



The British
Psychological Society

Guidance document on the management of disclosures of non-recent (historic) child sexual abuse



May 2016

Contents

Page

1	Acknowledgements
2	Rationale
3	Key points
4	Introduction
6	Incidence of sexual abuse
7	Actions following a disclosure of non-recent sexual abuse
10	No immediate action
10	Anonymous action
11	Referral to the MASH
11	Report to the police
13	Issues facing practitioner psychologists when a non-recent abuse allegation is made
14	The potential impact on the therapeutic relationship
14	Balancing the needs of the client versus needs of (potential) other victims
15	Breaching confidentiality
17	Decision-making
18	Strategy meetings
20	Special circumstances
20	Assessment and record-keeping
23	What to expect if the client wishes to report a crime
23	Making a formal statement to police
23	Waiting for court and pre-trial therapy
25	Support at court and post-court
26	The wider role of the psychologist
29	Concluding remarks
30	Useful resources
30	The Caldicott Principles – Revised September 2013
31	References

Please note that additional, important resources to support this document can be found at www.bps.org.uk/historicalsexualabuse. We encourage readers to refer to these in conjunction with this guidance.

If you have problems reading this document and would like it in a different format, please contact us with your specific requirements.

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Acknowledgements

Particular thanks to Katie Barrow Grint, Detective Chief Inspector, Oxfordshire Protecting Vulnerable People Unit, Thames Valley Police; Mike Foster, Acting Deputy Director of Nursing and Caldicott Guardian, Oxford Health NHS Foundation Trust; Dr Rebecca Mitchell, Consultant Clinical Psychologist; Martina Mueller, Consultant Clinical Psychologist; Anne Peake, Educational Psychologist; Dr Lucy Johnstone, Consultant Clinical Psychologist; The Faculty of Children, Young People and Families; Sophie Holmes, Consultant Clinical Psychologist; Gill Evans, Jenny Cutler and other members of the Safeguarding Children and Young People Working Group; Alice Scott, Detective Chief Inspector c/o NPCC CPAI Working Group (National Police Chiefs Council Child Protection Working Group) and Graham Marshall, Force Disclosure manager, ACPO Disclosure Advisor, West Midlands Police; Tink Palmer, CEO, Marie Collins Foundation, Visiting Professor of Child Protection, University of Suffolk; Duncan Craig, Chief Executive Officer & Psychotherapist, Survivors Manchester; members of the Division of Counselling Psychology. Thank you to Oxfordshire Safeguarding Children's Board for permission to use their 'Seven Golden Rules for information sharing'. We also extend our thanks to many others who offered comments on the document.

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A note about terminology: It is recognised that some people who have suffered sexual abuse prefer to be referred to as 'survivors' of abuse. This document has attempted to use this term, but also uses the term 'victim' at times, to acknowledge that people have been the victims of a crime.

'Perpetrator' is used to refer to those who have been alleged to have sexually abused children or vulnerable adults. It recognises that abuse refers to behaviours perpetrated against a child or vulnerable adult. The term is not meant to imply that those who abuse are a homogenous group, and neither does it imply that change is impossible, following appropriate, ethical and evidence-based intervention.

Rationale

This guidance has arisen as practitioner psychologists are becoming increasingly concerned about how to respond to client disclosures of non-recent sexual abuse during assessment or therapeutic work. 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 show the potential extent of abuse by one individual.

Practitioner psychologists 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.

This guidance aims to address some of these dilemmas. It will outline options for responding to disclosure and help practitioner psychologists be clearly accountable for the decisions they make. It is hoped that this guidance will enable the psychologist's response to be as effective as possible in supporting vulnerable adults, as well as in ensuring they meet their duty to safeguard children, young people or adults who may be at risk now.

Although aimed predominantly at supporting psychologists who are working with adults in mental health settings, this guidance applies to any setting where historic abuse disclosures may be made, including group work.

At the time of writing, an Independent Inquiry into Child Sexual Abuse (IICSA) is currently 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.

Key points

- Practitioner psychologists have a key role to play in the area of non-recent sexual abuse, both in direct clinical work with abuse victims/survivors and more broadly, working systemically to improve the response to victims of non-recent sexual crime.
- Recent cases of historic/non-recent abuse have highlighted that those who sexually abuse children may present a long-term threat to others. This is the case whether the perpetrator has offended within or outside the family.
- Not sharing concerns beyond the consulting room could mean that other children and young people could be at risk.
- A client's allegations should be taken seriously, regardless of their presenting problems or mental health diagnosis. Psychologists need to be alert to the possibility that abuse may be organised, severe and complex.
- Assessments should always be thorough, and detailed assessment of information is paramount in such cases. The lack of access to children identified through familial relationships, work or volunteering roles should not eliminate concerns about risk, given opportunities for abuse to occur within communities.
- It is crucial that practitioner psychologists seek advice from colleagues, particularly colleagues in safeguarding services, within the organisation and also from other agencies tasked with leading on safeguarding (i.e. social services).
- It is always best practice to share information with the client's knowledge and consent.
- In exceptional circumstances it may be necessary to breach the client's confidentiality either with or without their immediate knowledge and consent. This could be the case where there are significant risks to the client's psychological wellbeing; where the alleged perpetrator may be a current risk to others; or there is risk of jeopardising a potential investigation.
- Any decision to breach confidentiality cannot be taken lightly, but can be justified and accounted for if made in good faith because of safeguarding concerns. This is supported by professional guidance.
- There may be times when, in the interests of supporting a client's psychological readiness for disclosure, therapy may continue without requiring identifying details to be provided to the practitioner psychologist. It is important that a client's lack of readiness to disclose does not become an obstacle to receiving psychological help.
- It is important to recognise and emphasise that while traumatising things can and do happen to people, with the right support and help, people can emerge from traumatic events and still thrive.
- Practitioner psychologists should use regular supervision to ensure their own wellbeing when working with complex cases.

Introduction

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. However, it is also important to recognise that a young person, under 18 years old, may disclose non-recent abuse.

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 care homes. Allegations have also been made within the English and Irish churches and there has been a string of 'celebrity' cases. 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).

Practitioner psychologists are often in a unique position regarding disclosures of non-recent abuse for the following reasons:

- Within multi-disciplinary teams practitioner psychologists are often recognised as the most appropriate professionals to work with people who have been traumatised.
- They may treat people who have been referred for help specifically with a history of child sexual abuse.
- People may disclose abuse as part of their assessment, and practitioner psychologists may be in a unique position to identify perpetrators and potential victims.
- Outside of direct client work, practitioner psychologists may have additional responsibilities where people may discuss or disclose historic abuse, such as:
 - supervision, consultation or training of other staff;
 - feedback about clients at a team meeting;
 - informal discussions with staff or patients in other settings.

There is a large literature on the negative consequences of the untreated trauma of abuse, such as post-traumatic stress, emotional problems, trauma-related beliefs, shame, self-harming behaviours, suicide (e.g. Browne and Finkelhor, 1986; Zwi et al, 2007) and being diagnosed with a 'personality disorder' (Ross et al., 1990).

It is clear that the impact of sexual abuse on mental health can be long-term and profound, particularly if people do not get a helpful response when they disclose, nor access to specialist evidence-based intervention. It is important to counteract attitudes that suggest that survivors of abuse cannot survive traumatic experiences. Professional and societal hopelessness about the future of victims may lead people to believe, for instance, that the survivor will go on to abuse their own children, or that they will never enjoy good mental health. For this reason, it is also important to consider the issue of post-traumatic

growth. Post-traumatic growth refers to experiences of positive psychological change that can result over time following a traumatic event (Calhoun & Tedeschi, 2001). This captures the notion that awful things can happen to people, but with the right support and help, people can emerge from bad events and still thrive.

The experience of disclosure can promote or hinder the potential for post-traumatic growth. For instance, negative responses to disclosure of abuse have been found to lead to increased psychological distress (Easton, 2013). Conversely, positive experiences of disclosure have been identified as important in the process of growth following childhood sexual abuse (e.g. Draucker & Petrovic, 1996). Positive experiences of disclosure allow the person to feel heard, validated and accepted (Woodward & Joseph, 2003). While it is crucial for psychologists to manage the disclosure and adhere to procedures and guidelines in doing so, it is as important to acknowledge and validate a person's experience to foster rather than hinder the potential for post-traumatic growth.

Incidence of sexual abuse

Establishing the true incidence of child sexual abuse is notoriously difficult, because of the hidden nature and under-reporting of this crime. Of an estimated number of victims, a minority of people come forward to report the crime, and of those who do report, only a tiny proportion of cases will be successfully prosecuted. As an example of data indicating the prevalence of abuse, there were 17,186 sexual crimes against children under 16 recorded in England and Wales in 2011/12 (Chaplin et al, 2012). The Ministry of Justice's (2013) report reveals that around 90 per cent of victims of the most serious sexual offences in the previous year knew the perpetrator, compared with less than half for other sexual offences, which is likely to act as an obstacle to disclosure and prosecution.

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 per cent 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.

The abuse will often involve the corruption of a trusting relationship through a process commonly termed 'grooming'. This is a somewhat euphemistic term, given that this process can actually involve the use of violence, the threat of violence or other forms of coercion and manipulation (e.g. Smallbone and Wortley, 2000). 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, minimisation 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).

Actions following a disclosure of non-recent sexual abuse

A practitioner psychologist may be unsure of how to respond to the client's disclosure in the therapy room. It is important that the psychologist demonstrates that s/he is listening, taking the disclosure seriously and that they may need to think about what the client has said. Practitioner psychologists can powerfully communicate that they have heard the client, that they take their disclosure seriously, that it was not their fault, and that the responsibility always lies with the perpetrator. Practitioner psychologists can also demonstrate that it is the perpetrator's behaviour that was unacceptable and that it is the perpetrator's behaviour which needs to be addressed.

Practitioner psychologists may need to reframe their active response to child protection concerns as potentially **therapeutic, and ensure that they act in a manner consistent with this ultimate goal**. Many practitioner psychologists fear that acting will destroy the therapeutic relationship. For the client, this may be the first time they have been heard and believed by anyone.

It is better to make careful, considered and well timed decisions rather than hasty and mechanistic decisions. The latter can lead to negative consequences, such as client disengagement from therapy and their loss to help; potential increased risk of harm to the client; or the loss of important safeguarding information.

It may also need to be said either immediately or at a later point, that in order to ensure that the alleged perpetrator is not harming other young people, it may be necessary to pass on what has been disclosed to other agencies (such as the police and social services). The timing of these discussions is crucial. If the client is disclosing at assessment, then not enough may be known about their circumstances and there may be a risk of disengagement. It may be necessary to extend assessments across several appointments, and to take a gentle approach to finding out more and seeking advice on how to respond to what the client is saying.

Whilst anxiety provoking for clients, anecdotal reports indicate that many people do not want other children to suffer the same experiences as they did, and that they are prepared to consider passing on concerns in order to be protective of others (especially when they understand that there are options for making allegations that do not necessarily involve going to court).

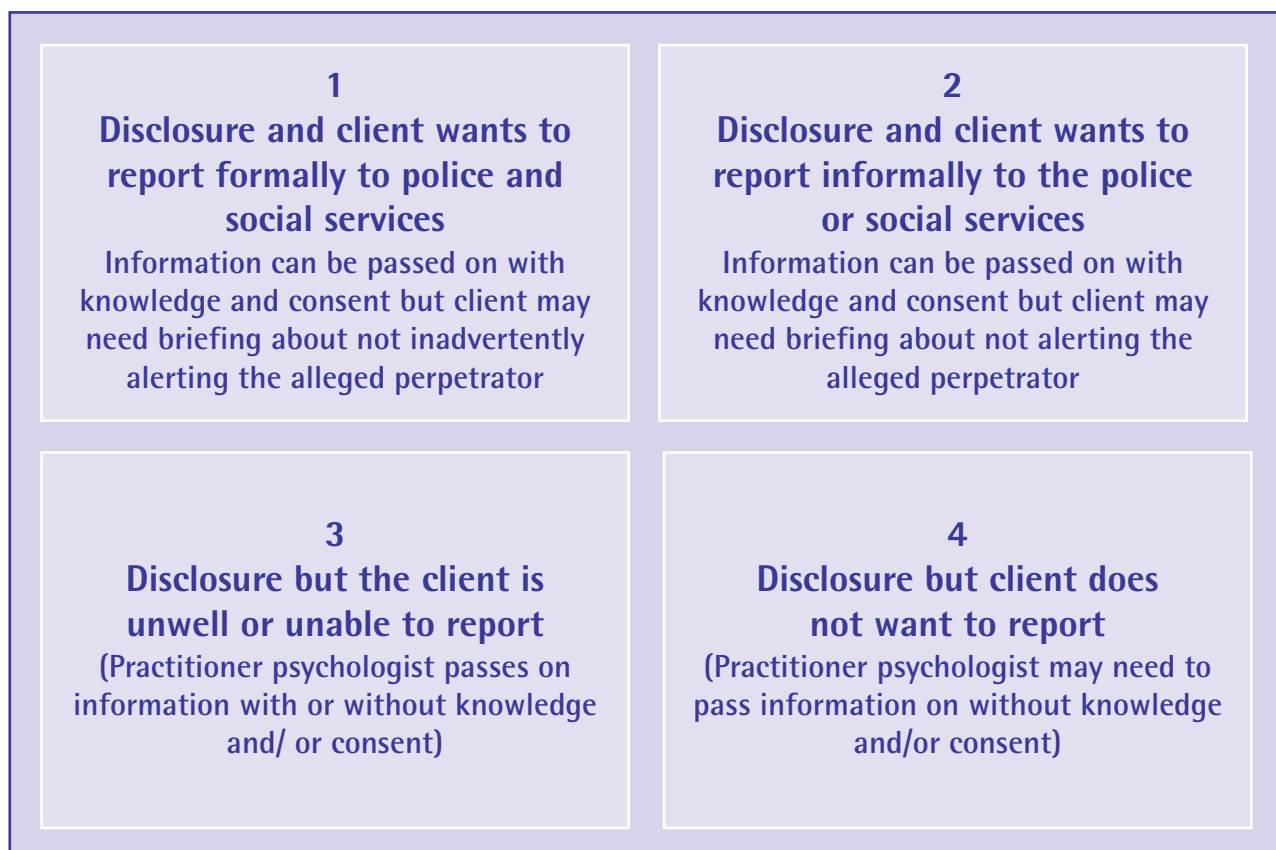
If it is anticipated that the disclosure may lead to legal proceedings, it is advisable not to go into significant details of the actual alleged abuse so as not to prejudice potential investigation, as a person's disclosure is evidence. However, this is not always possible, and therapy may need to take priority if there are concerns about the survivor's safety and wellbeing. Even if therapy proceeds, it does not necessarily have to focus on actual incidents of abuse, but can help survivors to make sense of what has happened to them.

This guidance cannot cover every clinical nuance or situation, but when an adult client discloses, the likely scenarios are:

1. The client discloses abuse and is prepared to make a formal statement to the police (i.e. to report a crime).
2. The client discloses abuse and gives consent to the psychologist making an informal/anonymous report to the police or social services on their behalf.
3. The client discloses abuse and is not well enough to make their own report to other agencies but the practitioner psychologist has sufficient information and believes the risk is substantial enough to require reporting.
4. The client discloses abuse but does not wish it to be reported to other agencies (police and/or social services).

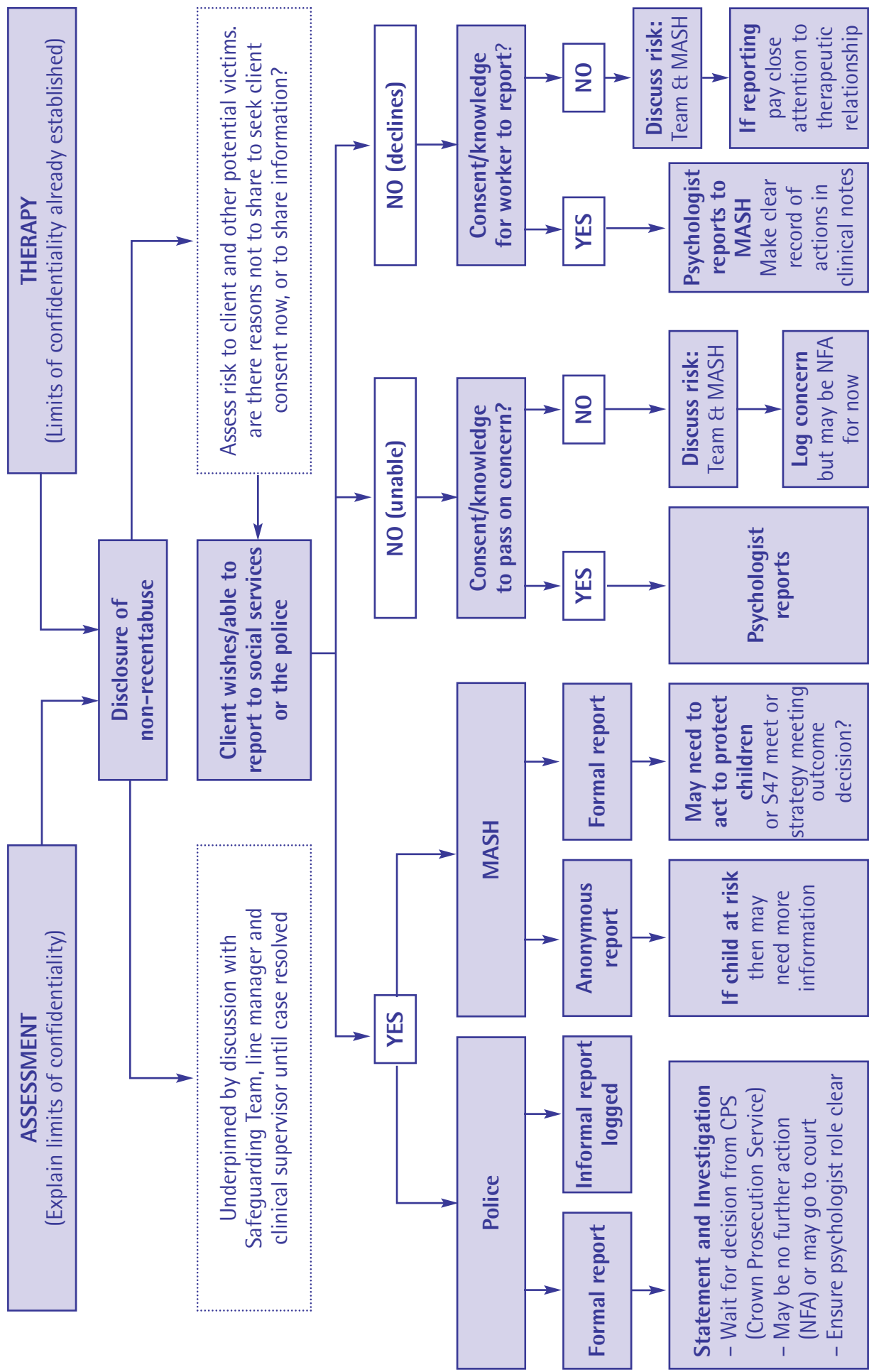
It is recognised also that the client may disclose abuse but be ambivalent about whether or not they wish to report or if reporting is necessary. A client may decide to report, and then change their mind, retracting their allegation and possibly cancelling arrangements to be interviewed, and then later decide to re-disclose. Clients may even say that they were unwell at the time of disclosure. These are not unusual reactions and are often part of the survivor trying to cope with the enormity of disclosure. Talking about traumatic events takes time, and this can be particularly marked when events have involved sexual abuse.

Figure 1: Likely scenarios when a client discloses non recent abuse



The flowchart in Fig.2 gives an overview of how to respond if a client discloses non-recent sexual abuse. Each stage of the chart should be considered carefully alongside the information presented in the rest of this document.

Figure 2: Flowchart for psychologist's response to disclosures of historic abuse



The following options present themselves to practitioner psychologists upon receiving an allegation of non-recent abuse:

No immediate action

As stated previously, clients who disclose abuse may have strong feelings about not taking action, often based on the fear and shame generated by the experience of being victimised. The psychologist should use their clinical judgement to raise the potential risk to other children with the client, and to share information about options for taking action in a sensitive, timely manner so that the options can be considered over time. Caution should be exercised about initiating this kind of conversation at assessment if follow up for therapy is likely to be delayed for many months, as there is a possibility that such a conversation will heighten the risk of self-harm.

The complexity of the emotional response to disclosure and acting on such disclosures should not be underestimated. Practitioner psychologists are unable to act if no identifying information is given and clients cannot and should not be compelled or pressurised to supply information they do not feel ready to give. It is reasonable for therapy to proceed in the absence of identifying information about a perpetrator, so long as the psychologist is able to hold in mind the possibility of the client's readiness to share more information as therapy progresses.

If the practitioner psychologist's risk assessment suggests that the client risk to themselves would increase significantly if confidentiality was broken, it is reasonable to take a decision not to disclose, so long as the appropriate advice, guidance and supervision have been documented, along with a clear plan for reviewing this decision. It must be noted that even when an alleged perpetrator is deceased, or there is not clear identifying information, there should be a discussion about the need for information-sharing. A psychologist may have only the name of an alleged perpetrator, but if the police or other agencies have a name, they may still be able to run checks to see if the person is already known to them or to note intelligence about them.

Anonymous action

Clients caught in the dilemma of wanting to protect other children, but who feel unable to cope with the stress of a police interview may feel more comfortable with the option of anonymous reporting. Practitioner psychologists caught in the dilemma of wanting to preserve a therapeutic alliance and not subjecting their clients to a stressful investigation process, may also appreciate the middle ground this option appears to present. However, they should be prepared for the possibility that should the allegation correspond to previously logged allegations, there may be considerable pressure for the client to participate in an investigation. If the client's name is provided as a victim along with details of the alleged perpetrator, or if the client can be linked with the alleged perpetrator (e.g. a close family member), then the client may be contacted by police to request an interview. This latter issue needs sensitive handling.

Anonymous reporting by a psychologist is likely to mean that the psychologist identifies themselves and the alleged perpetrator, but does not disclose the identity of the client. This is different from a psychologist having a 'no client names' consultation with the safeguarding agencies. 'No names' consultations are problematic, as such consultations can be criticised for delaying safeguarding referrals and action. It also means that safeguarding agencies are trying to offer advice without being able to run agency checks on information about which the psychologist has been concerned enough to seek advice in the first place.

If a psychologist seeks a 'no names' consultation with safeguarding professionals, then advice may be given without ascertaining whether the alleged perpetrator is already known to other agencies. If the allegation is not progressed further, this could result in vital cumulative evidence being lost.

Crimestoppers provide a route for anonymous allegations to be logged against named individuals. Any report of abuse to Crimestoppers (whether it is made by the client themselves, a friend or family member or the therapist) is noted. Single allegations of this nature are generally logged on the system, but in the absence of additional evidence, action may not be taken. However, if the name has been noted in previous allegations, a Crimestoppers allegation could trigger an active police investigation (for example, interviewing the alleged perpetrator and other family members, or search warrants being granted enabling the seizing of computers and other materials).

The NSPCC also have a helpline, and can explain various options including reporting anonymously to their organisation.

Referral to the MASH

Many areas will already have a Multi-Agency Safeguarding Hub (MASH) or be working towards having such a team. However, please note that these are still in the early stages of development at the time of writing, and vary in the services they deliver and the way they operate. If the local area does not have a MASH, then refer to the local safeguarding team. What needs to be stressed here is that all psychologists need to know what their local resources are, and how and to whom to report.

If the local area does have a MASH, this can also be contacted directly by a psychologist on behalf of an anonymous client, and an allegation made. This may result in the same sort of process as described above: if the allegation corresponds to one or more previous accusations, active investigation is more likely; if it is the first time a name has been logged on the system, and if no identifiable victim is named, no action may follow. However, a record of contact has been established. If risk is identified in relation to a named child, this is likely to lead to an investigation relating to that child (and may include an interview of the child and their family).

Report to the police

It may be suggested that the client is encouraged to make a direct report to the police and social services. If this is the case, practitioner psychologists should actively support the client in doing this and verify with other agencies that the information has been passed on. It is advised that this is framed as part of routine practice in such cases. It is important that practitioner psychologists do not assume that victims/survivors, who are vulnerable and may experience considerable ambivalence about reporting, have acted on advice to pass information on. The danger here is that if a client feels unable to take that step, then potentially important safeguarding information has been lost to services, possibly increasing ongoing risk for other children and young people.

The police have specially trained detectives available to interview victims of abuse, and when clients are ready to do so, being interviewed by staff with the appropriate skills can be a helpful part of the recovery process. However, alongside some of these beneficial effects, the experience may also have the effect of heightening distress and intrusive memories temporarily.

It may be appropriate for practitioner psychologists to be involved in supporting clients through this process, and the police are generally supportive of their involvement. Work with people who disclose non-recent abuse may involve stepping outside of the usual or typical role of the psychologist, and this can very much be the case during an active investigation.

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 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.

Even when the client is making their disclosure directly to social care staff or the police, it may be appropriate for the psychologist to be involved in the discussions. Consideration should be given to the interface between adult mental health and safeguarding within Local Safeguarding Children Boards (LSCBs), so that shared protocols can be developed to manage these cases well. It is essential to have clear lines of reporting within organisations and for practitioners to have a clear pathway showing who needs to be consulted and at which stage.

However, the resulting investigation and the very real risk that the allegation will not lead to successful prosecution, along with the consequences for families when the abuse has been familial, can be highly distressing and re-traumatising. It can be unsettling for partners and families, as this may be the first time the person has spoken about abuse, and friends, colleagues and other members of their social circle may be distressed by learning that the person is a victim/survivor and that they are being treated as such by the police.

In cases that go to court, it may be necessary to offer support after the court has reached its decision. This could be the case regardless of verdict. The client may have mixed feelings whether there is a successful conviction or if their assailant goes free. Where the court process does not result in a successful conviction of the alleged perpetrator, the practitioner psychologist should have supportive discussions with the client, emphasising their bravery, that they have done the best they can and that the verdict does not reflect on them. Receiving a verdict can increase victims' vulnerability and practitioner psychologists should be aware of this

In some situations, the client may not wish to report the crime themselves or may be unable to do so but the psychologist has sufficient concern about the safeguarding of others that they may feel the need to make a report themselves, and may have sufficient information to pass to the police regarding the potential victim(s) and alleged perpetrator.

Difficulties can arise when a client has not provided such information but where the psychologist is able to identify individuals involved, such as in small communities or in cases where the alleged perpetrator is a family member. In such circumstances, practitioner psychologists should carefully balance the risks of sharing the information with the risks of not doing so. Breaking confidentiality in this situation, even without the client's consent, would be supported by guidance on safeguarding. If the client does not feel able to take information forward, their reasons should be gently explored to understand what the client's specific fears are, and whether there are any dangers of retaliation by the alleged perpetrator or wider community.

Issues facing practitioner psychologists when a non-recent abuse allegation is made

There are a number of things which a practitioner psychologist will need to weigh up when working with a client who has disclosed non-recent sexual abuse. Adults alleging non-recent sexual abuse are victims/witnesses and may be very vulnerable. If they are being seen within a clinical setting the disclosure may be part of a complex set of circumstances; the client may already be experiencing high levels of psychological distress and may be a risk to themselves.

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;
- love or attachment to the person who has abused them;
- being in denial about what has happened or experiencing dissociation triggered by memories of abuse;
- feeling that they are the only person that this has happened to;
- feeling scared 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; or
- Fear of court processes and their ability to withstand them.

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, working with multiple clinicians over a long period of time, facing social exclusion and stigma due to their mental health problems or facing other hardships, such as trying to live on a low income. 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. 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.

The potential impact on the therapeutic relationship

There is often a worry that reporting of abuse will destroy the therapeutic relationship. However, as previously mentioned, it can be an opportunity for a client to feel heard and believed. It must be noted that a psychologist supporting a client to report non-recent abuse can be therapeutic, especially when the timing has been carefully considered, and the client feels involved in the decision-making process. This must be judged on a case-by-case basis, with a risk assessment.

Herman (1997) draws attention to the potential therapeutic value of taking action against a perpetrator of non-recent abuse in a context where successful outcomes are far from guaranteed. There is some literature on resilience in those who are able to survive their experiences and recover through psychological treatment (Woodward & Joseph, 2003).

Ainscough and Toon (1993) also highlight that there may be a range of reasons for survivors wanting to confront the people who abused them, including to protect other children from the perpetrator, to break the silence, and to feel that they have agency to break the hold the perpetrator may still have over them, enabling closure.

A client may disclose that they were sexually abused but not go into the details of the abuse. Again, it is vital to be aware of the impact of disclosure on the adult and to assess potential risk around disclosing. The psychologist should not seek to elicit information about the details of the abuse, but neither should they prevent a client talking about their abuse. All discussion should be framed within clear limits of usual confidentiality, good note-keeping and making it clear that the psychologist works as part of a team and is in receipt of supervision.

Seeking advice about a client's allegation without their express knowledge or consent can be an extremely uncomfortable position for a psychologist to be in and risks jeopardising the therapeutic relationship. In such circumstances, careful consideration should be given to how to mitigate any resulting increase in risk. The dilemma is that the client could experience the psychologist as behaving in ways that potentially feel to the client like re-victimisation (by taking control away from them).

Adult clients may have come to therapy, seeking help for issues other than the consequences of child abuse. They may not wish to deal with issues around abuse and may be unwilling to take information forward themselves. Practitioner psychologists may need to reframe their active response to child protection concerns as potentially therapeutic, and ensure that they act in a manner consistent with this ultimate goal.

Balancing the needs of the client versus needs of (potential) other victims

If a client discloses that they were sexually abused in childhood, the practitioner psychologist's concerns should be heightened if:

- the alleged abuse has not been previously reported or there has not been previous professional intervention from the police, medical or social services;
- the alleged perpetrator is a family member with ongoing contact with children;
- the alleged perpetrator holds a position of trust (paid or voluntary) which is likely to bring them into contact with children and young people;
- the client is aware (though they may not be) that other young people were victimised;

- it is clear that there was organised or ritual abuse; or
- the adult client is continuing to be abused by the perpetrator.

However, the absence of any or all of these factors cannot be assumed to mean there is no ongoing risk. Perpetrators with no known access to children either through familial, social or occupational context will still live as part of communities and may well have access to children in their daily lives. The survivor may be unaware of other victims and feel that they were uniquely singled out/to blame, when in fact the perpetrator may have abused other children extensively.

The adult client may be experiencing high levels of distress and symptoms of trauma (including psychotic symptoms and dissociation), which may be accompanied by a risk of self-harm and/or suicide. The practitioner psychologist may assess this risk as being potentially heightened by sharing information with other agencies. Even if information is shared about allegations, it may not be possible to proceed, as the victim's testimony may be felt to be too fragile.

There is a need for careful consideration before assuming that the right course for the client will always involve onward disclosure and involvement of the police. In any case of disclosed abuse, it is crucial to include the survivor's reasons for not telling as part of risk assessment, and to be clear with colleagues that these risks may present real threats to the person's ongoing safety.

Risk assessments need to be extended to consider potential safeguarding issues raised by non-recent abuse allegations, the impact on the client, and the risks associated with placing them on a waiting list during any potential investigation. The client may also be a parent themselves, and the impact of distress upon their parenting capacity should also be considered. This can raise complex ethical dilemmas in its own right, and is beyond the scope of the current guidance. However, it is recognised that there is tension when holding in mind (a) the needs of children; (b) the needs of adult survivors; and (c) the survivor as potentially having compromised parenting capacity. Again, these dilemmas need to be discussed with safeguarding professionals and with supervisors who have experience in working with such complex cases. Practitioner psychologists can assist with systemic thinking and family-based work that might be necessary following disclosure, regardless of the safeguarding outcomes.

Breaching confidentiality

There may be circumstances when a psychologist needs to breach confidentiality in order to safeguard others.

Most understand that the duty to respect confidentiality is not absolute; nevertheless every practitioner psychologist must clearly outline the parameters of confidentiality whenever they begin assessment or therapeutic work with an individual or a family. It is important that the rules around confidentiality are established at the outset ensuring clients understand that confidentiality may need to be breached in certain circumstances without their consent. Clients also need to understand the extent of information-sharing between professionals bound by the same rules. The fundamental obligation is that a client ought to know in advance of disclosing anything to any professional, that the professional may not be permitted to keep secret the information the client has disclosed. Honesty about this

issue is crucial and avoids risks of clients later feeling let down or misplaced in their trust of the professional.

Disclosure of abuse which may be subject to legal proceedings should be an additional prompt for the practitioner psychologist to revisit the question of informed consent to ensure the client fully appreciates the potential implications of therapeutic discussions. The practitioner psychologist should also consider again key professional questions relating to the client's readiness for therapy and the importance of timing in trauma-related psychological interventions.

As a general rule, confidentiality will always be respected, and there are only limited exceptions permitting breach of confidentiality without an individual's consent. The Society advises that psychology practitioners:

- (vi) Restrict breaches of confidentiality to those exceptional circumstances under which there appears sufficient evidence to raise serious concern about:
 - (a) the safety of clients;
 - (b) the safety of other persons who may be endangered by the client's behaviour; or
 - (c) the health, welfare or safety of children or vulnerable adults.

British Psychological Society, Code of Ethics and Conduct (2009)

No psychologist is likely to feel comfortable about passing on information without a client's consent or perhaps even knowledge. It would always be advisable to discuss this with the police and safeguarding team, and to come to a joint decision about when to disclose professional action to the client, in order to avoid compromising the safety of the client or others, and without prejudicing an investigation.

If practitioners have to take decisions for the protection of children, which clients may disagree with, then it is important to explain the rationale for this clearly and respectfully. The issue of timing of telling the client what the psychologist is doing needs to be clearly balanced with the risk of adult clients inadvertently alerting an alleged perpetrator to multi-agency involvement. If alerted, the alleged perpetrator may take action to destroy evidence or silence children/other witnesses. Once again, it is important to hold in mind the complex issues around the protection of children, the needs of the client and information sharing.

The Caldicott Principles (1997, 2013) were drawn up in response to changes in information technology and recommendations arising from the Climbié Inquiry 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. The Principles can be found at the back of this document and a full reference can be found under 'References'. Further relevant documentation and links to the original source can be found at www.bps.org.uk/historicalsexualabuse.

In summary, no breach of confidentiality can be taken lightly, and it is advisable always to be as open and transparent as possible with the client and as soon as possible. While it must be recognised that there may be times where there may need to be an initial breach or an initially undisclosed breach in order to safeguard others from an alleged perpetrator, generally it is advised that individual practitioners seek advice before breaching confidentiality in these situations and refrain from making unilateral decisions.

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.

Standards of Conduct, Performance and Ethics 2012, p.5

Decision-making should be based on evidence-based research and practice but can be complex and as result, subjectivity can enter into judgments and decisions at times. Practitioner psychologists should remember that all professionals can be prone to thinking errors, particularly under such stressful or difficult conditions.

It is important to discuss complex cases with colleagues. It is better to make careful, considered and well-timed decisions rather than hasty and mechanistic decisions. The latter can lead to negative consequences, such as client disengagement from therapy and their loss to help; potential increased risk of harm to the client; or the loss of important safeguarding information. All decisions must be underpinned by up-to-date training and the use of good supervision.

Psychologists are strongly advised that unless, for example, there are exceptional circumstances (perhaps of urgency), decision-making should be shared with senior managers and safeguarding staff within their organisation. The judgements and decisions in these cases can be complex and stressful and it is important to share information with colleagues on a 'need-to-know' basis (i.e. named safeguarding professionals, line managers, clinical supervisors and potentially across agencies).

Decisions should be embedded within an equality/anti-discriminatory framework. In reality, this means that psychologists should be aware of their own responses to cases, and endeavour to base their practice on clear and ethical principles, rather than attitudes. For instance, multiple inquiries have revealed that the way in which professionals view survivors can influence thresholds for acting on information. Decisions may be based on not seeing people who disclose abuse as victims, questioning the truthfulness of what they are saying or believing them to be too fragile or not sufficiently credible in the eyes of the law to report their experience. Psychologists may unwittingly harbour assumptions about motive, class, gender, ethnicity, disability or age that adversely affect their decision-making. Psychologists are also likely to have their own thinking biases, as all people do, so it is imperative to seek advice and use ongoing clinical supervision.

Professionals also need assured support from their professional body/professional indemnity providers to ensure prompt access to advice that will protect from a legal suit in the event of immediate or later challenges in relation to their involvement in decision-making.

Strategy meetings

In some cases, the authorities may not have the names of potential children at risk – there may be information only about an alleged perpetrator’s name and grounds for concern (e.g. the alleged perpetrator is or was a sports coach). A strategy meeting may then be called.

The strategy meeting should be recorded in writing. It should be multi-agency, and discuss both safety and risk to children or vulnerable adults who may be at risk from the alleged perpetrator, and take careful consideration of the client’s mental health.

As the person who has most contact with the client, the practitioner psychologist may be asked to speak with the client further. It is important to establish roles clearly, e.g. if the psychologist remains involved, what is expected of their role should be clearly delineated, especially if they have needed to provide a witness statement.

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

Following a strategy meeting, there may be no further action at that time. If this is the case, 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.

If the practitioner psychologist is concerned with decisions that have been reached at the strategy meeting, they should discuss mechanisms for reviewing decisions with their local safeguarding team. In exceptional circumstances, practitioner psychologists may have concerns about the way a case has been managed. It is important to be clear about how such concerns can be raised within and across agencies, and taken to the LSCB for review.

If significant concerns remain or there are major concerns which are in the public interest to disclose, it may be necessary for a psychologist to refer to their whistleblowing policy. Practitioner psychologists should also consider seeking support from their own professional bodies and supervisor/mentors throughout their involvement in complex cases. Managing personal resilience is essential to ensuring practitioner health and avoiding adverse impact on capacity arising from sustained requirement to handle complex ethical dilemmas and client support needs.

The following diagram from Working Together 2015, illustrates the next steps in the process that social services and /or the police may take if it is thought that a named child is in danger.

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. If there is felt to be immediate significant risk to children, then safeguarding agencies will need to intervene.

Health organisations may also need to consider that there may be instances when alleged perpetrators may be known to mental health services, and it should be considered how to manage this information if it is not known to MASH.

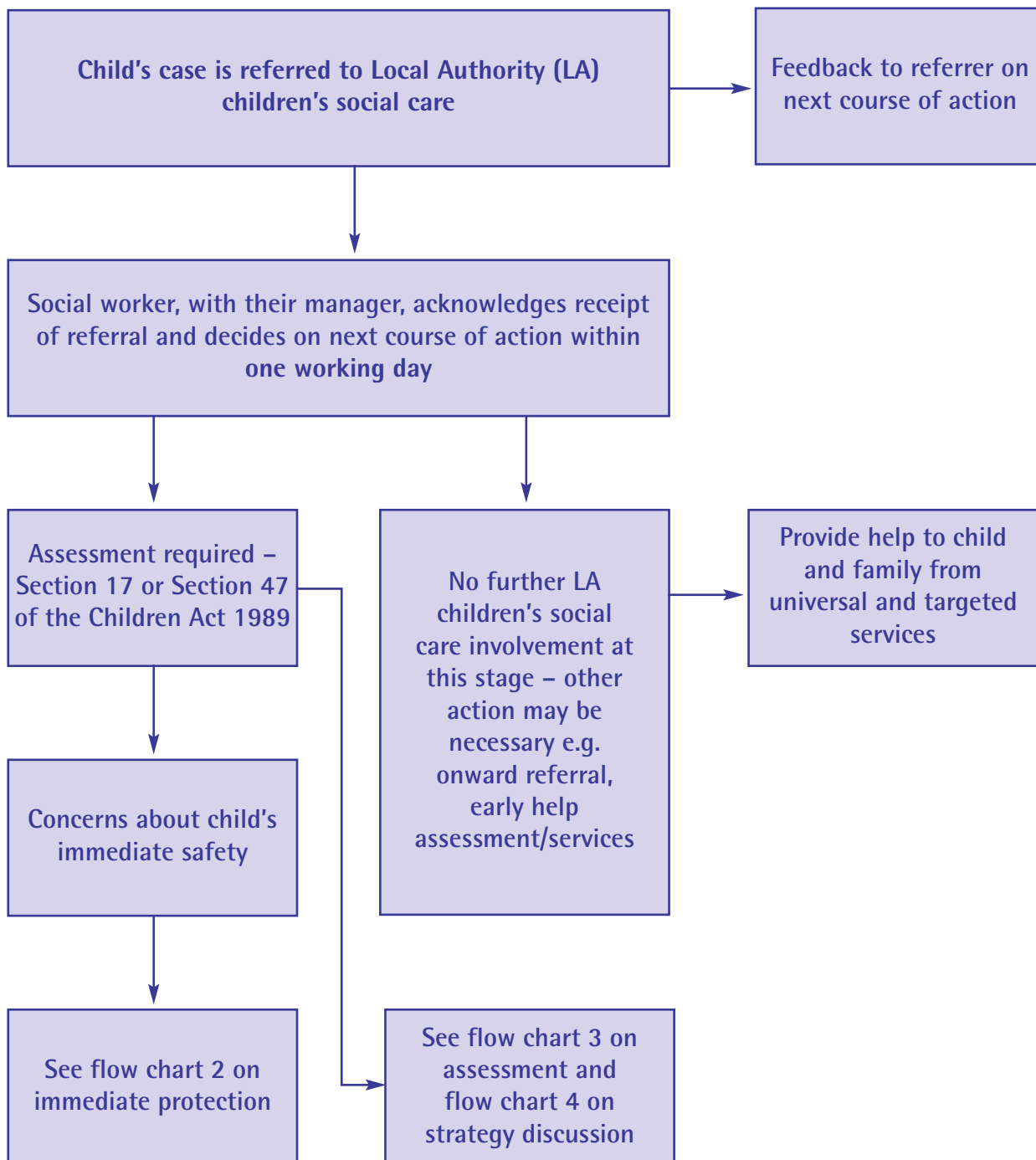


Figure 3: Action to be taken when a child is referred to local authority children's social care services from Working Together 2015, p.30.

Please note: the references to flow charts 2, 3 and 4 mentioned in this figure can all be found in Working Together (2015).

Special circumstances

There can be additional factors which mean that issues around safeguarding become more complex:

- **Allegations against former or current members of staff** – If the alleged perpetrator is a public service employee or clinician they may have ongoing access to children and young people, or vulnerable adults. They may also have current access to medical or other confidential records that could alert them to information having been shared with other agencies. If such an allegation has been raised then it is important to follow LSCB policy and to potentially involve the Local Authority Designated Officer (LADO). Your organisation should support your referral.
- **The alleged perpetrator is a high profile person** – High profile cases must be managed closely by the senior investigating officer (SIO). Each case must be treated individually to manage any specific challenges it may pose. Relevant professionals should have regular meetings as the case progresses, so that the interests of victims/witnesses are looked after. The wider investigation would handle media and criminal legal matters (Scott, personal communication).
- **Allegations concern local authority residential settings** – If such an allegation has been raised then it is important to follow LSCB policy and to involve the LADO. Your organisation should support your referral.
- **Allegations concern a different Local Authority area** – Advice should be sought from the safeguarding team and LADO local to the victim, and it should be clearly outlined how the information is being transferred on.
- **The alleged perpetrator has died** – It is hoped that the high profile case of Jimmy Savile has highlighted the importance of an investigation after death. Ensuring that victims receive support, and identifying those organisations that may have flawed systems which allow abuse to occur or go undetected, are two clear reasons for proceeding with an investigation after the perpetrator's death.

Assessment and record-keeping

In cases where non-recent abuse is disclosed, it is wise for the practitioner psychologist to pay particular care and attention to the quality of their questions around disclosure. It is important to keep questions open-ended, and not to lead the client making a disclosure (Marshall, personal communication).

There has been considerable debate amongst practitioner psychologists regarding the reliability of recovered memories and whether they are historically accurate. Many people who disclose abuse are speaking about 'never forgotten' memories. However, clients may also disclose memories of sexual abuse which are recently remembered (sometimes before seeking therapy, sometimes during therapy). These appear to be previously forgotten incidents, which the client has newly remembered. This may cause some concern with practitioners psychologists that they will be accused of creating illusory memories in the client, or that the client has experienced 'memories' which are not real.

It is clear that abuse is still taboo and that many people have been silenced by accusations of 'fantasising' or 'lying' about abuse. Andrews et al (2000) report that recovered memories were similar to those reported by patients diagnosed as having post-traumatic

stress disorder (PTSD), following an event known to have occurred, such as a car crash. The memories were fragmented but detailed, accompanied by high levels of emotion and experienced as reliving the original event.

The use of evidence-based therapies should prevent practitioner psychologists appearing to have unduly influenced a client's memory or account of trauma. Psychological therapy for developmental or complex childhood trauma (particularly when linked with PTSD) is still being developed. The NICE guidelines (2005) outline that trauma-focused cognitive behavioural therapy has the most reliable evidence base for the psychological treatment of PTSD.

Practitioners should take as detailed a history as possible at assessment. This is the point at which they are likely to gather information about family history, which in cases of familial abuse should include genograms. The detailed gathering of information for genograms should include information about dates of birth for family members, addresses and, if possible, schools or pre-school if there are young children potentially at risk. It is also helpful to have GP details (if possible). If this is the point at which a disclosure is made, then it is important to note the nature of the allegations (without going into unnecessary detail about specific incidents), details about alleged perpetrator(s), such as name, date of birth, address, occupation and age at the time of the abuse, if the client is able and willing to provide this.

It is extremely important to keep clear and accurate notes. Clear recording of decisions as they unfold are the basis of accountable practice. It is particularly important in case of records being needed for judicial purposes. Therapists cannot offer complete confidentiality as the therapeutic relationship is not a 'privileged' one in the legal sense. The therapist and their notes can be called to court. It is imperative, regardless of setting, to have case notes which are of a good standard.

Notes should include:

- The date, time and method of contact;
- Any allegations recorded using the client's own words;
- 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.

It is particularly important to have clearly thought out and recorded risk assessment. There may be multiple risks to the client's care, including disengagement from services; suicide risk; risk of mental health crisis; on-going contact with an alleged perpetrator; and/or risks of harm to others.

Sometimes practitioners will be working via interpreters, and in these instances it is important to accurately record what the interpreter says that the client has disclosed. There will be need for additional discussion with the safeguarding team about complexities that may arise when disclosure is heard by an interpreter working with a therapist.

Additional issues may arise when practitioner psychologists make audio/video recordings of sessions with clients. For practitioner psychologists, consent will have been sought for recording sessions in this way, but this may have been done for the purposes of supervision or (if a trainee psychologist) for training. If a disclosure is made during a recording, advice should be sought from the safeguarding team and/or clinical governance team, as this information may then be treated as evidence and requested by the police or court, if a case is reported and proceeds through the legal process.

What to expect if the client wishes to report a crime

Making a formal statement to police

The police will need to speak to your client, potentially with the support of an Appropriate Adult. A witness statement will be taken, either in written form, or on video. A police investigation will follow with witnesses contacted and the suspect interviewed. Any third party material or other evidence will be gathered. The police will then seek expert charging advice from the Crown Prosecution Service (CPS) who will decide if there is sufficient evidence to take the case to trial. The police will explain what making a statement will involve and may involve an independent sexual violence advisor (ISVA). These advisors are a valuable source of support for victims; they work with victims of sexual crime, to provide them with information about counselling, how to report a crime if they wish, and support them through police and legal processes. ISVAs are funded through the Home Office and Sexual Assault Referral Centres, and are trained but they are not specialists in mental health.

It is important to emphasise to clients that their allegation/concern will be treated seriously; that they are acting protectively on behalf of other potential victims; that their information will be treated sensitively and carefully; that if they make a formal complaint, they should be interviewed by specialist officers in plain clothes; that witness statements are often recorded, rather than written; and that they can take breaks during the interview.

Generally medical records/therapy notes should not be shared with the police without the police going through the normal formal route. However, there may be circumstances where urgency and need in relation to management of a safeguarding issue requires consideration of disclosure relying on Caldicott principles. The Caldicott principles are important in ensuring that only relevant information is shared with those who need to know. For instance, the police may need to know about a client's capacity, risk and vulnerability, and the nature of the alleged offence. They do not need to know about the client's wider life circumstances or other personal details that are not relevant to the alleged complaint.

Waiting for court and pre-trial therapy

This can be a highly challenging time for people, as they do not know whether the case will proceed to court. This uncertainty can continue for long periods of time, and then if a case does go ahead, they have to face being called as a witness. The attrition rate from complaint to court is high. Again, ISVAs are a valuable source of support at this time.

The Crown Prosecution Service (2002) and the Home Office (2002) have provided clear guidance regarding the provision of pre-trial therapy, which addresses the ethical issue of not withholding a person's right to help but also addresses concerns about inadvertent 'coaching' of witnesses or contamination of evidence. It also clarifies that a psychologist's notes can be called as evidence in legal proceedings. Practitioner psychologists may also be called to give evidence in person.

Barrett's (2013) media report highlighted that many police and other agencies are not always well informed about guidance concerning vulnerable witnesses accessing pre-trial therapy, and that this has led to tragic consequences for witnesses. Jenkins (2013) outlined the case for the Government to make explicit recommendations for victims and witnesses to be offered funded pre-trial therapy. He comments that:

‘It is important to distinguish carefully between the different types of support available: between preparation for giving evidence in court on the one hand, and ongoing pre-trial therapy on the other. It can also be important for support roles to be clearly demarcated, and for the different forms of support provided by different people to be distinguished.’

Jenkins (2013)

Practitioner psychologists are trained in a range of different models and so may adapt the intervention based on the needs of the client and the system. Different forms of therapy have different potential impacts on the legal process. The diagram below, adapted from Bond and Sandhu (2005), summarises the different facets of therapy and their increasing levels of impact on the court process.

This outlines that more direct focus on the incidents of sexual abuse and its aftermath can potentially impact on the legal process.

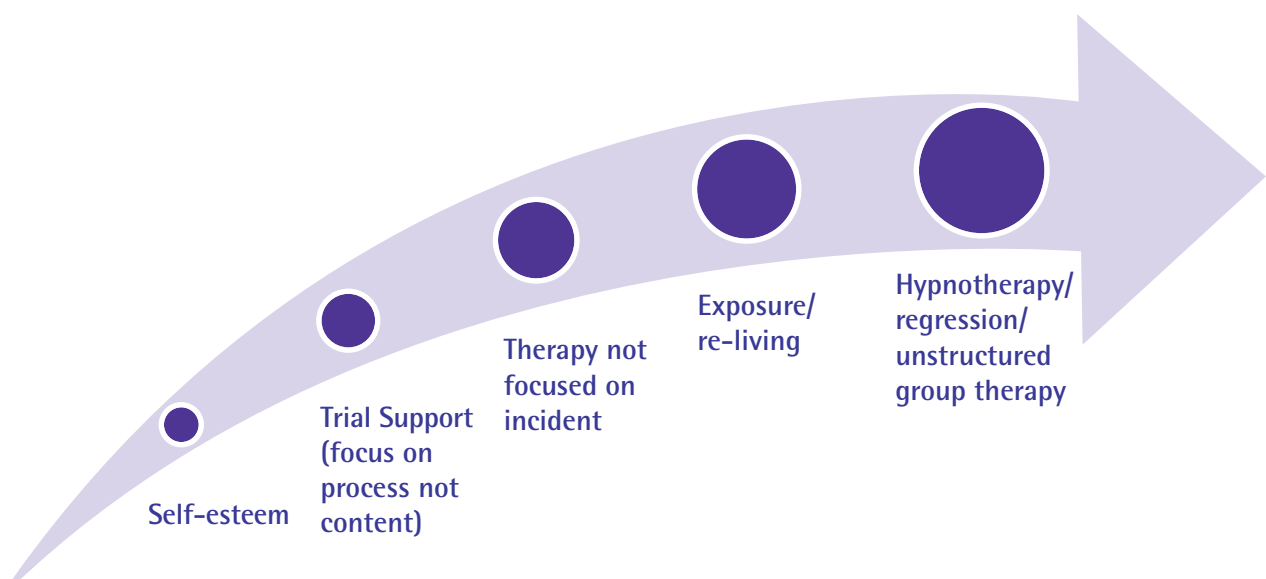


Figure 4: Therapy focus and potential impact on legal process

The use of evidence based therapies should prevent practitioner psychologists appearing to have unduly influenced a client’s memory or account of trauma. It is recommended that practitioner psychologists do not use techniques which could be seen to have reduced reliability of memory, such as hypnosis, or be seen to ‘lead’ the client.

The need for evidence based intervention cannot be overstated, though it must be acknowledged that psychological therapy for developmental or complex childhood trauma (particularly when linked with PTSD symptoms) is still being developed. The NICE guidelines (2005) outline that Trauma Focused CBT has the most reliable evidence base for the psychological treatment of PTSD.

Practitioner psychologists have an ethical duty not to withhold therapy, though this comes with many challenges within and outside their control. For example, increasing a person’s wellbeing and presentation may well influence how the jury perceives the credibility of their evidence. Although it may be uncomfortable to engage with these dilemmas, it is important to do so.

Support at court and post-court

Practitioner psychologists may have a role in helping clients to understand what to expect at court and how to manage this stressful process. It is useful to link with ISVAs in this process. Child sexual abuse and non-recent abuse seldom features forensic evidence, it remains largely one person's word against another's, which is why pejorative views of victims can have such an impact. It will be useful for practitioner psychologists, who remain in contact with their clients, to link with court liaison officers or ISVAs. Practitioner psychologists may be able to support pre-court briefings to discuss any vulnerabilities and needs (and to ensure that the client can exercise their right to give evidence via video link or behind a screen).

Practitioner psychologists can also liaise with Registered Intermediaries for court. These are communication specialists who assist vulnerable victims, witnesses, suspects and defendants with significant communication deficits, to understand questions and communicate their answers more effectively during police interviews and when giving evidence. There could also be a 'Ground Rules Hearing' where evidence is presented in order to argue for special measures in court and when questioning in cross-examination is planned.

The adversarial nature of the courtroom may seem routine to those who work in it, but words such a 'lying'/'liar' may feed straight into distressing memories and negative core beliefs about the self and result in a catastrophic collapse in someone's psyche. The 2013 Chethams case shows how stressful it can be for witnesses, and the potential for tragic consequences (Walker, 2013).

Advocates' Gateway Toolkits are a valuable source of information to increase awareness about the court process. The Toolkits and additional resources are available by visiting our online resources page: www.bps.org.uk/historicalsexualabuse.

Post-court debriefs may help to pick up any problems in terms of procedure or support that have occurred during the trial, and ensure that these don't happen to other witnesses in future. If there is perception of risk to a client, this should ideally have been discussed well before trial or even with the involvement of the police so that all arrangements are in place and managed in the run up to a trial. If there has been an acquittal, there may need to be further discussion with the client about witness protection, victim support, staying safe from reprisals, and stalking and harassment measures. All of this takes the practitioner psychologist outside of their usual therapeutic remit. In addition, there may need to be service level discussions, as the service needs to be flexible in order to meet the client's needs.

The wider role of the psychologist

Practitioner psychologists should consider their wider role in relation to non-recent sexual abuse and work systemically to help the psychology profession and others to meet the needs of survivors of non-recent sexual abuse more effectively. Some suggestions are made below, and it is important to highlight that this list is not exhaustive.

1. Awareness raising – Practitioner psychologists can help to raise awareness of safeguarding, and be proactive in asking clients whether they have experienced abuse, especially within mental health settings. There is also a role for practitioners to help colleagues be more aware that non-recent abuse allegations may mean there are live child protection issues. Practitioner psychologists could participate in the development of organisational policies and procedures regarding non-recent abuse. It would also be useful to develop information leaflets for practitioner psychologists and/or service users about non-recent abuse, how to raise concerns, how to report it and what to expect if it is reported.

Public awareness campaigns and stakeholder involvement of other agencies and the third sector, are also important in order to improve awareness and responses to the issue of non-recent sexual abuse. There is emerging global evidence on the impact of prevention programmes to reduce violence (including sexual violence) against women and girls which could be adapted to a UK context (Ellsberg et al., 2015).

2. Supervision – In both clinical and case management, safeguarding issues should routinely be considered when working with victims/survivors of abuse. Practitioner psychologists need support with the complex decision-making that often accompanies such cases. Such cases can also be stressful and distressing for practitioner psychologists, who may also struggle to manage the demands these complex cases can have on their time, so there may need to be discussions about limiting or reducing workload to allow them to prioritise this safeguarding work.

3. The usual role of psychologists should be more flexible in cases where non-recent abuse is reported, to include extended assessment or a discrete piece of work around facilitating the onward sharing of important information which may help to safeguard children now, or to involve supportive work during court proceedings. Service level discussions with senior managers may also be required, as this would have service implications. Services should consider prioritising clients for therapeutic work who present with non-recent sexual abuse at assessment in order to address the issues raised.

4. Risk assessments may need to be extended to consider potential safeguarding issues raised by non-recent abuse allegations, the impact on the client's level of risk and the risks associated with placing a client on a waiting list during any potential investigation. The client may also be a parent themselves, and so the impact of distress upon their parenting capacity should be considered too. This can raise complex ethical dilemmas in its own right, and is beyond the scope of the current guidance.

5. Working with the police and judiciary – The attrition rate from complaint to court is disturbingly high. Recent high profile cases also raise questions about how abuse survivors are treated during the period of investigation of concerns and during the court process. It is likely to be beneficial for the CPS and the police to receive training

about the psychological needs and vulnerabilities of people going through the stress of reporting non-recent abuse allegations. Training and information is needed for the public and judiciary to raise awareness about particular aspects of this crime, such as the shame-based nature of the trauma experienced by survivors, which make it hard for people to come forward and make a complaint. It is also important to recognise that poor mental health may be the consequence of child abuse, rather than being seen as a reason to doubt the veracity of someone's disclosure or doubt their credibility as a witness. It would help to raise awareness that victims often test the waters when disclosing, by telling a bit, then telling more before making a full disclosure. Some victims may retract their statements. This can be a sign of fear when faced with the potentially enormous consequences of disclosure. Retraction does not mean that victims are lying about their initial disclosure.

It would also help to train the police and judiciary about the effects of trauma upon mental health and memory, and how this can lead to phenomena such as dissociation. Traumatic memories may be fragmentary and non-linear; this is a typical feature of memories laid down during periods of high stress. These features do not necessarily mean that the allegation is either false or mistaken.

Jenkins (2013) confirms the concerns mentioned previously about the adversarial nature of the court system in relation to sexual offence cases, and suggests that this model should change. Psychologists could help inform training and the criminal justice response to adults reporting sexual crimes and potentially advocate for changes to a judicial system that currently does not appear to serve survivors of non-recent sexual trauma well. There may be a case for changing the way evidence is heard in court, reducing the need for cross examination, particularly for vulnerable witnesses or advancing the use of hearsay. Besides the issues around the nature of court-room proceedings, low conviction rates have concerning implications for ongoing safeguarding of children in the present.

- 6. Additional training implications** – It would be helpful for there to be regular multi-agency training at all levels of the system, so that education, health, the police, primary care and social care services are all able to understand the parameters of each profession's roles and responsibilities in relation to allegations of non-recent abuse, and some of the psychological consequences of this type of trauma which can make disclosure so frightening or shameful for people.

It would be useful to work more closely with GPs, who often refer clients who have disclosed non-recent abuse allegations to them. It is often unclear whether safeguarding issues have been explored as part of this, and indeed, GPs may have key information about family members who may potentially be at risk, as well as holding 'old' medical evidence, without necessarily realising its significance.

It is important for there to be a reflective cycle on how non-recent cases have been managed and whether the outcomes of this have been successful. Reflective processes must engage closely with victims and survivors so that services can be responsive to their experiences and feedback. Such initiatives are occurring in adult social care, with the development of the 'Making Safeguarding Personal' agenda.

- 7. Lobbying** for changes to the way abuse survivors are treated – It is suggested that this could be achieved through linking with Director of Public Prosecutions, the police,

LSCB, particularly focusing on the pathway from reporting to child protection, and also to possible court action against the alleged perpetrator(s). The current high attrition rate from report to court suggests that our systems are not working effectively enough to help survivors. It is possible that changes to how victims of sexual crime are treated could improve this situation, in a similar way to the changes that have been made to help children and other vulnerable witnesses whose cases go through the court system. Changes in legal definitions around domestic abuse now recognise the actual effects and symptomatology associated with psychological harm (Home Office, 2013) and it is argued that this richer understanding of the impacts of violence should be extended to sexual abuse. Hawkins and Taylor (2015) have written an All Party Parliamentary report concerning services for sexual and domestic violence. The group is a cross-party group of MPs and Peers working towards the elimination of domestic and sexual violence through the development of public policy and cross party collaboration. They have highlighted extremely worrying trends regarding services for women and girls experiencing violence and abuse. They note the uncertain funding for services such as Rape Crisis. Practitioner psychologists could work with groups in the voluntary sector, to lobby for improved funding of these vital services, as well as ensuring that NHS and Local Authorities also provide high quality help for victims of sexual crime.

There is also a need for more specialist psychology resources, which must be accompanied by additional funding. There is a shortfall of immediate professional psychological support from Local Health Trusts, meaning that lots of work falls to volunteers/charities/survivors groups and ISVAs. Some interventions for victims/survivors require complex decision making and highly specialised therapy, and it is important that there is provision within statutory services to provide this.

Concluding remarks

This document is the first substantive piece of guidance for practitioner psychologists on managing disclosures of non-recent abuse. It will be reviewed in light of feedback from clinical practice and as national guidance and legislation is refined in this area.

Within the BPS, the Safeguarding Children & Young People Working Group is now leading on this issue, and it is hoped that this document will be a starting point for facilitating awareness, reflective practice and clinical decision-making in this complex area.

Written in May 2016

Review date May 2017

Useful resources

Links to the Caldicott Report and to additional resources can be found online at: www.bps.org.uk/historicalsexualabuse

For ease of reference, the Caldicott principles are laid out below.

The Caldicott Principles – Revised September 2013

Principle 1. Justify the purpose(s) for using confidential information

Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

Principle 2. Don't use personal confidential data unless it is absolutely necessary.

Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

Principle 3. Use the minimum necessary personal confidential data

Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

Principle 4. Access to personal confidential data should be on a strict need-to-know basis

Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

Principle 5. Everyone with access to personal confidential data should be aware of their responsibilities

Action should be taken to ensure that those handling personal confidential data – both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality.

Principle 6. Comply with the law

Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

Principle 7. The duty to share information can be as important as the duty to protect patient confidentiality

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

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