Child Sexual Abuse (CSA) Referral and Assessment

What happens guide

This guide is to enable professionals to understand and describe to a child, young person/family/carer/supporting friends what happens from referral and during assessment

Contents

There are three key stages involved in the initial management of any form of child abuse, including child sexual abuse, and these are:

1 Recognition

2 Referral

3 Response

The purpose of this 'What Happens' guide is for all practitioners to be able describe what happens once CSA has been Recognised and has been Referred for assessment. The Brook CSA Traffic Light Tool is used for recognition.

Working Together to Safeguard Children (2018) **states:**

High quality assessments are child-centred. Where there is a conflict of interest, decisions should be made in the child's best interests, be rooted in child development, be age-appropriate and be informed by evidence. They must:

- Be focused on action and outcomes for children
- Be holistic in approach, addressing the child's needs within their family and any risks the child faces
- Ensure equality of opportunity
- Involve children and their families, ensuring their voices are heard and provide appropriate support to enable this where there are specific communication needs
- Identify further risks to the safety and welfare of children
- Build on strengths as well as identifying difficulties
- Be integrated in approach
- Be multi-agency and multi-disciplinary
- Be a continuing process and not an event
- Lead to action, including the provision of services
- Be transparent and open to challenge

Services which are provided must be regularly reviewed.

As each child and circumstance is unique, every assessment is different, with varying outcomes and plans. When urgent, the assessment is a rapid process with the main focus on safety, injury treatment and forensic gathering. When non-urgent, the assessment is still focused on safety and information gathering.

Both urgent and non-urgent assessments follow the same process once any urgent issues are managed.

The assessment is a continuous process, with the child's wishes and feelings being sought and included where it is safe to do so in all plans.

Recognition

Disclosure / sexualised behaviour(s) “Thinking of abusing” or medical examination identifies abuse / urgent immediate recognition.

Referral

If urgent the Police **999**

Cornwall: MARU **0300 123 1116** Out of hours: **01208 251300**

Isles of Scilly: **01720 424 354** Out of office hours: **01720 422699**

Response - urgent

Police for urgent child/ young person protection.

Response - immediate

Hospital Emergency Department for urgent injuries.

For sexual abuse disclosure / allegation or abusing behaviours

Response - Social Worker or Police

Telephone call to Sexual Assault Referral Centre (SARC) to decide **urgent** or **non-urgent** medical needed, including forensic evidence gathering.

SARC Tel: **0300 303 4626SARC**
www.sarchelp.co.uk

Strategy Discussion (same day) as the start of the assessment - tri-agency

On receipt of the referral information a Strategy Discussion / Strategy Meeting will take place between the Police, Public Protection Unit (PPU), Social Worker, Children’s Social Care (CSC) and SARC (SARC includes pediatric health) to analyse the referral information and consequently decide next steps.

Key

Urgent Non-urgent On-going

Referral process

Telephone call – followed up in writing.

To make a referral – call either:

Cornwall

9am - 5pm: **0300 123 1116**

Out of hours service: **01208 251300**

To access the referral from for Cornwall Multi-Agency Refferal Unit (MARU):

www.cornwall.gov.uk/health-and-social-care/childrens-services/cornwall-and-isles-of-scilly-safeguarding-children-partnership/policies-procedures-and-referrals

Isles of Scilly

9am - 5pm: **01720 424354**

Out of hours service: **01720 422699**

To access the referral from for the Isles of Scilly: **http://scilly.gov.uk/node/2763**

In an emergency MARU will bring together the key services: police, emergency health and the SARC (Sexual Assault Referral Centre). These all work at the same time together.

1 In an emergency

The police will make sure the child or children are safe.

Consideration should be given to the use of early evidence kits and/or seizing of clothing, bedding, etc.

The SARC has a 24 hour paediatric advice line which should be utilised for the purpose of emergency specialist paediatric (pediatrics is up to 18th birthday) advice so that consideration of an urgent referral to SARC can be discussed and made if appropriate. This is part of the assessment and will inform decisions.

If a child/children has acute injuries then the paediatric advice line will direct that the child/children is taken to the hospital emergency department so that these needs can be addressed. Consideration will be given for a joint forensic examination within the acute setting but this will be a clinical decision which is made regarding what is in the best interest of the child.

The hospital emergency department will make sure any injuries are treated and emergency care is given. Some medications are needed as soon as possible and do not work if given too late. HIV Pep (post-exposure prophylaxis, is a short course of HIV medicines taken very soon after a possible exposure to HIV), Emergency Contraception and unwanted pregnancy should always be considered.

2 MARU

On receipt of a referral the MARU will undertake an initial fact-finding assessment and will analyse this information in order to determine the validity / credibility of the concerns and decide what action, if any, needs to be undertaken and by whom. Actions may include:

- Taking steps to keep the child or children **SAFE** by way of convening a Strategy Discussion / Meeting (as described in the next section).

Every MARU assessment is different and the actions / outcomes depend on:

- What information is shared
- The professional concerns
- What has happened and when
- What must be done for safety
- Whether there are other children involved
- Whether the person accused is an adult, child, professional or a family member
- Whether there is the potential of forensic recovery
- The health needs of the child, including sexual health
- Whether there is any injury (acute) or evidence of healed injury
- If the child is known to Children's Social Care (if so the case would continue to be held in the same team (if appropriate)

3 Strategy meetings

Strategy discussions take place within two hours of the information being received onto the MARU.

The strategy discussion is to decide on the immediate action to keep a child/young person safe from harm.

Information is gathered in the MARU from involved professionals and a chronology of social care involvement is undertaken and shared as part of the discussion.

The outcome of the strategy discussion would be one or more of the following:

- A Joint visit by Children's social care and the police to speak with the child/young person away from the family home.
- A Joint visit to the family home to remove risk and ensure safety whilst additional information is gathered.
- Child/young person placed elsewhere for their safety if needed.
- Coordinating and taking the child to SARC or Health Safeguarding.
- Achieving best evidence interview undertaken.

Following one or more of the above a child protection assessment will be undertaken as part of the S47 enquiry.

The outcome could be one of the following:

- Care proceedings
- Child Protection Case Conference
- Child Protection Plan
- Child In Need Plan
- Step Down to Early Help
- Closure.

Note:

- Initial response and safety plan for child/ young person and all recorded decisions must be shared with all relevant agencies
- Health needs MUST take precedence over the forensic evidence. Consideration for siblings (if perpetrator under 18, they may need medical assessment too)
- Use Escalation Process if children are not referred into SARC quickly enough.

Children's Social Care

- Most children are offered a CiN – this is an assessment completed by the social worker which has a focus on risk/safety
- Police and social work assessments diverge straight away. Possible outcomes of a CiN assessment include referral on to:
  - SARC (Sexual Assault Referral Centre - (see section 7)
  - Jigsaw (where there is immediate concern re emotional wellbeing, then referral should be made before CiN assessment is completed. If non-urgent, then Jigsaw referral is made towards end of the ChiN assessment) - (see section 14)
  - CAMHS if high risk mental health concerns - (see section 15)

4 The Police

Referral to Police for urgent child protection and medical care

If police need to take steps to remove the child/children they would make contact with the MARU during 8.45 - 17.15 hrs or the out of office hours service after 17.15 hrs. A joint decision would be made as to where the child/children need to be placed (e.g. with extended family/friends, foster placement), dependent on the circumstance.

A referral would be created over the telephone with a written referral sent in retrospect (to avoid delay), and information collated from MARU systems (Health, Education, Social Care).

A chronology of social care history for the child/children will be formulated, and a request for a strategy discussion would be sent out to the area team. A telephone strategy discussion would be held between the police, children's socialcare and the safeguarding paediatrician (**SARC**) where the medical would be arranged and the pre achieving best evidence interview booked.

As part of the S47 child protection enquiry other involved professionals would be contacted by the allocated social worker as part of the assessment process.

5 Police

Initial response – the safety and welfare of the child is paramount.

Following the strategy discussion a joint visit between police and social care will take place in order to assess the safety and welfare of the child and obtain a brief account from the child or parent/trusted adult to whom the initial account was given. A First Response Booklet will be completed to obtain this initial account and any other relevant information to assist the investigation. When a joint visit is undertaken a 'pre-interview assessment' will also be carried out to assess whether the witness would be able to undergo an interview.

Early Evidence Kit (EEK) – where appropriate EEKs can be used, for example to obtain a urine sample.

Consultation will take place with a paediatrician – in acute cases a referral will be made to Exeter SARC and a specially trained officer called a SOLO (Sexual Offences Liaison Officer) will be allocated and will assist with the arrangements for the medical examination. The child will attend with parent/carer/responsible trusted adult and where appropriate/necessary a social worker may also attend.

6 SARC

SARC should be contacted to participate in strategy discussions regarding children who have been abused or where there are concerns around sexual assault/abuse.

It is important to note that:

- SARC should be involved at the earliest opportunity for a strategy discussion with police and children's social care and can be accessed via a 24/7 number
- SARC is not just a forensic facility and there are many additional benefits to a referral into SARC for children and their families
- Health care takes precedence over forensics

The specialist paediatric advice line is 0300 303 4626. The clinician on call will contribute to the strategy discussion and make a decision regarding the appropriateness of an urgent or non-urgent referral to SARC.

Urgent referrals are time critical therefore SARC should be involved at the earliest opportunity.

Children who do not have any acute medical needs but need an acute forensic examination will be seen at the Paediatric Centre of Excellence in Exeter. This service is for all children 0-17 years, staffed by paediatric consultants, specialist forensic examiners and specialist nurses.

The assessment may include:

- An assessment of the child's health and social background
- Checking the child's ears, nose and throat, listening to their heart and lungs and examining their abdomen
- Checking for any injuries on body surfaces as well as the genital and anal area (external examination only)
- Collecting forensic samples
- Discussing the risk of sexually transmitted infections and arranging testing when required
- Considering and administering emergency medications such as emergency contraception
- Providing reassurance to children and families
- Providing onward referrals to support agencies

It may be clinically decided that a non-urgent referral into SARC is appropriate for a child. In these circumstances a child can be seen by the community paediatric team in Treliske Hospital who will conduct an assessment to include documentation of any healed injuries, reassurance to the child and family and onward referral for support.

Everything is done with the consent of the child and they can choose what services they wish to access/decline.

Further information about SARC can be accessed via **www.sarchelp.co.uk**. Non urgent referrals should be made via the secure online referral form.

This is time critical for evidence.

7 Health Emergency

Accident and Emergency

A team of doctors and nurses assess, diagnose, treat and manage injuries. Things that would be considered and may need to be treated include:

Child/Young Person presents with physical symptoms of sexual abuse:

- Ano-genital injury or foreign body in a girl or boy with no explanation / unsuitable explanation
- Anal or vaginal soreness
- Confirmed STI
- Unusual vaginal discharge (not fitting with vulvo-vaginitis)
- Recurrent unexplained UTI
- Bruising in a particular pattern

Emergency Contraception (time critical)

Antiviral medication (time critical)

Pregnancy – 'CSA and sexual exploitation should be considered when a young person, aged 13 to 17 years, is sexually active and / or pregnant' (Child Protection Companion RCPCH)

8 Paediatrician

This is a Doctor that is specially trained to care for children 0 to 18 years. They make decisions about the:

- Urgency of examination
- Emergency contraception/ PEPSE (Post Exposure Prophylaxis following sexual exposure) and emergency treatment or any other treatment needed
- The risk and treatment for possible STI (Sexually Transmitted Infection)
- Other health issues and who is best to look after you and your health

The Sexual Health Service see a number of children / young people affected by the above.

9 Achieving Best Evidence (ABE)

Where it has been agreed by the police and children's social care, in a strategy discussion/meeting, that it is in the best interests of the child that a full criminal investigation be carried out, the police are responsible for that investigation, including any investigative interview commonly referred to as an ABE (Achieving Best Evidence which is a process carried out to gather information which may / can be used in court)

The main purpose of an ABE interview is evidence gathering for use in the investigation and in criminal proceedings; it is not a 'therapeutic' interview.

The ABE interview should normally take place before the medical; however, there will be circumstances where this is not the case, for example where medical intervention is urgently required. In any event this must be discussed with the SARC Doctor at the initial strategy stage.

Having responsibility for the criminal investigation does not mean that the police should always take the lead in the investigative interview. Provided both the police and social worker have been

adequately trained to interview child witnesses there is no reason why either should not lead the interview. The decision as to who leads the interview will depend on who is able to establish the best rapport with the child. In circumstances where a social worker leads the interview, the police will retain their responsibility for the criminal investigation by ensuring that the interview is properly planned and that the police officer has an effective role in monitoring the interview. Similarly, where a police officer leads the interview, the local authority should retain their duty to make enquiries under Section 47 by ensuring that the interview is properly planned and that the social worker has an effective role in monitoring the interview.

Intermediaries – in some cases involving younger children (and in all cases of children aged under 10 years) a Registered Intermediary (RI) can be employed. A RI may be able to help improve the quality of evidence of a child witness who is unable to detect and cope with misunderstanding, or to clearly express their answers to questions, especially in the context of an interview or while giving evidence in court. The RI is there only to assist communication and understanding; they are not allowed to take on the function of investigator.

It will be necessary for the RI to conduct one or more assessment meetings with the witness. The criminal case is not discussed during assessment meetings. These meetings enable the intermediary to consider the witness's communication needs and devise strategies and recommendations for how to maximise understanding.

There are two Police ABE interview suites in Cornwall, one at Barncoose Public Protection Unit (PPU), Redruth and one at Carew House PPU, Bodmin.

10 What happens next

Non-urgent ASSESSMENT once immediate safety is in place

Outcomes are determined by the Cornwall 'Threshold' principles.

No Further Action required because: Enquiries conclude that there are no concerns for the child / children requiring action to be taken.

Early Help Referral required because: There are low level concerns but the child / children's needs don't meet the threshold criteria as ChI N / Child Protection but there are indicators that early help services would help to prevent escalation of the concerns.

Early Help Assessments have to be completed within 30 working days.

Section 17 ChI N assessment required because: The threshold criteria for initiating a ChI N assessment have been met.

ChIN assessments and child protection assessments have to be completed within 45 days of allocation to the social worker.

Child Protection Assessment required because: The threshold criteria for initiating section 47 enquiries have been met. The child protection assessment may lead to **Child Protection Conference** - Evidence that the child / children have or may have suffered significant harm and there is a continuing risk of significant harm occurring and professionals need to consider whether a protection plan is required for the child / children.

A child protection conference is held within 15 working days of the decision being made.

During the assessment process if a need is identified, support will be offered; this support is not dependent on the completion of the assessment. For example, if a young person would benefit from therapeutic support from Clear, the referral would be made at the earliest opportunity. The assessment will also identify what support / intervention the child's family / carer may need and how the concerns relating to the perpetrator are to be addressed.

11 What happens next

Once urgent and non-urgent issues have been addressed e.g. once child's immediate safety is in place

Advocate ISVA support through the CSA assessment and process

Independent Sexual Violence Advisers (ISVAs) provide specialist support to victims and survivors of sexual violence (male/female and children/young people) who have made a report to the police about their abuse. They can also discuss options with a victim/survivor about the choices they have, such as accessing a Sexual Assault Referral Centre, sexual health or reporting to the police.

The type of support an ISVA provides will vary from case to case. It depends on the needs of the individual and their situation. From receipt of the referral a client will be contacted within 24 working hours. A full Safety and Support Risk and Needs Assessment will be completed with the client. The ISVA will engage with the client and support them throughout the length of the criminal justice process, liaising with the police to assist the client with understanding the progress of the investigation and court.

ISVAs also provide information on other services that the client may require, for example health and social care, housing, or benefits. They will liaise with other professionals to assist the recovery of the client enabling a targeted approach to recovery. For more information on the ISVA role: **https://sarchelp.co.uk/information-sexual-assault/what-is-an-isva/**

12 Emotional Help Assessment

What happens?

Future in mind (March 2015) specifies that there needs to be a multiagency assessment and treatment pathway for sexual abuse, ensuring those who have been sexually abused and/or exploited receive comprehensive assessment and referral to appropriate

evidence-based services. Those who are found to be more symptomatic, who are suffering from a mental health disorder, should be referred to specialist mental health services.

Children who are the victims of CSA will be affected in a variety of ways and will often experience some level of harm to their emotional heath. **Best practice** is that the child's **emotional health is considered as soon as possible** and appropriate support / intervention provided by a relevant professional /service.

In most circumstances, a referral to the Jigsaw service is the correct route if there are concerns about a child's wellbeing. However, if there are serious concerns about the mental health or risk of harm to self or others, a referral should be made to the specialist CAMHS team.

13 Jigsaw

Jigsaw is a program that aims to help children, young people, parents and carers who have alleged sexual abuse. This is achieved through:

- Listening, supporting through difficulties, offering appropriate confidentiality and exploring ways to keep safe in the future.

Who is Jigsaw for? Children and young people from 3 to 18 years old, parents and carers of these children/young people. Jigsaw sessions are arranged through a social worker working for children's social care.

www.cornwall.gov.uk/education-and-learning/schools-and-colleges/special-educational-needs-file/information-advice-and-support/council-services/childrens-psychology-service/jigsaw/

Current referral options to Jigsaw include:

1. Referring the child
2. Referring the child and parent
3. Referring the parent (e.g. if the child too young or the child is refusing Jigsaw but the parent wants help)

Currently only available to children open to children's social care.

Assessment steps taken by Jigsaw include:

- checking that there has been a CSA disclosure and that this is suitable for short term work (10 sessions)
- undertaking an introductory consultation with the family
- asking the parent (or child depending on age) to set goals for the work and rate this on a ten point scale pre and post, asking the parent/ child to complete a Briere Trauma Checklist (usually in the 1st or 2nd session). This is a standardised and validated measure of post-abuse trauma and covers a range of symptoms including depression, anxiety, anger, PTSD, dissociation and sexual distress /preoccupation.

There are three versions (one that children aged 7+ can self-complete, one for parents of children aged -12 who are not able to self-complete and an adult trauma checklist for 17+ years). The Briere checklist is repeated at the end of the session to review progress and inform next steps.

14 Child Adolescent Mental Health Service (CAMHS)

Referral links between Social Care and CAMHS;

- If a child is referred to Jigsaw and there are concerns about the level of risk on assessment, a referral to CAMHS is made and joint work undertaken with them.
- If at the end of the Jigsaw work the child is still presenting with trauma, there are two options;

One, if there is no risk, but it is believed a child can make progress with a few more sessions then Jigsaw will offer up to 10 more sessions if there is capacity.

Two, if there are significant mental health concerns(as evidenced by the Briere assessment) that are impacting on a child's functioning (as evidenced by the CGAS) then a referral is made to CAMHS. CAMHS will offer an in depth mental health assessment, and make a decision as a multi-disciplinary team about a young person's care. CAMHS try

to see people within 28 days of referral. CAMHS can make an offer of specialist treatment which can include psychological therapy, care management and sometimes medicine.

- Current treatment plan
- If closed -relevant past history to be shared as part of any section 47 investigation and put on a waiting list.

15 Education

Education staff will be part of the multi-agency network to support children, young people and their families. Appropriate staff will be asked to contribute to social care assessments and attend multi-agency meetings, e.g. section 47 meetings, initial child protection conferences.

The educational setting will have a range of resources and support which may include

- In-house counselling/mentoring services
- Group or individual interventions to support anxiety, low mood, building resilience
- Whole school approaches that focus on supportive relationships such as trauma-informed schools approach, mental health in Schools leads, mental health champions, pastoral support teams.
- Access to external professionals and organisations, e.g. Dreadnought, Educational Psychology Services

Educational Psychology Service

The Educational Psychology Service (EPS) provides services to schools in two different ways; through a service level agreement or for a child or young person who is in the care of the local authority or has a child protection plan. Please see the EPS brochure for more details (link below).

www.cornwall.gov.uk/media/32585476/educational-psychology-services-brochure-2018-19.pdf

All work is done as part of a multi-agency response.

Indirect work

- Consultation with school staff/parents/carers about the best way to support the child /young person (either victim or perpetrator)
- Supervision or coaching for school staff (this could be part of Trauma Informed Schools (TIS)/Thrive work)
- Training for staff on:
  - impact of trauma on children and young people
  - impact of working with children or Young People who have experienced CSA (vicarious trauma)
  - emotion coaching
  - person-centred approaches e.g. using strategies to help young people identify goals and ways to make progress towards them
  - social stories
  - Advice and guidance for staff on putting risk assessments in place e.g. how to supervise bathroom breaks
- How to promote safe touch with pupils if that is what they want such as sitting to the side of the pupil, and arms around the pupil sideways etc. NSPCC Pantosaurus video –it's fun, non-threatening and not just for the child but also the rest of the class/family so they know what to do if there is inappropriate touching as well, implement safety plans, advice from other professionals

Direct work

- Interventions such as three session change, Draw and Talk, Lego Therapy, emotion coaching.
- Assessment in relation to anxiety, wellbeing, resilience

16 Health Visitor, School Nurse

(0 to 19 Service)

The Health Visiting and School Nursing service provides Universal Services to children in line with the "Healthy Child Programme" which ensures safeguarding is core to the delivery of services. Further information about this can be accessed via the following link:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/686928/best_start_in_life_and_beyond_commissioning_guidance_1.pdf

- Health Visitors and School Nurses access safeguarding supervision and seek advice from the safeguarding team in line with policy to discuss any concern or worries regarding abuse.
- Health Visitors and School Nurses provide information to support a social work assessment and will attend strategy discussions / meetings as requested.
- Children subject to section 47 enquiry will receive a health assessment by the Health Visitor or School Nurse, who make referrals to other health services as required
- Health Visitors and School Nurses will attend Initial Child Protection Conferences to support safety planning.

17 General Practice

- Share relevant information with MARU to inform the assessment / investigation
- Provide additional healthcare information to SARC medical examiner if requested
- Are available to receive advice from SARC medical examiner re possible ongoing issues that may require further medical intervention and to liaise if necessary with an appropriate plan of action. Offer support if necessary to child and other family members if deemed appropriate e.g. already has a good therapeutic relationship with child and family
- Should be aware of other services that are involved e.g. Jigsaw, CAMHS, educational psychology service and to liaise with them and Health Visiting or School Nurse as required
- Are a point of contact for family and other services regarding any ongoing possible health issues

18 Referral for at risk of sexual abuse and / or exploitation

Referral for a young person at risk of sexual abuse and / or exploitation from another young person through MARU:

There is the need for a written referral to the MARU, with information collated from MARU systems (Health, Education and Social Care). The parent of the alleged victim would need to be made aware of the referral, as they will need to be contacted as part of the investigation and give consent to agency checks.

A chronology of social care history for the child / children will be formulated and relevant agency checks undertaken.

Possible Outcomes include:

No further action - because consensual relationship (same aged peers (15 to 16 plus years), no coercion or identified vulnerability, supportive parents who do not want to progress the matter.

Request for TYS (Targeted Youth Support) - As above but a piece of work appropriate to support around healthy relationships.

S17 Assessment - Some vulnerability identified, concerns regarding parental ability to keep safe.

S47 Strategy discussion - Coercion and control evident, history of vulnerability, evidence of harm requiring health intervention, joint working with police for ABE facilitation.

In all of the above outcomes would consider the need for health input, from the GP through to forensic evidence request.

An alleged perpetrator MUST be considered in their own right -

Possible Outcomes include:

No further action - Consensual relationship (same aged peers (15 to 16 plus years), no coercion or identified vulnerability, supportive parents who are able to support YP.

Request for TYS - As above but a piece of work appropriate to support around health and healthy relationships.

S17 Assessment - Input from Gweres Kernow felt to be beneficial to young person. Risk to siblings to be considered within assessment

S47 Strategy discussion - Coercion and control evident, threshold met for police intervention, need for action to protect siblings.

Use the Resolving Professional Differences Policy at any stage if children are not receiving a "timely" or good enough response e.g. referral to SARC. (Resolving Professional Differences Policy and Flowchart, available from OSCP website)

16 Resources

Other services that may be considered include:

Locally

Gweres Kernow

Gweres Kernow is a small team of specialist social workers and clinical psychologists who work in partnership with other services to safeguard children who have displayed concerning sexualised behaviour, working with children of all abilities under the age of 18.

For primary school aged children who have engaged in concerning sexualised behaviour, the service helps these children and their parents/caregivers and schools to gain the understanding, knowledge and relevant skills to support the child.

For adolescents the service is aimed at helping young people of secondary school age from 11-18 years who have engaged in harmful sexual behaviour.

CLEAR - Children Linked to and Experiencing Abusive Relationships.

CLEAR is a unique child/young person centered service in Cornwall, offering counselling, face to face and group work with children and young people aged 0 to 18 and up to 25 yrs with additional needs, who have been traumatised by either direct experience of and/or witnessing, psychological, sexual or emotional abuse.

Telephone **01872 261147**

Email **info@clearsupport.net**

www.clearsupport.net

www.supportincornwall.org.uk/kb5/cornwall/directory/service.page?id=GXx_n6tjBFQ

Nationally

NSPCC – Harmful sexual behavior

www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/harmful-sexual-behaviour/

www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/harmful-sexual-behaviour/signs-symptoms-effects/

Brook Traffic Light Tool - supports professionals working with children and young people by helping them to identify and respond appropriately to sexual behaviours

https://legacy.brook.org.uk/our-work/category/sexual-behaviours-traffic-light-tool?gclid=EAIaIQobChMIy9v3-bW15QIVFeDtCh0mFgWyEAAYASAAEgJUFfD_BwE

If you would like this information in another format or language please contact:

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Treyew Road, Truro, TR1 3AY

e: equality@cornwall.gov.uk
t: 0300 1234 100

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Cornwall recycles
Kernow a wra eylgylghya