How clinical psychologists respond to child safeguarding dilemmas: A qualitative study

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Abstract
This research aimed to explore how clinical psychologists respond to child safeguarding dilemmas, with special attention to the role of psychology in child welfare. Transcripts from 20 semi-structured interviews with clinical psychologists working in Child and Adolescent Mental Health Services in England were analysed using a qualitative framework approach. In these interviews, two family case vignettes were used to examine how psychologists respond to child safeguarding dilemmas. We identified three overarching themes: operating within a system of stretched resources; characterising who is considered ‘supportable’ by psychological services; and challenges around conceptualising and responding to risk. Clinical psychologists viewed social services as responsible for family cases with safeguarding concerns and were reluctant to engage in high-risk cases where stability in the home was not yet established. They saw their role in child welfare primarily as sense-makers for families, by offering a contextualised explanation/formulation for the presenting difficulties.

KEYWORDS
child protection, child safeguarding, clinical psychology, risk

Key Practitioner Messages
• Clinical psychologists saw their role in child safeguarding as threefold: offering a provisional formulation or explanatory discourse for the families’ current circumstances, tending to their mental health needs by offering psychological support, and initiating change in behaviour.
• Psychologists were sometimes reluctant to provide support to families in high-risk cases whilst there was a lack of safety or family stability for the child.
• An implication of the difficulties coordinating services is that families with complex needs who do not neatly fit eligibility criteria may fall through the gaps between services.

INTRODUCTION
Among frontline staff in the UK, social workers are generally considered to hold primary authority regarding child safeguarding. However, as described in statutory guidance documents such as ‘Working Together to Safeguard Children’ (Department for Education, 2018), the responsibility for safeguarding extends to all professionals who are
working with children. Psychologists occupy a potentially challenging position in relation to child safeguarding. They are required to be vigilant to safeguarding concerns in practice whilst simultaneously holding key components of psychological therapy in mind, including client confidentiality, the therapeutic alliance, and the need to provide safety and containment within the therapeutic space (Bunting et al., 2010). Research from the United States and Canada on child abuse reporting behaviour has highlighted concerns from psychologists that a report to child protection services can rupture a strong therapeutic alliance and be more harmful over the course of therapy if a client subsequently disengages (Beck, 2000; Blanchard, 2003; Kalichman & Craig, 1991).

The British Psychological Society (BPS) released guidelines in 2018 on safeguarding children and young people, reflecting increasing awareness of the crucial role that psychologists play in the identification and management of child safeguarding concerns. The guidelines are intended to act as a tool to aid decision-making and provide a framework for clinicians to tackle the complexities of safeguarding children in clinical practice. The BPS (2018) encourages psychologists to watch out for potential thinking traps and to regularly check their patterns of thinking and formulations about a case with colleagues and in professional supervision. The guidelines advise clinicians to trust – but also test – their gut feelings and continuously engage in reflective practice. Maintaining good relationships in interprofessional working and collaboration was also underscored as a key factor in building safety culture.

The importance of collaboration and effective information sharing among practitioners is widely acknowledged in the literature (see Department for Education, 2018; Schrader-McMillan & Barlow, 2017). Yet previous research has identified specific professional tensions in relation to child safeguarding. Godar (2017) found that some UK social workers report difficulties in the relationship between children’s social care and child and adolescent mental health services (CAMHS). Possible reasons proffered by the social workers for the difficulties included the demand pressures faced by CAMHS, different perspectives on the causes of children’s difficulties, and psychologists viewing family stability as necessary prior to providing therapeutic input. The tension sparked by differing professional perspectives is also considered by Loades (2021) who speculates that social worker’s emphasis on social explanations of mental health might be sometimes in misalignment with explanations offered by CAMHS. However, the process of psychological formulation may go some way to reconcile these perceived differences in conceptualisation, as biological, psychological and social influences on mental health are often interwoven to provide an explanatory discourse for the child’s difficulties. Finally, according to a survey of social work and mental health professionals in Australia (Darlington et al., 2005), other barriers to interagency collaboration include inadequate resources, confidentiality and unrealistic expectations around other professionals’ authority to act. Whilst inadequate resources were identified as the most important barrier by the professionals in this study, the authors suggest that the conceptualisation of this as a predominantly resource-based issue may obscure broader failures of the child protection system to support collaborative working.

The issue of unrealistic expectations across professionals also arose in a survey of clinical psychologists in Scotland about their role in child protection (McKenzie & Cossar, 2013). This study found that psychologists valued close working with other agencies, though some felt that social services had unrealistic expectations around psychology’s contribution to a case, given that the work was seen as reactive and resourceful. Some factors which compounded psychology’s ability to meaningfully contribute to a case were cited as boundary issues with other professionals, a lack of organisational resources and challenges maintaining a therapeutic relationship with parents in the child protection system.

How psychology can specifically contribute within the child protection system was discussed in a mixed methods study, which examined how UK-based educational psychologists’ work with child safeguarding issues (Woods et al., 2011). The provision of direct therapeutic work with vulnerable groups (e.g., children with mental health issues or neurodevelopmental conditions) was emphasised, alongside parenting courses and training for other professionals on attachment and resilience. By providing specific expertise on how child protection concerns could be understood in the context of a child’s development over time, the authors proposed that psychologists could also complement the social work approach, which they viewed as being inevitably ‘more forensic’.

Child safeguarding in CAMHS is likely further complicated by a range of service-level factors related to the existing CAMHS model, such as issues with inequalities in patient access (Griffin et al., 2022), lengthy waiting times (The Lancet., 2020) and unclear eligibility criteria (Ani et al., 2022). To date, there is a paucity of qualitative work examining how clinical psychologists working in this context reason about child safeguarding issues. McKenzie and Cossar (2013) found that clinical psychologists working in CAMHS were significantly more likely to be involved in child protection work than clinical psychologists working in other services, highlighting the important role of this particular group of psychologists in child safeguarding. The survey methodology used in McKenzie and Cossar’s (2013) research prevented deep exploration of their involvement however, and the authors highlighted that qualitative research would be beneficial. The current study used family case vignettes and interviews to qualitatively examine how UK clinical psychologists respond to child safeguarding dilemmas. It is hoped that this study will add to the limited body of research on the role of clinical psychologists in safeguarding children in a UK context, highlighting elements of the decision-making process for clinicians faced with child welfare concerns.
METHODS

Participants

Participants for this study were recruited from CAMHS at two National Health Service (NHS) Foundation Trusts in England. Participants were eligible to participate if they were clinical psychologists working directly with children and/or families, who had been in professional practice for at least one year. Information about the study was circulated in writing to the services, and 20 eligible psychologists (14 female, six male) responded and chose to participate. There were seven participants with 1–5 years of post-qualified children and families experience, six participants with 6–10 years of experience, and seven participants with 10+ years of experience.

Research design

This study reports findings from face-to-face interviews conducted with the 20 participating clinical psychologists. During the interviews, participants were all presented with the same two family case vignettes and asked to discuss them in turn. Family case vignettes were used as an analogue for practice, and the vignette method was chosen in order to enable exploration of the participants’ thinking in action when considering child safeguarding concerns (Barter & Renold, 1999). The interviews were conducted between June 2017 and January 2018, as part of a broader study led by the last two authors. Participants provided written consent to participate and for their interviews to be audio recorded. The study received approval from the Health Research Authority and Northumbria University Faculty of Health and Life Sciences Research Ethics Committee.

Materials

Two family case vignettes were developed for this study (see Appendix A). The vignettes were based on serious case review cases to increase their realism and pilot tested with practitioners prior to their use. The vignettes depicted families with young children, ranging in age from six months to eight years. The vignette cases contained a range of factors which could lead to child safeguarding concerns including domestic violence, maternal mental health issues, maternal history of childhood difficulties and indicators of child neglect. Semi-structured interview questions were used to guide the participants’ discussion of the cases. Participants were asked for their initial impression of the level of risk in the cases. Participants were also asked for their views on the most noteworthy features of the cases in relation to the well-being of the children, their next steps in relation to the cases and what they believed would need to happen to ensure the children’s safety in the future.

Analysis

This study adopted a framework approach. Framework analysis offers a systematic structure to develop a ‘thematic framework’ which is used to identify, collate and report significant themes and subthemes (Gale et al., 2013). An initial framework was developed deductively from a literature review of psychologists’ experiences of child safeguarding. In a second stage, themes were coded inductively through open coding of the transcribed interview data. Data were charted into a framework matrix, which involved summarising the data by participant and theme to facilitate data interpretation. The software package NVivo12 was used to support data analysis.

FINDINGS

Three overarching themes were developed to demonstrate how clinical psychologists respond to child safeguarding dilemmas (Table 1).

Operating in a (stretched) system

This theme considers how clinical psychologists situated their initial responses to child safeguarding dilemmas within the context of the wider child protection system and the pressures stemming from resource limitations on that system.
A collaborative approach

In line with policy guidance (Department for Education, 2018), the need for a multiagency approach to cases with safeguarding concerns was consistently emphasised. Participating psychologists highlighted that they had a role in encouraging and ensuring such collaboration; for ‘agitating the wider system to get involved’ (CP02). Social services were identified by the psychologists as the critical agency to involve in cases with safeguarding concerns, but not the only important one.

Two key reasons for multi-agency collaboration were discussed by the participants. The first was to pool information in order to gain a fuller picture of a family’s situation and a clearer understanding of the risk and need.

I’d just want all of the team that was seeing the children, so like school and health visitor and everybody, around a table sharing their concerns. (CP13)

The second reason was to ensure appropriate support and intervention for a family. No single agency was seen by the psychologists as being able to provide sufficient support to families facing complex challenges across multiple domains.

I think this family need a multi-agency package around them, to make sure not only the mental health needs are being taken into account […] but also the social needs as well. (CP04)

Safeguarding before support

Where families were deemed to be in the throes of a crisis, there was perceived to be a hierarchy of support needs which started with immediate safety for the child.

I think you have to prioritise the needs of the children and the safety of the children first, and then think about what the therapeutic needs are going to be going forward and how as a service we might be able to support that. But safeguarding needs to take priority. (CP01)

Psychologists were reluctant to provide support to families whilst there was a lack of safety or family stability. This was based on a rationale that stability was needed to ensure therapeutic input would be viable and would involve the appropriate caregivers.

They would probably need attachment-focused work, and I do not think that that is the most valuable when we do that individually with kids, I think it’s the most helpful when we do that with a caregiver. So that could be a foster carer, but I would not want to begin that work if it was just going to be a short-term foster placement. […] Any kind of therapeutic work needs to come after there’s a plan and they have got that safety and security. (CP10)

There was dissensus among the psychologists as to what level of family stability was necessary prior to providing support. In response to the case vignettes presented, some of the psychologists interviewed indicated that they
would accept these cases and work with the families at the same time as social services input, whereas others indicated that they would want social services to stabilise the situations before they accepted the cases and provided CAMHS support.

> It depends on your CAMHS service, but I think CAMHS would want […] the children to be in a stable home, stable kind of position before any assessment or work’s done. […] So I’m not sure CAMHS would necessarily take this case now, or they’d be very specific about what they would be offering or what could be done at this current time. (CP04)

### Child welfare: Ideal versus reality

As participants attempted to delineate the appropriate next steps to navigate safeguarding concerns and support the children’s wellbeing, there was an apparent disparity between views on what should ideally occur and what was believed to be a more likely scenario. Participants described their experiences of working within a stretched child protection system that was ‘chronically, massively under-funded and under-resourced’ (CP02). These resourcing issues were felt to contribute to a tendency for the child welfare system to respond to safety concerns on a surface level, failing to target the root of the problem.

> There’s not the resource to give people what they actually need. […] It’s a sort of surface level problem that will be managed. (CP17)

> More intensive and longer term intervention than that currently available was felt necessary to facilitate enduring change for families on the edge of crisis.

> If we want as a society to help people like this […] then you would need a whole raft of services providing intensive and effective intervention. […] Proper intervention, all working together for a good few years, and then we might be able to create genuine, long-lasting change. (CP02)

> The psychologists felt that more resources should be directed towards provision of preventative services for parents in order to interrupt intergenerational cycles of maltreatment, and towards early intervention services for families in order to avoid escalation to crisis point.

### The supportable client

This theme draws out the factors considered by the psychologists in relation to what direct support they would provide, and to whom, when working with families with child safeguarding concerns.

### Support routed via caregivers

In relation to the case vignettes presented, the psychologists tended to suggest that their psychological interventions and support would at first be mainly directed to caregivers, whether parents or foster carers. The psychologists viewed initial support for caregivers as the primary gateway to reach the children, perhaps in response to the relatively young ages of the children in the cases and thus their high dependence on caregivers.

> There’d have to be consideration about what work the parents needed first, as adults, to be able to parent these children. (CP06)

> Proposed support for parents ranged from individual therapy for mental health issues to more practical advice around parenting, whilst proposed support for foster carers focused on psychoeducation to understand and manage behavioural difficulties that the children might present with. Some participants suggested attachment-focused work for parents and children together, such as Dyadic Developmental Psychotherapy.
Psychologists as sense-makers

Psychologists tended to suggest that a key part of their role when working with families where there are safeguarding concerns was as ‘sense-makers’. Part of this sense-making was directed towards helping parents make sense of their struggles and to consider how past experiences and circumstances may have shaped present difficulties in parenting. Psychologists anticipated that this sense-making activity could act as a catalyst for change within the parent, helping them to safely care for their children.

Talking to her [the mother] about the fact that as a young child she probably did not have the experiences that she would need, to learn to be a parent. And just opening up what’s happened for her. (CP06)

Where children were in the looked after system, the psychologists felt their role entailed supporting foster carers to make sense of underlying reasons for the children’s behaviour and how to respond to this.

I think very commonly we are telling the story of a child, we are saying, well this is where they are at, and this is the way they are, because of this. (CP16)

Psychologists also saw a role for their profession in making sense of a family’s difficulties for other professionals using psychological theory and clinical judgement, which provided the backdrop for their recommendations from a mental health perspective on future care planning for a child.

In sum, it appears that psychologists saw their sense-making role as threefold. Firstly, psychologists were well placed to provide an explanatory discourse or formulation for the family’s current circumstances based on their theoretical knowledge and psychological assessment. Indeed, psychologists emphasised their ability to build a coherent narrative collaboratively with the family, which affirmed the children’s difficult experiences and ultimately united the family to overcome them. Secondly, psychologists suggested that offering this contextual understanding could initiate change within the family unit. Finally, psychologists used this formulation in interprofessional contexts to offer recommendations on future care planning.

Blame as a barrier to support

Psychologists often described the need to navigate feelings of guilt and shame expressed by parents of children with safeguarding needs, citing blame as a barrier to therapeutic support for parents in providing adequate care to their child. Yet the means to manage the burden of blame varied among psychologists. Whilst some psychologists emphasised the importance of ‘trying to remove the blame and shame away from what’s happening’ (CP06) in order to foster a trusting alliance with parents, others emphasised that parents had to take responsibility for harm caused to the children in order to convey a capacity for change.

Sensitivity to blame sometimes manifested as a barrier of defensiveness which psychologists felt they had to gently overcome or work around to support parents effectively, with an acute awareness of the parent’s likely discomfort.

She’s probably really defensive and thinking people are going to blame her, and underneath she’ll have a sense that she has not done a brilliant job, but then it’s about helping her to think about what she’s been through herself, and I would start with that probably. Build up a bit of trust with her and then get her to open up about what’s happened to her and then just gradually get her to see the links between that and what’s happened more recently. But you have to do it in a really gentle, sensitive way because otherwise she’s going to be putting up the barriers. (CP18)

Psychologists reported that working with parents where issues of blame and defensiveness were in play was a challenging aspect of their professional role. Some felt that a risk management approach to safeguarding could sometimes be counter-productive.

I think as soon as we talk about risks parents are on the defensive, which I think is a very logical response. It’s, it’s a blaming language…. and if people walk in and try and stop it and start ordering [the mother], that just increases the load on her, it’s going to not help with lack of confidence and lack of self-esteem and all the other bits of depression, it’s likely to make her more jumpy, which means she has less emotional resource for the children. (CP17)
Challenges responding to risk

This theme describes how the psychologists conceptualised and responded to issues of risk presented in family cases containing safeguarding concerns, and how their ways of doing so were sometimes felt to conflict with the current pressures of the child protection system.

Conceptualising risk as multidimensional

Psychologists tended to treat risk as a multidimensional term, signalling the likelihood of various forms of harm occurring. Whilst some were willing to give a single assessment of the level of risk in each of the case vignettes presented, most broke their assessment down explicitly or implicitly, for example into risk for different family members, into physical and emotional risk, and/or into short and long-term risk.

In response to the case vignettes presented, the psychologists generally first considered risk in relation to physical harm to the children. Physical harm was conceptualised by participants as an immediate and pressing risk, but one that had the potential to be transient and resolved relatively quickly. Emotional harm was conceptualised as a longer term, chronic risk to the children that could persist long beyond the resolution of immediate physical risks, due to the pervasive impact of early experiences.

I think physically they are safe but emotionally there is clearly potential for this episode to impact on them for many years. (CP03)

The immediate risk to these children, I would not see it as a major priority [...] [but] my concern for these children is high in terms of the risk for their emotional development. (CP16)

Concern for children’s emotional wellbeing was paramount for the psychologists, as this was considered most relevant to their remit. However, psychologists’ ability to prioritise support for families where children solely faced risk of longer term emotional harm and no specific immediate or physical risk was acknowledged as challenging in practice.

As services we respond to events, and what we miss is the gradual creeping with nothing clear can be just as harmful if not more so. (CP20)

Risk responsibility tensions

There were indications that tensions can emerge between services in relation to who should hold responsibility for risky family cases. The psychologists typically viewed social services as having responsibility for risk, regarding them as the principal decision-makers in safeguarding dilemmas. In response to the case vignettes presented, the participating psychologists generally did not feel it would be appropriate for them to be the sole agency working with the family.

I would be happy if there was somebody else involved, so I would not want to just hold this case on my own. (CP15)

Yet psychologists also identified situations where their decision to become involved in supporting families in crisis had led to other services deciding to withdraw, leaving the psychologist holding the case and responsibility for the attendant risk in isolation.

Unfortunately, what sometimes happens is, CAMHS is involved, right, everyone else is going to pull out, because they think we are going to solve things. (CP04)

Threshold tensions

Although psychologists suggested that much of the responsibility for responding to family risks should be held by social services, some felt that the thresholds for intervention from social services were too high, and that there was disparity between the psychologists’ view of what constituted a concerning level of risk, and social services’ view on this.
I think I would be rating this as kind of quite risky, but myself knowing that the thresholds are increasing in social care I think I’ve got an idea that that would be rated very differently by social care. (CP04)

Such tensions and raising of thresholds were perceived to be in part due to pressures faced by social services in terms of the number of referrals received and the need to manage them rapidly, particularly in the current context of funding pressures in social services in England. Psychologists also highlighted perceived inconsistencies in the application of safeguarding thresholds by social services. For instance, some psychologists were concerned that the thresholds for social services intervention were applied inconsistently, due to organisational pressures.

The threat to a child […] should be based on what’s going on in that family and not the pressure of services, and the threshold should not move, it should be consistent but it’s not. (CP15)

However, this disparity over risk assessments and thresholds was particularly notable in relation to discussion of case vignette 1, where risk was more diffuse and predominately emotional rather than physical and immediate. This suggests that a second factor contributing to the threshold tensions could be differences in the weighting given to different types of risk by different professionals, with psychologists giving greater weight to the long-term risks associated with emotional harm compared with social services potentially focusing more on whether there is immediate risk of physical harm.

DISCUSSION

This study explored how clinical psychologists think about and manage child safeguarding concerns, through the use of two family case vignettes. We identified that clinical psychology was regarded as having three primary functions: (i) to provide an explanatory discourse for the child and family’s presenting difficulties; (ii) offer mental health supports and psychological interventions; and (iii) to initiate change in the parent’s behaviour. Providing an empathic space to explore parents’ difficulties and allow them to feel heard without judgement was perceived as an important and distinctive role for psychologists. Participants referred to this as ‘sense-making’ activity. The emphasis on therapeutic work with the parents of maltreated children suggests that psychologists very much view themselves as having an important role in child safeguarding.

Psychologists were clear that they would seek further guidance from social work when dealing with suspicions of child maltreatment, which is in line with the BPS (2018) recommendations when managing uncertainty. Psychologists tended to situate activities such as holding risk and making concrete decisions about the safeguarding of the child in the domain of social work. This may reflect a tension for psychologists in balancing their safeguarding and risk management responsibilities alongside their responsibility to act as advocates and trusting allies for families in need of support, a tension that has been raised in previous research with psychologists (e.g., Beck, 2000; Blanchard, 2003; Kalichman & Craig, 1991). Bilson et al. (2017) highlighted an ‘investigative turn’ within the child protection system, with England showing a 108 per cent increase in Section 47 investigations from 2010 to 2017. The authors questioned the overall effect on families of this increase in child protection investigations, particularly in deprived communities where families may already be suffering feelings of shame and low self-worth. Therefore, psychologists may prefer to distance themselves from the role of investigator in favour of protecting the therapeutic relationship.

It is noteworthy that, despite Bilson et al.’s (2017) finding of an increase in Section 47 investigations, some psychologists in this study perceived social work thresholds for involvement beyond investigation as too high, particularly where concerns predominantly relate to emotional rather than physical risk. When considered alongside the finding that some psychologists in this study would not accept cases deemed to have too much family instability (a finding which aligns with previous research by Godar, 2017), this perhaps signals that there is a zone of child safeguarding issues that essentially fall between professional territories, i.e., those that raise concerns regarding children’s emotional wellbeing but do not meet the threshold for social work involvement nor have sufficient family stability for CAMHS involvement. A policy report by Action for Children (2017) estimated that 140,000 children in England were falling through cracks in the child protection system, with many families stuck in a perpetual ‘revolving door’ of re-referrals to social services until a crisis point is reached. An implication of the reported difficulties coordinating care for families with complex needs due to inconsistent thresholds means that some families will at best have only some needs addressed and at worst fall through the gaps in services. Future work is required to explore how relevant professionals proceed when their referrals to social work are rejected, and the outcomes for the children and families involved.

Several studies with other professionals have noted limitations with the CAMHS model and commissioning practices particularly pertaining to diagnostically oriented pathways, unclear eligibility criteria and long waiting times.
(e.g., Ani et al., 2022; Coughlan et al., 2022; Godar, 2017). In general, there was a sense that psychologists in this study were cognisant and sympathetic to these critiques of CAMHS. Although it was not a strong theme in the data, it seems reasonable to speculate that organisational factors and the configuration of CAMHS is also likely to have had a material influence on safeguarding practices, even when not explicitly acknowledged by the psychologists. Future qualitative work on this topic might benefit from anonymised analysis of case notes, reports and correspondence to explore how these service-level factors (e.g., eligibility criteria and lengthy waiting times) actively shape safeguarding in CAMHS. Analysis of anonymised correspondence would also provide a vantage point from which to empirically explore possible tensions between social work and CAMHS in practice.

In this research, use of intraprofessional supervision remained absent from participants’ discussions of what their next steps would be in response to the case vignettes presented. The BPS (2018) strongly suggest that psychologists’ handling of safeguarding concerns should be underpinned by proper supervision, to offer a reflective space for clinicians to ‘think about their thinking’ and have feedback on their case formulation (BPS, 2018). This study did not explicitly ask about supervision and so it is possible that the lack of reference to this does not reflect a lack of prioritisation of supervision use in practice. It is feasible, however, that the absence of discussion on supervision use could reflect the limited availability of clinical supervision within an overstretched system (Brandon et al., 2011; Schrader-McMillan & Barlow, 2017), or psychologists viewing the holding of safeguarding concerns as ultimately social services’ responsibility. Further research on this would be useful.

Fathers were infrequently mentioned and largely criticised in psychologists’ dialogue around familial support in these cases. Participants perceived the fathers as a risk factor to be removed rather than as individuals in need of psychological provision or support. This may be because the case vignettes used in this research described fathers accused of domestic violence who were no longer in the family home, influencing the focus of psychologists’ responses. However, a lack of father engagement by practitioners in child protection is not new (Clapton, 2009; Osborn, 2014). Indeed, service involvement with fathers accused of domestic violence has been argued to be crucial to prevent future violence (Scott & Crooks, 2006).

This study has some limitations that require consideration. Although there was no indication that the safeguarding practices described by the professionals in this study were atypical, these matters require further exploration – especially in light of the BPS (2018) guidance appearing subsequent to our data collection. The findings of this study may not be transferable to other countries with quite different child welfare contexts (see Benbenishty et al., 2015). In addition, this study asked participants to reflect on vignettes. Although vignettes are an established method for research in social sciences, the hypothetical nature of this research may have been construed as ‘low stakes’ by the psychologists, giving them more room to explore personal opinions on the next steps in a case without any real implications. Further observational work is required to explore the extent that these reflections are in concert with actual clinical practice.

In conclusion, this study adds to our understanding of the role of psychologists in child safeguarding. Overall, our findings suggest that the statutory recommendations for multi-professional working in child safeguarding are well understood by clinical psychologists. We traced a number of core functions of clinical psychology in this context, as well as some tensions around safeguarding thresholds and risk conceptualisations and responsibilities. In particular, some psychologists were hesitant to engage with high-risk cases where the safety and stability of the child had not been established by children’s social care. However, thresholds for social care involvement were sometimes viewed as inconsistent and problematic. Other barriers to effective collaboration and provision of psychological support included stretched resources and parents’ perceptions of service involvement. Together, these barriers permeate through the systemic layers and exert influence on decision-making and outcomes in child safeguarding work, particularly for those children and families who might fall through the gaps in services.

CONFLICT OF INTEREST STATEMENT
There are no conflicts of interest to disclose.

ETHICS STATEMENT
The study received approval from the Health Research Authority and Northumbria University Faculty of Health and Life Sciences Research Ethics Committee.

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REFERENCES


APPENDIX A: CASE VIGNETTES

Case 1

Mother – Jade, age 35 years  
Father – Alex, age 37 years  
Son – Sam, age eight years  
Son – Tom, age six years  
Daughter – Poppy, age six months

Jade was known to the locality team as a child. She was on a child protection plan for 16 months from the age of two and placed in foster care on a care order from the age of five to seven. Jade has ongoing depression and anxiety, and is taking anti-depressant medication.

Over the past five years there have been a number of reported incidents of domestic abuse. These include reports from Jade herself about Alex’s violence, and others from neighbours when they heard angry scenes in the home. Alex no longer lives with the family but sees them on a regular basis and is sometimes the carer for the children.

During Jade’s recent pregnancy, the midwife asked about the domestic abuse. Jade said she ‘didn’t want to discuss it’. She said that the threat from Alex and their upsets and arguments were ‘all in the past’, and that there was no current violence.

There have been several reported accidents involving the children, which appear to relate to inadequate supervision. Since the birth of Poppy, there have also been a number of missed essential health appointments for the children. The Health Visitor’s records note that Jade ‘has difficulty providing stimulation for the children and often leaves them in front of the TV’. The Health Visitor has also noted the poor state of the family home: unclean and very cluttered, with not enough space for the baby to develop physically. The Health Visitor believes Jade ‘has good intentions, but easily forgets’.

Jade says that she is unable to manage her children’s behaviour. Sam has been diagnosed with ADHD and receives medication for this. Jade has suggested to professionals that Tom also has ADHD, reporting that he shows ‘wild behaviour’, but clinical assessment indicated that he did not meet diagnostic criteria for ADHD. Jade has asked for an assessment of autism spectrum disorder for Tom. Jade describes Tom as violent and out-of-control at home and says that he and Sam fight and risk physically hurting each other.

The children regularly arrive late at school and there is a high, and increasing, level of school absences. Teachers have noted that the boys’ academic progress is below average in all areas of the curriculum. Tom is described by his teacher as quite quiet and subdued at school. The SENCO has expressed concerns about Tom’s ‘extremely withdrawn and unhappy behaviour’ at school and made a referral.

Case 2

Mother – Amy, age 22 years  
Father – Chris, age 39 years  
Daughter – Ellie, age five years  
Son – Jack, age 18 months

Concerns arose six months ago when police were called by neighbours about a domestic violence incident. When they arrived, they found Chris outside the family home: drunk, shouting and causing damage. The children were inside the house alone. Amy had taken an overdose of pills and fled on foot from the house. Chris was arrested and a search started for Amy. The Local Authority Emergency Duty Service attended and worked with the police to place the children with an emergency foster carer.

Amy was located the following day. She was taken by ambulance to the local hospital. Despite some minor physical injuries caused by Chris, the overdose and having been outside overnight, Amy presented well. She was cleared physically and revealed no current thoughts of self-harm. The overdose was interpreted as an isolated incident in response to the domestic abuse. It was decided that admission to a mental health ward was not required, and Amy was referred to her GP for further support.

Chris was charged with common assault and released on bail with a range of bail conditions including not to contact the children or Amy.

Whilst placed with foster carers, Ellie disclosed details of neglect, and repeated abuse she had witnessed against her mother by her father. The foster carer reported that Ellie was having difficulty going to sleep, had regular nightmares about being alone and lost, and often seemed ‘on edge’. The foster carer also mentioned that Jack would sometimes lie prone on the floor, barely moving and eyes glazed, even when they tried to rouse him.
Amy was seen by her GP. She disclosed being physically and emotionally abused by Chris. She also disclosed that she had experienced difficulties in her childhood but was not specific about this. Amy was assessed as moderately to severely depressed, with severe anxiety. She was offered and agreed to medication and counselling. In the first counselling session it was noted that Amy might have unresolved feelings about the death of her father two years ago. She reported sometimes seeing her father’s angry face in Jack’s features when she looked at him.

Regular supervised contact is being facilitated between the children and Amy. Assessments have begun into Amy’s parenting ability and the children’s attachment to her, and Amy’s willingness to engage with this process has been noted. As part of the assessments, both children have been assessed as having a disorganised attachment.