Professional Practice Guidelines 1995

DIVISION OF CLINICAL PSYCHOLOGY
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Introduction

The Division of Clinical Psychology of The British Psychological Society first published Guidelines for the Professional Practice of Clinical Psychologists in 1974. These were rewritten in 1983 and 1990, in the light of developments in the practice of clinical psychology and the need for advice from the Division regarding cases of alleged professional misconduct.

Since the Guidelines were last reviewed, a number of external influences have affected the professional practice of clinical psychologists. These include The Children Act (1989), the Access to Health Records Act (1990) and changes in the way that health services are managed and delivered following The National Health Service and Community Care Act (1990), The Patients Charter and The Mental Health Act Code of Practice (1990 and 1993). The current guidelines have, therefore, been rewritten taking these changes into account. It is anticipated that as further legislation is enacted and clinical practice develops further, future revisions will be made. This document is the product of a working party which was convened in 1993 for the purpose of updating the 1990 edition. It identifies key professional issues and dilemmas in the current climate and the resulting ethical difficulties which arise at the individual and departmental level.

These guidelines do not purport to be a definitive guide. Rather, they are intended to describe principles of good practice in clinical psychology. They provide a supplement to the Society’s Code of Conduct for Psychologists, with specific regard to clinical practice. Whereas the Code of Conduct provides a minimum set of standards for psychologists, this document describes the components of good standards of practice that will ensure the delivery of the highest quality service by clinical psychologists. As in the original and subsequent editions of the guidelines, they have been designed to reduce the likelihood of poor practice developing which could result in allegations of misconduct being made to the British Psychological Society under its Code of Conduct.

It is acknowledged that in clinical practice, psychologists are sometimes faced with difficult dilemmas. In recognition of this, these guidelines provide a framework within which there is a clear statement of the principles of good practice to be adopted. Some of the dilemmas are set out and are followed by possible solutions or actions. It is considered essential to continue to adhere to the principle of generality that previous editions developed. This accommodates the variation in the forms of practice which develop across specialties and specialisms within clinical psychology. Where appropriate, the working party has spelt out specific issues – for example, differences across the life span, as they relate to client groups.

Clinical psychology is now a registered profession although at the time of writing, registration is not compulsory. The document is written with the assumption that clinical psychologists value integrity, impartiality and
respect for their clients, and seek to establish the highest ethical standards in their work. Equal opportunities and non-discriminatory practices are actively promoted through behaviour, language and attitudes to others. Clinical psychologists are committed to providing clinical services that are seen to positively value our clients, and which treat them with respect and dignity.

A reading list is provided on related themes throughout the document.

This revised edition of the guidelines evolved from a series of meetings between Irene Sclare, Peter du Plessis, Alick Bush, Sue Hingley, Graeme Geldart, Kathryn Nicholson Perry, John Marzillier, Lindsay Royan and Stephen Bell. Several colleagues commented on earlier drafts, and we are particularly indebted to John Cape, Roger Paxton, Lesley Cohen and Jon Fraise for their advice and support. The result is a composite piece of work in which the many strands of clinical psychology practice are reflected. We make no apology for the multiplicity of perspectives which this process created, and welcome feedback for future editions.
In their professional activities, clinical psychologists must ensure that they work to the best of their ability and adapt their skills and expertise appropriately to changes in the working context. Clinical psychologists have an obligation to the public and to the profession to maintain and develop their professional competence throughout their working lives, and to recognise and work within their limits. They need to recognise that their initial professional qualifications testify only to required general levels of competence, and that the skills and knowledge acquired in the course of training will need to be maintained, extended and enhanced in a number of ways. In addition, they need to remain aware of theoretical and research developments and changes in legislation which impact on their fields of work.

**Principles**

**1.1 Appraisal**

1.1.1 In order to maintain high standards of practice which are in line with advances in developments in clinical psychology and which fit the challenges posed by the working context, competencies should be appraised at all stages of the career life cycle. These appraisals of competence should take place on a regular basis through a range of mechanisms including audit processes, peer supervision and consultation.

1.1.2 Formal appraisal systems should be put in place for all grades of experience to identify the need for new skills and knowledge. Support from managers is required to ensure that sufficient resources are allocated to facilitate necessary changes.

**1.2. Supervision**

1.2.1 In order to maintain the quality of performance and to extend a psychologist's range of skills, supervision should be organised for all levels and grades of experience. All aspects of professional practice should be accessible to supervisory inputs, including research activity, administrative and managerial work, service developments and the process of supervising others.

1.2.2 If no clinical psychologist is available with the necessary expertise and skill to provide specialist supervision for key aspects of work, clinical psychologists should seek supervision from an appropriately qualified psychologist in a neighbouring authority or from a related discipline.

1.2.3 The agreement to set up specialised supervision should always be ratified by the responsible manager. (See Section 9.2, Continuing professional development.)

1.2.4 More experienced clinical psychologists also have a requirement for regular supervision at the appropriate level for their experience and responsibilities. It is recommended that this be obtained from a senior colleague in clinical psychology, if necessary from outside their professional specialty or organisation, to
maintain and develop advanced level skills and experience. This may be achieved by creating a network of such senior staff via special interest group or Division branch frameworks.

1.3. Maintaining knowledge and skills

1.3.1 All clinical psychologists should participate in elements of continuing professional development, regardless of status or level of experience. This should encompass all aspects of clinical psychology practice, including research, management and therapeutic skill. (See Section 9.2, Continuing professional development.)

1.3.2 Time should be set aside on a regular basis to allow clinical psychologists to read relevant psychological literature, attend conferences and maintain professional networks with colleagues, for example via the special interest group frameworks of the Division of Clinical Psychology. This will be particularly important for those working in isolation from other psychologists.

1.4 Misrepresentation

1.4.1 Clinical psychologists must not claim to have qualifications which they do not genuinely hold nor claim to have expertise in skills, techniques or understanding which they do not possess. Clinical psychologists equally have a duty to ensure that their status and role is not misrepresented by others.

1.4.2 Clinical psychologists have a responsibility to work within their own limits of competence and to undertake, or offer to undertake, only those activities which they are competent to carry out. When developing innovatory skills, there can be a tension between the need to develop new skills and procedures and the requirement to provide only those psychological services in which practitioners are deemed to be competent. In addition to consulting the available literature and discussing with others who are more experienced in the area, the clinical psychologist should, where possible, pursue specialised training and supervision from another professional with more experience in the area.

1.4.3 Clinical psychologists must ensure that their own feeling of confidence to carry out certain activities is reflected by genuine competency in the area, and must not misrepresent their experience or status. They may be concerned that giving information about their status will undermine the development of a therapeutic alliance. This dilemma may be most pertinent when activities are being undertaken for the first time, or when someone is working as an assistant to a clinical psychologist or as a clinical psychologist in training. However, the client has a paramount right to be given accurate information about the psychologist's actual level of experience and status.

1.4.4 A clinical psychologist needs to ensure that he or she does not claim to have skills or experience that he or she does not possess
when asked to act as an expert. This may be a risk when the psychologist is asked to give an opinion about a client in court proceedings, to provide an opinion about the nature of a client's difficulties and the appropriateness of an intervention which has been carried out by another professional, or to provide written advice to a general population, for example in a magazine article or book, where the psychologist may not be sufficiently expert.

1.5. Referring on

1.5.1 It is never appropriate to continue with an intervention or service solely because there is no alternative which can be offered if that intervention or service is of no obvious benefit to the client. Consultation must be sought from a senior psychologist or the responsible manager as to the best course of action to take on behalf of the client.

1.5.2 To reduce the likelihood of psychology services being unable to meet clients' needs, auditing procedures and supervision should be used on a regular basis to help individual clinical psychologists to evaluate which of their cases could be managed more effectively by them, more appropriately discharged, offered additional interventions or referred instead to another psychologist or members of another profession or service.

1.5.3 A client who is receiving a clinical psychology service may request additional and different skills from a complementary therapist offering, for example, homoeopathy and hypnotherapy, or may initiate contact with a complementary therapist himself or herself. The psychologist should ensure that the client is put in contact with a complementary therapist who is suitably qualified and is registered with the relevant professional body.
This section considers aspects of the professional relationships between psychologists, their clients and their colleagues which relate primarily to issues of power imbalances, boundaries and respect. In particular, it considers the various ways in which a failure to recognise the relevance of these issues may lead to abusive and potentially abusive relationships. The relevance of race, culture, gender and class differences are all part of these considerations. (see Section 3, Obligations to services and clients). Personal awareness is central to psychologists being able to recognise any risks of abuse or exploitation within their individual practice, and it is the duty of all psychologists to raise their own degree of awareness (see also Section 8.1 on Self-Care). Power in itself is a two-sided phenomenon - within it lies the power to help and the power to exploit or abuse.

**Principles**

**2.1 Relationships with clients**

**2.1.1 Power differentials and the misuse of power.** Psychologists need to be alert to the power differentials between themselves and their clients, and monitor any aspects of their professional relationships which may involve misuse of that power. Misuse of power lies in any manipulation of the professional relationship to fulfil the psychologists’ own personal needs, and in any infringement of a client’s personal rights and well-being. Particular attention needs to be paid to therapeutic processes which may exacerbate imbalances of power, particularly when powerful aversive or positive consequences are used (see The Code of Practice of the Mental Health Act 1983, Chapter 19). Risks of abuse may be increased when power imbalances are accompanied by prejudices associated with race, culture and gender.

**2.1.2 Interpersonal boundaries.** Psychologists have a duty to ensure that there is a clear interpersonal boundary to their relationship with clients and to maintain it appropriately. They should make clients aware of this boundary at the point of first contact and when commencing any therapeutic intervention. Boundaries may be reflected in such practices as forms of address, style of dress, the sharing of personal details, the nature of therapeutic interventions, and the various aspects of the therapy setting - time, place, etc. Psychologists should consider the boundary implications of each of these. Such implications may vary across client groups and across settings, and may involve balances of costs and benefits.

**2.1.2.1 Home visits and their constructive use** relate to the issue of boundaries in terms of location of contact. Psychology Departments should have clear policies in relation to home visits which take into account:
- potential benefit to the client and psychologist (with the reason for the visit being clearly guided by the former);
- potential disadvantages to client and psychologist;
- appropriateness of the visit (therapeutic, economic, practical etc.);
2. Personal conduct (continued)

- procedures for the safety of the psychologist, particularly where any risk of violence is indicated (see Section 9 on Self-Care).

2.1.2.2 Psychologists should be aware of the issues involved in the use of physical touch and any form of physical contact within therapeutic relationships, and of the need to work within and recognise the significance of cultural norms. Touch can be acceptable and beneficial, but should be considered carefully in the context of the client’s needs and vulnerabilities, the potential for misinterpretation, and the risk of intrusion.

2.1.3 Dual relationships. Particular risks for the abuse of power and the breaking of the professional boundary lie within dual relationships. These exist when a psychologist has allowed a further relationship to co-exist with a professional one, for example friendship. Some dual relationships may appear more innocuous than others, maybe even helpful at times, but all carry risks. The ability to fulfil the roles of the primary professional relationship can be seriously compromised. Furthermore a dual relationship may involve the abuse of power. (See Section 5.1.4 for relevant issues in training.)

2.1.3.1 A pertinent example of an abusive dual relationship lies in the existence of a sexual relationship between psychologist and client. Any form of sexual advance or contact between client and psychologists is unacceptable, harmful and is grounds for allegation of professional misconduct.

2.1.3.2 It is essential that psychologists seek advice and support as soon as they become aware that they may be at risk of developing a dual relationship with a client (e.g. become aware of sexual attraction).

2.1.3.3 In all such instances the well-being of the client is paramount, and in some cases it may be necessary to refer the client to another psychologist.

2.1.3.4 Psychologists must not enter into a sexual relationship with former clients for at least two years after discharge and the ending of services. Even after this period, the burden of demonstrating non-exploitation remains, and the psychologist must consider the following:

- the amount of time that has passed since ending therapy;
- the nature of treatment;
- the circumstances of ending;
- the client’s personal history;
- the client’s current mental status;
- the likelihood of adverse impact on the client and others;
- any statement or actions made by the psychologists during the course of therapy suggesting or inviting the possibility of post-treatment sexual or romantic relationship.

The same careful consideration must be applied in relation to all other forms of potential personal contact between client and psychologist, including those with other family members of the client.
2.1.4 Gifts. Psychologists need to take care they do not exploit clients for personal gain in the form of gifts and financial endowments.

2.1.4.1 Psychologists may accept small inexpensive gifts, particularly at those times of year which are significant within a client’s culture. Expensive gifts should be refused. When gifts are offered frequently, the psychologist should consider their meaning within the therapeutic relationship and the impact of receiving and accepting them. Local guidelines should be consulted. (See also the Standards of Business Conduct for NHS Staff HSG (93)5.) Psychologists should never accept money from a client as a gift, nor should money ever be offered to a client on that basis or as a loan. Receipt of expensive gifts, money or even regular gifts may leave the psychologist who is working in the statutory sector open to accusations of charging for services which should be free at the point of delivery, of encouraging preferential treatment, of expecting favours from the client or of competing with the employer. Any such suspicion may lead to criminal prosecution.

2.1.4.2 Should a client choose to leave money to a psychologist in his or her will, psychologists must be sure that they have in no way influenced the client’s decision. Possibilities for coercion could depend on the contact between psychologists and client – i.e. whether the client was in treatment when the will was made or at the time of death. In responding to any such legacy, psychologists should make the interests of the client’s relatives primary. Any bequest may be interpreted as one to the employing body and not the named individual, and psychologists are advised to inform the employing authority to clarify the position.

2.2 Relationships with colleagues

The principles defined here relate equally to psychologists and to colleagues from other professions.

2.2.1 Psychologists should adhere to high standards of behaviour towards members of their own and other professions, within an atmosphere of mutual respect. They should not publicly denigrate colleagues regarding their personal, professional or ethical conduct.

2.2.2 Psychologists should establish frameworks for personal and professional support for themselves and their colleagues within their organisation, so that good professional practice may be enhanced and maintained. (See Section 1.2, Competence, and Section 8, Safeguarding fitness to practise.)

2.2.3 It is recognised that power imbalances may exist in relationships between junior and senior colleagues. Delegation of tasks and workload should be based on negotiation, consultation and mutual respect wherever possible, to reduce the risk of exploitation.

2.2.3.1 The power and boundary issues involved in dual relationships need to be carefully considered between colleagues,
especially when the primary work relationship coexists with supervisory, therapy, academic or personal relationships. (See Section 2.1.3 above and Section 9.1.3, Training.)

2.2.4 There may be times when psychologists have reason to be concerned about the competence or ethical practice of other colleagues. Such concerns may relate to the competence of a colleague to carry out a particular intervention, the appropriateness of an intervention for a particular client or problem, the use of a particular intervention or the nature of the relationship between a colleague and his or her client (e.g. potential abuses of power).

In any such instances the following steps are advisable:

- approach the colleague in confidence with relevant scientific evidence, informed opinion and relevant ethical guidelines;
- if misgivings continue, approach an appropriate colleague without malice or breaching confidentiality in order to share concerns;
- if the conclusion is that misconduct has occurred, psychologists should bring the matter to the attention of those charged with the responsibility to investigate such concerns.

When deciding whether to proceed in such circumstances, psychologists should be guided by any relevant local guidelines, the BPS Code of Conduct, and the relevant sections of this document.

Further reading


HSG(93)5. Standards of Business Conduct for NHS Staff.

This section addresses aspects of clinical psychology practice which safeguard a therapeutic and professional milieu in which effective partnership and respect for clients’ values are key principles, whether working directly with clients, with their carers or with staff colleagues. Clinical psychologists have a duty to provide services which are always in the interests of the client, which are accessible and non stigmalising and which enhance self efficacy, self-worth and personal dignity.

In addition and as importantly, it addresses the need for psychologists to respect the viewpoints and independence of other professions, to communicate effectively with colleagues and ensure that efficient administrative systems are in place.

**Principles**

**3.1 Values in interventions with clients**

**3.1.1** Psychological health is strongly influenced by context. It is essential that psychologists pay particular attention to the influence of race, gender and culture in the expression of psychological difficulties and the professional response, and the relationship of these variables to accessibility and acceptability of services.

**3.1.2** In considering therapeutic goals, psychologists must ensure that they do not unreasonably impose their own values nor those of the institution in which care is being provided to clients or their carers. They are not, however, obliged to accept the client’s values. They must not condone those which are illegal, immoral or harmful to the client or others. Where there is a conflict of values, the psychologist must weigh up the need for the client to receive the help they are seeking against the risks, and may need to assist the client to find alternative sources of support and care. If there is a risk of significant harm as a result of a client’s intentions or beliefs, the psychologist must act to protect those at risk.

**3.2 Interfaces with other services**

**3.2.1** Psychologists should not knowingly undertake interventions with a client who is already receiving care for the same, or associated, difficulties from another psychologist, except when in collaboration, nor should they offer consultation or training initiatives in services for which another psychologist has responsibility, unless by agreement.

**3.2.2** They should not carry out interventions in settings where they do not normally operate and where another clinical psychology service has responsibility, without the agreement of the responsible psychologist, ideally the head of the section or department. These principles also apply to research at all levels (see Section 10.4, Research).

**3.2.3** Psychologists are expected to establish orderly, clearly delineated arrangements for the joint care of clients when working with...
3.0 Obligations to service users and the service (continued)

colleagues and maintain good, mutually respectful working relationships (see Section 2.2, Personal conduct). This is especially important in multi-disciplinary team working and in inter-agency work. Psychologists need to ensure that others are kept informed of their involvement and that actions are recorded and co-ordinated with other approaches, for the benefit of the client.

3.2.4 Psychologists’ clinical responsibility needs to be clearly defined, to clients as well as colleagues, and delineated from that of medical responsibility. (See separate relevant guidelines which have been issued by the Division of Clinical Psychology.)

3.3 Service administration responsibilities

3.3.1 Psychologists must ensure that they maintain high standards in the administrative aspects of their work in order for their work to be effective. Administrative work needs to comply with minimum standards set by employing authorities, and should also conform to agreed policies or procedures within clinical psychology services. Adequate records of their activities and correspondence should be maintained for future reference, for service managers and for other psychologists who may take over their duties in future. For example, records should include details of date, time and place of contacts with clients, those present, the nature of action taken and the plans for future action. On closure, records should include length and nature of contact and outcome of involvement. Referrers should be informed.

3.3.2 An appropriate response must be made to every referral. They should be assessed prior to allocation with respect to appropriateness and urgency, and at a minimum, within the standard set by the commissioning authority for the psychology service. Responses should include written communication to the referrer and the client regarding the action that will be taken. Clients need to be informed if they are placed on a waiting list, and referrers should be informed too.

3.3.3 It may not be appropriate in all cases to inform a client’s GP about involvement if the GP is not the referrer. The psychologist must balance the risks attached to not sharing this information with those of respecting clients’ wish for privacy.

3.3.4 When, due to circumstances beyond their control, services cannot meet demand, psychologists should set up systems to determine priority of need and equitable access to the existing service. Whenever a long waiting list develops for a service, psychologists should assess levels of need and appropriateness and make every effort to improve response times. Psychologists are faced with the risk that clients could deteriorate while waiting for a service to become available. They need to ensure that waiting times do not exceed the standards set for the service by the commissioning authority. Should this occur, they have a duty to discuss
the limitations of the service with the appropriate manager, with a view to changing the type of service being offered, improving the staffing levels of the psychology service, restricting access to the service or, in extreme cases, closing the service to referrers for a defined period of time.

3.3.5 Facilities and working conditions should be accessible, safe, comfortable and clean, appropriate to the client group and able to ensure their privacy and dignity. It is never appropriate for psychologists to provide a service in inadequate settings, for example in noisy, crowded or unsoundproofed offices, or in a context unsuited to the special needs of particular client groups.

3.3.6 When a psychologist terminates employment in an established service and no qualified psychologist remains, he or she needs to ensure that equipment, records, test materials and a written inventory of these are left in safekeeping of a manager or administrator, and that there are accessible records available about the nature of work which has been carried out. The psychologist who is leaving has a duty, in addition, to ensure clear communication to clients and colleagues, to show good organisational skills with respect to closure of work and to arrange any necessary hand over of work where there are clients in great need of a continuing service.
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. The following principles apply to both clinical and research practice, and are further elaborated for research purposes in Section 10 on Research, Audit and Publication. The complexities of the consent process involve the impact of power imbalances, the client's capacity to understand the information given, and the difficulties inherent in predicting the unfolding path of an assessment or intervention process. It is only in exceptional circumstances in the public interest that psychological services may be provided without a client's consent.

Principles

4.1. The timing of informed consent

4.1.1 Clinical psychologists should obtain informed consent prior to undertaking any assessment or intervention activities.

4.1.2 Consent should be revisited between assessment and intervention and at any time when a new step is taken in an intervention programme, or when the purpose and nature or focus of an intervention alters.

4.1.3 If it is deemed necessary to move from individual contact to include other members of a client's family or social network, this should only be done with the client's prior consent.

4.2. The process of informed consent

4.2.1 Obtaining informed consent involves a process which may take place over several sessions. Clinical psychologists should pay attention to the nature of this process and the psychological factors which may influence it, adapting their procedures accordingly.

4.2.2 Clinical 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.

4.2.3 Consent should be reviewed, formalised and recorded, rather than taken for granted from the continued participation of the client.

4.2.4 At times, 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.

4.3. Providing Information

4.3.1 Clinical psychologists should provide information to clients prior to undertaking any psychological activity. The following should be outlined and made available, relevant to the service being provided:

- the role and function of clinical psychology;
- the clinical psychologist's qualifications,
areas of expertise, and limitations (see Section 1, Competence);
- the extent of the clinical psychologist’s power and responsibilities;
- the availability of services, and the existence of any waiting lists for intervention;
- the nature of assessment activities, the reasons for doing them and the possible implications of their outcomes;
- the purpose and nature of any proposed intervention, its probability of success, and any aspects of that intervention that might influence the client’s decision to take part, including the likelihood of emotional distress;
- alternative interventions and their availability;
- the use of video, audiotape or one-way screens;
- the nature and location of any records kept and the client’s rights of access (see Section 5, Access to health records);
- confidentiality and its limits (see Section 6, Confidentiality);
- their right to withdraw consent at any stage;
- what the Society’s Code of Conduct and the Guidelines for the Professional Practice of Clinical Psychology entitle them to as clients (copies of these documents should be made available).

4.3.2 Some of this information may usefully be provided in written form as a basis for further discussion. The process should take the client’s intellectual abilities, language and culture into account, so that information is readily comprehensible, but not at the expense of giving incomplete information.

4.4. Factors influencing informed consent

4.4.1 Issues of power and control. Clinical psychologists should take into account the power imbalances which may reduce the voluntary nature of informed consent, considering their own role in the process and those of other staff, family and carers. The impact of such imbalances is likely to be greatest in institutional settings and high-dependency services; it may also be particularly important when working with children and families. Empowering a client to make his or her own choice, independent of persuasive others, may be the most therapeutic course of action in some situations.

4.4.2.1 The emotional state of client and psychologist. Clinical psychologists should be aware that a client’s desire for help, and the immediate impact of the psychologist’s supportive listening, may restrict the client’s ability to make informed choices about the help they wish to receive.

4.4.2.2 They should also be aware that their own desires to help troubled clients may bias their presentation of information, such as the probability of successful outcomes.

4.4.3.1 The nature of therapeutic interventions. It is recognised that it is not
possible to predict psychological outcomes with certainty, and clinical psychologists should base their prediction on best clinical judgements.

4.4.3.2 For many therapeutic approaches, intervention follows an evolving path, unique to each client and his or her life circumstances, which again cannot be precisely predicted in advance. Clients should be made aware of this uncertainty.

4.4.4.1 Client competence. The client’s competence to give informed consent may be restricted by a learning disability, by neurological deficits, by severity of disturbance or by physical disability, illness, pain or anxiety.

4.4.4.2 In all such instances clinical psychologists should ensure that clients are enabled and encouraged to take for themselves those decisions which they are able to take.

4.4.4.3 It will often be necessary to make a judgement about a client's ability to give informed consent. This should include an assessment of his or her ability to understand the relevant information, to deliberate upon it, to make conclusions which are logically consistent with the question in hand, to communicate their decision, and to maintain that decision long enough for an intervention to get under way. There are no clear cut criteria defining these abilities.

4.4.4.4 If a client is not deemed capable of informed consent, it should be obtained from the person seen as having the legal authority to give it on the client’s behalf.

4.4.4.5 It is good practice to give full information to clients even when they are not deemed able to give informed consent.

4.4.4.6 Interventions based on such decisions should only proceed when they are deemed to be in the best interests of the client. They should be as limited as possible and in keeping with the client’s own goals.

4.4.4.7 Adequate safeguards must be taken to prevent exploitation, neglect and physical, sexual or psychological abuse.

4.5. Working with children

4.5.1 Clinical psychologists must include children’s feelings and wishes in any decision making (see The Children Act, 1989).
4.5.2 If children are of sufficient understanding to make informed choices, clinical psychologists must obtain their informed consent prior to undertaking any psychological activity, irrespective of the child's age. Children deemed as such may give consent even if their parents are against treatment. In practice, clinical psychologists should obtain consent from both children and their parents.

4.5.3 Children and young people can consent to treatment and have the right to that treatment without their parents’ consent. However, clinical psychologists should encourage any such children to inform their parents, and to include them in some way in the treatment, unless to do so would put the child or young person at risk of harm.

4.5.4 If children and young people refuse consent, or withdraw it during intervention, their decision may be overruled by their parents or those in loco parentis, who can give consent to treatment that is deemed to be in the child's best interest. However, it is likely to be anti-therapeutic to impose therapy on a child, and the psychologist should explore ways in which parents may influence their troubled child to accept treatment. If parents are unable or unwilling to give consent, or unable to influence the child, and the child's problems are judged to be sufficiently severe and complex, clinical psychologists should consider taking action to detain the young person under the Mental Health Act.

4.5.5 If parents refuse consent, thus depriving their child of therapeutic help to which the child consents, and the child's problems are judged to be sufficiently serious to impair his or her well-being and development, clinical psychologists should consider taking action through the Courts under the Children Act.

4.5.6 If clinical psychologists become concerned that a child or young person is experiencing actual harm within his or her family, they must make a judgement about the degree of risk to the child's general safety and protection. They should contact the local authority for advice and notification under such circumstances, whether or not parents give consent. It is important to bear in mind that ‘significant harm’ refers to physical, sexual and emotional abuse. It is essential to discuss consent issues and limits of confidentiality at the start of individual treatment.

4.6. Intervention decisions in the public interest

Psychological services may constitute part of the compulsory treatment plans of clients detained under the Mental Health Act (1983) because they pose a risk to themselves or to others.

4.6.1 Clinical psychologists should always seek a client's informed consent under these circumstances.

4.6.2 If informed consent is not given, they must give careful consideration to the wisdom of proceeding, and balance the risks of doing
4. Informed consent (continued)

so against the risks to the client and others of not proceeding.

4.6.3 Clinical psychologists should only attempt to intervene against the express wish of a client after the gravest consideration.

Further reading


Code of Practice: Mental Health Act 1983. London: HMSO.


Guidelines for the Practice of Professional Educational Psychologists. Leicester: Division of Educational and Child Psychology, BPS.


This section considers the nature and quality of record keeping, and issues of client access.

**5.1. The nature of records**

**5.1.1** Psychologists need to take care to include in written reports and case notes only such information concerning clients, their relatives and associates as is required for the purpose of the report or notes, and to exclude superfluous information. Psychologists must also bear in mind the potential impact of the information on other professionals, and the possibility of the client’s access to records. Distinction should be made between fact, observation and opinion, and judgemental comments should be avoided.

**5.1.2** Psychologists must legitimately record aspects of the therapy process and hypotheses which are guiding their interventions. Where such hypotheses are recorded, their tentative nature should be made clear. Again, the potential access of clients and other professionals to such notes should be borne in mind.

**5.1.3** When psychology notes are requested by subsequent clinicians, the client’s consent should be obtained where possible.

**5.2. Access to records**

**5.2.1** All identifiable computer-based and written records fall within the combined remits of the Data Protection Act 1984 and the Access to Health Records Act 1990, and in each case apply to records made since the commencement of the Acts. Clients have the right to a copy of personal data held on computer, to inspect their medical records and have a copy if requested, within 40 days of application. Psychologists should be aware of the requirements and exemption categories of both Acts. Clients should be made aware of their rights to access at the point of first contact (see Section 4, Consent).

**5.2.2** The Access to Records Act also allows for people with parental responsibility to apply for access, as well as those appointed by the courts to manage the affairs of clients deemed incapable of managing their own. The Act requires that the client has given their consent to the application, unless they are deemed incapable of understanding its nature. In that event psychologists need to decide whether it is in the client’s best interest to provide access.

**5.2.3** If the client applying for access is a child, the psychologist needs to be satisfied that he or she is capable of understanding the nature of the application (see Section 4, Consent).

**5.2.4** Psychologists should respond to any query which clients make about the nature of records kept and reports made by them about the client, and provide information on an informal basis as they deem appropriate in the context of their professional relationship with the client.
5. Access to health records (continued)

feel able to provide on an informal basis, psychologists should advise clients to pursue their rights under the Access to Health Records Act.

5.2.5 Under the Act psychologists may deny the right of access to parts of a record which are deemed likely to cause serious harm to the physical or mental health of clients. Psychologists need to assess the potential impact of information on the client and on the intervention, and particularly to bear in mind any risk of suicide. It may be difficult to predict the impact of information, particularly on children. Psychologists also need to consider the effects on the client of denying access.

5.2.6 Information in records cannot be changed following an application for access, unless it would have been changed anyway.

Further reading


Access to Health Records Act, 1990: A Guide for the NHS. Health Authorities or Health Publications Unit, No. 2 site, Manchester Road, Heywood, Lancashire OL10 2PZ. Serial no. HSG(91)6.

The legal duty to confidentiality refers to identifiable personal health information. However, psychologists have a duty to treat all such information, identifiable or not, with respect and be cautious regarding sharing it with others. Issues of confidentiality may pose difficult dilemmas, some of which have no ideal solutions. While the need for confidentiality may be clearest within one-to-one therapy relationships, it is still crucial to be aware of its potential limits. Psychologists also have a duty to share certain information with professional colleagues or carers, as and when it is necessary to the client's care. They may sometimes come under pressure to reveal confidential information, with or without a client's consent. In such instances, psychologists need to resist any overt pressures to disclose, and ensure that their decisions are based on their own independent professional judgement of the situation. It is essential that they establish their own positions and are able to defend these. Consultation within and outside the profession, and personal support, help to build a firm ground to decision making and to coping with the stress that may sometimes ensue.

**Principles**

**6.1. Routine practice: interactions with clients**

6.1.1 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 employers and managers.

6.1.2 Psychologists have a duty to inform clients of their confidentiality standards and practice at the point of first contact (e.g. letters to referrers, information shared in team meetings, identified information shared in supervision, any potential limits to confidentiality). Clients should be informed of the circumstances where information about them is likely to be shared and be given the opportunity to state any objection to this. The nature and extent of information sharing with referrers and with team members is likely to vary in different specialties, and in different therapeutic approaches (e.g. more information is likely to be shared when working with children than when working with individual psychotherapy with adults).

6.1.3 If disclosure of information is deemed necessary (beyond the routine sharing of information with other health care professionals) psychologists have a duty to obtain specific informed consent from their clients, making the consequences of disclosure as clear and unbiased as possible (see Kat, 1994, for the issue of ‘implied consent’ and Department of Health views). An explicit request for information not to be disclosed to particular people must be respected except in exceptional circumstances, for example where the health, safety or welfare of the client or someone else would otherwise be put at serious risk (see Section 4.13). If confidentiality
is then broken without consent, the client should be told what has been said and to whom.

6.1.4 Psychologists have the duty to ensure that the above principles of confidentiality apply to any information about clients which is used in teaching and training psychologists or other professions. Client identity and identifying details should not be revealed. Teachers should check whether any trainees or students have identified the person and ask them to leave that section of the teaching session if they have, unless this identification stems from their own clinical involvement. Trainees or students should be instructed to regard the information as confidential. Identifiable information must only be used with the client’s informed consent (see Section 9.1.9, Training).

6.1.5 Psychologists must obtain clients’ written informed consent before audio or video taping their interactions with them, or the consent of a guardian or carer in cases where the client is unable to provide written consent. If material is to be used for teaching purposes this must be made clear to clients, including the nature of trainees and students to whom the material will be presented. Psychologist and client should come to an agreement about how long recorded material should be kept. The security of the material must be maintained, and it must be destroyed at the agreed time limit or if no longer used.

6.1.6 Psychologists should ensure that the confidentiality of client information shared during supervision is respected. Unless it is otherwise necessary, clients should not be identified. If they are identified, clients should be informed of the supervision.

6.1.7 It is recognised that psychologists need to be able to discuss and share their clinical work experiences in a supportive context with colleagues. When doing so, they have the duty to ensure that where possible client identity is protected. Discussions should take place in a secure environment, so that confidentiality is maintained.

6.1.8 Psychologists are responsible for ensuring the security of any records they keep or contribute to, and should be aware of the range of access to any such records (see Section 5, Access to health records).

6.1.9 Informed consent is required before client material may be published in case studies or other research reports (see Section 10, Research, audit and publication).

6.2. Routine practice: interactions within teams and networks

6.2.1 When working in multi-disciplinary teams, psychologists must inform themselves of the confidentiality practices of other team members. They must decide what information it is appropriate to share with team members to enable the team to perform its duties, and make clear that such information is given in professional confidence. These issues may be addressed more clearly in some settings than
others, and may pose particular problems in diffuse service networks with highly dependent clients, for example, those with learning disabilities or acquired neurological impairments, older people and those with enduring severe mental illness. Psychologists must deal with them as effectively as possible to balance confidentiality with disclosure of necessary information.

6.2.2 Psychologists have a duty to be aware of the content of any other professional guidelines which set out local expectations relating to confidentiality. Whilst such guidelines will be recommendations and do not have statutory status, they should only be broken in exceptional circumstances, if there is a conflict of interest regarding client confidentiality and the likelihood of harm (see Section 6.1.3).

6.2.3 If psychologists wish to use reports on clients which have been compiled by other professionals, they should only do so with the consent of those professionals. Similarly, they have a duty to make it clear to other professionals that clinical psychology reports should not be used by those professionals in any context other than that for which the report was specifically provided, without the prior consent of the psychologist.

6.2.4 When working with clients experiencing enduring, severe mental health problems, specific dilemmas may relate to case management, care programming and to supervision registers. Professional judgements of client needs and their potential risk to others may be in conflict with clients’ expressed wishes for professional input and for confidentiality, and with their own views regarding supervision registers. Both public and client interests must taken into account, and clients should be informed, if and when information about them is shared, within the implementation of case management and care programming, and in decisions regarding supervision registers.

6.2.5 Clinical audit must ensure that data is anonymous, and that individual clients are not identifiable to any third parties. If this cannot be ensured it is necessary to obtain specific informed consent for the use of client data (see Section 10, Research, audit and publication).

6.2.6 Principles of confidentiality should also be deemed to apply to information received by psychologists about other members of staff in the course of their professional practice. Such information should only be shared with others if psychologists can justify that it is necessary for the fulfilment of their professional duties.

6.3 Disclosure without the client’s consent

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 and cannot be delegated or overridden by a superior or
other professional. Psychologists have the duty to consult fully with other practitioners and professional bodies and must be able to justify their decisions.

**6.3.1 Disclosure in relation to clinical management.**

**6.3.1.1** When the client is below the legal age of consent, psychologists normally communicate appropriate relevant information to the legal parent or guardian. A child also has a right to expect that information given in confidence will not be released to others without their consent. Issues of safety must always override those of confidentiality, however. Practice regarding disclosures without consent should follow paragraphs 6.3.2 to 6.3.5.

**6.3.1.2** When a client is suffering from a severe learning disability, or is sufficiently disturbed to be judged as incapable of giving valid consent to disclosure of information, psychologists must exercise great caution, and take care to satisfy themselves that any disclosure of information is in the client’s best interests.

**6.3.2 Disclosure in the public interest.**

Circumstances may emerge where clients may present a risk to others or to themselves, or be at risk from those 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 or handling machinery.

In exceptional circumstances, 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. Such disclosure may particularly be required where there is a risk of, or actual, sexual or physical abuse of children.

**6.3.2.1 Sexual abuse of children.**

Psychologists may become aware of a risk, or have actual evidence of ongoing abusive practices, either through their work with children or via work with adults as survivors or as perpetrators. The situation may well involve a conflict of interests between the needs of clients and the needs of others. For psychologists working with children and families, the requirements of the Children Act 1989 and the associated guideline document ‘Working Together’ direct their prime responsibility towards the interests of children, and advocate that concerns be shared with other professionals. The sharing of concern may itself involve breaking confidentiality.

Balance of risk situations may prevail, where the needs of children and the risk they are exposed to may not be clear cut. The balance needs to be assessed to guide decision making. A further balance of risk situation may exist for psychologists working with adults, with
specific responsibility for their confidentiality, therapy needs and risk status. A particular example of this balance of risk might involve the disclosure of a perpetrator of prior sexual abuse who is currently in contact with children, against the strong wishes of an adult survivor who is in therapy. There are no statutory requirements for psychologists to disclose in such situations.

Psychologists have a duty to assess the ‘balance of risk’ to the best of their abilities in all such circumstances, to gain knowledge and advice from other professionals and psychologists, and to be able to justify their decisions. Should current abuse of children be indicated, the balance will shift in the direction of disclosure.

6.3.2.2 The Children Act. Psychologists may be asked to disclose information to a local authority investigating children at risk, under the Children Act 1989. Psychologists should comply with such requests, although they are not obliged to assist where to do so ‘would be unreasonable in all the circumstances of the case’. Disclosure without consent may need to take place, and if so should be decided on the same basis as 4.13.2.1. above.

6.3.3 Disclosure in connection with judicial proceedings. Unless a client has given informed consent, psychologists should not disclose confidential information unless a court order has been made, and not simply in response to requests from third parties within the legal system.

6.3.4 Disclosure to clients’ employers, insurance companies and others regarding competence and eligibility. Psychologists have a duty to ensure, at first contact, that clients understand the purpose of any assessment undertaken at the request of employers, 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.

6.3.5 Disclosure after a client’s death. A client’s death does not remove the necessity for confidentiality. If prior consent has not been given decisions need to be made according to circumstances.

Further reading


British Association of Social Workers (1986). A Code of Ethics for Social Workers. BASW, 16 Kent Street, Birmingham, B5 6RD.

6. Confidentiality  (continued)


Notes

1. The nature and structure of this section was guided by the General Medical Council document, Professional Conduct and Discipline: Fitness to Practise (1993).

2. The legal issues surrounding confidentiality are being addressed in ‘A Bill Governing Use and Disclosure of Personal Health Information’ prepared by a multi-disciplinary working group including the BPS, and is led by the BMA. At the time of writing, the draft Bill is under revision, and is likely to become an Act of Parliament in 1996.
Skill in the application of psychometric and other standardised tests and procedures is an integral part of clinical psychology. As such, psychologists need to ensure that they use appropriate tests, and remain competent in their use and application. They must also pay attention to confidentiality, respect for the client and the process of communicating test results.

**Principles**

7.1 Clients may experience stress when undergoing psychometric and other standardised psychological assessment procedures. Psychologists have a duty to ensure that they act in a fashion which minimises clients’ distress without invalidating assessment procedures.

7.2 Tests should be administered only when this is judged to be in the best interests of the client and only when clients consent to the procedure. If a psychological test is administered solely for research purposes, the client must be informed and give specific consent.

7.3 Psychologists must take steps to ensure that they are competent to administer a psychological test before so doing, including being able to provide the client with an adequate verbal description of the function and purpose of the test.

7.4 Psychologists need to ensure that a trainee or assistant psychologist under their supervision administers a test only if the supervisor judges the trainee to be competent.

7.5 Psychologists should communicate test results and assessments to appropriate persons in such a way as to guard against misinterpretation and misuse. Generally, an interpretation rather than a test score should be communicated, and never solely the latter when it may not be in the client's best interests. Interpretation of the results should always include consideration of the context of the assessment and the client's understanding of its purpose.

7.6 It is the responsibility of the psychologist to provide an adequate explanation of the significance and limits of the test results to appropriate others. Some form of feedback should always be provided for the client, in addition to colleagues. Communications about test results should be accompanied by advice and recommendations about further actions needed.

7.7 Psychologists who publish new tests must do so with full regard to the limitations of those tests. They should incorporate accurate statements of the test’s dependability and any design limitations, and be clear about the risks relating to aspects of the tests not substantiated by research.

7.8 If it becomes necessary for a psychologist to leave test materials in charge of people not normally qualified to have access to them, steps must be taken to ensure the confidentiality of the test materials and to guard against their misuse.
This section addresses clinical psychologists’ need to ensure that they safeguard their physical and psychological well-being so that they maintain their fitness to practise by attending to their personal safety, personal development and the interactions between themselves, their life experiences and their clinical work. The section also gives guidance about not attempting to carry out professional activities when not able to do so competently. It involves balancing the risks to the quality of service provided, as well as to the reputation of clinical psychology, of continuing to work when unfit with those of desisting from working.

In the event that a colleague has become unfit to practise, psychologists have a responsibility to take action on their behalf. Making judgements about one’s own and others’ fitness to practise involves balancing personal and professional priorities and loyalties with the costs which clients, colleagues and self may incur.

Principles

8.1 Self-care: safeguarding standards of practice

8.1.1 Psychologists need to recognise that caring for themselves enables them to develop and maintain the quality of their professional work, and that in many instances, the capacity to fulfil ethical guidelines requires self-awareness and the ability to change.

8.1.2 Psychologists should always ensure that they have adhered to basic requirements of personal safety, for example not seeing clients when alone, not making initial home visits alone, the practice of risk minimisation and the de-escalation of anger.

8.1.3 Psychologists should seriously consider the value of professional indemnity insurance in order that they may be able to meet any liabilities they may incur beyond those covered by their employers. This is essential for psychologists in private practice.

8.1.4 All psychologists should recognise the value of attending to their personal development needs, since personal and professional development often go hand in hand, the one facilitating the other or restricting it. Such development may be helped by mentor relationships, peer group discussions, and personal psychotherapy, depending on the nature of individual circumstances.

8.1.5 Psychologists need to recognise that the demands of clinical work interact with their own personalities and that it is important that any consequent stresses are accepted as normal and understandable. They have a duty to address issues of stress and burn out, and to ensure that stress management and personal support are drawn upon to maintain optimum functioning over their professional lives.
8.1.6 Heads of Service have a responsibility to ensure that operational policies enable and encourage the above guidelines to be followed.

**8.2 Reducing the risk of problems occurring**

Clinical psychologists need to ensure that they actively pursue a lifestyle and a method and style of working which safeguards fitness to practise. Those working alone, and those with excess work demands and inadequate support, may lack opportunities to protect their capacity to maintain professional standards. There is a joint responsibility in this regard between the psychologist and the employer.

8.2.1 Regular appraisal allows for clarity about realistic levels of work and priorities for that work.

8.2.2 Training needs should be addressed on a yearly basis at a minimum and before adopting new work roles.

8.2.3 It can be helpful to set guidelines about acceptable caseloads. New work demands and changing priorities for clinical time need to be discussed with managers and in supervision where available, to allow for a review of resources.

8.2.4 Senior staff need to take responsibility for monitoring stress within psychology departments, and for avoiding procedures which increase staff stress unnecessarily. Exhausted or disaffected staff are less likely to be effective in their work as psychologists.

**8.3 The client/therapist relationship as a source of stress:**

8.3.1 Negative interactions can develop between a client and psychologist which could affect the formation of a therapeutic relationship. These may include religious or cultural differences, threat or perceived threat of violence, attitudes which conflict, or a discrepancy between level of the psychologist’s skill required and the complexities of a client’s problems. Psychologists need to identify these concerns in confidence, and in a supportive rather than judgemental milieu, with a more experienced colleague.

8.3.2 Solutions to alleviate such difficulties must include referring the client to a colleague rather than continuing, if the psychologist does not feel competent to continue.

**8.4 Dealing with personal distress at work**

8.4.1 Stresses and pressures in the work environment can cause personal distress which may become unmanageable. Distress can also arise as a result of home-based factors. Clinical psychologists who are experiencing high levels of personal distress because of either home-based or work-related difficulties, or both, have a duty to seek support and guidance to explore ways to resolve distress appropriately, if their fitness to practise is being impaired.
8.4.2 This course of action needs to be supported and encouraged by colleagues and handled sensitively and responsibly. Support could take a variety of forms including provision of therapy, personal support and supervision inside or outside of the organisation.

8.5 Responding to problems

8.5.1 Given the subjective nature of judgements about our own and others’ fitness to practise, and the external pressures which many service settings face, it would be helpful for psychology managers to ensure that support frameworks are identified and made accessible to staff.

8.5.2 It is not appropriate for psychologists under stress to be provided with personal therapy from colleagues within the same department.

8.5.3 Should a psychologist of any grade or experience continue to show signs of distress and this is affecting their working practice, it is the duty of others to attempt to persuade that psychologist to seek help, ideally outside the immediate work context.

8.6 Addressing workplace stressors

8.6.1 It is the duty of all clinical psychologists and their managers to ensure that the workplace is a setting which promotes mutual support, collaboration and concern for colleagues’ well-being.

8.6.2 Excessive pressures at work can build up from multiple external sources, including inadequate staffing levels, role overload, excess referral levels and lack of safety in the workplace.

8.6.3 Uncertainty about the direction of a service, conflict within the organisation and rigid or inflexible styles of management can also contribute to personal distress at work.

8.6.4 All of these reduce the capacity to practise at an optimal level and will inevitably affect the quality of the service which an individual psychologist can offer to a client, unless addressed at a systems level.

8.6.5 If such pressures exist, the psychologist must bring the matter to the attention of his or her employer, via the psychology manager in the first instance.

Further reading

BPS/DCP. Prevention and Management of Violence at Work.


Violence at Work. DCP/BPS.


BPS/PAB Professional liability insurance. The Psychologist, 8, 82–85.


There is an expectation that all psychologists will be actively involved in transmitting skills and expertise to others. This includes providing training and supervision to both trainees and assistant psychologists and to members of other professions. There will also be situations in which this is provided to carers, voluntary organisations and other non-psychologists.

The practice of clinical psychology is changing and developing rapidly. In recognition of this, psychologists are expected to take corporate responsibility for keeping themselves up-to-date.

9.1. Clinical psychologists basic training

The training process carries mutual professional responsibilities for Courses, trainees and qualified clinical psychologists, and depends upon effective, collaborative relationships between them.

**Principles**

**9.1.1** Tutors, teachers and supervisors should adhere to CTCP procedures and guidelines.

**9.1.2** Supervisors and academic tutors must ensure that trainees have a copy of the Guidelines for the Professional Practice of Clinical Psychology and are aware of their duty to abide by these Guidelines. The organisers of training courses should ensure that their syllabus includes teaching which addresses the range of ethical issues and good practice recommendations therein. Supervisors should take every available opportunity to relate the Guidelines to trainees’ routine clinical experience on placement.

**9.1.3** Supervisors and tutors must be aware of the importance of boundary and power issues within their supervisory and teaching relationships. Dual personal and supervisory or teaching relationships should be avoided, so that any potential abuse of power is minimised and the teaching role is not compromised. Should such a relationship exist, the supervisor or teacher must withdraw from any professional responsibility towards the trainee. Supervisors who are also teachers must not exploit the trainee’s vulnerability in being dependent on reports of competence, or exploit the relationship of trust for improper personal or financial gain. In this respect, the principles described within the Personal Conduct section apply just as much to relationships with trainees as they do to relationships with clients.

**9.1.4** Trainees and supervisors or teachers should be free to pursue their professional and academic activities without any kind of overt or covert sexual harassment. Supervisors and teachers have a duty to maintain workplaces free from such harassment and intimidation and should endeavour to ensure that satisfactory procedures for complaint are available. Any form of sexual advance or request for sexual favours by supervisors, trainers or teachers engaged in a professional relationship with trainees is unacceptable.
Trainees should be informed that agreed procedures for complaint exist within the BPS, and be made aware of local procedures within universities and NHS Trusts and other health providers.

9.1.5 Supervisors should make clear to trainees that as trainees they are individually responsible for their conduct with clients, and the extent to which responsibility for clinical work is shared with the supervisor.

9.1.6 Although trainees may be concerned at doing so, they should inform clients of their training status and that they will be discussing information about them with their supervisor, in confidence, and that information about them may be used anonymously in case reports for examination purposes only (see 9.1.10 on case studies). Trainees and supervisors should consider the best way of raising this issue with potential clients, perhaps by discussing with them advantages and disadvantages of being seen by a trainee. Training courses should establish guidelines in this respect (see Section 1.6, Competence).

9.1.7 Supervisors and trainees must ensure that the trainees' work does not exceed their competence, whilst enabling new learning to take place at an appropriate pace. This will involve adequate prior discussion and preparation before new strategies are employed, and sufficient time for review and revision. If the clinical needs of a client exceed the competence of a trainee, the supervisor must consider whether to take over the client themselves or refer elsewhere. This will need to be balanced against the intensity of supervision which can be provided, the potential for the trainee to develop, the value of the current therapy relationship to the client and the consequences of ending the current therapy.

9.1.8 The accurate monitoring of competence needs to include some level of observation, either by direct observation (e.g. one-way screen, sitting in, joint work) or indirect observation (e.g. video or audio tape recording). This is best done at more than one time point during a placement, and should involve both assessment and intervention sessions. Trainees and supervisors need to develop strategies to facilitate the constructive use of observation, and to desensitise all parties involved. The requirements of Section 6.1.5, Confidentiality, will apply to audio and video recording.

9.1.9 When using case material in teaching sessions, teachers must adhere to Section 6.1.4, Confidentiality, and ensure that material does not allow clients to be identified.

9.1.10 When writing up client details for their case studies, trainees must ensure that they do not include information that would enable their clients to be identified by those reading the studies. Specifically, client names should be altered or not used and the names of all health care professionals involved with the client should be removed, as should details of location. Course organisers must ensure that
9. Teaching, training and supervision (continued)

All case studies are held in a secure place which prohibits access by other professionals or the public, and that materials for examination are posted using as secure means as possible.

9.1.11 Effective teaching and learning is the mutual responsibility of both parties, supervisors or teachers and trainees. This involves active participation in both supervision and teaching sessions.

9.1.12 Supervisors and trainees should respect each others' perspectives, particularly where these involve differences of opinion and preferred practice, which may relate to cultural factors. Trainees should be guided by a supervisor's advice, be prepared to test out interventions and cease a specific course of action if instructed to do so. Supervisors should respect the trainees' right to develop an individual orientation to their work. Trainees have a right to refuse to undertake certain actions on ethical or other legitimate grounds. In the case of disagreement, a third party may be consulted as arbiter.

9.1.13 Supervisors should act within their competence, and should arrange for additional supervision from another psychologist if the needs of supervision exceed their current abilities. Psychologists should resist pressures or temptations to supervise before they have two years' post-qualification experience after becoming eligible for Chartered status. They should attend relevant workshops on supervision before undertaking supervision.

9.1.14 Supervisors should make assessments of trainees' competence that are not influenced by personal differences, including those relating to race and culture. They will provide constructive, accurate and impartial feedback on trainees' performance, which takes account of the possible distress which feedback may cause. Difficulties should be dealt with as they arise, with sensitivity and objectivity.

9.1.15 Supervisors, tutors and trainees should recognise the importance of personal development and its relation to professional development (see Sections 8.1 and 8.2, Safeguarding fitness to practise). All parties need to be open to recognising personal issues which interact with clinical work, and the value of understanding that interaction. Supervisors and tutors should help trainees to identify such issues. If personal therapy would be useful, they should facilitate trainee access to a suitable therapist rather than take on that role themselves.

9.2. Post-qualification training for clinical psychologists: Continuing professional development

In order for clinical psychologists to be able to provide the most effective interventions, and effectively teach and train others, they must continue to develop throughout their professional careers. This helps maintain competence and their professional standing (see Section 1, Competence).
Principles

9.2.1 It is recommended that each psychologist have a current personal development plan that indicates the steps they will take to keep their practice up to date. This should include a balance between clinical skills and other aspects of professional development.

9.2.2 There is considerable benefit for the professional practice of clinical psychology from regular supervision and this applies to all grades and levels of experience. Clinical practice evolves continuously and therefore psychologists are advised to draw on supervision to ensure that the quality of their work is maintained and new skills developed with appropriate support (see Sections 1.3. and 1.4, Competence).

9.2.3 Psychologists who provide supervision should ensure that they have in place an appraisal system that takes account of their supervisees' needs for continuing professional development.

9.2.4 Basic training courses should ensure that they contribute to the training of supervisors as part of psychologists' continuing professional development.

9.2.5 Training and supervision provided within continuing professional development should follow the same principles as those outlined above in Section 9.1 on Basic Training, except that the clinical psychologists in receipt of training will carry the independent legal responsibility for the work done.

9.3 Training and supervising other professions and non-psychologists

Various members of other professions and lay people make use of psychological procedures, including parents, nurses, doctors, residential and day workers. Clinical psychologists' specific responsibilities for teaching specific psychological skills and specific techniques have been acknowledged in the MAS Report. This section addresses the responsibility issues involved in both the training and monitoring of psychological procedures. Within mental health work, psychologists' potential role in this respect is indicated by the Mental Health Act 1983 Code of Conduct, which states that 'psychological treatments should be conducted under the supervision of those properly trained in the use of the specific methods employed'. Since non-psychologists may have access to potentially powerful techniques by a variety of routes, the potential for clinical psychologists to influence training and monitoring may be problematic.

Principles

9.3.1 Psychologists should assess the need for the monitoring and training of non-psychologists in psychological techniques within their work setting, and endeavour to establish their role in providing it. It is recognised that such provision may be restricted both by attitudes within the work environment and by time constraints.
Psychologists have a particular role to play in ensuring that local policies on psychological treatments include appropriate safeguards for approaches such as behaviour modification (particularly time out and other aversive techniques), and for the use of restraint.

The principles of good practice regarding teaching and supervision as outlined in Sections 9.1.1–9.1.5, Training clinical psychologists: Basic training, apply equally to teaching and training non-psychologists.

In teaching non-psychologists, clinical psychologists should take account of their level of psychological knowledge and skill in designing and applying specific training procedures. The level of authority, legal and clinical responsibility to be carried by the non-psychologists should be agreed in advance with them, and with their line manager.

Psychologists have the responsibility to maintain adequate standards in the application of psychological principles. Within the limits of their responsibility and influence, they should ensure that the welfare and rights of clients are preserved and that ethical safeguards are maintained. Should a non-psychologist’s activities indicate inappropriate application of psychological procedures, clinical psychologists should advise them to alter or cease involvement. If problems persist, it is the duty of the psychologist to take formal action through the non-psychologist’s line manager, professional body or council of registration.

Clinical psychologists carry an extra degree of responsibility for monitoring performance when providing training or advice to lay people such as voluntary workers, parents, spouses or other relatives of clients, since such people do not have the benefit of a professional training or qualification.

In all instances clinical psychologists ensure that non-psychologists are aware of their need for continuing access to advice or supervision as appropriate.

Non-psychologists may wish to administer psychometric assessments. Clinical psychologists should ensure that test materials are not provided to staff who are not eligible to use them, and that adequate supervision in administration and interpretation is provided to those that are (see also Section 7).

Meeting the supervisory needs of assistant psychologists is crucial, both in ensuring appropriate service provision and in providing clinical experience as a potential preliminary to clinical training. It is not appropriate for assistant psychologists to be deployed to provide an autonomous clinical service in place of qualified staff. Their role is to assist, rather than substitute for, clinical psychologists. This may take many forms, including assessment and therapeutic contact with clients, research and service evaluation and training initiatives. All of this work must be supervised and supported.
An honorary clinical contract is essential where there is client contact as part of research initiatives.

**Principles**

**9.4.1** Clinical psychologists should make clear decisions about the tasks appropriate for assistant psychologists to perform, and should not allow assistants to carry out work which is beyond their competence and which should more appropriately provided by qualified psychologists.

**9.4.2** Assistant psychologists should not carry out work involving contact with clients unless they are receiving adequate supervision for that work.

**9.4.3** The amount and level of supervision provided should be commensurate with the current abilities of the assistant and the clinical or research tasks they are undertaking.

**9.4.4** The principles of good practice regarding supervision as outlined in Sections 9.1.1–9.1.5, Training clinical psychologists: Basic training, apply to the supervisory relationship between clinical psychologists and assistant psychologists.

**9.4.5** Assistant psychologists must make their assistant, non-qualified status clear to clients at first contact, and also the fact that they are being supervised by a qualified psychologist.

**Further reading**


This section addresses aspects of research and scholarship which have not already been covered in the sections on routine clinical practice. It will particularly look at issues of consent to research and to the publication of research and clinical material. Research may involve non-clinical and clinical populations. If the latter, the quality of client care should be primary, and the dilemma for researchers may lie in evaluating the potential impact of research procedures on that quality.

**Principles**

**10.1** Psychologists must make a careful evaluation of the ethical acceptability of research proposals, and subject them to the scrutiny of an ethics committee, unless working with an entirely non-clinical population. Even in this event, the approval of an ethics committee is recommended.

**10.2** Where clinical services are involved in a research project, psychologists must undertake a careful analysis of the potential impact of the research on the nature, timing and quality of care provided to clients, ensuring that as far as is possible the quality of care remains primary. If there are any negative consequences these must be ethically justified, and should be explained to participants in advance of consent.

**10.3** Before seeking a client’s consent to participate in a research project, psychologists should obtain the consent of any other professional having a significant responsibility for the client’s well-being. When clients have consented to take part, psychologists should take all reasonable steps to communicate this decision to others with an active role in the client’s care.

**10.4** When considering research in a setting within which psychological services are provided by psychologists other than the investigator, the investigator should inform the psychologists concerned and obtain their consent before proceeding (see Section 3.2, Service responsibilities).

**10.5** Participants should be informed of all features of the research that might reasonably be expected to influence their willingness to participate, including any anticipated risks of distress. The aims and value of the research should be described, but no pressure put on potential participants to consent. Clients and patients should be informed that neither consent nor refusal will in any way influence the nature of care they receive, and that they will be free to withdraw consent at any time during the research. In longitudinal research it may be necessary to revisit consent at different stages of the research process. Consent must always be obtained in writing, and should follow the general principles described in Section 4 of these guidelines.

**10.6** Informed consent should address both the research procedures and the publication of results. The latter will become increasingly significant if detailed information about individual participants is to be reported, as in...
some qualitative approaches, for example case examples. This has further relevance when clients are participants and where case study material refers to the details of individual or family experiences of intervention.

10.7 Psychologists should be aware that clients may find it hard to say no, and should do their best to ensure that they do feel free to do so.

10.8 Participants should be informed of the level of detail at which material about them would be communicated in research reports and publication, and, if detailed information is to be used, of the ways in which their identity will be disguised. Consent should be obtained on this basis. For clients consenting to the publication of case studies, consent should be revisited at the end of therapy, since clients would then be aware of the nature of material that they are releasing.

10.9 It is advisable to inform clients that their psychologist may wish to draw on their experience of intervention within academic publications. This could be included as a general statement in department information sheets, and addressed with individual clients, so that their views about consent may be obtained. Specific consent should be obtained on the same basis as 10.8. above.

10.10 Psychologists must not use any procedure likely to cause serious or lasting harm. If more distress is experienced than expected, procedures must be stopped and appropriate professional advice sought.

10.11 In any instances where deception or the withholding of information is deemed necessary to a research protocol, where any form of stress or distress is anticipated or where privacy may be encroached upon, psychologists should seek the opinion of experienced and disinterested colleagues regarding the ethical basis of protocols. Such features should only be considered acceptable if psychologists are satisfied that the aims of the research cannot be achieved by any other means, and that the aims are ethically justified.

10.12 If deception or concealment has been necessary, this should be revealed during debriefing following participation. If it has been substantial, informed consent must be revisited, and the participants given the option of withdrawing their data, which would then be destroyed.

10.13 Debriefing should normally follow participation unless this has been on an anonymous postal basis. Any participant misconceptions and concerns should be clarified, and any unhelpful or distressing reactions dealt with. Referral to an appropriate source of help should be offered if there are continuing negative effects of participation or participation has revealed previously unidentified psychological problems.

10.14 Research data must be treated with confidence and respect. It cannot be shared with others involved in a client's care without the explicit consent of the client according to the principles of Section 4.
individual participants are described in research reports they must be altered so that they will not be identifiable to third parties, and as far as possible would not be recognisable to the participants themselves.

10.15 Audit practices will often involve completely anonymous data. However, detailed audit may overlap with research in its investigation of clinical efficacy and patterns of service provision. In such instances all of the above principles should apply.

10.16 Publications must always acknowledge the contributions which other people have made to the work. Authorship should be discussed with those concerned, and decisions based on judgements of practical contributions and intellectual ownership. Other people’s work should not be reported without such collaboration.

10.17 Appropriate research and scholarship are crucial to the advancement of knowledge and clinical practice. Psychologists should make every effort to undertake such work, and to communicate their theoretical knowledge and empirical findings.

Further reading

This section deals with the particular situation of psychologists in private practice, and the ethical issues stemming from their relationship to the public and to the statutory services, above and beyond those guidelines already provided.

**Principles**

11.1 Psychologists must ensure that their potential clients are aware of the public services available to them and if necessary facilitate their access to such services. This is particularly necessary should a client’s needs range beyond the role and function of the private psychological service.

11.2 Psychologists have a duty to regard the quality of service provided as primary, and the fees charged as secondary to this. The welfare of the client is paramount and this may not be subjugated to commercial considerations. Fees should be determined with due regard to the costs of services and the fees charged by other professionals for comparable services. They should be restricted to a reasonable level without prejudice to quality. If clients become unable to afford continuing services, psychologists are under an obligation to ensure that appropriate referral is made to the public sector.

11.3 Psychologists must not pay for any referrals.

11.4 Psychologists must be aware of the potential conflict between client and public interest and commercial motives, and between the roles of promoter and practitioner. They must not associate themselves with the promotion of any psychological devices, books, therapy approaches or other products offered for commercial sale where claims for these are not supported by evidence of a standard acceptable to the profession. Where psychologists are employed by a public body, they must ensure that the service they provide for their employer is not in any way prejudiced by their private practice. They should ascertain if they are in breach of their employment contracts if they undertake private practice whilst employed by another authority.

11.5 Psychologists should not offer to undertake assessment or provide treatment or guidance to individuals by means of correspondence alone.

11.6 Psychologists in private practice must recognise and address the need for peer support and supervision in continuing professional and personal development. This need will be increased by the relative isolation of some private work settings.
12. Relationships with the public and the media

Psychologists may be asked to comment or talk to various media sources (e.g. press, radio or television), education authorities, prison services, clubs, charities, the legal profession and other organisations interested in health issues, on aspects of psychological theories, interventions and service delivery. Whilst this may be potentially positive for the psychologists, services and the profession, there are certain pitfalls which should be avoided. In addition, psychologists should take care to judge issues with respect to their limits of competence (see Section 1, Competence).

Principles

12.1 Employing authorities have their own guidelines regarding the media and the public which will need to be followed. Psychologists should consult the relevant media person in their employing authority about their entitlement to make any comment on a particular topic, and the extent of that entitlement.

12.2 To avoid any risks of misrepresentation, psychologists should bear in mind that where information is recorded, it will inevitably be edited and therefore potentially subject to misrepresentation. Psychologists’ interests are protected by seeing the edited version prior to transmission. Psychologists should also make it clear that statements made are personal ones and do not necessarily represent the views of other psychologists or the employing authority. Psychologists should avoid commenting on a topic beyond their competence.

12.3 Potential breach of confidentiality should be avoided by not using descriptions that could lead to identification of an individual or organisation.

12.4 Comments should be based on valid research or other empirical evidence, even though that evidence may not be explicitly quoted.

12.5 Psychologists may want to express concerns publicly about employers, practices or legislation. In such instances they should consult relevant individuals and professional bodies (e.g. line manager, trade union, personnel department, or legal adviser) to ensure that their comments do not breach guidelines and risk disciplinary action.

Further reading

NHS Management Executive, EL (93) 51: Guidance for staff on relations with the public and the media.