Ed Elf Child Protection & Safeguarding Policy

Client records will be kept safely and in good condition for eight years from the date of the client's last session, until his or her 25th birthday, or 26th birthday if the client was 17 when the treatment ended.

Guidance in safeguarding vulnerable adults and children
The NHS Code of Ethics gives the following guidance to all registrants about client confidentiality:

"Confidentiality, Maintenance of Records and Recording of Sessions"

All Practitioners undertake to:

Maintain strict confidentiality within the client/therapist relationship, always provided that such confidentiality is neither inconsistent with the therapist's own safety or the safety of the client, the client's family members or other members of the public nor in contravention of any legal action (i.e. criminal, coroner or civil court cases where a court order is made demanding disclosure) or legal requirement (e.g. Children's Acts)."

Confidentiality within the client therapist relationship

Confidentiality is considered to be one of the foundations of the therapeutic relationship. Clients may share / disclose personal information with a therapist and they will feel more confident to do this if they are reassured that their personal information will be discussed and recorded in confidence.

There are ethical and legal frameworks about the protection of sensitive information and there are also legal and ethical frameworks for the protection of the public and individuals.
There may be occasions when there is a perceived conflict between the professional and moral duty of confidentiality and the need to disclose information that is considered to be in the public interest or individual protection.

The Law
Legal rights to confidentiality are enforceable by legal orders e.g. injunctions or actions for breach of contract, damages, orders for compensation.

Common law (decisions made by the courts) which imposes a duty of confidentiality where information is disclosed in confidence or in circumstances where a reasonable person ought to know that the information ought to be confidential.

Statutory provisions (e.g. GDPR, Human Rights Act 1998 Article 8 – right to private life)

Contracts i.e. between: Therapist and client and/or Therapist and agency

These rights are enforceable by a complaints procedure and investigation process, disciplinary proceedings, and in the case of actions by public bodies, possibly legal action for judicial review of administrative or other actions challenged.

The rights of the client
At the outset of therapy it is the responsibility of the therapist to explain to the client (and ensure they understand) about confidentiality:

To know the extent and limitations of the confidentiality
To be told the circumstances in which the therapist may wish to breach confidentiality
To have a clear therapeutic contract with terms which they fully understand, accept and support
To know who will make, keep and have access to their notes and records, how they will be kept, for how long they will be retained and for what purposes they may be retained/destroyed/disclosed.
To be informed of circumstances when the therapist may have to or is about to breach their confidentiality (unless there are defensible reasons why this cannot be the case, in cases of certain child protection or mental incapacity)
To know how, why and to whom information will be given by the therapist
To know the import of and/or see what is being said about the client if that client so wishes

The duties of the therapist – exceptions to confidentiality
Crime
A therapist cannot be legally bound to confidentiality about a crime. Courts have concluded that it is defensible to breach confidence, in good faith, in order to assist the prevention or detection of a crime. However, there is no general duty to report crime except in specific circumstances. There is also no general obligation to answer police questions about a client. A polite refusal on the grounds of confidentiality is sufficient if this is considered appropriate, but deliberately giving misleading information is likely to constitute an offence. (There is specific home office guidance for therapists working with addicts or offenders).

Prevention of serious harm to the client or to others
The Department of Health offers the following guidance on what counts as serious crime. ‘Murder, manslaughter, rape, treason, kidnapping, child abuse or other cases where individuals have suffered serious harm may all warrant breaching confidentiality. Serious harm to the security of the state or to public order and crimes that involve substantial financial gain and loss will generally fall within this category.

Statutory obligations to disclose
The Terrorism Act 2000 makes it a criminal offence for a person to fail to disclose, without reasonable excuse, any information which he either knows or believes might help prevent another person carrying out an act of terrorism or might help in bringing a terrorist to justice in the UK.

Court orders
A court may order disclosure, or order the therapist to attend court and to bring notes and records with them. Refusal to answer the questions of the court may constitute contempt of the court. Therapists may be asked to produce a report for court relating to work with a client. Consent should be obtained direct from the client wherever possible and in writing. Clients may ask to see the reports written about them, and in accordance with the legislation on Human Rights, GDPR, Freedom of Information clients should have access to their reports in the same way as records, unless there is a cogent reason in their interest or that of the public not to do so.

Requirements to produce therapy records
Family courts dealing with child protection cases have different rules of evidence from other civil and criminal courts. They may order the production of documents including personal medical reports which would otherwise have been protected from disclosure.

The police acting on behalf of the Crown Prosecution Service and usually with the written consent of the client, may seek access to therapy and counselling notes. This is most likely to happen if they contain reports of allegations of rape or sexual abuse.

Disclosures to enhance the quality of service provided
Technically, it may constitute a breach of confidence when therapists discuss cases in counselling supervision, training and research. Ed Elf will anonymise client information in these circumstances and redact any written documents.

Child protection
A ‘child’ is defined as a person under the age of eighteen. The Children's Act 1989 (CA 1989) in conjunction with subsequent legislation including the Children's Act 2004, places a statutory duty on health, education and other services to co-operate with local authorities in child protection. There is a statutory duty to work together, including information sharing, in conducting initial investigations of children who may be in need or subject to abuse. Further information at Every Child Matters.

Therapists working with children and young people should have supervision with a person suitably qualified and experienced in child protection matters. If there is a concern that a child may be at risk of serious harm and the therapist does not have consent from the child or from a person with parental responsibility for the child to make a referral, then the therapist will have to decide whether to make a referral anyway, without consent. Those working within government, organisational or agency settings should already have policies and procedures in place to follow. For those that work independently, this is a matter for supervision, and where necessary for expert professional advice on child protection law and practice, which should be available from the legal department of the local authority, the department of social services, or specialist lawyers.

Clients at risk of suicide or serious self-harm
Responding appropriately to suicidal clients creates one of the most challenging situations encountered by therapists. As there is no general duty to rescue in British law, therapists need to be explicit about reserving the power to breach confidentiality for a suicidal adult client. To do so without explicit agreement may constitute an actionable breach of confidence.

A therapist who knows that a client is likely to harm himself or others but who will not give consent for referral must carefully consider the ethics of going against the client’s known wishes and also the possible consequences for their client of either referral or non-referral.

Therapists are advised to discuss with the client if appropriate, and ideally also discuss in supervision these issues:

What has the client given the therapist permission to do?
Does that permission include referral?
If the therapist does refer, what is likely to happen?
If I do not refer, what is likely to happen?
Do the likely consequences of non-referral include serious harm to the client or others?
Are the likely consequences preventable?
Is there anything that the therapist or anyone else can do to prevent serious harm?
What steps would need to be taken?
How could the client be helped to accept the proposed action?
Does the client have the mental capacity to give explicit informed consent at this moment in time?
If the client does not have mental capacity, then what are the professional responsibilities to the client and in the public interest?

If the client has mental capacity, but does no consent to the proposed action (e.g. referral to a GP), what is the legal situation if I go ahead and do it anyway?
Therapists' professional responsibility requires that they must act within the area of their personal expertise, and should consider their own limitations. The implication of this is that when they reach the limits of their expertise, consideration should be given to referral on with the client's consent. If the client does not consent to referral on and if the client or others may be at risk of harm, the therapist should address the issues listed above in supervision and with their professional organisation and/or other professional advice.

If a client consents to referral on or to a change in the confidentiality agreed with them at the outset of the work with their therapist, then there is little likelihood of any ground for legal or other action against the therapist if the actions then taken are with the full knowledge and explicit consent of the client.

In the event of a complaint or legal action, both therapist and client are best protected by a therapeutic contract with terms including explicit consent, which are evidenced in writing.

Mental capacity and consent
Mental capacity is a legal concept of a person's ability to make rational, informed decisions. It is presumed in law that adults and children over the age of sixteen have the mental capacity and legal power to give or withhold consent in medical and health care matters.

Children and young people under the age of eighteen
Therapists working with children and young people will need to have valid consent to enter into the therapeutic contract. 'Parental responsibility' is the legal basis for making decisions about a child, including consent for medical or therapeutic treatment.

It is advisable to take all issues of potential breach of confidentiality to supervision, whenever possible, and to discuss them fully and openly with the supervisor.

SUPPORTING CHILDREN

Ed Elf support children and vulnerable adults by:

- ensuring the treatment delivered includes social and emotional aspects of learning;
- ensuring a response to online safety concerns, enabling children and parents to learn about the risks of new technologies and social media and to use these responsibly
- ensuring that safeguarding is paramount to help children stay safe, recognise when they do not feel safe and identify who they might or can talk to;
- helping children identify other appropriate adults to approach if they are in difficulties;
- supporting the child's development in ways that will foster security, confidence and independence;
- encouraging development of self-esteem and self-assertiveness while not condoning aggression or bullying;
- liaising and working together with other support services and those agencies involved in safeguarding children;
- monitoring children who have been identified as having welfare or safeguarding concerns and providing appropriate support.
- ensuring that parents and carers are aware of the Early Help and Local Offer where there are identified difficulties beyond the remit of the therapist

Additional vulnerabilities and characteristics can include:

- Children Looked After by the local authority
- Children previously looked after
- Care leavers

- Children with special educational needs or disabilities
- Young carers
- Children showing signs of being drawn in to anti-social or criminal behaviour, including gang involvement and association with organised crime groups
- Children who frequently go missing from care or from home
- Children at risk of modern slavery, trafficking or exploitation;
- Children in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems or domestic abuse
- Children misusing drugs or alcohol themselves;
- Children who have returned home to their family from care;
- Children showing early signs of abuse and/or neglect;
- Children at risk of being radicalised or exploited;
- Privately fostered children

Children with special educational needs and disabilities (SEND) can face additional safeguarding challenges and additional barriers can exist when recognising abuse and neglect in this group of children. These can include:

- assumptions that indicators of possible abuse such as behaviour, mood and injury relate to the child's disability without further exploration;
- being more prone to peer group isolation than other children;
- the potential for children with SEND being disproportionally impacted by behaviours such as bullying, without outwardly showing any signs; and
- communication barriers and difficulties in overcoming these barriers.

To address these additional challenges Ed Elf will ensure that these children receive additional monitoring and pastoral support by speaking to parents and carers, education providers and Children's Services where appropriate,

Children who have a social worker due to safeguarding or welfare needs may be vulnerable to further harm due to experiences of adversity and trauma, as well as educationally disadvantaged in facing barriers to attendance, learning, behaviour and positive mental health. Our school will identify the additional needs of these children and provide extra monitoring and pastoral support to mitigate these additional barriers.

Mental health problems can, in some cases, be an indicator that a child has suffered or is at risk of suffering abuse, neglect or exploitation. Where it is known that children have suffered abuse and neglect, or other potentially traumatic adverse childhood experiences, this can impact on their mental health, behaviour and education. Where necessary, referrals will be made to mental health professionals for further support.

Ed Elf will support individual children as necessary when we receive a notification of an incident of domestic violence or abuse.

Ed Elf takes a trauma informed approach to supporting children, considering their lived experience, and factoring this into how we can best support them with their welfare and engage them with their therapy.

WHISTLEBLOWING AND COMPLAINTS

About other professionals: Ed Elf's responsibilities

We recognise that children cannot be expected to raise concerns in an environment where adults fail to do so.

Ed Elf are aware of their duty to raise concerns, where they exist, about the management of safeguarding and child protection, which may include the attitude or actions of other professionals. If necessary, we will speak with the Local Authority Designated Officer (LADO).

About Ed Elf – Client Responsibilities:

Parents and carers with concerns about Ed Elf are advised to also speak to their local LADO and they can call the NSPCC *what you can do to report abuse dedicated* helpline on 0800 028 0285.

The CNHC have a clear procedures for children, parents and other people to report concerns or complaints about practitioners, including abusive or poor practice:
Concerns about practitioners | CNHC

If you would like to discuss anything in this policy, please contact evalynnecharmer@outlook.com
Tel 01482 887095

APPENDIX A

Child Protection and Safeguarding Procedure

1 DEFINITIONS

1.1 **Children** are any people who have not yet reached their 18th birthday; a 16-year-old, whether living independently, in further education, in the armed forces or in hospital, is a child and is entitled to the same protection and services as anyone younger.

1.2 **Child protection** is part of safeguarding and promoting the welfare of children and refers to activity undertaken to protect specific children who are suffering, or likely to suffer, significant harm.

1.3 **Early help** means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years to teenage years.

1.4 **Harm** is ill treatment or impairment of health and development, including impairment suffered from seeing or hearing the ill treatment of another.

1.5 **Safeguarding** is the action we take to promote the welfare of children and protect them from harm.

- protecting children from maltreatment;

- preventing impairment of children's mental or physical 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.

2 CATEGORIES OF ABUSE

2.1 **Abuse:** a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults or by another child or children.

2.2 **Physical abuse:** a form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

2.3 **Emotional abuse:** the persistent emotional maltreatment of a child such as to cause severe and adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability as well as overprotection and limitation of exploration and learning, or preventing the child from participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, although it may occur alone.

2.4 **Sexual abuse:** involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

2.5 Child sexual exploitation is also sexual abuse; it involves children and young people receiving something, for example accommodation, drugs, gifts or affection, as a result of them performing sexual activities, or having others perform sexual activities on them. It could take the form of grooming of children, e.g. to take part in sexual activities or to post sexual images of themselves on the internet.

2.6 **Neglect**: the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy, for example, 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); or ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

2.7 Depending on the age and capacity of the child, staff should be aware of possible self-neglect, e.g. where a child may not be following medical guidance or taking medication as prescribed. Where this is this the case this should be raised as a safeguarding concern.

3 RECOGNITION – WHAT TO LOOK FOR

3.1 Ed Elf practitioners should refer to the detailed information about the categories of abuse and risk indicators

3.2 In an abusive relationship, the child may:

- appear frightened of their parent(s)
- act in a way that is inappropriate to their age and development, although full account needs to be taken of different patterns of development and different ethnic groups
- however, they may also not exhibit any signs of stress/fear

3.3 In an abusive relationship, the parent or carer may:

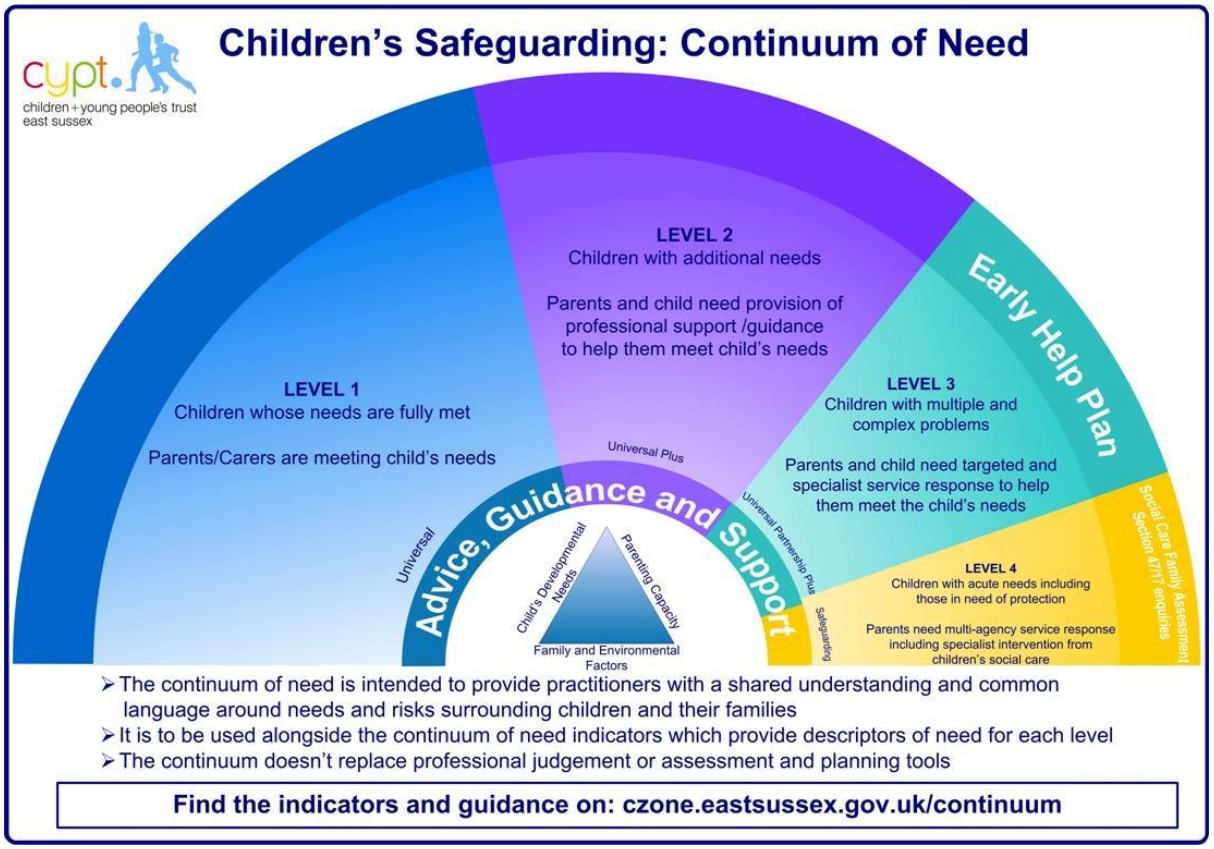
- persistently avoid child health services and treatment of the child's illnesses
- have unrealistic expectations of the child
- frequently complain about or to the child and fail to provide attention or praise
- be absent
- be misusing substances
- persistently refuse to allow access on home visits by professionals
- be involved in domestic violence and abuse
- be socially isolated

3.4 Serious case reviews, now known as safeguarding practice reviews, have found that parental substance misuse, domestic abuse and mental health problems, if they coexist in a family could mean significant risks to children. Problems can be compounded by poverty, frequent house moves or eviction.

4 SAFEGUARDING CHILDREN CONTINUUM OF NEED

4.1 The Safeguarding Children Continuum of Need has been developed so that everyone working with children in England has a common language for understanding the needs and risks surrounding children and their families. It is important that all members of staff are familiar with it.

4.2 The Continuum of Need shows that a child's or family's additional needs can be on a range from one to four, and that needs can shift from early help to child protection and back to preventative early help. It covers children whose needs are increasing as well as children whose needs are decreasing after Children's Social Care involvement. The Continuum of Need will help practitioners to identify the right level of support for the child in the least intrusive way while keeping the child safe. Here is the Continuum of Need from East Sussex as an example:



4.3 **The Continuum of Need identifies four levels of need.**

Level 1:

- children who are achieving expected outcomes
- their needs are met by their parents and by accessing universal services such as health and education
- they do not have additional needs

Level 2:

- children with additional needs
- parents need professional support or guidance to help them meet their children's needs
- extra support can usually be provided by agencies that already know the family, e.g. their pre-school, school or college or NHS community services such as Health Visiting

Level 3:

- children with multiple and complex needs
- children and parents need targeted early help or specialist services to meet the children's needs
- needs are met through multi-agency support and the use of Early Help Plans

Level 4:

- children with acute needs, including those in need of protection
- children and parents need multi-agency responses which include specialist intervention from Children's Social Care through the family assessment process

4.4 By referring to the Continuum of Need and indicators, the therapist can identify when assessment and support for a child and family need 'stepping up' to a referral to Social Care and when the needs of a child and their family have been reduced enough for them the be 'stepped down' to early help services.

4.5 When assessing cases of possible neglect the Neglect Matrix will be used. This tool mirrors the Continuum of Need, but with greater focus upon potential indicators of neglect mapped across each of the four levels of need.