Safeguarding Adults and Children in Therapeutic Practice: Law, Recognition and Response

THE TALKING THERAPIES UK PRACTITIONER SERIES

Safeguarding Adults and Children in Therapeutic Practice: Law, Recognition and Response

A premium, in-depth programme on safeguarding law, recognition, response and accountability for therapists, current to October 2026

Advanced level · 30 hours of continuing professional development

TALKING THERAPIES UK

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First edition, 2026.

This manual accompanies the Safeguarding Adults and Children in Therapeutic Practice: Law, Recognition and Response course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 4. This printing was set on 2 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

This premium programme is a comprehensive, practice-focused course on safeguarding children and adults for psychological therapists, counsellors, psychotherapists and allied practitioners working in the NHS, the voluntary sector, schools and independent practice in England, with notes throughout on the different framework in Wales. It is written for practitioners who hear, often before anyone else, what is happening in people's lives, and who must decide what to do with what they hear.

The course is current to October 2026. It teaches Working Together to Safeguard Children 2026, which replaced the 2023 edition in March 2026, and the information sharing duty in section 16LA of the Children Act 2004, which came into force on 30 September 2026. It explains the duty to report child sex offences in the Crime and Policing Act 2026 in detail and makes clear, wherever it is mentioned, that the duty is not yet in force. It covers the Care Act 2014 and its statutory guidance as updated in 2025, the Mental Capacity Act 2005 and the inherent jurisdiction, the Domestic Abuse Act 2021, the FGM reporting duty, the Prevent duty, modern slavery and forced marriage law, and the professional standards of BACP, UKCP and the HCPC, including the date from which the new BACP Ethical Framework becomes mandatory.

Across six modules and thirty lessons you will study the legal and ethical foundations of safeguarding; the recognition of abuse, neglect and exploitation of children and adults, including domestic abuse, coercive control, self-neglect and online harm; receiving disclosures, judging thresholds, making referrals and keeping defensible records; specific harms such as radicalisation, trafficking, forced marriage, so-called honour-based abuse, technology-facilitated abuse, harm in families and abuse by professionals; Making Safeguarding Personal, capacity and coercion, children's voices and Gillick competence, trauma-informed and anti-racist practice, and work with people who may pose a risk; and learning from reviews, professional curiosity, supervision, vicarious trauma and integrated case consultation.

Every lesson contains a worked clinical example, the common pitfalls in practice and a reflective question, together with key points, a practice task for the week, study activities and further reading. The course includes an extended case study, a glossary and a 25-question assessment with a pass mark of 80 per cent. Every reference has been checked against its publisher, legislation.gov.uk, the National Archives or the issuing body.

The course is clear throughout about what the law requires of whom, and about the therapist's own role and its limits. It does not replace your employer's mandatory training or your local safeguarding procedures, and it asks you at each stage to check the current position, because safeguarding law and guidance continue to change.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 30 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Explain the statutory frameworks for safeguarding children and adults in England, the main differences in Wales, and the professional and ethical duties of therapists.
- Recognise the categories and indicators of abuse, neglect and

exploitation of children and adults, including domestic abuse, coercive control, self-neglect and online harm.

- Receive disclosures in ways that support the person and protect any later investigation, and record them accurately in the person's own words.
- Judge thresholds for children and adults, make clear and specific referrals, and use escalation procedures when a response seems inadequate.
- State accurately which reporting and information sharing duties apply to you, including the FGM duty, the section 16LA information sharing duty and the pending duty to report child sex offences.
- Respond proportionately to radicalisation, modern slavery, forced marriage, so-called honour-based abuse, technology-facilitated abuse, harm in families and allegations against professionals.
- Apply Making Safeguarding Personal, the Mental Capacity Act 2005 and the inherent jurisdiction to adults with and without capacity.
- Hear children's voices, assess Gillick competence and explain confidentiality and its limits to children and young people of different ages.
- Practise in ways that are trauma-informed, anti-racist and inclusive, and work safely with people who may pose a risk to others.
- Use learning from reviews, professional curiosity, supervision and attention to your own wellbeing to make defensible decisions under uncertainty.

PART 1

Foundations: law, principles and the therapist's position

What safeguarding means for children and adults, the statutory frameworks in England and Wales, the professional and ethical duties of therapists, and how safeguarding works across very different practice settings.

CHAPTER 1

What safeguarding means: definitions, values and the evidence on harm

Most safeguarding concerns in therapy do not arrive as formal disclosures. They arrive sideways: a remark about a neighbour's child, a joke about a grandmother's bruises, a complaint about the son who now "looks after" his mother's bank card, a memory of a childhood in which the person who caused the harm still lives a few streets away. This lesson asks what safeguarding obliges a therapist to notice, and why. It begins with definitions, because the law's distinctions decide what happens next, and ends with the evidence on how common and how damaging abuse and neglect are.

Safeguarding is the wider idea. For children it covers everything done to promote welfare and to prevent harm, from help offered early to a family under strain through to proceedings in the family court. Child protection is the narrower part of that work, concerned with children who are suffering, or are likely to suffer, significant harm; in England that is the point at which a local authority's duty to make enquiries under section 47 of the Children Act 1989 is engaged. Adult work has a similar shape with different vocabulary. Adult safeguarding includes prevention and the promotion of wellbeing, while its protective core is the enquiry duty in section 42 of the Care Act 2014. Therapists need both levels in view. A practitioner who thinks of safeguarding only as protection tends to act late, waiting for something that looks unmistakably like abuse. One who thinks of it only as general welfare may fail to recognise the moment at which a statutory duty has been engaged and a different response is required.

The statutory guidance for England, Working Together to Safeguard Children 2026 (UK Government, 2026), was published in March 2026 and replaced the 2023 edition. Its definition of safeguarding and promoting the welfare of children is deliberately broad. In paraphrase, it means providing help and support to meet children's needs as soon as problems emerge; protecting children from maltreatment, whether inside or outside the home and including online; preventing impairment of their mental and physical health

or development; ensuring that they grow up in circumstances consistent with safe and effective care; promoting their upbringing with their birth parents, or otherwise within their family network, wherever that is possible and in their best interests; and taking action so that all children can have the best outcomes. Two features of this definition matter for therapists. It starts with help rather than investigation, which fits the guidance's emphasis on Family Help, a model that combines targeted early help with support for children in need under section 17 of the Children Act 1989. And it reaches beyond the household: harm in the community, in peer groups and online sits inside the definition, not at its margins.

For adults, the Care Act 2014 does not offer a single definition of safeguarding, but it does define who is owed the enquiry duty. Under section 42 the duty arises where a local authority has reasonable cause to suspect that an adult in its area has needs for care and support, is experiencing or is at risk of abuse or neglect, and, as a result of those needs, is unable to protect themselves against it. Such a person is commonly described as an adult at risk. Each limb does real work. The care and support needs do not have to be ones the local authority is already meeting, but they must exist; the abuse or neglect may be actual or anticipated; and the inability to protect oneself must flow from the needs, not simply from difficult circumstances. The statutory guidance (DHSC, 2014) describes ten categories of abuse and neglect, ranging from physical and domestic abuse to modern slavery and self-neglect, and frames the work through six principles and through Making Safeguarding Personal, the person-led and outcomes-focused approach covered in lesson 1.3. The older phrase "vulnerable adult" survives in case law and some local policies, although critics argue that it locates the problem in the person rather than in the situation.

Behind the definitions sit values that govern how the law should be used. For children, the organising idea is that the system should be child-centred. Munro (2011) argued that procedure and compliance had crowded out direct attention to the child's experience and that professional judgement needed more room; her final report was subtitled A child-centred system. The United Nations Convention on the Rights of the Child (United Nations, 1989) adds a rights framing, including the child's right to express views on matters that affect them and to have those views taken seriously in line with their age and maturity. For adults, the counterweight to protection is autonomy. An adult with capacity is entitled to make decisions that others regard as unwise, and

adult safeguarding is meant to proceed with the person's involvement and, wherever possible, their agreement. These values sometimes pull against each other. The child-centred principle can justify acting against a parent's wishes; the person-led principle can require a practitioner to respect an adult's decision to stay in a harmful situation, provided that no one else is at risk and the decision is genuinely the person's own rather than the product of coercion. Lesson 5.1 works through that conflict in a specific case, where an adult refuses a referral and grandchildren visit the home.

How common is the harm in question? Prevalence figures in this field are estimates, sensitive to the definitions and methods used, and they should be quoted with care. The NSPCC study by Radford et al. (2011) surveyed parents of younger children, young people and young adults across the UK, and estimated that around one in four young adults aged 18 to 24 reported having experienced severe maltreatment during childhood. That is an estimate from a single study, based on self-report and on the study's own definition of severity. It is nonetheless a large figure, with a direct implication for practice: in any adult caseload, a substantial proportion of clients will carry histories of maltreatment whether or not they present with them, and some will remain in contact with the people who harmed them, sometimes in families where there are children now.

The evidence on impact is dominated by the Adverse Childhood Experiences study. Felitti et al. (1998) asked adults attending a health appraisal in a large United States health plan about seven categories of childhood abuse and household dysfunction, and found a graded relationship between the number of categories a person reported and their likelihood of health risk behaviours and of several of the leading causes of adult death. Its central finding, a dose-response relationship between adversity and later ill health, has been influential far beyond the original sample. It is also widely misused. An ACE score is a count of categories; it records nothing about severity, duration, protective relationships or what the experience meant to the child. It was derived from insured adults recalling childhood retrospectively, and it describes risk across populations rather than the future of any individual. Used as a screening tool or a label, it can lead practitioners to treat clients as defined by their histories, or to overlook adversities the original list did not include, such as racism, bullying and violence in the community.

Some groups of children face greater risk than others, and disabled children

are among the clearest examples in the research. In a systematic review and meta-analysis of observational studies, Jones et al. (2012) found that disabled children were at substantially higher risk of violence than their non-disabled peers. A meta-analysis is only as strong as the studies it pools, and these used varying definitions of both disability and violence, but the direction of the finding fits mechanisms that practitioners will recognise: communication differences that make telling harder, dependence on others for intimate care, social isolation, and a tendency for professionals to attribute signs of harm to the impairment rather than to what is being done to the child. Those mechanisms do not end at 18, which is why the same alertness is needed in work with disabled adults.

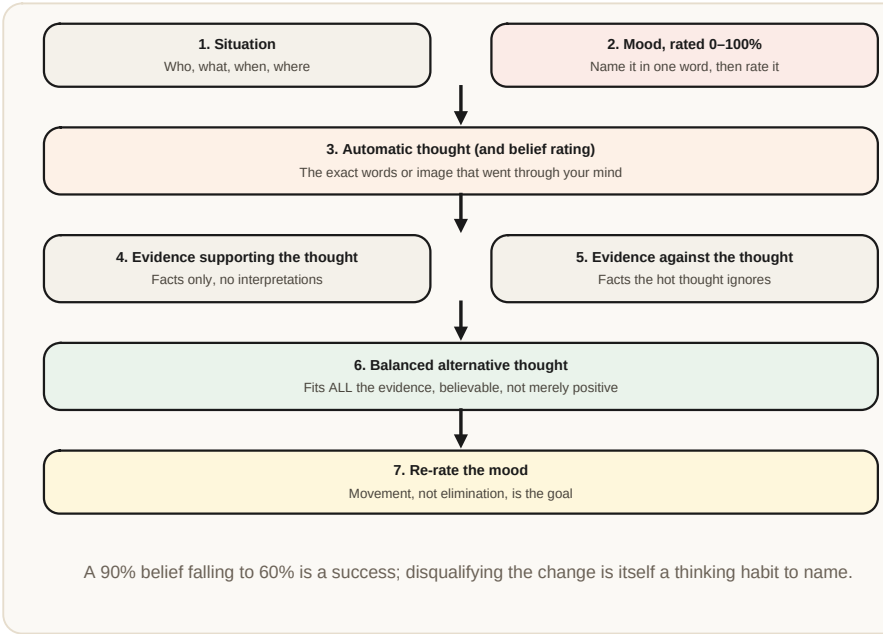


FIGURE 1.1 Working through a thought record

The classic seven-column thought record as a sequence: capture the situation and mood, catch the automatic thought, weigh the evidence on both sides, build a balanced alternative, and re-rate the mood. The learning is in the discipline of evidence before reassurance.

Therapists hold a distinctive position in all of this. They see people regularly and for long periods, in private, with an explicit agreement about confidentiality and an invitation to talk about exactly the material that other services rarely reach: family relationships, shame, fear, sexuality, memory and secrets kept for years. That is why disclosures happen in therapy that

have happened nowhere else, and why therapists so often hear about people who are not their clients. An adult client describes how her partner treats the children; a grandfather mentions his son-in-law's temper; a man recalls the family friend who abused him and who still babysits for relatives. The therapist may be the only professional who knows. The inquiry into the death of Victoria Climbié (Laming, 2003) is remembered for showing how many agencies each held part of a picture that nobody put together. A therapist who keeps such information inside the consulting room repeats that pattern, however sound the reasons for doing so feel at the time.

The tension follows directly. Confidentiality is a condition of the work: without it many clients would never speak. Yet confidentiality in therapy has never been absolute, and each of the professional codes that govern most learners on this course recognises circumstances in which it gives way to the protection of the client or of others (BACP, 2018; UKCP, 2019; HCPC, 2024). The common error is to treat the tension as a contest between two goods in which one must lose. In practice it is managed rather than resolved: by being clear at the outset about the limits of confidentiality, by sharing only what is necessary and proportionate, by involving the client in decisions wherever that is safe, and by recognising that protecting a child or an adult at risk can itself be therapeutic for a client who has carried knowledge they could not act on. Lesson 1.4 deals with the law of confidence and information sharing in detail.

A critical reader should notice what this evidence does and does not show. Prevalence studies depend on disclosure, and disclosure is shaped by fear, loyalty, language and the person's own understanding of what happened to them; the true figures are probably higher for some groups and are poorly measured for others, including disabled adults and people living in institutional care. Studies of impact are largely correlational and retrospective, which makes causal claims about any individual unsafe. The concept of safeguarding has its own critics. When it expands to cover every risk to wellbeing, referrals multiply, thresholds harden in response, and the families who most need help can experience the system as surveillance rather than support. The definitions in Working Together 2026 and in the Care Act guidance try to hold prevention and protection together; how far they succeed depends on local resources and on the quality of professional judgement at the moment a concern is first raised, which in many cases happens in a therapy session.

Worked clinical example. Callum Reid is a CBT therapist in an NHS adult psychological therapies service. His client, Danielle Okafor, is 38 and in her sixth session of treatment for panic disorder. While they review her sleep diary she says she has been sleeping badly because the little boy next door cries for hours at night, and adds, half joking, that his mother is “never in” and that she once saw him out on the shared walkway in just a nappy on a cold evening. Callum registers the remark, judges it to be off the agenda and returns to the panic formulation. An hour later, writing his notes, he stops at that sentence. His reasoning from that point is worth following. The child is not his client and the account is second-hand, but it is specific: prolonged crying most nights, a toddler outside without supervision in cold weather, and a parent described as absent. None of this proves neglect, and Callum cannot know what lies behind it. That is not the question he has to answer. His question is whether a child may be at risk of harm and whether the people whose job it is to assess that risk know about it. He cannot tell, and Danielle’s comment that the whole block can hear the boy does not mean that anyone has said anything.

Callum’s service policy asks staff to discuss concerns about children with the duty safeguarding lead, and he does so that afternoon. They agree that the information should go to the local authority’s children’s services front door, and that Callum should first speak to Danielle, because she is the source and may know more, and because the therapeutic relationship will matter in what follows. He telephones her, explains why he is calling, and asks a few open questions about what she has seen and heard and when, taking care not to suggest answers. She says the crying happens most nights, that she has seen the boy outside twice in the past week, and that she thinks he is about two. She is worried about being identified. Callum explains that she can ask for her details to be withheld from the family, although that cannot be guaranteed in every circumstance, and that what is being shared concerns a child next door, not the content of her therapy. Danielle agrees to the referral and to her name being given. Callum makes it by telephone and confirms it on the local authority’s online form, giving the address, what Danielle reported in her own words, the dates and the fact that the information is second-hand. His record notes the original remark, his initial decision to move on and why he revisited it, the consultation and its outcome, the call with Danielle, the referral and its reference number, and a plan to review at the next session how the episode has affected her. At that

session Danielle says she felt relieved: she had been lying awake wondering whether she ought to do something herself.

Common pitfalls. The first is to treat safeguarding as concerning only the client. Risks to third parties, especially children in the client's household or street and older or disabled relatives who depend on them, are as much the therapist's business as risks to the client, and a brief routine question at assessment about who else lives with or depends on the client makes them harder to miss. The second is waiting for certainty. Therapists sometimes hold back until they are sure that abuse is happening, but the trigger for sharing a concern is a genuine worry about a person's safety or welfare, not proof; establishing what happened is the task of the statutory agencies and, ultimately, the courts. The third is assuming that someone else has already acted. Neighbours, teachers and health visitors may all have noticed the same child and each concluded that another person would make the call, so a short call to check costs little compared with that assumption proving wrong. The fourth is misusing the evidence on harm, either by treating an ACE count as a prediction about an individual client, or by assuming that a client with no history of maltreatment cannot be harming, or failing to protect, someone else. Use population findings to decide what to ask about at assessment, and base any judgement about a particular person on what they and others actually report.

Reflective question. Think of a session in the last few months in which a client mentioned, in passing, a child or an adult who was not your client and whose circumstances gave you a moment's unease. What did you do with that moment, what made it easier to move on than to return to it, and what would need to change in how you structure sessions or write notes for such remarks to be caught reliably rather than by chance?

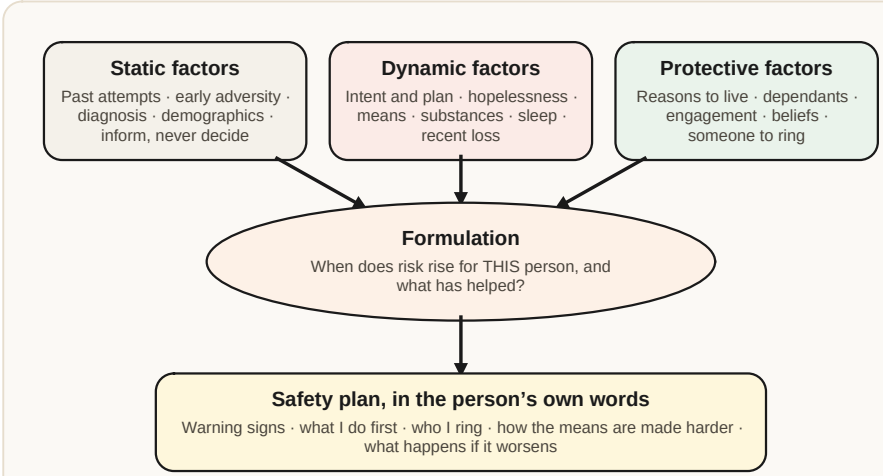


FIGURE 1.2 From risk assessment to risk formulation

A defensible approach to risk does not predict, it formulates: it separates the factors that cannot change from those that can, names what protects, and converts the picture into a plan somebody could actually follow at three in the morning. A checklist score recorded without a formulation and a plan is a record of an assessment, not the management of a risk.

Points worth keeping

- Safeguarding is the wider work of promoting welfare and preventing harm, while child and adult protection are its narrower statutory core under section 47 and section 42.
- Working Together to Safeguard Children 2026, published in March 2026, defines safeguarding broadly, beginning with early help and including harm outside the home and online.
- Section 42 of the Care Act 2014 concerns adults with care and support needs experiencing or at risk of abuse or neglect who, because of those needs, cannot protect themselves.
- Radford et al. (2011) estimated that around one in four young adults aged 18 to 24 reported severe maltreatment in childhood, an estimate from a single UK study.
- The ACE study found a graded relationship between childhood adversity and adult ill health across populations, but an ACE count cannot predict

an individual client's future.

- Jones et al. (2012) found disabled children at substantially higher risk of violence than non-disabled peers, and the mechanisms involved continue into adulthood.
- Therapists often hear about children and adults who are not their clients, and may be the only professional who knows of a risk to them.
- Confidentiality is a condition of therapy but has never been absolute, and the BACP, UKCP and HCPC codes all recognise circumstances in which it gives way.

PRACTICE TASK

This week: Choose ten recent session records from your own caseload and read them looking only for references to people other than the client: children in the household, grandchildren, neighbours, partners and their children, and older or disabled relatives. For each reference, note whether anything in the record suggests a possible risk to that person and, if it does, whether you followed it up and recorded what you did and why. Where you find a gap that still matters, discuss it with your supervisor or safeguarding lead before the week is out. Finally, draft two sentences you could add to your assessment template to prompt a brief check on who else lives with, or depends on, each client.

Study activities: The first is a reflective-practice activity whose purpose is to examine your own threshold for noticing. Write a short account of a time when you heard something in therapy that later seemed more significant than it did at the time. Describe what you noticed, what you told yourself in the moment, and what helped or hindered a return to it, then name one change in your practice that follows from the account. Allow 25 minutes. The second is a skills-practice activity whose purpose is to rehearse returning to a passing remark without leading. Using the worked example in this lesson, script the opening of the telephone call Callum made to Danielle: how he explains the reason for the call, the open questions he asks, and how he describes what happens next and the limits of anonymity. Read the script aloud, then revise any question that suggests its own answer. Allow 25 minutes.

Further reading:

Working Together to Safeguard Children 2026: statutory guidance (UK Government, 2026)

Radford et al. (2011) Child abuse and neglect in the UK today. London: NSPCC.

Felitti et al. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4).

Jones et al. (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. The Lancet, 380(9845).

CHAPTER 2

The legal framework for children

A therapist who telephones a children's services front door sets in motion a process governed by a statute more than thirty-five years old, by statutory guidance revised in March 2026 and, in time, by a new Act whose main provisions are not yet in force. Therapists do not make the legal decisions in that process, but they shape them: the facts they report, and the way they report them, influence which pathway a child's case takes. Knowing the framework allows a therapist to anticipate what is likely to happen to a referral and to explain it honestly to a child or parent who wants to know what comes next.

The Children Act 1989 remains the core statute. It separates support from compulsion, and most of what therapists encounter sits on the support side. Section 17 places a general duty on each local authority to safeguard and promote the welfare of children in need in its area and, so far as is consistent with that duty, to promote their upbringing by their families, by providing services appropriate to their needs. A child is in need, broadly, where without such services they are unlikely to achieve or maintain a reasonable standard of health or development, or their health or development is likely to be significantly impaired, or where they are disabled. Section 17 support is voluntary: a family can decline it, and the local authority cannot impose it without moving to a different legal footing. Section 20 provides for the local authority to accommodate a child in need who appears to require it, for example because no one has parental responsibility for the child or because the person caring for the child is prevented from providing suitable accommodation. Accommodation under section 20 is not a care order. It cannot be provided where a person with parental responsibility who is willing and able to provide or arrange accommodation objects, such a person can ordinarily remove the child at any time, and the courts have criticised arrangements in which a parent's agreement was neither informed nor freely given.

Section 47 is the gateway to child protection. Where a local authority has reasonable cause to suspect that a child who lives, or is found, in its area is suffering, or is likely to suffer, significant harm, it must make the enquiries it

considers necessary to decide whether to take action to safeguard or promote the child's welfare. The test is suspicion on reasonable grounds, not proof, and it looks forward as well as back: likely future harm is enough. The local authority leads the enquiry; other agencies contribute information and professional assessment, and a therapist may be asked to join a strategy discussion or to provide a report. Two emergency powers sit alongside. Under section 44 a court may make an emergency protection order, a short-term order enabling a child to be removed to, or kept in, safe accommodation where there is reasonable cause to believe the child would otherwise be likely to suffer significant harm. Under section 46 a police officer with reasonable cause to believe that a child would otherwise be likely to suffer significant harm may take the child into police protection for a short period without a court order. Therapists do not invoke these powers, but an emergency call to the police may lead to their use, and clients who have lived through them often describe them simply as the day their children were taken.

Section 31 sets the threshold for care and supervision orders. The court may make an order only if satisfied that the child is suffering, or is likely to suffer, significant harm, and that the harm or likelihood of harm is attributable either to the care given, or likely to be given, not being what it would be reasonable to expect a parent to give, or to the child being beyond parental control. Harm means ill-treatment or the impairment of health or development, and since an amendment in 2002 it expressly includes impairment suffered from seeing or hearing the ill-treatment of another (section 31(9)). That amendment matters to therapists working with adults who live with domestic abuse, because the children in those households are not bystanders in law; the Domestic Abuse Act 2021 later went further and recognised such children as victims in their own right, as lesson 2.4 explains. The Act does not define "significant". Where the question turns on a child's health or development, it is compared with what could reasonably be expected of a similar child; beyond that, significance is a matter for professional judgement and, in proceedings, for the court, taking account of the nature, severity, duration and impact of the harm. Crossing the threshold does not itself justify an order. The court must then decide what the child's welfare requires and whether the order sought is proportionate, and in Re B (A Child) (Care Proceedings: Threshold Criteria) [2013] UKSC 33 the Supreme Court emphasised that a care order with a plan for adoption is a

last resort, appropriate only where “nothing else will do”.

The standard of proof in care proceedings was settled in Re B (Children) (Care Proceedings: Standard of Proof) [2008] UKHL 35: it is the simple balance of probabilities. The seriousness of an allegation does not raise the standard, and a fact in issue is treated as either proved or not proved. Two practical points follow for therapists. First, the court’s standard is not the therapist’s standard for acting. A therapist shares a concern long before anyone could prove anything, and section 47 itself turns on reasonable cause to suspect. Second, what a therapist records may later become part of the evidence on which a court decides whether something happened. Accurate notes, with the client’s own words where they matter and a clear separation of observation from interpretation, serve the child better than a confident summary; lesson 3.5 deals with records in detail.

Two later statutes organise the system around the child. Section 11 of the Children Act 2004 requires specified bodies, including NHS bodies and local authorities, to make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children, and that services provided on their behalf by others are provided in the same way. An independent therapist is not a specified body, but one who works under contract to such a body will usually find the duty reflected in the contract. The Children and Social Work Act 2017 replaced local safeguarding children boards with arrangements led by three statutory safeguarding partners: the local authority, the integrated care board and the chief officer of police. The partners decide which other agencies, such as schools and voluntary organisations, are part of their arrangements, and they arrange local child safeguarding practice reviews where serious cases raise issues of importance for their area. The same Act created the national Child Safeguarding Practice Review Panel, which oversees the review system and examines cases of national importance.

Working Together to Safeguard Children 2026 (UK Government, 2026), published on 18 March 2026, is the statutory guidance through which these duties are put into practice in England, and it replaced the 2023 edition. Several of its changes matter to therapists. It strengthens expectations that practitioners identify and challenge racism and discrimination. It gives specific attention to babies, including concerns that arise before birth, to the impact of domestic abuse on children, to children experiencing several

harms at once, and to the connection between harm online and harm in person. It brings targeted early help and section 17 support together as Family Help, and it brings children in care more firmly within multi-agency safeguarding arrangements. It expects information sharing that is clear, lawful, proactive and timely, and it tightens the deadline for notifying serious child safeguarding incidents, which must now be notified even where a child's identity is unknown. Later lessons take up each of these themes. The practical point here is that local procedures should already reflect the 2026 edition, and a procedure that still cites the 2023 guidance needs checking with whoever owns it.

The Children's Wellbeing and Schools Act 2026 received Royal Assent in April 2026, and its commencement is phased. One part is already in force: section 4 inserted section 16LA into the Children Act 2004, creating a statutory duty on relevant persons, including local authorities, NHS trusts, integrated care boards, primary care practitioners, the police, education and early years providers and youth justice services, to share information that may be relevant to safeguarding or promoting the welfare of a child. That duty came into force on 30 September 2026, with statutory guidance from the Department for Education (Department for Education, 2026), and where it applies, consent is not required. The other provisions described here are not yet in force. Section 3 will require multi-agency child protection teams in every local authority area; section 4 also provides for a consistent identifier for children across agencies, which has not yet been introduced; section 13 will create a statutory route for using accommodation to deprive children of their liberty, by amending section 25 of the Children Act 1989; and sections 37 to 40 will establish registers of children not in school. The multi-agency teams follow the national review into the murders of Arthur Labinjo-Hughes and Star Hobson (Child Safeguarding Practice Review Panel, 2022), which recommended multi-agency child protection units. Until these provisions are commenced, therapists should work to their existing local arrangements and check the current position on legislation.gov.uk, rather than assume that the new teams or identifiers already exist in their area.

Practitioners in Wales work within a different statutory scheme. The Social Services and Well-being (Wales) Act 2014, in sections 126 to 130, creates adult protection duties and places a duty on relevant partners to report adults and children at risk to the local authority, and the Wales Safeguarding Procedures set out how concerns are handled. Working Together is

guidance for England. Therapists who see clients across the border, or online, need to know which framework governs the child concerned, which in practice means knowing where the child lives. Scotland and Northern Ireland have their own legislation.

The framework is coherent on paper, and in practice it has well-documented difficulties. Thresholds between support and protection are applied differently from one area to another, so families with similar needs can meet quite different responses. Munro (2011) argued that a culture of procedural compliance had displaced the professional judgement that children's circumstances require, and the local authority's dual role, as both helper and investigator, remains hard for families to understand and easy for them to fear. The national review into the deaths of Arthur and Star found that information held by different agencies was not brought together and acted on, a finding that echoes decades of earlier reviews. There are also long-standing concerns about disproportionality, which the 2026 guidance's emphasis on racism and discrimination acknowledges. None of this weakens a therapist's duty to share a concern. It does mean that a referral should be precise, should state what the therapist is worried about and why, and should be followed up rather than treated as the end of the therapist's involvement.

Worked clinical example. Hannah Price is a counsellor in a voluntary-sector counselling service for young people in the north of England. Leon Mensah, 13, was referred by his school for low mood. In his third session he mentions that he is often hungry by the evening, that his mother has been "in bed for weeks" since his father left, that the electricity metre sometimes runs out, and that he gets his six-year-old sister, Amara, ready for school, which is why he is often late. There is no disclosure of abuse. Hannah's reasoning starts from what she knows: Leon carries a caring role beyond his age, basic needs are not reliably met and his mother appears unwell. These are indicators of unmet need and possibly of neglect, but nothing suggests that either child is currently suffering significant harm. The service's designated safeguarding lead agrees that a referral for support is warranted and that consent should be sought. With Leon's agreement Hannah meets him and his mother, Kerry, who is ashamed but relieved and agrees to the referral. Hannah's referral sets out the facts, their sources and dates, Leon's own account of his week, Kerry's agreement and what the family would find helpful. The front door decides that the family should receive Family Help, including an assessment

of both children as children in need under section 17, and Hannah, with Leon's agreement, contributes a short summary of his wellbeing to the first child in need meeting.

Five weeks later Leon arrives with a bruise on his cheek. He says that his mother's new partner hit him when he refused to hand over his phone, and that Amara is frightened of the man. Hannah listens, asks only what she needs to understand what he is telling her, and does not question him further. The position has changed. A visible injury attributed to an adult in the household, with a younger sibling described as frightened of that adult, gives reasonable cause to suspect significant harm, which is now a matter for section 47. Hannah tells Leon that she must pass this on today and explains what is likely to happen. She does not contact Kerry first, because that could alert the partner and increase the risk to the children, and the information sharing advice is clear that a practitioner need not inform the family where doing so would put a child at greater risk (Department for Education, 2024). She telephones the front door at once, then confirms in writing. A strategy discussion between children's social care, the police and health follows that day, and Hannah's service contributes what it knows. Her record states what Leon said in his own words, what she saw, the time, who she consulted and spoke to, why she did not inform Kerry, and the agreed plan. Her counselling continues alongside the enquiry, focused on Leon's safety and his feelings about what is happening, while any questioning of Leon is left to those conducting the enquiry.

Common pitfalls. The first is describing the pathways inaccurately to families. Telling a parent that a referral is "just for some support" when the concern is about significant harm, or implying that any referral risks the removal of children, misleads in opposite directions; describe the likely route honestly, and say that the local authority, not the therapist, will decide it. The second is confusing the thresholds. A therapist does not need to establish significant harm, still less prove anything on the balance of probabilities, before sharing a concern; those are tests for the local authority and the court. The opposite error is to present a concern that plainly reaches the section 47 level as a request for support, which delays a protective response. The third is assuming that the Children's Wellbeing and Schools Act 2026 is already operating. Its multi-agency child protection teams and consistent identifiers are not yet in force, so a procedure that refers to them is describing the future; work to the arrangements your local safeguarding

partners currently publish. The fourth is applying English procedures to a child in Wales, or assuming that an online client's children fall under the authority where the therapist practises. Ask where the child lives, and keep the contacts for that area.

Reflective question. When you last explained to a parent or a young person what would happen after a referral, how accurately could you have described the difference between Family Help, a child in need assessment and a section 47 enquiry, and how might the words you chose have shaped their willingness to keep working with you and with children's services?

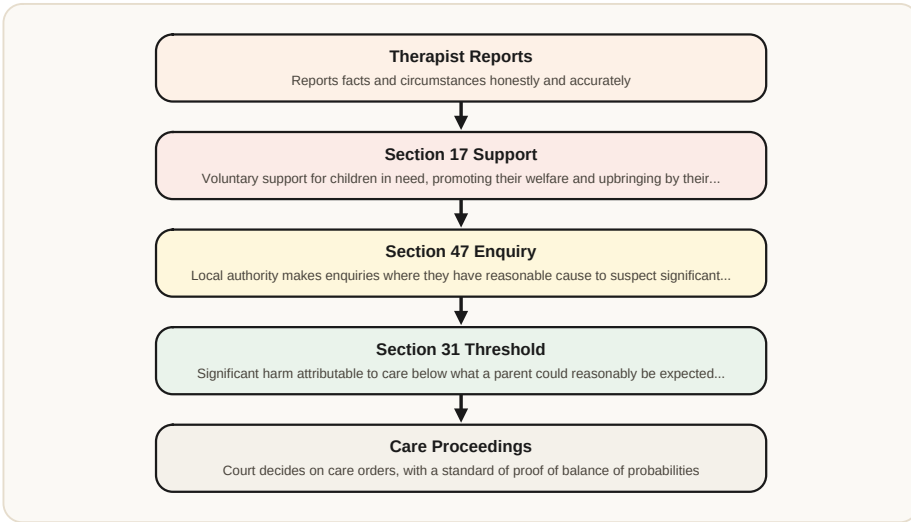


FIGURE 2.1 Referral Process

Therapists influence the pathway of a child's case by reporting facts and circumstances honestly and accurately. The Children Act 1989 is the core statute governing child safeguarding in the UK, separating support from compulsion. The statutory guidance Working Together to Safeguard Children 2026 combines targeted early help and section 17 support as Family Help, while the Children and Social Work

Points worth keeping

- Section 17 of the Children Act 1989 places a general duty on local authorities to safeguard and promote the welfare of children in need by providing services.
- Section 47 requires a local authority to make enquiries where it has reasonable cause to suspect a child is suffering, or likely to suffer, significant harm.

- The section 31 threshold requires significant harm attributable to care below what a parent could reasonably be expected to give, or to the child being beyond parental control.
- Since 2002, harm has expressly included impairment suffered from seeing or hearing the ill-treatment of another, which matters wherever children live with domestic abuse.
- Re B (2008) settled that the standard of proof in care proceedings is the simple balance of probabilities, which is a test for courts, not for referrers.
- Under the Children and Social Work Act 2017, the local authority, integrated care board and chief officer of police are the three statutory safeguarding partners.
- Working Together to Safeguard Children 2026 combines targeted early help and section 17 support as Family Help and strengthens expectations on racism and information sharing.
- The information sharing duty in section 16LA of the Children Act 2004 has applied since 30 September 2026, while the other Children's Wellbeing and Schools Act 2026 reforms are pending.

PRACTICE TASK

This week: Find the threshold or levels of need document published by the local safeguarding partners for the area where most of your child clients, or your clients' children, live. Read it alongside one current case in which you hold some concern about a child. Decide which level the case most closely matches, write down the specific facts that place it there, and note what new information would move it to a different level. Check that the referral route for each level, including the out of hours number, is recorded somewhere you can find it within a minute. Discuss your reasoning with your supervisor or safeguarding lead before the end of the week.

Study activities: The first is a reflective-practice activity whose purpose is to surface the assumptions you bring to children's services. Write about one occasion, professional or personal, when a family's contact with children's social care seemed helpful and one when it seemed harmful. Note what made the difference, then consider how the dual role of helper and investigator described in this lesson shows up in each account and how your view of it affects the way you present referrals. Allow 20 minutes. The second is a skills-practice activity whose purpose is to explain the pathways accurately in plain language. Write two short scripts of no more than 150 words each, one for a 14-year-old and one for a parent, explaining what may happen after a referral and how Family Help, a child in need assessment and a section 47 enquiry differ, without promising any outcome. Check each script against this lesson, then read them aloud to a colleague and ask what they understood. Allow 30 minutes.

Further reading:
Children Act 1989, c. 41.
Working Together to Safeguard Children 2026: statutory guidance (UK Government, 2026)
Munro (2011) The Munro Review of Child Protection: final report. A child-centred system.
National review into the murders of Arthur Labinjo-Hughes and Star Hobson (Child Safeguarding Practice Review Panel, 2022)