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# ACAT guidance: Safeguarding Children and Vulnerable Adults

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## **This statement sets out ACAT's guidance to its members and requirements of them in regard to safeguarding children and vulnerable adults.**

Safeguarding presents the greatest challenge to the principle of confidentiality as it is understood and practised by psychotherapists. It is particularly difficult within CAT which seeks to establish and work through a collaborative relationship between therapist and the patient. 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 also appraise themselves of the policies and guidance issued by their own professional bodies.

Practitioners working within NHS, social care or voluntary sector settings 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, NHS and educational services. Although the terminology can sound punitive or bureaucratic the aim of all safeguarding activities will be to protect the child or vulnerable adults in the least confrontational and least restrictive way possible to achieve that goal. Supportive options will be explored if these are considered appropriate and formal proceedings or prosecutions only pursued where this is appropriate.

Practitioners are required to be cognisant of local safeguarding policies and protocols for reporting concerns: these will usually be directed to the social services duty team which orchestrates a response across all the relevant agencies. Each authority has a Safeguarding Children Board and a Safeguarding Adults Board and these groups manage the arrangements for reporting, sharing information, investigating concerns and assessing risk. The Boards publish policies and guidance locally advising local services and professionals about how and when to report concerns.

These policies cover physical, sexual, emotional (and for adults, financial) abuse and exploitation as well as wilful neglect. Thresholds vary and can be quite subjective as recent inquiries demonstrate: 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.

- 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 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.

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

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❑ is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation”  
 (“No Secrets” DoH 2000 p9)

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 be able to make decisions for themselves in these circumstances. Under the terms of the Mental Capacity Act 2005, a person is not deemed to have, or not have capacity in global terms but this has to be assessed in relation to a particular decision or set of decisions. 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 in-patient 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.

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