The British Psychological Society

Safeguarding children and young people: Every psychologist's responsibility

June 2018

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Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.

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The document will be reviewed five years after publication, in line with BPS policy. After this time documents are no longer regarded as reflecting the Society's current position. Referral to or use of documents after this time should be with the caveat that the legislation and evidence bases referred to may be outdated or incorrect.

The authors are:

- **Gillian Evans –** Chair – Cpsychol, AFBPsS, Independent Consultant Forensic, Child and Educational Psychologist
- **Laura Cowley –** MBPsS, PhD Student, Division of Population Medicine, Cardiff University
- **Dr Simone Fox –** Cpsychol, Consultant Clinical and Forensic Psychologist, Kings College London and South London Maudsley NHS Foundation Trust
- **Dr Liz McMonagle –** Cpsychol, AFBPsS, Consultant Clinical Psychologist, Newry, Northern Ireland
- **Anne Peake –** Cpsychol, FBPsS, Educational Psychologist, Oxfordshire
- **Dr Khadj Rouf –** Cpsychol, AFBPsS, Consultant Clinical Psychologist, Oxford Health NHS Foundation Trust.

With contributions from:

- **Jennifer Cutler –** Cpsychol, AFBPsS, Consultant Forensic Psychologist, Forensic Psychology Services Ltd
- **Dr Ian Colpitts –** Cpsychol, AFBPsS, Principal Clinical Psychologist, No Wrong Door, Tees Esk and Wear Valleys NHS Foundation Trust
- **Sue Ryan –** Cpsychol, AFBPsS, Clinical & Forensic Psychologist Resettle (Intensive Intervention & Risk Management Service) Merseycare NHS Trust
- **Hannah Farndon –** Policy Advisor.

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Foreword

The UN Convention on the Rights of the Child made a clear commitment to the safeguarding of children globally. It is one of the most profound statements recognising the status of childhood and the rights which should be integral to the experiences of children growing up to be the citizens of tomorrow.

Sadly, many children and young people are facing horrendous conditions, both here in the UK and overseas. A four-nation study into child welfare[1] found that almost 70 per cent of children in Northern Ireland were living in the most deprived 40 per cent of neighbourhoods in the UK and a little over 40 per cent of children in England. In Scotland, children in the most deprived 10 per cent of small neighbourhoods were around 20 times more likely to be looked after or on the child protection register than children in the least deprived 10 per cent. It also found that almost five children in 1000 in Wales and Northern Ireland are on a child protection plan or register with just under four in 1000 children in England and just under three in Scotland.

In 2003, *Every Child Matters*[2] was the UK government's response to the recommendations made in the Laming report into the death of Victoria Climbié. The government set out its aim to 'ensure that every child/young person has the opportunity to fulfil their potential and no child slips through the net' (p.5). Based on consultation with children, young people and their families, the paper set out five outcomes which services should work towards to provide positive outcomes for children:

- Being healthy
- Staying safe
- Enjoying and achieving
- Making a positive contribution
- Economic wellbeing.

The overarching message is that prevention is better than cure; preventing harm to children and young people is preferable to having to deal with the aftermath of abuse and suffering. It is recognised how Adverse Childhood Experiences (ACEs) can have hugely negative impacts on health and wellbeing.[3]

It is striking therefore, that Lord Laming once again found himself considering another child death; that of Baby P[4] in 2009, and asking what happened to his recommendations following the death of Victoria Climbié. It is important to also remember that these examples are amongst a number of inquiries where children have died or suffered serious harm. Each inquiry represents a tragedy at a personal, familial, professional and societal level, and a subsequent need to scrutinise what went wrong in order to try and prevent such harm in the future.

There are repeated themes across safeguarding inquiries, both those concerning harm to children and to vulnerable adults. Parental mental health problems were identified as a factor in over half of a sample of Serious Case Reviews in England[5] and form one strand of the toxic trio; parental mental ill health, substance misuse and domestic violence in terms of risk of harm to children.[6] Psychologists can do much to disseminate and use

psychologically informed evidence to safeguard children and young people, and to help those who have suffered abuse and its consequences. Psychologists are well placed to educate on subjects such as 'denial', to foster an environment of communication and to challenge what Margaret Heffernan[7] refers to as 'wilful blindness'.

Safeguarding should also look at what is meant by health, given that psychologists are trying to facilitate this. Some useful definitions are:

> *'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.'[8] (p.1)*

> *'Mental health is defined as a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.'[9]*

It is also important to consider the issues facing young people in contemporary society. The Children's Society large-scale study of children's happiness and wellbeing has been running since 2005. Their study of 60,000 young people in 2015[10] showed the following key findings.

- 5–10 per cent of children in the UK report low levels of wellbeing. This has been declining since 2008.
- Low wellbeing is associated with a range of negative outcomes including mental and physical health problems.
- Children who are disabled, or those who do not live with their families of origin, are particularly vulnerable.
- In an international comparison of children's subjective wellbeing in 15 countries, children in England ranked 14th out of 15 for satisfaction with life as a whole. England ranked position 9 or lower (out of 15) for 24 out of 30 aspects of life, with especially low rankings for children's satisfaction with their 'self' and with their school lives.
- There was higher reported bullying for children in England, and there was also evidence of gender disparity (with girls reporting less confidence and body satisfaction than boys).

It is also recognised that as children develop they have increasing access to the internet and that online activity is now a major part of daily life.[11] Children face particular challenges in the new world of technology. There are positive aspects to technology, such as access to information and peer support, but risks are also well documented, such as lack of exercise and obesity,[12] vulnerability to online abuse,[13] online bullying and radicalisation.[14] There are moves to use technologies such as online gaming, to improve adolescent mental health, such as SPARX (currently only available in New Zealand)[15] and mobile phone technology, but there needs to be much more evaluation of whether these interventions are acceptable, accessible and effective in helping young people.

Some challenges facing children in High Income Countries (HIC) are an over-emphasise on risk, leading to over-protection.[16,17] An increase in physical health problems such as obesity and diabetes, related to lowered exercise and poor diet; the inequality gap which is high in the UK and is associated with a number of poor indicators such as mental health problems.[18]

Internationally, young people in Low and Middle Income Countries (LMIC) may be unable to gain access to education, face food insecurity, and displacement through conflict[19] or climate change.[20] At a global level, there are several challenges in providing services to those in need: a lack of money; a lack of staff; centralised and institutionalised resources; a lack of political will/awareness to prioritise mental health; stigma about mental illness.[21] There are also cultural aspects to consider and differing norms about mental health.

The Marmot Review[22] is a reminder that there needs to be universal action across the social gradient to maximise individual and community potential. Objectives were set out: giving every child the best start in life; enabling all children, young people and adults to maximise their capabilities and have control over their lives; creating fair employment and good work for all; ensuring a healthy standard of living for all; creating and developing sustainable places and communities; strengthening the role and impact of ill-health prevention.

Aims

This document aims to expand on *Every Child Matters*[2] and provides a model for psychologists to aid thinking and decision-making around the complexities of safeguarding children. The model outlines systems and factors which can affect a child, and guides psychologists in the best practice of how to consider these, make decisions and safeguard children.

This document is intended to:

- Guide safeguarding best practice for psychologists
- Help psychologists to 'think about thinking' and decision-making
- Be a professional resource for all psychologists throughout their careers
- Be psychologically informed
- Be reflective of the shift from child protection to thinking about safeguarding **all** children.

The document outlines the features of safe systems as well as influences on professional decision-making and the wider systemic influences which affect safeguarding. This document seeks to promote safeguarding healthy organisations where children/young people are seen, such as healthy effective schools.

This document cannot give an exhaustive list of different potential safeguarding issues but aims to provide a model for 'thinking about thinking' which can be applied to different contexts in the UK and abroad.

This document is specifically about safeguarding children and young people, however, the BPS recognises the importance of safeguarding throughout the lifespan; further information regarding vulnerable adults and safeguarding can be found in the Society document: *Practice Guidelines* (2017, 3rd edn.)

How to use the document

The document is a resource for work around the wellbeing of children and young people. It is laid out so that a reader can:

- use a suggested model for thinking psychologically about safeguarding, which outlines how key factors can influence safeguarding at a number of different levels
- think about risk and resilience factors related to safeguarding, and how to synthesise these in a meaningful way
- consider how to formulate information related to safeguarding, including reflecting on our own thinking
- consider interventions which promote safety and health, at a number of different levels
- access training scenarios so that psychologists can engage in reflective practice and training with colleagues to enhance practice.

The document is designed to be a 'living' resource, so it is read and re-read on a regular basis. To that end, it has been laid out so the sections can easily be found and it is deliberately written in a practical style.

The first part of the document outlines a model for thinking, reflecting and decision-making in safeguarding practice. This is briefly explained to the reader, as it considers a number of factors that influence systems, and which may ultimately have an impact on children. An exploration of the model in more depth follows, which aims to flesh out the detail.

The document then moves into an exploration of decision-making, and the factors that can affect people when making decisions about safeguarding and risk. It is important to be aware of these issues as they are **key** in how professionals synthesise information and form judgements about risk, resilience and potential for growth. It is these judgements which then lead a practitioner to appropriate interventions and recommendations.

The document then moves into an exploration of how psychologists can form judgements about risk, resilience and growth. Once again, these are considered across a number of layers, so that practitioners can think broadly about interventions, which may range from helping individual children and families, or actually widen the scope to consider population level interventions, via influencing communities, organisations or systems of government.

1. A model for decision-making in safeguarding practice for psychologists

This guidance introduces a model for outlining the factors which exert influence on judgement, decision-making and outcomes in relation to safeguarding. Psychologists are encouraged to consider these factors in their formulations and decisions about safeguarding. The model draws on the Assessment Framework[23] and Brofenbrenner's Ecological Systems Model,[24] along with factors including government policy; the funding, values and ethics of organisations, power and professional decision-making. The model (below) is comprised of layers (e.g. education) and wedges (e.g. values and ethics). Psychologists are encouraged to consider these factors in their formulations and decisions about safeguarding. There is a worked example at the end of section 2.3 as a guide to how the model could be used in practice.

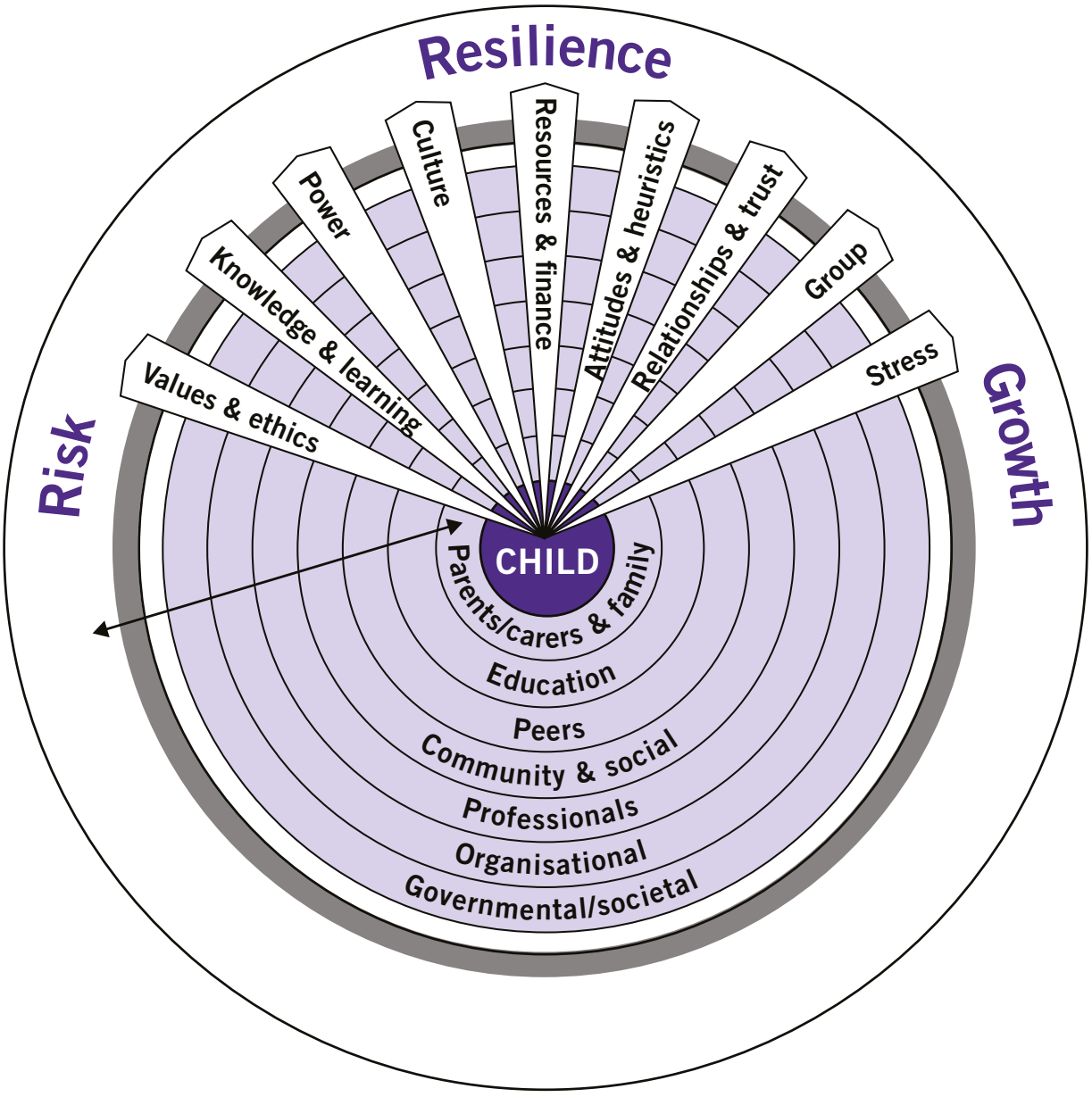


Figure 1: A Model for decision-making in safeguarding practice for psychologists

The child, from birth to 18 years, should be at the heart of thinking, and so is represented at the centre of the diagram. Each layer represents a system exerting influence on the child. Some of these layers are proximal (parents and peers) and some are distal (professions/organisations) but all exert influence on a child's life, with different significance at different points in time. At each layer, there will be factors which render that part of the system more or less vulnerable. These layers interact with each other, which can lead to increased risk or increased resilience.

The systems (layers)

- **Child:** Includes factors which are personal to the child, such as age and developmental level, temperament and disability.
- **Parents/carers and family:** Includes factors related to significant adults, which may make them more or less vulnerable, and influence parenting capacity. Parenting capacity includes the ability to give basic care; safety; warmth and boundaries.
- **Education:** Pre-school, nursery, school and college will exert an influence over the child, not only academically, but in terms of social learning and emotional development.
- **Peers:** Peer relationships become more important as a child develops. There will be factors which render a child more or less vulnerable, such as bullying or extensive use of social media.
- **Community and social:** Community factors can increase or decrease vulnerability and resilience for children. Community is not just about geography, but also includes communities based on shared identities, such as religion or ethnicity.
- **Professionals:** Concerns the factors associated with professional practice which can increase or decrease vulnerability and resilience.
- **Organisational:** Concerns the factors associated with any organisation which can increase or decrease vulnerability and resilience for children.
- **Governmental/societal:** Concerns factors associated with government and social policy which can increase or decrease vulnerability and resilience for children.

The influencing factors (wedges)

These are influences that permeate every layer of influence on the child. They are based on themes which appear and reappear in inquiries and are critical determinants of whether a system is more or less safe. They are:

- **Values and ethics:** Values are underlying principles or beliefs about what is important in life. Values are not automatically ethical. Ethics are the principles governing virtuous behaviour.
- **Knowledge and learning:** Concerns the levels of information and expertise held within the different layers of the system.
- **Power:** Power can be organised at the structural level, with systems being able to direct or influence the behaviour of others. It can also operate at the relational level, where individuals exert power over others.
- **Culture:** Concerns the ideas, customs, and social behaviour of a particular people or society. Within the model, each layer will have its own culture, which may or may not be closely aligned with the next layer outwards.

- **Resources and finances:** Zimbardo[25] comments that, 'Systems provide the institutional support, authority and resources that allow situations to operate as they do.' (p.226). Power is unevenly distributed in society, so there are structural influences on us[26] and these are most detrimental where gaps between rich and poor are widest.[18,27]
- **Attitudes and heuristics:** People are prone to predictable biases in thinking.[28] This has far reaching implications: heuristics/mental short-cuts have been identified in cases where tragedies have occurred.[29,30]
- **Relationships and trust:** Trusting relationships are important to safe systems. Trust is built up over time, through respect, consistency, compassion, dependability, feeling valued, empathy and ability to perspective take, responsiveness and fairness. A safe space can allow people to communicate easily and also provide opportunities for conflicts to be aired and ruptures to be repaired. A system that feels safe, allows people to speak and be heard without fear of reprisal.
- **Group:** People behave differently when they are in a group; groups can create particular identities; and groups exert subtle pressures through implied norms.[31,32,33,34] Zimbardo[25] argues that we need to understand the role of situational and systemic power and its impact on human behaviour. Healthy individuals placed in certain contexts can develop pathological symptoms and behaviour.
- **Stress:** Refers to how a person or system reacts under conditions of challenge. Not all stress is bad – we need challenges to stay engaged and to provide opportunities to develop and learn. However, stress becomes problematic when it is unmanageable and overwhelming. Under these conditions, people's ability to think clearly can become compromised. This adversely affects judgement and decision-making.

2. The model in depth

The UN convention on the Rights of The Child delineates fundamental rights of the child. The model reflects these principles and is based on a combination of the work of Reason,[35,36] Pearce and Cronen's work on the Coordinated Management of Meaning[37] and Power-mapping.[26] It also draws on other psychological theory, reflected in dimensions which impact on systems and the individuals within them, ultimately meaning that they are safer or less safe. The model draws on the Assessment Framework[23] and Brofenbrenner's Ecological Systems Model.[24] These are government policy; the funding, values and ethics of organisations (such as the NHS, education and social services), power, and how these impact on professional decision-making. It also draws on work about safe systems.[35]

On-going psychological support will help the child and the other systems within the diagram to develop the necessary insight into the relationship between what the child does, what the child feels and what has happened to the child.

The outer circle of the model diagram is the level at which risks and factors of resilience and growth are identified. This level creates the learning opportunity to explore interventions and best practice that will provide the inclusive safeguarding by developing problem-solving skills and learning not to rely on past unhelpful responses (growth potential).

It is suggested that only by considering this complex matrix of influence, can psychologists develop a textured and qualitative understanding of risk, resilience and areas of potential growth within the system.

The model is built on the following underlying principles:

An emphasis on values

- **The child is paramount** and at the heart of the model.
- The model is rooted in **anti-discriminatory practice**. It acknowledges that there is an unequal distribution of power and resources within society. Children should not only have equality of opportunity but also equality of outcome.

A dynamic model

- The model is **interactional** (thus acknowledging that environments, circumstances, and people shape how people react).
- Not all dimensions will have equal weight. One factor may outweigh others.
- The model is **dynamic** in order to recognise that things can change over time and can change fast: just because something seems safe at one snapshot in time, it does not mean that it will remain that way.

An emphasis on systems

- The model is rooted in systems thinking. Things can go wrong when there is a failure at each level (e.g. policies/procedures; individual decisions) and an accident permeates through different layers of an organisation. Here, a seemingly small error can have catastrophic consequences as the impact of a mistake accumulates.
- The model can be used to think about **resilient** or **safe systems –** factors which make it less likely that the system might go wrong in the first place.

- The model also encourages the system to be **'risk sensible'**, building in safety at all levels of the organisation[35] and supporting professional expertise.[38]

Underpinned by supervision/consultation

The Society expects that practice be under-pinned by good supervision, which allows critical appraisal in a space which 'balances safety and support with challenge'.[39] This allows time to reflect on gaps in knowledge, personal biases and the impact of working with colleagues, which can shape decisions both positively and negatively.[40] It is also important that supervision and caseload management are separated out, so that professionals can focus on the needs of children and families, rather than external pressures to close cases.

Child protection work necessitates both critical analysis and reflection skills and the application of these skills to real-world practice. In the Munro review of child protection[38] it was suggested that professionals should spend more time analysing and reflecting on their experiences and their knowledge of the situations of the families that they are working with. Both Reder and Duncan[41,42] and Kolb[43] emphasise the use of reflective practice to enhance professional decision making. The model is designed to be used as an aid to thinking during assessment, in intervention or within reflective practice (such as supervision) to help make sense of and formulate work.

It is suggested that a community psychology approach could be adopted in working across the layers and wedges. Community psychology is grounded in social justice principles, works at the whole community level and seeks to work with the most marginalised members of society (those who may not come to the attention of psychology services at all). The model is based around social action, encouraging consciousness raising, and group social action to lead to improved social conditions, and it operates at multiple levels.

2.1 The systems

This section considers each of the system layers in turn, looking at the key features of each. Within each system, there will be issues which render that part of the system more or less vulnerable. These systems interact with each other, which can lead to increased risk of or resilience to a breakdown in safeguarding or harm to a child.

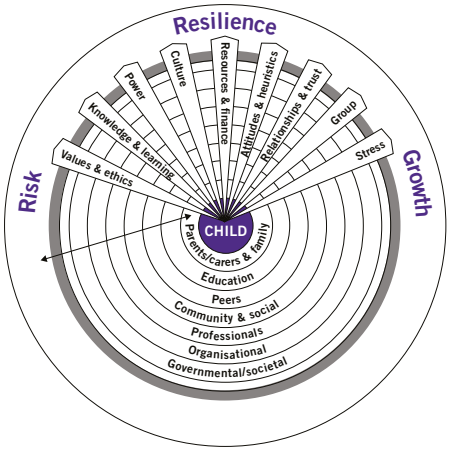
Newman[44] writes that resilience/protective factors operate through one or more of the following by:

- changing the child's perceptions about risks
- minimising the impact when risk factors compound and multiply
- helping the child improve self-esteem and self-efficacy
- creating opportunities for change.

Newman[45] further identifies factors that appear to underlie resilient patterns of adaptation, notably attachment (child-significant caregiver), individual problem solving capabilities and self-regulation of attention, emotion and behaviour.

Rutter[46] has also highlighted the importance of stable attachments; having positive experiences; learning coping skills; access to education and involvement in meaningful activities and socially valued roles in building resilience.

Child

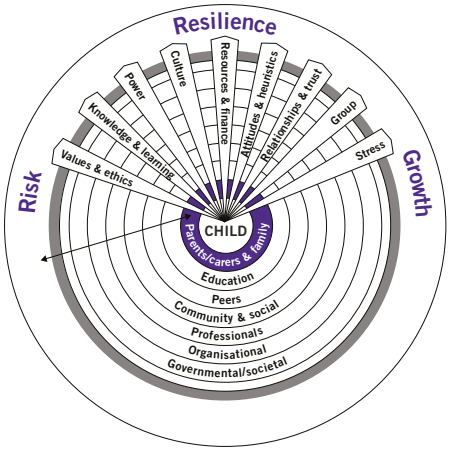


The child needs to be at the centre of assessment and procedures with regard to safeguarding. Messages from Serious Case Reviews highlight the need to put children at the centre: *'At the time, Daniel appeared to have been 'invisible' as a needy child'*.[47] An understanding of a child's individual development and identity should take account of:

- Age and stage of development
- Abilities/disabilities
- Gender identity/sexuality
- Temperament
- Additional/special educational needs
- Class/poverty/disadvantage
- Culture
- Ethnicity and language
- Faith and religion.

The Equality Act 2010 stresses the need to eliminate discrimination and promote equality of opportunity: *'this applies to the process of identification of need and risk faced by the individual child and the process of assessment'*[48] (p.10). Psychologists should also be mindful of the intersections between identity and context to understand how systems may privilege or discriminate certain groups.

Parents/carers and family



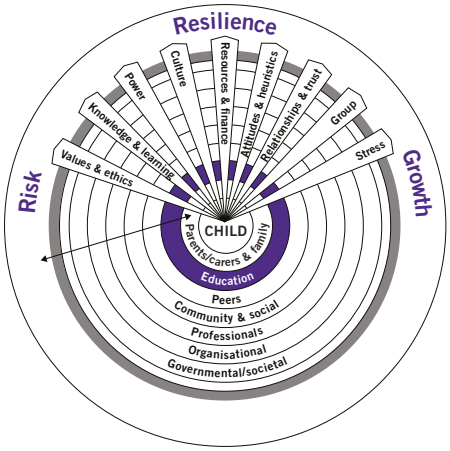
This layer includes factors related to significant adults, which may make them more or less vulnerable, and influence parenting capacity. Parenting capacity includes the ability to give basic care; safety; warmth and boundaries. The circumstances of parents/ carers and the family make children more or less vulnerable. The Assessment Framework[23] for children in need of support and protection points to the need for an assessment of parenting capacities:

- Basic care
- Emotional warmth
- Guidance and boundaries
- Ensuring safety
- Stimulation
- Stability.

Wider features of the family affect capacity to parent:

- Family history, composition, and the capacity of the extended family network
- Settled family life or frequent unplanned/disadvantageous family life
- Adequate income, accommodation and resources, or limited resources whereby there are adverse effects on children
- Parental health or ill health (physical or mental) which undermines capacity to supervise and protect children
- Family harmony or family strife/domestic abuse/violence
- Parental misuse of alcohol/drugs/substances which heighten risks to children
- Social integration and resources to support children.

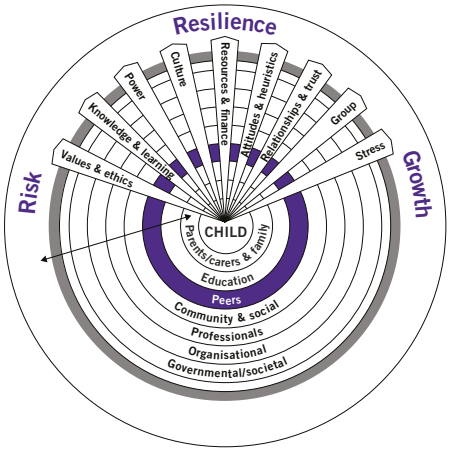
Education: Pre-school/nursery/school



Education provision and teachers are responsible for creating an environment in which children and young people thrive. Education provision can act as a protective force in the lives of children. Educational environments will exert an influence over the child, not only academically, but in terms of social learning and emotional development.

- Teachers are trained in child development. They work with large numbers of children. This means that the concerns about a child can be considered in the context of the normal development of children of a given age and ability.
- Teachers (and many pre-school staff) are the only professionals who are in regular daily contact with children. They can make trusting relationships with children which can be a basis on which a child may feel safe and confident to reveal their fears.
- They are able to make detailed observations of children over time and in a variety of situations involving interactions with peers and adults. Observations of: attendance; mood changes; body language/behaviour; children's language; children's play; drawing/writing; PE/medicals; and contact with parents. This creates opportunities for assessment and support for children about whom there may be concerns.

Peers



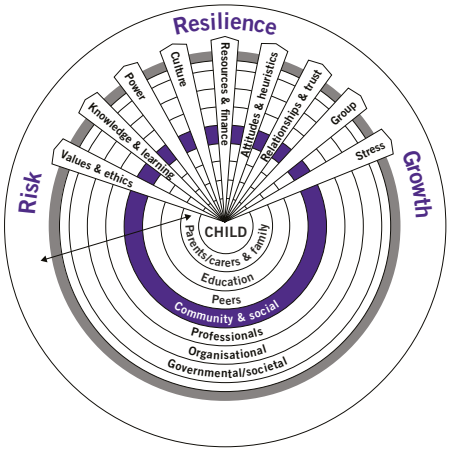
Peer relationships become more important as a child develops. There will be factors which render a child more or less vulnerable, such as bullying or extensive use of social media. Watching other children, copying them, and playing with them, are cornerstones of children's development. Relationships with peers become more important and influential as children develop towards independence with a sense of their own self. Children need nurturing and teaching to learn skills to make and sustain pro-social friendships.

Assessments and interventions with children about whom there are concerns need to understand the peer group of the child. In particular, the extent to which it supports the self-esteem and growth of self-confidence of a child, or renders a child more vulnerable and even more at risk. There is a need to recognise issues which make reciprocal positive peer group relationships harder to achieve:

- Histories of maltreatment and neglect; who have lived with family strife, domestic abuse and violence; or who have been displaced from their families and are in care/adopted/subject to Special Guardianship.
- Children of families who have left their homes/countries following experiences of war and/or natural disasters, or who have had frequent moves of home which are unplanned.
- Children of families with limited socio-economic resources whereby there is an adverse effect on the child's actual presentation in school; or where parental ill health is such that their capacity to parent and nurture the child is compromised, and the child becomes a young carer who has no time or energy for peers.

There can be pressures within peer groups which create challenges and risks for children in a given setting such as: sub-group cultures which undermine values of achievement and social awareness; bullying/cyberbullying; gang cultures; racist and sexist attitudes; influences with regard to alcohol/drug/substance misuse; pressures consequent on experiences of child sexual exploitation.

Community and social

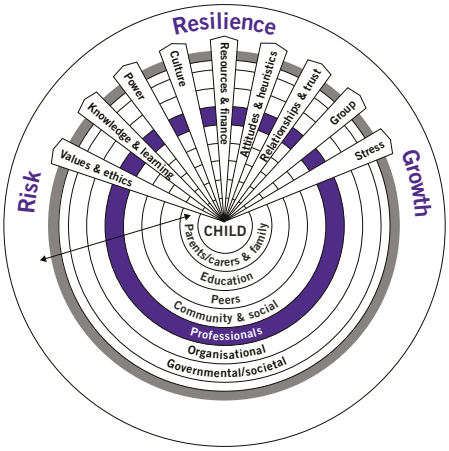


Community factors can increase or decrease vulnerability and resilience for children. Community is not just about geography, but also includes communities based on shared identities, such as religion or ethnicity. All families need supportive networks. These can include: relatives; friends; neighbours; faith groups; community support (such as Children's Centres); voluntary agencies; more formal support from social workers and foster carers. Communities consist of a wide range of infrastructures, which include physical, social, civic, economic, human development and health and wellbeing structures.

Features within a community which can contribute to the risks for children, include:

- **Housing:** Should be uncrowded and adequate for the family and needs of the children.
- **The family setting:** Should be settled, where residents can feel safe from crime, violence and alcohol/drug/substance misuse.
- **Neighbourhood:** Should be well lit, with safe streets, with traffic measures which protect pedestrians and children, nearby shops, and safe places for children to play.
- **Clubs and activities:** Should be affordable, accessible and alongside advice when families are in need.

Professionals



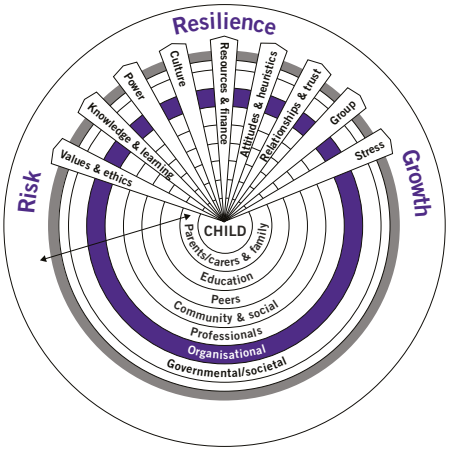
This layer encompasses the factors associated with professional practice which can increase or decrease vulnerability and resilience. The overwhelming majority of Serious Case Reviews document poor inter-agency communication, failed handover arrangements and tardiness of actions, as key contributing factors to tragic outcomes.

The adequate and effective provision of professional services/roles and agency organisation is integral to a response to safeguarding. There is a duty for psychologists to scrutinise their own work and that of their agency, every bit as closely as they scrutinise children and families.

Professional responses to children and families of concern can make the difference between those who are more likely to be resilient and those who are more likely to be at risk. Factors such as:

- early intervention rather than crisis intervention
- qualified/experienced professionals rather than unqualified/inexperienced professionals
- a manageable workload rather than a professional feeing over loaded
- positive supervision/management rather than a professional working without adequate supervision/management
- professionals working as part of a multi-professional network and not in isolation
- goals of intervention which are agreed with the family/parent/child
- appointments which are regularly made and consistently kept, at a frequency which is consonant with the issues
- professionals who are accessible and available and prepared to listen, explain and discuss with the family/parent/child, rather than a rigid approach/agenda
- open and transparent record keeping
- support for the family and child to learn about proactive lifestyle factors, to promote an awareness of the need for there to be conditions for children with regard to safety and wellbeing
- ready access to a Designated Safeguarding Lead for advice and guidance.

Organisational



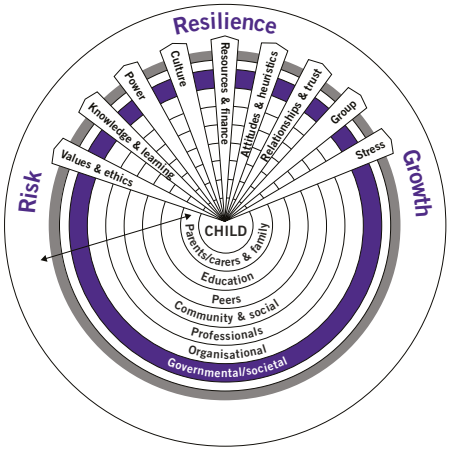
This layer encompasses the factors associated with any organisation which can increase or decrease vulnerability and resilience for children. The duty on Local Authorities to work with partners was re-emphasised as a result of the Lord Laming Inquiry leading to the remit of Safeguarding Boards, which was set out in the Children Act 2004.

The Boards are statutory bodies which are made up and funded by organisations including: the Local Authority; Fire service; District Councils; Police; Probation; all Health sectors; Children and Family Court Advisory and Support Service (CAFCASS); local college; and voluntary agencies and charities. Local Authorities have a Designated Officer who works alongside the Board and who is responsible to it. The role of the Boards is to hold agencies to account for their work around safeguarding children and young people. There are Boards for safeguarding vulnerable adults. Local Safeguarding Boards do not deliver services, but they do work to ensure that agencies work well together. Their work includes:

- ensuring safeguarding/child protection procedures are in place and effective
- designing, developing and delivering the training to all professionals across all agencies
- the commissioning and conduct of Serious Case Reviews following the injury or death of a child(ren)
- monitoring and evaluating how effectively agencies do work together
- planning and commissioning
- raising community awareness.

The message is that child welfare is paramount and safeguarding is everybody's business. Boards have websites for resources, inter-agency procedures, training available and findings from Serious Case Reviews.

Governmental/societal



This layer encompasses factors associated with government and social policy which can increase or decrease vulnerability and resilience for children. The change in terms from child abuse, to child protection, to safeguarding, charts the growing understanding by government and society of the complexities with regard to the protection of children. Safeguarding is an 'umbrella' term, which covers a range of measures to ensure that children and young people have the best opportunities to be protected from harm. Government revisions to *Working Together*[48] set a pace for defining safeguarding, developing policies and improving practice.

It is action at governmental level which facilitates the prompt and effective responses to child neglect and abuse, particularly when aspects of abuse are newly recognised, such as female genital mutilation and breast ironing.

Safeguarding now has a wide remit. It includes the definitions of the guises of harm for children which have now moved from: neglect, physical, sexual and emotional abuse, to include: domestic abuse/violence; self-harm; trafficking and modern slavery; forced marriage; female genital mutilation; and the statutory duty placed on staff to recognise those vulnerable to extremism.

The government legislates for changes to the physical environment and rules in settings for children and young people which contribute to the Safeguarding agenda: the security of school sites; speed humps/parking restrictions outside settings for children; safe pedestrian crossing on roads by schools and nurseries; systems for monitoring visitors arriving and leaving settings; protective coating or unbreakable glass in windows; policies with regard to mobile phone use.

The government also has the decision-making capacity to decide how resources and finances are distributed within society. At macro level, it influences the accessibility of services for the public, and it also determines the resources which are available to public services in order to discharge their duties.

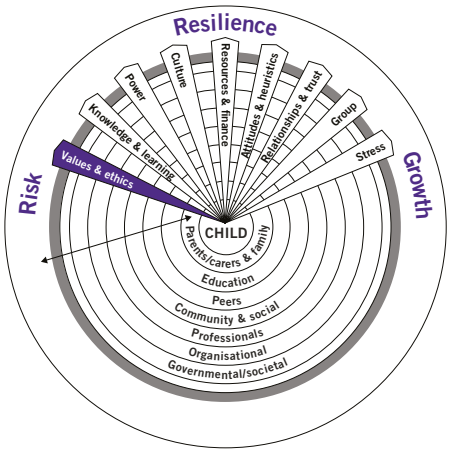
It should be noted that *Working Together* refers to England. The Devolved Nations have their own policies; further information is available in the Resources section.

2.2 The influencing factors

This section considers each of the wedges in the diagram, these are the influences that permeate different systems and hence, every system affecting the child. They are based on themes which appear and reappear in inquiries. For instance, governments will be guided by values and ethics and budgets, as will organisations, individual professionals, communities, schools and families. These may be aligned with each other, or not. Some values may be explicit and transparent, whilst others may be secret or hidden.

This section also suggests best practice for the aims of psychologists for each area, examining how psychologists can work systemically to inform psychologically informed approaches which foster prevention, provide therapeutic intervention and promote growth, so that children and young people can develop healthily.

Values and ethics



Values are underlying principles or beliefs about what is important in life. Values are not automatically ethical. There should be ongoing reflection about how competing values and ethics may inform and progress a system towards wellbeing, or indeed move it away from health. An understanding of values and ethics can aid formulation, alert psychologists to any issue of concern and inform intervention. Ethics are a set of principles governing virtuous behaviour. No system is neutral or value free, and as Burden[49] stated there should be a common commitment to giving regular, careful thought to everything that takes place within a system.

Situations where there is low social accountability and little self-evaluation/censorship, can lead to unethical behaviour. Even factors such as time pressure and competing task demands can affect morality and actions. Experimental studies highlight that people are less likely to stop and help someone in distress if they are in a rush to get somewhere else.[50]

Individuals involved in authority/obedience experiments find it difficult to exit from abusive situations (either as actors or observers) due to various factors including: signing a contract to participate (thus feeling committed), being given a meaningful role to play, the abusive changes emerging in small steps or gradually increasing in the harm they are causing, opportunities being created for the diffusion/abdication of responsibility (i.e. people felt they were following orders), the process of exiting was difficult, unscripted or the costs of leaving were high and there were 'ideological' reasons used to justify an 'essential goal', such as the reduction of civic freedoms for distal or nebulous concepts around 'security'.[25]

Recommendations for best practice

Social justice principles are at the heart of the psychological profession, in its endeavours to alleviate suffering and to maximise people's life chances. The Human Rights Act 1998, the UN Convention on the Rights of the Child and the Equality Act 2010 provide clear

social, ethical and moral models for equality. As psychologists, the British Psychological Society's *Code of Ethics and Conduct* is based on the four ethical principles of respect, competence, responsibility and integrity. These should guide practice so that service users are treated with compassion and humanity.

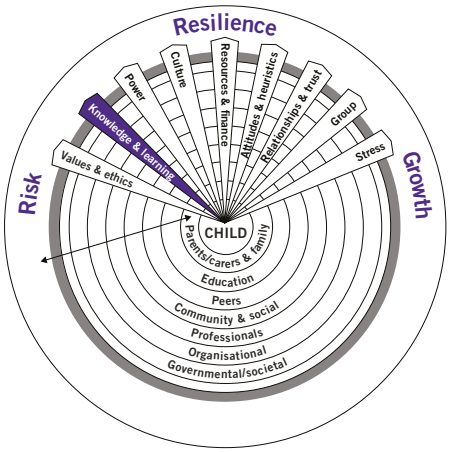
Psychologists should assess the values and ethics of systems in which they work (whether organisationally, family or directly with individuals). This should focus on explicit values and ethics, but also the nuances of those that are not stated or perhaps appear hidden. Psychologists need to be clear about their own values and ethics, both personally and professionally.

There should be ongoing reflection about how competing values and ethics may inform and progress a system towards wellbeing, or indeed move it away from health. An understanding of values and ethics can aid formulation, alert psychologists to any issue of concern and inform intervention.

Psychologists should consider

- If their organisation and practice holds to the foundations of safe systems (i.e. systems which are just; flexible; have an open/ reporting culture; informed/ skilled and also place a high value on learning and reflective responsive practice).
- Whether they are clear about the underlying values upon which you are making judgements and decisions.
- What the underlying values on which you are making judgements and decisions about intervention are.
- Whether they teach people how to 'step in' and be active bystanders who challenge practices which could lead to harm.

Knowledge and learning



This concerns the levels of information and expertise held within the different layers of the system. Psychologists should facilitate knowledge and learning at differing layers of the system. This fosters knowledge based upon evidence (and clarity about its limitations) rather than attitude based intervention. Knowledge can be defined as the levels of information and expertise held within the different layers of the model. Learning may reflect what is learnt, how it is learnt and how it is acted upon. This may be implicit (beneath awareness) or explicit and transparent. Every individual involved in exerting influence on the child, including the child themselves, will each have their own unique experiences, knowledge and skills, acquired through multiple modes of learning.

There are multiple influences on meanings. Locating actions within context enables people to develop an understanding of meanings[37] and for psychologists, exploring those meanings can help us to develop a sophisticated understanding of difficulties and how best to intervene to provide support and promote growth and resilience.

At a professional level, serious case inquiries have highlighted problems with knowledge and expertise and how these are acted upon, but also with how professionals deploy analytical thinking. Keeping up to date with child protection guidelines and other advances in the field should be a part of all psychologists continuing professional development activities.

Recommendations for best practice

A team stays up to date with safeguarding training and is able to recognise warning signs early on. They have regular skills sharing sessions where they discuss messages from research, and think about how to apply this best practice to their casework. More experienced practitioners support less experienced workers, and both formal and informal reflection on casework is encouraged and welcomed. Practitioners recognise that signs of child maltreatment can include externalising and internalising symptoms and behaviours, as well as physical signs, and that certain patterns of injuries such as bruising to the ears or cheeks are highly suggestive of abuse.

Psychologists should facilitate knowledge and learning at differing layers of the system. This fosters knowledge based upon evidence (and clarity about its limitations) rather than attitude based intervention.

Psychologists have an important role to play in facilitating better understandings of safeguarding at different layers, such as:

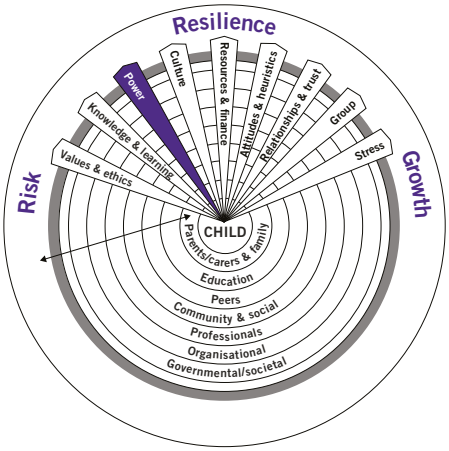
- helping children to understand parental ill health to raise questions about worries
- helping parents to develop adaptive behaviours
- helping the school team to understand the meaning of a child's behaviour
- working at a public engagement level, to increase understanding of mental health.

Knowledge and learning should include evidence-based practice, but should also include practice-based evidence. Psychologists should be aware of risk factors, but their level of working and lived experience will also determine how skilfully they synthesise risk factors into a working model (or formulation) of problems, resilience factors and ideas for intervention. Knowledge and learning should also determine how thorough psychologists are about asking key questions, which help them formulate around safeguarding, (such as building detailed genograms, or understanding the social determinants of mental distress).

Psychologists should consider

- Whether they have knowledge of risk factors
- Where the gaps are in what they need to know
- Whether they have knowledge of risk factors
- What influences their formulation of the problem?
- The psychological impact of realising there may be safeguarding concerns
- Whether they have access to mechanisms that allow them to reflect on their work over time (supervision; reflective practice).

Power



Power can be organised at the structural level, with systems being able to direct or influence the behaviour of others. It can also operate at the relational level, where individuals exert power over others. Psychologists should pay attention to and be mindful about how power is distributed within the systemic layers that they are working within. Power can be thought about at multiple levels within Society, and it can take many forms.[51] It can also operate at the relational level, where individuals can exert power over others, or we can have the ability to act. Zimbardo[25] argues that situational and systemic power impacts on human behaviour.

Structural power is unevenly distributed in society[26] and these are most detrimental where gaps between rich and poor are widest.[18]

Power influences the dynamics of decision-making. This power may manifest in how resources are funded at a societal level, or within an organisation. There may also be differences in how power is held within an organisation, such as whether there is a dominant model which prevails to the exclusion of others, which can mean that understandings become less psychologically informed.

Structural inequalities impact at multiple levels, including interpersonal relationships. There is psychological theory which acknowledges structural inequality and makes suggestions about psychologically informed interventions – see Feminist Discourses and interventions such as that of Sue Holland[52] and Hagan and Smail's[26] power-mapping.

Recommendations for best practice

Here we can reflect and learn from examples of good practice from other professions. For instance, nursing frequently tops polls for the most widely respected and trusted professions. In order to achieve trust that nurses act in patient's best interests, a very successful model has been developed for maintaining professional boundaries to establish and maintain the best interest of patients and to respect their dignity. Professional boundaries represent the space between the nurse's power and the patient's vulnerability. The nursing model posits a continuum of professional behaviour[53] where under-involvement includes distancing, disinterest and neglect, and can be detrimental to the patient and nurse; over-involvement includes boundary crossings, violations and professional sexual misconduct. There are no definite lines separating the therapeutic relationship from under-involvement or over-involvement; instead, it is a gradual transition. This continuum provides a frame of reference to assist nurses in evaluating their own and their colleagues' professional-patient interactions.

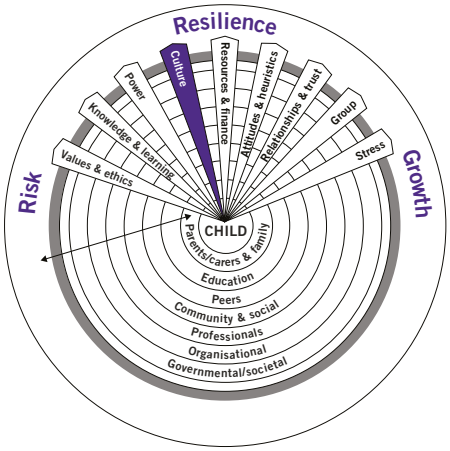
Psychologists should pay attention to and be mindful about how power is distributed within the systemic layers that they are working within. Of course, psychologists are also subject to powerful influences and it is important to reflect on how this may impact on judgment and decision-making. Power can structurally embedded or located within certain in-groups, which exclude others. Again, the aim of prevention and intervention should be to work towards the principles of 'informed, reporting, just, flexible and

learning'.[35] Psychologists can be better informed and more realistic about where to intervene in a system if they have a better understanding of power relationships.

Psychologists should consider

- Who holds power within the system they are working with (e.g. clinical team; family; school; residential setting).
- Whether this affects their judgment and decisions in positive and/or negative ways.
- How power is expressed and whether it is overt or covert.
- Whether the habit of compliance is strong in a culture or whether people are encouraged to develop critical thinking skills and openly question.

Culture



Culture concerns the ideas, customs, and social behaviour of a particular people or society. Even within one dominant culture, many subcultures exist, which may be based on common identity, such as ethnicity, faith or sexuality. Once again, within the model, it is recognised that each system will have its own culture, including organisational culture which may or may not be closely aligned with the next layer outwards. Psychologists should ensure that they have meaningfully considered culture in their assessment, formulation, intervention and evaluation.

For instance, a particular family culture may not be closely aligned with the wider community, particularly if that family is from a marginalised group. A professional team can exist within an organisation and be closely aligned with the organisation's culture or have moved away from it.

Of particular interest, regarding professional practice is the notion of being embedded in a learning culture[35] which creates a safer system. Several authors highlight the importance of explicit use of the learning cycle and the importance of reflection within professional judgement and decision-making.[41,42,43,49]

Recommendations for best practice

Syed,[54] in his book *Black Box Thinking* proposed that healthcare settings would benefit from learning from the aviation industry. Rather than concealing failure, or skirting around it, aviation has a system where failure is data rich. In the event of an accident, independent investigators, are given full rein to explore the wreckage and to interrogate all the evidence. Mistakes are not stigmatised, but regarding as learning opportunities. The interested parties are given every reason to co-operate since the evidence compiled by the accident investigation branch is inadmissible in court proceedings. This moves away from a culture of blame and increases the likelihood of full disclosure.

Heine[55] defines culture as having two aspects – information acquired through social learning and groups, who have shared experiences. Psychologists should ensure that they have meaningfully considered culture in their assessment, formulation, intervention and evaluation. Particular care should be taken not to pathologise minority cultural norms because they may differ from majority cultural norms. Once again, there should be a careful consideration of power imbalances. There is a need to accommodate pluralism around models of wellbeing. Reflective practice is crucial: there should be regular training around working with culture and ethnicity, and confidence building around working with difference. Once again, psychologists should aim to ensure that their thinking meets the principles of 'informed, reporting, just, flexible and learning', but also recognise that these may also be culture bound.

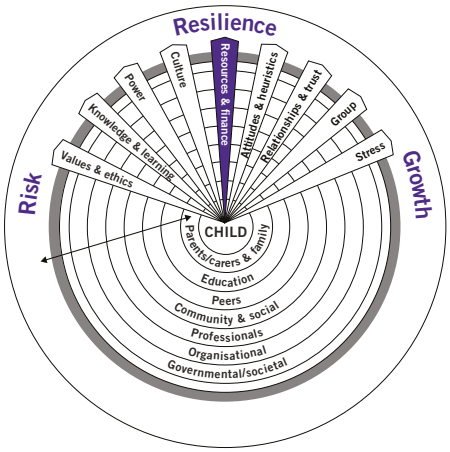
Culture concerns the ideas, customs, and social behaviour of a particular people or society. Psychologists need to reflect on what position they take in relation to those who are culturally different, to ensure that they do not inadvertently pathologise difference or slip into an equally unhelpful stance of being frightened of addressing safeguarding issues for fear of being labelled racist. Dingwall et al.[56] identified how beliefs in 'cultural relativism'

(i.e. the idea that differences in child rearing practices are elastic on the basis of culture) can lead to serious warning signs being missed. Similarly, psychologists should be aware of their own implicit biases and assumptions regarding those who might be similar to them, which can lead to missing or minimising the significance of safeguarding information.

Psychologists should consider

- What the cultural issues are in the case.
- If there are any risks of seeing difference in a damaging way.
- If there are any issues related to ethnicity and culture.
- If the organisation is culturally different or similar to them.
- If the organisation is culturally different to the people that they are working with.
- If the system values diversity.
- If there is any risk of institutional racism or individual racism – either overt/covert; intended or unintended.

Resources and finance



Recent austerity measures have placed services under huge pressure. In Britain, public spending is being reduced across health, education and local authorities, threatening the future running of established services.[57] Psychologists can do more to advocate for those who have lived experience of disadvantage, and to facilitate community groups that can advocate for improved social circumstances.[52] Zimbardo[25] comments that, 'Systems provide the institutional support, authority and resources that allow situations to operate as they do' (p.226). As already highlighted, power is unevenly distributed in society, so there are structural influences on us[26] and these are most detrimental where gaps between rich and poor are widest.[18,27] Wilkinson and Pickett[18] documented the impact of wealth inequalities on whole societies, where poor outcomes on key social indicators, such as crime, health, mortality, and teenage pregnancy are all higher where the gap between rich and poor is widest. These issues are longstanding: The Black Report[58] and The Health Divide[59] clearly linked mortality to class, and recommended a reduction of child poverty through increased welfare spending. More recently, Stuckler and Basu[27] have also evidenced that when government's spending on welfare increases, that national productivity is also improved, thus highlighting the socially protective role of addressing poverty at policy level. Dorling[60] outlines how governmental level action can lead to improved wellbeing at a population level.

All public services are experiencing funding cuts and greater pressures, forcing swift and radical service redesign. There is an increased emphasis on increased bureaucracy, productivity and targets. There are threats to funding for longer term service provision,[61] with an increased emphasis on competitive tendering. An Oxfam report[62] highlighted that there are plans to cut 900,000 public sector jobs over the coming years.

The division between rich and poor is growing, with approximately 13.5 million people in the UK living in poverty.[63] More than 25 per cent of British children live below the official poverty line.[64] Almost half of the world's wealth is now owned by just one per cent of the population.[65] The emphasis needs to go beyond equality of opportunity to focus on equality of outcomes. Wealth gaps are widening and this will affect children's wellbeing.[66]

There are fears about the current economic climate and its impact on public service spending, and how this may further severely disadvantage the most vulnerable within society. The Child Poverty Action Group outlines the UK prevalence and the negative impacts of child poverty, including negative health, education and long-term financial impacts. Under current government policies, child poverty is rising, with an estimated 300,000 increase in children living in poverty over the last five years.[67] This upward trend is expected to continue with 4.7 million children projected to be living in poverty by 2020.[68] Two-thirds of children growing up in poverty live in a family where at least one member works.[64]

A major factor in rates of child poverty is the extent to which the state provides a 'safety net' to relieve poverty. Since 2010, major reforms to the welfare system, have affected children in poor families disproportionately harshly.

Examples include:

- freezing of working age benefit rates
- the 'bedroom tax'
- the overall benefit cap
- removal of council tax benefit
- a more severe benefits sanctions regime
- tougher work capability assessments
- tighter criteria for disability benefits
- Universal Credit payment delays and implementation problem.

On top of this, support services for poorer families have also been reduced, either directly or through the reduction in local authority funding, for example:

- Sure Start centres
- youth services
- youth offending services
- supported housing services, including for young mothers and for women fleeing domestic violence.

Despite there being such strong evidence that inequality and poverty affects life chances, there is no serious narrative about poverty as a form of discrimination. A Socio-Economic Duty was included in the UK Equality Act but has not yet been implemented. The Scottish government have now acknowledged and activated this duty, meaning that public bodies in Scotland will be required to put reducing poverty and inequality at the heart of their decision-making.

Recommendations for best practice

Examples of healthy resourcing include the King's Fund, a not-for-profit organisation attempting to improve health and social care throughout England, including child and adolescent mental health services (CAMHS). Their projects as of the beginning of 2016 include a campaign for funds to support change in the NHS, recommendations for more integrated health and social care services, provision for the development of new care models involved in the NHS Five-Year Forward View, and research to ascertain the impact of public spending reductions on social care services, among many others.

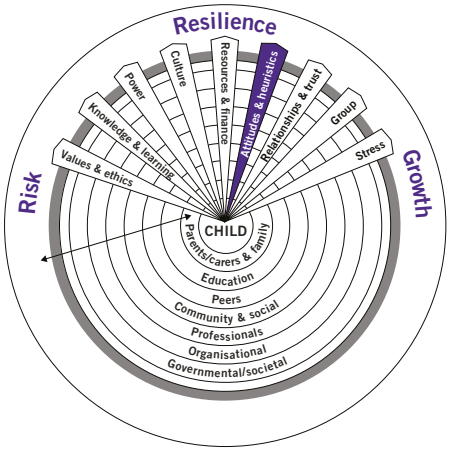
Once again, psychologists need to ensure that they have a meaningful understanding of the impact of economic disadvantage upon people's life chances. There also needs to be an understanding that often those most in need of psychological help and advice do not receive it. Psychologists may have more impact upon safeguarding if they intervene at different points in the system, and this may require the profession to be much more 'outward facing' than has traditionally been the case, and to work with organisations that are closest to working with those who are living in highly challenged circumstances. However, it is important to remember that safeguarding issues occur within all social groups, and not to lose focus on working with groups that may have more economic advantages, but who also may have vulnerabilities. Psychologists can do more to advocate for those who have lived experience of disadvantage, and to facilitate community groups that can advocate for improved social circumstances.[52]

In the context of shrinking public sector spending, one response to managing fewer resources, is to limit access to those resources. This can lead to an inconsistency in risk thresholds between those agencies tasked with providing universal access (such as GPs) and those providing specialist services (such as clinical psychology services). These differing thresholds can have serious implications for safeguarding, as early specialist help may be unavailable, meaning that difficulties have to become significantly worse (and potentially entrenched) before people are seen for help.

Psychologists should consider

- How well resourced is the system they are working within.
- If there are any issues related to resourcing or finances which could be negatively impacting upon their decisions.
- How well resourced are the systems that they are working with.
- How this might be impacting upon their understanding of the case.
- What this suggests about appropriate intervention points.

Attitudes and heuristics



People are prone to predictable biases in thinking.[28] This has far reaching implications for everyone. Heuristics/mental short cuts have been identified as operating within cases where tragedies have occurred.[29,30] Psychologists can help others to develop reflective practices and embed them within their teams. Psychologists can help to highlight the impact of attitudes and heuristics upon decision-making. Common reasoning biases have been outlined concisely by Sutherland:[69]

'First, people consistently avoid exposing themselves to evidence that might disprove their beliefs. Second, on receiving evidence against their belief, they often refuse to believe it. Third, the existence of a belief distorts people's interpretations of new evidence in such a way as to make it consistent with the belief. Fourth, people selectively remember items that are in line with their beliefs.' (p.151)

People's beliefs and attitudes can affect their judgements and decisions. Reflective practice allows underlying beliefs and assumptions to be made explicit in every day practice.[70] The following heuristics and problems with decision-making have often been identified as repeated inquiry themes.

- Written evidence was attended to less than verbal evidence.
- Failures to revise risk assessments in light of new information.
- Not understanding the meaning of events.
- Thinking biases, such as discounting evidence that contradicted the worker's view of the family; over optimism.
- Unhelpful interactions between internal mechanisms of decision-making and external demands. Munro[30] commented, 'professionals with heavy caseloads and limited time can easily feel overwhelmed by the range of potentially important details to consider when assessing a family.' (p.754)
- Not keeping the child at the centre of thinking.
- Groups may not consider alternative viewpoints – 'Groupthink' (see section 3.1 Thinking Traps).
- Framing – for example, not considering issues affecting parental capacity as they are not familiar with issues affecting the parent. For instance, Falkov[71] reviewed cases where there had been fatal child abuse and where there had been adult mental health issues. He found that it was rare for child care case discussions to include concerns about psychiatric problems. It was also noted that mental health workers tended to divert away from child issues, instead focusing much more on the adult's symptoms.
- Emotional reasoning – emotion impacts upon reasoning and decision-making, particularly if practitioners feel anxious. They may then be prone to defensive practice.
- Beliefs and attitudes – for example, in Rotherham – where police did not see young women as victims of sexual crime so failed to act. There were suggestions that there was organisational anxiety about accusations of racism if they intervened.[72]

- Attitudes to mistakes – Reason[73] has highlighted that professional attitudes toward mistakes can lead to serious injury or death. He reported that annually between 45,000 and 98,000 Americans die because of the treatment they receive in hospital. He outlined how a defensive culture can make systems less safe as people will defend against or hide mistakes. He calls for an organisational change towards medical mistakes in order to improve patient safety.

Although these cases fall at the extreme, there is evidence that the workers were not atypical in their decision-making. A reflective and open approach is designed to aid professionals' decision-making and guard against error.

Recommendations for best practice

Psychologists are well placed to help people at different layers of the system to identify thinking that underlies judgement and decision-making, such as:

- testing 'intuition'/'gut feelings'/'discrepancy detectors'
- being frame vigilant
- thinking biases, such as the 'sunk cost effect' or 'anchoring'
- unhelpful group processes, such as 'scapegoating'.

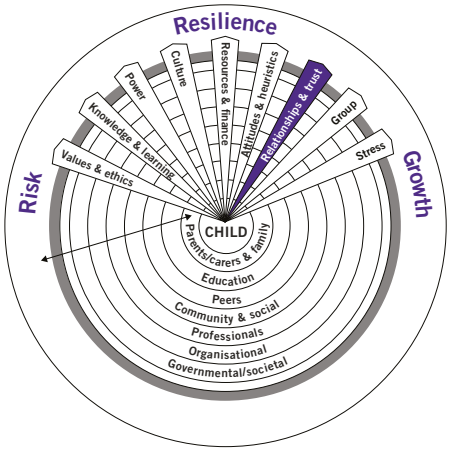
Psychologists can help others to develop reflective practices and embed them within their teams. Psychologists can help to educate others about the impact of attitudes and heuristics upon decision-making. Further information is available in Section 3. Decision-making: Broadening perspectives on risk.

Humans are prone to taking mental short-cuts in their thinking. It is important for psychologists to be aware of these short-cuts, and potential biases in thinking. This can include the decisions which are based on particular frames, the role of emotion, satisficing, discounting and other biases. These biases operate at an individual level but also within groups.

Psychologists should consider

- If they are clear about whether there are any thinking biases which may be operating in their decisions.
- Whether these are at an individual or group level.

Relationships and trust



Trusting relationships are key to safe systems. Trust is built up over time, through respect, consistency, compassion, dependability, feeling valued, empathy and ability to perspective take, responsiveness and fairness. Psychologists can use the model to identify those relationships that may support safeguarding, and if these are absent, to promote interventions which build social connections and meaning for young people.

A safe space can allow people to communicate easily and also provide the opportunity for conflicts to be aired and ruptures to be repaired. A system that feels safe, allows people to feel they can speak and be heard. This is true in individual relationships, whether friendships, intimate relationships or a trust placed in professionals, organisations or governments.

For children and young people, psychologists may consider whether young people have been able to form healthy attachments with their caregivers, family and peer group. Healthy relationships are predictive of good mental health and the ability to regulate emotion; the less opportunity for healthy attachments, the more vulnerable a young person is likely to be.[74,75,76] Unresolved disturbed/disorganised attachments and developmental trauma are linked to later difficulties with mental health and relationships.[75] Psychologists need to consider the particular vulnerabilities of children who have suffered significant broken attachments, such as the death of a parent, experience of abuse or being taken into local authority care. These experiences can make children feel vulnerable to isolation and to have difficulty in terms of trust, forming positive and secure relationships/attachment to significant others.

At a systems level, organisations become less safe when people become mistrustful, scared to speak up or feel disengaged. Staff may not communicate well with each other, and there may be poor communication across agencies, which is a repeated theme in serious cases.

Munro[30] reported that evidence fragmented across agencies could have been shared and would have increased consensus about risk. Other seemingly small distortions in communication also led to grossly inaccurate messages being passed between workers. Sinclair and Bullock[77] also found evidence of poor communication between workers in cases where children had died.

At the extreme, within command and control type structures, or where there is a blame culture, people may feel afraid to raise concerns for fear of the consequences of doing so (such as threats to safety; fear of job loss; being stonewalled; fear of not being able to work again). The treatment of staff raising concerns about malpractice or abuse, shows that the law to protect people who 'whistle blow' or raise concerns needs to be considerably strengthened.[78]

Recommendations for best practice

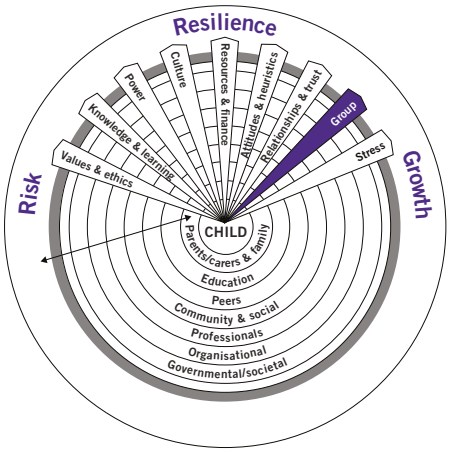
Psychologists can use the model to identify those relationships that may support safeguarding, and if these are absent, to promote interventions which build social connections and meaning for young people. Resilience literature identifies that the

presence of supportive older role models, such as siblings or a supportive adult, can provide children with someone they can confide in, or who can advocate for them. Supportive relationships can also foster empathy, and emotional regulation. Psychologists can encourage systems to promote clubs or other social networks, which allow opportunities for achievement and pleasure, peer relationships, connection and meaning. All of these factors are associated with wellbeing. Particular attention needs to be paid to the experiences of those young people who are from marginalised groups, where unhelpful dynamics may be operating against them.

Psychologists should consider

- Whether they are working in a cohesive team where they can communicate easily with colleagues.
- Whether there are good inter-agency relationships.
- Whether people can talk to their colleagues and managers about concerns that they have.

Group



People can behave quite differently when they are in groups than they do as individuals. Groups may behave in their own particular ways and take greater risks, and they can follow the most outspoken or powerful members rather than adopting more democratic decision-making. The tendency of groups to search for consensus and certainty can lead to 'groupthink' and poor decisions, where a consensus prevails without referring to evidence.[79]

Groups can create particular identities, and groups exert subtle pressures through their implied norms.[31,32,33,34] People assigned a particular identity may then confirm to the socially constructed norms of that group, facilitating institutionalised behaviour and thinking.[80] This can lead to conditions where abuse occurs and vulnerable groups are persecuted, as they have 'out group' status or are socially excluded. Zimbardo[25] argues that there is a need to understand the role of situational and systemic power and its impact on human behaviour. Healthy individuals placed in certain contexts can develop pathological symptoms and behaviour.

Munro's analysis of Serious Case Reviews[29,30] highlighted thinking biases, such as groupthink and over-optimism. Rotherham and other serious cases show us how attitudes and power interacted with group processes to lead to 'no action' and group paralysis. Telling the authorities was not enough to protect young people. Over time, it is likely that the authorities habituated to the information and continued to frame it as an issue where the young girls and women were perceived as being victims, but were making 'lifestyle choices'.

Recommendations for best practice

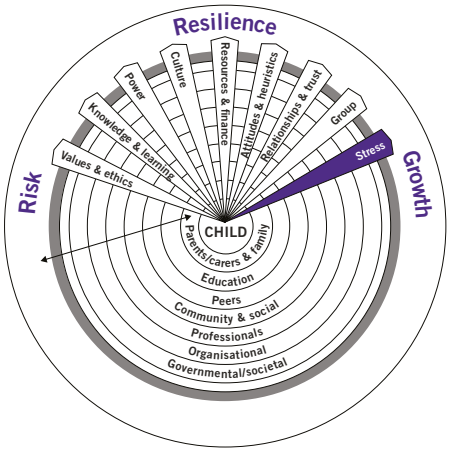
Based on the work of Zimbardo,[25] psychologists should be clear about their values and ethics, making sure that their systems are open to regular, random checks at all levels and ensuring that all staff are aware of this. Systems should have explicit rules and ensure that they are followed up with consequences when they are broken. Respect should be encouraged for a just authority, but action should be taken against an unjust authority. All staff should undergo regular supervision and training, acknowledge their mistakes, take responsibility for their actions and be mindful and reflective. They should think about how language shapes behaviour and be aware that smaller misdemeanours can lead to larger ones. They should encourage others to think about the consequences of their actions and help people to aspire to be the best they can be. It is important to maintain space within social relationships, promote altruism, be vigilant to how issues are framed, as they will affect our perceptions of them, to balance time perceptions and be open to diversity. Psychologists should trust and test their intuition and gut feelings. Most importantly, all psychologists need to be prepared to accept that abuses can happen, and that they can occur in ordinary everyday settings.

Psychologists should aim towards practice that enhances positive group relationships. Psychologists should ensure that they are skilled in understanding group dynamics and where they are working with marginalised groups, seek to enhance resilience of those who are socially excluded, and work towards improved social inclusion.

Psychologists should consider

- Whether there are any pressures for the group you are working with.
- Whether there is any risk of groupthink.
- Whether the group is functioning based on the principles of safer systems (just; informed; reporting; flexible; learning).

Stress



The experience of stress is very personal, stress can be perceived both positively and/or more negatively. Stress is a part of life, and refers to how a system or person of any age (including infant) reacts under conditions of challenge. Eustress, a positive response to challenge fosters motivation, hope and active engagement. People need a certain level of stress to stay engaged and to provide opportunities to develop and learn. It is part of human evolutionary inheritance, forming a fundamental part of our survival mechanism: fight, flight or freeze.

Stress has clear physiological, cognitive, emotional and behavioural impacts.

Stress can become problematic when it is prolonged, unmanageable and overwhelming. The survival mechanism is designed to react under short-term conditions of stress. Conditions of prolonged stress, particularly those associated with feeling powerless and unable to change one's situation, can lead to negative impacts upon a person. For instance, psychological and emotional impacts include feelings of helplessness, hopelessness and depression. This can affect behaviour, leading to passivity, extreme avoidance or inappropriate displays of anger. Physiological changes associated with the prolonged release of stress hormones can lead to health problems, such as high blood pressure. People can experience cognitive changes, and the ability to problem-solve and think clearly can become compromised. This will adversely affect judgment and decision making. At its worst, prolonged stress can lead to 'burnout', which is associated with emotional exhaustion, depersonalisation and a low sense of accomplishment (i.e. a sense of failure).

Stress can be the result of complex and interactional processes. It is important to consider different layers of the model to understand where different pressure points may be located. It is important to examine the role of power and powerlessness that exert influences on people's lives – these may be distal or proximal sources.

It is important to help people build internal resilience to stress, which may be achieved through experiences of achievement, having control and agency, learning problem – solving and stress management skills.

However, it is also important to address system stressors, or to at least identify them and formulate them with people, so that there is a realistic appraisal of why an individual or group is suffering. For example, it is hard from anyone to benefit meaningfully from relaxation exercises if the source of stress is a chronically understaffed team or a manager whose behaviour is bullying. It is important for a single-parent on benefits to re-appraise negative stereotypes which appear in the media, about being 'a scrounger' before these become internalised and unquestioned, potentially leading to a compounding of stress through feeling 'to blame' for one's situation.

Marmot[81] has highlighted how whole population interventions can and do make effective differences to health and life expectancy. He says, 'Individual level determinants may need counselling and treatment. Workplace stressors and population determinants require social action.' (p.69).

Overwhelming stress can also clearly impact on safeguarding. Munro[30] argues that there is an interaction between internal mechanisms of decision-making and external demands. People take mental shortcuts partly because of the constraints of memory and attention when faced with a high volume of information. She comments that *'professionals with heavy caseloads and limited time can easily feel overwhelmed by the range of potentially important details to consider when assessing a family.'* (p.754)

Such pressures can lead to overload, or 'risk saturation', and mean that people make poorer decisions. Potentially, this can lead to situations where decisions are either directly or indirectly harmful to children.

The impacts of stress for service users

There is a marked social gradient in health, with those living in poverty having shorter life expectancies and living in ill health for a longer time before they die. Poor social conditions can impact on physical and emotional wellbeing. The experience of people living in relative poverty can, at worst, be characterised by feeling powerless, excluded and struggling every day to meet even basic needs. This can impact on mental and physical wellbeing. Marmot[81] highlights that people with poor mental health have life expectancy of between 10 and 20 years shorter than people who are not diagnosed with mental illness

Recommendations for best practice

Psychologists are well trained in the identification of stress and intervention at both individual and group levels. It is suggested that occupational psychologists have much to offer and can help to identify systemic and individual interventions which can improve work related stress.

Practitioners should be aware of documents such as the Health and Safety Executive's *The Nature, Causes and Consequences of Harm in Emotionally Demanding Occupations*,[82] and should follow the recommendations laid out within them.

Systems which are based on equality and a human rights approach are likely to be healthier. Practitioners should work with stakeholders who are trying to achieve such a cultural milieu

Psychologists should consider

- Whether there are any pressures in the workplace/stress that is making it hard for them to think.
- Their own wellbeing.
- Whether there are any factors that are impacting on the emotional or cognitive load they are carrying.
- Whether there is an 'empathy gap' meaning that it is hard to retain a service user centred perspective.
- Whether they have had enough time to think about their formulation.
- How stress may be impacting on the lives of children and their families.

2.3 A worked example

Maria has gone to see her GP. She is suffering with anxiety and emerging symptoms of depression, with fleeting suicidal thoughts. The GP has agreed to refer her to the local mental health service.

The referral from the GP explains that Maria is a 34-year-old lone parent of a 12-year-old daughter, Ella, and a 10-year-old son, Joe. Her ex-partner does not have contact with her or her children, as he was violent and abusive. She was able to leave that relationship eight years ago, and has had previous help from social services and mental health services, to help her in the aftermath of that abusive relationship. The GP says that Maria has recently lost her job.

Anita, a psychologist from the mental health team meets Maria for assessment. She misses her first appointment as she has become anxious about opening 'official looking' letters, and so missed the appointment date.

At the rescheduled appointment it becomes apparent that she is very worried about her living situation. She lives in a privately rented three-bedroom flat in Hackney, East London, with rent set at the 'local housing allowance' rate. It is an area of social deprivation.

Maria recently lost her job as a receptionist in a solicitor's firm. She tells you that her weekly benefit entitlement is calculated from:

- Allowances for living costs (Jobseekers allowance; Child tax credits; Child benefit)
- Local housing allowance for rent.

Maria says that the benefit cap has reduced her housing allowance by £137 per week. She is trying to make this up from her from her other benefits, which leaves her just over £87 per week to pay all her bills, food, clothing, transport and other living costs for herself and her two children.

There are few three-bedroom flats available in Hackney for less than £400 per week, so Maria is struggling. She says that if she is unable to find work quickly, she is terrified that she won't manage financially. She now lives near her parents and several siblings, who are supportive to her and her children, but she is worried that she may be forced to move out of the area.

The psychologist assesses how things are for Maria, and then goes back to talk to mental health team.

The local mental health team is well-established, has a stable staff group and has a good skills mix. However, the team is also going through a current restructure, and has to make savings of four per cent across the service. Staff are concerned about this, particularly as the referrals to the team have increased significantly in the last six months. There is also a new IT system being introduced into the service, which is making it hard to access old notes.

How can the model help us think about Maria's situation?

A psychologist may consider different factors

When psychologists are asked to do a piece of work, they are usually given a specific issue or 'problem'. Here, the agencies who are seeing Maria are the Department of Work and Pensions (via the Job Centre), the GP and the mental health team. The psychologist in the mental health team may be 'presented' with a 'depressed and anxious woman'. This immediately frames the problem as helping Maria as an individual, and does not see her as part of a wider system. With this in mind, the example will deliberately start with the wider system, and then work through the layers to the heart of safeguarding children. A psychologist could map who important people are outside the family network, to get an idea of social and community support.

At **governmental/societal level,** policies have been introduced that impose risks for children and families on a low income. This places risks around the rights of the child. There may also be risks around the culture within which these policies are formed, as various reports highlight that politics does not reflect the diversity that exists within the population. The government policies impact at organisational level, reflected in the push to make cost savings which lead to risks regarding finances and resources, and also the potential loss of good will of staff as the service reorganises and shrinks. The introduction of new technology has a two-fold effect of intended efficiency, but in reality creates additional stress for the staff as they try to embed this new system into their practice. The strengths of the organisation are in the workforce, who are skilled and experienced in helping people with mental health problems (knowledge and learning).

At a **professional** level, there are strengths within staff, whose values and ethics are regulated by professional bodies. There is also a culture of knowledge and learning, with a good skills mix between newly qualified staff and more experienced staff. There is a culture of reflective practice and supervision which facilitates supported challenge of professional decisions, thus reducing the risk of thinking biases. There is an emphasis on working collaboratively with service users, seeking their feedback and involving them in service changes, which creates a healthier distribution of power between professionals and the public who use the service. There are good team relationships, but there is a risk of unhealthy group dynamics emerging, as the entire system is under stress due to cuts to budgets. Within this milieu, Anita has been allocated Maria's case for assessment and has made an initial home visit.

At the level of **community and social factors,** the local area is deprived but it is bustling, with a local community centre that is well used, though run down. There are several local faith groups in the community, and a small group of youth workers attached to the local church. There is an early intervention hub locally, which is well used. There are local shops and most people walk there, increasing the chances for social contact. Philip, a shopkeeper at the newsagents, knows many of his customers by name. Many neighbours know each other. The local primary and secondary schools have been working with the local sports centre to get more team sports happening, and there are now local football teams, for both girls and boys.

At the level of **peers,** there are some pressures for young people to form into groups. Ella has strong friendships with a group of girls in her year, and they are in the local girls' football team. Joe is very shy and does not link well with his peer group, and has seemed very isolated from other boys. There have been a couple of incidents when he has been teased by other children for being 'slow' and because he is not good at sport.

At **school's level,** Ms Pryce is the Head at the local secondary school. The school has a strong anti-bullying ethos, and there are posters displayed to highlight equality issues, such as anti-racism posters, anti-homophobia and everyday sexism. There are school counsellors on site. The school is working with a local leisure centre to increase team sport activity. The school has a strong learning and respect ethos. Ella is doing well at school, and Ms Pryce is aware of her earlier history.

Mr Thompson is the Head at Joe's primary school. He too is aware of Joe's history as his Mum has linked with the school on several occasions, when she has been worried about her son. Joe has some difficulties concentrating and learning, especially with male teachers. He has some classroom assistance with reading. Mr Thompson has asked Joe's class teacher to encourage him to get involved with more after-school clubs, especially drama. There is a committed teaching team at the school, but there is little awareness of parental mental health issues, and so the Head is unsure of how best to be supportive to Joe around his Mum's current difficulties.

At the **parent/family level,** Maria is struggling with low mood and anxiety. She has been having fleeting suicidal ideas as she is so worried about how she will manage financially. She is finding it hard to get out of bed, and to keep her usual routines going. She is not eating well. She is under considerable stress, but she does have good family support. Her siblings are helping with childcare, offering what they can in terms of financial support and are inviting the family to eat with them regularly. Maria is also a member of a local faith group, and is getting emotional support from other members of that group.

Maria worries about Joe in particular, and feels guilty about the impact of her previous relationship on Joe's behaviour. She no longer sees Joe's Dad and feels that he misses a male influence. She finds it difficult to be firm about boundaries with him, concerning bed time and screen-time.

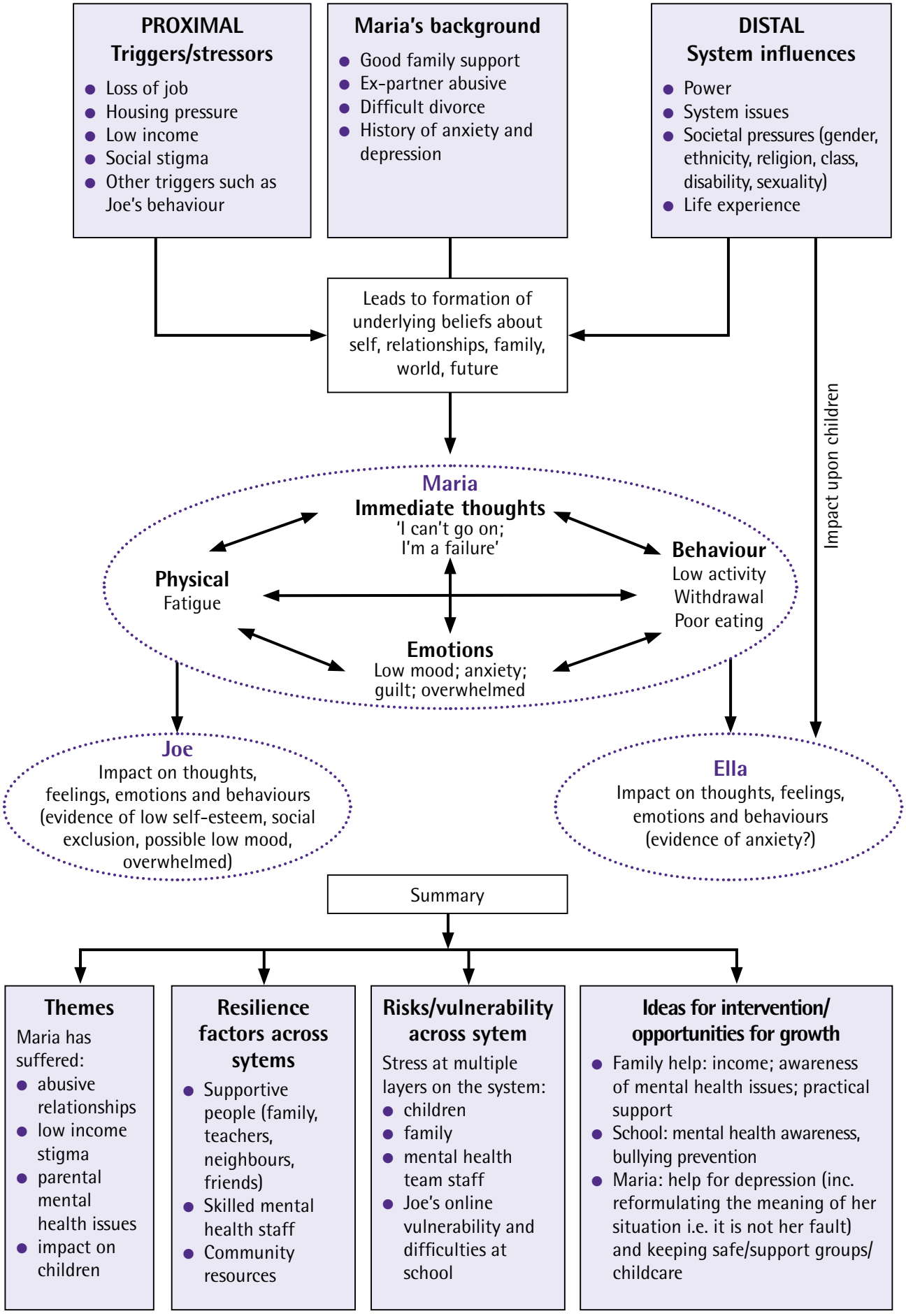
The child should be at the core of thinking. As the layers are worked through towards the core, it can be seen how many influences there are upon Ella and Joe's lives. Ella is bright and doing well at school. She has a strong peer group and at least one teacher who is aware of her history. Ella is very worried about her Mum and just wants things to 'get back to normal'. She knows that her Mum is seeing the doctor but she is confused about why her Mum is not getting up in the morning. She saw Anita arrive to speak to her Mum, but does not understand who she is and why she is there.

Joe is having some difficulties socially, emotionally and with learning at school. He is also worried about his Mum, and tends to want to stay up and spend time with her. When he is stressed, he tends to escape into online video games, and online chat. He feels tired in the mornings and struggles to get up.

Psychologists can consider

- Where are the identified risks and safeguarding issues in this case?
- What are the strengths in the system, and where are they located?
- Where are the areas for potential growth?
- What would an overview of all these factors suggest about where, how and who psychologists could involve in intervention?

Figure 2: Formulation of dynamic relationships between factors in Maria's case, using adapted CBT model



3. Decision-making: Broadening perspectives on risk

This section examines decision-making in its own right and examines how judgements, formulations and decisions develop. This chapter aims to help psychologist reflect on how judgments and decisions are made and:

- to watch for potential thinking traps
- consider strategies to promote clear thinking
- consider the particular pressures and stresses which can emerge in decisions around child protection
- offer some good practice points.

Judgement has been defined as the ability to make considered decisions or come to sensible conclusions.[83] It often encompasses the formation of opinions about a situation, and these opinions become the assumptions which decisions and actions are based upon.

Decision-making has been defined as *'the act or process of choosing a preferred option or course of action from a set of alternatives. It precedes and underpins almost all deliberate or voluntary behaviour.'*[84] (p.192).

3.1 Thinking traps – heuristics can influence decisions

Reliance on heuristics or mental shortcuts is typical of everyday decision-making. During periods of stress or high emotion, people may be more likely to rely on stereotypes or heuristics.[85] However, it can have serious implications.[86]

Although professional training encourages a more rational and analytical decision-making (based around comprehensive assessment), evidence based practice, reflectivity and problem solving approaches, are not always utilised.[87]

Over 150 thinking biases have been described, some in particular are found to recur in safeguarding and child protection reviews.

- **Availability** – when probability is overestimated because something happens frequently or has happened recently.
- **Anchoring and adjustment** – when an initial guess at a decision is taken as an anchor, and then readjust are made around that initial guess, even though it may be more sensible to reject that idea and start anew. Munro[88] has identified how clinicians can often not want to let go of their initial judgements about a case, even in light of contradictory evidence.
- **Framing** – the description, labelling or presentation of a problem can have a big impact on how people respond. For example, Dingwall et al.[56] identified 'natural love' as a potential bias in how child protection cases were framed; this occurred when workers thought that parents must naturally love their children and viewed their interventions through this lens.
- **Over-confidence/optimism bias** – occurs when it is thought that a negative outcome is less likely to happen. Dingwall et al.[56] noted that this was a common bias in child protection work and could lead to serious errors of judgement.
- **Satisficing** – designed to reduce the information processing load. People may not be working towards finding the best outcome, rather the one that is achievable and reasonable within constraints of time and information.

- **Hindsight bias –** this is commonly associated with regret or blame. People look back at an event, usually a difficult or traumatic event and assume that they or others should have known what was going to happen, as though the outcome was obvious.
- **Minimising and magnifying –** thinking traps can lead to the overplaying or downplaying of certain pieces of information.
- **Ignoring contradictory information –** a recurring theme in Serious Case Reviews is when clinicians have not taken on board information which does not fit with their case formulation, and could potentially change interventions if it were integrated into the understanding of the situation.
- **'Gut feelings' –** people may rely on inductive processes (previous experience, intuition) when making decisions. However, intuition should not be written off as inherently flawed. There are predictable errors in human reasoning, which in the context of child protection can lead to serious consequences. It is perhaps unhelpful to look at inductive and deductive reasoning processes as dichotomous. Rather, intuition and analytical reasoning should be viewed as points on a continuum.[89] Munro[30] argues that, *'These products of intuition, however, then need to be corroborated by using deductive logic to derive predictions whose truth or falsity can be ascertained by experts'* (p.747).

Group decision-making

Groups tend to focus on what is known by everyone and relevant information possessed by individuals is either unmentioned or unnoticed.[90] Individuals and groups can make decisions quite differently; for example, people will act in a group in ways that they would not do alone. They may be more willing to take risks in a group rather than individually, a phenomenon called risky shift or group polarisation.[91,92]

There is also evidence that people acting in groups may not consider alternative viewpoints, particularly if they are not part of the organisational psyche. Janis[93] refers to this as 'groupthink'. Kelly and Milner[94] reported evidence of 'groupthink' processes in their review of child abuse inquiries. They report that case conferences showed evidence of *'shared rationalisations to support the first adequate alternative suggested by an influential group member; a lack of disagreement; a belief in unanimity and cohesiveness; direct pressure on dissenters and a high level of confidence in the group's decision.'* (p.93). For example, case conference participants are typically accorded differential status, yet it is often a low status attendee, for example, family support worker, nursery key worker, learning support assistant who knows the child best (and often the family). However, unless the conference is well chaired, their voice/opinion is often not heard or accorded sufficient weight. The worker will often lack the confidence to challenge a discrepant view. Good practice would seek to support the family support worker, nursery key worker, learning support worker to attend the case conference supported by safeguarding staff member from their organisation (e.g. nursery/school). A headteacher/designated safeguarding teacher will often lack the specific knowledge of the child to make the links, provide the missing piece of the jigsaw that the adult working directly with the child/family will often be able to provide arising from information sharing at the conference.

It is really important that psychologists are aware of thinking biases/heuristics, and that they may lead to errors of judgment. If they are recognised in others or personally, then opinions (or formulation) of a case may need to be rethought.

3.2 Strategies to promote clear thinking

Sutherland's[69] work suggests that there are key considerations that which need to be introduced into judgement and decision-making processes. Broadly, psychologists need to be actively and openly testing their ideas about a case. If contradictory evidence is found it must be incorporated into the understanding of a case. Psychologists must test their own beliefs or thinking traps and must do this over time. This section considers some ways of reducing bias, both in individual thinking, but also at a group and systems level.

There are individual psychological factors associated with riskier and healthier thinking styles. Psychologists can develop resilience against unhealthy thinking through considering the following.

- **Being clear about values and ethics**
  In relation to safeguarding, it is crucial that the child is held in mind, despite the likelihood that workers need to hold multiple perspectives and agendas in their work.
- **Building knowledge and skills**
  This can help psychologists to know the risk signs of potential abuse; practice problem-solving abilities; develop skills in formulation/sense-making; and check what thinking biases might be operating in decisions. It's important to have a skills mix so that there is access to more experienced colleagues, who are able to advise on safeguarding.

  Regularly test thinking with colleagues and ensure there is access to quality case supervision, so that thinking can be stretched and judgements and decisions can be stressed tested.

  It is easy to slip into patterns of thinking which are habit based or automatic, and when this happens, important information can be missed. A learning culture is key to a safe culture.[35]
- **Being aware of thinking traps and biases**
  It is crucial that psychologists are aware of thinking biases, including those listed above. It is important to frame these thinking traps as natural human processes, not as failings and it is important to stress test thinking in order to ensure judgements and decisions are robust. Developing an ability to pick up on discrepancies, listen to intuition or 'gut feelings' is also an important skill if thinking can then be tested out. Skills in emotional intelligence are an important part of a psychologist's repertoire.

  It can also be useful to have a 'cultural review' of cases in order to identify any unhelpful assumptions, prejudices or lack of knowledge in working with people who may be culturally different.[95]
- **Promoting wellbeing**
  Looking after health is incredibly important, and psychologists may talk to service users about this often. It is important that psychologists also observe the advice they give to others. Psychologists should ensure they are taking steps to protect their own psychological health and wellbeing.

  Psychologists should cultivate a questioning stance to unhelpful thoughts; engage in activities within and outside work that encourage the development of a strong locus of

control/sense of personal competence. Trying new experiences can often help people to think in new ways. Ensuring a healthy balance between work and personal life, and observing good self-care practices, such as eating well, good sleep and nurturing social relationships. These strategies can help guard against stress and think more clearly.

- **Building good relationships at work**
  To reiterate, Reason[35] comments that in building safety culture, 'the single most important factor is trust' (p.302). The relationships that can be built through team cohesion and collaboration can lead to better care. A clinician's ability to communicate effectively, be trustworthy, compassionate and build proportionate trust are key.
- **Noticing and reporting**
  It is important that all psychologists are active agents in noticing and reporting issues of concern. Psychologists are trained to observe behaviour and think about its function, meaning and the consequences. Anyone seeing something that could have negative impacts should be active in raising this. Psychologists may become attuned to situations with experience and so may be able to develop 'discrepancy detectors', which can alert them to 'something feeling wrong'. Psychologists need to be able to trust this intuition, but also test 'gut feelings' or intuition.

Reducing group bias in judgements and decision-making: Systems versus individuals

An important cultural shift is the development of an organisational atmosphere where errors are reported and reflected upon. Reason[35] writes about achieving safe cultures and comments that 'the single most important factor is trust' (p.302).

Reason recognises that individuals may be responsible for accidents or errors. If a person has **intended** to cause an accident; has used or been under the influence of **alcohol or drugs**; has been deliberately **reckless or careless**; and/or has been involved in a pattern of **repeated errors** which they have not changed.

However, if these conditions have **not** been met, and any reasonable person may have taken the same action, then it may be necessary to examine the distal and situational (proximal) factors, which led to the error. Reason argues that major accidents can occur because of a series of smaller failures in the checks within a system, leading to catastrophic consequences.

Reason suggests that organisations where there is top-down control, low levels of autonomy and where people are encouraged to be over-confident in their decisions, are more prone to harmful errors. Organisations can become safer by adopting a learning culture (as opposed to one which punishes individual unintentional errors).

In order to develop resilience to groupthink in an organisation and promote a safety culture, some key questions can be asked:

- What is the current culture of the organisation?
- Does the organisation have a sense of cultural continuity or an 'organisational memory'?
- Is it non-blaming, transparent, safe, honest, safe to speak out?

- How is the organisation framing work priorities?
- Does it feel safe to approach colleagues who are peers, juniors, seniors?

Once again, there are some strategies for preventing groupthink.

- Allow a colleague to take the nominated role of devil's advocate active helping and take the opposite opinion in order to test the team's thinking. This role should regularly rotate between staff.
- Allow someone to take the role of critical friend or questioner.
- Facilitate discussion of group processes (this may need an external assistant) to guard against processes such as deindividuation.
- Prevent bullying/scapegoating by having clear ground rules and policies about this.
- Have a culture where people are trained to be active (rather than passive) bystanders.
- Encourage a reporting culture where it is safe to raise concerns without negative consequences (as opposed to a culture where staff are afraid to speak up, which can result in silence and secrecy). Be responsive to concerns being raised.
- Train staff how to be active bystanders who intervene when they see poor practices.
- Encourage colleagues to be active participants within the organisation, and encourage people to raise ideas.
- Regularly ask 'what if'/cultivate the ability to think the unthinkable.
- Ensure that workload/stressors/demands are manageable.

The importance of supervision

The Society expects that supervision be an integral part of professional psychological practice. The objectives of supervision are:

- to provide practitioners with consultation on their work
- to enhance the quality and competence of practice
- to offer psychologists intellectual challenge enabling reflection, transformational learning and psychological support to maximise their responsibility for appropriate self-care
- to contribute to the CPD of both psychologist and supervisor by developing competence in the use and practise of supervision.

In making decisions and reflecting on practice with regard to safeguarding children and young people, good supervision has an essential role.

Supervisors should also facilitate culturally competent practice, by enabling supervisees to consider the impact of diversity in all its forms (e.g. gender, ethnicity, age, sexuality, disability, etc.) on the vulnerability of the child, as well as on their own perspectives and decision making, keeping the needs of the child central. Good decision making about safeguarding in supervision will involve supervisors and supervisees having knowledge of relevant local and national policies, and using these to guide their decisions. Supervisors can provide structure and facilitate clarity about the issues discussed, and decision making and agreed outcomes should be documented carefully, with appropriate review and follow-up of any further actions needed. Additionally, supervision can be a space in which the lessons learnt from practice can be reflected upon, and used to guide future decision making.

The importance of reflective practice

One of the key processes that should be encouraged for psychologists is having a complex understanding of self in the context of others. Psychologists may make decisions about service users which may have a profound impact on their lives. As mentioned above, decision making is often subject to various competing biases. Psychologists should be aware of the possibility that they may be influenced by considerations which are not driven by professional knowledge, skills or experience.

A reflective style can ensure that psychologists adapt to feedback. It also ensures that whilst experience is respected, so are novices or less experienced staff, who may have 'fresh eyes' and bring insights or questions which widen the perspectives of more experienced staff. It is recommended that psychologists engage in self-reflection including how the following might that affect their decision-making:

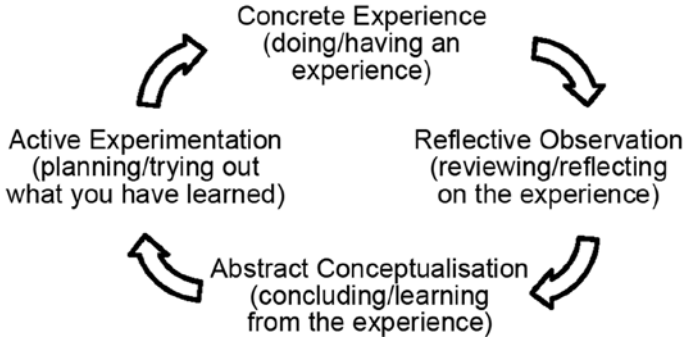
- what kind of learner they are
- what their strengths and weaknesses are
- how they react to feedback
- how they react to being wrong
- how they deal with conflict
- how they react under pressure.

Individual workers need to work reflective practice into their routine work, but organisations also need to do the same. Many psychologists can cite anecdotal examples of changes which are implemented within organisations which are not properly evaluated or reflected upon. Psychologists are an asset to organisational thinking, and can help services improve over time, by bringing psychologically informed thinking and evaluation into their workplaces.

Reflection is important in reviewing the judgements and decisions which psychologists make, and should occur during the ongoing process of formulation (and re-formulation) of cases. It is helpful to consider a framework on which to base such thinking. Kolb's Experiential Learning Cycle[43] provides a helpful overall learning cycle for psychologists, which shows how reflection should be embedded into learning in order to improve performance at any task.

Kolb's Learning Cycle

A reflective cycle can help to refine practice and improve safeguarding outcomes. Individual workers need to work reflective practice into their routine work, but organisations also need to do the same. Many psychologists can cite anecdotal examples of changes which are implemented within organisations which are not properly evaluated or



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Reflective cycles are important in reviewing the judgements and decisions which we make, and should occur during the ongoing process of formulation (and re-formulation) of cases.

The importance of formulation

Formulation is the summation and integration of the knowledge that is acquired by the assessment process. This will draw on psychological theory and research to provide a framework for describing a service user's needs. Because of their particular training in the relationship of theory to practice, psychologists will be able to draw on a number of models to meet needs or support decision-making.

This process provides the foundation from which actions derive. What makes this activity unique to psychologists is the knowledge base, experience and information on which they draw. The ability to access, review, critically evaluate, analyse and synthesise data and knowledge from a psychological perspective is one that is distinct to psychologists, both academic and applied.

Good quality assessments and formulations inform our interventions, and thus ultimately how psychologists try to help children and families. Formulation is dependent on the questions psychologists ask themselves.

Formulations typically incorporate an understanding of history; current triggers to problems; how these are maintained and formulation should suggest points of intervention. Trauma informed formulations which take a perspective on power should also be meaningfully considered and should consider the impact of intersectionality.[96].

The potential benefits of formulation are:[97,98]

- developing a shared understanding of difficulties
- collating and making use of different perspectives
- developing empathy and collaboration
- looking at beliefs and assumptions
- reflecting on the meanings of behaviours
- thinking about thinking
- generating new ideas
- looking at areas of change, hope and resilience
- improving risk management
- generating ideas for intervention, both short and long term.

3.3 Issues particular to safeguarding where there may be child abuse concerns

Decision-making around risk

One of the key differences in safeguarding judgements and decisions is that they involve risk assessment, and psychologists may encounter circumstances where they feel children are at risk of significant harm, may be suffering abuse or disclose actual abuse to us.

When thinking about safeguarding, making judgments about risk are often highly complex. Cooper[99] describes how trying to analyse risk relations suggested by the Assessment Framework can be 'fantastically complex' (p.116). He writes that trying to examine how many permutations are possible even in one case, with one child, within a time-limited period is potentially vast (he suggests there are at least 787,050 risk relations within a 35-day period).

Cooper suggests that essential features of risk assessment are:

- the co-operation and motivation of the service user
- the probability of harm
- the magnitude of harm
- the chances of successful intervention
- what outcomes are specified
- the timescale of intervention.

He also argues that this process should be underpinned by peer scrutiny and reflection, as well as a consideration of potential consequences of non-intervention.

After considering information, psychologists may have to think about whether children are in the groupings shown below.

- Children are safe – there is 'good enough' parenting/Risk sensible systems.
- Children are in Need/Vulnerable – there is need for supportive intervention in family or wider system.
- Child abuse – there is need for intervention in an unsafe system, either family or organisational.

Although these are listed as distinct groupings, in reality a child may not clearly fit into any of these categories and may sit in a 'grey area' of uncertainty.

Psychologists need to ensure that their understandings of how people behave in relation to safeguarding are psychologically informed. There is an emotional impact upon practitioners working in such circumstances. Safeguarding can be complex and uncertain. Practitioners can worry about decisions, and they may fear jumping to conclusions or missing information which places a child at significant risk.

The meanings of a child's behaviour may not be clear, and suspicions about an adult may be hard to clearly articulate. There can be great societal pressures to minimise, ignore or deny child abuse, and these attitudes may be encountered in others or personally. In order to ensure thinking is as clear, ethical and compassionate as possible, it is beholden upon practitioners to 'think about their thinking' and to carefully reflect on judgements and decisions which they make about the children, families and systems in which they work.

It is also important to pay attention to prevention, through reducing situational factors which can increase children's vulnerability to abuse.[100,101]

Dealing with suspicion and uncertainty

It is recognised that life rarely provides us with neatly packaged and complete bundles of information at one point in time. Different pieces of information emerge at different rates, and psychologists will be making the best judgments and decisions which they can at specific points in time. Formulations and assessments need updating and revising.

It is also recognised that psychologists may be making decisions under uncertain conditions. Potential risks may be unclear, and abusive situations are often hidden. The field of child protection recognises that 'gut feelings', 'bad feelings' and suspicion can be the professional's first alarm signal to something 'not being right' for a system, a family or a child. It is important to seek further clarity, to evidence and concretise these concerns.

It is vital that any psychologist understands the 'warning signs' that abuse may be occurring, whether these signs are being expressed by a child, showing in adults, or seem to be in evidence at an organisational level. Psychologists need to be vigilant to signs within systems, such as people running away from their homes or residential homes; or signs such as high turnover of staff or residents, which can make it easier for abuse to occur, as it is easier to be anonymous. Unsupervised and unmonitored spaces also create opportunities for abuse to occur (though abuse can also occur in busy and supervised areas too).

If a psychologist feels suspicious that there may be potential abuse or safeguarding issues, then it is vital that they discusses this with their supervisor, manager, local safeguarding named professional or local Multi Agency Safeguarding Hub. Additionally, there may be other people who should be informed and psychologists should familiarise themselves with local policy and procedure. It may be that issues have already been flagged by other individuals or other agencies regarding a particular child or concerns raised about an adult or both. If these are held in isolated fragments, then important information is lost. Collated information, even information which seen alone may be considered unimportant or insignificant, when considered together will mean a situation can be better understood and appropriate action can be taken.

Denial and child abuse

There are few harder truths than the reality of child abuse and neglect. Denial in child abuse remains a global problem. It is estimated that in the UK for every abused child known to children's services, another eight children have suffered abuse but remain unknown to the authorities.[102] Denial has been defined as the maintenance of a social world in which an undesirable situation is unrecognised, ignored or normalised.[103] Cohen[103] proposed that there are three states of denial: literal, interpretive and implicatory.

- Literal denial refers to the inability or unwillingness to accept or face the evidence or facts in front of us. An example of literal denial in the context of child abuse would be to refuse to accept that the abuse is happening.
- Interpretive denial is to accept the evidence or facts, but attribute them to another cause in order to justify not taking the appropriate action, for example, attributing external evidence of abuse such as cuts and bruising to the child's clumsiness.

- Implicatory denial involves the downplaying of the seriousness of the situation, for example believing that the abuse was a one-off incident and so not worth reporting.

Cohen[103] also emphasises that denial operates at different levels:

- at a personal, individual level
- at the official level
- at a cultural level.

and that the normalisation of abusive behaviours enables suffering to become invisible. In order to effectively address child abuse, it must be acknowledged; and in order for it to have the recognition it deserves, other people's behaviour must be challenged around children at an individual, official and cultural level.

NICE Guidelines updated in 2014[104] document the warning signs of child physical, emotional and sexual abuse and neglect, as well as fabricated and induced illness, with recommendations about when to 'consider' maltreatment, and when to 'suspect' it. To 'consider' maltreatment means that it is one of a number of hypotheses for the observed behaviours, whilst to 'suspect' it means that there is severe concern about the possibility that maltreatment has occurred.

Factors which affect children and young people disclosing abuse

An overview of the literature on the delay between an abusive event and a child's disclosure indicates that there are a number of variables which influence the victim being able to tell about what has happened.

Goodman et al.[105] posited five variables that influenced the delay:

- the child's age
- gender
- type of abuse experienced (intrafamilial or extrafamilial)
- perceived responsibility for the abuse
- fear of negative consequences.

All these factors were found likely to contribute to predicting delay of disclosure. They also found that children who were older and had suffered incest, felt greater responsibility for the abuse and so feared negative consequences of telling and took longer to disclose.

In one qualitative study, children reported finding it difficult to disclose as they could not find situations containing enough privacy and prompts to facilitate them sharing their experiences. They were also sensitive to other's reactions and whether their disclosures would be misinterpreted. The children found disclosure less difficult if they perceived that there was an opportunity to talk, and a purpose for speaking, and a connection had been established to what they were talking about.[106]

The literature is clear that disclosure tends to stop if the information is not believed or not handled sensitively or the child fears threats and punishment. Disclosures are made by children when they have developed trust in non-abusive adults, whether foster carers, the police, staff in schools and nurseries or psychologists. This development of trust can only begin when the child feels that they would not be abused by these adults, and that

they would not be rejected if they disclosed. New carers and other professionals must prove to the child that they are trustworthy and can engage in frank, non-judgemental counselling and provide a safe environment. Delays in responding to a first disclosure may be particularly detrimental, especially if made to agencies that then need to try to engage and provide support for the young person. Further information is available in the Society document: *Guidance on the Management of Disclosures of Non-Recent (Historic) Child Sexual Abuse.*

3.4 Practice points

Psychologists should endeavour to keep a reflective, open and learning stance to their practice. All formulation should consider and include the layers within the context of the wedges:

Values and ethics

- Keep the child at the heart of thinking.
- Be accountable for their practice.
- Be mindful of equality, diversity and inclusion.

Knowledge and learning

- Reflect on how decisions are made and ensure that thinking is clear.
- Be aware that reflection and supervision is essential.
- Revise formulations and decisions over time or in light of new information.
- Be aware that there are multiple influences on decisions about safeguarding.
- Be aware that safeguarding formulations can be complex and may be associated with uncertainty.
- Stay up-to-date with training.

Power

- Include service users in decision making processes and be mindful of importance between therapist and service user.
- Ensure that practice is under-pinned by equality and inclusivity.
- Able to use best practice around Trauma Informed approaches.

Culture

- Be able to reflect on issues of culture.
- Build services in partnership with local communities and third sector organisations to ensure that services are culturally informed.
- Have a professional and organisational commitment to equality, diversity and inclusion and work to reduce health inequalities.
- Ensure the use of interpreters as appropriate.[107]

Resources and finances

- Have knowledge of the impact of inequalities on wellbeing and access to services.
- Take an active professional role in addressing these at an individual level.
- Take an active professional role in addressing these at a population based level.

Attitudes and heuristics

- Have awareness of their own beliefs and attitudes affecting decisions.
- Actively seek to reduce the impact of heuristics through reflective practice, considering alternative perspectives and testing hypotheses built through formulation.

Relationships and Trust

- Regular team meetings for shared learning.
- Reflective practice based team meetings.
- Good communication within and across systems.

Group

- Be able to challenge thinking and practice at an organisational level.
- Work with the organisation to build a healthy culture in line with Reason's[36] principles for safe systems.
- Ensure that there is meaningful organisation commitment to equality, diversity and inclusion.

4. Risk, resilience and growth

Psychologists believe in resilience and growth. Facilitation of which involves a working appreciation of vulnerability and risk. This section considers Risk, resilience and growth.

Risk of a certain outcome refers to the probability of the event occurring (positive or negative) but has increasingly been used only in a negative context (unwanted outcome).

Within safeguarding, there is a danger that a focus on risk assessment and risk management can lead to a distortion of the child protection system and detract from a focus on interventions to help maximise a child's welfare and potential.

Conversely, the promotion of a more needs-led assessment approach with a focus on strengths not balanced by an assessment of risks does not allow for a risk-balancing exercise (strengths and concerns/weakness framework).

Resilience is about doing well in the face of adversity; to do better than might be reasonably be expected. Fraser[108] outlines three dimensions of resilience as: overcoming the odds, being successful despite exposure to high risk, sustaining competence under pressure – adapting to high risk; recovering from trauma – adjusting successfully to negative life events.

Resilience reflects the complex interaction between: the nature of the risk and adversity involved; the qualities and experiences of the young person/individual involved; and the qualities of the relationships and environment in which the young person has/is growing up in.

An individual is only as resilient as their environment allows, and it is vital to consider the impact of systems and context when exploring resilience.[109]

Growth refers to personal growth to help children and young people form more secure attachments; work towards achieving their potential, intellectual, social, emotional and behavioural; to be supported in working towards achieving the aspirational outcomes of being healthy, staying safe, enjoying and achieving, making a positive contribution and economic wellbeing.

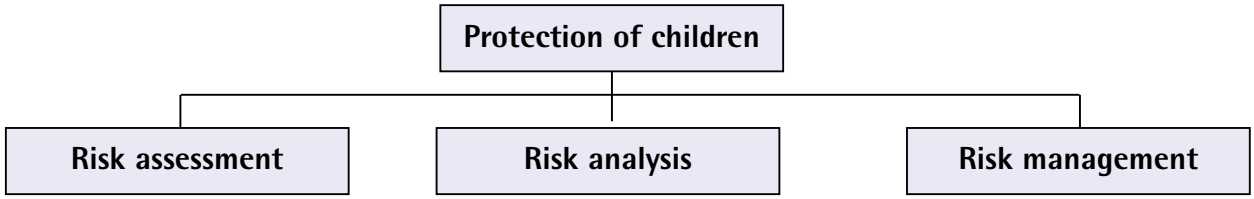
Recent trends in health and social care have tended to emphasise risks for children rather than opportunities for growth and adaptation.[110] It has been argued compared to earlier generations, children nowadays are less able to cope with stresses and obstacles, partly because they are more sheltered from challenging opportunities, with an acknowledged increase in referrals related to child and adolescent mental health problems.

Recommendations of the inquiry into the death of Victoria Climbié focussed on finding better ways of organising the processes in place to identify and manage the risk of harm to children. The inquiry report helped to broaden thinking in relation to the identification of and pre-emption of risks faced by all children (and childhood itself).

Every Child Matters placed the protection of children at risk within the framework of effective universal services and early intervention. The Children Act 1989 introduced the concept of 'Significant Harm' which has a predictive, anticipatory element 'to identify children at risk of harm'.

4.1 Risk assessment

Calder[111] presents the following model of a risk assessment process:



A model of risk assessment can be presented in the following terms of risk factors.

- **Static –** risk and protective factors which are historical and therefore unchangeable.
- **Stable –** constant across the lifespan, may be open to moderation but are relatively resistant to change.
- **Dynamic –** those that are constantly changing either purposefully or by chance; clearly changeable.

4.2 Resilience and growth

Resilience refers to positive adaptation and development in the context of significant adversity.

It is now accepted that resilience arises from multiple interactions and influences in an individual's life. The quality of individual adaptation results from interactive processes operating at the levels of individuals, families and communities as well as broader physical and social environments.

Factors promoting resilience in all phases of the lifecycle have been identified as:

- the ability to retain or engender hope
- strong social support networks
- the presence of at least one unconditionally supportive parent or parent substitute
- a committed mentor or other person from outside the family
- positive school/educational experiences
- a sense of autonomy and a belief that one's own efforts can make a difference
- participation in a range of extra-curricular activities/outside interests
- the capacity to reframe adversity over time so that the beneficial as well as the damaging effects are recognised
- the ability and opportunity to have meaning and purpose by helping others and/or through part-time work
- not to be excessively sheltered from challenging situations that can provide opportunities to develop coping skills.

Personal functioning – recovery in adulthood/rebuilding of resilience

Whilst it is widely acknowledged that a parent's own childhood history of being parented will have laid crucial foundations in terms of capacity to be a parent and nature of relationships with others, exposure to adverse experiences as a child may not necessarily result in problematic parenting and/or problematic parental partnerships.

Resilience factors have been identified[112,113,114] which can help to compensate for/reduce the impact issues of Adverse Childhood Experiences. The key factors are as follows:

a. History of support from a significant adult.
b. Areas of success in individual functioning (school, work, sport).
c. Readiness to recall Adverse Childhood Experiences.
d. Recognition of the link between the way they were parented and how they in turn function as a parent.

In addition, considering wider systems, Reason[35] has written about the five features of healthy systems and it is worth having these in mind when thinking about any system.

- **Informed**
  - evidence-based (vs. not up to date with research)
  - ability to map unintended consequences (vs non-reflective)
  - clear record-keeping and accountability (vs lack of accountability)
  - safer recruitment (vs. poor recruitment practice, like not checking references).

- **Reporting**
  - open culture (vs. closed)
  - ways for the least powerful in the structure to speak out
  - a culture of noticing (rather than habituation or ways to prevent habituation)
  - ability to think the unthinkable/worst case scenario/stress test).

- **Just**
  - healthy use of power
  - founding principles are based on human rights, equality, fairness, recognise problems and mistakes can happen
  - mechanisms at every level of the structure to 'hear' (vs. command and control)
  - independent complaints routines
  - valuing of individual staff so that they are fully invested in the work that they do (and hence have lower staff turnover, low staff sickness and burn out. If this is a society, perhaps it is reflected in lower migration rates out of areas or even countries)
  - collaborative (vs. didactic)
  - supportive (vs. bullying or punitive)
  - non-stigmatising (vs. shaming)
  - being given meaningful choices
  - commitment to helping the marginalised/least powerful/most vulnerable members of the group and shaping environment to enable them
  - well-resourced
  - informed versus uninformed/disinformation/opacity/secretive

- honest
- more equal societies better outcomes; unequal societies have worse outcomes
- values/attitudes.

- **Flexible**
  - active organisation (vs. reactive)
  - good communication between systems (e.g. family and school; school and health services; social services and the Police) which is collaborative rather than competitive
  - inclusive and universal (rather than exclusive, and containing high thresholds for access to services)
  - stable staff group (vs. high turnover)
  - time (dynamic and changing rather than static).

- **Learning**
  - reflective practice vs. unthinking /curious and questioning (vs. defensive and didactic)
  - good organisational memory (vs. organisational 'amnesia')
  - clear policies (vs. lack of policies, or imposed policies)
  - intuitive systems wrap around people (vs. bureaucratic and blocked)
  - predictable/well-regulated (vs. chaotic/distressing)
  - theory of mind – perspective taking (vs. rooted in one perspective).

Risk and protective factors

In planning prevention and intervention programmes, psychologists should consider the following issues.

- Evidence-based practice may be limited, and there is a need for practice based evidence and qualitative approaches which allow for an increased presence of children's voices in saying which interventions work for them.
- An understanding of the social determinants of health and the impact of poverty and low income on health (physical and psychological), which then requires psychologists to work psycho-socially, rather than only at the level of the individual, or only at the level of the family unit.
- A meaningful incorporation of cultural sensitivity into prevention and intervention, particularly adopting a position of *cultural humility* which fosters more meaningful collaboration and more innovative psychological practice.
- An understanding of how to create psychologically informed environments, and a milieu that promotes wellbeing.
- Systematic steps in the identification of risk, a clear formulation of which are the layers at which to intervene and a way of evaluating the impact of interventions.
- Being aware that any formulation of risk involves a cost benefit analyses – reducing one safety concern can create unintended consequences (e.g. reports of not letting

kids out due to fear of stranger abduction may be one factor in rising levels of obesity and health problems amongst young people). Checks and balances should be built in to interventions to recognise unintended consequences and take action if needed.
- An ongoing dialogue within the profession and outside it, to acknowledge and progress the evidence base around the complex decision-making that is needed around safeguarding, especially where there are suspicions or franks concerns that children are in need of protection. Whilst the universal approach towards safeguarding is imperative, the specialist skills needed to help vulnerable children should not be lost.

Child's developmental stage, circumstances, and events

Children are very dependent; physically, socially, emotionally and financially. Impacts depend on age and development – some examples following.

- **Unborn children –** may be at risk of foetal damage from alcohol/substance misuse; exposure to domestic violence.
- **Pre-school children –** may not have the language to explain what is happening; are at risk of accidents/physical danger; be neglected; not able to develop their own sense of identity or self-efficacy.
- **Middle childhood –** children may be at risk of poor self-esteem; social withdrawal; there may be gender differences in expression of distress.
- **Pre-teens and teens –** may be at risk of psychological problems; increased risk of bullying; vulnerable to exploitation; taking a caring role for the parent; risk of social exclusion; risky sexual relationships, STDs or unplanned pregnancy.
- **Disabled children –** professionals who work with disabled children tend to work with them for a long time in a supportive role. They also work in partnership with the parents and there is often empathy for the challenges the children can pose and the strain on the parents. Disabled children are at a higher risk of being abused: 3.8 times more likely to be neglected; 3.1 times more likely to be sexually abused; 3.8 times more likely to be physically abused; 3.9 times to be more likely to be emotionally abused. Profoundly disabled children are living longer, research suggests that the pressure of multiple disabilities appears to increase the risk of both abuse and neglect.
- **Young carers –** a young carer is a person under 18 years who provides or intends to provide care for another person. The concept of care includes practical or emotional support. Young carers can be very vulnerable but can also present as highly resilient and a false sense of maturity, such that their needs go undetected. Census statistics show young carers are 1.5 times more likely to be black and twice as likely to not have English as their first language; one in 20 misses school; they are more likely to have special educational needs; and are more likely to be not in education, employment or training between 16 to 19 years. *'Many young carers remain hidden from official sight for a host of reasons: including family loyalty, stigma, bullying, and not knowing where to go for support'*[10]

Impacts also depend on circumstances, which may affect barriers to recognition and disclosure – some examples following.

- **Social class –** there is evidence that social class does impact on child protection decision-making. The professional status, qualifications, affluence, and assertiveness, of some middle class families, can prevent professionals from recognising the severity of harm and neglect. The parents can be terrified of reputational damage if they are associated with social services, such that they are not receptive to interventions to safeguard their children. Relatively middle-class social workers can shrink from acting in ways they would act, if the family was working class.
- **Disguised compliance –** this involves parents giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns, and to delay or thwart professional intervention. Babies and very young children are at particular risk from a lack or delay in timely intervention due to disguised compliance. Serious case reviews have identified a number of ways in which this can lead to the deaths and serious injuries of children: physical abuse including head injuries and shaking; neglect including dehydration and malnutrition; co-sleeping with parents who have consumed alcohol and drugs; children who ingest drugs in the home. Parents use a variety of forms of disguised compliance: engaging well with one agency to deflect attention from their lack of engagement with another set of professionals; parents who criticise professionals to divert attention from their own short-comings; on pre-arranged visits the house is clean and tidy with no evidence of other adults who may live there or be visiting the house; promising to take up services and then failing to attend; promises to change behaviours and then avoid monitoring visits/reviews. Disguised compliance can lead to a focus on adults rather than on achieving safer outcomes for children.
- **Child sexual exploitation –** this can be particularly hard for professionals to recognise and respond effectively. The victims are mainly girls; many are in local authority care, foster placements or residential care; many have experienced difficult early life experiences at home, including childhood physical or sexual abuse and domestic violence. They may have a poor self image, low self esteem, and a poor sense of their own identity. They may have misused drugs and alcohol, gone missing from home, have become disengaged from education and have sexual health concerns. They may also be difficult to engage and display challenging or offending behaviours. Young people are unlikely to disclose sexual exploitation due to: fear of perpetrators; loyalty to perpetrators; lack of knowledge or acceptance that they are being exploited; or a lack of trust or fear of authorities. Too often when they have disclosed abuse, no actions are taken by agencies against perpetrators or to support the young people, and the abuse continues.
- **Culture and faith –** Serious Case Reviews highlight the increase in risk where there are issues around culture, religion and faith, from: social and cultural isolation or fear of isolation; cultural and religious beliefs overriding self-interest; cultural conflict within families; religion and culture as a distraction from child protection issues; professional misconceptions, lack of confidence and lack of knowledge; self-identity; converting to a partner's religion; spirit possession; and the interplay between religion and mental health issues.

- **Particular groups that may face discrimination –** First generation migrants, asylum seekers and refugees – Serious Case Reviews point to a number of factors which can increase the risks to children when one or more family members have recently arrived in the UK. These include: social and cultural isolation; language barriers; lack of knowledge about entitlements and means of accessing support; being part of a transient population; uncertainty over right to remain; trafficking; family separation; exposure to violence and trauma; and gaps in knowledge of family history.
  Gypsy, Roma and Traveller families – For practitioners working with Gypsy, Roma and Traveller families, trust is not easily won. These communities have faced persecution for years. Many are constantly on the move, making it difficult to offer sustained support. These communities can bring challenges to any safeguarding concerns about children in their midst: some 80 per cent of adults are illiterate; the lifestyle of the families means frequent changes of schools which undermine their educational progress; less than four per cent of the children achieve a basic set of GCSEs; when the children do attend school they can be subject to abuse and bullying which leaves them socially isolated. These challenges leave children more at risk, if they are subject to harm, as they can fear speaking out and exposing their communities to shame.
- **Military families –** are part of a closed community. When issues arise such as domestic violence or divorce or abuse, the forces have parallel services for welfare support and enforcement. The consequences for children are affected as their families are dependent on the system, not only for employment but also for accommodation. Matters of rank can influence outcomes.
- **Children who are home educated –** home educating parents are not more likely to abuse or neglect their children, however, there is a risk that home educated children can become invisible to the authorities. Common threads from Serious Case Reviews with regard to elective home education are: the child's invisibility and isolation; dominant personalities of parents/carers; the understandings of professionals with respect to their roles and responsibilities with regard to safeguarding home educated children; the health care of the children; and the limitations of current legislation and guidance with regard to powers to monitor or inspect home education provision.
- **Missing children –** children and families who go missing are very vulnerable. 100,000 children under 16 years go missing for one night or more each year in the UK. Of these: 8 per cent are harmed or are involved in risk behaviours; 16 per cent sleep rough; and 12 per cent resort to survival strategies such as begging and stealing.[115]
- **Online abuse –** the internet poses new risks to children and new challenges for those working to protect them. Serious case reviews record instances of children dying or being seriously injured in the following ways: suicide in the aftermath of cyber bullying; online grooming leading to sexual abuse and exploitation; vulnerable parents being targeted by abusers on dating websites and social networking sites; children being sexually abused in order to get images of child sexual abuse which are then shared online. Factors which enable this kind of abuse include: virtual identities; unsupervised contact; online communities; the ease of sharing information; and the lack of controls on information sharing.

Children are also rendered vulnerable by the actions of others and by events. Trauma and abuse make children vulnerable, see examples following.

- **Sudden and critical events:** (for example, Aberfan, Dunblane, Hillsborough, Manchester Arena attack): There are events when children, families, and communities are devastated, not only at the time but potentially for generations.
- **Death:** Winston's Wish estimated that 20,000 children a year are bereaved of a parent.[116] Mortality rates vary by social class, geography and also for children who are disabled by complex special needs.
- **Life limiting and terminal illnesses:** Parents try to protect children from depressing realities, such as illnesses. Parental fear underlies a great deal of the dishonesty perpetrated in the guise of protecting children. When parents don't know if they will survive, that is not a conversation they want to have with their child.
- **Mental health difficulties:** When a parent has mental health difficulties, there is a need for the child to know, at a level appropriate to the age and stage of the child. Without information and key people with whom to talk, ideas about where and how to get help, children flounder and feel alone, they may even feel to blame.
- **Addiction and the consequences of addiction:** Many people with alcohol/drug dependency hide their dependency and deny their problems. There can be immediate risks for children exposed to the consequences of addiction such as: deteriorating home conditions, poor care and inappropriate models of behaviour.
- **The breakdown of relationships in families, and for some children, the breakdown of their family whereby they need alternative care:** When families break down, some children have attachment difficulties caused by absent, rejecting or multiple caretakers in their early life, institutional care, and/or neglect and abusive experiences. These causes can undermine their sense of self and their capacities to trust in relationships.
- **Self-harm:** Deliberate self-harm is intentional self-poisoning or injury, irrespective of the apparent purpose of the act. Self-harm is an expression of personal distress, not an illness.[117] Studies show that around 10 per cent of adolescents report having self-harmed, of whom some will report some extent of suicidal intent underpinning their self-harm. Suicide in adolescence is often under reported. In 15 to 19 year-olds, it is the most common cause of death in females, 8.2 per cent, and the third most common cause of death in young males after road traffic accidents and violence, 6.5%.[118]

How society responds to vulnerability can heighten the risks for children and families. Recent revelations about organised abuse such as: by celebrities; in the church; in sport; highlight the silencing powers of abusers despite the number of victims and the years passed. The systemic problems of setting up an independent inquiry into organised abuse and the limitations on compensation, in terms of time elapsed since offences, definition of consent and a failure to recognise the extent of harm caused, point to the importance of the layer of government factors in the model.

Children and families need services which are fully staffed, with professionals who are trained and supported to work with the most needy in our society. Vulnerable children are affected by the cuts in the staffing of services with whom we work. The fragmentation of

services can lead to: duplication; complex referral systems; long waits for services; people falling through the net of provision; and inequalities based on service users' presentation, post code or capacity for agency. This surely leads to more children and families facing risk and a consequent undermining of safeguarding for children and families.

Traumatised and abused children can become invisible children, such was the description of Daniel Pelka. The Serious Case Review into Daniel's death was published in 2013.[47] He was described as *'at times Daniel appeared to be invisible as a needy child against the backdrop of his mother's controlling behaviour. His poor language skills and isolated situation, meant there was often a lack of child focus to interventions by professionals.'*

There continue to be incremental austerity measures, which impact most harshly on families with high level and complex needs, such as cuts in public services, more part-time working, zero hours contracts, increases in waiting times in mental health services, and the closing of children's centres/community hubs.

Summary

Every child matters

Children have the right to be healthy and safe; to be happy and achieve their own potential; to make a positive contribution to society and to experience economic wellbeing.

Safeguarding now spans a horizon which ranges from prevention to crisis intervention. It has broadened its reach to include wellbeing and safety across a range of environments, settings and systems.

Psychologists need to match this breadth of thinking, to ensure that effective safeguarding occurs for children. This may be at the level of individual intervention or working at an organisational level within a variety of contexts which may afford the opportunity to help influence key decision-makers at community, regional or national level.

This document has outlined a model to guide thinking, to ensure that practitioners are psychologically informed in their safeguarding decisions. It also encourages psychologists to broaden their perspectives, to incorporate areas which they may not normally consider, including issues around power. The model considers a number of key factors which influence safeguarding at a number of different levels of social structures. It also considers a number of factors which can influence those systems to become more or less safe. These are expanded upon in the frameworks which follow in the appendices.

It is hoped that this document enables psychologists to:

- consider how to formulate information related to safeguarding, including reflecting on our own thinking
- think about risk and resilience factors related to safeguarding, and how to synthesise these in a meaningful way
- consider interventions which promote safety and health, at a number of different levels including at population level
- examine risk and resilience factors across different systems, including organisations with key decision-making powers, also reflects the advances in practitioner training, which include leadership.

Psychologists are privileged to work with people in a multitude of settings, across the lifespan, and may work with people at a time when they are facing some of the greatest hardships of their lives. The profession has much to offer and should be both ambitious and confident about influencing safeguarding in society, and to influence policy makers, who can change circumstances at a population level.

The British Psychological Society is taking a more active role in influencing decision-makers using experts from the field to inform commissioners, government and other policy makers across a range of areas. Whilst these are challenging times, they also provide opportunities for psychologists to work in different ways with children, young people and families.

Improved human rights for the children of today, will ensure that the world is a fairer, safer and healthier place for the future.

Resources

Co-operating to Safeguard Children and Young People in Northern Ireland
www.health-ni.gov.uk/publications/co-operating-safeguard-children-and-young-people-northern-ireland

Getting it right for every child
www.gov.scot/resource/0042/00423979.pdf

Let's Talk FGM – Let's Talk FGM is an iPad app to assist professionals to make sensitive enquiry about FGM. It incorporates key information on the impact of FGM, why it happens, the law, how to protect children and suggests support for survivors – https://itunes.apple.com/gb/app/lets-talk-fgm/id1096760919?mt=8

National Self Harm Network
www.nshn.co.uk/

National Guidance for Child Protection on Scotland
www.gov.scot/Publications/2014/05/3052

NSPCC resources for staying safe online
www.nspcc.org.uk/preventing-abuse/keeping-children-safe/online-safety/

Papyrus – an organisation dedicated to the prevention of young suicide
www.papyrus-uk.org/

Programme for Children and Young People (Wales)
http://gov.wales/docs/dsjlg/publications/cyp/151106-core-aims-comprehensive-version-en.pdf

Respect Yourself – site for young people about sex education, consent, etc. Moderated website with staff replying to questions.
https://respectyourself.info/

Safeguarding Children: Working Together under the Children Act 2004 (Wales)
http://gov.wales/topics/health/publications/socialcare/guidance1/safeguardingunder2004act/?lang=en

UN Convention on Rights of Child (available in Child Friendly Language)
www.unicef.org/rightsite/484_540.htm

Working Together
www.gov.uk/government/publications/working-together-to-safeguard-children–2

Young Minds – an organisation dedicated to the mental health of children and young people
https://youngminds.org.uk/

Appendix 1. Risk and resilience factors

Resilience and risk factors, presented below, are explored in relation to children/young people's emotional wellbeing, mental health, overall development, stability and security.

Protective factors are those which serve to increase resilience, minimise the risk of developing more complex long-term emotional/mental health difficulties, instability and emotional insecurity. These are factors which promote healthy development and achievement.

Risk factors are those which are likely to increase the probability of a young person developing emotional/behavioural difficulties and/or mental health difficulties, underachievement, instability within relationships/lifestyle.

The framework below is organised according to the layers in the model, and considers factors which are associated with healthier development, safer systems and the building of resilience, and those which are associated with risk.

The factors listed here are based on research and recommendations from reports, particularly the work of Cleaver et al.,[119,120] Munro,[48,121] Rutter,[46] Zimbardo[25] and Daniel and Wassell[122] They are distilled themes.

There is also an emphasis on psychologically informed literature. Some of the themes are based around of the work of Jim Reason on safe systems. We also draw on Maslow's work, outlining the hierarchy of needs for people to develop healthily which includes the meeting of basic human needs for adequate shelter and food. There is also the need for love and attachment, which helps build healthy emotional wellbeing and self-soothing.[74,75,123] There is also a literature on what can help build resilience.[44,74,124]

Safeguarding and promoting the development of children is everybody's responsibility. This depends on families, communities, and professionals, understanding the need for a child-centred and whole family approach to: gathering high quality information; identifying concerns; assessing risks; sharing information; taking appropriate actions; and offering effective support and resources.

This framework for assessing resilience and risk rests on some basic principles.

1. The assessment takes a holistic view of the child, family, school, peers, community, and the impact of the work of professionals.
2. The age, stage, abilities and situation of a child will be an essential context to any assessment of resilience/risk, for example, 'difficulties recognising and articulating feelings' as a risk factor will need to be very clearly viewed differently depending on age and understanding.
3. Any assessment of concerns about a child should be open and transparent, and shared with the child's parents, unless it is unsafe or inappropriate to do so. The use of the framework must include the views of the child.
4. Everyone working with children and families has a responsibility to identify concerns early, and to provide help or support to get help. Early help and support prevent the escalation of difficulties and reduce adverse impacts on the wellbeing and development of children and families.

5. Assessments of resilience/risk need to be undertaken over a period of time, with consideration given to views about the child in different settings.
6. The framework is written as 'more likely to be resilient' vs. 'more likely to be at risk', to emphasise that absolutes of resilience and/or at risk, are not accurate or helpful.
7. There is no suggestion that factors are weighted equally, with regard to concerns which might trigger interventions. When the framework is used to address concerns about an individual child, it needs to be discussed in a multi professional setting before intervention is planned.
8. The factors do not imply blame and any use of the framework should seek to avoid a judgemental approach, while being clear about what needs to change and actions/ responsibilities for bringing about change.
9. Some factors are a given and not open to intervention, for example, 'difficult birth and consequent concerns about early development'. It remains relevant information for an assessment. However, with many of the risk factors, the accompanying resilience factor provides a target for intervention, for example, the risk factor 'little or no involvement/support for play activities/the child is isolated from social/ play opportunities', v the resilience factor 'parent(s) facilitates appropriate child-centred play activities with appropriate toys and resources.'
10. Some factors are complex and need more detailed assessment: parents who misuse alcohol or drugs or substances, young people who have self-harmed or are self-harming. Where there are/could be additional assessment frameworks, these should be used in conjunction with this framework.
11. The assessment of professional/agency factors is an integral part of the framework as it is with regard to any assessment/intervention. We have a duty to scrutinise our work and that of our agency, every bit as closely as we scrutinise children and parents.
12. The use of the framework is part of record keeping by professionals. It should be shared with service users unless it is unsafe to do so. Records need to be: systematic and appropriately detailed; in clear language/format; accurate; up-to-date; and relevant to professional work and to the purpose for which the information was sought.

Child factors	
More likely to be resilient	**More likely to be at risk**
Uncomplicated birth/no concerns about early development	Difficult birth and consequent concerns about early development
The needs of a child with disabilities are being met by universal services	Disabled child(ren) with additional complex needs requiring more support and protection
Good physical health	Sudden changes in physical health
Meeting normal milestones/ regular health care appointments are kept	Little or no information about development, not taken to regular health checks
Appears to be thriving	Frequent presentation for medical attention
Good quality early attachments	Concerns about attachments and the impact on relationships and mental health
Affable, calm temperament	Reactive temperament
Age appropriate language skills and confidence to communicate	Speech, language and communication difficulties
Adequate/good nutrition, regular meals	Poor nutrition
Good hygiene and appropriate clothing	Concerns about hygiene affecting self esteem, development, and causing isolation, and inappropriate/ inadequate clothing
Regular sleep patterns	Poor/disturbed sleep
Appears to be securely attached to parents/caregivers	Presentation suggests attachment difficulties, such as: frozen watchfulness, rocking, extreme clinging
Experiences of being valued and loved	Experiences of maltreatment and/ or abuse/ neglect/physical/sexual/emotional
Positive self-regard and a sense of belonging	Low self-esteem which impacts on relationships and on functioning in situations
Age appropriate emotional literacy	Difficulties recognising, articulating and controlling feelings
Able to regulate behaviour, appropriate to age and stage of development	Behaviours which impact on health, wellbeing, development, and relationships
Demonstrates an age/stage appropriate awareness of safety	Risky behaviours which could cause harm to self and others

Child factors *cont.*	
More likely to be resilient	**More likely to be at risk**
The child is able to adapt to change	The child is unable to manage changes commensurate with peer capabilities
The family is supportive and as far as is known, the young person is not under pressure at home	The young person is under pressure at home, for example: the young person is a young carer, other children have difficulties, there is domestic abuse/violence
Child feels and is secure in the family	Child is in kinship care, subject to SGO, in the Looked After System or Adopted
Child can form and sustain relationships with wider family and significant others	Difficulties with relationships in wider family and little/no positive community links
Attends school regularly, on time, with necessary equipment for lessons	Frequent lateness, authorised and unauthorised absences
Able to listen to instructions, concentrate and complete tasks, which are appropriately set for age/abilities	Restless, unable to attend to instructions, poor concentration and execution of tasks
Consistent and appropriate behaviours	Significant and/or persistent changes in behaviours which adversely affect presentation and relationships
Abilities to learn and evidence of progress, the child has a range of skills and interests	Low ability/learning difficulties whereby the child feels/is unsuccessful. No sustained skills and interests are displayed
Successes and achievements in school	Failure to make progress in different areas of education
Skills to make and sustain pro-social peer relationships	Isolated or rejected in peer group or has an anti-social peer group
Has enduring positive peer group relationships, which are mutually reciprocated	Is a member of a socially disadvantaged/ socially excluded group which increases barriers to peer group opportunities
Has the ability to see events as specific, situational and short-lived	Sees events as negatively personalised/ internal, self blaming, and pervasive across situations
Appears happy, confident and relaxed	Evidences behaviours which may indicate underlying distress
Growing levels of appropriate practical competencies and emotional skills	Inappropriate self-care and personal skills affecting development

Child factors *cont.*	
More likely to be resilient	**More likely to be at risk**
When upset, the child is able to draw the attention of a supportive adult	When upset, the child is not able to secure support from a familiar adult/isolates self from potential support
The child can name familiar adults or local services which are available to her/him in times of stress/need	The child is guarded and isolated when stressed, and unaware of people and resources for support
No known incident of self-harm	One/multiple incidents/methods of self-harm (use the framework for thinking about concerns with regard to a child who has self-harmed or who is self-harming)
As far as is known the child does not have mental health difficulties	There are concerns about the child's mental health and wellbeing, for example: depression, eating disorders
The child is clear about available professional/ voluntary agency support if she/he has concerns about parent(s)/family	The child is not able to name and find available support if she/he has concerns about parent(s)/family

Parents/carers and family factors	
More likely to be resilient	**More likely to be at risk**
Warm, positive nurturing parental care	An absence of warmth, with negative, critical parental behaviour
Parents provide pro-social models of behaviour	Parents display difficult behaviours in the family/community settings
Positive relationships in family with a parent/ grandparent/extended family members/ siblings	Critical/negative relationships in the family/ extended family
The child is included and seen as a valued family member	The child is isolated/ scapegoated within the family
Family harmony	Family strife/domestic abuse/violence
The child's needs are prioritised	There are difficulties recognising and prioritising the child's needs
Consistent parenting and positive role modelling	Inconsistent parenting which leads to negative role modelling, impacting on the child's development
Settled housing and lifestyle, which may include planned moves.	Frequent moves of housing which are unplanned and to the disadvantage of the family/children
The family is accepted in the local community and relationships with neighbours are mutually reciprocated	The family is isolated or marginalised in the local community whereby there is stress on the family
Secure and well maintained accommodation- adequate size/resources	Insecure or inadequate accommodation which affects the child's sense of security
Socio-economic advantages/adequate resources	Limited socio-economic resources whereby there is an adverse impact on children
Parents can manage home, work, or lack of work, without undue stress	Parents experience significant stress about home conditions, relationships, work/ lack of work, which affects their parenting and the development of the child
Parents engage with services for the child when these are needed	No or limited engagement/ disguised compliance, with services needed for the child
Parents are in good physical health/ any health condition is being well managed with appropriate medical support	Parental ill health, which is severe or chronic, which undermines their capacity to parent/ supervise and protect, or whereby the child(ren) become young carers

Parents/carers and family factors *cont.*	
More likely to be resilient	**More likely to be at risk**
The parent(s) have no mental health difficulties, or have mental health difficulties for which they have support and which don't affect their capacity to parent and protect the child(ren)	The parent(s) have mental health difficulties which affect their capacity to parent and protect the child(ren)
If the parent(s) has mental health problems, the child has an age appropriate understanding of the parent(s)' mental health issues and can articulate worries to a supportive adult	The child does not know that the parent(s) has mental health issues, does not know the warning signs when help is needed, nor how to get help
The child is able to depersonalise the manifestations of parental mental health and see that they are not to blame	The child feels to blame or ashamed about the manifestations of the parent(s)' mental health issues
The child has been taught coping strategies for when parent(s) is unwell and is able to name available support	The child has poor coping strategies and may be unsure what to do if parent(s) are unwell and help is needed
The child sees no or minimal amounts of parental distress	The child witnesses parental distress, such as: self harm, domestic abuse, behaviours consequent on alcohol/drug misuse, psychotic behaviours
No family history of suicide	A family/extended family member has died by suicide
No family history of self-harming behaviours	Family member, adult/child, has or is self-harming
No alcohol/drug/substance misuse by parents	Parental alcohol/drug/substance misuse (Use the framework for working with families about Safeguarding concerns when alcohol/drug dependency is a problem with the family)
Parents are in employment or choosing to stay at home	Parents are not in employment such that this is creating stress in the family in terms of resources/relationships
No records of family members involved in anti-social or criminal behaviours/record of offending	Parental/sibling record of anti-social, criminal, law breaking behaviours
Parent(s) facilitates appropriate child-centred play activities with appropriate toys and resources	Little or no involvement/support for play activities/the child is isolated from social/play opportunities

Parents/carers and family factors *cont.*	
More likely to be resilient	**More likely to be at risk**
Age/stage appropriate supervision of children	Poor/no/or too much supervision of children
Parents aware of safety/ protection needs in situations/online	Lack of awareness of risks for the child, including online risks
Parents previously successful/happy in school	Parents previously unsuccessful/unhappy in school
Parents support the child in school/ education matters/enrichment activities	Parents not supporting child in school/ education matters and the child's access to enrichment activities
Parent willing to believe and not blame a child who has been abused	Parent disbelief of a child's experience of abuse
Parent willingness to engage appropriately with professional agencies	Parent unwilling to engage/over dependence on professional agencies

School factors	
More likely to be resilient	**More likely to be at risk**
Attended pre-school provision	Did not attend pre-school provision
Settled school placement	Moves of school (given any concerns about moves of school/transitions and the inclusion of a child, use the assessment framework with regard to inclusion)
Successful school	School has systemic difficulties
Settled teaching staff	Frequent changes of staff/supply staff
School proactive in promoting positive behaviours/a healthy school system and dealing with bullying	Incidents of bullying, challenging behaviours and exclusions
School has a system of rewards/positive recognition, consistently applied daily	Lack of positive regard given to the child in school
Opportunities to achieve in lessons and out of lessons	The school has a limited view of what constitutes success in school
Positive regard from teachers	The child feels criticised by staff in school
Experiences of success in education settings	Experiences of failure in education settings
School staff seeing themselves as needing to be vigilant, supportive proactive agents of change	Staff view of difficulties as within-child problems/unlikely to change
Children with special educational needs are well supported to manage in school educationally and socially	Children with special educational needs facing challenges in school, whereby they are additionally vulnerable
The school knows the families of children about whom there are concerns, and that a supportive family life is key to children's performance in school	Teachers blame families when children cause concerns, and are unsupportive to the child
The school has family liaison workers who are trained and experienced to support families and who work with senior managers in school	Home school links are seen by parents in a negative way, as mainly consequent on attendance/behaviour problems
The school has an induction programme for new staff, a knowledgeable Designated Safeguarding Lead, regularly reviewed Safeguarding policies, and staff are trained according to LSCB expectations	There are concerns about the school's knowledge of Safeguarding and its capacity to respond to and act on Safeguarding concerns

School factors *cont.*	
More likely to be resilient	**More likely to be at risk**
Willingness of school to engage support agencies	Late, little, or no use of support agencies
The school has a copy of the current local policy and practice on self-harm, has had training and feels confident to deal with concerns about a child who self-harms	The school staff are unaware of procedures for concerns about a child who self-harms
The school is aware of children who are young carers, the implications of this, monitors their progress, and offers support	The school is not aware of which children are young carers and does not understand the implications for the child, socially, emotionally, in terms of success in school, and financial issues
School staff have information about the parent(s) mental health difficulties and the implications of these with regard to the child	School staff are unaware that the child's parent(s) have mental health difficulties which may be adversely affecting their care of the child

Peer factors	
More likely to be resilient	**More likely to be at risk**
There are groups of peers who achieve well and are enjoying school, who are open to including the child	There are peer subgroups which create challenges and risks for the child, such as: bullying, alcohol/drug/substance misuse, law breaking
The child is well supported by the family with regard to school, and is accepted by peers	The family's socio-economic situation has an adverse effect on the child's presentation in school whereby the peer group reject the child
The child has an identifiable peer group in keeping with the child's age/stage/abilities	The child does not have an identifiable peer group/gravitates to peers in ways which raise concerns about the child or other children
The child makes and sustains mutually reciprocal, positive peer group relationships	The child's vulnerabilities, such as a history of maltreatment/exposure to domestic strife, in care or adopted, affect peer group relationships
The child has a best friend in whom she/he can confide and who can be relied upon to be supportive	The child does not have a best friend and has no friend on whom she/he can depend, and so is isolated and vulnerable
The child has good social skills and is included socially in school and locally	The child is part of a socially excluded group and is subject to peer and local hostility
The child belongs to social networks/clubs which offer social space for achievements and pleasure	The child is not included in local social groups/clubs and so has minimal opportunities for achievements and social pleasure with peers

Social/community factors	
More likely to be resilient	**More likely to be at risk**
Living in a peaceful country	Experiences of war and/or natural disasters
Settled neighbourhood where residents feel safe	Neighbourhood where there are levels of crime and violence and alcohol/drug misuse
The area has low levels of social deprivation	The area is socially deprived
Supportive extended family network/ friendships	Family isolated from extended family support/ friendships
Accessible support networks for the parents/ carers and family, such as health care, a Children's Centre or Community Hub	Family isolated in the local community and cannot access support/resources needed for health and wellbeing
Safe streets which are well lit and clean, with traffic calming measures and safe crossings which protect pedestrians and children	Hazards on the streets which undermine the security and safety of pedestrians and children
Reliable public transport links	Unreliable/no public transport
Local shops which cater for family needs: groceries, Post Office, chemist	Few or no shops
Safe resources/play areas for children	Lack of local resources/play areas for children
Affordable accessible clubs/activities for children and families	No local clubs/resources for children and families
Community open door advice centres	No advice centres/or centres where access is only on the basis of a referral

Professional/agency factors	
More likely to be resilient	**More likely to be at risk**
Early intervention	Crisis intervention
Qualified/experienced professional	Unqualified/inexperienced professional
Professional has a manageable workload	Professional is feeling over worked
Professional is positively supervised/managed	Professional is working without adequate supervision/management
Professional is part of a multi-professional network and using colleagues as resources appropriately	Professional is working in isolation
Goals of intervention agreed with the family/parent/child	Unclear goals for the intervention
Appointments are regularly made and consistently kept at a frequency which is consonant with the issues	Appointments which are characterised by cancellations, and are too frequent/not frequent enough
Professional is prepared to listen, explain and discuss	Parents/child perceives professional as having a rigid approach/agenda
Professional who is accessible/available	Contact with professional is difficult to establish and maintain
Open and transparent record keeping	Record keeping is not shared with family/parent/child
Professional has ready access to information/advice about self-harming behaviours	A referral based system for young people who self harm which has a waiting list
The family and child are supported to learn about proactive lifestyle factors to promote personal wellbeing	There is no planned proactive programme to support parenting and to help the child to develop self-help skills
What the child knows and their understanding of their life is regularly reviewed, questions are answered, and support is offered	There is no or little on-going monitoring of the child's understanding and feelings about their situation
Child is supported by parents, when this is not possible, reliable alternative support from family network and the community is in place	The child is a young carer and this impacts on wellbeing, development and relationships, and little or no reliable support is available
There is a named knowledgeable person to whom the professional can talk about mental health difficulties, who is also alert to safeguarding issues	There is little agency awareness about mental health difficulties/safeguarding issues

Organisational factors	
More likely to be resilient	**More likely to be at risk**
The system is based on a good understanding and valuing of diversity	The system allows for dehumanisation which blames or scapegoats vulnerable groups, as evidenced by a lack of empathy for the other
There is equitable access to non-stigmatising services, including good medical care and psycho-education support for children and families	There is inequitable access to help and health care, with limited services which are stigmatised
There is good availability of crisis help	Crisis services are not easy to access and there are waiting lists
Systems are open to regular, random checks at all levels and all staff know this	System values obedience, compliance and conformity to authority figures, and this influences the behaviour of staff
Altruism is promoted and questioning is valued	The staff in the service need to be part of the group and to have group approval
The system is explicit that individuals should think about and take responsibility for actions	The system feeds apathy by de-individuation/ anonymity, whereby staff assume someone else will take action
The system acknowledges mistakes and views them as opportunities for development	The system seeks to eradicate cognitive dissonance which leads to self deception and bias
The thresholds for services and between services are transparent and clear	The thresholds of services are high and vary between services
The system is prepared to accept that abuses can happen, and that they occur in ordinary setting	Language and processes within the system can conceal/minimise the recognition of abuse

Government factors	
More likely to be resilient	**More likely to be at risk**
Human rights and equality laws are strong and upheld	Human rights and equality laws are weak or flouted with impunity
There is social justice	There are low levels of social justice
There is universal access to legal justice	Access to legal justice is difficult and expensive
Systems are democratic, transparent and clearly accountable	Systems are autocratic, opaque/bureaucratic and accountability is diffused
Social and economic policy is evidence based and administration tests out its thinking to avoid biases	Social and economic policy is not based on evidence and administration does not test out its thinking to avoid biases
Administration allocates finances and designs services for the public which are based on evidence	The evidence base is suppressed
The government puts appropriate resourcing into training and workforce development to ensure population needs are met	Workforce planning not based on population needs and not adequately trained or resourced
The government acts on evidence about the detriment of Adverse Childhood Experiences ACEs and health inequalities and reduces those inequalities	Social policy pays inadequate attention to the need to reduce health inequalities
There is an emphasis on prevention and early intervention, but also access to specialist or crisis help	Services are under financial pressure and so limited in resources, access for support is stigmatised
Administration uses wellbeing indicators which are not just based on economic wealth	Administration only uses financial indicators to determine whether country is in a healthy state
Power, resources and finances – the government has transparent and responsive processes for making law; the principles of law are given independence	Power, resources and finances – the government is closed and secretive, and unresponsive to the public; the law-makers are influenced by political opinion rather than independent processes
The government seeks to reduce inequalities in power to ensure equality of opportunity and outcome for the vulnerable in society – health inequalities reduce	The government policies increase inequalities in power and wealth, and reduce state help for the most vulnerable – health inequalities persist and widen
The government makes a statutory commitment to provide equitable services for the population	The provision of services varies by location or with respect to minorities/ socially excluded groups
There is the means to question and call power to account – there is representation available for challenges against unjust authority	There is no transparency to question and call power to account – it is difficult to take action against unjust authority

Appendix 2. Scenarios

Scenario 1 – Children with disabilities

Stephanie and Mark are both 37 years old and are parents to Olivia, aged six, and Michael, aged 14. Olivia has cerebral palsy and severe learning disabilities and uses a wheelchair. Mark works full-time but Stephanie had to give up work in order to care for Olivia. The family are struggling financially. They have a social worker but are looking to access a wider range of support services. Stephanie would like to take Olivia to participate in leisure activities but her local leisure centre does not have a disabled ramp. Stephanie has also been considering returning to work part time but does not know how to arrange suitable childcare and is plagued by feelings of guilt. She is also worried about how this might affect the family's carer's allowance.

Michael has been displaying aggressive behaviour in school and it transpires that he has been the victim of bullying on social media due to his sister's disabilities. Mark's elderly parents are concerned that Stephanie and Mark may be neglecting the emotional needs of their teenage son due to their main focus being on Olivia's needs.

Stephanie visits her GP with symptoms of anxiety and depression, revealing that she feels unable to cope with her situation and that she needs more support in caring for Olivia. The GP refers Stephanie to a clinical psychologist. Stephanie confides to the psychologist that whilst Mark is not physically abusive he is becoming increasingly frustrated when caring for Olivia and by her lack of ability to communicate verbally.

At the **government** level, there are practice guidelines on how to safeguard disabled children and ensure that they are recognised as having the same rights as non-disabled children.[3,125] All psychologists should endeavour to make themselves aware of these guidelines as part of their continuing professional development and **learning**. Policies exist that may incur risk for those wanting to improve their circumstances for the better. Returning to work would give Stephanie a sense of freedom and a renewed sense of purpose, thereby enabling her to care for Olivia more effectively. However, to be eligible for carer's allowance you must spend at least 35 hours per week caring for someone. Local councils have various services that provide help to a family with a disabled child, including short break services and financial contributions towards travel costs.

At the **organisational** level, there are many different organisations involved, including children's social care, Olivia and Michael's schools, Stephanie's GP practice and clinical psychologist, the Benefits agency and even the various leisure facilities that could help to promote a sense of inclusion for Olivia. It is important that, where relevant, different organisations can communicate and work together in order to resolve the various issues. For example, the social worker could help Stephanie to identify leisure activities other than those at her leisure centre that are local and accessible for Olivia, and work with the organisation to ensure that the appropriate facilities, for example, changing facilities and building access, are in place.

At a **professional** level, the clinical psychologist has the skills, knowledge and experience to help Stephanie with her mental health difficulties, work towards a formulation of

her difficulties, and identify ways in which they can be alleviated. Placing Stephanie's problems in a wider context enables suggestions for practical changes which will impact both on Stephanie's wellbeing and the ability of the family to adequately care for their children. The GP, psychologist and social worker must gain Stephanie's trust in order to build up a working relationship with her, thus enabling them to support her in the best way possible. Each of these professionals also has a responsibility to consider the welfare of both children in the family, and be prepared to report any concerns to the relevant agencies. In this case, whilst there is no evidence of physical maltreatment to either child, the psychologist should note the concerns regarding the potential emotional neglect of the adolescent son, and the frustration of the father, and remain vigilant to any further developments. Psychologists should be aware that disabled children are at a high risk for physical, sexual, emotional abuse and neglect. In addition, many children are unable to verbally communicate what has happened to them. It is important to look out for physical signs of maltreatment in the child and be aware that there are different bruising patterns that may differentiate accidents from physical abuse in disabled children.[126,127] Do we need to consider further assessment of risk from her husband, and also how he could support? Consider including him in couple's work, if indicated?

At the level of **social and community factors,** the local leisure centre is not accessible for disabled people. Stephanie feels isolated as she spends much of her time caring for Olivia, and she has also experienced animosity from a number of her neighbours. The social worker can help Stephanie to contact the local council and the services of charities such as Mencap, who may be able to provide transport for days out and other support services. Some charities would be able to work with Mark to discover effective, non-verbal ways of communicating with his daughter.

At the level of **peers,** Michael has been experiencing cyber bullying due to his sister's disabilities. He is reaching puberty and his situation has caused him to act out in class. Do we need to add any more here? For example, parents and school could work together identify sources of support for Michael including engagement with positive peers.

At an **educational** level, Michael's teachers are aware of his sister's disabilities, and have recognised that something is wrong as he is usually mild-mannered and well behaved. The school have offered him counselling, have organised training days for teachers on cyber bullying and have called Michael's parents to invite them to discuss the bullying at the school. The school are conscious that Michael does not receive as much attention as he might need due to his sister's complex needs.

At the level of **parenting,** Stephanie is struggling with anxiety and depression due to the stress of caring for Olivia full time. She feels unable to cope, and is potentially neglecting the needs of her teenage son. Mark is also feeling increasingly frustrated and is also under stress, being the sole provider for the family financially. He feels he should be there for his son but does not have the time to devote to him in between working and helping to care for Olivia in the evenings. The parents could be offered support as a couple to help them to talk about the current concerns and generate strategies for addressing the needs of both children.

Scenario 2 – Case study

Kai is 12 years old. He has complex special needs for which he has an Education, Health and Care Plan (EHCP) and he attends a special school. His mother says that his difficulties were first apparent to her when he was 18 months old. By the time he was 6 years old, he was diagnosed as having Higher Functioning Autism, Tourette's Syndrome and Attention Deficit with Hyperactivity (ADHD). When he was 10 years old, he was diagnosed with Type 1 Diabetes. More recently, the local Child and Adolescent Mental Health Service (CAMHS) has reviewed him and see him as having problems associated with low mood.

Kai lives with his mother and baby brother, his half sibling. His mother reports that she can't manage him at home. His behaviours can include: shaking his mother, hitting her, shutting her in a room, overturning furniture, leaving the house when told not to, threatening to cut himself with knives, punching himself in the head, putting the lead from his DS round his neck and two incidents of insulin overdoses.

His mother says his birth father was adopted as a child and had a troubled childhood including misusing drugs. When they were together, his drug misuse and violence were such that, with Kai, she left him and they were in a refuge for a time. She has had a series of partners since, no one relationship lasting long. Kai will frequently say he wants to be in touch with his father. His mother is known to the Community Mental Health Services. Assessments have variously suggested she is depressed or has a Borderline Personality Disorder. She believes she has Autism and she feels unsupported with regard to having an assessment for Autism. They have moved several times and she is isolated in the community. She has approached Social and Health Care professionals for support with Kai, but she feels she is being blamed for his behaviour.

The school says he attends regularly. Kai is a bright boy with good literacy and numeracy skills. In a one-to-one situation he can be personable and articulate. However, Kai's behaviour is challenging the staff in school. His Diabetes Support Team in school note instances when he won't cooperate. They have needed the regular support of his named diabetic nurse and there have had to be visits to the local hospital over concerns about extreme blood sugar levels. His behaviours in school include: sexualised language, name calling, some days he will refuse to do work in class, his influence on other children can disrupt lessons, and on occasions he has tried to leave the school site.

The police have become involved, adding to the number of professionals in the professional network for Kai and his mother. There is disagreement in the network with regard to what needs to be done and huge concerns about limited resources, given recent cuts in local government provision.

The Educational Psychologist is approached by the school to consider the concerns they have in managing Kai. Staff are concerned that his behaviours are such that they can't manage him. They are also noticing the impact he is having on other pupils. Some parents are complaining too. They have talked to Kai's mother and her reports of his behaviours at home have alarmed them and raised Safeguarding issues.

The psychologist sees the wider picture and the need for any assessment to include family and school factors, safeguarding and a network of professionals who are, or need to be, around the family. A plan for work which takes account of the layers in the model, is a reassuring basis for proceeding.

At a **government** level, the Code of Practice for children with special educational needs[128] enshrines a statutory role for the psychologist to work in conjunction with the school. It sets out practice for the assessment and support of children like Kai, which includes: specialist staff who can recognise the difficulties of a given child; a system of providing support which is needed as part of an individual education plan for the child; a staged approach to assessment in the context of the child's family and school; regular reviews in school; moderated criteria for determining levels of need and a system for the provision of additional intervention where the school support is not able to cater for the needs of the child. In addition, the Local Authority has to provide specialist settings for children whose needs are not met with mainstream education. Much has already been done for Kai. His difficulties are significant, he has an EHCP plan, he is in a special school, and there are regular reviews of his progress.

At an **organisational** level, the school brings much that is positive; it has robust Safeguarding policies which are reviewed and updated annually and which have been rated as outstanding in the most recent OFSTED inspection; the designated Safeguarding Lead is an experienced and senior member of staff; staff training in Safeguarding is in accordance with the LSCB expectations and is up to date; the school buys in traded services of an educational psychologist and a worker from the local CAMHS, they work well together and with the staff. Cuts in public services have placed pressures in terms of the costings for these professionals and this impacts on the extent to which the school can develop its services. The school protects its use of services, but is aware of the dwindling resources in the other parts of the Local Authority. Staff who are concerned about Kai, are angry that deliberations about thresholds seem to be causing delay in the process of Social and Health Care decisions about whether to allocate a Social Worker. The talk about staff shortages and unallocated cases is adding to the stress felt by school staff about Kai.

At a **professional** level, the school has a series of features which suggest that they can take a protective approach: the staff group is experienced and stable with a low level of turnover of teachers and no use of supply staff; there is regular staff debriefing and discussion about how to manage children of concern; ready access for staff to the psychologist for consultation and direct work; systems for monitoring Safeguarding concerns are in place and used to good effect when the need arises. The school prides itself on a nurturing approach to children and families. All staff have weekly contact with the parents of the children in their class. Kai's mother uses the weekly contact calls to complain about his behaviour at home, this is upsetting the teacher and leaving her feeling powerless to help. Without social work input, she worries about whether what can be a volatile home life is upsetting Kai and impacting on his schooling. She thinks the situation at home may be risky for Kai, or his mother, or both. She has no way of weighing the risks. She hears his baby brother wailing in the background and fears for the little boy. The school started to systematically monitor Kai in school and have a weekly record; of attendance, presentation in school, relationships with adults/peers, learning, social and emotional issues and information from contact with mum.

The health issues for Kai given his Type 1 diabetes and his non-compliance with regard to his diet and blood tests, are serious. He has a named diabetic nurse who is experienced and supportive to his mother and school staff. She has provided training; is available for consultation and provided ideas for a school system of a named Teacher Assistants team who support Kai on a daily basis and who support each other. This works well and the school record keeping is good. When there are extreme sugar levels, her advice and visits to hospital are very necessary.

At the level of **parenting,** Kai's mother is struggling. She was previously known to the Community Mental Health Service, although she is currently experiencing low mood there is no ongoing input. It was helpful to her when there was. Pressures on the service to make cost savings mean that thresholds to access support are high and there is a long waiting list. She worries about Kai, and feels she cannot manage his challenging behaviours. There are times when she is afraid of Kai. The competing needs of Kai and his brother mean that it feels impossible to set boundaries. She has begun to think that he needs to be in care.

At the level of **community/social factors,** she has no extended family support and frequent moves mean she is not established in her local community whereby she feels she can ask for support. The behaviours of Kai adversely affect her making positive links with neighbours. Kai's mother is isolated and has limited social supports. She was the victim of domestic abuse and was for a time homeless, when Kai was a baby; she has had different relationships, but none have been supportive and lasting; she is a lone parent with a boy approaching adolescence, who has special needs, the health problems consequent on type I diabetes, and he has challenging behaviours; she also has a small baby.

The level of the **child** is complex. Kai has High Functioning Autism, ADHD, and Tourette's syndrome. He is known to the local CAMHS team and has regular six-monthly Care Plan Approach (CPA) reviews. The team has been flexible and ensured close liaison between his CPA coordinator and the CAMHS worker in school. This has meant she can monitor Kai on a weekly basis and advise staff about the interface between his mental health and his physical health. This has been a really useful piece of joined up thinking, as staff in school are unsure how much of Kai's non-compliance with his diabetes care is due to his autism or his physical state. The educational psychologist uses her skills and experience to work alongside her thinking about the context of his behaviour in school and advice for staff on de-escalation techniques. She arranges for Kai to have weekly one-to-one sessions so his voice can be heard. As both work in school on a weekly basis they join in the meetings with staff and with the diabetic nurse. This joined up working is helpful with regard to planning for Kai and it is supportive to the individual professionals. Kai has good abilities to learn, however, his challenging behaviours are a barrier for his access to the curriculum and they are disrupting the learning of other children.

Psychologists can consider

- In terms of Safeguarding, highlighting the complexity of the identified risks to Kai, his baby brother, his mother and other children in school, and supporting school staff to make a referral to the local Multi-Agency Safeguarding Hub, for an assessment.
- Supporting the systemic approaches in school to be reliable and consistent with record keeping which is contemporaneous, clear and available for scrutiny.

- Offering support to the form tutor with regard to peer group issues and her weekly contact with Kai's mother, which needs to be carefully recorded. The teacher is finding it stressful. It may be helpful to suggest regular mentoring for his teacher from a senior member of staff who is alert to safeguarding issues.
- Prioritising individual work with Kai whereby he can build a trusting relationship with a professional in whom he can confide.
- Supporting his mother to generalise some of the strategies that the school in order to help her set boundaries and perhaps build a behaviour management plan to address his challenging behaviours.
- Working to promote a network of professionals who meet regularly and work to achieve a holistic assessment of Kai at home and in school and a joint plan going forward.

Scenario 3 – Sexual exploitation

Joanne, aged 15 years, is the only child of Tim (62 years) and Amanda (59 years). Amanda has three children from a previous relationship. They are older than Joanne but she has always felt close to them. They all did well in school. They now live independently from the family and have settled jobs. They stay in touch, visiting when they can and for family events. Joanne has lived a relatively sheltered life in that she has been used to being mostly in the company of adults.

Joanne has also done well in school previously. She attended regularly, was seen as a high achiever, who was expected to do well in her GCSEs. She had a group of friends who were also doing well. She is now in Year 10. Her parents have begun to notice a change in Joanne over the past few months. She is spending more time in her bedroom and she is very focused on her phone and on Facebook and Instagram. She is less keen to talk to her siblings and to join in with family events. While she previously always seemed to enjoy school, she has recently been tearful and reluctant to go to school. She has started to complain of having headaches and feeling sick. Her mum has taken her to the doctor, but there seems to be no obvious signs of illness. The GP has suggested that she may be suffering from anxiety.

Over the past month, Joanne has been going out and asking to stay out later than usual. On one occasion, she stayed out well past the agreed time for her return. On this occasion, Tim and Amanda were sure that they could smell alcohol on her. They asked her about this, but Joanne vehemently denied she had been drinking. Her parents began to worry about her. Amanda decided to find a good time to talk to Joanne. After some coaxing, Joanne eventually told her mum that she had fallen out with her friends at school. They were no longer speaking to her and including her in their group. They were saying unkind things about her on social media and she felt bullied by them. Joanne had dealt with this by finding new friends who live locally and spending time with them in town. She said she really likes them. They are a 'bit wild' but she enjoys their company and she thinks they are not 'bitchy' like her school friends. Some of the girls have boyfriends who have cars and who buy presents for all the girls and fund activities. Joanne says one young man likes her and she loves him. Joanne is indicating that this relationship is helping her to feel better about herself.

In the meantime, the school is becoming concerned about Joanne's poor attendance and the deterioration in her grades. The Head of Year invites Joanne's parents into school and suggests that they seek professional support by, in the first instance, completing a Common Assessment Framework (CAF) and setting up a Team Around the Child (TAC).

At the **educational** level, the school contacts the Educational Psychologist and asks if she can attend a Team around the Child meeting (TAC). They are worried about Joanne, who is now not attending school regularly and as a consequence, her grades in school are disappointing. The psychologist does not know Joanne. She knows the school well and has been working with the staff over years, when they have concerns about students. It is clear that these concerns about Joanne are relatively recent, but significant. The psychologist sees her role as to help the family and staff to share their concerns, to contribute to work with Joanne whereby she can be helped to trust and confide in someone, and work with family, school and professionals to help Joanne get back on track. She wants to help all concerned to be alert to the need to ensure Joanne is safe. To do this, she aims to view Joanne in the wider context of factors which may be affecting her currently.

At the **child** level, Joanne is a bright girl with good abilities to learn. She has a supportive family who love her and who want her to do well in school. She has demonstrated in the past that she can do well in school and that she could make and sustain friendships. Opinions vary about why Joanne is currently having these problems. Some staff see her behaviours as behaviours typical of those of a challenging adolescent, a phase that many go through. While other staff see her parents as pushy and expecting too much of Joanne, to the extent that she has wanted to opt out and find friends who accept her for what she is. The CAF referral is timely. The system of using a CAF and the TAC is intended to set up as early as possible, preventative positive interactions and joint working by professional networks with children, families and schools. The process recognises that concerns about children are more likely to be cumulative rather than one-off incidents, and also that better outcomes are achieved for children through early interventions. The psychologist is keen to attend the meeting and to use the discussions to plan thinking around making sense of Joanne's behaviours. She has a series of hypotheses about why Joanne is unhappy, one of which is that there may be Safeguarding factors with regard to her new found friends.

At a **family** level, whatever is done to support Joanne, needs to respect and include the family. Family factors will inform the assessment and need to be understood in terms of Joanne's risky behaviours but also the capacity of the family and Joanne to be resilient. Within the Framework for the Assessment of children in need and their families is the expectation that professionals will assess parenting capacity. This includes: basic care; emotional warmth; stability; stimulation; guidance and boundaries; and ensuring safety. The psychologist is mindful that the needs of Joanne and the needs of her family may not be the same. She works to ensure that separate professionals who have appropriate skills and experience work separately, but together, with Joanne and the family. The family may need help to include extended family members. Joanne's older siblings are a resource in terms of their previous closeness to Joanne.

At a **local authority** level, findings from key reports need to be adhered to. School is key to any assessment and plan for support. A priority is to reinstate Joanne's regular attendance at school. Being in school on a regular daily basis is a protective factor for children, as many Serious Case Reviews highlight. The findings of the Laming Enquiry following the death of Victoria Climbie led on to changes in legislation whereby Safeguarding Boards were established across the country to ensure that there is a network of agencies working effectively together to protect children. Schools are in the foreground of such networks. There are statutory expectations of organisations like schools, to ensure that adults working within education are aware of safeguarding issues and are led by someone who is designated within the organisation to influence policy and practice (see Keeping Children Safe in Education.[129] The Designated Safeguarding Lead can be used to ensure that staff who know Joanne are included in an assessment of her difficulties and in understanding what went wrong with her peer group relationships, and whether this sheds light on what has happened since.

At a **peer** level, Joanne had friends, and she has since fallen out with them. Peer factors are likely to be an issue for Joanne's situation. She is an adolescent and as such, her peer group relationships will have assumed greater importance than when she was younger and more family orientated. Whether the falling out was a cause or a consequence of Joanne's difficulties needs careful thought. The professional network needs to include

what information it has about students' use of social media and the school's policy about bullying/cyberbullying. The professional network might need to draw in professionals who know about patterns of bullying in the school and the area, such as the school's police liaison officer. The police may have a very different perspective of troubles between students and whether there are wider influences in the local community, with regard to the exploitation of young people.

At a **community and social** level, there are factors that increase or decrease risk for children and young people. The Framework for the Assessment of children in need and their families reminds all professionals to include the community factors in understanding resilience and risk. These might include: poverty and unemployment; social isolation; shifting communities; violent communities; patterns of juvenile crime; spikes in figures for alcohol, drug and substance misuse; and incidence of self-harm/suicide. Being aware that young people may not always recognise the violence, coercion and intimidation of sexual exploitation, particularly in the grooming stage, is key. Grooming techniques used to gain a child's attention, admiration and affection can tap into existing insecurities and a desire for acceptance. Joanne's low self-esteem consequent on falling out with her friends, their subsequent unkindness and her poor grades in school, would have left her very vulnerable to exploitation.

At a **professional** level, there are factors that influence practice and decision making. The local authority, through the good offices of the Local Safeguarding Board, will have requirements with regard to the induction of new staff, policies and practice with regard to safeguarding children and young people; training for the workforce; and safer recruitment practices. The quality of this work can do much to ensure that professionals are aware of their legal responsibilities to identify abuse and promote the development and wellbeing of all children. The psychologist will be aware of this and careful to maintain her continuing professional development vis a vis safeguarding. The LSCB website will have details of a range of courses, particularly including sexual exploitation. There are LSCB screening tools which can inform the work of the psychologist in the network. The importance for the psychologist of the support of employing bodies and professional associations cannot be overstated with regard to: caseload weighting; record keeping; supervision; access to consultancy and an ongoing professional support.

The extent to which the organisation of services for children in the local authority is successful in decreasing the vulnerabilities in the child population is often highlighted in inquiries. There can be systemic problems which increase risk such as: poor uptake of early requests for assessments of concerns about children; high levels of decisions for no further action/repeat referrals; instances of borderline cases slipping through the net; duplication of processes across agencies; poor decision making among professionals based on insufficient, inaccurate and untimely information. Multi Agency Safeguarding Hubs (MASH) have been designed and established to combat such systemic problems. They are a multi-agency team, which co-locates safeguarding agencies and their data. The aim is to identify risks to vulnerable children and adults, at the earliest possible stage. They are set up to work to shared objectives and to use pooled resources. The MASH is in a position to act in a more co-ordinated and consistent way to ensure children, young people and adults, are kept safe. Concerns that don't reach thresholds for action can be signposted to specific early help services, ensuring they receive appropriate support and possibly

ongoing monitoring of concerns. The CAF/TAC set up given the school concerns about Joanne, would be a focus for discussions about safeguarding matters. It would be a forum for decision making about whether to refer Joanne's difficulties and the feature of her new found peer group's involvement with local young men with cars and money, to the MASH. It may be the shared data of the police and social and health care professionals will inform the thinking of the network around Joanne, her family and school.

Psychologists can consider:

- The formulation of a presenting problem and advise about how best to assess the safety and wellbeing of a child about whom there are concerns.
- Using skills and experience to support school staff to provide information about the strengths and difficulties of a child.
- Being an active agent in the professional network to clarify when more evidence of risk is needed and potential sources of support to secure necessary information.
- Advising on how the family and school system can be involved to monitor, protect and promote wellbeing.

It is through formulation, joint working, informed practice, and good supervision, that the psychologist can contribute to: better recognition of when children are at risk of neglect, abuse and exploitation; the prevention of impairment and the promotion of wellbeing.

Scenario 4 – Offenders

Thomas is 50-year-old male. He is quite isolated, is unfamiliar in the area and has little support. He struggles to have functional relationships with others and is over reliant upon alcohol as a way of coping. He has intermittent contact with his mother with who he has a fractured relationship. He was released from prison six months ago after serving a 12-year sentence for attempted murder on his friend. He also has various convictions for domestic violence towards ex-partners, including the mother of his two children who are 11 and 12 years old, who were exposed to the violence and emotional abuse. He has a restraining order, restricting him contacting their mother. He has not had any contact with his children since he has been released but is distressed by this. His mental health can deteriorate at times due to his sadness and the overwhelming feelings he has about this loss. He is not very able to understand, contain or verbalise his emotions well and has significant personality difficulties. He is on probation licence on an Indeterminate Public Protection Order and can therefore be returned back to prison should he breach the conditions of his licence. He has been complying with his licence conditions and appears to be maintaining a positive relationship with his probation officer. The probation officer has sought assistance in managing the work from the Psychologically Informed Consultation Service (PICS) which is a time limited consultation service to assist with developing a psychological formulation and identifying strategies for intervention and in developing an alliance.

He has recently been diagnosed with a terminal illness. Although there is no certainty regarding his life expectancy, in speaking with the nurse involved in his care, it is clear that he is dying. His health has deteriorated significantly in the past few weeks. In his last contact he has broached the subject about wanting contact with his children.

In thinking about this case it is important to consider the needs and rights of the child. In applying the model to help think through the issues in this example:

At a **government** level, policies have been introduced that recognise the importance of improving relational approaches to working with service users and the development and implementation of the Offender Personality Disorder Strategy is an example of this. Within society there is stigma and prejudice surrounding people who have seriously offended, with fundamental question regarding how deserving they are of having any rights as a consequence of their past actions, which infiltrates into the criminal justice system.

The government policies impact at **organisational** level, as there is a shift to think more psychologically, to support staff to work with service users who have struggled to engage meaningfully with probation and often breached their licence conditions previously. There is a strength in the alliance between the probation officer and psychologist. However there is a risk as social services are not engaged with the family and have stated that they will not re-open the case. Will the risks of the child and service user be held in mind by the organisation that is acting on behalf of the service user?

At a **professional** level, there is a working alliance with the service user. There are no identified professionals working with the children. In order to sensitively manage this situation, who would need to be contacted? There is a victim liaison officer who has had no recent involvement with the mother of the children. There are risks of avoiding this issue

due to the fact it is too difficult, unfamiliar and overwhelming. In doing so, there may be insufficient time remaining for the children to be supported to receive information about their father and make an informed choice about having any indirect/direct contact with him.

Psychologists can consider

- Where are the identified risks and safeguarding issues in this case?
- What are the strengths in the system, and where are they located?
- Where are the areas for potential growth?
- What would an overview of all these factors suggest about where, how and who, psychologists could involve in taking this forward?

Scenario 5 – Research perspective

James is 15 years old and is currently serving a short sentence in a Young Offenders Institution (YOI) for anti-social behaviour and juvenile delinquency. James has had a youth worker named Mark for two years, who has been helping him to manage his behavioural difficulties. James trusts Mark, and continues to meet with him on a regular basis whilst based at the YOI. Mark has told James about a qualitative research study exploring the effectiveness of a treatment programme to reduce reoffending and encourages him to take part. During the study James discloses to the female research psychologist that the reason he engages in delinquent behaviour is because his father, whilst not physically violent, neglects and emotionally abuses him. His father has turned to alcohol to cope following the death of James' mother when he was 11. James states that he tried to disclose his neglect previously to a female teacher, who was unsympathetic and down-played his concerns. Although he trusts Mark, he has not confided in him as he feels ashamed and embarrassed.

Since being in the YOI James has had suicidal thoughts. He wants to better himself but has low self-esteem due to the emotional abuse from his father and feels helpless. The research psychologist suggested that James may benefit from seeing a clinical psychologist to get some help with his internalizing behaviours. Neither the research psychologist nor the clinical psychologist is sure whether to report James' home situation to child protective services.

At the **government** level, there are practice guidelines on how to safeguard young offenders.[125,130] All psychologists should make themselves aware of these guidelines when working with young offenders. There is evidence to suggest that the juvenile justice system may not consider maltreatment in adolescents, failing to address their underlying needs[131] and even evidence to suggest that maltreated adolescents may receive tougher punishments than non-maltreated adolescents for delinquency.[132] Psychologists should consider whether any young offenders they are working with may have been maltreated, and work with other agencies in order to ensure they receive the appropriate help and support. James himself has directly attributed his behaviour to the neglect and emotional abuse he is subjected to from his father, and has also expressed a willingness to change.

At the **organisational** level, there is involvement from the youth justice system, the youth worker, the research and clinical psychologist and the school. The youth worker and psychologists are in a position to challenge the values and ethics of the justice system and enable James to address the issues underlying his offending behaviours. The youth worker could also potentially help James with reintegration into the school environment and help him to reach out to his teachers for more support. Some consideration could be given to whether James should have a female or male psychologist, given his tendency to try to disclose to females in the past but unwillingness to confide in Mark despite having a good relationship with him.

At a **professional** level, the clinical psychologist has the skills, knowledge and experience to help James with his suicidal thoughts and low self-esteem. Recognising that James' behaviour is due to his maltreatment may be paramount to his recovery and will help him to stop offending. Each of the professionals also has a responsibility to report

James' maltreatment to child protective services. Any form of maltreatment in a child of any age should be taken seriously. Evidence suggests that neglect may be as damaging for adolescents as it is for younger children.[131] One study found that maltreatment in adolescence had a greater and more enduring impact on later adjustment than maltreatment in younger children.[133] Neglect during adolescence also affects brain development.[134] Psychologists should also be aware of other potential risk factors that may or may not be related to underlying maltreatment in this age group, such as substance abuse and teen dating violence. In addition, they should signpost James to Al-Anon, a group offering a programme of recovery for the friends and families of alcoholics.

At the level of **social and community** factors, psychologists should consider the impact that James' offending has had on his local community and how they may react to his release. Mark may be able to help James to reintegrate into society effectively and to show his community that he is willing to change.

At the level of **peers,** James has managed to isolate many of his peers in school due to his challenging behaviours, and has ended up getting in with the wrong crowd who are older than him and exploit him. He feels he does not want any friends his own age as he has had to grow up quicker than most children his age to look after himself, and he relies on Mark for friendship and support. Psychologists could think about the ways in which James can untangle himself from his peers that encourage his criminal behaviour and to find new friends who can offer him support and true friendship.

At the level of **school,** James attempted to disclose his abuse to a teacher but the teacher was unsympathetic and disbelieving, due to his previous disruptive behaviour in class. This may have led to him losing trust in the education system.

At the level of **parenting,** James' father is emotionally abusive and neglectful and is also an alcoholic. Consideration will need to be given to any potential safeguarding concerns when James is released from custody as well as what interventions could be put in place to support his father at an individual level as well as a family when James is released.

Scenario 6 – Forced migration

Amal is a Syrian refugee She has two children, Hasna aged 11 years old and Nasim, 8 years old. They have lived in the UK for 12 months and have been granted refugee status. They were initially living as a family, but Amal's husband was physically abusive and left. She no longer has contact with him, and this has led to family disapproval with distancing from her relatives. Amal and her children are able to communicate relatively well in English, as they were from a middle-class, educated background, when they were living in Syria. However, their capacity to communicate in English is reduced when they are anxious.

They are living in a London borough, where there are marked differences between wealthy and low income families. She is living in a deprived part of the area, but there is high ethnic diversity and many families who help each other. The children have settled well at their respective schools, though Hasna has experienced some racist bullying in her year group.

Amal has clear symptoms of PTSD. She does not sleep well due to nightmares, and during the day, she is regularly fainting when she has flashbacks to war. Her children often find her; when Amal regains consciousness, she is often in a state of distress, and her children are upset by her symptoms, which involve their mum not appearing to recognise them for around 15 to 20 minutes at a time.

Amal is being seen by a specialist psychological therapies team after a referral from the GP, who has asked for help for Amal's symptoms of PTSD. The clinical psychologist makes contact with children's services to see if they can help, but Amal is then threatened with eviction by her private landlord because she hasn't paid any rent for three months. This overtakes any discussions about psychological care. It emerges that Amal stopped paying rent because lots of things were broken and the landlord would not fix them. She reveals that she has spent the housing benefit money on things to make house look nice. The landlord serves a notice of eviction with four weeks notice. Amal is very shocked; she did not appreciate that the landlord would evict her when he had failed to repair things in the property. There appear to be different cultural understandings here.

The psychological therapies team make contact with children's services again, and also involve the Housing Team. The Housing Team say they are not obliged to house the family, as they consider Amal to have made herself intentionally homeless. Housing recommend that the team talk to children's services. The psychological therapies team try to contact Children's Services over a three-week period, but no one returns the calls, and Amal's family are not recognised as being on the Children's Services system. A week prior to the eviction, the psychological therapies team become very concerned about impact on Amal and her children of the prospect of forced eviction, and the potential involvement of bailiffs. Her symptoms appear to have worsened with her fainting several times a day. Hasna is frightened to leave her mum alone, and is now not attending school regularly.

The day before eviction, a duty worker at Children's Services agrees that the family will be housed in temporary accommodation. They are placed in a local low cost hotel.

The psychologist feels that she needs to talk to Amal about why she spent money, as she is concerned that Amal's decision-making may be compromised and she wishes to check her Capacity.

Children's Services discuss the case with the psychological therapies team, and feel that they do not need to provide additional family support regarding the impact of Amal's PTSD and fainting, as they feel that the children are old enough to get help when she does faint.

This is a highly complex situation, and there are a number of potential questions that arise:

- What might be a helpful way to formulate the case?
- How might the psychologist proceed?
- Where are the identified risks and safeguarding issues in this case?
- What are the strengths in the system, and where are they located?
- Where are the areas for potential growth?
- What would an overview of all these factors suggest about where, how and who psychologists could involve in intervention?

A psychologist may consider different factors:

When psychologists are asked to do a piece of work, they are usually given a specific issue or 'problem', in this case, working with Amal's PTSD symptoms. Here, the agencies who are seeing Amal are the specialist psychological therapies team, the GP and Children's Services.

The family need to be seen in context; again beginning with the wider system until we come to the heart of safeguarding children.

At **government** level, there have been changes around the treatment of Syrian refugees since 2014, in the wake of public pressure, and Amal's family have been helped under the Syrian Vulnerable Person Resettlement Programme. There is an emphasis on the Local Authority helping to settle and integrate vulnerable families into the local community. There is more public recognition that children are particularly vulnerable in conflict situations and their aftermath. There are concerns expressed about the lack of funding into specialist mental health services and local authority cuts, though Parity of Esteem has been promised by 2020.

At a professional level, there are strengths within services, as there is a specialist team to help with the mental health needs of those who have suffered forced migration. The team's values and ethics are regulated by professional bodies, there is trauma informed practice and high value is placed on skills, knowledge and learning.

However, there are also risk points here, as the service user group holds little power in Society, and so the funding into the service is not afforded high priority. Local cutbacks across agencies mean that there is a high workload for staff, and this is leading to an increase in waiting lists, delays and staff stress and sickness. There has been a reduction of joined-up working as a way for agencies to manage the high volume of work, and there is a danger that this is leading to compromised thinking about individual families.

At the level of **community and social factors,** the local area is deprived but there are active local community groups who are helping each other. There is a strong Christian Church group and a strong Muslim community, There is also a small group of volunteers helping local refugee families. There is a local market, where people tend to meet each other. There is a risk that Amal's family may now be moved out of area due to pressure on local social housing and lack of affordable private accommodation.

At the level of **peers,** the local schools have a good ethnic mix and a good gender balance. Although there has been some racist bullying at secondary school, this seems to have been dealt with effectively by teachers.

At **school's level,** Mr Morgan is the Head at the local secondary school. The psychologist asks Amal how she thinks the children are getting on at school and whether there are any

difficulties there. Amal is concerned that Hasna is not going to school regularly and may be falling behind with her work. The psychologist decides to link with the school nurse, to get a broader overview about the situation. The nurse is able to link with the school team and is informed that there are problems with Hasna's attendance and that she is falling behind with her homework. The school takes pastoral care very seriously. They have a number of children at the school who have special needs or challenges at home. They value equality and diversity and also have effective bullying prevention strategies.

Mrs Joyner is the Head at the local primary school. She has been in touch with her local safeguarding team for advice, as she has noticed that Nasim's behaviour has changed recently. He seems withdrawn and worried and is spending time in the toilets at break. He is also looking dishevelled and sometimes smells of stale urine. She has asked to meet with Amal, to discuss this and enquire about how things are at home.

At the **parent/family level,** Amal is struggling with the aftermath of domestic abuse, the trauma of being caught up in war and the aftermath of subsequent forced displacement experiences. She has developed PTSD, and has been having regular fainting episodes. She is not eating well. She has been trying to buy nice things to make the previous flat look nicer and to try to make the children feel better about their surroundings. She feels guilty that she is not parenting well. Amal's family have not been supportive to her since her husband left, as there is stigma about divorce in her community. Amal feels embarrassed, upset and ashamed about this. She has not connected meaningfully with other local Muslim families as she is worried that she will be judged by them. She is worried about the children, as she wants them to continue with their education and to do well.

The **children** should be at the core of thinking. There are many influences upon Hasna and Nasim's lives. They have seen war and conflict, been displaced and had harrowing experiences as they migrated across to Europe. They were not welcomed by authorities in France, and were stuck at a camp there for two months before being able to travel to the UK and seek asylum. The children have witnessed domestic abuse and Hasna is very worried about her mum's health. She is increasingly taking a caring role for her mum. Nasim is also worried about his mum, and has started wetting the bed at night. Both Nasim and Hasna are very anxious about being rehoused in temporary accommodation, and are frightened that they are going to be taken away to a detention centre. They do not talk to their mum about their worries, because she already seems so fragile.

In thinking broadly about this case, we can see that the entire system is under stress due to cuts to budgets. There are a number of challenges here which could compound the problems already faced by this vulnerable family and which render the children at risk of poor social integration, poor educational outcomes and developing their own mental health problems.

There are key issues around socio-economic pressures, which are affecting all layers of the system. For the family, this means that there may be less income for food, heating and rent. Amal is having mental health issues which may compromise some of her decision-making abilities. Her feelings of guilt about her parenting and family circumstances, may have led her to spend money in an unwise way, rendering the family potentially homeless. The pressures on the children are impacting at school, as Hasna is taking on young carer responsibilities. Both children are worried about the future and are fearful of showing this to their Mum.

Amal is struggling with the impact of trauma leading to forced migration, domestic violence, relationship breakdown and feeling rejected by her family.

There are areas of resilience which emerge. For instance, at a governmental level there have been changes to policies following public pressure, and local service staff may wish to consider channelling any concerns that they have about service issues, through their professional bodies, trade unions or other campaigning organisations. This could help to draw attention to systems level issues. There may also be a need to draw attention to some of the issues around the treatment of local refugee families with local commissioners and councillors.

The specialist psychological team can help to formulate the case, and make suggestions about how the different professionals who know this family can communicate with each other regularly; help those who are not trained in mental health to be trauma-informed; make suggestions about what information may be important for the children to be given so they can better understand their mum's mental health issues.

Any sources of support at a familial, professional and community level can be mapped, and this may help to consider who else can support an intervention. It seems important to help Amal feel more confident to connect with the local community in gentle ways.

Intervention may involve ensuring that there is a team around the family; support with benefits and housing; trying to foster better social support; ensuring that the school are aware of the challenges that the children are facing at home, and have a named teacher or school counsellor who they can talk to. For Amal, when there is more stability in her everyday living situation and her basic needs are met, she may be more able to focus on therapy for trauma symptoms.

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The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel: 0116 254 9568 Fax 0116 247 0787 E-mail: mail@bps.org.uk
Website: www.bps.org.uk

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