CRANIOSACRAL THERAPY ASSOCIATION

CSTA - Safeguarding vulnerable clients

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Introduction

This document is in two main parts – the first brings together relevant aspects of the law and the CSTA's Code of Ethics and Standards of Practice relating to the care of vulnerable clients, and the second gives information, guidance and support for working with and protecting vulnerable people, whether children or adults. Awareness of these issues is fundamentally important in any therapeutic practice - we are often dealing with clients who are in some way vulnerable and our basic role as a practitioner is one of support. All of us when unwell or in need of help are feeling somewhat vulnerable, and there are also specific situations, such as children and adults who are in receipt of certain kinds of support, who are deemed legally to be especially vulnerable. It goes without saying that this same protection must be offered to all clients regardless of gender, age, ethnicity, disability, sexuality, religion or any other characteristic.

CSTA-registered practitioners are expected to adhere to both the Code of Ethics and Standards of Practice (available on the CSTA website), and to have regard to the Advertising Guidance, and confirm this annually on renewal. Within those documents are laid out in detail the basic ethical requirements of good practitionership, so this will not be repeated here except as brief summaries. The aim of this document is to bring the more specific safeguarding-related information together and to offer support and advice for situations that we may encounter as practitioners, such as suspected abuse or suicide risk. We hope this will be helpful and can be used as a resource and for reference. It will be reviewed approximately yearly by the trustees and updated at any time we become aware of changes in relevant laws. If in doubt, please contact the CSTA, your supervisor or an experienced colleague for help and support.

PART 1 – Policy and legal considerations

A: Definition of safeguarding

Safeguarding is a term which is broader than 'child protection' and is seen as everybody's responsibility, not only statutory professionals'. A child is currently defined in law as someone who is under 18 in England, Wales and Northern Ireland, and who is under 16 in Scotland. A vulnerable adult is defined in the Care Act 2014 as someone who has needs for care and support for reasons of mental or other disability, age or illness (whether or not the local authority is meeting any of those needs) and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of harm, abuse or neglect.

If you suspect a child or vulnerable adult is being abused, neglected or mistreated you are obliged to inform the relevant authorities such as the social services child protection team, GP, or in an emergency the police. This duty takes precedence over the usual confidentiality. It is not your duty to find out whether abuse is taking place, but to inform the relevant authorities of your concern. Please see part 2 section 1 'What to do if you suspect a child or vulnerable adult is being harmed, abused or neglected' for further details about which bodies to contact. The most usual avenue would be local social services but in case of more immediate danger you can call the GP or 999.

Safeguarding is defined in 'Working Together to Safeguard Children 2015' (see Appendix 1) as:

- protecting children from maltreatment
- preventing impairment of children's health and development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care and
- taking action to enable all children to have the best outcomes

In the Care Act 2014 (see Appendix 1) the aims of safeguarding for vulnerable adults are listed as:

- stop abuse or neglect wherever possible
- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- support vulnerable adults in making choices and having control about how they want to live
- raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult

These ideas can and should also be extended to all clients as appropriate. The term 'harm' includes ill treatment or impairment of health or physical, intellectual, emotional, social, behavioural or sexual development.

Safeguarding for Craniosacral Therapy practitioners

In essence, safeguarding is simple – in all our actions as professional practitioners, we must always have complete regard for the actual or potential vulnerability and best interests of our clients, and prioritise their physical and emotional safety. In practice it may be somewhat complex, with sometimes overlapping or apparently contradictory needs arising.

Although we are not usually providing unsupervised services to vulnerable people – for example when treating children or vulnerable adults we would have a caregiver present – and so the work itself is 'low risk', nevertheless we need to be aware of the issues and do all we can to ensure the safety of our clients.

Working unsupervised with vulnerable people

If you are in a situation of providing unsupervised care to vulnerable people whether children or adults, for example in a hospice, we would expect that the organisation should have its own safeguarding procedures in place, usually including training, DBS checks etc. If they do not then we advise you to enquire of them what their processes are for ensuring the safety of their clients, and if necessary to get your own DBS check. This will not generally be the same 'level' of check as would be available to an employer or organisation, but for your own protection you may wish to explore this, or request your organisation to get a check on your behalf.

DBS checks are inherently limited as of course they are only truly valid on the day they are issued. However they are the standard safeguarding check for organisations and institutions, and some practitioners may find it helpful or advisable.

For Scotland, England and Wales you can get a disclosure check from –
Disclosure Scotland (for Scotland, England and Wales) -
http://www.disclosurescotland.co.uk/basicdisclosureonline/index.htm tel 0870 609 6006,
or Mayflower Disclosure Services - http://dbsdirect.co.uk/.

For Northern Ireland, you can use Access NI - http://www.nidirect.gov.uk/index/information-and-services/crime-justice-and-the-law/accessni-criminal-record-checks/accessni-checks.htm.

For more information about the DBS system see the government page on DBS -
https://www.gov.uk/disclosure-barring-service-check/overview.

Working with adopted and adoptive children, adults or families

If you work specifically with adopted children (including as adults) or parents including the birth parents to support them for adoption-related issues, you need to ensure you are working with an agency that is properly registered with OFSTED. Under law, all agencies providing specific support for adoption-related issues must be registered with OFSTED – you can find further details here - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/443510/Introduction_to_adoption_support_agencies.pdf.

If the adoption issues are not the main focus of your work with the client, or are unknown until you begin work, you do not need to ensure this registration but OFSTED advises for counsellors "it is good practice for you to seek advice from someone registered to provide adoption support services. It may be better for your client to be referred to a specialist service. If it becomes clear that matters related to adoption is the main purpose for the counselling, you should make clear to the client their right to access adoption support services and consider referring the client to a registered adoption support agency."

B: Awareness and skills

Safeguarding sits within a context of practitioner skills and commitments. These include such aspects as –

- the necessity for confidentiality
- ensuring genuine informed consent has been given for any part of the treatment
- being sure Craniosacral therapy is appropriate for the client and knowing when to refer
- never exerting influence over a client regarding treatment or any other matter
- recognising potential boundary issues and addressing them
- working inclusively and without prejudice based on any characteristics of the client
- being aware of potential 'red flag' symptoms
- ability and willingness to reflect on our practice and seek supervision where needed
- making sure a parent or carer is present when treating a child or vulnerable adult

1 Confidentiality

Confidentiality obviously underpins all of our work, both during and after the lifetime of the client, and should only be broken in rare circumstances as described below. Confidentiality includes the identity of the client as well as any information about them.

Occasions where confidentiality may be broken with consent – to pass on information to another health care provider, or if it is in the client's interests. Without consent – if it is required by law, or in the public interest, or in an emergency. For more details and cautions, see the Code of Ethics 8.2.1, 8.2.2.

See Code of Ethics para 8, Standards of Practice p6 'Confidentiality'

Additional information

Vulnerable adults – in law, all people over 16 are assumed to have the capacity to give or withhold consent for disclosure of confidential information, unless there is evidence to the contrary, and must be involved in these decisions. This does not override the need to have a carer present during the session – see section 9.

Children – children who are aged 12 or over are generally expected to have capacity to give or withhold their consent to the release of information, although the practitioner needs to assess their understanding and maturity if under 16 in England, Wales and Northern Ireland. In Scotland, anyone aged 12 or over is legally presumed to have such capacity. As with vulnerable adults you should still have a responsible adult present during the session – see section 9.

If a child asks you to withhold information from their carer you are advised to seek advice from the CSTA or a lawyer. As ever it is the needs of the child that are of paramount importance, and you may need help and support to assess this.

End of life care – sometimes relatives may request to be present when treatment is given. This needs careful negotiation with all concerned, to preserve the confidentiality of the treatment and also the relationship with the caregivers.

Suspected abuse - in cases of suspected abuse there may also be a need to release confidential information, and this will be described below under Part 2 section 1, what to do if you suspect abuse.

Parental responsibility - please see Appendix 2, parental responsibility, for details on who has responsibility for the child where this is not straightforward.

2 Consent for treatment

As with confidentiality, consent is a clear necessity for all of our work. The importance of a safe therapeutic relationship cannot be overstated. We are intending to support the client's empowerment and need to be aware of the subtle ways this can be undermined including within the craniosacral session.

Definition of informed consent – this means that the person has both understood and agreed to what is being proposed. With care to explain in simple language and enable the client to ask questions or express concerns, this is often straightforward. However we need to be aware of more subtle signals especially in the case of children, vulnerable adults and in fact all clients at certain times eg when in in a trauma response. We need to be alert to the possibility that a client may not, because of age, capability to understand or retain information, or momentary difficulty, be able to voice their concern or desire for the work to stop, and use our sensitivity to ensure we have negotiated or re-negotiated contact as appropriate.

See Code of Ethics para 3.1.6, 4, 7.1.1-3, 7.2, 7.3, Standards of Practice p7 'Effective communication', p10 'Consent', p19 'Consent', p24 'Consent'

Additional information

For children under 16 and vulnerable adults – in addition to the above, consent must normally be obtained from a parent or guardian. Care must be exercised if the parent is also under 18 years. Please see Appendix 2 for more detail on who has parental responsibility where this is not straightforward. If a child under 16 requests treatment without knowledge of the guardian, you should seek legal advice.

If a parent or guardian wishes the child or vulnerable adult to have treatment but it is clear to you that the client is unwilling, you need to negotiate this with the caregiver and always have regard to the client's needs.

We also strongly advise that a guardian is present within the session. If for some reason they are not you should obtain consent in writing from them for both the session and stating their absence –

however this should not be the norm but only for documented good reasons. Please see section 9 for more information, and the Code of Ethics para 7.1.3-4 for cautions in this situation.

For a child between 16 and 18 - it is preferable but not essential to have the guardian's consent.

For end of life care - if the client is unable to give verbal consent, it may be necessary to obtain written consent from the client or other authorised person. If the client lacks capacity to give informed consent, you must obtain consent from the person responsible for their welfare, always with clear regard for what you believe to be in the best interests of the client. Particular care should be taken if lasting Power of Attorney has been granted. This is a sensitive area and we suggest legal advice to support these decisions.

Fluctuating capacity – some people who have certain forms of mental health difficulties may be deemed to lose capacity during acute episodes of illness, but capacity will be regained during periods of health.

Parental responsibility - please see Appendix 2 on parental responsibility for details of who has responsibility for the child where this is not straightforward.

3 Appropriateness

We need to be willing if necessary to pass a client on to another practitioner, for example if it becomes apparent we do not have adequate skills to help them, or that another modality may be appropriate either alongside or instead of craniosacral therapy. This may include advising the client to speak to their GP, or asking consent to contact the GP on their behalf.

See Code of Ethics para 3.1.2, 3.1.8, 19.2-3, Standards of Practice p12 'Client Contract', p13 'Therapeutic Awareness', p15 'Ensuring Treatment is Appropriate', p19 'Choices', p21 'Child Development', p22 'Common Illnesses', p25 'Effects of Medical Treatment'

Additional information

For children and vulnerable adults – we need to assess carefully, taking into account our training, knowledge and life experience.

For end of life care – we need to consider carefully our readiness to care for the dying, including the working environment and our own beliefs in relation to those of our clients and their families.

4 Never exerting influence

Undue influence is a legal term and in the case of practitioners would include pressurising, overtly or subtly, clients to have or continue to have treatments, or withholding a needed referral, as well as charging unreasonable or unclear fees or pressurising a client to buy any products from us.

Imposing our personal beliefs on a client about their process could also be seen as exerting an inappropriate influence. We need to be aware when we may fall into unconscious patterns or power dynamics with clients and seek supervision.

See Code of Ethics para 3.1.1, 3.4, 18, Standards of Practice p10 'Empowerment', CSTA 'Advertising Guidance'

Additional information for all vulnerable clients - we need to be especially aware of this possibility and seek to support empowerment and choice at all times.

5 Recognising and dealing with potential boundary issues

We are expected to be aware of potential boundary issues and seek supervision and support as needed. This could be in the case of a dual relationship or a process that triggers client and practitioner into transference and counter-transference, which unless worked with can significantly undermine the therapeutic relationship, particularly when the client is working with vulnerabilities. The client's therapeutic needs and physical, mental and emotional safety must be our primary consideration.

See Code of Ethics para 3.3, Standards of Practice p13 'Boundaries', p25 'Boundaries'

6 Working without prejudice

We need to work without prejudice based on social status, ethnicity, sexual orientation, gender, disability, culture, beliefs, lifestyle, age, communication difficulty or any other aspect. Where we notice judgment arising in us we must take time to explore this and if needed seek supervision to support us to work through this.

See Code of Ethics para 3.1.7, Standards of Practice p9 'Inclusiveness'

7 Referrals to doctors and 'red flag' symptoms

We need to be aware of the possibility of serious illness and ready to refer immediately to doctor or hospital where appropriate, and of the potential for babies and small children to go downhill extremely rapidly. Please see Appendix 3 for a list of 'red flag' symptoms in adults and babies.

See Code of Ethics para 3.1.2, 3.1.8, 3.4.1, 19.3, Standards of Practice p8 'Referrals and 'red flag' symptoms'

<u>Additional information for babies and children</u>

We need a working knowledge of child development and to be ready to refer to a medical practitioner if there is cause for concern.

Parents and guardians have a legal duty to give their children the best care possible. If you are treating a sick child under 16 you should check they are also under the care of their doctor. If they are not then you should insist this is put in place, offering to contact the GP on their behalf if necessary. You could find yourself being accused of being complicit in a criminal offence if a serious illness is undiagnosed and the child suffers harm as a result. You are advised to seek legal advice if such a situation presents itself and keep a written record of your advice to the guardian to seek medical attention.

8 Reflection, supervision and support

We are expected to continually reflect on our practice, identifying any gaps in our skills, knowledge or awareness and seeking to grow. Regular supervision is a support for any practitioner, and enables our work to be held, and as such represents one way of being looked after as a professional. Supervision may be general, exploring all aspects of practice and the therapeutic relationship, or at times the practitioner may seek specific supervision, for example with someone with experience of working with children or the dying.

Especially in the case of vulnerability and extreme situations such as possible abuse or suicidal crisis, we are likely to need strong support in our practice. We give more suggestions in part 2 below.

See Code of Ethics para 3.1.7, 3.3.2-3, 8.2.3, 9.1.4, Standards of Practice p7 'Deepening professional understanding', p7 'Self-reflection', p8 'Duty of self-care', p23 'Supervision and training', p24 'Readiness', p25 'Supervision'

9 Caregiver present for treatment of child or vulnerable adult

We very strongly suggest a parent or other carer should always be present when a child or vulnerable adult is treated. This enables the carer to observe what happens and to be part of the process as appropriate. Assuming a relationship of trust between the client and guardian, it supports the client to feel able to express any concern or discomfort with the process, and reduces potential intimidation in an unfamiliar situation. As always, the therapeutic, safety and security needs of the client – mentally, emotionally and physically - must always be paramount, if necessary insisting that guardians respect this by being present.

If the carer wishes not to be present you should obtain confirmation of this in writing, but always carefully question the reasons and give highest regard to the needs of the client, for example asking them what their preference is or what would help them most and recording this. If you feel the client is uncomfortable to be alone with you, you must stop the session or refuse to work without the guardian present.

Occasionally it may be more appropriate for a client to be treated without their carer present, for example an older teenager may feel more comfortable with this and may feel more able to speak openly. However this should not be the norm for your practice, should not be suggested by you as a matter of course, and you should record the reasons and consent given by both client and caregiver. Always be aware that you must carefully balance the genuine welfare needs of the client – if they are vulnerable then almost always they are in fact safer with a trusted caregiver or advocate present. In case of doubt, do not treat alone, consult the CSTA or your supervisor and take legal advice first. For more details and cautions see the Code of Ethics para 7.1.4-5.

Some practitioners are working in unusual, mostly institutional, settings that for various reasons may involve unsupervised treatment for children or vulnerable adults. As mentioned in Section A 'Working unsupervised with vulnerable people', in these situations we would expect the institution to have its own rigorous safeguarding procedures and norms in place, for example replacing the usual parental responsibility, and we encourage practitioners to enquire about these.

See Code of Ethics para 7.1.4-5, Standards of Practice p19 'Keeping safe'

PART 2 – Guidance

1 What to do if you suspect a child or vulnerable adult is being harmed, abused or neglected

See also Code of Ethics para 7.1.6, Standards of Practice p20 'Child protection'

Report and refer

If you suspect a child or vulnerable adult is being abused, neglected or harmed you are obliged to inform the relevant authorities such as the social services child protection team, GP, or in an emergency the police. This duty takes precedence over the usual confidentiality. It is not your duty to find out whether abuse is taking place, but to inform the relevant authorities of your concern so that they can ascertain what is happening.

As mentioned, 'Working Together 2015' (see Appendix 1) states that safeguarding is everybody's responsibility, and the Care Act 2014 states that "no professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult's welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information with the local authority and, or, the police if they believe or suspect that a crime has been committed".

Stopping abuse is important not only for the immediate safety of the child or vulnerable person, but also for their long term development. Being abused as a child can lead to poor physical or mental health later in life including depressive and anxiety disorders, eating disorders, behavioural or conduct disorders, drug or alcohol use, suicide attempts, risky sexual behaviour, criminal risk taking behaviour.

When to inform authorities

(adapted from http://www.safenetwork.org.uk/help_and_advice/Pages/What_is_child_abuse.aspx, http://www.nhs.uk/conditions/social-care-and-support-guide/pages/vulnerable-people-abuse-safeguarding.aspx, http://www.elderabuse.org.uk/)

If you are concerned abuse is taking place you should inform local social services who will investigate, though you can contact the GP or in case of immediate danger call 999.

Guidance for children and adults is slightly different, but in general a concern should be raised if any kind of abuse or neglect – physical, emotional, sexual – has happened or is happening to a child or vulnerable adult. It is good practice to ask the client why they are upset or how a cut/ bruise was caused - this may clarify any vague concerns.

Once you have made contact with Children and Young Peoples Service or Social Services they should contact you within 24 hours of receiving your referral to discuss your reasons for concern. You should keep a written record of any conversations with social services.

For children, if you have concerns but are in doubt about whether to report them you can speak to the NSPCC helpline for advice on 0808 800 5000 – available 24 hours a day, 7 days a week.

For adults there is presumed to be capacity for them to agree or not to intervention and disclosure and the initial suggestion is to discuss your concerns with them in private if that is possible, with sensitivity that if they've been abused, they may be reluctant to talk about it – shame is a fundamental element of all kinds of abuse. Unless you're concerned for their immediate health and safety and feel it's vital to act straight away, you are advised to give them time to think about what they'd like to do. Let them know who can help them, offer to seek some help on their behalf if they

want or if it's difficult for them to do so themselves. It's important to listen to what they say and not to press into action if this isn't what they want. If relevant you might want to talk to other people who know the person you're worried about to find out if they have similar concerns.

If there is more immediate concern then their safety is paramount and you must report in order to protect them. Local authorities have social workers who deal specifically with cases of abuse and neglect. If you have concerns about an adult but unsure whether to report these you can contact the person's local council anonymously and ask for the adult safeguarding co-ordinator, or for elderly people you can call the Action on Elder Abuse helpline, free and in confidence, on 0808 808 8141 http://www.elderabuse.org.uk/ , or contact the CSTA for advice.

Confidentiality - the best interests of the client must guide decisions. Sometimes a client may not want confidential information disclosed despite this being necessary to ensure they do not suffer harm. This is a complex situation and may also be part of an abuse pattern of protecting the abuser. It's best to avoid promising you won't tell anyone, as you may have to break this promise in order to seek help. You need to balance the trust in the relationship with any immediate danger to the client - the ideal is always to have consent for disclosure, but the safety of the client and avoidance of harm is paramount. Where there is any doubt as to whether disclosure is in a child's best interests, it is recommended to discuss with a lawyer or the NSPCC who can give specialist advice.

Signs of abuse and neglect

We all need to be informed beyond our own assumptions of how abuse may play out. We also need to be aware of the more recently highlighted possibilities such as online abuse, exploitation or bullying, and child trafficking.

Please see Appendix 4 for some possible signs and symptoms of abuse. In general we might suspect possible abuse when a child or vulnerable adult shows a change in behaviour, perhaps becoming more aggressive or withdrawn, is uninhibited sexually, avoids certain people or situations, falls behind in school or exhibits behaviour or has knowledge that is markedly unusual for a person of their age and situation.

Please also see Appendix 5 for statistics on abuse and Appendix 6 for general information about mental health issues and possible signs, many of which will apply to victims of abuse.

As a practitioner we need to be aware of our assumptions. We may like to think that abuse doesn't really happen to our clients, or we may have unresolved trauma from abuse ourselves and be unwilling to see it in others or project this possibility onto others where it is not present. As ever supervision is helpful, as well as your own ongoing therapeutic process.

Where your concern is less urgent – not that a child or vulnerable adult may be at risk of abuse, but that they or their family may benefit from help and support – there may still be a need to share information with agencies, but this should be done with consent.

Seek supervision and support – these issues are always stressful to deal with and you should get support. Our strong recommendation is to have supervision with someone you trust to be able to hold a strong process, both of yourself and of your client. If you are in doubt about where to find help please contact the CSTA. You can also share any dilemma with the NSPCC 0808 800 5000 – available 24 hours a day, 7 days a week.

2 What to do in the case of suicide risk

Please also see Appendix 6 for general information about mental health issues and possible signs.

Always refer

Suicide risk is a specialist and intensive area of work and although you may be able to give a lot of meaningful support, you should ensure the client is primarily and adequately supported by a person or agency trained to work with this risk. This will ensure the best support for your client and also look after you legally, ethically and energetically. Do not fall into trying to take on too much, beyond your scope of expertise, which can easily happen in such an inherently intense situation.

Refer the client to support services such as their GP or social services, or for immediate risk local hospital A&E and independent services, such as the Samaritans http://www.samaritans.org/ 08457 90 90 90 or Maytree http://www.maytree.org.uk/ 0207 263 7070, who will be able to offer support 24 hours a day. Maytree have a unique free residential short-term respite option in London for acutely suicidal people. They will also offer phone support to anyone feeling suicidal, or anyone with concerns about a possible risk.

Always make a written record of all conversations with the client in their notes and encourage them to continue to receive specialist support as well as anything you can offer.

Identifying immediate risk

It is hard and not advisable for non-specialists to try to discern who is an immediate risk, compared to someone with more general or vague suicidal ideation. However for information, some possible warning signs and risk factors may be -

- The client is very low and/or depressed, and there seems to be no solution
- Recent major life stress
- Anniversary of a loss
- History of suicide attempts, especially pre-meditated or where the person regrets having survived
- Recent discharge from psychiatric unit
- Diagnosis of bipolar disorder
- History of or current alcohol or substance abuse
- Has the means easily available

In addition, new research (August 2015) by the European College of Neuropsychopharmacology (ECNP) can be seen at - http://www.ecnp.eu/~/media/Files/ecnp/About%20ECNP/Press/AMS2015/Popovic%20PR%20FINAL.pdf

The research concluded that certain behaviour patterns precede many suicide attempts, with the risk of an attempt being at least 50% higher if a depressed person displayed:

- risky behaviour such as reckless driving or promiscuous behaviour
- psychomotor agitation such as pacing around rooms or wringing their hands
- impulsivity - defined by the researchers as acting with "little or no forethought, reflection, or consideration of the consequences"
- in general, depression mixed with ‘excitation’ or manic states was more of a risk for suicide

Factors noted as already established included people being very withdrawn or very anxious.

As mentioned it is a very specialised skill to identify risk, and should not be attempted by us as craniosacral practitioners – these indicators are provided for reference in case you find yourself in the position of supporting somebody.

In case of emergency or immediate danger

You may need to make a judgment about whether to call social services or even 999 on the client's behalf. It is hard for us as non-specialists to assess the immediate risk, and disclosing without consent may have negative effects on your therapeutic relationship – balanced against this is the potential urgency of the situation. If the client is mistrustful of authorities, try to encourage them to seek support from an independent source such as the Samaritans or Maytree, who are trained to work with and assess immediate risk. This is much preferable to trying to make a decision yourself about whether to contact agencies, and even in the case that they have already harmed themselves it is quicker and easier for emergency services to reach them if they call. However if you believe the person needs and will not seek emergency help, you may need to call on their behalf without permission.

If there is a child present with an adult who you believe is going to harm themselves, this makes the situation more urgent again and you may need to breach confidentiality in order to protect the child as well as the adult. However it is still much preferable for the client to call emergency services themselves, or to give their consent for you to do this.

Points to remember when dealing with clients at apparent immediate risk

- Don't panic, remain calm.
- They have called you, indicating they want to talk and get help, which is a positive step.
- Tell them you are concerned about their situation, and encourage them to use a more specialist and appropriate service (including an emergency service if necessary). For example the Samaritans on 0845 790 9090 or Maytree 0207 263 7070.
- If necessary consider asking them to make a 'contract' with you – to agree not to harm themselves until a later time/ day, when you can speak again – all the time encouraging referral to a more appropriate source of help.
- Don't be tempted to give false hope - eg suggesting their adopted child might be returned to them.

Be aware of your tendencies and get support

The threat or risk of suicide is by definition a heightened, extreme situation and we may fall into our deepest and not always most functional coping mechanisms. This is why as practitioners we always need support in this kind of situation.

It is common to feel upset or worried, possibly thinking that you could have done more to help. Remember you are not ultimately responsible for the client, and can only give your best help within your remit. By acknowledging the extent of their distress, taking them seriously and offering them suggestions for the most appropriate support available, you have given appropriate and sensitive help.

Seek supervision as soon as possible and stay in regular touch with your supervisor. You may benefit most from support from a supervisor experienced in this area, or with someone you know and trust to be able to hold a strong process, both of yourself and of your client. If you are in doubt about where to find suitable support please contact the CSTA.

Appendices

Appendix 1 - Relevant statutory information

Working Together 2015 – can be found at https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Sets out requirements for statutory agencies but contains information applicable to all.

Care Act 2014
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

As with Working Together, sets out statutory requirements but contains applicable information. Section 1 on p1 describes 'Promoting wellbeing' and section 14 on p229 defines and describes safeguarding for adults.

BMA guidance - http://www.medicalprotection.org/uk/resources/factsheets/england/england-factsheets/uk-eng-consent-children-and-young-people

Aimed at health professionals within the NHS. Includes information about consent in different parts of the UK.

Appendix 2 - Parental responsibility

A child is currently defined in law as someone who is under 18 in England, Wales and Northern Ireland, and who is under 16 in Scotland. Parental responsibility is a legal concept that lasts until a child reaches this age. Often it may be obvious who has parental responsibility but in case of more complex situations there are accepted rules. Those who can have parental responsibility are as follows:

For children born after 1 December 2003 (England and Wales), 15 April 2002 (Northern Ireland) and 4 May 2006 (Scotland) – Both of a child's biological parents have parental responsibility if they are registered on a child's birth certificate. A child's biological mother automatically has parental responsibility, unless this has been given up.

For children born before these dates - A child's biological mother automatically has parental responsibility, unless this has been given up. The biological father will only automatically acquire parental responsibility if the parents were married at the time of the child's birth or at some time afterwards. If the father has not been married to the mother, he can acquire parental responsibility by agreement with the mother or by court order.

In addition -

- Neither parent loses parental responsibility on divorce.
- Parents who do not have parental responsibility nonetheless play an essential role in determining best interests and may have a right, under the Human Rights Act, to participate in the decision-making process.
- In some circumstances parental responsibility can be delegated to other carers such as grandparents and childminders. If there is doubt about whether the person giving or withholding consent has parental responsibility, legal advice should be sought.

- In some circumstances people other than parents acquire parental responsibility, for example by the appointment of a guardian or on the order of a court.
- Where the child has been formally adopted, the adoptive parents are the child's legal parents and automatically acquire parental responsibility.
- A local authority acquires parental responsibility (shared with the parents) if a child is the subject of a care or supervision order.
- Where the child has been born as a result of assisted reproduction, there are rules under the Human Fertilisation and Embryology Act 1990 that determine the child's legal parentage.

Appendix 3 - Red Flag symptoms

Symptoms needing immediate referral / contacting of emergency services include:

- Symptoms coming on suddenly which could indicate stroke:
  - numbness or weakness of face, arm or leg - especially on one side of the body.
  - confusion, difficulty with either speaking or understanding.
  - trouble seeing in one or both eyes.
  - trouble walking, dizziness, loss of balance or coordination.
  - severe headache with no known cause

- Shortness of breath and/ or pain in left shoulder and arm after exercise or stress, particularly if accompanied by clamminess and thoracic pain which is crushing

Symptoms needing referral to primary health-care practitioner for investigation as soon as possible:

- Unexplained sudden acute internal pain, with or without nausea, which worsens or does not ease with a change in position or loosening tight clothing.
- Pain associated with breathing, regular abdominal pain occurring either before or after eating
- Blood in sputum, vomit, urine or stool; vaginal bleeding between cycles, or post-menopause.
- Changes in bladder and bowel habit or control; black 'coffee ground' stools
- Persistent vomiting or diarrhoea
- Unexplained significant weight loss or gain
- Uninvestigated continuing altered sensation / numbness / loss of sensation in any area of the body, especially bilateral pain or loss of sensation in the legs
- Night sweats beyond the menopause
- Undiagnosed continuing or worsening high fever
- Persistent worsening cough (especially in smokers)
- Increased thirst and increase in urination

Signs of possible immediate concern for babies –

- Vomiting (green or yellow, bloody or occurring more than 5 times per day)
- Change in stool (constipation or diarrhoea, especially with blood or mucous)
- Abnormal temperature - rectal temperature below 36.1°C/ 97.0°F or over 38.0°C/ 100.4°F
- Irritability (crying all day with few calm periods in between)
- Lethargy (excess sleepiness, lack of smiles or interested gaze, weak sucking lasting over 6 hours)
- Poor weight gain (gaining less than 15 grams per day)

Signs a baby or infant may have a head injury -

- visible signs of an impact such as swelling, bruising or fractures
- being comatose
- respiratory problems
- seizures
- vomiting
- unusual responses – irritable, poor feeding, lethargic, unresponsive

Appendix 4 – Definitions, signs and symptoms of abuse and neglect in children and adults

A) Child abuse –

Taken from NSPCC website http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect

Definition of abuse - Child abuse is any action by another person – adult or child – that causes significant harm to a child. It can be physical, sexual or emotional, but can just as often be about a lack of love, care and attention. Neglect, whatever form it takes, can be just as damaging to a child as physical abuse – see further down for more information about neglect.

An abused child will often experience more than one type of abuse, as well as other difficulties in their lives. It often happens over a period of time, rather than being a one-off event.

Many of the signs that a child is being abused are the same no matter how the abuse happens. Watch out for unusual behaviour such as -

- withdrawn
- suddenly behaves differently
- anxious
- clingy
- depressed
- aggressive
- problems sleeping
- eating disorders
- wets the bed
- soils clothes
- takes risks
- misses school
- changes in eating habits
- obsessive behaviour
- nightmares
- drugs
- alcohol
- self-harm
- thoughts about suicide
- compulsive habits
- reports from school that their behaviour is affecting their progress and achievement

Emotional abuse

Emotional abuse often overlaps with other kinds of abuse, and may not always be deliberate. It includes:

- humiliating or constantly criticising a child
- threatening, shouting at a child or calling them names
- making the child the subject of jokes, or using sarcasm to hurt a child
- blaming, scapegoating
- making a child perform degrading acts
- not recognising a child's own individuality, trying to control their lives
- pushing a child too hard or not recognising their limitations
- exposing a child to distressing events or interactions such as domestic abuse or drug taking
- failing to promote a child's social development
- not allowing them to have friends
- persistently ignoring them
- being absent
- manipulating a child
- never saying anything kind, expressing positive feelings or congratulating a child on successes
- never showing any emotions in interactions with a child

Physical abuse

Physical abuse is deliberately hurting a child or vulnerable person, causing injuries such as bruises, broken bones, burns or cuts. It includes violence such as being hit, kicked, poisoned, burned, slapped or having objects thrown at them.

Shaking or hitting babies can cause non-accidental head injuries (NAHI).

Sometimes parents or carers will make up or cause the symptoms of illness in their child, perhaps giving them medicine they don't need and making the child unwell – this is known as fabricated or induced illness (FII).

Signs and symptoms of physical abuse

Bumps and bruises don't necessarily mean a child is being physically abused – all children have accidents, trips and falls.

There isn't one sign or symptom to look out for that will say a child is definitely being physically abused. But if a child often has injuries, there seems to be a pattern, or the explanation doesn't match the injury then this should be investigated.

Sexual abuse

A child is sexually abused when they are forced or persuaded to take part in sexual activities. This doesn't have to be physical contact, and it can happen online. Sometimes the child won't understand that what's happening to them is abuse. They may not even understand that it's wrong.

Sexual abuse includes 'contact abuse' where an abuser makes inappropriate physical contact including penetration, and non-contact abuse - other acts where the abuser doesn't touch the child, such as grooming, exploitation, persuading children to perform sexual acts over the internet, showing a child sexual images, and flashing.

Signs and symptoms of sexual abuse

Children who are sexually abused may:

- Stay away from certain people
  - avoid being alone with people, such as family members or friends
  - seem frightened of a person or reluctant to socialise with them

- Show sexual behaviour that's inappropriate for their age
  - become sexually active at a young age
  - show a lack of inhibition
  - be promiscuous
  - use sexual language or know information that is significantly unexpected for their age
  - sexual interest in adults or children of very different ages to their own
  - forceful or aggressive sexual behaviour

- Have physical symptoms
  - anal or vaginal soreness
  - an unusual discharge
  - sexually transmitted infection (STI)
  - pregnancy

Online abuse

Online abuse is any type of abuse that happens on the web, whether through social networks, playing online games or using mobile phones. Children and young people may experience cyberbullying, grooming, sexual abuse, sexual exploitation or emotional abuse.

Children can be at risk of online abuse from people they know, as well as from strangers. Online abuse may be part of abuse that is taking place in the real world (for example bullying or grooming). Or it may be that the abuse only happens online (for example persuading children to take part in sexual activity online).

Children can feel like there is no escape from online abuse – abusers can contact them at any time of the day or night, the abuse can come into safe places like their bedrooms, and images and videos can be stored and shared with other people.

Signs and symptoms of online abuse

A child may be experiencing abuse online if they -

- spend lots, much more or much less time online, texting, gaming or using social media
- are withdrawn, upset or outraged after using the internet or texting
- are secretive about who they're talking to and what they're doing online or on their mobile phone
- have lots of new phone numbers, texts or e-mail addresses on their mobile phone, laptop or tablet

Signs and symptoms of domestic violence

Witnessing domestic violence is abusive for the child. Children who witness domestic abuse may -

- become aggressive

- display anti-social behaviour
- suffer from depression or anxiety

Signs and symptoms of neglect

Taken from https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/neglect/signs-symptoms-effects-neglect/

Neglect is the most common reason for taking child protection action. Government definition of neglect – "Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food, clothing and shelter (including exclusion from home or abandonment); protect a child from physical and emotional harm or danger; ensure adequate supervision (including the use of inadequate care-givers); ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs."

Neglect can be anything from leaving a child home alone to the very worst cases where a child dies from malnutrition or being denied the care they need. In some cases it can cause permanent disabilities. Children who are neglected often suffer other forms of abuse.

Children who have been neglected may experience short-term and long-term effects that last throughout their life. Children who don't get the love and care they need from their parents may find it difficult to maintain healthy relationships with other people later in life, including their own children. A parent or carer's behaviour has a big impact on a child. It can also affect the relationship between parent and child.

This relationship, or bond, between a child and their primary caregiver - usually mum or dad but sometimes another family member or carer - is described by attachment theory. When a child is neglected they don't usually have a good relationship or bond with their parent. Psychologists would describe this as a poor attachment. Poor attachment can significantly affect the relationships that people have throughout their lives, including how they interact with their own children.

Early intervention can change attachment patterns, reducing harm to a child and helping them to form positive attachments in adulthood. The first years of a child's life have a big impact on how their brain develops. That is why neglect can be so damaging – a child's experiences can change their thought processes and neural pathways. If a baby is malnourished, neural cells can become weak or damaged and this can cause lowered brain function. If a child has a poor relationship, attachment or little interaction with a parent then it can change how their brain develops emotional and verbal pathways.

Neglect can severely alter the way a child's brain works. This can lead to an increased risk of depression in later life as well as dissociative disorders and memory impairments. Changes to the brain caused by neglect have also been linked to panic disorder, posttraumatic stress disorder (PTSD) and attention deficit and hyperactivity disorder (ADHD). Young people may also take risks, such as running away from home, breaking the law, abusing drugs or alcohol, or getting involved in dangerous relationships - putting them at risk from sexual exploitation.

Neglect can be difficult to identify, making it hard for professionals to take early action to protect a child. Having one of the signs or symptoms below doesn't necessarily mean that a child is being neglected. But if you notice multiple, or persistent, signs then it could indicate there's a serious problem.

Poor appearance and hygiene. They may:

- be smelly or dirty
- have unwashed clothes
- have inadequate clothing, e.g. not having a winter coat
- seem hungry
- have frequent and untreated nappy rash in infants.

Health and development problems. They may have:

- faltering weight or growth and not reaching developmental milestones (known as failure to thrive)
- poor language, communication or social skills
- inappropriate behaviour for the circumstances or their age
- untreated injuries, medical and dental issues
- repeated accidental injuries caused by lack of supervision
- recurring illnesses or infections
- not been given appropriate medicines
- missed medical appointments
- poor muscle tone or prominent joints
- skin sores, rashes, flea bites, scabies or ringworm
- thin or swollen tummy
- anaemia
- tiredness

Housing and family issues. They may be:

- living in an unsuitable home environment for example not having any heating
- left alone for a long time
- taking on the role of carer for other family members

B) Adult abuse –

Taken from Care Act 2014 -
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

And NHS - http://www.nhs.uk/conditions/social-care-and-support-guide/pages/vulnerable-people-abuse-safeguarding.aspx

Exploitation is a common theme in the following list of the types of abuse and neglect.

- Physical abuse
  - including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.
- Domestic violence
  - including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.
- Sexual abuse
  - including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing

sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

- Psychological abuse
  - including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.
- Financial or material abuse
  - including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
- Modern slavery
  - encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
- Discriminatory abuse
  - including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.
- Organisational abuse
  - including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.
- Neglect and acts of omission
  - including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating
- Self-neglect
  - this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding

<u>Patterns of abuse</u> vary and include:

- serial abusing in which the perpetrator seeks out and 'grooms' individuals. Sexual abuse
- sometimes falls into this pattern as do some forms of financial abuse;
- long-term abuse in the context of an ongoing family relationship such as domestic
- violence between spouses or generations or persistent psychological abuse; or
- opportunistic abuse such as theft occurring because money or jewellery has been left
- lying around.

<u>Domestic abuse</u>

In 2013, the Home Office announced changes to the definition of domestic abuse:

- Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse... by someone who is or has been an intimate partner or family member regardless of gender or sexuality
- Includes: psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence; Female Genital Mutilation; forced marriage.
- Age range extended down to 16.
- Many people think that domestic abuse is about intimate partners, but it is clear that other family members are included and that much safeguarding work that occurs at home is, in

fact is concerned with domestic abuse. This confirms that domestic abuse approaches and legislation can be considered safeguarding responses in appropriate cases.

Financial abuse

Financial abuse is the main form of abuse by the Office of the Public Guardian both amongst adults and children at risk. Financial recorded abuse can occur in isolation, but as research has shown, where there are other forms of abuse, there is likely to be financial abuse occurring. Although this is not always the case, everyone should also be aware of this possibility.

Potential indicators of financial abuse include:

- change in living conditions
- lack of heating, clothing or food
- inability to pay bills/unexplained shortage of money
- unexplained withdrawals from an account
- unexplained loss/misplacement of financial documents
- the recent addition of authorised signers on a client or donor's signature card

Abuse in the elderly

Behavioural signs of abuse in an older person could include:

- becoming quiet and withdrawn
- being aggressive or angry for no obvious reason
- looking unkempt, dirty or thinner than usual
- sudden changes in their normal character, such as appearing helpless, depressed or tearful
- physical signs of abuse, such as bruises, wounds, fractures and other untreated injuries
- the same injuries happening more than once
- not wanting to be left on their own or alone with particular people
- being unusually light-hearted and insisting there's nothing wrong
- their home may lack heat, be unusually dirty or untidy, or you might notice things missing
- a sudden change in their finances, not having as much money as usual, or getting into debt

Appendix 5 – Statistics on child and vulnerable adult abuse

Statistics on child abuse

Taken from NSPCC - http://www.nspcc.org.uk/ - which includes links to all statistics given.

Findings from research studies usually reveal much higher numbers of children who have been abused than official statistics. This gives an indication of how much child abuse does not come to the attention of authorities. Many children do not tell anyone of the abuse at the time because they are scared of the consequences or because they are unsure who to tell or how to tell someone. More people will disclose abuse during research because they are able to do so anonymously and confidentially, without worrying about an investigation from the authorities or the effect on their family.

- Over 50,000 children are identified as needing protection from abuse in the UK
- Over 62,000 children and young people talked to ChildLine about abuse in 2013
- NSPCC estimates that for every child identified as needing protection from abuse, another 8 are suffering abuse

Physical abuse

- 1 in 14 children have been physically abused
- 20% of contacts to the NSPCC's helpline in 2013 were concerns about physical abuse
- Nearly 200 babies suffer from non-accidental head injuries each year.

Sexual abuse

Official statistics, published annually, show the incidence of child sexual abuse recorded by authorities in the year. However it is likely that most sexual abuse isn't reported, detected or prosecuted, and that most children don't tell anyone that they're being sexually abused. It is a crime that is usually only witnessed by the abuser and the victim.

- Over 23,000 sexual offences against children were recorded in the UK in 2014
- Over 2,800 children were identified as needing protection from sexual abuse in 2014
- 1 in 20 children in the UK have been sexually abused
- Over 90% of sexually abused children were abused by someone they knew
- 1 in 3 children sexually abused by an adult did not tell anyone
- Over 18,600 children and young people talked to ChildLine in 2013 about sexual abuse
- The NSPCC's helpline responded to over 7,300 contacts about sexual abuse in 2013
- 16% of contacts to the NSPCC's helpline in 2013 were concerns about sexual abuse

Emotional abuse

- 1 in 14 children have experienced emotional abuse by a parent or guardian.
- Almost 18,000 children were identified as needing protection from emotional abuse in 2014
- Emotional abuse is the second most common reason for children needing protection from abuse
- 13% of contacts to the NSPCC's helpline in 2013 were concerns about emotional abuse
- The NSPCC's helpline responded to over 6,000 contacts about emotional abuse in 2013

Online abuse

We don't know how many children and young people are affected by online grooming. Children often don't tell anyone because they feel ashamed or guilty, may not know who to tell, or may not realise they are being abused.

- 60 per cent of young people have been asked for a sexual image or video of themselves.
- 1 in 4 young people have created a sexual image or video of themselves and sent it to someone else.
- 1 in 4 children have experienced something upsetting on a social networking site.
- Over 1,000 young people talked to ChildLine in 2013 about online sexual abuse.

Cyberbullying

- A third of children have been a victim of cyberbullying.
- 4,500 young people talked to ChildLine about online bullying in 2013

Statistics on vulnerable adult abuse

These are harder to find but in 2011 Councils received 31,000 allegations about social care workers and 24,000 about family members. There were 39,000 complaints about physical abuse, 34,000 about neglect and 25,000 about financial abuse.

Of the 83,500 incidents that were fully investigated in 2011-12, 41 per cent were found to be either substantiated or partially substantiated, while 31 per cent were not substantiated. (Source Telegraph newspaper http://www.telegraph.co.uk/news/health/9714867/Sharp-rise-in-reported-cases-of-abuse-of-vulnerable-adults.html)

Appendix 6 - General information about mental health in adults and children
Taken from http://www.safenetwork.org.uk/help and advice/best safeguarding practice/Pages/mental health and self harm.aspx

Some facts and figures about mental health

- Mental health problems can affect anyone, at any time in life
- In the UK, around 1 in 10 young people is diagnosed with a mental health disorder
- In 2011/12 Childline received 9,378 calls from children and young people about depression and mental health
- Nearly 80,000 children and young people suffer from severe depression, over 8,000 of these are under 10 years old
- Every day, on average eight children and young people talk to Childline specifically about suicide

Some of the more common mental health difficulties faced by young people include -

- Anxiety
- Depression
- Eating disorders
- Self-harm
- Bipolar disorder
- Obsessive Compulsive Disorder (OCD)
- Schizophrenia
- Post-Traumatic Stress

Effect of home environment

Children and young people can be affected not only by their own mental health but those of their family and loved ones too. Having a parent or carer with mental health difficulties can be a worrying and anxious experience for a child. In some cases children may end up taking additional responsibilities around the house, or caring for their parent or other siblings. A child or young person's role as a young carer may start to impact on their own lives. It is important as adults working with children and young people we know how to access support for young carers and how to respond when we have concerns over children's welfare.

Signs and Symptoms of mental health issues

Some of the signs and symptoms may be -

- noticeable weight loss or gain
- restlessness and irritability
- hyper-sensitivity to surroundings or actions of others
- being easily distracted or unable to concentrate
- being tearful or 'on edge'
- being less sociable with friends
- unusual behaviour or actions
- showing little interest in things that usually bring enjoyment
- lack of personal care in appearance or hygiene

Self-harm

There are growing concerns about the number of young people who find an outlet for emotional distress through causing themselves physical harm. It is important for adults who work with children to be able to spot any worrying signs and get the right help. Some forms that self-harm can take include -

- Cutting, burning, biting
- Substance abuse
- Head banging and hitting
- taking personal risks
- Picking and scratching
- Neglecting oneself
- Pulling out hair
- Overdosing and self-poisoning

Eating Disorders

Eating difficulties will affect many people throughout their lives and could include increase or loss of appetite. Eating disorders however are a way that people can try to cope with their feelings of mental distress. Young people can suffer from a range of different eating disorders, a combination of more than one or an undefined disorder.

Eating disorders can have serious effects on the body and are a sign that a child or young person needs support coping with life or particular issues from the past or present.

Anorexia Nervosa

People with anorexia may drastically reduce food intake, exercise excessively and have a preoccupation with weight loss and calorie counting.

Bulimia

People with bulimia may excessively over-eat, make themselves sick or use laxatives, and starve or drastically reduce food intake in the days following. People with bulimia may remain an average weight which can mean this goes unnoticed for some time.

Binge Eating Disorder (BED) or Compulsive Over Eating

Binge Eating can involve eating excessive amounts of food in a short period of time, often away from meal times, and eating until uncomfortably full. Compulsive eating can involve 'picking' at food all day as a way of trying to cope with difficult emotions. Both disorders can lead to feeling a lack of control, increase feelings of depression and lead to further over-eating.

Symptoms of these disorders sometimes include:

- Severe weight loss or gain
- Obsession or feelings of guilt associated with food
- Excessive exercising
- Binge eating
- Avoiding meal times
- Being secretive or lying about eating
- Depression
- Mood swings
- Poor skin, teeth or general health
- Sleeping problems or tiredness

Appendix 7 - Useful contacts

NSPCC helpline 0808 800 5000 – available 24 hours a day, 7 days a week
Young minds
Committed to improving emotional wellbeing of children and young people. Includes a helpline for anyone who has concerns about the emotional problems or behaviour of a young person.
Samaritans
Provide confidential emotional support to those experiencing despair, distress or suicidal feelings.
Teenage Mental Health
Information and advice for young people, parents, carers and professional on teenage mental health.
Child and Adolescent Mental Health
Free source of information for young people, parents and professionals about a range of mental health difficulties.
National Self Harm Network
Support individuals who self harm to reduce emotional distress and to improve their quality of life.
Harmless
Provide support, information, resources, training and consultancy to people who self-harm and those at risk of self-injury.
Beating Eating Disorders (BEAT)
UK charity for people with eating disorders and their families.
MindEd
Online e-learning resources for adults supporting children and young people with mental health issues.
Mind
Mental health charity with local groups, phone support open Monday to Friday, 9am-6pm 0300 123 3393
getconnected.org.uk
A free advice service for people under 25 0808 808 4994; help@getconnected.org.uk
http://www.nhs.uk/conditions/social-care-and-support-guide/pages/vulnerable-people-abuse-safeguarding.aspx
Includes advice for vulnerable adults about abuse

Training

Please note the CSTA has not checked these trainings for content or suitability – they are offered as general information.

If you would like to learn more about safeguarding there are many options available. Here is a small selection which are available online, some free and some for a fee -

http://www.eintegrity.org/e-learning-healthcare-course/safeguarding-children.html
http://www.virtual-college.co.uk/products/child-protection.aspx
http://www.safecic.co.uk/e-shop/all-categories/product/9-online-training-cou
http://www.scie.org.uk/publications/elearning/adultsafeguarding/index.asp

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