The Society of Analytical Psychology

Policy Document

Title:	Safeguarding Policy
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Clinical Owner:	Safeguarding Lead on Council
Circulation:	Members, Trainees, Staff, Volunteers, Seminar Leaders, Course Convenors
Cross Reference:	Trainees' Handbook; Clinic Handbook; Code of Ethics; Complaints Procedure for Clinic Patients

Statutory and Legal Context:

Children Act, 2004
Chidren and Families Act, 2014
Working Together to Safeguard Children, 2015
The Care Act, 2014

1. Introduction

1.1 The Society of Analytical Psychology is referred to here and throughout as the SAP

1.2 This policy is based on our responsibilities under the Children Act 2004 and the Children and Families Act 2014, with regard to the need to safeguard and promote the welfare of children.

This policy is predicated on the Children Act 1989; the Children Act 2004; the Children and Families Act 2014 and the Children and Social Work Act 2017. In relation to adults, the Mental Health Act 1983, as amended by the Mental Health Act 2007 and the Mental Capacity Act 2005 and the Care Act 2014. In addition, the GDPR, 2016 and the Data Protection Act 2018.

In addition, procedural and guidance references including the following:

- Working Together to Safeguard Children, 2018
- London Child Protection Procedures, 2020; 6th Ed.
- Intercollegiate Document (Children) 2019
- Intercollegiate Document (Adults), 2018
- Care and Support Statutory Guidance, 2020
- BPC Safeguarding Procedures https://www.bpc.org.uk/professionals/registrants/safeguarding/
- Charity Commission: 'Safeguarding and Protecting People for Charities and Trustees', 2019.

1.3 This policy document also incorporates provisions within the Care Act 2014 including the reference to adults at risk, which succeeded the term vulnerable adults.

1.4 In line with the British Psychoanalytical Council's Code of Ethics, we believe 'Registrants must at all times act in a way that they reasonably believe to be in the best interests of their patients. At all times the welfare of the patient must be paramount and every care taken to ensure that the patient is not exploited in any way'. *Note, the BPC's Code of Ethics is currently being revised. Members will be advised when the updated document is available.*

2. The SAP's Policy Commitment

2.1 The SAP believes that all children, young people and adults at risk have the right to be safe, the right to improved wellbeing and the right to be protected from abuse. The SAP is committed to safeguarding from harm all children, young people and adults at risk using any of its services and involved in any of its activities, and to treat them with respect during their dealings with the members, trainees and staff of the Society.

2.2 The SAP will achieve this through the biennial review of its safeguarding policy and procedures and the delivery of an annual safeguarding training programme.

3. Aim of the Policy

3.1 The aims of the policy are to:

3.1.1 Support the promotion of a safe working environment and a culture of care in which the rights of all children, young people and adults at risk are protected and respected;

3.1.2 Promote best practice in how members, trainees and staff of the Society interact with children, young people and adults at risk while providing services;

3.1.3 Ensure the SAP develops clear guidance and procedures for those members, trainees and staff working with children, young people and adults at risk and ensure through support that they are aware of these and able to implement them;

3.1.4 Ensure the SAP provides a suggested protocol to help members, trainees and staff identify children and adults at risk and take appropriate action in response to safeguarding. It is particularly applicable to those working in independent private practice;

3.1.5 Further to 3.1.4, to ensure everyone at the SAP is able to act upon the Safeguarding Four Rs: Recognise, Record, Report, Refer;

3.1.6 Ensure there are safe recruitment and acceptance procedures in place for staff, volunteers, members and trainees;

4. Scope of the Policy

The policy is in respect of the SAP's responsibility towards:

4.1 Children and young people, legally defined as any person under the age of 18. From this point the terms child or children will be used to refer to this group.

4.2 Adults at Risk – as defined below:-

Care Act 2014 s.42(1)

a) has needs for care and support (whether or not the authority is meeting any of those needs),
b) is experiencing, or is at risk of, abuse or neglect, and
c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

An adult at risk is 'any person who is aged 18 years or over and at risk of abuse or neglect because of their needs for care and support' (Care Act 2014 [England]). This definition is broadly consistent with definitions across the devolved nations. In Scotland, the definition of an 'adult at risk' or 'vulnerable adult' applies to those aged 16 years and over.

In Northern Ireland the definition is, helpfully, broken down to assist in understanding as follows: Adult at risk of harm is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:
a) Personal characteristics which may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain and/or
b) Life circumstances which may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

Care Act 2014 s42 (3)

Abuse includes financial abuse; and for that purpose 'financial abuse' includes:

a) having money or other property stolen,
b) being defrauded,
c) being put under pressure in relation to money or other property, and
d) having money or other property misused.

The Care Act 2014 makes it clear that abuse of adults links to circumstances rather than the characteristics of the people experiencing the harm. Labelling groups of people as inherently 'vulnerable' is seen to be disempowering.
See: https://www.anncrafttrust.org/resources/safeguarding-adults-at-risk-definitions/

There has been a long review process regarding the inequities of the Mental Health Act 1983. www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/reforming-the-mental-health-act

See also the implications of Modern Day Slavery Act 2015: https://www.legislation.gov.uk/ukpga/2015/30/contents/enacted

4.3 The members and trainees of the Society who have dealings with children, young people and adults at risk and who are required to act in a position of trust and to act responsibly and within the law.

4.4 Children and adults at risk about whom members and trainees might receive information pertaining to Safeguarding concerns through their practice, including training practice, or supervision.

5. Confidentiality

The SAP attaches the highest importance to the maintenance of confidentiality in the communications between patients and their psychoanalyst or psychotherapist and in the privacy of any written notes. However, the need to share information and act upon a concern to keep children and adults at risk safe from abuse, may take precedence over the usual commitment to confidentiality.

We share a professional interest in patient's psychological functioning and are therefore in a particularly relevant position to identify interactions or circumstances that can affect the health and safety of a child or vulnerable adult. In relation to child protection, one does not have to be working directly with a child and could be working with an adult patient, who may make historical or current disclosures of abuse or raise concerns about child protection within their families or communities. Similarly, a vulnerable adult might make their own historical or current disclosures.

No single professional can have a full picture of a child or vulnerable adult's needs and circumstances and everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action as detailed in the 'Raising a Concern' section of the Safeguarding Procedures document.

There is, of course, an inherent challenge regarding privacy, maintaining confidentiality and the safety of patients. However, the various legal acts regarding both children and adults requires health and social care professionals, including psychoanalysts and psychotherapists, to 'act' when there are safeguarding issues.

Confidentiality hinges on establishing the patient's consent to share information. The most challenging and difficult aspects of clinical work occur when there is a necessity to share information but without the patient's consent.

In under 18s, the presence of significant harm supersedes the need to maintain confidentiality and clinicians can breach confidentiality because the patient's welfare overrides the need to maintain confidentiality.

'Adults at risk' need to also be considered alongside consent, mental capacity and risk as determined by professional judgement. Professional bodies permit the disclosure of confidential information when such disclosure is necessary to safeguard the interests of the child or vulnerable adult. The protection of a child/vulnerable adult overrides the right to confidentiality.

6. Safe Recruiting Policy

6.1 The SAP is committed to:

- safeguarding and protecting all children and adults at risk by implementing robust safer recruitment practices, where 'recruitment' includes the process of accepting trainees and course participants onto SAP programmes;
- identifying and rejecting applicants who are unsuitable to work with children and adults at risk;
- responding to concerns about the suitability of applicants during the recruitment process;
- responding to concerns about the suitability of members, trainees, staff and volunteers once they have begun their role;
- ensuring all new staff and volunteers complete an induction which includes the protection of children and adults at risk.

7. Useful Information

The NSPCC website provides advice on keeping children safe. Go to www.nspcc.org.uk.

www.education.gov.uk/childrenandyoungpeople/safeguardingchildren is the link to the Government website that provides information on the legislation and the wider issues of child welfare.

The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) - www.gov.uk/government/organisations/disclosure-and-barring-service

https://www.ihasco.co.uk/blog/entry/2508/what-is-the-childrens-act-2004

https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

https://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

Appendix 01

Definitions

1. Definitions of Child Harm or Abuse

The SAP believes every child, regardless of their age, disability, gender reassignment, race, religion or belief, sex, or sexual orientation, has a right to equal protection from harm.

1.1 Physical abuse

This may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm, including by fabricating the symptoms of, or deliberately causing, illness in a child.

1.2 Factitious or Induced Illness

FII is when a carer deliberately causes a child to display symptoms of a particular illness or general unwellness to gain medical attention. There are three main forms: fabrication, falsification or inducement. This could be of medical records, results or symptoms and can lead to unneeded procedures and treatments being provided to the child as the doctors to whom the child has been presented make efforts to understand and treat them. In very serious cases, the child may have been poisoned or the perpetrator may have tampered with medical equipment or medication prescribed to the child in good faith and based on the false history given by the carer.

1.3 Emotional abuse

This is the persistent emotional ill-treatment of a child or such as to cause severe and persistent adverse effects on the victim's emotional development or self-esteem. It may involve conveying to the victim that they are worthless or unloved, inadequate, or valued only in so far as they meet the needs of another person. It may involve age or developmentally inappropriate expectations being imposed, causing the victim frequently to feel frightened, or the exploitation or corruption of children or adults at risk. It may involve deprivation of contact, control, coercion, intimidation or harassment.

1.4 Sexual abuse

This involves forcing or enticing a child to take part in sexual activities, whether or not the victim is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include involving the victim in looking at, or in the production of, pornographic material, or encouraging them to behave in sexually inappropriate ways.

1.5 Sexual Exploitation

Child sexual exploitation (CSE) is a type of sexual abuse. When a child or young person is exploited they're given things, like gifts, drugs, money, status and affection, in exchange for performing sexual

activities. Children and young people are often tricked into believing they're in a loving and consensual relationship. This is called grooming. They may trust their abuser and not understand that they're being abused.

1.6 Criminal Exploitation

Children and young people involved with gangs and criminal exploitation need help and support. They might be victims of violence or pressured into doing things like stealing or carrying drugs or weapons. They might be abused, exploited and put into dangerous situations.

1.7 Child Harm to Self and Others

Self-harm or injury to self refers to a range of things which a child deliberately does to themselves that causes harm or some kind of physical injury.

Children may also abuse other children. This is generally referred to as 'peer on peer **abuse**' and can take many forms. This form of abuse occurs when there is any kind of physical, sexual, emotional or financial abuse or coercive control exercised between children. This includes bullying, cyberbullying, sexual violence, harassment and sexting:
https://safeguarding.network/safeguarding-resources/peer-peer-abuse/

It is influenced by the nature of the environments in which **children** spend their time (i.e. home, school/college, peer group and community) and is built upon notions of power and consent.

1.6 Neglect – Eight Pathways to Harm

Information taken from the July 2020 report:
https://seriouscasereviews.rip.org.uk/wp-content/uploads/2019_triennial_analysis_of_serious_case_reviews_health_professionals_Jul2020.pdf

1. Severe deprivational neglect where the neglect was the primary cause of death or serious harm; neglect of the child's basic needs leads to impairments in health, growth and development; severe illness or death may result from malnutrition, sepsis, or hypothermia among others.

2. Medical neglect – failure to respond to a child's medical needs (acute or chronic) and necessary medication; such failure may lead to acute or chronic worsening of a child's health.

3. Accidents which occur in a context of neglect and an unsafe environment; hazards in the home environment and poor supervision may contribute.

4. Sudden unexplained death in infancy (SUDI) within a context of neglectful care and a hazardous home environment; deaths may occur in dangerous co-sleeping contexts, or where other recognised risk factors are prominent and not addressed.

5. Physical abuse occurring in a context of chronic, neglectful care; the primary cause of serious harm or death may be a physical assault, but this occurs within a wider context of neglect.

6. Suicide and self-harm in adolescents with mental health problems associated with early or continuing physical and emotional neglect.

7. Vulnerable adolescents harmed through risk taking behaviours associated with early or continuing physical and emotional neglect.

8. Vulnerable adolescents harmed through exploitation associated with early or continuing physical and emotional neglect. Poverty and neglect Chapter 3 of the report includes an in-depth qualitative analysis of a subsample of 32 SCRs in which neglect was a recognised feature. Three overarching issues stood out:

- Poverty as a feature of families' lives
- The complex and cumulative nature of neglect
- The invisibility of some children and young people to the system.

Poverty leads to additional complexity, stress and anxiety in families, which can in turn heighten the risk of neglect or abuse. The impact of impoverishment is not always fully understood or captured effectively in recording or assessment processes, however. The majority of children living in poverty do not experience neglect, but where poverty and neglect coexist, adverse outcomes for children will be escalated. There are ongoing debates about the links between poverty and maltreatment but we can recognise with certainty that both are damaging to children's health and development, and to the wellbeing of their families. Recognition of poverty and its impact was of

2. Definitions of adults at risk of harm or abuse

Living a life that is free from harm and abuse, is a fundamental human right for every person and an essential requirement for health and well-being. Safeguarding adults is about safety and well-being but providing additional measures for those least able to protect themselves from harm or abuse.

The Government has issued a policy statement on adult safeguarding which sets out six principles for safeguarding adults. Whilst not legal duties, these do represent best practice and provide a foundation for achieving good outcomes:

- Empowerment - presumption of person led decisions and consent.
- Protection - support and representation for those in greatest need.
- Prevention of harm or abuse.
- Proportionality and least intrusive response appropriate to the risk presented.
- Partnerships - local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability and transparency in delivering safeguarding.

2.1 Physical Abuse

Examples of physical abuse are assault, rough handling, hitting, pushing, pinching, shaking, misusing medication, scalding, inappropriate sanctions and exposure to excessive heat or cold. Unlawful or

inappropriate use of restraint or physical interventions and/or deprivation of liberty are also physical abuse.

2.2 Sexual and Sexual Exploitation

Some examples of sexual abuse/assault include the direct or indirect involvement of the adult at risk in sexual activity or relationships which:

- They do not want or have not consented to;
- They cannot understand or lack the physical or mental capacity to be able to give consent to;
- They have been coerced into because the other person is in a position of trust, power or authority, for example, a care worker or;
- They have been coerced into through organised criminal activity, such as people trafficking;
- Required them to watch sexual activity.

2.3 Psychological/ Emotional

This is behaviour that has a harmful effect on the person's emotional health and development or any form of mental cruelty that results in:

- Mental distress;
- The denial of basic human and civil rights such as self-expression, privacy and dignity;
- Negating the right of the adult at risk to make choices and undermining their self-esteem;
- Isolation and over-dependence that has a harmful effect on the person's emotional health, development or well-being;
- Bullying;
- Coercive control;
- Verbal attacks; or
- Intimidation.

2.4 Neglect

This is when a person's well-being is impaired and care needs not met. Behaviour that can lead to neglect includes ignoring medical or physical needs, failing to allow access to appropriate health, social care and educational services, and withholding the necessities of life such as medication, adequate nutrition, hydration or heating.
Neglect can be intentional or unintentional.
Intentional neglect would result from:

- Wilfully failing to provide care;
- Wilfully preventing the adult at risk from getting the care they needed; or
- Being reckless about the consequences of the person not getting the care they need.

Unintentional neglect could result from a carer failing to meet the needs of the adult at risk because they do not understand the needs of the individual, they may not know about services that are available or because their own needs prevent them from being able to give the care the person needs. It may also occur if the individuals are unaware of or do not understand the possible effect of the lack of action on the adult at risk.

2.5 Discrimination

Discriminatory abuse exists when values, beliefs or culture result in a misuse of power that denies opportunity to some groups or individuals and this results in harm.
Psychological abuse that is racist, sexist or linked to a person's sexuality, disability, religion, ethnic origin, gender, culture or age.

2.6 Honour-based Violence and Forced Marriage

Forced marriage is where one or both parties do not consent to a marriage and one or both parties are forced into the marriage. It is different from an arranged marriage.

Honour-based violence is a crime and is a criminal issue as well as a safeguarding one.

2.7 Financial

This is the use of a person's property, assets, income, funds or any resources without their informed consent or authorisation. It includes:

- Theft;
- Fraud;
- Exploitation;
- Undue pressure in connection with wills, property, inheritance or financial transactions;
- The misuse or misappropriation of property, possessions or benefits; or
- The misuse of an enduring power of attorney or a lasting power of attorney, or appointeeship.

2.8 Domestic Abuse (Children and Adults)

It is the clinician's responsibility to signpost, direct, refer and when necessary act without consent to either protect a patient or a person at risk, who is not in the consulting room. Domestic abuse, including coercive and controlling and violence could affect many patients and may be masking other presentations. Assessors need to ask questions such as, when individuals last attended A&E and need to be highly explorative regarding potential causation regarding mood and anxiety disorders.

People who witness or are victims of domestic violence suffer emotional and psychological maltreatment. They tend to have low self-esteem and may experience increased levels of anxiety, depression, anger, fear, aggressive and violent behaviours, including bullying, lack of conflict resolution skills, lack of empathy for others and poor peer relationships.

Some of the risks to people living with domestic violence include:

- Direct physical or sexual abuse of the child or adult at risk.

- Emotional abuse and physical injury to the child/vulnerable adult from witnessing the abuse.

The impact of domestic violence on children and adults at risk is similar to the effects of any other abuse or trauma and will depend upon such factors as:

- The severity and nature of the violence.
- The length of time the child/vulnerable adult is exposed to the violence.
- Characteristics of the child/vulnerable adult, including gender, age, disability, socio-economic and cultural background.
- The warmth and support the child/vulnerable adult receives in their relationship with others.
- The nature and length of the child/vulnerable adult's wider relationships and social networks.
- The child/vulnerable adult's capacity for and actual level of self-protection.

Legal requirements and procedural guidance:

- Mental Capacity Act 2005 https://www.legislation.gov.uk/ukpga/2005/9/contents

- Mental Health Act 1983 https://www.legislation.gov.uk/ukpga/1983/20/contents

- Care Act 2014 https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

- Coronavirus Act 2020
  https://www.legislation.gov.uk/ukpga/2020/7/contents/enacted/data.htm

- Adult Safeguarding: Roles and Competencies for Health Care Staff, 2018 (for information)
  https://www.researchgate.net/publication/330114951_INTERCOLLEGIATE_DOCUMENT_Adult_Safeguarding_Roles_and_Competencies_for_Health_Care_Staff

Appendix 02

Safe Recruitment Procedure

Those engaging any of the above will seek guidance from the CEO to determine the level of DBS (formerly CRB) check required for the role. Clearance must be obtained before the individual commences work. As an employer of staff in a 'regulated activity' the SAP has a responsibility to refer concerns to the DBS in accordance with the Safeguarding Vulnerable Groups Act 2006. Individual concerns must be reported to the CEO.

Anyone who has access to patient information or unsupervised contact with patients must have an enhanced DBS check. The SAP follows the government guidance regarding who requires a standard or enhanced DBS check. The relevant guidance can be found here:

Employers Guidance:
https://www.gov.uk/government/organisations/disclosure-and-barring-service

DBS Update:
https://www.gov.uk/government/publications/dbs-update-service-employer-guide

All applicants for work with the SAP (either employed or self- employed/voluntary or paid) are to submit a formal application and full CV, to attend a formal interview with at least two senior staff members and, before an appointment is made, will be asked to provide at least two references. All such references will be followed up.

It will be made clear to applicants that the position is exempt from the provisions of the Rehabilitation of Offenders Act 1974. See the most recent government guidance:
https://www.gov.uk/government/publications/dbs-filtering-guidance/dbs-filtering-guide

The Charity Commission requires:
'A charity that uses information from the DBS must also have a policy on the recruitment of ex-offenders, in order to comply with the DBS Code of Practice.'
See: https://www.gov.uk/guidance/safeguarding-duties-for-charity-trustees

See also the DBS Code of Practice:
https://www.gov.uk/government/publications/dbs-code-of-practice

All applicants for SAP professional trainings and courses with a clinical component will be interviewed and screened in accordance with the SAP Training Faculty's procedure.

Appendix 03

Training and DBS checks

- Practitioners working in private practice may need to apply for a basic DBS check
- All members of the Safeguarding Advisory Group should undertake annual safeguarding training. This will be provided by the SAP and could involve online training.
- All SAP Trainees will undertake safeguarding training as part of their training programme.
- SAP Members will be provided with safeguarding training on an annual basis.

Useful information about DBS checks can be found here:
https://www.personnelchecks.co.uk/knowledge-hub/the-ultimate-guide-to-dbs-checks-for-the-self-employed