene meetings on, and seek out hard-to-find information about, the rape-clause. In the words of one General Practitioner:

You could say, and quite rightly say, this is a tiny thing, I think it's recognising that at the moment, everybody's flooding their tiny things to us.

General Practitioner

Practically speaking, this may undermine practitioner confidence, compromise the quality of information approved third-parties are able to obtain, delay rape clause certification further, and – as one General Practitioner intimated – shape the relationship between practitioners and sexual violence survivors in less than desirable ways.

So, there isn't much mental or physical capacity in general practice at the moment to take on additional stuff. And the way that that plays out, I would say, for patients is that they experience probably quite a stressed workforce that they maybe don't feel are as empathic to their needs as ideally, they would be, because they're largely fire-fighting. They don't get enough time because appointments, you know, are necessarily short just to get through the numbers.

General Practitioner

3.4 Certifying the Rape Clause

The majority of practitioners reported that a disclosure of sexual violence was a significant event, with significant professional and ethical implications, that necessitated a level of sensitivity not normally demanded by administrative exercises.

Because it's not just, like, okay, well, yes, you apply for benefits and, yes, I can say you've been raped. So that's great you'll get your however much money at the end of the day. Like, shall we weigh the baby now? Do you know, it's one of those things where it's, like, that disclosure requires so much more than just the tick-box to say you can get your benefits.

Health Visitor

Indeed, the vast majority of practitioners said that working with survivors effectively involved seeing them on several occasions, building trust and rapport, and considering a range of possible referrals and interventions (see safeguarding, below). In turn, they expressed significant concern that some women might feel coerced into disclosing an experience of sexual violence, during a one-off meeting, purely for the sake of rape-clause certification.

...I would feel concerned for them, just the idea that they effectively have to come in with no...there's no relationship being developed. There's no sense of this being a safe space for the client, and they're being asked to disclose really difficult, disturbing traumatic experiences. Open that box, give the information, leave again. I mean, just from a therapy point of view that is very incongruous. It feels pretty brutal and there's definitely nothing therapeutic about that.

Sexual Violence Support Worker

On these grounds, and others, most practitioners imagined that they would undertake rape clause certification in a way primarily designed to minimise immediate and future harm. For many, this meant treating women as highly credible survivors, and avoiding non-invasive questions as much as possible.

Believing Women

Most practitioners said that they would - as a matter of best practice - believe women if they made a disclosure of non-consensual conception. Relatedly, many said they would require minimal information to certify rape clause eligibility.

I think that, like, if someone said to me that they'd been raped, that would be enough for me to want to sign a form. I wouldn't need to know the details or, like, if not, I'm very much in the belief that it's not my business how you got to that point. And if you, if somebody forcefully had sex with you, somebody raped you I don't really, I don't need you to justify what got to that stage. If you tell me that you've been raped, I think that, like, if they want to talk to me about it more and they want to talk about the, you know, the process for themselves, but from a professional point of view I wouldn't need any more information than somebody telling me that.

Health Visitor

Well, if the woman came to me and said...and many women have said, yes, I was sexually abused or raped when I was younger, and if they say that, I didn't give consent, it wasn't...I didn't make them... yes, that would...I'd trust them, that is enough for me, I don't need to know the details of that, whatsoever.

Nurse

If the client asked me to fill the form in, I would take it that the client has a very good reason for me to fill the form in. I wouldn't even necessarily ask who it was, if I didn't have a relationship with the client, who was the person that raped them or anything like that. You know, if they're asking me to fill the form in, I would take them...they meet the criteria for the form to be completed.

Sexual Violence Support Worker

Broadly speaking, practitioners struggled to imagine a situation in which they would disbelieve a service user, or consider their disclosure to be 'inconsistent' with non-consensual conception. It is important to note, however, that this position *did not* stem from a politics of refusal, e.g., a desire to avoid implication in the administration of the rape clause. Rather, this position reflects a context specific mobilisation of relevant practice-based experience, i.e., experience of how sexual violence 'shows up' (or does not show up) in professional encounters.

I mean, if somebody had told me that that's what had happened, I can't really see a situation where I would...because my belief in all instances is to believe somebody and I just, like, I feel like it's such a serious thing to say that's happened to you, that I feel like it's very unlikely that someone would have motives other than to get what is deserving, what they deserve and what they're entitled to.

Health Visitor

Researcher: Can you imagine a situation in which a patient comes to see you and she starts to describe a situation, you know, which led to her non-consensual conception, and you start thinking, I don't think that's actually a non-consensual conception, can you imagine that as a scenario?

Nurse: I feel like the women I've met, I've not...I mean, it could...I don't think it would happen necessarily, I can't imagine it. I think the women that I've met here, well, they've been through so much that I don't think...yeah, I can't see that happening, I don't think. No.

Relatedly, many practitioners said that service users – far from over-classifying their encounters as non-consensual – tended to *under-classify* their experiences as such. In turn, practitioners were much more familiar with providing service users with language to describe their experiences as violent or sexually violent, than they were with policing use of that language.

We find ourselves, more often than not, having to explain to people that we think they're in a controlling relationship, you know.... Because it's, to be honest, it's quite unusual, I can't think of many women who have come forward and said, look, he's really controlling me. But what they will say is like, you know, he's texted me 80 times on Saturday, what's that all about, you know.

Social Worker

Yeah, I think I'd be far more likely to have someone describe to me a situation and me tell them, I think you might have been raped, than someone say to me, I think I've been raped...

General Practitioner

Indeed, a number of practitioners said that some survivors – particularly older survivors, and survivors living in intensely patriarchal contexts – might not immediately recognise non-consensual sex as violent.

Clients that I work with who are my age or older tend to not even consider alcohol or even sleep being something that would be described as non-consensual.

Sexual Violence Support Worker

But then also I don't know whether some of those women would even necessarily ever think that that's what had happened to them, because it's not their job to consent or not. It's their job to do what's expected of them by their husbands.

Health Visitor

In summary, practitioners did not have much, if any, experience with 'questionable' disclosures of sexual violence and, based on their practice, could not imagine a situation in which such disclosures would arise. In turn, they did not feel it would be necessary to interrogate service users when it came to ascertaining the 'consistency' of a story with non-consensual conception.²¹

Significantly, when reflecting on their lack of experience with 'questionable' disclosures, practitioners also expressed low levels of confidence when it came to assessing 'circumstances' as 'inconsistent' with sexual violence. In brief, they possessed little to no experience when it came to contradicting a service user who labelled a sexual encounter violent, and little confidence that they would be able to do so effectively if prevailed upon.

I don't think I have...I don't think I'm qualified to say that. I feel like I don't have the training or experience to do it that way round... to deny somebody or tell somebody that they're lying to me or not correct, that's much harder.

General Practitioner

21. Clearly, the finding that survivors appear to very often under-classify their experiences of sexual violence, and do not necessarily understand what constitutes non-consensual sex, raises serious doubts about the efficacy of the rape clause in achieving its own objectives. If some women, for whatever reason, struggle to classify conception following a non-consensual sexual encounter as violent they are unlikely to recognise their entitlement to an exception under the rape clause.

You know... are we necessarily trained or competent or have enough time or expertise to have those deep dive nuanced discussions about consensual sex? I would suggest that quite a lot of GPs would feel, I could give it a go but I'm not sure that when it comes down to whether or not someone is entitled to money to support their family that's living in poverty, whether I would want, you know, to say, yes, I am kind of fully qualified to do that.

General Practitioner

This, then, limited their willingness to exercise power in a way that contradicted a survivor's understanding of their child's conception.

Defining Rape

The concern, expressed above, that practitioners might not be sufficiently qualified to contradict a survivor's understanding of a sexual encounter as violent is arguably warranted. One research encounter aptly demonstrates this. A practitioner, a GP, said that she *would* feel obliged to refuse rape clause certification if she did not feel that a situation described to her constituted non-consensual conception, but that she had significant concerns about her ability to make this kind of determination. This subsequently led to a discussion about what she did, and did not, consider to be rape:

Researcher: Yeah, so I guess, so if a client came and said, I think I was raped and I think I'm eligible for this, what happened was, I was having sex with somebody and it was completely consensual, and then he didn't tell me that he removed the condom, is that rape?

General Practitioner: I wouldn't say so.

Researcher: How about if somebody pretended to be somebody they weren't?

General Practitioner: I mean, yes, my gut instinct is yes, but I don't know what I'm basing on that, and there's a load of questions that go with that, because could you not see them, did they say they were a different name and a different person, or... I don't know, there's loads of questions that go with that phrase.

This conversation highlights, among other things, that rape is not a self-evident category. In England, Wales, Northern Ireland, and Scotland 'stealthing' – removing a condom during sex without consent – *does* constitute rape according to the criminal law. However, until recently, the legality of stealthing in Scotland and Northern Ireland was ambiguous, as there had been no relevant test cases²². Indeed, when I spoke to the GP quoted above the Scottish stealthing test case was yet to be tried.

Moreover, the legality of impersonation as it relates to rape is complex²³. The GP's inclination to ask nuanced questions regarding the nature of an impersonation is therefore well founded, legally speaking, though it is not clear that her assessment of responses would be correct 'in law'. There is, therefore, significant scope for mistake and misunderstanding that may, in turn, undermine a survivor's ability to access a rape clause exception.

Of course, the *Social Security (Restrictions on Amounts for Children and Qualifying Young Persons) Amendment Regulations 2017* does not specify the criminal law as the standard by which practitioners

22. "Stealthing Case Rapist Luke Ford Jailed for Years of Abuse," *BBC News*, December 18, 2024, sec. Tayside & Central Scotland, <https://www.bbc.com/news/articles/cx2v39z30rro>; Police Service of Northern Ireland, "Former Police Officer Sentenced after NI's First Conviction for 'stealth' Rape," 2023, <https://www.psn.police.uk/latest-news/former-police-officer-sentenced-after-nis-first-conviction-stealth-rape>.

23. Crown Prosecution Service, "Chapter 6: Consent," in *Rape and Sexual Offences: Prosecution Guidance*, 2021, <https://www.cps.gov.uk/legal-guidance/rape-and-sexual-offences-chapter-6-consent>.

should assess a survivor's allegation, though this is not made clear in the government's guidance. Clearly, it would not be reasonable to expect health and social care practitioners to have encyclopaedic knowledge of sexual offences, particularly given many are expected to possess encyclopaedic knowledge of a very different kind. Nor should we treat the criminal justice system as the arbiter of what does and does not constitute rape. However, this raises an important and currently unanswered question: by what metric or according to what kind of technical knowledge does the state expect practitioners to adjudicate the conditions of conception? And if practitioners are required to use their discretion, basing their determinations on whether or not they personally consider something to be rape, how can we be confident that all potential claimants will be treated fairly and equally?

In reality, a majority of practitioners used a victim-centred definition of non-consensual sex, rather than a criminal justice definition. Indeed, the credulity of health and social care practitioners, when it came to allegations of sexual violence, stemmed from more than a belief that survivors of sexual violence do not lie. Rather, the majority of practitioners felt that women were the *ultimate experts* when it came to their own experiences of non-consensual sex. In other words, many health and social care practitioners defined rape as a largely subjective, rather than 'objective', phenomenon.

No, I mean, I primarily see my role as working from a victim-focused perspective, and for me, if somebody was in a fawn response, then that isn't consensual. You know, maybe the other person might not necessarily recognise that, but from the client's perspective, then, you know, that ability to be able to say no is still limited, you know, if they are in a fawn response. So, I suppose I really wouldn't be seeing my role as investigative around that, and actually that isn't consensual, from the client's perspective.

Sexual Violence Support Worker

Social Worker: We have a lot of experience of supporting women who have been raped, who have had non-consensual sex, who are in relationships with their partners where, you know, sex is happening and they aren't, kind of like, willing participants in it. So yes, I mean I think that we have quite a broad understanding around the wide spectrum of non-consensual sex and how that manifests itself across various situations.

Researcher: And would be, sort of...would that be a criminal justice definition or would that be a more, kind of, victim-centred definition? Because, I guess, the difference for me is with respect to how much value you place on the perpetrator's perspective and whether or not, you know, he could have reasonably known.

Social Worker: No. It would be victim-centred.

This light touch approach, which treats survivors as both highly credible and experts in what constitutes sexual violence, is arguably the most appropriate approach to rape clause certification. Not only does it mobilise established practice-based experience to engage with a new and poorly explained task, it mitigates the damage that could result from confusion or disagreement regarding the proper definition of rape. If, however, practitioners are taking this light touch approach – and if this is the most appropriate approach to take – it begs the question: do we need a third-party evidence model at all? In practice, health and social care professionals are not 'confirming the consistency' of a conception with a pre-agreed standard of non-consensuality, rather they are *credentialing* the subjective experience of another.

Disbelieving Women

A very small number of practitioners indicated that they would *not be* prepared to certify the rape clause under any circumstance, arguing that it would not be possible for them to assess a disclosure without additional evidence. On one occasion, this refusal was premised on doubts regarding the credibility of survivors, generally: a GP argued that the rape clause constituted a financial incentive, and that there was existing evidence to suggest that financial incentives could induce women to lie about sexual violence.

General Practitioner: I also wonder, it's my understanding is that even raising the question of rape will attract twenty thousand to a female who has accused the male of rape. That's a huge financial incentive, if you live in an area where my patients live, understandably, this is a massive financial incentive. So, the unintended consequence of that it is that it puts a huge bias on a fact of a claim of an offence.

Researcher: Criminal compensations, you mean?

General Practitioner: Yes, criminal compensation.

Moreover, she felt that taking a victim centred and light touch approach would result in an unmanageable influx of women claiming rape clause eligibility.

What you then get with that is, every child is a rape clause and so the whole thing is pointless and futile. It's utterly pointless.

General Practitioner

In assessing the weight of this finding, it is important to acknowledge three things. First, the rape clause does not – technically – require practitioners to make an assessment of credibility (rather it requires them to confirm that the description of a sexual encounter is 'consistent' with the proper definition of non-consensuality, whatever that may be). Second, some claims made in the above statement are inaccurate, or based on demonstrably faulty assumptions. Research performed by the *Crown Prosecution Service* clearly shows that false allegations of rape are very rare and often derive from complex circumstances and situations.²⁴ Indeed, the idea that women, generally, lack credibility when it comes to reporting sexual violence is a pervasive 'rape myth'. What is more, whilst criminal compensations can be paid to a victim in cases without a conviction, evidence collected during a police investigation is still evaluated according to the civil standard of proof (the balance of probabilities). It is also worth noting that very few rape survivors who receive a favourable decision from the Criminal Injuries Compensation Authority are awarded as much as £20,000, and the majority receive much less.²⁵

Third, I wish to reiterate that concerns regarding the credibility of survivors were not pervasive in the data. The vast majority of practitioners felt that women who made allegations of sexual violence were credible. Moreover, despite her views on survivor credibility, the practitioner quoted above expressed a clear desire to maintain positive therapeutic relationships with women who disclosed rape and offer them different kinds of care (e.g., a referral to counselling). With that said, it is important to note that health and social care practitioners – particularly those without specialist training (who are the majority)

24. Alison Levitt and Crown Prosecution Service Equality and Diversity Unit, "Charging Perverting the Course of Justice and Wasting Police Time in Cases Involving Allegedly False Rape and Domestic Violence Allegations," 2013, https://www.cps.gov.uk/sites/default/files/documents/publications/perverting_course_of_justice_march_2013.pdf; Rape Crisis Scotland, "False Allegations of Rape: Briefing Paper," 2013, <https://www.rapecrisisscotland.org.uk/files/false-allegations-bp-170913-1-1.pdf>.

25. "Statistics at CICA," GOV.UK, accessed March 3, 2025, <https://www.gov.uk/government/organisations/criminal-injuries-compensation-authority/about/statistics>.

– are vulnerable to misconceptions about rape and rape victims²⁶, and that they may act on these misconceptions in deleterious ways. Indeed, we must accept the possibility that a minority of approved third-parties will – like the general public²⁷ – entertain common ‘rape myths’.

Whilst the government have taken steps to quell potential concerns regarding credibility (by asking for confirmation of consistency rather than veracity), many rape myths relate to the constitution of rape, rather than credibility per se. Given that practitioners appear to have significant discretion when it comes to defining rape, this is significant. By way of example, if a practitioner believed that consent to one sexual act constituted consent to a related sexual act, as many members of the public do,²⁸ they might not classify the withdrawal of consent during a sexual encounter as *consistent* with rape. This position would contradict the criminal law, as well as a victim-centred position, that consent is an ongoing rather than ‘once and for all’ affair.

3.5 Claimant Capacity

An aspect of rape clause certification that provoked particular concern for practitioners, was the potential requirement that they certify survivor capacity. Capacity (or lack thereof) is rarely a static or absolute trait: it fluctuates over time and varies in relation to different tasks. For instance, an individual might be deemed to lack capacity to, e.g., make healthcare decisions, but be considered capable when it comes to, e.g., making every day financial decisions. Moreover, the rape clause requires practitioners to assess *historic* capacity, complicating matters considerably.

I think it can be difficult with capacity, assessing someone's capacity for anything is going to be different depending on what it is they are consenting to. Or, you know, when we talk about capacity, we have certain parents on our caseload that wouldn't be considered to have the full capacity to make every decision that needs to be made in an adult life. And so, but that doesn't mean they don't have the capacity to make certain decisions. So, again, I think it's quite... you can't necessarily make decisions about how much capacity someone had nine months ago to have sex with somebody, and I think it's naive to say that someone like me, just sitting in a room who is meeting a parent, has got the ability to make a capacity decision.

Health Visitor

26. Marie Skov, Sarah van Mastrigt, and Andreas V. Jensen, “Comparing Rape Myth Acceptance Among Police Trainees and Medical Students: A Preliminary Danish Validation of the Updated Illinois Rape Myth Acceptance Scale,” *Violence Against Women* 28, no. 11 (September 1, 2022): 2649–76, <https://doi.org/10.1177/10778012211038967>; Milone et al., “The Effect of Lecture and a Standardized Patient Encounter on Medical Student Rape Myth Acceptance and Attitudes Toward Screening Patients for a History of Sexual Assault.”

27. YouGov and End Violence Against Women Coalition, “Public's Attitudes to Sexual Consent | YouGov,” 2018, <https://yougov.co.uk/society/articles/22262-publics-attitudes-sexual-consent>.

28. YouGov and End Violence Against Women Coalition.

So, I think it's not...it wouldn't be necessarily an easy one, unless it was a very clear-cut case of this person has got severe and enduring mental health problems, they're on a long-term prescription for chronic schizophrenia or bipolar, or unless they'd been in and out of hospital, I'd say it's pretty unlikely that they lack capacity. Or this person has had a very significant alcohol dependency for ten years, or this person has been on a methadone prescription for a really problematic and unstable drug use for ten years – fair enough. But for the people who are fluctuant, which will be a big cohort, then it's quite difficult retrospectively to say at the time that you conceived you're telling me that you didn't have capacity because of X? I just have to take that on face value.

General Practitioner

The expertise required to properly evaluate capacity is not necessarily possessed by all health and social care practitioners. Rather, capacity is often determined by specialists.

So, who is it that's actually doing that assessment? So, for us, as social workers, I think we would probably err on the side of agreeing that there was a lack of capacity... because we know that, to have that assessed would take a long time. We can only do it based on the information we've got in front of us, which is, it's not enough, because we're not qualified to make that decision.

Social Worker

But a lot of doctors just feel, whoa, that feels really difficult, I don't know if I can do that, I'm going to ask for a second opinion, or, I'm worried about what my legal liability might be if I get it wrong, you know, how do I prove it... But psychiatry would be able to do a capacity...there'd be a big long waiting list, but psychiatry would be able to do a complex capacity assessment.

General Practitioner

In concert with the excerpts above, most practitioners felt they would 'err on the side of agreeing there was a lack of capacity', once again taking a light touch approach to certification. However, as the last quote illustrates, it is possible practitioners will experience concern when asked to certify – on an official state form – that someone lacked capacity historically, and refer to a specialist with a 'big long waiting list'. Moreover, during the resonance seminars it became clear that officially confirming that a service user once lacked capacity might precipitate other forms of scrutiny. For instance, one social worker said that questions regarding capacity might raise a statutory 'duty to inquire' under the *Adult Support and Protection (Scotland) Act 2007*, necessitating further investigation into the health and wellbeing of the survivor. This, in turn, could disrupt the service user's engagement with services, challenging existing parameters of involvement or intervention against their will.

3.6 Safeguarding

A majority of practitioners reflected that a disclosure of sexual violence, regardless of its motivations, would trigger a range of discussions, including discussions regarding further support and care. A number also acknowledged that services users might not welcome these discussions. Most notably, practitioners working for statutory agencies reflected that a disclosure of sexual violence, particularly when that disclosure came from a person responsible for the care of several children, would likely provoke safeguarding concerns and – potentially – safeguarding interventions. For instance, one GP felt safeguarding would take precedent over certifying a survivor's eligibility for a non-consensual conception exception.

There's a whole, kind of, professional expectation of what we need to do with a disclosure like that, you know, in terms of particularly if there are other kids at home. So, that would immediately become the number one priority would be thinking, oh my God, do we need to get social work involved here, does the school know? You know, we're going to need to put a flag in the notes of the mum and of the kids and, you know, does anyone know who the dad is, is he registered at the surgery, what's his issues, has he got mental health problems? Do you know what I mean, it's like this huge cascade of things and the form would quite quickly I think become, oh yeah and the form, which is why you came in. So, I think, you know, that, in reality, that would become the main focus of that ten-minute discussion would be just, I need to do a quick safety assessment of you and your family.

General Practitioner

What this means, in practice, is that whilst – as promised by Esther McVey – many practitioners will avoid invasive questioning regarding rape clause eligibility, they are very likely to ask invasive questions with respect to safeguarding a vulnerable adult and/or her children.

What is more, a handful of practitioners acknowledged that safeguarding investigations and their outcomes can be devastating:

Yes, so if somebody's telling us that, you know, this happened and there are other children in the household, it could potentially have really horrendous outcomes, could potentially have really good outcomes, yes, I mean it could. But it also could absolutely shatter people's lives and, you know, kind of, in having services involved does not necessarily mean a silver lining, right. You know, children go into the care system. They don't have good outcomes. Children who have social work involvement don't all have good outcomes. Right, you know. Not all social work is done ethically. Not all social work is done in a way that is careful...

Social Worker

Overall, safeguarding (and the aforementioned duty to inquiry) are necessary if ultimately flawed processes designed to protect vulnerable adults and children. It is nonetheless important to note how the threat of safeguarding might a) deter women from claiming benefits to which they are entitled and b) shape the rape clause certification process and its aftermath. Given that most practitioners have a duty to safeguard survivors and minors, seeking certification support is unlikely to be a non-invasive process.

What also became clear, during the resonance seminars, was that unwanted investigations and inter-

ventions could profoundly undermine a woman's ability to exercise their agency in relation to their own lives and the lives of their children. This, practitioners felt, was particularly problematic given that women eligible for the rape clause might be negotiating and/or managing the conduct of a violent former partner, whose reaction to an intervention could be undesirable.

It is not clear that the interaction between rape clause certification and statutory responsibilities like safeguarding was subject to *any* scrutiny or consideration during the legislative process.

3.7 Inequities

Taken together, evidence of rape myth acceptance and ambivalence regarding the definition of rape, suggest that there could be meaningful inequities in rape clause administration and receipt. Survivors may face a lottery when it comes to the approach their chosen practitioner favours. Whilst commentary on the nature and extent of these inequities is beyond the scope of this research, it is nonetheless worth flagging that any such trend could be exacerbated by broad – and well documented – racist and classist approaches to sexual responsibility.²⁹

One potential inequity that did emerge from the data, however, related to the distinction between a service user who had a well-established relationship with a service, and a service user who was not previously known to services. Practitioners were clear that it would be significantly easier, and much more appropriate, to certify eligibility for a non-consensual conception exception if the service user in question had already sought support for an experience of sexual violence.

I'm just thinking of patients of mine who I know have been in coercive abusive relationships, and are very much living with the sequelae and potentially the mental health sequelae of that, but, you know, you already know, and it really wouldn't...yeah, they would have no problem because you know them.

General Practitioner

If somebody had disclosed quite early on in their pregnancy that they'd been raped, and it was well known and professionals were involved and supports were in place, and they didn't want to pursue criminality. But we still knew that this had happened, et cetera, then it might be something that you'd be like, okay, at some point maybe I'll be the person who does that with them because I'm the person that's in their house all the time, and I can see that that would be much less out of the blue and you probably could do it in quite a practical way, because that's the point that you'd got to. But if somebody who you had no known history of sexual violence presented you with it, I think it would be wrong to fill it in and hand it back to them. I think that would be a very strange thing to do.

Health Visitor

What this means in practice, is that the particular vulnerabilities of women who do not have an existing positive relationship with a specific health and social care practitioner, may be intensified by reduced access to benefits. Notably, there are numerous structural barriers to establishing this kind of 'relational continuity of care', particularly with GPs.³⁰

29. Beverley Skeggs, *Formations of Class and Gender: Becoming Respectable* (1 Oliver's Yard, 55 City Road, London EC1Y 1SP United Kingdom: SAGE Publications Ltd, 2002), <https://doi.org/10.4135/9781446217597>.

30. Deep End GP Group, "Deep End Report 42: What Can General Practice Do to Strengthen Continuity of GP Care for Those Who Need It Most," 2024, https://www.gla.ac.uk/media/Media_1124679_smxx.pdf.

4. Conclusions and Recommendations

When the 2017 Conservative government moved forward with plans to mitigate the impact of the two-child limit with a 'non-consensual conception exception', it sparked outrage. Concerned commentators were reasonably alarmed by the idea that subsistence level benefits were to be made conditional on a forced disclosure of sexual violence. Moreover, and as stated in Section 1, the *Equality and Human Rights Commission* expressed concern that the government had failed "to fully consider the impact of the implementation of this exemption". This report indicates that, in addition to its failure to consider the *impact* of rape clause implementation, the state has roundly failed to fully consider implementation itself. Indeed, this report demonstrates that fair, consistent, and effective administration of the rape clause is profoundly undermined by a range of knowledge deficits, access challenges, and legislative ambiguities.

In many ways, the findings of this research report are positive. Whilst clearly discomfited by the demands made of them by the rape clause, a majority of interviewed practitioners expressed a deep desire to support women in claiming their benefit entitlement as non-invasively and compassionately as possible. They reported an intention to certify rape clause eligibility based on minimal information, using a victim-centred approach that frames survivors as both highly credible and expert in identifying non-consensual sex. In the main, these practitioners struggled to conceive of an instance in which they would contradict a survivor's classification of conception as non-consensual.

However, the good intentions of these practitioners were clearly undermined and complicated by a range of factors including lack of policy and legal knowledge, service design and capacity (and associated barriers to access), and the need to safeguard vulnerable adults and children. Interviewed practitioners knew little to nothing about the rape clause prior to their involvement in this research project, and consistently expressed a desire for training and guidance that does not presently exist. Indeed, a number of practitioners reported a likely knowledge desert with respect to the clause, in which colleagues, employers, and trade organisations were expected to be similarly unclear about the specifics of certification. Relatedly, whilst practitioners felt confident in their ability to affirm a survivor's report of rape, they were significantly less confident about contradicting any such report. And whilst the majority did not anticipate ever contradicting a survivor, there were some who could foresee circumstances in which they would feel it necessary to do so, and who expressed concern about those circumstances. By and large, practitioners do not possess a detailed understanding of rape as a criminal offence, and it is not clear what kind of technological knowledge might 'stand-in' for the law to provide a different threshold for certification. In lieu of a clear legislative metric of, or threshold for, non-consensuality, it is highly likely that administration of the rape clause will be inequitable *at the least*. Indeed, evidence of rape myth acceptance amongst practitioners suggests that the rape clause may be implemented in a way that reproduces damaging misconceptions about women and their relationship to sexual violence.

Given the significant flaws in the design and implementation of the rape clause, it is clear that urgent policy and legislative changes are needed to mitigate harm and ensure that survivors can access a high standard of care, without barriers to equitable provision, or the risk of re-traumatisation. In what follows, I make a series of recommendations that address both the fundamental shortcomings of the rape clause and the immediate steps that could be taken to minimize harm, improve access to necessary welfare benefits, and ensure a more equitable and survivor-centred approach, in the absence of necessary welfare reform.

Recommendation 1: Repeal the Two-Child Limit

The UK's current Labour Government has made a commitment to 'halve' violence against women and girls.³¹ If they are sincerely interested in achieving this goal, then they must repeal the two-child limit. Research demonstrates that access to material resources, and a survivor's capacity to become financially independent, play a significant role in whether or not they feel able to leave an abusive partner.³² The two-child limit will undoubtedly threaten some survivors with significant financial hardship, often destitution, if they decide to remove themselves from an abusive context. That a small portion of these women *may* be able to rely on the rape clause, if they can overcome the practical and emotional hurdles to certification, provides next to no mitigation.

Moreover, lest there be any doubt, there is *no way* to reform the rape clause such that it becomes an acceptable way to administer welfare benefits. The rape clause forces women to disclose an experience of sexual violence to a delegate of the state, and requires them to register their children (by name) as a consequence of violence, to ensure basic levels of subsistence. Moreover, as this research has demonstrated, existing frontline service provision is simply not designed to administer a policy like this, and the absence of a clear metric for evaluating allegations of non-consensuality in a health and social care context, clearly frustrates its fair and consistent implementation. Given that, by creating the rape clause in the first place, the state has acknowledged the injustice of penalising parents for something that is, by definition, beyond their control, the unworkability of the rape clause signals the unworkability of the two-child limit.

In what follows, I make a handful of recommendations of how the rape clause could be designed or implemented to *mitigate* its worst excesses. These recommendations should not be read as tacit approval of the two-child limit, for the reasons stated above.

Recommendation 2: Move to a self-certification model

"If they're asking me to fill the form in...they meet the criteria for the form to be completed."

Sexual Violence Support Worker

By their own admission, the practitioners interviewed for this research brought very little expertise to the table when it came to certifying eligibility for the non-consensual conception exception. The majority did not feel qualified to define and enforce thresholds of non-consensuality, and were therefore largely unwilling to contradict a survivor's understanding of a sexual encounter and conception as violent. Moreover, a majority believed non-consensuality to be a largely subjective, rather than objective phenomenon. In turn, they reported an intention to certify eligibility following little to no questioning.

Notably, those who did express an intention to evaluate disclosures indicated some confusion about what, precisely, constituted non-consensuality, and a small minority demonstrated rape myth acceptance. Practitioners, reasonably, do not have expertise in the criminal law, and it is unclear what alternative form of technical knowledge they could draw on to determine the 'inconsistency' of a 'circumstance' with non-consensual conception. Rather, it seems likely that individual practitioners would need to exercise significant, largely unmonitored, discretion. In exercising that discretion to determine what does and does not constitute rape, they may act inconsistently or, in the worst-case scenario, use rape myths to evaluate allegations.

31. Alexandra Topping, "How Can Labour Deliver on Its Pledge to Halve Violence against Women and Girls?," *The Guardian*, October 13, 2024, sec. Society, <https://www.theguardian.com/society/2024/oct/13/labour-violence-against-women-and-girls-vawg-policy>.

32. Laura Johnson, "Economic Abuse within Intimate Relationships," in *The Routledge International Handbook of Domestic Violence and Abuse*, ed. John Devaney et al., 1st ed. (Abingdon, Oxon; New York, NY: Routledge, 2021: Routledge, 2021), 297–310, <https://doi.org/10.4324/9780429331053-23>.

In other words, this research suggests that practitioners will *either* affirm survivors' understandings of what constitutes non-consensual sex, or run the risk of applying contested definitions of the same, potentially depriving survivors of a benefit they are entitled to. In this sense, they are – at best – gatekeepers for gatekeepers' sake: tasked with *credentialing* rather than *verifying* a disclosure. In the context of sexual violence, where disclosures can be experienced as highly distressing and even retraumatizing, this is *simply unacceptable*.

This report recommends that, if the repeal of the two-child limit is delayed, the state should immediately shift to a different evidence model with respect to its non-consensual conception exception. In short, claimants eligible for the two-child limit should be permitted to self-certify.

In practice, what is currently in place is already a form of self-certification, albeit with an intermediary. Amongst other things, moving to full self-certification would put an end to forced disclosures, and address pressing issues of access, policy knowledge, and expertise. It would protect women from possible re-traumatization, and the various pitfalls of third-party involvement.

There is no evidence-based reason to suspect that a self-certification model would be abused, or be abused any more freely, than the current model. There is no evidence to suggest that women routinely overestimate what constitutes sexual violence and little indication that practitioners would routinely contradict them even if they did. The current model does not require any assessment of veracity, and the pervasive idea that women systemically lie about non-consensual sex has been roundly disproven. What is more, the rape exception ties a child's life to the violent conditions of their conception. The idea that women would be prepared – with any meaningful regularity – to fabricate such a tie, is implausible at best.

Recommendation 3: Increase the number and kind of professionals able to certify eligibility for the rape clause



Yeah, I'm not sure why my MBCHB [medical qualification] makes me more able to listen to this person.

General Practitioner

If the repeal of the two-child limit is delayed, and the state refuses to implement a self-certification model for rape clause administration (as recommended above), it should **create a wider pool of professionals with approved third-party status as a matter of urgency**.

Whilst, technically, all recipients of 'Universal Credit' should have access to an approved third-party (due to 'universal service' involvement), there are a number of compelling reasons to create a wider pool of professionals with approved third-party status, allowing a wider diversity of professionals to administer the clause. In brief, increasing the diversity of approved third-parties could: support best practice; limit coerced disclosures; overcome access barriers; and increase specialist service involvement.

Practitioners interviewed for this research routinely said that, whilst they would struggle to fully support a service user whose history of sexual violence was not known to them, they would feel relatively confident in certifying rape clause eligibility if they had existing knowledge of a non-consensual conception. This suggests that the rape clause could be more effectively administered if those with pre-existing knowledge of a non-consensual conception were permitted to act as an approved third-party, whenever possible. The likelihood of this being the case is increased if approved third-party status is widely distributed.

As discussed, survivors often find disclosing sexual violence challenging. It is therefore imperative that they are not obliged to make a disclosure to someone they do not know or trust. Again, widening the pool of approved third-parties could facilitate this. And of course, increasing the type and number of approved third-parties decreases the chance that a survivor will encounter considerable access challenges (e.g., a waiting list).

Beyond this, it could also be advantageous to provide increased access to specialist and tailored support. Universal Credit is a complex benefit, and many people require assistance to ensure they are claiming their full entitlement. Some rape clause eligible claimants may find it easier to disclose to an individual already helping them in this respect (e.g., a Citizens Advice Bureau worker) rather than a health visitor or social worker who does not understand welfare benefits. Moreover, many practitioners interviewed for this report told me that they worked collaboratively with community and welfare officers (who were expert in supporting service users to maximise their benefit income) and counsellors (who could support a service user in negotiating the aftermath of sexual violence) but who did not – themselves – qualify as approved third-parties. Many said that if they did receive the necessary approvals, they would be inclined to refer rape clause eligible survivors to them.

The explanatory note to the *Social Security Amendment Regulations 2017* indicates that the approvals process for third-party evidence gatherers is designed with change in mind:

"The list of third parties from whom we will accept evidence in the case of the rape exemption will not be listed in the Regulations, but will instead be set out in guidance, so as to retain flexibility to adjust the list in the future."

Widening the pool of potential approved third-parties may therefore be a procedurally straightforward way to improve the front-line administration of rape clause certification.

Recommendation 4: Improve awareness of the measure



But often we aren't trained in that and it just becomes, like, we'll get an email with this guidance, probably, and then suddenly it will be, that's now your job. But somebody should come and talk to us about what that conversation should look like, where you should direct someone. Because it's not just, like, okay, well, yes, you apply for benefits and, yes, I can say you've been raped.

Health Visitor

In lieu of meaningful, and much needed, structural change (the repeal of the two-child limit or the implementation of a self-certification model) it is imperative that all approved third-parties, and gatekeepers working in related organisations, are provided with necessary information and training.

In the present system, one of the most significant barriers to exception access is a lack of rape clause knowledge or informational literacy among practitioners, many of whom are unaware that they may be asked to administer the rape clause. The state must proactively alert practitioners to this fact as a matter of urgency. What is more, clarified guidance and training resources – which recognise the limitations of practitioner expertise and insight with respect to sexual violence, addresses the inconsistencies that may arise from differing understandings of non-consensuality, and takes a victim centred approach – should be developed and disseminated widely. This information and training should be developed with specialist sexual violence services and survivor reference groups and networks, tackle rape myth acceptance and disabuse practitioners of common rape related misunderstandings, and provide clarity on how on the spot assessments of historic capacity can be performed.

This information should also be made widely, proactively available to potential claimants, both to alert them to a potential benefit entitlement, and to give them a clear sense of what practitioners should and should not do when certifying eligibility, as well as what to do if they are mistreated.

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