



The British
Psychological Society
Promoting excellence in psychology

Practice Guidelines

Third edition



August 2017

If you have problems reading this document and would like it in a different format, please contact us with your specific requirements.

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

Contents

Preface	3
Glossary of terms	4
1. How psychologists work	5
1.1 Legal and professional obligations of psychologists	5
1.2 Cycle of professional practice	9
1.3 Reflective practice	11
1.4 Continuing professional development	12
1.5 Consultation/supervision	13
1.6 Leadership	15
2. Where psychologists work.....	16
2.1 Working environment.....	16
2.2 Working in the digital age	19
2.3 Working for the court	20
2.4 Working for defence and security organisations.....	21
3. Who psychologists work with	23
3.1 Working with Experts by Experience.....	23
3.2 Working with assistants/interns	23
3.3 Working with trainee psychologists.....	24
3.4 Working with multiple clients	24
3.5 Working with other professionals.....	25
3.6 Boundaries in professional relationships.....	26
3.7 Working with children and young people	27
3.8 Working with people with intellectual disabilities and impaired cognitive abilities.....	28
3.9 Working with detained people	28
3.10 Working with people who are, or would like to be employed.....	32
3.11 Working with cultural difference	32
3.12 Working with people of faith, religion and spirituality.....	34
3.13 Working with sexual and gender minorities.....	34
3.14 Working with people who may be socially excluded.....	36
4. Safeguarding.....	38

4.1 Safeguarding children.....	39
4.2 Safeguarding adults at risk of harm	41
4.3 Terrorism and extremism	43
5. Making and maintaining agreements	45
5.1 The practitioner’s right to withdraw their service.....	46
5.2 Referrals.....	46
5.3 Representation of the qualifications and status of the psychologist	47
6. Obtaining informed consent.....	48
6.1 Informed consent for court.....	50
6.2 Informed consent with children and young people	50
6.3 Informed consent with people who may lack capacity	51
6.4 Informed consent with people as employees	52
6.5 Informed consent with detained persons	53
7. Managing data and confidentiality.....	55
7.1 Information governance	55
7.2 Confidentiality	57
7.3 Confidentiality when safeguarding	60
7.4 Confidentiality for the court.....	61
7.5 Confidentiality with children and young people	62
7.6 Confidentiality with detained persons	62
7.7 Confidentiality obligations during training.....	63
8. How to respond when things go wrong	64
8.1 Managing conflict with a client	64
8.2 Transparency and duty of candour	64
8.3 Managing conflict in team settings	65
8.4 Supporting a colleague when a complaint has been made	66
8.5 If the client remains unhappy	67
9. References.....	68
Acknowledgements	71
Appendix 1 – Relevant legislation	73
Appendix 2 – Websites and further information.....	81
Appendix 3 – How this document has been developed.....	85

Preface

This Third Edition of the Practice Guidelines replaces the second edition published in 2009. Legislation, practice and technology have moved on since then and these changes are captured in the new guidance.

This edition of the guidelines was produced through the British Psychological Society's Professional Practice Board by a working group drawn from the range of Member Networks across The Society whose members are engaged in professional practice, as well as representatives from relevant expert reference groups of The Society, in particular areas of practice. Further information is available in *Appendix 3: How this document has been developed*.

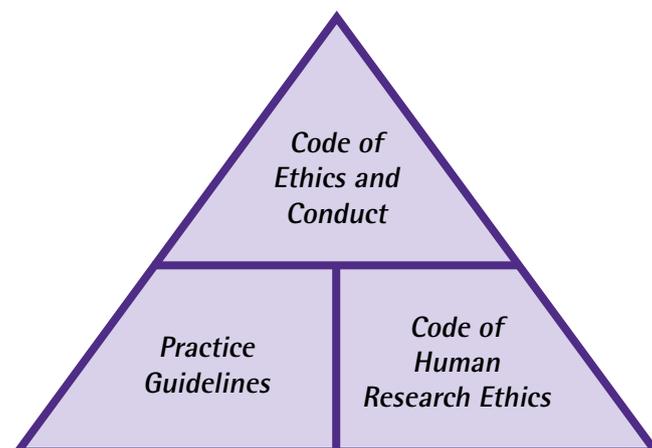
These Practice Guidelines aim to define good practice for all psychologists whether registered, chartered or in training and offer guidance for decision making. The Guidelines have been designed for broad application across the full range of applied psychology.

The first part of the guidance (sections 1–3) set out considerations for psychologists on different contexts of practice. The second part of the guidance (sections 4–8) sets out guidance for psychologists on how to manage work with clients.

It is recognised that in addition psychologists may require more detailed guidance for some particular roles and responsibilities or for particular situations in which they work. Further information is available in the *Appendices*.

The Society expects that the guidelines will be used to form a basis for consideration, with the principles being taken into account in the process of decision-making, together with the needs of others and the specific circumstances. No guidance can replace the need for psychologists to use their own professional judgement. Effective practice means exercising this professional judgement in a defensible way that does not put clients or the public at risk, or undermine, or call into question the reputation of the profession as a whole.

The Guidelines will be reviewed in accordance with Society policy within a maximum period of five years in order to reflect current legislation, evidence and practice contexts. Psychologists using the Practice Guidelines should do so in conjunction with the *BPS Code of Ethics and Conduct* and the *BPS Code of Human Research Ethics*, as necessary.



Glossary of terms

Client

The Society's *Code of Ethics and Conduct* uses the term person or people throughout, this is in recognition of the fact that the document is generic and may be used by all psychologists; academics, researchers, students and practitioners alike.

Throughout this Practice Guidelines document the term 'client' is used and refers to any person or persons with whom a psychologist interacts on a professional basis.

For example, the 'client' may be a couple, a family group, an educational institution, a community organisation or group or a private or public organisation including a court, an individual (sometimes referred to as, for example, athlete, child/young person, patient, prisoner, coachee, service user, stakeholder, leader, or student), who are in receipt of the services of the psychologist.

Psychologist

Throughout this Practice Guidelines document the term 'psychologist' is used and refers to all psychologists whether registered, chartered or in training who provide psychological services across the full range of applied psychology, in any context of practice.

1. How psychologists work

1.1 Legal and professional obligations of psychologists

Psychologists' professional practice is impacted upon and governed by a range of legislation and regulation. Particular psychological disciplines may also need to consider additional legislation, regulation and guidelines. It is the psychologist's responsibility to ensure they are aware of the legislation and guidelines that govern their particular area of practice as well as the terms of their employment or terms contracted with a commissioner of their services.

Psychologists are also advised to consider membership of a union or similar body to ensure they have access to appropriate representation, support and legal advice should they be subject to a complaint or disciplinary action, or require support for example with an employment grievance, which may be related to concerns over quality and standards of psychological service provision.

Further information is available in the *Appendices*. Important examples to note are:

Health and Care Professions Council (HCPC) Registration

It is a statutory requirement for all psychologists wishing to practice using one of the titles protected by the HCPC to register with the HCPC. Unregistered psychologists offering services to the public in any of the domains regulated by the HCPC may commit an offence by doing so, even if they refrain from using protected titles, provided intent to deceive can be proved. The Society's position is that it is in the interests of both the public and the profession for all psychologists providing services in a regulated domain to be registered with the HCPC.

Professional competence

Psychologists should value the continuing development and maintenance of high standards of competence in their practice and the importance of working within the recognised limits of their knowledge, skill, training, education, and experience. Psychologists should consider advances in the evidence base, the need to maintain technical and practical skills and knowledge and the limits of their competence. This is stipulated in both the *BPS Code of Ethics and Conduct* and the *HCPC Standards of Proficiency*.

Professional indemnity insurance

The UK Government has introduced legislation (The Health Care and Associated Professions (Indemnity Arrangements) Order 2014) which now makes it mandatory for health professionals to have a professional indemnity arrangement in place. The HCPC has made having such an arrangement in place a condition of registration.

This may be achieved either through the employer or through a privately arranged policy. An employer's insurance may provide cover only for a negligence claim but not for the costs of a disciplinary hearing. It is the psychologist's responsibility to check carefully that

they have cover in place that meets their personal/professional needs. Further information is available in the *Society document: Career Support and Development*

Disclosure and Barring Service (DBS) Checks

Psychologists working in certain fields, for example with children or in healthcare, will need to demonstrate they have had a satisfactory criminal records check at the appropriate level for the nature of the work undertaken.

Applicants will be provided with a certificate to demonstrate this. Applicants cannot request a check personally, this can be requested by a psychologist's employer. For psychologists practising independently the Society offers this as a service to members. Further information is available on the *Society Website: <https://beta.bps.org.uk/Practice-Guidelines>*

Equality Act 2010

This Act protects people against unfair treatment, promotes equality and prevents discrimination against any of nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. Respect is a core ethical value for psychologists and a commitment to equality of opportunity is embedded in all aspects of psychological practice. Psychologists, where they operate in an organisational context, must also seek to encourage and influence others in ensuring that equality of opportunity is embedded in all thinking and all practice relating to access to services for client groups and recruitment and employment practices.

Providers of service to the public must also make reasonable adjustments for people who have a disability under the Act. This requirement is anticipatory so requires consideration, and adjustment where reasonable, of any barriers which may prevent a person with a disability from using a service.

Data Protection Act 1998

The Data Protection Act defines personal and sensitive personal data, and data must be processed in accordance with eight principles. It gives individuals the right to know what information is held about them and provides a framework to ensure that personal information is handled properly.

Good information governance is at the heart of safe practice. It encompasses physical data security, access controls and acceptable use, data quality, and records management, among other things. Psychologists must have appropriate security to prevent any personal data held from being accidentally or deliberately compromised. In most circumstances, independent practitioners will also need to register as a data controller with the Information Commissioner's Office.

Further information is available in *Section 7.1: Information governance, Appendix 1: Relevant legislation* and *Society Document: Data Protection Act 1998 – Guidelines for Psychologists*.

Freedom of Information Act 2000

The Freedom of Information Act 2000 provides public access to information held by public authorities. Public authorities include government departments, local authorities, the NHS, State schools and police forces.

It does this in two ways:

- public authorities are obliged to publish certain information about their activities; and
- members of the public are entitled to request information from public authorities.

The Act covers any recorded information that is held by a public authority in England, Wales and Northern Ireland, and by UK-wide public authorities based in Scotland. Information held by Scottish public authorities is covered by Scotland's own Freedom of Information (Scotland) Act 2002.

This legislation permits information to be withheld from disclosure in certain prescribed circumstances, for example information provided in confidence, related to law enforcement or where it relates to personal matters.

Health and Safety at Work Act 1974

This Act places a duty on all employers 'to ensure, so far as is reasonably practicable, the health, safety and welfare at work' (Part 1, Section 2.1) of all their employees. Employees themselves also have obligations under the legislation.

Working together to safeguard children guidance

The Government website provides statutory guidance on inter-agency working to safeguard and promote the welfare of children. Statutory guidance is issued by law; it must be followed unless there is a good reason not to. All organisations, including charities, are expected to comply with this government inter-agency statutory guidance. Psychologists have a duty of care to both their clients and the public. Any allegations of abuse, either ongoing or historic, must be taken seriously and consideration must be given about breaking confidentiality especially in cases where other vulnerable people may be at risk. Further information is available in *Section 4: Safeguarding*.

Mental Capacity Act 2005

The Mental Capacity Act (2005) provides a clear and comprehensive framework with regard to capacity and consent for all individuals aged 16 years and above in England and Wales.

There are five key principles set out in the Act which underpin practice (quoted from legislative source):

- (i) A person must be assumed to have capacity unless it is established that he lacks capacity.
- (ii) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- (iii) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

- (iv) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- (v) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

In Scotland the Adults with Incapacity (Scotland) Act 2000 applies and in Northern Ireland the Mental Capacity Act (Northern Ireland) 2016 is used.

Mental Health Act 1983 as amended 2007

The main purpose of the Mental Health Act 1983 as amended 2007 (MHA) is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they require for their own health or safety, or for the protection of other people.

The Act sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients. The Code of Practice¹ provides statutory guidance for mental health professionals on how they should carry out their responsibilities in practice under the MHA. Although the Act allows for people to be compulsorily detained and treated without their consent if required, empowerment and involvement of patients as far as is possible is required by the Code of Practice.

Those involved in working with people subject to provisions of the MHA, including psychologists, must understand and give consideration to the five key principles set out in the Code:

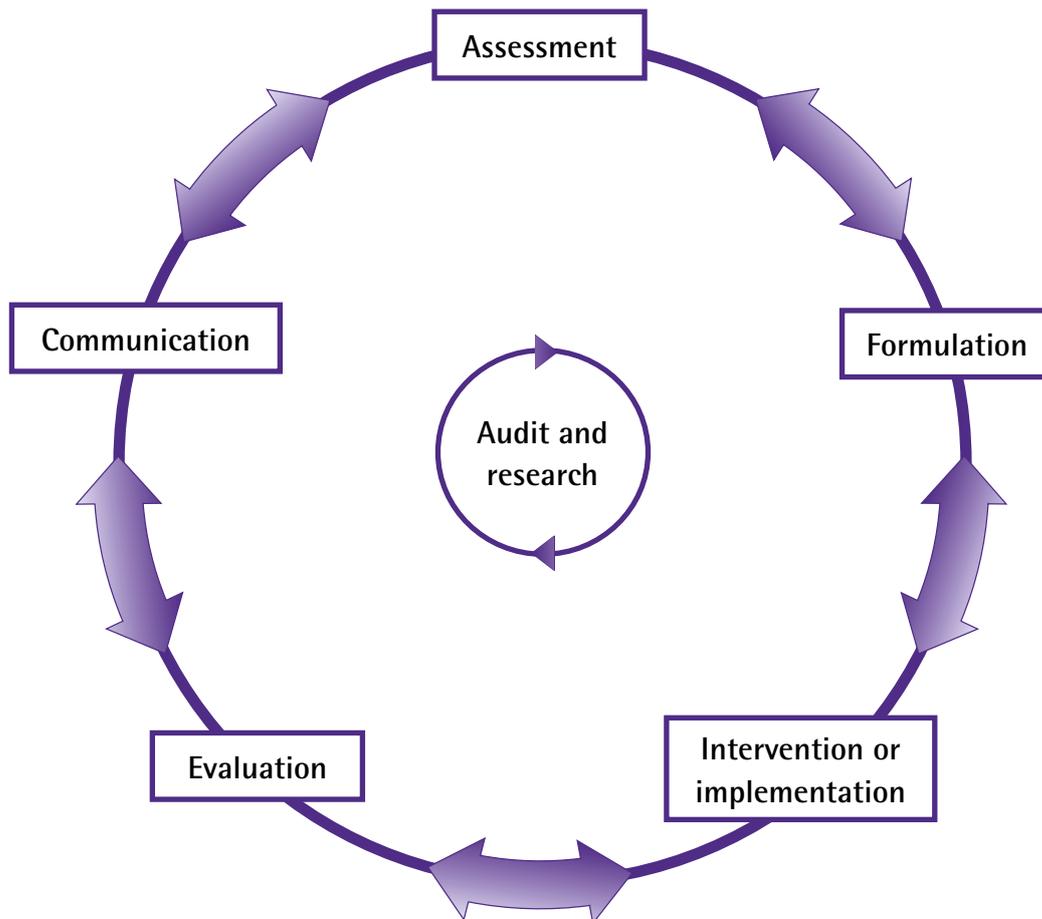
- (i) least restrictive option and maximising independence;
- (ii) empowerment and involvement;
- (iii) respect and dignity;
- (iv) purpose and effectiveness; and
- (v) efficiency and equity.

1.2 Cycle of professional practice

The professional practice of psychologists is underpinned by four key ethical values – Respect, Competence, Responsibility and Integrity – and five core skills:

- **assessment** and establishment of agreements with the client;
- **formulation** of client needs and problems;
- **intervention or implementation** of solutions;
- **evaluation** of outcomes; and
- **communication** through reporting and reflecting on outcomes.

These core competencies flow and inform each other as illustrated below.



Assessment and establishment of agreements with the client

Assessment of psychological processes and behaviour is derived from the theory and practice of both academic and applied psychology. It includes both assessing change and stability, and comparison with others. Assessment procedures used will depend heavily on the practice context and may include:

- the development and use of psychometric tests following best practice;
- the application of systematic observation and measurement of behaviour in a range of contexts and settings;
- devising structured assessment strategies for individual clients, teams and organisations; and
- the use of a range of interview processes with clients, carers, other stakeholders and other professionals.

Results of these assessments are integrated within the context of the historical, dynamic and developmental processes that will have shaped the client as well as future aspirations or needs. Psychologists have the ability to assess the suitability of different measurement procedures, depending on the purpose for which the assessment is needed, as well as being competent to devise and use context-specific procedures.

Formulation of client needs and problems

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 client'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.

Intervention or implementation of solutions

This will be the stage where the client's needs, as described by formulation, begin to be met. This may involve the use of psychological models or approaches to, for example, facilitate change, solve a problem or improve the quality of a relationship. All these interventions, or implementation of solutions, are tests of the provisional hypotheses contained in the formulation, and are subject to repeated modification in the light of experience and new data.

Evaluation of and reflecting on outcomes

Evaluation is used to measure the effectiveness of activities and interventions both during and after their implementation. The results of any evaluation and reflection will impact the next steps taken by a psychologist.

Although employers and others may demand certainty about outcomes, psychologists should always be careful to make it clear that they are able to provide only interpretations of behaviour, and advice and guidance, rather than necessarily predicting future behaviours.

Communication through reporting

Communication skills are integral to all aspects of a psychologist's role. Effective communication skills are essential in relation to all aspects of work with others. Communication skills include communication with clients, all forms of electronic and verbal communication, professional letters and reports, and the dissemination of research findings.

Audit and research

Audit and research underpin the cycle, as they help to inform all stages of professional practice.

Audit aims to evaluate how close assessment, formulation, intervention and implementation are against a set of previously given standards of practice. Audit also evaluates how protocols and procedures, for example related to consent or recording of activity, have been followed.

Research provides the evidence base for the practice of psychology. Research methods in psychology vary from qualitative observation to quantitative scientific method, so it is important to distinguish the nature and quality of the evidence underpinning any knowledge or techniques being applied. In general, basic research develops theories, models and data to describe and explain psychological processes and structures, while primary research develops and evaluates ways of using psychological knowledge to intervene with people, organisations, processes or technologies to achieve desired effects. Secondary research consolidates other research to identify higher order trends and directions.

1.3 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. The HCPC requires reflection in the record of continued professional development in order to retain continued registration.

Psychologists will need to make decisions about clients which may have a profound impact on their lives. 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. Maintaining awareness of these biases is important when trying to think through dilemmas.

Sources of influence and bias may include:

- **Cognitive Biases** – Over 150 have been described^{2,3,4} including salience (how readily something comes to mind), confirmation bias (the human tendency to look for evidence that confirms their belief and to ignore other evidence), loss aversion (risky behaviour to avoid loss), beliefs about disclosure (tendency to be more honest when they believe their actions will be known by others), and dissonance reduction (justifying actions if consequences are considered worth it).
- **Personal Experience** – the experience of the psychologist may affect how they view or treat a client or situation. This may include current or historical trauma, or the kind of organisation and culture with which they are most familiar. Interventions which may be appropriate in one context may be ineffective and cause distress in another.
- **Motivation** – the original reasons for undertaking the profession may change or be challenged due to fatigue or experience within the profession which may affect the psychologist's viewpoint.
- **Health** – psychologists should be mindful of the potential effect of health conditions or medications which they may be taking, on their practice.
- **Control over the psychologist's own practice** – this refers to clarity and openness in the management of the psychologist's business and maintaining the professional's autonomy in their interactions with clients.
- **Pro bono public work** – psychologists are encouraged, and personally motivated to

engage with such work, while being mindful of impact on the value that is placed on the profession as a whole.

- **An unethical environment** – maintaining self-recognition of what the appropriate ethical standard should be, irrespective of the prevailing situation.
- **Environment** – political realities may lead the psychologist to make compromises; while there is nothing wrong with compromises, their constant use may mean a decline in overall standards.

The literature is generally pessimistic about the ability of practitioners to overcome some of these biases, considering them to be inherent in human thinking patterns. By being aware of and acknowledging them, it can be possible to manage their influence. For example, biases can be levelled out by presenting information in different ways, by engaging the perspectives of people with different experiences and expectations, or by priming thinking with different examples.

A key factor in developing and maintaining these skills is the use of consultation or supervision and having a space where it is possible to open up thinking to the mind of another with a view to extending knowledge about the self.

It is important that psychologists from all disciplines look after their own wellbeing. This is not only important for them as individuals, but also for the quality of the care they give their clients. In their practice and, for example, within their CPD plans and supervision psychologists should consider self-care and how they can maintain their own wellbeing.

It is also important for psychologists to evaluate effectiveness of practice, by welcoming feedback from clients. This can be difficult due to fears of criticism but reflective practitioners are eager to improve and welcome any feedback that will support this process.

1.4 Continuing professional development

Continuing professional development (CPD) is the professional and work-related aspect of lifelong learning. It is an integral part of the process of adapting to change, and essential for maintaining and enhancing professionalism and competence. The Society provides an online facility to record CPD, further information is available on the *Society website: <http://beta.bps.org.uk/Practice-Guidelines>*.

- CPD is both a professional expectation and an individual responsibility to taking a structured and self-managed approach to further learning through:
 - actively engaging in a range of CPD
 - maintaining a record of CPD
 - applying learning from CPD to professional practice.
- There is a range of formal and informal learning activities that may be used for CPD and it is recommended that psychologists engage in a mix of CPD activities.
- Professional development is not purely about inputs (i.e. undertaking CPD activities); it also requires a reflective, outcomes-based approach which focuses on the learning gained from CPD and its application to current or future practice, together with the associated benefits for clients and the services provided.

- All members who are registered with the HCPC are required to comply with their CPD requirements as a condition of continued professional registration. Further information is available in *Appendix 2: Websites and further information*

Mentoring

Psychologists may seek a mentoring relationship with colleagues in order to focus their attention on skills to add to their competencies. Psychologists taking on the role of mentor often support the psychologist with their career path. Early career psychologists may find it beneficial to be mentored by a more experienced psychologist.

1.5 Consultation/supervision

Consultation or supervision is considered an essential part of good practice as a psychologist. There is no legal requirement for supervision, although it is considered an ethical and professional expectation to engage in appropriate consultation in order to support effective practice. Provision of this is therefore an important underpinning to good quality service delivery. The Society's position is, for safe and effective practice in clinical and mental health settings, or with other vulnerable groups, supervision is a requirement of practice.

The objectives of consultation/supervision are:

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

All aspects of practice are appropriate for discussion in supervision, including research activity, administrative and managerial work, service developments, team working, teaching and the process of supervising others. Supervision is not personal therapy and nor is it a form of, or substitute for, line management or appropriate training.

For psychologists working in a wide range of settings such as therapeutic and organisational settings, supervision is a core component of the psychologist's CPD. For some areas of practice, the nature of supervision changes over time. This may be unique to each psychologist and the context of their application. Expectations should be agreed from the outset and reviewed at appropriate intervals.

Forms of consultation/supervision

Supervision may take the form of clinical supervision, mentoring, coaching, supervision on placement/work setting, tutorials and peer support. Psychologists may engage in one to one supervision; group supervision (facilitated or non-facilitated) or peer supervision and any of these may be face to face or virtual. Whilst it should not be a substitute for line management, a psychologist's supervisor may also be their line manager.

Those working in independent practice, or in the absence of service-based supervision, should seek supervision from appropriately qualified and experienced personnel as appropriate. Peer supervision (individual or group) may be an appropriate way to find collegial support.

Psychologists may select different supervisors, depending on their preferred supervisory style, nature, orientation and their needs at the time. Particularly for experienced psychologists, this may be from an experienced colleague from outside their profession, professional speciality or organisation. Psychologists could also invite supervision from experts by experience for whom they provide services, where appropriate to the context of practice.

The Society maintains the Register of Applied Psychology Practice Supervisors (RAPPS), which recognises psychologists with special expertise in supervision and supervisory practice. Further information is available on the *Society Website: <http://beta.bps.org.uk/Practice-Guidelines>*.

Amount of supervision

While there is a specified number of supervision sessions for trainees (e.g. for their Chartered status) which varies across different sub-disciplines of psychology, no definitive amount of supervision is specified as part of CPD. To determine both the quantity and nature of the supervision, the psychologist may consider their need for supervision from various perspectives: their own assessment of need, the competencies required for their practice; the context of their work; organisational requirements; and the support available. For psychologists in employment the arrangements for consultation/supervision should be agreed after considering these factors in consultation with the employer.

Roles and responsibilities of the supervisor

Psychologists undertaking supervision should ensure that they are sufficiently experienced, competent and appropriately trained to provide supervision. Psychologists are often called upon to supervise non-psychologists, in which case these guidelines would also apply.

In supervision, the psychologist as supervisor needs be aware of their own competence in relation to the work of the psychologist and, where necessary, recommend additional supervisors who may have the appropriate level of expertise. Psychologists may offer consultancy supervision to professional colleagues, organisations and stakeholders in line with their competencies.

Psychologists should avoid personal relationships between the supervisor and psychologist which could adversely affect integrity and objectivity.

Psychologists providing consultation/supervision should do so in line with the guidance in other relevant sections of these Practice Guidelines.

Issues of power and control

The nature of supervision itself creates a power imbalance, even between peers. Both the person providing supervision and the person receiving it need to be aware of this.

The supervisory leadership relationship should be both informative and reflective. Psychologists in leadership roles as supervisors should provide regular, informative feedback to the psychologist as well as motivating them to reflect on their own practice, continue to self-assess and improve self-awareness.

1.6 Leadership

Psychologists at any stage of their career are likely to find themselves in a position where they are required to demonstrate or model leadership. This may be an integral part of their practitioner work or may arise through being a leader of a team, including leading in Society work. Leadership is widely quoted and described in the context of leading change as, '*accepting responsibility to create conditions that enable others to achieve shared purpose in the face of uncertainty*'⁵. Furthermore, leaders 'can create conditions interpersonally, structurally, and/or procedurally'⁶. These descriptors highlight the often complex process of psychological change through clinical intervention and also through leading others.

Contemporary leadership styles are generally more aligned to working *within* a team or a system rather than being directive. Leading as a psychologist is likely to include dealing with highly complex information and systems whatever the context. Leading in this way demands high levels of skill in developing, managing and maintaining professional relationships. This may include communicating complex and sensitive information, and reflexivity to enable individuals and teams to co-formulate around difficulty and challenge.

2. Where psychologists work

2.1 Working environment

When undertaking work with clients, psychologists need to give consideration to providing an environment which is welcoming, accessible, safe, and offers privacy. Although choice of workspace is not always available, it is important wherever work takes place with clients that psychologists consider:

- whether lighting, acoustics, heating and seating are comfortable;
- whether confidential conversations may be audible to others;
- whether there are arrangements to ensure client and practitioner safety, for example through easy access to another member of staff if a difficulty arises;
- whether access and exits are safe, well-lit and in areas which are likely to be overseen;
- that reasonable adjustments can be made to support effects of special needs and/or disability;
- whether the setting is culturally acceptable to clients; and
- whether there are facilities and equipment suitable for the clients, for example lavatories, play materials for children.

Where context of practice allows, psychologists could seek the assistance of relevant workplace representatives, for example their trade union representative or human resources staff, in situations where appropriate workplace conditions are not being provided.

However, it is acknowledged that sometimes the ideal workspace may not be available or that psychologists may not have access to these workplace representatives due to their context of practice and psychologists should, within the limits of safe practice, be able to adapt to situations within local constraints in order to provide the best service for clients.

Sometimes, it is important to work with clients in representative environments in order to understand behavioural drivers. This will apply if the psychologist's task is to understand behaviours in such environments and provide support, for example through the use of technology, design of procedures, training or team design. Psychologists should consider carefully how to create representative conditions without causing harm. Equally it may sometimes be necessary for psychologists to work in a client's own context as that is where any intervention may be formulated or put in place. Psychologists should ensure they follow the relevant health and safety guidelines in place at their working location even if that location is not their usual place of work.

There may be a temptation to make assumptions about what sort of environment is most suitable, comfortable and culturally appropriate for clients, however it is helpful to ask them and endeavour to make appropriate adjustments to meet their needs.

Lone working

Many psychologists practise in a lone worker workplace and on occasion visit clients in their own homes. When working at home, it is necessary to ensure the proper insurance

and protocols for this type of work, as well as manage boundaries between personal and private space. When working alone, the Suzy Lamplugh Trust recommends always ensuring that someone else has access to schedules and contact details for clients. Psychologists may also want to put in place a ‘code word call’, where should they fail to answer or speak the correct code word, the police are alerted. This is just an example of an additional safety practice, and there may be different ideas for ensuring personal safety when lone working. However, the important point is to think about keeping safe, have a plan and stick to it. Further information is available in *Appendix 2: Websites and further information*.

Harassment and bullying

Bullying is behaviour that may take the form of actions or comments that are offensive, which are intended to humiliate, undermine, demean or injure the recipient. It may target an individual or group of individuals and is a form of abuse that may be explicit and therefore obvious, or it may be insidious, an experience recognised only by the recipient and harder to notice by others. Bullying may be vertical (i.e. between managers/supervisors and staff) or horizontal (i.e. between colleagues). Clients may also experience bullying by professionals. While bullying may involve a misuse of power and be committed in the workplace by a manager, supervisor or senior colleagues (sometimes known as downwards bullying), it should be borne in mind that it is not uncommon for senior staff to be bullied by those whose work they oversee.⁷ What can be legitimately classified as bullying may take into account the particular personal sensitivities and characteristics of the person suffering the alleged bullying.

Harassment can be defined as actions or comments that are unwanted and which may be related to age, disability, gender reassignment, race, sex, sexual orientation, religion or belief or any other personal characteristic of the recipient. Harassment occurs when someone engages in unwanted conduct in relation to the aforementioned characteristics and that conduct has the purpose or effect of violating the other person’s dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for the other person.

The Society is a charity and bound by its objects which do not include providing direct assistance to individual psychologists in these situations by offering advice. Psychologists with concerns over the above behaviour should seek the support of their supervisor, line manager or other appropriate senior staff member, accredited trade union workplace representative or human resources department. Further information is available in *Appendix 2: Websites and further information*.

Whistleblowing

Whistleblowing is the disclosure of wrong doing (beyond normal managerial channels) and is important as it is a critical way not only of seeking justice for the individual or individuals affected, but also of developing inside information within organisations about incorrect or unfair practices,⁸ thereby increasing the evidence required for corrective action to take place.

A whistle-blower is protected by law (the Public Interest (Disclosure) Act 1998) if:

1. They are a worker (this includes trainees and can include self-employed personnel servicing an organisation in certain circumstances).
2. They are acting in the public interest.
3. The disclosure relates to past, present or likely future wrongdoing which involves one or more of the following:
 - criminal offences (which may include fraudulent actions);
 - a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
 - a miscarriage of justice has occurred, is occurring or is likely to occur;
 - the health or safety of any individual has been, is being or is likely to be endangered;
 - the environment has been, is being or is likely to be damaged; or
 - information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

If the individual has been victimised or if they have lost their job due to whistleblowing, the legislation provides them with the right to take a case to an employment tribunal. Whistleblowing is a complex legal area and it is important that anyone considering it considers appropriate advice, for example from an accredited trade union workplace representative or helpline. The relevant human resources department which will have a policy relating to this, or it may be appropriate to seek formal legal advice. Some organisations such as NHS Trusts have a nominated Director responsible for dealing with disclosure issues who may be contacted directly. The Society is a charity and bound by its objects which do not include providing direct assistance to individual psychologists in these situations by offering advice. Further information is available in *Appendix 2: Websites and further information*.

Psychologists can inform on all aspects of the establishment of workplace cultural norms that promote positive managerial and leadership behaviour and can help facilitate the development of cultures that support the disclosure of inappropriate practices. Psychologists are also appropriately qualified to support workers who have been subject to bullying or harassment or who are contemplating or indeed have already 'blown the whistle'. Whistleblowing, and even the prospect of such, can create traumatic responses in workers⁹ and can lead to retaliation as a consequence. Empirical evidence highlights the link between whistleblowing and the devastating effects on health that may follow, such as depression, anxiety and symptoms relating to post-traumatic stress¹⁰. Psychologists are able to work with affected employees and in a consultative capacity with organisations to manage work-related stress disorders caused by these incidents of bullying, harassment and whistleblowing to lessen the risk of absenteeism and to facilitate a return to work following a period of absence. Further information is available in *Section 8: How to respond when things go wrong*.

2.2 Working in the digital age

Digital media continues to advance in terms of choice and functionality. It is becoming increasingly common for psychologists in particular when working with clients to make use of the internet and/audio-visual technology. These technologies require the psychologist to ensure that the network used is as secure as reasonably possible and, as far as is feasible, assures privacy to their clients.

There can be no guarantee of security when using the internet, and voice over internet protocol (VOIP) services such as ‘Skype’ or ‘FaceTime’ are no different, as they use the same data infrastructure as the rest of the internet.

Most, if not all, VOIP systems encrypt the voice into waveforms during digital transit across the internet, and it would be impossible to eavesdrop on these data packets in real time. However, the information is potentially vulnerable to eavesdropping/compromise before encryption by the speaker’s system, and after decryption by the listener’s system. This will depend upon the security measures in place for the end user’s (speaker and listener) own networking infrastructures, be that a company, institution or home user. If an end user’s computer has been compromised by any form of malware, then there will be a risk of eavesdropping, data theft and/or denial of service.

The risk for eavesdropping on VOIP systems is no more or less than that of traditional analogue phone systems, and both would require specialist knowledge, equipment and software to be achieved. However, it is recommended that only fit-for-purpose VOIP systems are used, and that public networks, such as Social Media sites, are avoided for VOIP communications. Further information is available on the *Society website: <http://beta.bps.org.uk/Practice-Guidelines>*.

Some employers may have their own rules about which media are acceptable to use. The USA has the Health Insurance Portability and Accountability Act (HIPAA) which sets standards for security for electronic data. There is no such provision in the UK to date, and so psychologists must satisfy themselves that any media used to communicate personal data is secure. This is a rapidly changing area and so technology-specific guidance has not been provided in this document. Further information is available in *Section 7.1: Information governance* and *Appendix 2: Websites and further information*.

The use of online ‘Apps’, computer assisted decision-making and artificial intelligence in psychological practice and research is evolving rapidly. When recommending or using computerised systems psychologists should pay due regard to peoples’ health, wellbeing and safety being mindful of Clinical Safety Evaluations, Medical Device Evaluations and other relevant guidance such as NICE.

Use of social media

Many psychologists are using social media, networking sites or blogs to communicate with friends, family, professionals, colleagues and clients. This specific guidance therefore addresses the use of social media by psychologists, and provides practical advice for using them responsibly. Further information is available in *Appendix 2: Websites and further information*.

Psychologists should:

- Remember that social networking sites are generally public and permanent. Once something is posted online, it remains traceable even if it is later deleted.
- Keep their professional and personal life as separate as possible. This may be best achieved by having separate accounts for work-related communications to those for friends/family.
- Consider whether, in their context of practice, it is appropriate to accept 'friend' requests from current or past clients, if necessary, decline the request via more formal means of communication. It is highly unlikely to be appropriate to accept in a clinical or forensic context.
- Be minded to act responsibly at all times and uphold the reputation of the profession, whether identified as a psychologist or not on the social media platform.
- Be aware that social networking sites may update their services and that privacy settings can be reset to a default that deletes personalised settings.
- Remember that images posted online by family or friends may be accessible, as they may not have set privacy settings as tightly.
- Be minded that social networking sites can make it easier to engage (intentionally or unintentionally) in professional misconduct.
- Report the misconduct of other psychologists on such social networking sites to any relevant parties (such as the employer or the HCPC).
- Be aware of their employer's social media policy.

Psychologists should not:

- Establish inappropriate relationships with clients online.
- Discuss work-related or confidential issues online in any non-secure medium.
- Publish pictures of clients online, where they are classified as clinical records.
- Use social networking sites for whistle-blowing or raising concerns.
- Post defamatory comments about individuals or institutions. Defamation law can apply to any comments posted on the web, irrespective of whether they are made in a personal or professional capacity.

2.3 Working for the court

Psychologists may be asked to act as professional or expert witnesses in court. The main difference between an expert witness and an ordinary witness (i.e. a witness to fact), is that the former are able to give an opinion, whereas ordinary witnesses can give only factual evidence. A professional witnesses' remit can cross the boundary of both fact and opinion.

Psychologists are responsible for ensuring they are sufficiently competent and expert in offering an opinion. It is not appropriate for trainee or assistant psychologists to act as expert witnesses. Indications of competence in respect of the knowledge required by the court, and expertise within a specialised field, may include:

- qualifications and/or degree(s) in the areas(s) in question;
- a number of years of post-doctoral/post-qualification experience;
- academic, professional and scientific publications in relevant areas;
- demonstrations of professional practice, competence, specialist knowledge and expertise with a bearing upon the issues in the case; and

- current experience in applying psychology in the area of claimed expertise.

It follows that a psychologist with trainee or assistant status is unlikely to have the necessary experience and qualifications to be retained as an expert witness by a legal firm. However, trainees or assistants who have written reports on individuals in the course of their employment may be required to give evidence (for example, at a tribunal). If so, they should bear in mind that only qualified psychologists should give evidence of opinion, and that their supervisor is responsible for the professional quality of their work in this situation as in all others.

Psychologists instructed as experts need to ensure that they can provide an independent and impartial opinion, and that their independence is clear to all. Any potential conflicts of interest should be made explicit and should be reported as soon as they arise. This can extend to being asked to provide an expert report on someone the psychologist is providing with therapy as an 'Applicant', 'Claimant' or 'Complainer'. This dual relationship is an unacceptable conflict.

When lawyers seek to introduce expert psychological evidence, it is the judge in the case who decides whether an individual has the requisite expertise to give evidence with the potential to be relevant to the case. The judge also decides whether what the expert asserts is relevant and, therefore, admissible in law.

Expert evidence in civil court proceedings is governed by Part 35 of the Civil Procedure Rules 1998, and its associated practice direction. This rule makes clear that an expert's overriding duty is to help the court on matters within their expertise and that this duty overrides the expert's duty to the person from whom they are receiving instructions. Any report must be written in accordance with the criteria in Practice Direction 35.

Further information is available in *Society documents: Psychologists as Expert Witnesses: Guidelines and Procedure* and *Psychologists as Expert Witnesses in the Family courts in England and Wales*.

2.4 Working for defence and security organisations

Psychologists may work with defence and security interests in many different capacities. This may include supporting military or security personnel to perform their roles through the development of skills and behaviours, supporting the mental health and wellbeing of people affected by threats, activities and events in this context, and offering advice and consultancy. It is also UK Defence practice to enlist uniformed psychologists for roles associated with psychology. However, in general, psychologists in defence will be in a civilian role and therefore not under military command.

While there is a strong sense of common culture within the defence and security sectors, there are also important variations. For example, each of the armed forces has its own organisational culture resulting in different attitudes and behaviours. There are also differences within different sectors of each organisation. All these differences are very important to the individuals concerned, forming a large part of their sense of identity.

Psychologists working with these populations should ensure they investigate and acknowledge cultural differences, particularly when working with other national cultures. They should also take careful account of the environments in which people are living and working. Psychologists can be working with civilians and/or members of the armed forces who are operating in life threatening environments and are required to make decisions under extraordinary pressure. It is usually invalid to extrapolate from behaviour in benign conditions to behaviour under threat, hardship and stress.

3. Who psychologists work with

3.1 Working with Experts by Experience

In relevant services it is best practice for psychologists to work collaboratively with clients and Experts by Experience in developing and delivering all aspects of psychological services. In mental health, the Government is committed to shared decision-making and the principle ‘no decision about me without me’¹¹. This applies from work with an individual client through to changes in government policy relevant to the services provided by psychologists. Psychologists should develop services, policies and guidelines in collaboration with the people who use their services.

In professional practice it is important and helpful to work collaboratively with clients and, where relevant, others in order to ensure that the application of psychological research and theory is understood by and adapted appropriately to the client group and context, which may differ from the populations on which the research was based.

3.2 Working with assistants/interns

Many graduate psychologists take up assistant psychologist positions on either a paid or an unpaid basis.

The following (non-exhaustive) list provides examples of activities which can be carried out by assistant psychologists/interns. This list can guide those who are working as assistant psychologists/interns to request or refuse a task or assignment, as well as assist those who are practising and supervising to observe boundaries and limitations:

- research, audit and service evaluation;
- literature searches, developing and maintaining training packs, information leaflets, libraries of equipment, and other tasks necessary to the efficient running of the service;
- assessment of individuals and groups, for example, direct observations, formal psychometric testing, semi-structured interviews, and writing appropriate reports;
- delivery of interventions with individuals, groups and organisations;
- undertaking supportive work with carers, family members, employers, human resources professionals, team members, health staff and other professionals;
- delivering training for other professionals (if and when competent to do so); or
- promoting applied psychology services by providing relevant information to referrers, commissioners and others.

An assistant psychologist/intern should not be employed to:

- substitute for qualified applied psychologists; or
- undertake solely administrative or clerical duties for which a clerical assistant should be employed.

In occupational settings, the issue of appropriate supervision and guidance is of particular importance when the needs of individuals and organisational demands need to be balanced. Appropriate mechanisms need to be in place to ensure that no assistant psychologist/intern is, for instance, put in a position where they have to design or decide on any materials or processes which could have a potential harmful impact on individuals or groups or to an organisation (such as potential loss of profit or revenue).

In clinical and forensic settings, there are some additional limitations, related to the clear delineation between qualified and assistant psychologist/intern, as follows:

- An assistant psychologist should carry out only prescribed interventions with individuals or in groups, and should write reports only when under close supervision of the primary, qualified psychologist. Any report should be signed as having been written ‘under the supervision of’ followed by the name, registration status and job title of the qualified psychologist.
- When an assistant psychologist is called to give evidence in a legal setting, such as a tribunal, the qualified psychologist remains responsible for the professional quality of the assistant’s work. This means the qualified psychologist should attend the hearing also, as there may be questions which an assistant cannot answer. Both should bear in mind that an assistant is not qualified to give evidence of opinion.
- An assistant psychologist should not undertake tasks in areas where there is not a competent supervisor.
- An assistant psychologist should not carry out the duties of a care assistant.

The managing or supervising psychologist has a responsibility to ensure that assistant psychologists are not given work to do that is over and above their level of competence. Further information is available in *Society Document: Applied practitioner psychologist internship programmes and unpaid voluntary assistant psychologist posts*.

3.3 Working with trainee psychologists

The Society’s standards related to working with trainees across the domains of applied psychology are set out in the Standards for accreditation of training programmes. These set out: the required core competencies that trainees need to develop, the curriculum and assessment requirements that programme providers need to deliver against, and the requirements of supervised practice; expectations around trainees’ understanding of and ability to work ethically and legally; selection and recruitment of trainees; personal and professional development of trainees whilst in training; academic staffing and leadership for accredited programmes; and expectations in relation to quality management. Psychologists working with trainees as practice educators should familiarise themselves with these standards and adhere to them in their work with trainees. Further information is available on the *Society Website*: <http://beta.bps.org.uk/Practice-Guidelines>.

3.4 Working with multiple clients

Psychologists will sometimes be in situations where their client will not be one clear individual or group, for example, a psychologist may be employed by an organisation to

provide assessment or psychological support for employees. Psychologists need to consider and be mindful of the demands that this might place on their ethical practice and how this might lead to conflicts of interest.

Identification of the following client hierarchy may be considered^{12,13}:

- Primary client – the person or persons with whom the psychologist is interacting directly: the recipient of a psychological service.
- Commissioning stakeholders – the organisation or overall commissioning body that has sought the psychologist.
- Others affected by the primary client’s actions – the customers of the organisation or service, or the personal acquaintances, friends and family of the primary client. In some circumstances, this will be the general public or larger groups interested in the outcomes of the intervention.

The psychologist’s role will be mainly to the primary client and then the commissioning stakeholder. It is paramount that issues around boundaries and sharing of information are made explicit and addressed appropriately through a clear contracting agreement. Further information is available in *Section 3.5: Working with other professionals*, *Section 5: Making and maintaining agreements* and *Section 7: Managing data and confidentiality*.

Within each of the levels of the hierarchy, varying allegiances to associates (friends, family, acquaintances, colleagues) will need to be attended to, as will consideration of the impact of professional activity on the reputation of the profession and all those concerned.

3.5 Working with other professionals (including in multi-agency settings)

In order to meet the complex needs of clients fully, psychologists will often be required to work collaboratively with other professionals from their own or other agencies.

Such collaborative working will be for the benefit of clients and/or the promotion of the safety and protection of the public or the benefit of the organisation, and is required by national policy and legislation in a number of areas in which psychologists work. Engaging in partnerships drawing on a wide range of services and agencies enables psychologists to address identified community issues with the optimum use of resources.

Where appropriate to their context of practice, and consistent with the requirements of psychological practice, psychologists should:

- Work together with colleagues to develop a shared view of the aims and objectives of work at all levels. They should respect the professional standing and views of other colleagues and commit themselves to joint working.
- Make it clear to other professional colleagues what can be expected of them in collaborative work, the work that will be done, and the point at which the work will be terminated.
- Ensure that there are explicit agreements about information-sharing and confidentiality and its limits, and that these are adhered to.

- Practise and encourage in others full and open communication with colleagues/agencies to support effective collaboration within the boundaries of the agreed limits on information-sharing and confidentiality,
- Demonstrate their commitment to involving clients in multi-agency work, finding ways to engage them and retaining the central principle of better outcomes for clients as the rationale for multi-professional and multi-agency work, as long as this is consistent with public safety.
- Be sensitive to the effects of clients receiving contradictory advice from different professionals or agencies and should work towards a co-ordinated view wherever possible.

3.6 Boundaries in professional relationships

Psychologists seek to establish good relationships and trust with their clients, other professionals, organisations and the community. They are aware of the complexity of professional relationships and the need to observe their boundaries. Multiple relationships occur when a psychologist is in a professional role with a client or colleague and at the same time is in another role with the same person or group e.g. as a supervisor, sports club member or co-author in a publication or where a psychologist is asked to work at a school where their child is a pupil.

Psychologists should:

- Ensure that the relationship reflects the appropriate context within which the practice is taking place.
- Be aware of the issues of multiple relationships and professional boundaries which may lead to (real or perceived) conflicts of interest or ethical considerations.
- Clarify for clients and other relevant stakeholders when these issues might arise.

When acting as leaders in practitioner or managerial roles, psychologists should maintain an awareness of the importance of respect for boundary and power issues within leadership relationships. In particular, an awareness of the possible abuse of these relationships should be maintained at all times. It is important that psychologists explicitly define the boundary of the relationship and negotiate and respect the responsibility that each holds in relation to it. Where psychologists are in a position of power/leadership with individuals, it is particularly important that they exercise caution and consider the possible issues which may arise from developing a personal relationship with these individuals. It may be necessary to seek further supervision where appropriate, with additional peers as necessary.

Psychologists have a duty of care towards their clients, who may be vulnerable, and should maintain a professional emotional distance from clients, service users or relatives and should not enter into an intimate or sexual relationship with any clients, service users or relatives they come into contact with as part of practice. Psychologists should also be aware that their duty of care can continue after a client/practitioner relationship has ended.

As far as is reasonably practical, psychologists should not enter into a professional relationship with someone with whom they already have, or have had, a close personal

relationship. This includes family members and friends. Where there is no reasonable alternative, such as a lack of availability of other professionals, and it is acceptable in the particular context of practice, the psychologist should make every effort to remain professional and objective while working with the individual they know or have known. In such circumstances, at the earliest possible opportunity, this should be disclosed and discussed with a manager, where there is one, and supervisor and a note should be made in client records.

A range of psychologists work with people who initially have accessed the services in a dependent position, and have then transitioned to becoming partners and colleagues in service and policy development and design. The nature of the work becomes more collegiate and the psychologist holds multiple roles including facilitating participation, adapting communication and advocacy.

3.7 Working with children and young people

When seeking to work with children and young people, psychologists should consider how they can develop ways of communicating with the child or young person that will be most effective in ensuring they can express their views and feelings.

In most instances psychologists will use their specialist professional training and experience working with children, young people and families in order to understand the developmental needs of the child or young person in question; where a psychologist does not have specialist training that has included children and young people then there would be an expectation that advice or supervision should be sought before working with a child, young person, or their family. Similarly, work with children, young people and their families should take account of wider systemic factors outside of the child or young person; this will usually involve the child's family and may also include their school, and other settings.

As with adult clients, there can be misunderstandings and confusions about the role of a psychologist, the nature of the work being undertaken, and the possible outcomes of the work. It is essential to ask the children and young people about their understanding of what is happening on a regular basis (this may be appropriate at each session) and address any confusion that has arisen.

When working with children and young people, psychologists are advised to ensure that they have ascertained who has parental responsibility and that those with parental responsibility are aware of their planned involvement, if this is appropriate. Psychologists working with children, young people and families need to be aware that young people who are deemed to be competent to make their own decisions: 'Gillick competent'¹⁴ can give their own consent to involvement with a psychologist, and that if a young person gives consent under these circumstances, then parental consent is not required. Similarly, a young person who is 'Gillick competent' can give consent even if parents have declined to give consent; such young people can also ask that parents are not informed of any involvement, and this should be respected by the psychologist; an example here would be in a school setting where a young person may give their own consent to see a psychologist

and may ask for parents not to be informed. Psychologists also need to be aware that where separated or divorced parents share parental responsibility, one parent can give consent.

3.8 Working with people with intellectual disabilities and impaired cognitive abilities

Psychologists are likely to work at some point with a range of people whose cognitive abilities are either temporarily or permanently altered, either by organic or developmental changes. Appropriate assessment of the abilities and skills is required, so that adaptations can be made to further interventions, treatments or management. The implications of the cognitive abilities on the person, their family and the reason for psychology involvement, will need to be considered.

Psychologists working with people with intellectual (learning) disabilities will need to consider adaptations to their approach to ensure the service they are offering is clearly understood, and is adapted to the individual's preferences, strengths and needs. This can include considering adaptations to oral or written communication, psychological assessment, intervention, and outcome evaluation.

Psychologists will need to be flexible and to make reasonable adjustments to their usual practice to ensure an appropriate service is offered. Psychologists should ensure their work is person-centred and respectful of the individual's needs, whether that work involves working with the individual with intellectual disabilities directly, or whether it also includes, or even may predominantly involve, working indirectly with family, carer or professional systems around the individual.

Psychologists will need to be mindful of the range of complex factors that often affect people with intellectual disabilities (e.g. communication needs, poorer mental and physical health outcomes and healthcare service experiences, unemployment, disempowerment, social isolation and exclusion, including experiences of bullying, abuse and hate crime, being overrepresented in the prison population, among others) and, therefore, the specific policy and practice guidance that applies. Further information is available in *Section 4.2: Safeguarding adults at risk of harm* and *Section 6.3: Informed consent with people who may lack capacity*.

3.9 Working with detained people

Where clients are detained involuntarily there will always be a legal framework within which professionals must practise, and they should be aware of how their work fits into that framework. Involuntary detention is not only covered by professional rules and national legislation, but also by international agreements.

Psychologists should be aware that having the approval of one's employer is not necessarily a guarantee that practice is either ethical or legal, as described for example in the Hoffman report¹⁵. Where practitioners have doubts about the legal or ethical acceptability of employer demands, they should seek advice from an accredited workplace trade union representative, a human resources department, or appropriate helpline. They should

follow their organisation's guidelines on raising concerns at work. Seeking advice outside the immediate setting is helpful as colleagues within the workplace may be subject to the same pressures as they are.

Under the headings below, the role of the practitioner can be seen to be key to the way that detained persons are understood, and this can have a great impact on the way that their cases are handled by the detaining authority. The practitioner therefore has considerable power, whereas the client has very little. This power imbalance should always be borne in mind by practitioners dealing with detained persons. They should also bear in mind that the imbalance can be implicit as well as explicit.

Prisoners

Putting psychological pressure on detained persons to obtain a confession to an offence is illegal under the UN Convention on Torture¹⁶. In this context, 'psychological pressure' could well include such things as telling indeterminate-sentence prisoners who maintain innocence that they are unlikely to be released unless they engage with an intervention that relies on acknowledgement of guilt. Decisions about release are not the role of the practitioner, unless they are directly involved with, or are a member of the release authority, with a delegated role in the formal decision-making process. An approach to engagement such as this would not be considered beneficial to the client. However, those instructed by any party to the formal Parole Board decision-making process may properly be asked to give an opinion on suitability for release.

Practitioners dealing with detained offenders who have committed violent or sexual offences should guard against being morally judgemental. It is routine for practitioners in this field to encounter offenders who have committed very unpleasant acts with whose victims they can readily identify. Psychologists should be mindful that their own views about a client do not impact on their work.

Care should be taken when working with detained persons whose literacy is poor or whose first language is not English, and who cannot read a report which has been written about them. Even clients who are literate in English will probably not be familiar with psychological terminology, and may need considerable time to read and fully digest a report. People who are detained can also have cognitive challenges or intellectual disabilities which might make this process more difficult.

Persons detained under immigration legislation

Detained people may be afraid of raising a particular topic in case it is misunderstood, or too embarrassed because of cultural standards. For example, in some cultures it is difficult or unacceptable to discuss sexual matters, but sexual violence has been suffered by many asylum seekers in conflict zones, and some discussion of it may be essential in assessing their case. Even within the same culture there can be considerable generational differences.

Psychologists should guard against unwarranted interpretations of psychological evidence by commissioners or authority figures. For example, reporting that someone's story shows inconsistencies may give the impression that they are lying. This may be the case, but inconsistencies alone are insufficient proof of this. It is commonplace for evidence to be

inconsistently reported when people have been through traumatising experiences in areas of conflict, as is often the case with persons detained under immigration legislation.

Practitioners should take particular care in dealing with detained persons whose first language is not English. The opportunities for misunderstanding in both directions should be obvious, and in many cases the correct procedure will be to interview with the help of an interpreter. Failing to use interpreters when it was clearly appropriate to do so could inappropriately compromise the quality of the psychologist's work.

Mental Health Detentions

Mental Health Act 1983 as amended 2007 (England and Wales)

Under the Mental Health Act (MHA) a person can only be detained for treatment if that person is suffering from a mental disorder of a nature of degree that makes it appropriate for them to receive medical treatment in hospital. In the Act 'mental disorder' is defined as 'any disorder or disability of mind'. This definition is very broad but the *Code of Practice* provides guidance on clinically recognised conditions that fall within its meaning. Major categories of mental illness (e.g. affective disorders, schizophrenia and organic mental disorders) are included along with personality disorders, autistic spectrum disorders and learning disabilities (the latter only if accompanied by abnormally aggressive or seriously irresponsible behaviour). Dependence on alcohol or drugs is not considered a mental disorder under the MHA.

In the Act, all 'medical treatment' including psychological interventions is for the purpose of alleviating, or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations. The medical treatment must be required for the health and safety of the client or for the protection of others. This means that the primary purpose of psychological interventions offered and provided to detained persons has to be to reduce the risks that their mental disorder presents to the detained person or others; as once those risks are reduced or minimised the client will no longer require detention and can progress to a less restrictive environment. This requirement points to the importance of an individualised formulation of a client's treatment needs that includes a careful assessment of the risks to self and others (see section on Risk Assessment, p.32).

Under the MHA appropriate medical treatment must be available. This is described as the 'appropriate medical treatment test' in the *Code of Practice*. Such treatment must have the *purpose* of alleviating or preventing a worsening of the disorder or its symptoms or manifestations, even if it cannot be shown in advance that the treatment is likely to have an effect for a particular patient. Thus, appropriate medical treatment need not be likely to achieve those purposes. That is, purpose is not the same as likelihood. The nature and degree of the patient's mental disorder and all the patient's particular circumstances are all relevant to whether the treatment is appropriate.

The appropriate medical treatment test is designed to ensure that patients are not detained for treatment unless they are actually to be offered appropriate treatment for their mental disorder. Thus, the MHA requires only that appropriate treatment is available to a detained patient. The patient's refusal to accept treatment is not an obstacle to detention, so long as appropriate treatment is available.

This has particular relevance for psychological therapies. The Code at chapter 23.20 states:
In particular, psychological therapies and other forms of medical treatments which, to be effective, require the patient's cooperation are not automatically inappropriate simply because a patient does not currently wish to engage with them. Such treatments can potentially remain appropriate and available as long as it continues to be clinically suitable to offer them and they would be provided if the patient agreed to engage.

Whilst the availability test of appropriate medical treatment applies to psychological interventions in the same way as for other forms of treatment, it is important for psychologists to avoid placing pressure on clients to participate in such treatment. In order for there to be an effective therapeutic alliance there needs to be trust and this only develops in the absence of coercion. Psychological therapy works when the client decides they are ready for therapy and freely consents to it. There is an inevitable power differential in favour of the clinician. Thus, every attempt should be made to emphasise patient involvement and choice and to avoid coercion in a manner consistent with the *Code of Practice* empowerment and involvement and respect and dignity principles. Further information is available in **Section 6: Obtaining informed consent**.

The Mental Health Act 2007, which amended the MHA 1983, introduced approved clinicians (AC) who may be drawn from a defined group of professions, including practitioner psychologists listed in the register maintained by the Health and Care Professions Council. ACs are approved by the appropriate national authority to act as an approved clinician for the purposes of the MHA 1983. Responsible clinicians (RC) are ACs who have overall responsibility for an allocated patient's case. The Code of Practice at chapter 36.3 says that a patient's RC should be the available AC with the most appropriate expertise to meet the patient's main assessment and treatment needs. At chapter 36.5 the Code says that where psychological therapies are central to a patient's treatment then it may be appropriate for a professional with particular expertise in this area to act as the RC.

Chapter 39 of the *Code of Practice* provides guidance on the circumstances in which potential conflicts of interest may prevent designated professionals from making an application for or recommendations supporting a patient's detention or guardianship. The potential conflicts of interest dealt with in the Code involve financial, business, professional and personal issues.

The Mental Health (Scotland) Act 2015.

This act, together with the Mental Health (Care and Treatment) (Scotland) Act 2003 sets out the law for detaining patients and restricting patients. For patients to be detained, this has to be considered by the Mental Health Tribunal for Scotland. This applies, for example, to those detained in the NHS who are not subject to a court (forensic) decision.

Restricted patients are 'detained in hospital under a compulsion order with a restriction order'. They have usually committed an offence punishable by imprisonment but as a result of mental disorder are not imprisoned but ordered to be detained in hospital for treatment, without limit of time. They are dealt with through a programme of treatment and rehabilitation – the aim being to prevent recurrence of offending by dealing with the mental disorder'.

Risk assessment

When dealing with detained people seeking release, such as parole applicants or patients seeking release from a mental health tribunal, risk assessment (usually for violence risk) will be a prime consideration. Psychologists should bear in mind that risk assessment is not prediction. Risk assessment instruments are rarely more than about 70 per cent accurate when predicting reconviction and many items on commonly used risk-assessment schedules are of poor predictive value.¹⁷ Psychologists should also bear in mind that risk-assessment instruments are better at identifying low-risk than high-risk individuals^{18,19}. A statement of risk is not a prediction about an individual, but a statement based on the behaviour of a criterion group with which that individual is being compared. Risk is statistical by its very nature, and the value of such comparisons depends upon the individual's similarity to the criterion group upon which the risk assessment instrument was developed. Accuracy may be greatly reduced if the similarity is low²⁰. It may be better to think of risk assessment as a process of identifying those risk factors which need to be monitored and controlled if supervision of the individual is to be reduced or withdrawn.

3.10 Working with people who are, or would like to be employed

Psychologists are sometimes commissioned to deliver psychological assessment or training with employees and potential employees. Psychologists should take particular care over the advice provided in follow-up reports, as employers are not trained professionals and may misinterpret advice or psychometric testing results. For example, citing a reading ability level using age is misleading, and could be interpreted as incompetent for the role, when in reality the role does not require a high reading level or a reasonable adjustment could be provided.

Similarly, psychologists should ensure that the tools they are using to assess competence or suitability are appropriate for the role, and have good reliability and validity. Any tools devised by the psychologist are likely to be interpreted by the employer as professional and authoritative, where there is ambiguity or multiple interpretations, this must be made clear, so that decisions about peoples' employment are not made in error.

There are people who work or who would like to work, who may experience cognitive difficulties caused by a range of factors, for example intellectual disabilities, dementia, acquired brain injury. Sometimes this information is known and needs to be considered when assessing and advising. At other times, this possibility of a cognitive or intellectual impairment needs to be considered. The impact of this can be far reaching, in terms of ongoing or future employment, access to benefits and of course associated psychological adjustments for the person and the people around them. Further information is available in *Section 7: Managing data and confidentiality* and *Society Document: Psychological Assessment of Adults with Specific Performance Difficulties at Work*.

3.11 Working with cultural difference

It is expected that all psychologists will have the necessary skills and abilities to work with all sections of the community.

Psychologists need to be aware of stereotypical beliefs and assumptions which manifest in thinking about culture and ethnic groups. Psychologists should bear in mind the history of racism and the early development of Western psychology²¹ and culturally biased testing in favour of white, middle-class children. Psychologists need to recognise that multi-ethnic groups are not homogenous groups and there are wide regional and local differences among these groups which can be split by language, dialect and regional variations. Each ethnic community has a distinct identity and religious focus may also vary within and across communities.

Race is not a biologically meaningful concept to apply to people, and even the artificial divisions between the so-called racial groups are nebulous and unstable, biologically, socially and physically.²²

Psychologists need to understand the discrimination suffered by people from diverse and/or minority ethnic and religious backgrounds as a result of:

- the interchangeable use of the terms race, culture and ethnicity leading either to the perception of black and minority culture, race and ethnicity as unitary or an assumption that knowing about these cultures solves the problem of equality, fairness and availability of services;
- the maintenance of the colour-blind approach in service where ‘one size fits all’, resulting in a lack of formal recognition of the varied diverse needs as well as these needs being ignored, unacknowledged or assumed to be the same;
- the lack of appropriate culturally relevant psychological therapy available to certain Black and Minority Ethnic (BME) communities;
- being discriminated against on grounds of ‘special’ needs, effectively considered as ‘cultural pathology’; and
- experiencing instances of indirect, subtle, or unintentional discrimination often called ‘micro-aggressions’.

It would be expected that all practising psychologists should develop a productive working relationship with culturally and linguistically diverse groups of people by:

- avoiding different types of biases and find new ways (verbally and non-verbally) to build rapport and respect;
- using and working with trained interpreters in assessment, formulation and intervention work as well as research work;
- being aware of the impact of culture, ethnicity and religion in assessment, formulation and intervention processes and the use of norm-referenced tests which do not include minority ethnic groups as part of their standardisation;
- pre-assessing and pre-incorporating ethnic identity (including its fine gradations, region, class and generation) which can have impacts on processes and outcomes of psychological work;
- acknowledging their own ethnocentricity and possible underlying socially conditioned prejudice to people who are ‘different’; psychologists need to acknowledge that people can change, irrespective of their differences and psychological distress;
- relooking at current models of mental health which traditionally reflect Western

- constructions, and incorporating other world views of psychological wellbeing; and
- understanding and respecting the different concepts of health and illness that exist within different ethnicities, including newly arrived people from Europe and refugees from Syria, Turkey, Somalia etc.

Psychologists need to: address the different life situations and life circumstances experienced by users who wish to use mental health services; hear their voices based on their personal experiences; and act and respond accordingly in a human way.

3.12 Working with people of faith, religion and spirituality

In working with clients who hold a variety of values and religious and spiritual beliefs which may be different from their own, psychologists should consider the following:

- Psychologists should respect clients' values and spiritual beliefs and need to be mindful that their personal beliefs should not be an impediment to engaging with the client.
- Spiritual beliefs are very often beneficial to the client's wellbeing and may be helpful to be incorporated into any intervention to achieve a positive impact where appropriate.
- In some circumstances the client's faith belief may be harmful or detrimental to themselves or others.

3.13 Working with sexual and gender minorities

Psychologists are committed to the fair treatment and inclusion of people who are intersex, people who do not identify as heterosexual and/or people who do not identify with their natal-assigned sex. This section provides guidance to address specific issues in support of these heterogeneous populations. In these guidelines we use the term 'sexual minority(ies)' to refer to individuals whose romantic attraction or sexual attraction is other than heterosexual (different from the majority in the surrounding society), and the term 'gender minorities' to refer to transgender, genderqueer and intersex individuals.

When working with gender and sexual minorities, psychologists are encouraged to:

- remember that sexual and gender minority identities are not indicative of mental health disorders;
- understand that attitudes towards sex, sexuality and gender are located in a changing social, cultural, and political context, and to reflect on their own understanding of these concepts and how it may impact their practice;
- reflect on the limits of their practice when working with certain sexual and gender minority clients, and to consider appropriate referral and training when necessary;
- understand how social stigmatisation (e.g. prejudice, discrimination and violence) poses risks to gender and sexual minority clients;
- consider engaging with the wider socio-political context regarding sexual and gender minorities in order to reduce social stigma;
- be knowledgeable about the diversity of sexual and gender minority identities and practices;

- use the preferred language of the sexual and gender minority individuals;
- understand the unique and particular circumstances and challenges facing clients with diverse gender and sexual identities and practices;
- understand the diversity of forms of relationships and families in gender and sexual minority clients;
- be aware of the potential challenges facing sexual and gender minority clients in their relationships and families;
- be mindful of the intersections between sexual and gender minority and socio-cultural/economic status;
- recognise the particular challenges experienced by gender and sexual minorities with physical and/or mental health difficulties;
- recognise the diversity of developmental pathways for sexual and gender minority children and adults;
- recognise the needs and issues of young people from gender and sexual minorities, and their particular vulnerabilities;
- support the self-determination of their clients in the development of their identities and practices; and
- avoid attempting to change gender or sexual minorities on the basis that they can be ‘cured’ or because of stigmatising theory, personal, religious and/or socio-cultural beliefs.

Working with racially and ethnically diverse Lesbian, Bisexual, Gay, Trans*, Queer (LGBTQ) populations

Black and minority ethnic (BME) LGBTQ people have to negotiate between the values and beliefs of the mainstream and minority ethnic cultures. Cultural differences in norms, beliefs, and values can be a source of psychological stress^{23,24,25}. There may be no particular sexual and ethnic minority group to which a BME LGBTQ person can anchor their identity and obtain acceptance and support. This may be a particular issue for BME LGBTQ youth who are exploring their sexuality and sexual identity.

When offering psychological services to racially and ethnically diverse LGBTQ populations, it is not sufficient for a psychologist simply to identify the racial and ethnic identity and background of the client. Ethnic minority status can complicate and exacerbate the issues, challenges and difficulties the client experiences. The client can be affected by the way their ethno-culture community view and understand sex, sexuality and gender. The issue of racism within the LGBTQ community is also an important issue to consider^{26,27,28,29}. Sensitivity to the complex dynamics associated with factors such as cultural values about gender roles, religious and procreative beliefs, degree of individual and family acculturation, and the personal and cultural history of discrimination or oppression is also important. All of these factors may have a significant impact on identity integration and psychological and social functioning^{30,31,32,33,34}.

Further information is available in *Society Document: Guidelines and Literature Review for Psychologists Working Therapeutically with Sexual and Gender Minority Clients*.

3.14 Working with people who may be socially excluded

Social exclusion refers to the extent to which individuals are denied access to the prevailing social system and the right to participate in key areas of social, economic and cultural life. This exclusion occurs due to constraints and restrictions rather than as a matter of choice. Exclusion is typically a result of poverty and/or belonging to a social minority group. The impact of social exclusion has been well documented and leads to the perpetuation of cycles of inequality for individuals and groups. These cycles of inequality are perpetuated in terms of income, health, opportunity, relationships and life-span. Further information is available in *Society Document: Socially inclusive practice*.

Social inclusion is the process where the needs of all members of communities and the groups which constitute them are recognised, prioritised and met, resulting in these individuals feeling valued and respected. Promoting social inclusion is a broader task than promoting equality and tackling discrimination and stigma. It requires psychology professionals to address wider structural issues in society which maintain excluding processes and power differentials.

The range of individuals and groups who may experience disadvantage and exclusion is not limited to the protected characteristics outlined in the Equality Act. For example, people may also experience exclusion because of their age, they are a carer or are in care, they have a low income or low educational achievement, or their cognitive ability is compromised.

When working towards social inclusion psychologists are encouraged to:

- acknowledge, understand and respect the diversity of the communities in which they practise;
- make adjustments where possible and needed, to enable people to fully participate, e.g. to communication, access to services, adaptation to materials and psychological assessment and interventions;
- recognise that they have a professional duty actively to promote equality and opportunity;
- recognise the shame and distress caused by discrimination, and the impact of discrimination on wellbeing;
- acknowledge and respond to the trauma and distress caused by exclusion;
- move beyond the level of the individual and recognise that social exclusion is a structural issue, and that inclusion will be achieved only by structural changes in society and broad policy initiatives;
- acknowledge that there is a responsibility to highlight the links between structural societal factors and mental health problems;
- make employers, policy-makers, clients and the general public aware of situations where policies, practice and the distribution of resources are oppressive, unfair, harmful or illegal;
- challenge social conditions, both as individuals and collectively, that contribute to social exclusion and stigmatisation;
- make services accessible in terms of time, space, familiarity and comfort; make reasonable adjustments to services to meet individuals' needs; people need to be able

to get to places, get into places, feel welcomed to places and feel that they belong in places;

- recognise that inclusive services reflect the communities they serve in terms of the identities and diversity of the staff team;
- recognise the range of interventions that can improve clinical and social outcomes and use influence to ensure these services are commissioned;
- emphasise social outcomes and participation alongside clinical outcomes;
- maintain an emphasis on empowering clients to achieve their social goals; and
- identify natural sources of support and reciprocal relationships for individuals within their communities, and seek out opportunities to help individuals transition out of formal mental health services.

4. Safeguarding

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect³⁵. This guidance addresses safeguarding of both children and adults.

Abuse takes many forms and cuts through various domains of life. The categories below are often referred to in investigation/legislation context and are not mutually exclusive with e.g. emotional abuse featuring in the other domains of abuse. Abuse can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

- Physical abuse – is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This could include hitting, poisoning, deprivation of food, water or liberty, rough handling or exposure to heat or cold, amongst other things.
- Sexual violence and abuse – sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding. Sexual violence and abuse can take many forms and may include non-contact sexual activities such as: indecent exposure, stalking, grooming or being made to look at, or be involved in the production of sexually abusive material, or being made to watch sexual activities.
- Psychological/emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, blaming, controlling, intimidation or coercion amongst other things.
- Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not, or could not, consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation, embezzlement, withholding pension or benefits or pressure exerted around wills, property of inheritance.
- Institutional abuse is the mistreatment or neglect by a regime or individuals, in settings which people who may be at risk reside in or use. Institutional abuse may occur when routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. It may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services and includes a failure to ensure the necessary preventative and/or protective measures are in place.
- Neglect is the persistent failure to meet basic physical and/or psychological needs. It may involve a parent or carer failing to provide adequate food, clothing and shelter, failing to provide or unresponsiveness to, basic emotional needs or failing to protect from physical harm.

Psychologists are in a particularly relevant position to identify interactions or circumstances that affect health and development. This applies not only to psychologists who undertake direct work with children and vulnerable adults in a variety of settings; but also to those who work with clients, seen for instance in clinics, hospitals or prisons, who may make historical disclosures of abuse or raise concerns about child protection or the welfare of people within their families or communities. Safeguarding is thus the responsibility of all psychologists whatever their role.

4.1 Safeguarding children

The Society endorses *Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children*³⁶. Safeguarding children is the responsibility of everyone.

The guidance defines safeguarding children as protecting children from maltreatment and preventing impairment of children's physical or mental health or development (physical, intellectual, emotional, social and behavioural). Promotion of welfare is defined as ensuring that children grow up in circumstances consistent with the provision of safe and effective care, and taking action to enable all children to have the best life chances.

Child protection within safeguarding refers to the activity that is undertaken to protect specific children who are suffering or likely to suffer significant harm. For the purposes of child protection legislation children are those who have not yet reached their 18th birthday. The child's needs are paramount, and the needs and wishes of each child be they a baby or infant or an older child, should be put first, so every child receives the support they need before a problem escalates.

The policy of Working Together is underpinned by two key principles: (a) safeguarding is everyone's responsibility and for services to be effective each professional and organisation should play their full part; and (b) safeguarding requires a child-centred approach based on a clear understanding of the needs and views of children.

Where there are concerns that a child is at risk of harm, such concerns should normally be communicated following the psychologist's work-place safeguarding protocol. Where this is not applicable, concerns about a child's welfare can be made directly to the local authority children's social care team.

Psychologists should:

- be alert to the heightened vulnerability/possible need for early intervention support for a child who: has a disability, has additional needs (including special educational needs), is a young carer, is showing signs of engaging in anti-social or criminal behaviour, has returned home from care and/or is showing early signs of abuse and/or neglect.
- be alert to heightened vulnerability where a child is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems and domestic violence.
- consider the potential impacts of parental/carer ill-health on the family and whether this creates any significant negative impacts or risks for children within that family;

- be aware that if an adult has responsibilities for children outside the home setting, such as working with children, their mental ill-health and/or their health more generally upon the adult's capacity to work safely;
- be aware that children within the same family can be treated differently (one child may be singled out for abuse);
- be aware/seek to understand how children can come to abuse other children;
- recognise that some professionals use their position to abuse children and vulnerable people; and
- challenge institutional abuse in its many forms.

Psychologists should be aware of situations of risk which require additional consideration, notably:

- sexual exploitation, which involves exploitative situations, contexts and relationships without the child recognising the harm on account of their age/understanding, social/economic and/or emotional vulnerability;
- internet abuse, which can involve cyber bullying, exposure to pornography or violence and exploitation of young people;
- domestic violence which may expose a child to violence directly or indirectly;
- shame-based abuse where children or young people may be physically assaulted or murdered because of bringing perceived 'shame' to their families or breaking cultural expectations of 'honour'; and
- Trafficking, any child transported for exploitative reasons is considered to be a trafficking victim, whether or not they have been forced or deceived. This is partly because it is not considered possible for children to give informed consent. Even when a child understands what has happened they may still appear to submit willingly to what they believe to be the will of their parents or accompanying adults.

Psychologists should have a knowledge and understanding of services for children in need and how to access them. Psychologists confronted with child abuse in any form should contribute to whatever actions are needed to safeguard children and promote their welfare. The needs/interests of adults should not be allowed to take precedence ahead of the needs of the child. Psychologists should work co-operatively with parents/carers unless this is inconsistent with ensuring the child's safety and ensure that the child's view is sought, heard and communicated. Psychologists should share appropriate information in a timely way, discuss any concerns and help analyse information so that an assessment can be made of the child's needs and circumstances. Psychologists should contact the children's services or social services department at the appropriate local authority (in some cases this role has been delegated to a multi-agency safeguarding hub) if they are concerned about a child or a vulnerable adult.

Managing cases of alleged historical abuse

There is a growing recognition that a disclosure of non-recent abuse may reveal current risks to others from an alleged perpetrator. Psychologists have a duty of care to their clients, and in the safeguarding of others. This may place psychologists in complex positions when trying to negotiate and balance their duties and responsibilities.

Psychologists who work with adult clients who disclose non-recent sexual abuse, should recognise that there may be current and ongoing risks posed by the alleged perpetrator to others. Not sharing concerns beyond the consulting room could mean that other children and young people could be at risk.

A client's allegations should be taken seriously, regardless of their presenting problems or mental health diagnosis.

Lack of access to children identified through familial relationships, work or volunteering roles should not eliminate concerns about risk, given opportunities for abuse to occur within communities.

It is crucial that psychologists seek advice from colleagues, particularly colleagues in safeguarding services, within the organisation and also from other agencies tasked with leading on safeguarding (i.e. social services). Psychologists working with clients without a referral and where no stakeholder agency is involved should seek advice from senior experienced colleagues on how to proceed. Psychologists need to be alert to the possibility that abuse may be organised, severe and complex.

There may be times when, in the interests of supporting a client's psychological readiness for disclosure, consultation may continue without requiring identifying details to be provided to the psychologist. It is important that a clients' lack of readiness to disclose does not become an obstacle to receiving psychological help. Further information is available in *Society Document: Guidance document on the management of disclosures of non-recent (historic) child sexual abuse*.

Where the disclosure is made by the perpetrator of the abuse, risk assessment should be made regarding the context of the setting of the disclosure but there may be a professional obligation to disclose the criminal offence in order to safeguard other potential victims as above.

4.2 Safeguarding adults at risk of harm

The Care Act 2014 brought in new legislation regarding the safeguarding of all vulnerable adults. In some regions there is a move away from the term 'vulnerable adult' towards the concept of an adult at risk of harm.

An adult at risk of harm is a person aged 18 or over with need for care or support, who is experiencing, or is at risk of, abuse or neglect, and as a result of their needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The needs referred to here may cover a variety of personal or life circumstances including (but not limited to) cognitive impairment, age, disability, illness, injury or mental health condition.

The legal context

There is no set piece of legislation for adult safeguarding. It is a mix of criminal law, case law and welfare law. The Care Act 2014, updated in 2016, brought in the first legal framework for safeguarding adults in a single act. It contains a range of regulations and statutory guidance, which form the base upon how social care will develop in the future.

It enshrines the new statutory principle of wellbeing and it makes it the responsibility of local authorities to promote wellbeing when carrying out any of their care and support functions. The act specifies the rights of those who need care and support, their carers, and the funding system for care and support. It recognises that this cannot be achieved by any single agency. Every organisation and person who comes into contact with a child or adult has a responsibility and a role to play to help to keep children and adults safe. Further information is available in *Appendix 1: Relevant legislation*.

Modern slavery

An important area of concern is modern slavery. The Government website provides details about the government's work to end modern slavery, including details about how to refer victims into the national referral mechanism (NRM). Modern slavery is a serious crime. It encompasses slavery, servitude, and forced or compulsory labour and human trafficking. Modern slavery victims can often face more than one type of abuse and slavery, for example if they are sold to another trafficker and then forced into another form of exploitation.

A person is trafficked if they are brought to (or moved around) a country by others who threaten, frighten, hurt and force them to do work or other things they don't want to do.

A victim of slavery is entitled to help and protection from the UK Government (this is called the National Referral Mechanism), all support is provided on a confidential basis, and support to talk to the police. The National Referral Mechanism has been put in place to identify victims of trafficking and refer them to organisations that will offer help and support. Further information is available in *Appendix 2: Websites and further information*.

Responding to concerns

Safeguarding adults means:

- Protecting the rights of adults to live in safety, free from abuse and neglect.
- People and organisations working together to prevent and stop both the risks and experience of abuse or neglect.
- People and organisations making sure that the adult's wellbeing is promoted including, where appropriate, taking fully into account their views, feelings and beliefs in deciding on any action.
- Recognising that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances and therefore potential risks to their safety and wellbeing.

Providers' safeguarding arrangements should always promote the adult's wellbeing. Being safe is only one of many things that adults want for themselves and there can be challenges in balancing safety and freedom in a way which protects and fulfils human rights.

Providers, and other professionals where relevant, should work with the adult to establish what being safe means to them and how that can be best achieved.

Care and support means different things in every case. The fundamental standard on safeguarding is that children and adults using services must be protected from abuse and improper treatment. Providers should establish and operate systems and processes

effectively to ensure this protection and to investigate allegations of abuse as soon as they are aware of them.

The standard states that care or treatment must not:

- Discriminate on the grounds of any of the protected characteristics of the Equality Act 2010;
- Include acts intended to control or restrain an adult or a child that are not necessary to prevent, or not a proportionate response to, a risk of harm to them or another person if the adult or child was not subject to control or restraint;
- Be degrading to the adult or the child;
- Significantly disregard the needs of the adult or the child for care or treatment.

The standard goes on to state that no adult or child must be deprived of their liberty for the purposes of receiving care or treatment without lawful authority.

Safeguarding Adults Boards were established to help and safeguard adults with care and support needs. The Safeguarding Adult Board must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies, according to the values of 'Making Safeguarding Personal' Guide 2014³⁷. Making safeguarding personal is not just for people with capacity, it is just as important for people who lack capacity. The Guide specifies outcomes that people might want including to be and to feel safe, to maintain or get friends, to know that this won't happen to anyone else or to be able to protect self in the future.

The following are not outcomes:

- Harm or abuse is substantiated/unsubstantiated.
- The person is receiving increased monitoring or care.

The role of the Care Quality Commission³⁸ is to monitor, inspect and regulate services to make sure that they meet the fundamental standards of quality and care. The Commission works alongside Safeguarding Adults Boards and Safeguarding Children Boards to share information and intelligence where appropriate to help them identify risks. This includes providing appropriate advice and support to people at risk of radicalisation in sectors such as healthcare and education.

4.3 Terrorism and extremism

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ('specified authorities' listed in Schedule 6 to the Act), in the exercise of their functions, to have 'due regard to the need to prevent people from being drawn into terrorism'. Depending on where the psychologist works, these duties may have relevance in the course of their employment. The term 'due regard' as used in the Act means that the authorities should place an appropriate amount of weight on the need to prevent people being drawn into terrorism when they consider all the other factors relevant to how they carry out their usual functions.

The current UK definition of ‘terrorism’ is given in the Terrorism Act 2000. In summary, this defines terrorism as an action that endangers or causes serious violence to a person/people; causes serious damage to property; or seriously interferes or disrupts an electronic system. The use or threat must be designed to influence the government or to intimidate the public and is made for the purpose of advancing a political, religious or ideological cause. People suspected of being involved in such activity must be referred to the police.

‘Extremism’ is defined in the Prevent Strategy³⁹ as vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty, and mutual respect and tolerance of different faiths and beliefs. Definitions of extremism can also include calls for the death of members of our armed forces, whether in this country or overseas.

While it is recognised there is no single profile associated with extremism, identity is considered to be central, and risk screening is based on assessment in relation to two general pathways into extremism – criminal and non-criminal. Disengagement follows a similar process. This is a contentious area of practice. Psychologists should ensure they focus on their core role, working in a non-stigmatising way, and avoiding profiling based on characteristics such as race, religion, ethnicity or any other aspect. The psychologist should carefully weigh relevant professional obligations and seek and follow appropriate local and employer guidance. Further information is available in *Appendix 2: Websites and further information*.

5. Making and maintaining agreements

Both client and psychologist benefit by having arrangements for the work clearly set out from the start. Psychologists should be aware that all professional engagements are ultimately governed by the law of contract. A legally enforceable contract can arise as a result of the parties' entering into a written agreement, but can also arise as a result of a verbal agreement between the contracting parties.

A contract arises if the following are present:

- one of the parties (the offeror) had made an offer to the other party (the offeree);
- the offeree accepts the offeror's offer;
- there is consideration (i.e. something of value) passing from each party to the other, e.g. the offeror provide services to the offeree; the offeree pays the offeror;
- the parties intended to create a legal binding arrangement; and
- the terms of the contract are sufficiently certain.

While this does not mean that all client engagements are made subject to an agreed contract document, it does mean that in the worst-case scenario of a complaint against a psychologist being made, it will be very helpful for the psychologist to be able to demonstrate that they have met their professional obligations to their client. This will be best done by demonstrating that an agreement was made by both parties who knew what they were agreeing to, that the parties had the legal capacity to make such an agreement and that what they were agreeing to is permitted under the law. Where the client does not have the capacity, best interest decisions need to be made in accordance with the Mental Capacity Act. Further information is available in *Section 6: Obtaining informed consent*.

Psychologists may wish to include the following when making agreements:

- the role and function of the psychologist;
- the psychologist's relevant qualifications, areas of expertise and ways of working;
- relevant limitations of the psychologist's practice, e.g. assessments not accepted or types of activity not undertaken;
- where the psychologist is appointed to work with a third party, the psychologist should make clear their obligations to each of the clients concerned and each client's obligations under the agreement and ensure that there are no conflicts or ambiguities;
- the extent of the psychologist's power and responsibilities when acting on behalf of other agencies;
- obligations in relation to duty of care and safeguarding, and related limitations to confidentiality;
- how confidentiality of client information and data is assured and any limitations to that confidentiality;
- how conflicts of interest will be managed if applicable;
- the client's, or other party's, rights of access to stored information;
- the use of any one-way viewing screens or video or audio recording and the security of any recorded material;

- the nature of psychological activities involved, the reasons for undertaking them and information about the likely outcomes;
- the availability of the psychologist to the client;
- details of fees, together with application of VAT if non-clinical services, or expenses to be billed in connection with the work undertaken;
- what is expected from the client as their contribution to the engagement with the psychologist, expectations for payment and consequences of non-payment;
- ownership of intellectual property rights;
- what might cause a breach of the agreement;
- the rights of each party to withdraw from the agreement and the consequences to any financial agreement;
- recourse to dispute resolution or law;
- the equality and justice aspects of social policies and their possible impact;
- external ethical scrutiny and approval of the engagement, where appropriate; and
- arrangements to terminate the retainer.

In advance of any psychological assessment, the client should be made aware of the availability of services, and the existence of any waiting lists for intervention.

For some approaches, intervention follows an evolving path, unique to each client and his or her life circumstances, which cannot be precisely predicted in advance. Clients should be made aware of this uncertainty, and predictions should be made on the best judgments. It is recognised that it is sometimes unrealistic and undesirable to provide detailed information on all aspects of psychological intervention, and consent should be obtained to a general strategy rather than specific procedures. Further information is available in this document or the *Society Website: <http://beta.bps.org.uk/Practice-Guidelines>*.

5.1 The practitioner's right to withdraw their service

There are circumstances in which a psychologist may decide to terminate the agreement for provision of psychological services. The circumstances may be personal or professional.

The personal circumstances may include but will not be restricted to leaving employment in a psychological service, incidences of illness or family commitments.

The professional issues may relate to service structural changes, safety, or provision of most appropriate service.

In these circumstances, psychologists will, as far as possible, work to ease the transition of service provision and give as much notice as is practical in the particular situation.

5.2 Referrals

Where a psychologist finds themselves unable to come to an agreement with a client, the psychologist may refer the client to a suitably qualified colleague. Psychologists will both make and receive referrals when working in services with other professionals.

In making referrals, psychologists should consider the needs of the client and to the best of their knowledge refer to another professional with the appropriate skills and experience.

In receiving referrals, the psychologist should consider whether the referral is appropriate for psychology, establish the client's understanding of the purpose of the referral, and consider as far as possible prior to meeting the client whether the referral falls appropriately within their own areas of practice.

5.3 Representation of the qualifications and status of the psychologist

HCPC registration and BPS Chartered Status

Psychologists are encouraged to state their registration with the HCPC and protected title(s). This will provide assurance that the psychologist meets national standards of training and professional skills.

Use of the 'consultant' title

The term 'consultant' generally does not have a formal definition. Within the medical field it is used by doctors who have considerable experience and proven expertise demonstrated through examination within their respective Royal Colleges.

While there is no clear comparable grading structure for psychologists outside the NHS (within the NHS, the consultant title is used by psychologists who are employed in Band 8C, 8D and 9 positions), the use of this title would be seen to reflect both seniority and specialist expertise.

There is a difference between a 'consultant' psychologist and a psychologist who provides consultations in their context of practice. The Society expects that psychologists should be honest and accurate in representing their professional affiliations and qualifications, including such matters as knowledge, skill, training, education and experience.

The Society's position is that this would be applicable in any situation where expert knowledge or skills is being marketed or promoted, whether or not this is for financial gain. Further information is available in *Society Document: Guidance on the use of the title 'Consultant Psychologist'*.

6. Obtaining informed consent

Psychologists should always ensure that they have sought and received the consent of those they work with, given of their own free will, without undue influence.

The concept of informed consent relates to the client's right to choose whether to receive psychological services, and to make this choice on the basis of the best information available presented in the most appropriate way. The principles apply, whether the psychologist works in the public, private or voluntary sector or in independent practice.

Psychologists should obtain the informed consent of the client in an appropriate manner prior to undertaking any assessment, intervention or research activities. In all circumstances, common sense and ethical practice should apply when considering the approach to gaining informed consent from those with whom the psychologist is working.

This section refers, in the main, to consent with adults with capacity. Further information on informed consent with discrete communities where further consideration may be needed is available in *Sections 6.1 to 6.4*.

Obtaining informed consent involves a process which is dynamic and is relevant to the specific assessment, intervention or decision being made at that time. When there are substantive changes in the intervention or when the psychologist has reason to consider the client may no longer consent, consent should be reviewed. Psychologists should ensure that their clients are enabled to play an active role in this process. Clients should be encouraged to ask questions whenever they are in doubt.

Psychologists should be aware that a client's desire for help, and the immediate impact of the psychologist's supportive listening, may affect the client's ability to make informed choices about the help they wish to receive. They should also be aware that their own desires to help a client may bias their presentation of information, such as the probability of successful outcomes.

Psychologists should be aware of the complexities of obtaining informed consent to treatment due to the perceived power, status and authority of the professional psychologist. It may not be clear if the consent given is freely given by the client or, for example, is part of a pattern of compliance towards authority figures. Equally, a client may say that they understand the explanation given by the psychologist, and accept a plan for intervention, in order to avoid the discomfort of being seen not to understand the psychologist's complex language and ideas.

Obtaining informed consent is particularly difficult when the client is obliged to undertake the psychological intervention as part of an employment process or performance measure where they may have obligations under their employment contract; or when detained.

There should ideally be an ongoing dialogue between client and psychologist, as part of the process of joint decision-making. At any point, the client should feel free to ask questions about the impact of the treatment and withdraw consent to continue.

Psychologists should attempt to intervene against the express wish of a client only after careful consideration and in line with relevant legislation, policies and professional practice.

Provision of information for informed consent

In order to ensure that the client has all the information necessary to make an informed decision about whether to take part or not in a psychological activity, they must be provided with relevant information, such as that listed below, in a format that is designed to meet their specific needs.

The psychologist should consider providing information about the following:

- what the psychological activity involves, as far as this is consistent with the model of interaction, e.g. there will be limits in the use of some non-directive therapies and psychometric assessments;
- the benefits of the activity, either directly to the client in the case of assessment or intervention, or indirectly in the case of systemic intervention, or to potential theoretical advances or service improvement;
- any alternative assessment or treatment options and their known availability;
- foreseeable risks and how minor or serious they may be, for example the potential to feel worse at stages during therapeutic interventions;
- what might be the benefits and potential costs and risks to them of engaging or not engaging in the proposed psychological activity; and
- the client's right to withdraw their consent from assessment, treatment or intervention at any stage, along with information about any likely consequences of such withdrawal.

Consent to involvement of others

Psychologists have an obligation to ensure that prospective clients are informed of the extent and limitations of confidentiality with respect to anticipated services, the purposes of any assessment, the nature of the procedures to be employed or the intended uses of any product such as notes or recordings, before the assessment or intervention starts. Further information is available in *Section 7: Managing data and confidentiality*.

The psychologist should ask the prospective client: whom they would wish to be informed of their assessment or treatment, if anyone; and the information they are willing to share where communication is essential, for example to the referring agent or organisation, management or court. Wherever appropriate, including in the law, the client should have copies of reports or letters or be given feedback so that they are kept fully informed.

If it is deemed necessary to move from individual contact to include others this should where possible be done with the client's prior consent.

Psychologists may be asked to provide consultancy or advice to colleagues about an identified client, without that person's knowledge or when the client has indicated that they do not want to have direct contact with the psychologist. In these circumstances, the psychologist will need to consider their potential involvement and the need for consent.

A psychologist who draws upon the work of other professionals in preparing a report, should seek their consent, where possible and if not already in disclosed records, to include that material and should acknowledge its source in the report.

If a report is requested which draws upon previous or concurrent investigations of a client in other contexts, for example NHS records in the preparation of a report for the court, the client's consent or relevant authority's consent for that information to be used should be sought.

If psychologists wish to use reports on clients which have been compiled by other professionals, they should do so only with the consent of those professionals and use the reports only in the context for which the report was specifically provided.

Information on and consent to record-keeping

Express consent must be sought in advance for the use of video, audio recording or one-way screens, with a clear explanation of the purpose of these. Further information is available in *Section 7.1: Information governance*

6.1 Informed consent for court

When a psychologist is instructed to give evidence in court, it is the court that should be informed and whose authority should be sought for the work undertaken. When serving as a witness in the legal arena, the psychologist is responsible to the court, rather than to either party.

6.2 Informed consent with children and young people

All children and young people, whatever their age or status, have a right to express their views freely and be involved in any decision-making that affects their lives, which includes judicial and administrative proceedings⁴⁰. Therefore, psychologists who seek to work with children or young people must gain their informed consent. This applies whether the child or young person or another agent with legitimate responsibility for the child or young person has made the request for involvement. Any direction or guidance provided by parents or other caregivers must be 'in accordance with the child's evolving capabilities' and support the 'exercise by the child of his or her rights'⁴¹. The onus is then on the adults to provide appropriate support to enable the child or young person to express their views and contribute to decision-making.

Every psychologist should consider how they can:

- provide an accessible explanation to the child or young person about their work as a psychologist;
- offer a clear reason for their possible involvement;
- provide an opportunity for the child or young person to talk about what working with the psychologist might involve.
- discuss and agree how information is recorded and possibly shared with others with an awareness that young people who are 'Gillick competent' can consent to information not being shared with parents;

- discuss how the child or young person will be kept safe;
- ensure that the child or young person has understood the psychologist's role and has given their informed consent;
- ensure the child or young person understands they can withdraw their consent at any point;
- ensure their practice acknowledges and respects the culture, community and context of the child or young person.

Occasionally, a disagreement over consent may arise between parent/carer and child or young person and/or between parents/carers. The psychologist would make every effort to resolve the difference of views, perhaps seeking, with agreement, involvement of an appropriate family member and/or a colleague, although as discussed above, a young person who is 'Gillick competent' can legitimately request that family members (including parents) are not involved or informed of any involvement. If the disagreement is not resolved, the psychologist should draw on their professional experience to act in the best interest of the child or young person seeking consultation and support through appropriate channels, including safeguarding and legal departments, and consultation with appropriate colleagues including other professionals.

6.3 Informed consent with people who may lack capacity

It is likely that psychologists at some stage within their careers will be working with people who lack capacity to consent to assessment or treatment. This could be because of a wide range of difficulties such as intellectual disability, brain injury, dementia, severe mental health difficulties, and neurological conditions. As a result, it will often be necessary to make a judgment about a client's ability to give informed consent. This should include whether the person is able to:

- understand the information relevant to the decision (e.g. psychological treatment);
- retain that information;
- use or weigh that information as part of the process of making the decision; and
- communicate their decision (whether by talking, using sign language or any other means.)

The Mental Capacity Act 2005 contains 5 key principles which it is important to understand:

1. A presumption of capacity;
2. Individuals being supported to make their own decisions;
3. Individuals have the right to make 'unwise' decisions;
4. Anything done on behalf of a person with a mental capacity issue should be in their best interests; and
5. An intervention should be on the basis of the 'less restrictive option' weighed up in the particular circumstances of the case.

The Mental Capacity Act Code of Practice⁴² expands upon these points (and indeed all aspects of the Act), highlighting the need to assist a client in making a decision for

themselves (with the use, for example, of memory aids, simplified resources, etc.). It should also be noted that the fact that a person is able to retain the information relevant to a decision for a short period does not prevent them from being regarded as able to make the decision.

The Mental Capacity Act (2005) provides a clear framework for what to do if a person lacks capacity to make a range of decisions, including consenting to treatment. The principle of 'best interest' must be followed, and the Act states clearly who needs to be consulted in relation to making such a decision and ensuring that the individual's wishes are considered.

It is good practice to give full information (possibly using adapted resources) to clients even when they are not deemed able to give informed consent. The psychologist must, so far as reasonably practicable, permit and encourage the client to participate, or to improve their clients' ability to participate, as fully as possible in any act done for the client and in any decision affecting them.

In some circumstances, it is possible that there may be others who have been given legal authority for decision-making on behalf of others, such as Power of Attorney for Health and Welfare or Deputyships for Health and Welfare. It is important to note that patients might also have created Property and Affairs Lasting Powers of Attorney. Those acting under a Property and Affairs power alone will not have authority to make decisions in relation to a patient's treatment. If someone is a Health and Welfare Attorney or Deputy, those persons will be able to make those decisions on behalf of others. It is also necessary to ensure that the client has not made an Advance Decision to refuse treatment prior to the loss of capacity, although this is unusual in relation to psychological treatment.

In some clinical contexts, particularly relating to brain injury, intellectual disabilities and dementia, issues related to capacity and best interest are particularly prevalent. Psychologists practising in these areas need to ensure sufficient knowledge and expertise. Further information is available in *Society Document: Guidance on determining the best interests of adults who lack the capacity to make a decision for themselves*.

6.4 Informed consent with people as employees

Tripartite arrangements where an employer commissions and pays for an assessment or intervention, such as diagnostic assessments for neurodiversity and cognitive functioning return to work assessments, or coaching, potentially give the employer access to data that they will struggle to interpret, or may misinterpret, for example test scores and details of personal life. It is important that the psychologist protects the employee by giving the employer only what they need to know and can reasonably require for the purpose of employment.

The Psychologist should consider whether they will be gathering information that is not usually held by an employer, or is not held routinely for all employees, for example IQ scores and childhood experiences. If so, the psychologist should consider abridging documentation so that the employer receives only the information they 'need to know',

and the employee can if necessary hold a full copy for future reference. This prevents discrimination against employees who are subject to in depth assessment for reasons related to illness, neurodiversity or disability from being unfairly compared to their peers. It also prevents complex psychological information from being held by those who are not qualified to interpret it.

Agreements should be made explicitly about the information which can be shared with the commissioning organisation. In order to aid transparency, information should normally be sent to the client prior to being shared with the organisation.

6.5 Informed consent with detained persons

Prisoners

Informed consent may be harder to obtain when a client is detained. Psychologists working with detained persons should be aware that, as well as UK law, the UK is signatory to a number of conventions on the treatment of detained persons. These conventions not only outlaw physical ill-treatment, but also certain kinds of psychological pressure. For example, it is contrary to the UN Convention on Torture to apply psychological pressure to elicit a confession, or compliance with a regime. In this context, 'psychological pressure' could include making progression contingent on compliance with a particular aspect of the regime. Practitioners should be particularly mindful of the power imbalance in forensic contexts, which is far more acute than is generally found in non-justice system based settings. Only offenders detained in secure hospitals can be required to comply with assessments or treatments under involuntary detention sections of the Mental Health Act.

Mental Health Detentions

For psychologists there can be potential conflicts of interest or what could be better termed 'competing duties of care' between the roles of Responsible Clinician (RC) (for further information on this role see Section 3.5) (including the duty to detain or otherwise compel participation in treatment) and that of psychologist (including, principally, the duty to establish freely-given consent wherever possible to enhance the efficacy of the therapeutic intervention). The MHA Code at chapter 24.34 (medical treatment) states that permission given by a patient to a particular treatment 'under any unfair or undue pressure' is not consent (p.257).

Good outcomes for psychological therapies are associated with positive therapeutic alliances and good working relationships between therapists and patients. The potential for even perceived abuse of power and the inherent power differential between an RC and a detained patient subject to the MHA runs a risk of rupturing this relationship or it becoming coercive. Psychologist RCs must therefore remain aware of and give full consideration to any potential competing duties of care between the RC and psychological therapist roles when providing psychological treatments to patients over whom they have compulsory powers.

The main issues to be considered by psychologist RCs when addressing potential competing duties of care in this context include the following:

1. Psychological treatments (with the possible exception of indirect interventions delivered by proxies such as paid staff and carers) are more likely to be effective when informed consent is obtained. As such, RCs acting as psychological therapists should utilise all reasonable and ethical attempts to obtain consent from patients before proceeding with psychological treatment. The *Code* at chapter 24.34–24.39 (p.257) provides guidance on obtaining consent.
2. The Act permits psychological treatment to be given without consent and the Code provides guidance on how to proceed with treatment in these circumstances (chapter 24.40–24.44, pp.257–258). There may be circumstances, especially when significant risks to others or self have been identified, when it is considered to be necessary for a psychologist RC to proceed with providing psychological treatment without consent. In such circumstances then there should be, where practicable, prior discussion with the MDT involved in the patient’s treatment and care about the risks involved. Careful consideration should be given to the availability and merits of another suitably qualified member of the team providing the psychological treatment required with the RC remaining in overall charge of the client’s care.
3. There may be situations where it is judged that informed consent cannot be clearly obtained, or where it would appear another available practitioner would be more likely to achieve a more effective outcome (perhaps due to the power differential between patient and RC). In such situations the psychologist RC is advised to refer on to other members of the treatment team who are able to provide the psychological treatment needed, while the RC remains in charge of overall care.

7. Managing data and confidentiality

7.1 Information governance

Psychologists should follow local and national guidance and statutory responsibilities regarding management of data. Psychologists should make, keep and disclose information in records only in accordance with national policy and legislation, and the policies and procedures of the organisation(s) they are employed by/working in collaboration with. Further information is available in *Section 1.1: Legal and professional obligations of psychologists*, *Appendix 1: Relevant legislation* and *Appendix 2: Websites and further information*.

Psychologists must bear in mind the potential impact of the information in their records on all who may have access to such records, for example, the client, other professionals, managers, authorised carers, etc. Where possible, distinction should be made between fact, observation and opinion, and judgemental comments should be avoided. Psychologists are responsible for holding their records securely to ensure the confidentiality of the information contained within them and to control access to them. Further information is available in *Society Guidance: Guidelines on the use of Electronic Health Records*.

This guidance applies to all record-keeping on clients, their relatives, carers and/or associates, and their organisations, regardless of the media in which information is held, e.g. written notes and reports, audio- and video-recordings, paper and electronic records, etc.

Records made, kept or accessed by psychologists should be:

- systematic and appropriately detailed;
- in clear language/format;
- accurate;
- up to date; and
- relevant to professional work and to the purpose for which they were collected.

Clients have a legal right to access records concerning them, and this right is enshrined in legislation. Additionally, it is good practice for clients to be given feedback on their content. Sharing records with clients supports the collaborative approach of psychologists and enables clients to have full and effective involvement. Client access to records will be restricted to information about themselves and not third parties. Restrictions will also apply when disclosure would place the clients or others at risk of serious harm.

In tripartite arrangements involving an employer access to information should be governed by agreements made explicitly about the information which can be shared with the commissioning organisation.

Shared records

In some organisations in which psychologists work single, multi-professional, client-based records are held. Such records are designed as shared documents (paper or electronic),

the function of which is primarily to facilitate inter-professional communication to ensure the safe and effective delivery of high quality services. Such records may be shared among organisations/agencies to facilitate care and/or exceptionally, to safeguard the client or others, including the general public. In some contexts, clients have the right to object to their data being disclosed to a third party even someone who might provide essential healthcare. Psychologists should be aware of local codes and policies. Further information is available in *Section 3.5: Working with other professionals*, *Section 7: Managing data and confidentiality* and *Appendix 2: Websites and further information*.

Psychologists should include in the shared record all information about their work with clients and related others which is required to ensure appropriate multi-professional care and to safeguard the client and relevant others, including the general public.

Third-party and sensitive material should be clearly marked. There should be clarity/clear communication within the multi-professional team about what is and is not shared with the client if there are safeguarding concerns. A system needs to be established about how suspicions and causes of concern are recorded and/or shared.

Where shared records are held, other professionals involved with the clients will have access to such records. This should be explained to the clients at the onset of engagement with them.

The use of sealed envelopes is no longer considered good practice following the findings from serious untoward incident investigations where the existence of sealed envelopes compromised care.

Assessment materials

Psychologists should be mindful at all times of the confidential nature of assessment materials. Many assessment measures are invalidated by prior knowledge of their specific content and objectives. Psychologists who use these materials are required to respect their confidentiality and to avoid their release into the public domain (unless this is explicitly allowed in the nature of the instrument and by the test publisher). Psychologists should, therefore, take reasonable steps to prevent misuse of test data and materials by others. Further information is available from *Appendix 2: Websites and further information*.

In many organisations, there is only one shared records system. In these cases, it is necessary for psychologists to be able to use the shared records system to hold raw data from psychometric assessment. The results of psychometric assessment will be incorporated into reports which explain their context and appropriate interpretation, and which are included in the shared institutional record. In relation to the visibility of the psychometric instrument and the raw data to other members of the multidisciplinary team who are not psychologists, the onus is on the other professionals not to interpret information where they are unqualified to do so, just as the psychologist would not interpret, for example, physical healthcare test results they are unqualified to interpret. Psychologists may consider whether it is appropriate to mark assessment materials so their nature is clear.

Additional data

Psychologists may wish to keep separate notes to aid their work but which are not intended for sharing with others or to be part of the permanent client record. These notes, often called process notes, which are written for the purposes of reflection on practice, should be anonymised with no other identifying links e.g. initials, appointment time, so that these notes therefore are clearly not part of the client record. Process notes may, for example, be used for reflection and supervision. If process notes are made to assist in compilation of a report, the material should be incorporated, as relevant, into the final report and the process notes then destroyed.

Long-term illness, incapacity or death of a psychologist

Most organisations will have procedures in place in the event of illness, incapacity or death of a psychologist. Psychologists in independent practice are advised to make a professional will and to appoint a professional executor, probably an experienced colleague, whose role it would be to take charge of client records, to inform the clients involved and, where appropriate and practicable, to make provision for continuity of the service provided.

Retention and destruction of records

Psychologists' records should be held securely for as long as they are required for the purpose of psychological work. Psychologists must follow legal requirements, national and local policy frameworks and procedures regarding the retention or disposal of records after the psychologist's work is concluded. Psychologists should ensure that they keep up to date with requirements.

For independent practitioners general guidance is that many independent psychologists keep records relating to contact with adults for 7 years, and follow NHS guidance in relation to children. Where the records derive from work undertaken within an organisation, the maintenance of these records is determined by the organisation's policies and legal requirements.

Retention and destruction of health records, both paper and electronic, is covered in the NHS code of practice for records management. Generally speaking, retention is until age 26 for people seen as children; 20 years after the last contact for adults, and 8 years after death if the death occurred while the person was in the care of the NHS. There are specific requirements for mental health services depending on the nature of the contact.

In education settings, Local authorities generally retain Education Health and Care Plans for 35 years after the case has been closed. Other records are retained until the child is 25.

All records must be destroyed under confidential conditions following organisational procedures or for independent practitioners using a destruction service or process which meets industry standards for document management and can provide the appropriate certification.

7.2 Confidentiality

Clients are entitled to expect that the information they give to psychologists about themselves and others will remain confidential. Psychologists have a duty not to disclose

such information except as discussed below and to bring their confidentiality practice to the attention of their clients, employers, managers and any other professionals involved.

Psychologists have a duty to inform involved parties of their confidentiality standards and practice at the point of first contact. Clients should be informed of the limits of confidentiality where information about them may be shared and confidentiality breached, for example for reasons of safeguarding, requirements of the law, and public protection.

Psychologists have a duty to be aware of the content of any other relevant guidelines and of any other policy guidelines which set out local expectations.

Use of client data for audit must follow the Caldicott principles, which, designed for the NHS, provide helpful guidance for any setting in terms of when it is appropriate to use with client-identifiable data and when anonymised data should be used⁴³. Generally under data protection legislation, it is necessary to obtain specific informed consent for the use of client data for particular purposes, and to inform clients of the purposes for which their data is being collected and how it will be used. Further information is available in *Appendix 2: Websites and further information*.

Disclosure of information

If disclosure of information is deemed necessary, psychologists should obtain specific informed consent from their clients, making the consequences of disclosure as clear and unbiased as possible. There are a number of circumstances where this might not be possible or may not apply: for example where the health, safety, security or welfare of the client or someone else may otherwise be put at risk; and if there are legal or safeguarding responsibilities, such as the need to avoid ‘tipping off’. If confidentiality is broken without consent, the client should be told what has been said and to whom, unless such disclosure may expose the client or others to serious harm or is contrary to legal or safeguarding obligations.

Psychologists who are faced with the difficult decision as to whether to disclose information without a client’s consent must weigh carefully the arguments for and against disclosure. The responsibility for this decision lies with the individual psychologist although they may seek advice and guidance from appropriate sources such as their employing organisation’s Information Governance or Data Protection Lead, Clinical Governance Lead, Caldicott Guardian, Safeguarding named and designated professionals, or legal departments. These other professionals can be the most helpful sources of advice in difficult disclosure situations. Independent practitioners may wish to consult the legal helpline of their professional indemnity insurer.

Circumstances may emerge where clients may present a risk to others or to themselves, or be at risk from others whom they wish to protect. It is then necessary to discuss the importance of disclosure and to encourage it, for example to partners of HIV positive clients, and to employers if a client’s mental health status presents a risk to others via driving, handling machinery or interaction in a working situation, for example, flight deck crew. Disclosure without consent, or against the client’s expressed wish may be necessary in situations in which failure to disclose appropriate information would expose the client, or

someone else, to a risk of serious harm (including physical or sexual abuse) or death.

The psychologist must weigh up the needs and interests of their own client against the wider welfare, protection and safeguarding of the public.

Disclosure to clients' employers, insurance companies and others

Psychologists have a duty to ensure, at first contact, that clients understand the purpose of any assessment undertaken at the request of employers, the DVLA or insurance companies, and of the psychologist's obligation to disclose the results of that assessment. In the case of assessment for fitness to work or to drive, they should obtain the client's written consent.

Psychologists should consider what each party involved needs to know, gaining understanding and agreement on which aspects will be fed back, in advance. For example, the full detailed and raw scores obtained by a psychologist in recruitment assessment processes may be unsuitable for an employer to receive in full. The commissioning body should be made aware of the decision-making data that they originally requested, in the case of an employer this could include strengths and weaknesses, and recommendations for employer actions, for example.

Primary clients should be advised about and able to preview, with opportunity to ask questions first, any data that will be sent to an employer about them. Bear in mind that the informed consent difficulties still stand and that an employee or potential employee can withdraw consent for the employer to be informed of any part of their results.

This can be very difficult to manage in practice, and requires psychologists to make these agreements with their commissioners before they start the work, so that all are informed of the risks in the service delivery. Further information is available in ***Section 3.4: Working with multiple clients.***

Disclosure after a client's death

After a client's death, relatives or other authorities may seek access to the psychologist's records. In the first instance, the psychologist is advised to follow organisational procedures where they exist which usually deal with the administrative proofs required such as proof of death, proof of kinship and right to access the material requested.

A psychologist's duty of confidentiality continues after a client has died. The psychologist will need to weigh up the circumstances around the request for disclosure and what personal information is being sought. If there has been a specific request by the client for their information to remain confidential, their wishes should usually be respected. If the psychologist is unaware of any instructions from the client, when considering requests for information the following should be taken into account:

- the purpose of the disclosure;
- whether the disclosure of information is likely to cause distress to, or be of benefit to, the client's partner or families;
- the permission of a surviving relative or next of kin is not required, and does not authorise disclosure of confidential information, although the views of those who were close to the client may help the psychologist decide if disclosure is appropriate;

- whether the disclosure will also disclose information about the client's family or anyone else; and
- whether the information is already public knowledge or can be anonymised or coded.

There may be circumstances where the disclosure of information is required, for example:

- to support an inquest or fatal accident inquiry;
- where the disclosure is required by law, is authorised under section 251 of the NHS Act 2006, or is justified in the public interest, such as for education or research;
- in the case of national confidential inquiries or for local clinical audit; and
- when a person has a right of access to records under the Access to Health Records Act 1990 or Access to Health Records (Northern Ireland) Order 1993.

7.3 Confidentiality when safeguarding

In exceptional circumstances it may be necessary to breach the client's confidentiality with or without their immediate knowledge or consent. This would be the case where there are significant risks to the client's psychological wellbeing; where the alleged perpetrator may be a current risk to others or where there is risk of jeopardising a potential investigation. Any decision to breach confidentiality cannot be taken lightly, but can be justified and accounted for if made in good faith because of safeguarding concerns. This is supported by professional guidance. The focus of any intervention including any breach of confidentiality must be on promoting a proportionate, measured approach to balancing the risk of harm with respecting the client's capacity to consent, their choices and preferred outcome for their own life circumstances.

Specified authorities may need to share personal information to ensure, for example, that a person at risk of radicalisation is given appropriate support. When considering sharing personal information, the specified authority should take account of the following:

- **necessity and proportionality:** personal information should be shared only where it is strictly necessary to the intended outcome and proportionate to it. Key to determining the necessity and proportionality of sharing information will be the professional judgement of the risks to an individual or the public;
- **consent:** wherever possible the consent of the person concerned should be obtained before sharing any information about them;
- **power to share:** the sharing of data by public sector bodies requires the existence of the power to do so, in addition to satisfying the requirements of the Data Protection Act 1998 and the Human Rights Act 1998; and
- **Data Protection Act and the Common Law Duty of Confidentiality:** in engaging with non-public bodies, the specified authority should ensure that they are aware of their own responsibilities under the Data Protection Act and any confidentiality obligations that exist.

In relation to health sector staff, government guidance states it is important that staff understand how to balance client confidentiality with the duty to report. They should also be made aware of the information-sharing agreements in place for sharing information with other sectors, and get advice and support on confidentiality issues when responding

to potential evidence that someone is being drawn into terrorism, either during informal contact or consultation and treatment.

7.4 Confidentiality for the court

Psychologists acting as expert or professional witnesses have a duty to disclose all of the evidence used to reach their opinion where directed by the court to do so.

This could include:

- the details of any tests and assessments administered with professional colleagues;
- notes made during report writing; and
- referenced academic articles or studies.

No information relating to an assessment or report should be disclosed outside the relevant proceedings without agreement. Psychologists should normally seek permission from the instructing party to disclose any information to another health care professional.

Where instructed directly by the court, the Crown Prosecution Service, Procurator Fiscal or a solicitor, the psychologist is required to report or comment on any or all aspects of the case that appear to the psychologist, as an expert in the field, to be relevant or pertinent. In such circumstances, the psychologist is not in a position to offer confidentiality to any person, and should make this position clear to any party with whom they have contact during psychological investigations or assessment.

In these circumstances, it will be important that the psychologist makes sure they are up to date with the legislation and policy guidance regarding public and media access to information available to whichever court or tribunal their instruction arises from. The psychologist will need this awareness so that they can explain to the adult or child concerned what the limits of privacy are in these legal circumstances. They will need to make clear to the client which information needs to be made accessible, by whom and under what circumstances. Only when the client understands this, can they give informed consent.

There are different levels of access to sensitive information in different legal contexts; this will include testimony, documents and professional and expert reports. Many proceedings typically take place in open court, to which the public has access. In these cases, there is a presumption in favour of providing information and documents to third parties which were relied upon by the court in reaching its decision, though not the entire court file.

Where court papers and other materials are received in electronic format, psychologists should ensure that these are stored in a secure, password-protected format. This may require the addition of additional security for documents that arrive in an unsecured form. Where psychologists submit reports in an electronic format they should ensure that these are in a secure, password-protected format.

Psychologists working with clients who are the subject of court proceedings may need to be careful to ensure that they keep all records which may be of relevance to the court process until it is clear that the court has reached a final conclusion, including any appeal that may have been heard.

With few exceptions, applications in the family court are heard in private, with only those immediately involved being allowed to attend and access information. It is possible, however, for duly accredited members of the media to attend hearings in the family court, subject to the power to exclude them on specified grounds.

In most family court proceedings, media representatives have no entitlement to receive or peruse court documents referred to in the course of evidence, submissions or judgment. If media representatives wish to see documents referred to in the family court they may apply to the judge for disclosure but they are subject to strict guidance in terms of what information they can divulge into the public domain.

7.5 Confidentiality with children and young people

When beginning direct work with a child or young person, the psychologist should discuss and agree who will have access to the information arising from the work, with direct reference to principles of 'Gillick competence'. In undertaking this discussion it is helpful to acknowledge that there may be those adults (e.g. parents/carers, other relevant professionals such as teachers, social workers, counsellors) who may have a supportive interest in the work and may wish to have appropriate access to information but the wishes of a 'Gillick competent' young person should take precedence unless there are safeguarding concerns.

Parents or those with legal responsibility may be made aware of this agreement if appropriate, although a young person deemed to be Gillick competent is able to agree to work with a psychologist independently. Those with parental responsibility do not have an automatic right of access to the psychologist's records by making a subject access request under data protection legislation.

The nature and purposes of any work will vary and this will determine how and to whom information will be shared, however the child or young person should always be made aware of who will have access to what and for what purpose and due consideration given to the wishes of a 'Gillick competent' young person about who can have access to information about any involvement with a psychologist. The child or young person should be fully aware of the content of any shared information, including as appropriate, copies of the documents. Whatever is agreed about information sharing including work where information is confidential, the psychologist must ensure the child or young person knows and understands that if there is a risk of harm the psychologist must follow safeguarding procedures.

7.6 Confidentiality with detained persons

When detained persons give informed consent to the collection of information, they do so for a specific purpose and for use by specific people. The use of such information for a different purpose or for use by different people would require separate consent. Thus, although a psychologist may interview and write a report on a detained person, consent for that purpose cannot be taken as allowing a third party access to the psychologist's records on that person, such as notes on (or recordings of) the interview. If psychologists are

put under pressure to reveal such information, they should seek the advice of colleagues including for example those responsible for governance or data protection. They should bear in mind that they have a legal duty to be aware of and comply with data protection legislation and professional confidentiality rules.

7.7 Confidentiality obligations during training

During training, no academic/training documents should identify clients to whom they relate (even by means for example of initials, service name or date of appointment) as any such potential identifiers could be used to trace the client and therefore make the document a part of the clinical record and subject to the relevant provisions of data protection legislation. This includes published reports, case studies prepared for trainee assessments and any articles or publications. Tutors and supervisors should communicate this to their trainees. Trainees should be clearly instructed to both make and keep separately those records which are part of the provision of psychological service and which belong to the service organisation and are subject to its policies and procedures; and papers which are anonymised and are part of the trainee's academic learning, and belong to the trainee and are subject to the training provider's policies and procedures.

Express consent should be obtained by trainees before audio- or video-recording their interactions with clients. If the client is unable to give informed consent, it is unlikely to be appropriate for the recording to be made. Careful consideration should be given before any material is recorded if the client is party to any legal proceedings or family or employment disputes. If material is to be used for purposes other than client care (including teaching and research), the client should be informed of the purposes of the recording. It should be made clear to clients how the material will be used and to whom it will be disclosed, for example, trainee students, other researchers, and supervisors.

The trainee and the client should come to an agreement about how long recorded material should be kept. The general principle is that recordings will be kept for as long as needed to fulfil the purpose for which the client has given consent and no longer. The security of the material must be maintained, and it must be destroyed at the agreed time limit if no longer required.

Informed consent is required before client material in an identifiable format may be published in case studies, presentations or other research reports. It is becoming common practice for clinical material in professional doctorate portfolios to be stripped out before the thesis is placed in online institutional repositories.

8. How to respond when things go wrong

8.1 Managing conflict with a client

Conflict with a client suggests that someone's expectations are not being met. The first objective should be to restore agreement or agree to make changes. The well prepared psychologist will have a client agreement in place and will be able to review the experience against the agreement with the client to address this question. Further information is available in *Section 5: Making and maintaining agreements*. Even in the absence of an agreement, the psychologist would be advised to enquire with the client where their expectations are unmet or raise their own unmet expectations with the client. This can be an opportunity to put a belated agreement in place.

It may be that the parties agree to set aside the agreement and bring it to an early close. Agreeing to disagree may be a better outcome for psychologist and client who cannot restore agreement. Take account of any need for onward referral either within the service or elsewhere or back to the original referrer, and depending on the nature of the work setting, any financial obligations in closing the work.

The psychologist may find it helpful to consult with appropriate colleagues in preparation for the conversations with the client, such as line or service managers, those with other relevant organisational responsibilities, and supervisors. There may be more general lessons to be drawn as part of reflective practice in relation to the quality of the client agreement for future use.

8.2 Transparency and duty of candour

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 duty of candour (regulation 20) requires all health and adult social care providers registered with the Care Quality Commission to be open with people when things go wrong. Psychologists need to be aware of the terminology relating to this regulation including:

- openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered;
- transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators; and
- candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Psychologists also have a responsibility to ensure that they engage in open and transparent communications with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. Guidance from the Care Quality Commission on duty of candour outlines the specific requirements that providers must follow when things go wrong with care and treatment, including informing people about

the incident, providing reasonable support, providing truthful information, and making an apology. Psychologists are instrumental in supporting organisations to promote a culture that encourages candour, openness and honesty at all levels. Further information is available in *Appendix 2: Websites and further information*.

8.3 Managing conflict in team settings

Dealing with breakdowns in working relationships, professional disagreements and fitness to practise concerns

As far as possible, psychologists should seek to resolve any conflict with or between other professional colleagues (including relating to consultation/supervision or line management) by clear communication, relevant evidence and collaboratively working through the issues in reasoned argument within the context of respectful relationships.

The psychologist should first approach the colleague in confidence, if it is appropriate, with relevant information, in a manner that is collegiate and helpful. If misgivings continue, the psychologist should consult with an appropriate colleague to share concerns and to seek advice. Where appropriate they should keep a written record of the meetings and steps taken to resolve any difficulties.

Where there is serious or continual disagreement, both parties need to take whatever action is appropriate in their professional context, consulting other experienced professionals as necessary.

Supervisors and line managers have professional obligations concerning professional standards, ethical practice and 'fitness to practise' issues. If line managers or supervisors have any concerns regarding performance in these areas, they have a duty to discuss these with the psychologist and, if necessary, address the matters by in the first instance following appropriate employment policies and procedures, or in the case of an independent practitioner, making a report to the HCPC.

Working in multi-professional or multi-agency contexts

Psychologists may find themselves in conflict with the approaches to work taken by other individual colleagues or by the multi-professional team or agency.

Psychologists should bring to the awareness of the multi-professional team or agency any difficulty in the group working together which may impact on the psychologist's ability to function effectively and ethically in their role. Such issues are best addressed when guided by national and local policy and current legislation before proceeding with multi-professional/multi-agency collaboration. Further information is available in *Appendix 1: Relevant legislation*.

The psychologist may also have cause for concern about the ability of the team to provide for the needs of the client owing to interpersonal difficulties between members of the multi-agency or multidisciplinary team that might have an indirect impact on the client. As far as possible, psychologists should seek to resolve any conflict with or between other professional colleagues by clear communication, relevant evidence and collaboratively

working through the issues in reasoned argument within the context of respectful relationships.

If the situation remains unresolved for any reason, for example because it is judged not to be an issue for active management, the psychologist must make a judgement about whether their involvement in the team is helpful to the client or the working of the team. If not, the psychologist should consult with an appropriate colleague about whether they should disengage from that team.

A psychologist may also experience concerns about the competence or ethical practice of individual colleagues involved in joint working. These concerns may relate to the competence of the colleague to carry out a particular intervention, the appropriateness of an intervention for a particular client or problem, the nature of the relationship between a colleague and his or her client (e.g. potential abuses of power).

The psychologist should first approach the colleague in confidence, if it is appropriate, with relevant information, in a manner that is collegiate and helpful. If misgivings continue, the psychologist should consult with an appropriate colleague to share concerns and to seek advice. Where appropriate they should keep a written record of the meetings and steps taken to resolve any difficulties.

If they conclude that misconduct has occurred, psychologists should bring the matter to the attention of those charged with the responsibility to investigate such concerns, generally in the first instance an employer or in the case of an independent practitioner, the HCPC. Further information is available in *Section 2.1: Working environment*.

8.4 Supporting a colleague when a complaint has been made

The receipt of a complaint or allegation can be distressing for all concerned, not least for the person who is the subject of the complaint or allegation. It is important that they receive advice and support from appropriate persons. Any potential conflicts of interest should be considered. It may be that a psychologist is not best placed to offer support and guidance as they may be called as a witness in the complaints process. Encourage colleagues to seek advice from an experienced colleague or supervisor where appropriate.

The psychologist should also be encouraged to seek the support of an accredited workplace trade-union representative who is skilled at supporting people in these situations and can access legal advice if necessary. Legal advice can also be obtained from the professional indemnity insurance broker, and sometimes from household insurance policies where the householder has taken out the legal advice additional option.

Complaints are an increasingly normal occurrence and must be handled in a professional manner. The complaint investigator or professional body will need the psychologist's version of events and any evidence before any conclusions are reached. Psychologists should support colleagues to respond promptly, objectively, factually and honestly to the complaint. The content of the complaint should always be held in confidence.

8.5 If the client remains unhappy

If any conflict or issue as referred to in this section cannot be resolved, it may be appropriate to advise a client or other individual that they have a right to raise any concerns about a psychologist with the Health and Care Professions Council, further details of which can be found at www.hcpc-uk.org

9. References

1. Department of Health (2015). *Mental Health Act 1983: Code of Practice*. Norwich: TSO.
2. Kahneman, D. (2011). *Thinking, fast and slow*. London: Allen Lane.
3. Slovic, P., Monaghan, J. & MacGregor, D.G. (2000). Violence risk assessment and risk communication. *Law and Human Behavior*, 24(3), 271–296.
4. Tversky, A. & Kahneman, D. (1974). *Judgement under uncertainty: Heuristics and biases*. *Science*, 185, 1124–1131.
5. Ganz, M. (2010) Leading Change. Leadership, Organization and Social Movements: Chapter 19 in N. Nohria & R. Khurana (Ed.) *Handbook of Leadership Theory and Practice: A Harvard Business School Centennial Colloquium* (p.1). Boston: Harvard Business Press.
6. Ganz (ibid).
7. Hoel, H., Cooper, C. & Faragher, B. (2001) The experience of bullying in Great Britain: The impact of organizational status. *European Journal of Work and Organizational Psychology*, 10(4), 443–465.
8. Miceli, M., Near, J. & Dworkin, T. (2008) *Whistleblowing in organizations*. New York: Routledge: Lawrence Erlbaum Associates.
9. Miceli (ibid).
10. Bjørkelo, B. (2013) Workplace bullying after whistleblowing: future research and implications. *Journal of Managerial Psychology*, Vol. 28, Issue 3, 306–323.
11. Department of Health (2011) No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf accessed 25 April 2017.
12. Francis, R.D. (2009) (2nd edn). *Ethics for Psychologists*. Chichester, UK: Wiley, BPS Blackwell.
13. Francis, R. (2009) Broad Issues of Practice: Chapter 10. In R. Francis *Ethics for Psychologists* (2nd edn). Oxford, UK: BPS Blackwell.
14. Gillick v West Norfolk & Wisbech Area Health Authority (1985) UKHL 7 (17 October 1985) from the British and Irish legal Information Institute (BAILII) website.
15. Hoffman, D., Carter, D., Lopez, C. et al. (2015). *Report to the Special Committee of the Board of Directors of the American Psychological Association*. Downloaded on 31 May 2016 from: <https://www.apa.org/independent-review/APA-FINAL-Report-7.2.15.pdf> (accessed 1 December 2016)
16. General Assembly of the United Nations. (1984). *Convention against torture and other cruel, inhuman or degrading treatment or punishment*. <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx> Accessed 01 February 2017.

17. <http://www.gov.scot/Topics/Health/Services/Mental-Health/Restricted-Patients> Accessed 1 December 2016.
18. Coid, J., Yang, M., Ullrich, S. et al. (2011). Most items in structured risk assessment instruments do not predict violence. *Journal of Forensic Psychiatry & Psychology*, 22(1), 3–21. doi: <http://dx.doi.org/10.1080/14789949.2010.495990>
19. Campbell, T. (2011). Predictive accuracy of Static-99R and Static-2002R. *Open Access Journal of Forensic Psychology*, 3, 82–106.
20. Helmus, L., Hanson, R.K., Thornton, D., Babchishin, K.M. & Harris, A.J.R. (2012). Absolute recidivism rates predicted by Static-99R and Static-2002R sex offender risk assessment tools vary across samples: A meta-analysis. *Criminal Justice and Behavior*, 39(9), 1148–1171.
21. Owusu-Bempah, K. & Howitt, D. (2000) *Psychology Beyond Western Perspectives*. Leicester: BPS.
22. Fernando, S. (2014) *Mental Health Worldwide: Culture, Globalization and Development*. New York: Palgrave Macmillan
23. Gock, T. (1992). The challenges of being gay, Asian, and proud. In B. Berzon (Ed.), *Positively gay* (pp.247–252). Millbrae, CA: Celestial Arts.
24. Greene, B. (1994). Ethnic minority lesbians and gay men: Mental health and treatment issues. *Journal of Consulting and Clinical Psychology*, 62, 243–251.
25. Bhugra, D. (1997) Coming out by Asian gay men in the United Kingdom. *Archives of Sexual Behaviour*, 26(5), 547–57.
26. Boykin, K. (1996). *One more river to cross: Black and Gay in America*. New York: Anchor Books.
27. Harley, D.A. Stansbury, K.L. & Nelson, M. (2013). Sisters gone missing: The lack of focus on African American lesbians in mental health counselling and research. In H. Jackson-Lowman (Ed.), *African American Women: Living at the crossroads of race, gender, class, and culture* (pp.287–304). San Diego, CA: Cognella Academic Press.
28. Mitchell, M., Howarth, C., Kotecha, M. & Creegan, C. (2008). *Sexual orientation research review 2008*. London: Equality and Human Rights Commission.
29. Stansbury, K., Harley, D.A., Allen, S., Nelson, N.J. & Christensen, K. (2010). African American lesbians: A selective review of the literature. *African American Research Perspective*, 11(1), 99–108.
30. Greene (ibid).
31. Harley (ibid).
32. Mitchel (ibid).
33. Morales, E.S. (1989). Ethnic Minority Families and Minority Gay and Lesbians. *Marriage and Family Review*, 14, 217–39.
34. Morales, E.S. (1990). HIV infection and Hispanic gay and bisexual men. *Hispanic Journal of Behavioural Sciences*, 14, 212–222.

35. Care Quality Commission available at <http://www.cqc.org.uk/content/safeguarding-people> accessed 1 December 2016.
36. HM Government (2015). Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf (accessed 1 December 2016).
37. *Making Safeguarding Personal Guide* (2014).
38. Care Quality Commission (ibid).
39. HM Government (2015). Revised Prevent Duty Guidance: for England and Wales. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf (Accessed 1 December 2016).
40. United Nations Convention on the Rights of the Child (UNCRC) (1989) available at www.unicef.org/crc (Accessed 1 December 2016).
41. Children and Families Act (2014) available at http://www.legislation.gov.uk/ukpga/2014/6/pdfs/ukpga_20140006_en.pdf (Accessed 1 December 2016).
42. Office of the Public Guardian (2007) Mental Capacity Act (2005) Code of Practice. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf. Accessed 25 April 2017.
43. Department of Health (1997) The Caldicott Committee Report on the Review of Patient-Identifiable Information. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4068404.pdf (Accessed 1 December 2016).

Acknowledgements

These guidelines were updated by a working group of the Professional Practice Board of the British Psychological Society. The working group was constituted to include all of the member networks of the Society whose members engage in practice, including the HCPC registered practitioners. It included representatives of the Society's national branches in Scotland, Wales and Northern Ireland, in order to ensure applicability to the different national contexts. It also included representation from the expert working groups of the Society's Professional Practice Board and others on specialist topics of practice. Thanks are due to the members of the working group, and to the founder authors of the first and second editions of the guidelines whose work is the core and the foundation stone of the current edition.

Role	Name
Chair of the Practice Guidelines Working Group	Nicola Gale
Academics, Researchers and Teachers in Psychology	Simon Goodson
Children, Young People and their Families	Katie Hunt
Clinical Psychology	Tejinder Kondel and Ste Weatherhead
Coaching Psychology	Paul Philipps
Community Psychology	Ho Law
Counselling Psychology	Helen Nicholas
Crisis, Disaster & Trauma	John Durkin
Defence and Security	Fiona Butcher and Karen Carr
Education and Child Psychology	Charmian Hobbs
Ethics	Martin Fisher
Expert Witness Advisory Group	David Crighton
Forensic Psychology	Robert Forde
Health Psychology	Andrew Haig-Ferguson
Independent Practice	Sonya Wallbank and Jill Wilkinson
Informatics	Graham Fawcett
Intellectual Disabilities	Kate Theodore
Mental Capacity Advisory Group	Gemma Gray

Role	Name
Mental Health Act Advisory Group	John Taylor
Neuropsychology	Katherine Carpenter
Northern Ireland	Alison Clarke
Occupational Psychology	Nancy Doyle, Julie Freeborn, Almuth McDowell and Rainer Kurtz
Older People	Carolien Lamers
Prevent	Clare Fuller
Psychology of Sexualities	Jimmy Couzens
Psychotherapy	Ho Law
Race and Culture	Zenobia Nadirshaw
Safeguarding Advisory Group	Gill Evans, Liz McMonagle and Anne Peake
Scotland	Louise Richards
Social Inclusion	Anna Daiches
Sport and Exercise Psychology	Lee Ann Sharp
Wales	Nicola Massie
Experts by Experience	Joanne Hemmingfield and Simon Mudie
Legal Support	Stephen Pearson, Freeths LLP
Administrator	Emma Smith
Editorial Support	Sally Anderson
Policy Advisor (Professional Practice)	Hannah Farndon

Appendix 1 – Relevant legislation

Unless otherwise stated, Acts can be found on the government website
<http://www.legislation.gov.uk/>

United Kingdom and England

Care Act 2014

An Act to make provision to reform the law relating to care and support for adults and the law relating to support for carers; to make provision about safeguarding adults from abuse or neglect; to make provision about care standards; to establish and make provision about Health Education England; to establish and make provision about the Health Research Authority; to make provision about integrating care and support with health services; and for connected purposes.

Care Standards Act 2000

An Act to establish a National Care Standards Commission; to make provision for the registration and regulation of children's homes, independent hospitals, independent clinics, care homes, residential family centres, independent medical agencies, domiciliary care agencies, fostering agencies, nurses agencies and voluntary adoption agencies; to make provision for the regulation and inspection of local authority fostering and adoption services; to make provision for the registration, regulation and training of those providing child minding or day care' to make provision for the protection of children and vulnerable adults; to amend the law about children looked after in schools and colleges.

Children Act 1989

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Children and Families Act 2014

An Act to make provision about children, families, and people with special educational needs or disabilities; to make provision about the right to request flexible working; and for connected purposes.

Data Protection Act 1998

An Act to make new provision for the regulation of the processing of information relating to individuals, including the obtaining, holding, use or disclosure of such information. The Act states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- fairly and lawfully processed;

- processed for limited purposes;
- adequate, relevant and not excessive;
- accurate and up to date;
- not kept for longer than is necessary;
- processed in line with your rights;
- secure; and
- not transferred to other countries without adequate protection.

Equality Act 2010

An Act to make provision to require Ministers of the Crown and others when making strategic decisions about the exercise of their functions to have regard to the desirability of reducing socio-economic inequalities; to reform and harmonise equality law and restate the greater part of the enactments relating to discrimination and harassment related to certain personal characteristics; to enable certain employers to be required to publish information about the differences in pay between male and female employees; to prohibit victimisation in certain circumstances; to require the exercise of certain functions to be with regard to the need to eliminate discrimination and other prohibited conduct; to enable duties to be imposed in relation to the exercise of public procurement functions; to increase equality of opportunity; to amend the law relating to rights and responsibilities in family relationships; and for connected purposes.

Health and Social Care Act 2012

An Act to establish and make provision about a National Health Service Commissioning Board and clinical commissioning groups and to make other provision about the National Health Service in England; to make provision about public health in the United Kingdom; to make provision about regulating health and adult social care services; to make provision about regulating health and social care workers; to make provision about public involvement in health and social care matters, scrutiny of health matters by local authorities and co-operation of health care services; to make other provision about information relating to health or social care to make other provision about health care; and for connected purposes.

Mental Capacity Act 2005

An Act to make new provision relating to persons who lack capacity; to establish a superior court of record called the Court of Protection in place of the office of the Supreme Court called by that name; to make provision in connection with the Convention on the International Protection of Adults signed at the Hague on 13th January 2000; and for connected purposes.

Mental Health Act 1983 as amended 2007

An Act to consolidate the law relating to mentally disordered persons. The main purpose of the Mental Health Act 1983 as amended 2007 (MHA) is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they require for their own health or safety, or for the protection of other people.

Offender Rehabilitation Act 2014

An Act to make provision about the release, and supervision after release, of offenders; to make provision about the extension period for extended sentence prisoners; to make provision about community orders and suspended sentence orders; and for connected purposes.

Official Secrets Act 1989

An Act to replace section 2 of the Official Secrets Act 1911 by provisions protecting more limited classes of official information.

Regulation of Investigatory Powers Act (RIPA) 2000/Investigatory Powers Act 2016

An Act to make provision for and about the interception of communications, the acquisitions and disclosure of data relating to communications, the carrying out of surveillance, the use of human intelligence sources and acquisitions of the means by which electronic data protected by encryption or passwords may be decrypted or accessed; equipment interference, bulk personal datasets and other information; to make provision about the treatment of material held as a result of such interception, equipment interference or acquisition or retention; to establish the Investigatory Powers Commissioner and other Judicial Commissioners and make provision about them and other oversight arrangements; to make further provision about investigatory powers and national security; to amend sections 3 and 5 of the Intelligence Services Act 1994.

Safeguarding Vulnerable Groups Act 2006

An Act to make provision in connection with the protection of children and vulnerable adults. Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.

Northern Ireland

Children Act 1989 – NI has a Criminal Justice Children's Order 1998

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Criminal Justice (Northern Ireland) Act 2013

An Act to amend the law relating to sex offender notification, sexual offences prevention orders and human trafficking; to provide for the destruction, retention, use and other regulation of certain fingerprints and DNA samples and profiles; to provide for the release on license of persons detained under Article 45(2) of the Criminal Justice (Children) (Northern Ireland) Order 1998.

Criminal Justice (Northern Ireland) Order 2008 and Public Protection Arrangements in Northern Ireland (PPANI)

The Criminal Justice (NI) Order 2008 introduced a new sentencing framework, including extended and indeterminate sentences for public protection to reduce the risk of dangerous sexual and violent offenders being released into the community until the risk they pose is considered by the parole commissioners to be at a manageable level. The Public Protection Arrangements in Northern Ireland (PPANI) contained within the Criminal Justice (NI) Order 2008, place a duty on a number of agencies, within the criminal justice sector and elsewhere, to cooperate in the interest of better assessment and management of risk posed by serious sexual and violent offenders.

Justice Act (Northern Ireland) 2015

An Act to provide for a single jurisdiction for county courts and magistrates' courts; to amend the law on committal for trial; to provide for prosecutorial fines; to make provision in relation to victims and witnesses in criminal proceedings and investigations; to amend the law on criminal records and live links; to provide for violent offences prevention orders; to make other amendments relating to the administration of civil and criminal justice; and for connected purposes.

Mental Capacity Act (Northern Ireland) 2016

This Act fused mental health and mental capacity law into a single piece of legislation. The Act provides a framework for broader decision-making which includes: a statutory presumption of capacity, a requirement to support decision-making, mechanisms to allow individuals to plan for times that they do not have capacity, and safeguards to protect the rights of individuals when compulsory interventions or substitute decisions are required. It will remove the ability for someone to be treated for a mental health condition against his or her wishes if he or she retains the capacity to refuse such treatment, thus putting it on a par with the rights that individuals currently enjoy to make decisions regarding physical health treatment.

The Parole Commissioners' Rules (Northern Ireland) 2009

The Parole Commissioners for Northern Ireland are an independent body responsible for making decisions on the release and recall of prisoners sentenced to life, indeterminate custodial sentences, and extended custodial sentences, as well as the recall of prisoners serving determinate sentences.

The Sexual Offences (Northern Ireland) Order 2008

The Sexual Offences (Northern Ireland) Order 2008 lowered the age of sexual consent from 17 to 16 and incorporated significant changes to the law in relation to sexual offences in Northern Ireland; better protection for young people and people with a mental disorder from sexual abuse and exploitation; and sought to clarify issues surrounding consent in sexual assault cases and rape.

Scotland

Adoption and Children (Scotland) Act 2007

An Act of the Scottish Parliament to restate and amend the law relating to adoption; to make other provision in relation to the care of children; to enable provision to be made in relation to allowances in respect of certain children; and for connected purposes.

Adults with Incapacity (Scotland) Act 2000

An Act of the Scottish Parliament to make provision as to the property, financial affairs and personal welfare of adults who are incapable by reason of mental disorder or inability to communicate; and for connected purposes.

Adult Support and Protection (Scotland) Act 2007

An Act of the Scottish Parliament to make provision for the purposes of protecting adults from harm; to require the establishment of committees with functions relating to the safeguarding of adults who are at risk of harm; to amend the law relating to incapable adults; to allow the Public Guardian to intervene in court proceedings; to amend the law relating to mentally disordered persons; and for connected purposes

Children (Scotland) Act 1995

An Act to reform the law of Scotland relating to children, to the adoption of children and to young persons who as children have been looked after by a local authority; to make new provision as respects the relationship between parent and child and guardian and child in the law of Scotland; to make provision as respects residential establishments for children and certain other residential establishments; and for connected purposes.

Children and Young People (Scotland) Act 2014

An Act of the Scottish Parliament to make provision about the rights of children and young people; to make provision about investigations by the Commissioner for Children and Young People in Scotland; to make provision for and about the provision of services and support for or in relation to children and young people; to make provision for an adoption register; to make provision about children's hearings, detention in secure accommodation and consultation on certain proposals in relation to schools; and for connected purposes.

Mental Health (Scotland) Act 2015

An Act of the Scottish Parliament to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 in various respects; to make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally-disordered persons; and for connected purposes.

Mental Health (Care and Treatment) (Scotland) Act 2003

An Act of the Scottish Parliament to restate and amend the law relating to mentally disordered persons; and for connected purposes.

Protection from Abuse (Scotland) Act 2001

An Act of the Scottish Parliament to enable a power of arrest to be attached to interdicts

granted to protect individuals from abuse; to regulate the consequences of such attachment; and for connected purposes.

Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005

An Act of the Scottish Parliament to make it an offence to meet a child following certain preliminary contact and to make other provision for the purposes of protecting children from harm of a sexual nature, including provision for implementing in part Council Framework Decision 2004/68/JHA; and to make further provision about the prevention of sexual offences.

Protection of Vulnerable Groups (Scotland) Act 2007

An Act of the Scottish Parliament to bar certain individuals from working with children or certain adults; to require the Scottish Ministers to keep lists of those individuals; to make further provision in relation to those lists; to establish a scheme under which information about individuals working or seeking to work with children or certain adults is collated and disclosed; to amend Part 5 of the Police Act 1997; to amend the meaning of school care accommodation service in the Regulation of Care (Scotland) Act 2001; and for connected purposes

Public Bodies (Joint Working) (Scotland) Act 2014

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

Regulation of Care (Scotland) Act 2001

An Act of the Scottish Parliament to establish the Scottish Commission for the Regulation of Care and the Scottish Social Services Council; to make provision for the registration and regulation of care services and for the registration, regulation and training of social service workers; to enable local authorities to provide and maintain residential accommodation in which nursing is provided; to make further provision as respects persons who have been looked after by local authorities; to amend the definition of 'place of safety' in the Children (Scotland) Act 1995.

Smoking, Health and Social Care (Scotland) Act 2005

To amend the Regulation of Care (Scotland) Act 2001 as respects what constitutes an independent health care service, the implementation of certain decisions by the Scottish Commission for the Regulation of Care or the Scottish Social Services Council, the provision of information to the Council and the minimum frequency of inspection of care services by the Commission to amend the Adults with Incapacity (Scotland) Act 2000 as respects authorisation of medical treatment; to amend the Public Health (Scotland) Act 1897 to introduce a right of appeal in certain cases under that Act; to enable the Scottish Ministers to form, participate in and provide assistance to companies for the purpose of providing facilities or services for persons exercising functions under the National Health Service (Scotland) Act 1978 or of making money available to the health service in Scotland

Social Care (Self-directed Support) (Scotland) Act 2013

An Act of the Scottish Parliament to enable local authorities to provide support to certain carers; to make provision about the way in which certain social care services are provided by local authorities; and for connected purposes.

Vulnerable Witnesses (Scotland) Act 2004

An Act of the Scottish Parliament to make provision for the use of special measures for the purpose of taking the evidence of children and other vulnerable witnesses in criminal or civil proceedings; to make provision about the admissibility of expert psychological or psychiatric evidence as to subsequent behaviour of the complainer in criminal proceedings in respect of certain offences to make provision about the admissibility of certain evidence bearing on the character, conduct or condition of witnesses in proceedings before a sheriff relating to the establishment of grounds of referral to children's hearings; to abolish the competence test for witnesses in criminal and civil proceedings; and for connected purposes.

Wales

The Mental Health (Wales) Measure 2010

This measure places new legal duties on local health boards and local authorities in Wales in relation to the assessment and treatment of mental health problems. The Measure became law in December 2010 and there are 4 parts to it which are as follows:

- Part 1 ensures that there are more mental health services available within primary care.
- Part 2 makes sure all patients in secondary services have a Care and Treatment plan.
- Part 3 enables all adults discharged from secondary services to refer themselves back to those services.
- Part 4 supports every in-patient to have help from an independent mental health advocate if wanted.

Social Services and Well-being (Wales) Act 2014

An Act of the National Assembly for Wales to reform social services law; to make provision about improving the wellbeing outcomes for people who need care and support and carers who need support; to make provision about co-operation and partnership by public authorities with a view to improving the wellbeing of people; to make provision about complaints relating to social care and palliative care; and for connected purposes.

Violence against women, Domestic Abuse and Sexual Violence (Wales) Act 2015

An Act of the National Assembly for Wales to improve arrangements for the prevention of gender-based violence, domestic abuse and sexual violence; to improve arrangements for the protection of victims of such abuse and violence; to improve support for people affected by such abuse and violence; and to require the appointment of a National Adviser on gender-based violence, domestic abuse and sexual violence.

Well-being of Future Generations (Wales) Act 2015

An Act of the National Assembly for Wales to make provision requiring public bodies to do things in pursuit of the economic, social, environmental and cultural wellbeing of Wales in

a way that accords with the sustainable development principle; to require public bodies to report on such action; to establish a Commissioner for Future Generations to advise and assist public bodies in doing things in accordance with this Act; to establish public services boards in local authority areas; to make provision requiring those boards to plan and take action in pursuit of economic, social, environmental and cultural wellbeing in their area; and for connected purposes.

Appendix 2 – Websites and further information

British Psychological Society – www.bps.org.uk

The Society website has guidance, advice and further information on many topics not covered in these guidelines as well as those mentioned.

Psychologists working in clinical fields will also need to take account of Clinical Guidelines produced by NICE in England and Wales <https://www.nice.org.uk/> or SIGN in Scotland <http://www.sign.ac.uk/>

1.1 Legal and professional obligations of psychologists

HCPC – <http://hcpc-uk.org>

The Health and Care Professions Council website has lots of information about professional registration including the standards of proficiency for the seven protected titles and information about indemnity insurance

Information Commissioner’s Office – <https://ico.org.uk/>

The ICO website contains lots of useful information for organisations, private practitioners and the public regarding the rights and responsibilities under the data protection and Freedom of Information Acts.

DBS Checks – <https://www.gov.uk/disclosure-barring-service-check>

The government website provides helpful information for employers regarding these checks.

1.2 Continuing professional development

The HCPC has provided guidance regarding CPD for registrants. <http://www.hcpc-uk.org/cpd>

2.1 Working environment

Lone Working

Suzy Lamplugh Trust – <http://www.suzylamplugh.org/>

The Suzy Lamplugh Trust campaigns for personal safety and has lots of advice for people working alone to help to keep safe. They have some good advices and resources available.

Harassment and Bullying

ACAS – <http://www.acas.org.uk/>

The Advisory, Conciliation and Arbitration Service (ACAS) is a statutory organisation providing help and advice for employers and employees. They have produced guidance on several topics including harassment and bullying aimed separately at employers and employees.

Whistleblowing

Whistleblowing for employees – <https://www.gov.uk/whistleblowing>

The government has produced some guidance for employees surrounding whistleblowing including what to do and what to expect.

2.2 Working in the digital age

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – <http://www.hhs.gov/hipaa/>

This American act makes provisions for health information privacy. The government website provides information for professionals regarding this act.

N.B This Act is ONLY law for practice in America.

Social Media

The HCPC has provided guidance regarding the use of social media by professional psychologists.

http://www.hcpc-uk.org/Assets/documents/100035B7Social_media_guidance.pdf

3. Safeguarding

Statutory guidance Working together to safeguard children –

<https://www.gov.uk/government/publications/working-together-to-safeguard-children-2>
Statutory guidance on inter-agency working to safeguard and promote the welfare of children.

Getting it Right for Every Child (GIRFEC) and the Early Years Framework –

<http://www.maternal-and-early-years.org.uk/getting-it-right-for-every-child-principles-and-values>
This is an NHS Scotland approach which establishes the principle of giving all children and young people the best possible start in life as a priority for all services.

UK Government Guidance – <https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care>

No Secrets sets out a code of practice for the protection of vulnerable adults.

It explains how commissioners and providers of health and social care services should work together to produce and implement local policies and procedures. They should collaborate with the public, voluntary and private sectors and they should also consult clients, their carers and representative groups. Local authority social services departments should co-ordinate the development of policies and procedures.

Protection of vulnerable adults scheme (POVA) – <http://www.scie.org.uk/publications/guides/guide03/law/adults.asp>

Individuals should be referred to, and included on, the POVA list if they have abused, neglected or otherwise harmed vulnerable adults in their care or placed vulnerable adults

in their care at risk of harm. By making statutory checks against the list, providers of care must ensure they do not offer such individuals employment in care positions. POVA checks are requested as part of disclosures from the Criminal Records Bureau.

Prevention and Protection in Partnership 2015 –

<https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf>

This policy from Northern Ireland is for all organisations working with, or providing services to, adults across the statutory, voluntary, community, independent and faith sectors. It sets clear and proportionate safeguarding expectations across the range of organisations.

Modern Slavery and the national referral mechanism (NRM) –

<https://www.gov.uk/government/collections/modern-slavery>

These pages provide details about the government's work to end modern slavery, including details about how to refer victims into the NRM.

Let's talk about it – <http://www.ltai.info/about/>

Let's Talk About It is an initiative designed to provide practical help and guidance to the public in order to stop people becoming terrorists or supporting terrorism.

4. Managing data and confidentiality

Information Commissioners Office – <https://ico.org.uk/>

The Information Commissioners Office produces guidance with regards to data sharing and the Data protection and Freedom of information Acts.

HCPC guidance on confidentiality –

<http://www.hcpc-uk.co.uk/assets/documents/100023F1GuidanceonconfidentialityFINAL.pdf>

The HCPC has provided guidance on confidentiality for registrants.

NHS – <https://digital.nhs.uk/article/402/Information-Governance>

The NHS has produced guidance regarding Information Governance and security for NHS and partner organisations. The NHS has codes of practice for Records management and Confidentiality.

Caldicott Report – <https://www.gov.uk/government/publications/the-information-governance-review>

A review was commissioned in 1997 by the Chief Medical Officer of England owing to increasing concern about the ways in which patient information is being used in the NHS in England and Wales and the need to ensure that confidentiality is not undermined. Such concern was largely due to the development of information technology in the service, and its capacity to disseminate information about patients rapidly and extensively. A committee was established under the chairmanship of Dame Fiona Caldicott. The Caldicott Report highlighted six key principles, and made 16 specific recommendations. In 2012 Dame Caldicott produced a follow up report which made 26 further recommendations including the addition of a seventh principle.

Psychological Testing Centre – <http://ptc.bps.org.uk/ptc/guidelines-and-information>

The PTC website contains lots of guidance about psychometric testing and the management of data generated from those tests.

5. Transparency and duty of candour

Care Quality Commission –

http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

The CQC has produced Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare with regards to duty of candour.

Appendix 3 – How this document has been developed

In developing these guidelines, the overall aim and scope of the guidelines was considered at length, and the decision arrived at that they should be applicable to all psychologists irrespective of registration status or practice context. The guidelines have therefore been written in a way which it is hoped is inclusive of the various contexts of practice. Drawing on a broad stakeholder group for the development work, the guidelines aim to cover all the important considerations for practice. It is however recognised they cannot cover every circumstance and also that new issues arise which will require careful consideration by the individual psychologist.

The Practice Guidelines development Working Group was constituted to include all of the member networks of the Society whose members engage in practice, including the HCPC registered practitioners. It included representatives of the Society's national branches in Scotland, Wales and Northern Ireland, in order to ensure applicability to the different national contexts. It also included representation from the expert working groups of the Society's Professional Practice Board and others on specialist topics of practice.

The content of the guidelines has been developed from a combination of revision of the previous edition in the light of professional consensus on current expectations of a good standard of practice of psychology; inclusion of key points from other Society guidance on specific topics with reference to further guidance; and in some cases development of new material drawing on the professional experience of our members or outside professionals in the field. The working group has not used systematic methods to search for or assess the evidence for the material included. Recommendations have been included based on working group consensus. Where there are known areas of professional difference of opinion this has been stated.

A draft of the guidelines was circulated for Society wide consultation and one month allowed for comment. This included circulation to Experts by Experience (psychology service user representatives) with whom the Society works in various contexts. The Guidelines were also sent for comment to the Health and Care Professions Council as the statutory regulator for practitioner psychologists. Comments received were considered carefully by the Working Group and changes made to the text of the guidelines where considered necessary. The annotated audit sheet of the comments received and disposal was provided to a meeting of the Society's Professional Practice Board to assist its consideration of the draft guidelines, by way of final peer scrutiny. The guidelines were reviewed by the Society's legal advisers prior to publication. Final approval of the guidelines was given by the Society's Board of Trustees.

The guidelines will be reviewed and updated in accordance with Society policy after five years or sooner if circumstances indicate this is needed.

To ensure clarity and presentation in a user friendly format, the Guidelines have been edited by professional staff within the Society and the format designed by the Society's Preparation for Print specialists. Where considered helpful, links have been made to

additional web based resources, both to assist practitioner development and to provide up to date information in areas where there is frequent change. Organisational providers of psychological services are encouraged to review how these guidelines are used in practice and feed back to the Society any barriers to application.

In ensuring an appropriate level of independence in the production of these Guidelines, the Society has ensured its conflict of interest policy has been complied with and that no member of the working group's input has been compromised by a conflict of interest. No member has received any form of remuneration other than reimbursement of travel and subsistence expenses in accordance with Society policy. The large size of the working group and peer scrutiny and challenge, as well as the robust consultation process, guards against the potential for any one member or small group of members inappropriately to bias the Guidelines.

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