

# Derbyshire and Derby City

## Practice Guidance for management of survivors of non-recent abuse in childhood

**There is a separate Strategy for survivors of non-recent abuse in childhood**

**Final version – March 2018**

Sign off by Derby and Derbyshire Safeguarding Children Board Policy and Procedures group

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## **Derbyshire and Derby City Practice Guidance for survivors of non-recent abuse in childhood – (There is a separate Strategy for survivors of non-recent abuse in childhood)**

**This guidance should be read in conjunction with Derby and Derbyshire Safeguarding Children Board policies and procedures.**

<https://www.derbyshirescb.org.uk/>

<http://www.derbyscb.org.uk/>

### **Rationale**

These practice guidelines have been developed to provide a framework for the safeguarding partnership across Derby and Derbyshire to follow in situations where a person makes an allegation of non-recent childhood abuse.

There is a growing recognition that a disclosure of non-recent abuse may reveal current risks to others from an alleged perpetrator. Some high profile cases e.g. Savile, show the potential extent of abuse by one individual.

All front line public servants and their management have a duty of care to their clients, and in the safeguarding of others. This may place them in complex positions when trying to negotiate and balance their duties and responsibilities. The practice guidelines have been developed to help to address some of these dilemmas. It will outline options for responding to disclosure and help front line staff to be clearly accountable for the decisions they make. It is hoped that this framework will enable any response to be as effective as possible in supporting adults at risk, as well as in ensuring they meet their duty to safeguard children and young people or adults who may be at risk now.

At the time of writing this strategy, an Independent Inquiry into Child Sexual Abuse (IICSA) is currently underway investigating whether public bodies and other non-state institutions have taken seriously their duty of care to protect children from sexual abuse in England and Wales. It is expected that this will take some time to be completed and may result in further guidance and possible legislative changes.

Safeguarding Adults guidance started with 'No Secrets' (2000) which provided a code of practice for the protection of vulnerable adults although there was no statutory requirement to implement this. The Care Act 2014 has replaced 'No Secrets' and for the first time, sets out a clear legal framework for how local authorities and other parts of the health and care system should safeguard adults at risk of abuse or neglect. In accordance with The Care Act (2014) the focus is on making safeguarding personal and where possible, facilitating the individual to make decisions regarding their safety and well-being, for them to be an integral part of the safeguarding process.

## Context and Background

The National Society for the Prevention of Cruelty to Children (NSPCC) defines non-recent abuse (also known as historical abuse) *as an allegation of neglect, physical, sexual or emotional abuse made by or on behalf of someone who is now 18 years or over, relating to an incident which took place when the alleged victim was under 18 years old.*

It is also important to recognise that a young person, less than 18 years old, may disclose non recent abuse, although this would be addressed in accordance with Safeguarding Children's Board policies and procedures.

Language in this area can be complex, so for clarity the following definitions are used:

- **Trauma** - This term is widely used but in this context refers to a 'stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost everyone' (ICD-10 1994). This is usually subdivided into two types of adverse and abusive life events (Terr 1991).
  - Type 1 trauma: Single-incident trauma, e.g. sudden and unexpected events which are experienced as isolated incidents such as road traffic accidents, rapes or terrorist attacks. This can happen in childhood or adulthood.
  - Type 2 or Complex trauma: This is often defined as traumatic events which are repeated/ long-term, interpersonal abuse, occurring on multiple occasions and often (although not always) beginning early in life (Herman, 1997). Complex Trauma includes all forms of childhood abuse which is chronic and cumulative such as childhood sexual abuse, childhood physical abuse, witnessing domestic abuse and neglect. Domestic abuse is the most common experience of complex trauma in adulthood.
- **Abuse** - Abuse can take a number of forms; emotional/verbal, physical and sexual but is always something that happens within a relationship, usually with someone who you know. Examples include childhood sexual abuse, childhood physical abuse, and neglect.

In the last few years, there has been increasing public awareness of the extent of historic child abuse, particularly sexual abuse. There has been high profile media coverage about non-recent abuse allegations by adults who have come forward about maltreatment in children's Local Authority Residential Care Homes and other statutory care establishments. Allegations have also been made within the English and Irish churches, and there have been a number of high-profile cases involving 'celebrities' as alleged perpetrators.

People often delay disclosure of abuse into adulthood (Read et al., 2006), however, publicity around these cases may make it more likely that people will disclose information that they may have previously felt too frightened or ashamed to share. The NSPCC reported an 84 per

cent increase in disclosures of abuse to its helpline, with 600 cases referred to the Police and social services after the Savile scandal (Ramesh, 2013).

### **Adverse Childhood Events (Key Points)**

Adverse Childhood Experiences (ACE) - This is an increasingly used term which describes the experience of range of adversity in childhood including abuse, neglect but also parental substance misuse, parental separation or incarceration, parental mental illness and living in care.

### **How common is this?**

Living through abuse and trauma is more common than often previously recognised. The World Health Organisation reports that 20% of girls and up to 10% of boys experience sexual abuse in their childhood. In some specialist services, prevalence rates are often much higher, for instance 75% of women and men in substance misuse services report abuse and trauma in their lives (WHO 2014).

It is now a well-researched and robust finding that survivors of trauma and complex trauma are at higher risk of a range of health, mental health and social difficulties (e.g. WHO 2014, Scot PHN 2016). It is important to stress; this does not mean any particular individual survivors will develop these difficulties but that they are at a higher risk and that the more trauma and complex trauma that is experienced by individuals, the higher the risk becomes. It is now well recognised that there is a common pattern of mental health difficulties which has been called Complex Post Traumatic Stress Disorder. Following many years of research this is to be included in the International Classification of Diseases (ISD-11) which is due to be published in 2017.

A recent survey in Wales (2015 Public Health Wales NHS trust), replicated the international research and found that those with 4 or more experiences of adversity and abuse in childhood were

- 4x more likely to be a high risk drinker
- 6x more likely to have had or caused an unintended teenage pregnancy
- 6x more likely to smoke
- 14x more likely to be a victim of violence
- 15x more likely to be a perpetrator of violence
- 16x more likely to have used heroin
- 20x more likely to be incarcerated

The development of these high risk health behaviours is easier to understand when viewed through the lens of being a survivor. For individuals affected this is likely to be complex and unique but overall we can start to think about these risky behaviours being a result of the impact of trauma or an attempt to cope with this impact.

### **Why is this relevant to my work?**

Survivors experience two significant areas of difficulty in relation to their health

1. Increased risk of health and social difficulties because of the direct and indirect consequences of their experience.

Direct impacts might include; difficulties in developing safe and trusting relationships, post-traumatic stress difficulties, disruptions to education, lack of capacity to develop skills in managing distress and emotional reactions (due to being subjected to 'insurmountable challenges' which overwhelm survivors coping strategies, particularly for those effected in childhood). Indirect impacts can include; unsafe coping strategies developed to manage their distress, this can include reliance on alcohol or drugs, self-harm and an impact on their eating patterns and all of these can have long term health and mental health harming consequences. Poorer relationships with others is crucial as we know that safe and supportive relationships are a key predictor of resilience in the face of difficulties that is turning insurmountable challenges into manageable ones (Couper and Mackie 2016).

2. Difficulties accessing services or maintaining access with services

This is again a complex area, but some elements which might be important include difficulties with trusting staff, difficulties with procedures that involve touch, not feeling understood by services and frequent disengagement for instance difficulties attending appointments.

### **Practice Guidance**

Having someone disclose historical abuse to you can feel unsettling, and can raise a number of questions for us as professionals. This practice guidance aims to support people in the workforce of Derby City and Derbyshire, to offer a consistent approach to survivors of non-recent abuse with an underlying approach of treating people with dignity and respect.

Whilst it is acknowledged that a number of people disclose non-recent abuse in therapy, it is possible for people to disclose when accessing a range of health and social care services, and within the criminal justice system. Therefore, this practice guidance is intended for use by staff working within health, social care, Police, probation and other appropriate services.

### **Incidents of abuse**

Key findings from a recent report (Bentley et al, 2017) included:

- "In recent years there has been an increase in emotional abuse as a reason for children being subject to a child protection plan in England and Wales, and increasing numbers of contacts to the NSPCC helpline about the issue.
- There has been an increase in public reporting of child abuse. In 2016/17 the NSPCC helpline responded to its highest ever number of contacts.
- There have also been increases in Police-recorded child sexual offences and indecent image offences across the UK and increases in child cruelty and neglect offences in all UK nations except Scotland.
- The last decade has also seen increased numbers of children on child protection plans and increased numbers of looked after children in the UK.

- But, without a new survey of child maltreatment prevalence we lack a clear picture of the extent of child abuse and neglect today. That's why we are calling on the UK Government to commission a new UK-wide study.
- Strong associations were found between maltreatment, sexual abuse, physical violence, and poorer emotional wellbeing, including self-harm and suicidal thoughts."

Some of the challenges of child abuse statistics include that some people may never disclose; some may not disclose until adulthood, and some people may only disclose anonymously to a helpline (for example NSPCC; ChildLine) and this can impact on accurate reporting as the location of the person may not be known (Bentley et al, 2017).

Research has been conducted by University College London (UCL) on behalf of the NSPCC in relation to the cost of child abuse and neglect, (Conti, G. et al, 2017) it does not however, include the intangible costs of abuse to those involved, including emotional distress, impact on relationships and so on. The study included a literature search, which concluded "having experienced any form of child maltreatment was associated with worse mental health outcomes, smoking behaviour, alcohol use, lower probability of employment, and greater welfare dependence." (Conti, G. et al, 2017)

## **Sexual abuse**

According to Radford et al (2011), 1 in 20 children in the UK have been sexually abused.

A recent report by The Centre of expertise on child sexual abuse (CSA, 2017) reviewed available research and made comparison with information from national statistics. This report highlighted that the level of child sexual abuse reported in surveys was much higher than that recorded by agencies. Furthermore, there are challenges in comparing data due to the way organisations record differently. For example, in 2015/16:

- The Police recorded 53,811 Child Sexual Abuse (CSA) offences in England and Wales;
- 3,090 children were on child protection plans for sexual abuse in England and Wales;
- 28,600 children assessed at risk of CSA by children's services in England.

(CSA, 2017)

In terms of statistics on perpetrators, there are similar problems around clarity of figures due to under-reporting. In March 2012, there were 40,345 individuals registered as sexual offenders in England and Wales (Ministry of Justice, 2012). Of these, 29,837 were on the Register for Sexual Offences Against Children (NSPCC, 2012).

Research shows us that the majority of people who have perpetrated sexual offences against children are men (Bagley, 1995), and that most perpetrators are personally known to their victims (Snyder, 2000). Only 5% of sexual assaults committed against children are perpetrated by strangers (Snyder, 2000). A small proportion of childhood sexual abuse is committed by females: 3.9 per cent (McCloskey & Raphael, 2005). This also continues to be under-reported/unrecognised, and there are particular barriers to people reporting sexual abuse by female perpetrators.

## **Other forms of abuse**

Whilst sexual abuse appears to receive the greatest coverage by the media it is important to remember that other forms of historical abuse can include physical, emotional, neglect, psychological and all forms of Domestic Abuse. All forms of abuse can have lifelong damaging effects which can have an intergenerational impact including where the young person has been physically abused by an adult/older person and where they have felt at risk or have been threatened with violence, (Bentley, H. et al, 2017)

## **Perpetrator Profile**

Abuse will often involve the corruption of a trusting relationship through a process commonly termed 'grooming'. People may perpetrate abuse for many years, and they can abuse the same victim or a number of victims over this period of time (Salter, 2003). Abusive behaviour is now recognised to be addictive and involves a number of cognitive distortions, such as denial, minimising of harm and victim blaming so that the offender will often not take responsibility for their behaviour or see it as personally problematic at the time. It is common for offenders to seek positions of trust, either in their personal lives or through employment, which allow them to gain access to children and young people (Sullivan & Beech, 2004).

## **Issues facing front line staff when a non-recent abuse allegation is made:**

People who are survivors of abuse may have a range of reasons that they have been unable to disclose their experiences, such as:

- fear of not being believed;
- fear of being blamed by others for what has happened;
- feeling shame about what happened to them;
- fear caused by threats by the perpetrator or by those who oppose the disclosure;
- love or attachment to the perpetrator who has abused them;
- being in denial about what has happened or experiencing dissociation triggered by memories of abuse;
- fear that they are the only person that this has happened to;
- fear that the family will break up as a result of disclosure;
- fear of racism;
- gender stereotyping;
- fear of excommunication or exclusion from a community/religious/peer or work or social group;
- fear that they may lose their job, damage their position on a career ladder or be deprived of opportunity for advancement;
- fear of being deprived of a place to live or any opportunity for moving on;
- fear of re-victimisation due to the prospect of strongly marshalled (often legally supported) counter-attack by the alleged perpetrator and associates;
- fear of re-traumatising effects of giving detailed evidence to the Police;
- fear of loss of control over their personal information; for example having to give consent for the Police to have their medical history;

- Fear of court processes and their ability to withstand them.

Being overwhelmed by these issues may increase the risk of mental health problems, risk of self-harm or suicide, loss of day to day functioning and ultimately disengaging from agencies

These feelings will be heightened by the prospect of wider disclosure to other agencies. In addition, victims/survivors may also have had difficult experiences within the mental health system, such as being sectioned under the Mental Health Act (1983, 2007), working with multiple clinicians over a long period of time, facing social exclusion and stigma due to their mental health problems/having a learning disability/ alcohol or substance misuse, or facing other hardships, such as trying to live on a low income, domestic abuse, being a parent of children with complex needs.

Some people may have internalised unhelpful stereotypes about having mental health issues and feel that no one will listen to them or take them seriously. Adults who are parents may fear that professionals may question their parenting and that their children may be taken into Local Authority care. These fears may be considerably more impactful where a person also has problems with substance use or a previous negative experience of services.

Some people may have disclosed abuse before and been disbelieved or silenced as a result of trying to tell. People with learning difficulties/disabilities may face obstacles in being able to communicate what has happened to them.

These are all barriers for people contemplating or making disclosures.

## **Confidentiality**

There may be circumstances when a front line worker needs to breach confidentiality in order to safeguard others. Most understand that the duty to respect confidentiality is not absolute; nevertheless every front line worker must clearly outline the parameters of confidentiality whenever they begin assessment or therapeutic work with an individual or a family.

It is important to establish an understanding about confidentiality, sharing information and boundaries within the therapeutic relationship when working with individuals and families. An individual should know in advance of the reason a professional might disclose anything, and that they may not be permitted to keep secret the information the client has disclosed. Honesty is crucial to protect the relationship between the worker and the individual through disclosure and support.

As a general rule, confidentiality will always be respected, and there are limited exceptions permitting breach of confidentiality without an individual's consent where there is sufficient evidence to raise serious concern about:

- (a) the safety and well-being of clients;

- (b) the safety and well-being of other persons who may be endangered by the alleged perpetrator's behaviour; or
- (c) the health, welfare or safety of children or vulnerable adults.
- (d) there is evidence that a crime has been committed

The Caldicott Principles (1997, 2013) were drawn up in response to changes in information technology and recommendations arising from national safeguarding children reviews to ensure the duty of confidentiality is not used as a shield against sharing information on a need-to know basis hindering management of safeguarding concerns.

## **Decision-making**

The Health & Care Professions Council (HCPC) states that:

*If you make informed, reasonable and professional judgements about your practice, with the best interests of your service users as your prime concern, and you can justify your decisions if you are asked to, it is very unlikely that you will not meet our standards. By 'informed', we mean that you have enough information to make a decision. This would include reading these standards and taking account of any other relevant guidance or laws. By 'reasonable', we mean that you need to make sensible, practical decisions about your practice, taking account of all relevant information and the best interests of the people who use or are affected by your services. You should also be able to justify your decisions if you are asked to.*

## **Actions for front line staff following a disclosure of non-recent sexual abuse:**

**Stay Calm-** It may be uncomfortable to listen to, but it is important not to appear shocked or upset. It may be helpful to express a genuinely sympathetic response which conveys that you care about what has happened to them but that conveys that you are not distressed and can cope with what they are saying.

**Take time to listen** – Being listened to can be liberating for people, particularly when they may have been ignored/ disbelieved, or indeed have not had the confidence to disclose previously. Making a disclosure of abuse can be a frightening prospect, and having chosen you to speak to about this often means they are comfortable speaking to you.

**Try to de-shame** - Survivors often feel ashamed and this feeling is notoriously difficult to release and may take professional help. However, it is always good practice to make it clear that this is not their fault, whatever and however this happened it is always the responsibility of the abuser. Be clear that they have done nothing wrong and that any actions you may need to take next are purely about keeping others safe and that they will not be punished. This is particularly important as adult survivors can revert to a 'child state' when disclosing and therefore they may have all the fears and confusion of a child and not be able to access helpful adult logic and experience.

**Take them seriously** - Do not ignore or dismiss the person's feelings. Being believed is extremely important. It is not your job to investigate, if someone has disclosed non-recent abuse to you, it is reasonable for them to be believed.

**Be clear about confidentiality** - Early on in the conversation you should make it clear that you may not be able to keep the allegation confidential. Explain that you will need to discuss the disclosure with your line manager and reassure the client that you will keep them informed of any actions before any next steps are taken. Next steps will usually involve informing the Police and Social Care with the consent of the survivor. The consequences need to be fully understood by the worker and the survivor before reporting into the Police.

**Do not ask probing questions** – Leave this for the Police. Allow the survivor to lead the responses as they will understand the position they are in more than anyone else

**Record the disclosure as fully as possible** - Record keeping should be in line with your organisations policies and include:

- The names and job titles of all those professionals that have been contacted;
- The date, time and method of contact;
- Any allegations recorded using the client's own words and phrases;
- The rationale behind any clinical decision-making and actions; and
- If it has been necessary for action to occur without the client's knowledge or consent.

If any other professionals within or across agencies are contacted to discuss safeguarding concerns, then it is important to keep records of the following:

- To whom you spoke and their job title;
- The reason that you spoke to the professional;
- Whether this was a consultation where you did or did not name the client;
- What information was shared and what the key points of the discussion were;
- What actions you agreed on the basis of the discussion, along with timescales and responsibilities attached to these;
- Any decisions or plans to discuss/not discuss any further safeguarding actions with the client;
- Whether it has been necessary for the conversation to occur without the client's knowledge or consent; and
- Any follow up to actions.

Where conversations have had to occur without the client's knowledge or consent, notes may need to be stored and clearly marked as third-party information within the documentation, so that it is restricted from the client at that time, and so that any safety issues are not inadvertently compromised, e.g. another worker inadvertently disclosing that there have been safeguarding conversations may be harmful to the client and inadvertently endanger other children.

**Assess immediate risks to the person and identify sources of ongoing support** – Be mindful that making a disclosure can be re-traumatising, and can trigger symptoms of trauma which can be distressing, including flashbacks, and nightmares. Clarify whether or not there are immediate needs for support following the disclosure. For example, do they have any urges to self-harm or any other risky behaviour.

If so, agree a simple safety plan with the person to include:

- What are the biggest risks at the moment;
- What can they / others do to minimise these;
- Who can contact if they require support;
- What to do in a crisis.

Make sure you have contact details for the client and have offered a further appointment/meeting in the near future in order to keep in contact with the client to identify any additional needs including health care.

**Ongoing support** – Be mindful that making a disclosure can be re-traumatising, and can trigger symptoms of trauma which can be distressing, including flashbacks, and nightmares. Clarify whether or not there is an immediate need for support following the disclosure. Make sure you have contact details for the client and have offered a further appointment/meeting in the near future in order to keep in contact with the client to identify any additional needs including health care.

### **Grounding Techniques:**

Some people are less able to regulate their emotions and stay within a “window of tolerance” (Siegel, 1999) when talking about their traumatic experiences. It is helpful then to intervene at these points to ‘ground’ the client, in other words to re-orient them to their present reality and a sense of stability within themselves.

Here are some examples, some of which can be adjusted to use on the telephone:

1. **Re-orienting to the face and voice.** “Come back to me (or to being here in the room). I’m right here with you. Notice that you are in (name the room) and you’re safe. Can you see me here with you? Look around and remember that was only a memory and that you are here with me safe and sound.

2. **Breathing and posture** - There are many variations on this (see soothing breathing guidance) however the key things are to help clients tune into their breathing, to breathe slowly and evenly in a rhythm which is comfortable for them but which is much slower than normal. Help them to sit straight and feel the support of the chair against their back and the bottom of their feet on the ground.

3. **Pillow Toss.** Play catch with a soft object – the act of catching requires a rapid orientation of attention to the object and therefore away from past memory etc.

4. **Mental Arithmetic.** E.g. ask them to start at 100 and keep subtracting 7.

5. **5 times 5.** Ask the client to identify 5 items around the room and describe each one visually, then identify 5 smells, then 5 sounds and then 5 textures.

All of these interventions require the client to 'shift states' from focusing on emotion to focusing on cognitive or perceptual or sensory domains. They can help the client feel more present and aware of their current safety.

## Recovery

People may ask you if they will ever 'get better,' they may also say 'I just have to get on with it.' Recovery from even the most severe trauma is possible, and survivors can go on to lead fulfilling lives where they may have previously struggled. However, we do acknowledge that learning to cope with the effects of trauma is not without challenge. The journey of recovery from trauma requires 'time, determination, and often support from others' (Cwm Taf University Health Board, 2014).

Not all the resources available (for example, distancing and distracting, use of grounding techniques) will be right for the survivor and it may take some time before strategies seem to make a difference. It is common for recovery to happen in small steps, may include the need to grieve from trauma, and sometimes things may deteriorate before they improve (Hill, 2016, updated 2017).

### **Actions for Professionals / Managers following a disclosure of non-recent sexual abuse:**

Professionals and Managers should familiarise themselves with the content of this procedure, including reference to what information should be provided to support Police and social care to make an informed decision.  
[http://derbyshirescbs.proceduresonline.com/p\\_adults\\_dis\\_historical.html](http://derbyshirescbs.proceduresonline.com/p_adults_dis_historical.html)

**Take time to listen and take any disclosure seriously** – Remember as an accountable officer you may need to justify what you knew, when you knew it and what you did about it in a future review.

**Every case is different** - What you need to know as a manager to help you make a decisional choice:

- The client discloses abuse and is **prepared to make a formal statement to the Police** (i.e. to report a crime) = The client should be encouraged and supported to make their own contact with the Police or the front line worker can do this with the client.
- The client discloses abuse and gives **consent to the front line worker** to make an informal/anonymous report to the Police or social services on their behalf. The client should be encouraged to provide personal details before the worker goes ahead to make an anonymous referral – There is anecdotal evidence that people are willing to provide personal information for the sake of helping to reduce the risk of abuse for other children.
- The client discloses abuse and is **not well enough to make their own report** to other

agencies but the worker has sufficient information and believes that the risk is substantial enough towards children to require referral to Police and children social care. In these cases a referral should be made and the manager and worker should consider the risk to the client and keep the client safe through supportive care planning.

- The client discloses abuse **but does not wish it to be reported to other agencies** but the worker has sufficient information and believes that the risk to children is substantial enough to require referral to Police and social care. In these cases a referral should be made and the manager and worker should consider the risk to the client and keep the client safe through supportive care planning.
- **Provide supervision and support to the worker** - To ensure best practice is maintained and risk factors are well managed. Also, to support the worker who may be managing challenging behaviours and complex situations

### **Referral Process – following Derby and Derbyshire Safeguarding Children Board Procedures**

<http://derbyshirescbs.proceduresonline.com/index.htm>

<http://www.derbyscb.org.uk/>

#### **Report disclosures of non-recent childhood abuse to:**

**Police** on Tel: 101

**Derbyshire County = Starting Point (via Call Derbyshire) on Tel: 01629 533190**

**Derby City = First Contact Team on Tel: 01332 641172 or Out Of Hours Tel: 01332 786968**

Prepare to complete the online child referral form on the relevant Local Safeguarding Children Board website.

#### **Next Steps – Following a referral of non-recent abuse in childhood.**

The Police have specially trained detectives available to interview victims of abuse, and when clients are ready to do so, being interviewed by professionals with the appropriate skills can be a helpful part of the recovery process. However, for some being interviewed in detail this may not be experienced as helpful at all. It may be experienced as highly intrusive and threatening and therefore also have the effect of heightening distress and intrusive memories temporarily.

It is helpful to provide clients with information about what to expect when they make a disclosure to the Police or other agencies. They need to be aware that one outcome may be that they may face a long wait of several months if their evidence is passed on to the Crown

Prosecution Service (CPS), who will decide on whether there is enough evidence to proceed with a case through to court.

Clients should also be supplied with information about making a complaint, should they feel that their case has not been appropriately handled.

Where an adult is known to adult mental health (AMH) services consideration should be taken to involve an AMH worker/or AMH specialist in interviews with the Police and Social Care to provide support.

It is essential to have clear lines of communication between Police, Social Care and AMH to ensure that joint consultation takes place in order to keep clients and children safe.

Requests for Adult Mental Health support should be made via Derbyshire Healthcare Foundation Trust on Tel: 01332 623700 ex 31537 and ask to speak to the Head of Safeguarding Adults.

There is a multi-agency practice guidance being developed for staff in relation to 'Non-recent abuse disclosures,' by key leads in health, Police and social care. The practice guidance will include a leaflet for survivors and scenarios regarding likely Police response to different types of disclosure.

### **Strategy discussions/meetings**

Where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm a strategy discussion/meeting should take place as per Derby and Derbyshire Safeguarding Children Board procedures.

[http://derbyshirescbs.proceduresonline.com/p\\_ch\\_protection\\_eng.html](http://derbyshirescbs.proceduresonline.com/p_ch_protection_eng.html)

The strategy discussion/meeting should be recorded in writing. It should be multi-agency, and include Police, Social Care and Health as a minimum requirement to share information, discuss both safety and risk to children or adults at risk who may be at risk from the alleged perpetrator, and take careful consideration of the client's mental health and wellbeing.

As the person who has most contact with the client, the front line worker may be asked to speak with the client further. It is important to establish clear roles and responsibilities of those involved and the need for witness statements need to be considered.

In the strategy meeting, plans and outcomes should be clearly agreed, what is known by whom should be clearly established, and there should be agreement on how to manage issues regarding what information will be shared and with whom, especially if it has been necessary to act without the client's current knowledge or consent.

In cases where the strategy meeting agrees to no further action at that time, the information that has been supplied about an allegation will still be logged with safeguarding agencies. If at a later date, further complaints are raised about a named alleged perpetrator, this name can then be cross-referenced to previous allegations.

Statutory Guidance on inter-agency working (Working Together 2015), illustrates the next steps in the process that social care and /or the Police may take if it is thought that a named child is believed to be at risk of harm.

Social care investigates to see whether any named children are known to them and where a child may be in need of protection. If not known, the Police will check whether the alleged perpetrator is known to them already, potentially through Multi Agency Public Protection Arrangements (MAPPA). This concerns known offenders and if there it is felt to be immediate significant risk to children, then safeguarding agencies will need to intervene.

### **Supportive measures for those identified as having an associated health need**

As previously discussed in this strategy/guidance, there are several risks and challenges to take into account when working with the complexities provided by survivors of non-recent abuse in childhood.

Each case is different and requires different approaches and timescales to facilitate best outcomes for bringing perpetrators to justice and for bringing therapeutic resolution for the survivors of childhood abuse who have already suffered and have demonstrated their bravery in order to keep future generations of children safe. Appropriate practical, emotional and psychological support may keep people safe and can sometimes help to resolve long-standing issues of complex trauma and in turn improve mental and physical health.

***Care pathway for survivors of non-recent abuse in childhood with identified health needs as below in Table 1.***

### **Support mechanisms following and through the court processes**

In accordance with practice guidance compiled by The Department of Health, The Crown Prosecution Service and the Home Office, a person should not be prevented from accessing therapy or support for mental health difficulties before, during or after court processes. Guidance on the Management of Disclosures of Non-Recent (Historic) Child Sexual Abuse (2016) <https://www.bps.org.uk/news-and-policy/guidance-management-disclosures-non-recent-historic-child-sexual-abuse-2016>

There are a number of considerations which need to be made, who leads on this will depend on the wishes and feelings of the client and local services available including:

- Consideration of additional needs and related support required;
- The timing, type and provider of therapy;
- Who needs to be involved and aware of support being offered and key issues regarding evidence which may be disclosed during therapy.

### **Support contact details for survivors of and those affected by Abuse:**

**Samaritans** 116 123 UK (open 24/7)

#### **CISTers (Surviving Rape and/or Sexual Abuse) 02380 338080**

Answerphone 023 80 338080 is usually monitored daily during the week and callers can choose to leave their name and phone number, and we will call them back and will take care when doing so. Or can email [admin@cisters.org.uk](mailto:admin@cisters.org.uk)

The helpline is available to female adult survivors of childhood rape/sexual abuse, and others can call if they have a concern about such issues. In the case of the latter we will seek to signpost them to appropriate services.

#### **HAVOCA – Help for Adult Victims Of Child Abuse**

HAVOCA is run by survivors for adult survivors of child abuse. “We provide support, friendship and advice for any adult who’s life has been affected by childhood abuse.” Please note: HAVOCA does not offer telephone support, they say they offer a number of resources online. Website: <https://www.havoca.org/>

#### **MOSAC (Mothers of Sexually Abused Children) 0800 980 1958**

Supporting all non-abusing parents and carers whose children have been sexually abused. We provide various types of support services and information for parents, carers and professionals dealing with child sexual abuse.

Website: [www.mosac.org.uk](http://www.mosac.org.uk)

#### **The National Association for People Abused in Childhood (NAPAC)**

Call 0800 085 3330 for free from landlines, 3, Orange and Virgin mobile phones.

Call 0808 801 0331 for free from O2, T-Mobile and Vodafone mobile phones.

NAPAC provides a national freephone support line for adults who have suffered any type of abuse in childhood.

Telephone support line opening hours: Monday – Thursday 10:00am-9.00pm and Friday

10.00am-6.00pm Website: <http://napac.org.uk/?gclid=CPzLmqmCtMsCFUKZGwodpd0FQg>

#### **Safeline**

Safeline is a specialised charity working to prevent sexual abuse and to support those affected in their recovery.

Please see website for details of the different helplines available and times of operation.

Website: <https://www.safeline.org.uk/>

**PODS: Positive Outcomes for Dissociative Survivors**

A project of Survivors Trauma and Abuse Recovery Trust (START)

PODS works to make recovery from dissociative disorders a reality through training, informing and supporting

Helpline: 0800 181 4420 – Tuesdays 6-8pm or appointments at other times by contacting the office

Email: [mail@start-online.org.uk](mailto:mail@start-online.org.uk) (for START) or [info@pods-online.org.uk](mailto:info@pods-online.org.uk) (for PODS)

Website: [www.start-online.org.uk](http://www.start-online.org.uk) and [www.pods-online.org.uk](http://www.pods-online.org.uk)

**SupportLine** 01708 765200

Confidential emotional support to children, young adults and adults by telephone, email and post SupportLine specialises in providing emotional support for adult survivors of childhood sexual abuse and anyone who has been raped/sexually assaulted.

Tuesday, Wednesday and Thursday evenings 5:00pm to 7:30pm

Website: [www.supportline.org.uk](http://www.supportline.org.uk)

**The Survivors Trust**

Support, Advice and Info - 0808 801 0818

The Survivors Trust (TST) is a UK-wide national umbrella agency for 130 specialist organisations for support for the impact of rape, sexual violence and childhood sexual abuse throughout the UK and Ireland.

Website: <http://thesurvivorstrust.org/>

**SurvivorsUK Helpline Web Chat**

National Helpline Web Chat for adult male survivors of rape or sexual abuse  
(Monday – Friday 10.30 – 21:00; Saturday – Sunday 10:00 – 18:00)

Website: [www.survivorsuk.org](http://www.survivorsuk.org)

**SV2 supporting victims of sexual violence**

Helpline 01773 746115 open 8am – 5pm on Monday - Friday

Email: [help@sv2.org.uk](mailto:help@sv2.org.uk)

**SAIL – sexual abuse and incest line**

Helpline 01246 559889 open 1pm – 4pm

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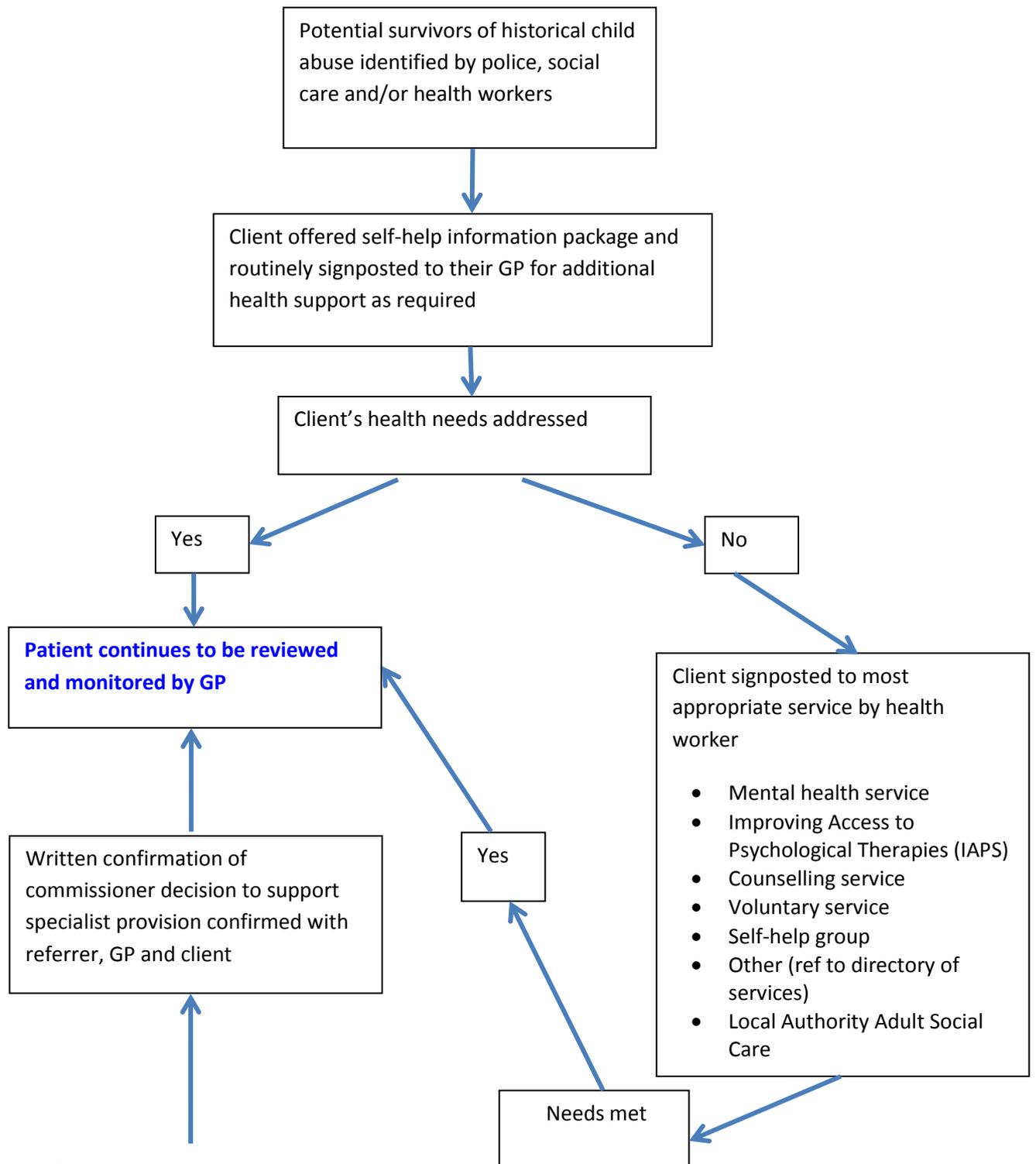
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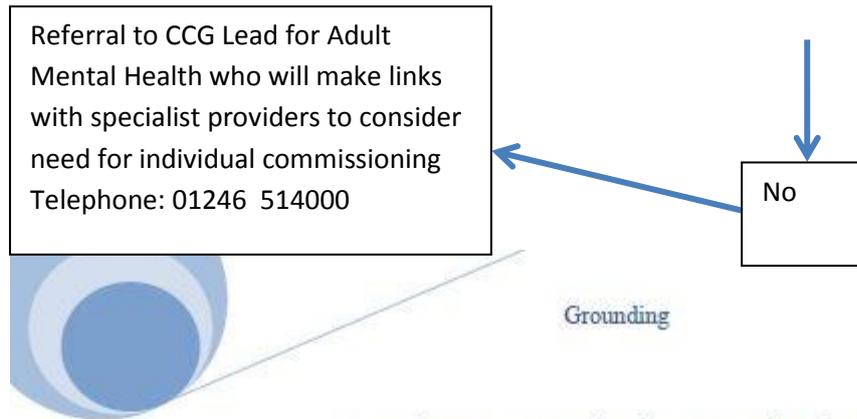
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Derby City Adult Safeguarding Board  
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Domestic Abuse and Serious Sexual Violence Committee  
Derbyshire Health care Foundation Trust  
Derbyshire Clinical Commissioning Group's  
Derbyshire Constabulary  
Derbyshire County Council  
Derby City Council  
Derbyshire Probation Service  
Derbyshire Trauma Informed Network

**CARE PATHWAY FOR SURVIVORS OF NON – RECENT ABUSE IN CHILDHOOD WITH AN IDENTIFIED HEALTH NEEDS (Table 1)**





### Grounding exercise 2: develop a grounding phrase

A grounding phrase is made up of a few words which are positive and remind you that you are surviving in the present.

A grounding phrase acknowledges the feelings you are experiencing, such as fear or panic, and also reminds you that you are safe now. For example, you may use the phrase 'I am feeling **frightened** and I am **safe** now'. The word 'and' is important here. This is sometimes called dual awareness – being aware of 2 different things at the same time.

Alternatively, you may want to use a statement that reminds you of your strengths, such as 'I have survived the past and I am safe now.' Some people find it helpful to leave copies or post-its of their phrase around the house. This allows you to become more familiar with it so you can recall it more easily when you need to ground yourself.

### Grounding exercise 3: Using your body

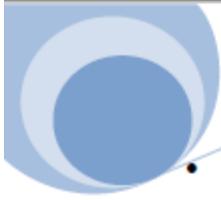
There are also a number of strategies using your body that you may find helpful.

- Using a "grounding object"

A grounding object is a comforting physical object you can hold which carries a positive meaning for you and can distract you when needed. When you start to re-experience unpleasant memories or feelings, hold your grounding object and really focus on its colour and different textures (temperature, roughness, smoothness, etc.).

Your grounding object should be something that you did not own when the trauma happened, and should be small enough to carry with you. For example, you might use a pebble from your favourite beach, or a ring given by someone important to you, or a piece of soft cloth.

Here are some other ways of grounding yourself in the present. Use them until you feel safer.



## Grounding

- Run cool water over your hands, noticing how this feels against your skin.
- Hold on to the arms of your chair as hard as you can, noticing the tension you feel when doing this.
- Touch every individual object around you: your keys, your clothing, a table, the walls. Notice textures, colours, materials, weight, temperature. Compare the different objects you touch: Is one colder? Lighter?
- Notice your body. The weight of your body in the chair; the feeling of wriggling your toes in your shoes; the feel of your back against the chair.
- Walk slowly, noticing each footstep, saying "left" or "right" with each step.
- Eat something, describing the flavours in detail to yourself.
- Focus on your breathing, noticing each breath as you breathe in through the nose, and out through the mouth. Repeat a pleasant word to yourself on each in breath. For example, a favourite colour, or a soothing word such as "safe" or "calm."

### **GENERAL GUIDELINES WHEN USING GROUNDING**

- Grounding can be used any time or place and no one has to know that you are doing it.
- Try to think about the things you notice just as they are, without judging them or thinking of them as good/bad or like/hate.
- Focus on the present and your surroundings. Try not to think about the past or the future.
- Practise as often as possible, even when you are not feeling anxious or overwhelmed. If you are able to use these strategies easily when you already feel relaxed, they will be much more helpful when your feelings, thoughts and/or memories become too intense to cope with.
- Notice which strategies or combination of strategies work best for you.
- Create your own methods of grounding. These may be more helpful than the suggestions here, because they are your own and will be especially meaningful to you.