POLICY ON SAFEGUARDING CHILDREN AND VULNERABLE ADULTS

This statement sets out ACCPI's guidance to its members and requirements of them in regard to safeguarding children and vulnerable adults.
The aim of this document is to:

1. promote shared minimum standards for all ACCPI members with regard to safeguarding;
2. help to inform other professionals and the general public of the roles, responsibilities and accountability of ACCPI members; and
3. raise awareness that all ACCPI members must be mindful of the needs of children and vulnerable adults in the family, irrespective of the setting in which they work (research/academic; statutory agencies; private practice), or their specialism.

Safeguarding presents the greatest challenge to the principle of confidentiality as it is understood and practiced by psychotherapists and psychological therapists. Nevertheless, the need to share information in order to keep children and vulnerable adults safe from abuse, takes precedence over the usual commitment to confidentiality, and this should always be clearly stated at the beginning of a therapy.
Practitioners should be bound by their agency's guidance. All agencies are required to have policies that are compatible with the statutory framework set out in law and coordinated by social services in collaboration with other statutory agencies including the police, Criminal Justice System and educational services.

Safeguarding children

Practitioners may have to make difficult judgments about whether a situation is of sufficient concern, or presents a serious enough risk to warrant concern. They should discuss their need to report information outside of the therapy with a patient and get their agreement if at all possible, but in exceptional circumstances they will have to share concerns without the patient's approval and/or against their wishes. Single, shocking incidents or injuries are easy to spot. What is more difficult is the calibration of concern in situations of ongoing neglect, domestic violence, or emotional unresponsiveness or manipulation, where the cumulative nature of the damage done to a child/children has to be managed and their failure to thrive or to meet milestones has to be continually assessed.
The core legal requirements are:

1. The child's needs are paramount, and the needs and wishes of each child, be they a baby or infant, or an older child, should be put first, so that each child receives the support they need before a problem escalates.
2. All professionals who come into contact with children and families are alert to their needs and any risks of harm that individual abusers, or potential abusers, may pose to children.
3. All professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children's social care.
4. Appropriately trained professionals are able to use their expert judgement to put a child's needs at the heart of the safeguarding system, so that the right solution can be found for each individual child.
5. All professionals contribute to whatever actions are needed to safeguard and promote a child's welfare and take part in regularly reviewing the progress of a child against specific plans and outcomes.

6. The Directions for Child Protection co-ordinate the work to safeguard children locally and monitor and challenge the effectiveness of local arrangements.

Any concerns about the current sexual abuse of children should be shared within the multi-agency network as paedophilia is widely assumed to be an ongoing and difficult to change orientation. Targeting and grooming, deception and manipulation make judgments about such matters complex and therapists should always bring such issues to supervision and if in any doubt consult with the statutory agencies.

If the information is discussed with someone other than the designated post holder, then an agreement about who will take it into the statutory process should be clearly spelt out and documented. For example if a therapist raises concerns about the children of a patient they are seeing with that person's GP, they should clarify whether they are expecting the GP to make a formal report, to assess the risk and act on their assessment or to leave them to make the decision themselves after the consultation.

Reporting on behalf of children is a statutory responsibility and a failure to do so in the face of a real and present threat to the wellbeing of a child might be seen as a breach of professional ethics.

Safeguarding vulnerable adults

The situation for adults is more complex. It relates only to "vulnerable" adults, who are, at the time of writing defined as someone who is or may be in need of community care services by reason of mental or other disability, age or illness and is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.

The first part of this definition covers people with learning disabilities and older people, some people with physical or sensory impairments or chronic illnesses, and people with mental problems that are serious or ongoing. These groups are all entitled to additional support when facing violence or abuse in their lives: social services are not an alternative to the police in these circumstances but the safeguarding adults' framework provides extra coordination and signposting.

The second part of the definition points to a group on whose behalf social and health care agencies have to take a more proactive stance because the patient/client may not able to make decisions for themselves in these circumstances. Situations that are compounded by intimidation, deception, violence, dependence on another, and so on are likely to be the most complex for a vulnerable person to take so that some patients who manage considerable parts of their lives independently may still lack capacity to make judgments and informed decisions in relation to safeguarding themselves against abuse or violence.

Therapists may encounter abuse in many different contexts and guises. They may have to make judgments about a very wide range of situations, for example

1. A patient tells you that she suspects her partner is sexually abusing their daughter but begs you not to act on this concern, threatening to leave the therapy if you break her confidentiality.
2. A patient discloses historical sexual abuse but refuses to say who her abuser was, only disclosing that he worked as a youth worker with a local church.
3. A patient with depression and an eating disorder tells the therapist that she is finding it difficult not to hurt her children
4. A patient discloses fears that they will harm their elderly mother who has dementia and whose care is becoming increasingly stressful and fraught
5. A patient who has been recently discharged from an inpatient psychiatric unit tells her therapist that she was sexually assaulted by another patient during her time on the ward.

6. A patient with alcohol related problems is finding it increasingly difficult to manage his life without violence: he has three children under five and tells you he has been violent to his partner.
7. A patient with learning disabilities discloses that one of the care staff shouts at him and has several times hit him when he has been upset.

The decision over whether and when to share this information beyond the therapy should be taken to supervision, and the timing of any report to a third party should be governed by risk to children or other vulnerable people, alongside the needs and wishes of the patient and their assessment of the current risk.

Where therapists struggle to contain the anxiety that these situations give rise to they should seek additional supervision or consultation, and if in any doubt share their concerns with an appropriate professional in a relevant statutory service.