SCPTI
Scarborough Counselling & Psychotherapy Training Institute

Safeguarding Policy and Procedure

Safeguarding policy statement: adults

The purpose of this policy statement is to protect adults at risk who receive SCPTI services. Our overarching principle is that every therapist has professional supervision and appropriate qualifications, including training in safeguarding. All practising therapists are expected to provide evidence of their insurance, their DBS check and their membership of a professional body. All therapists who work from the Institute must have gone through this process and have the training and qualifications to be competent in the services they offer. SCPTI monitors and reviews this regularly, especially through reaccreditation applications and its ongoing oversight of SCPTI training programmes and trainee assessments.

SCPTI trainees must be in regular supervision, where they must explore any safeguarding concerns about their client work.

Trainees on placement will discuss with their placement provider, regularly, the importance of acting quickly on any concern about a potential safeguarding issue in their clinical placement.

Whistleblowing

SCPTI has an open culture in which people feel able, supported and encouraged to raise concerns, including concerns about the practice of SCPTI's own staff. This includes support for whistleblowing. Any such concern is referred to the Executive Directors and, if it is not resolved, to the Ethics Committee. Formal concerns about a member's conduct can be raised under the SCPTI Complaints Procedure.

Safeguarding policy statement: children and young people

This policy is based on the legislation, policy and guidance that protect children and young people in England. A summary of the key legislation and guidance is available from www.nspcc.org.uk/childprotection.

The purpose of this policy statement is to protect children and young people who receive SCPTI services. It gives parents, therapists, trainees and staff the overarching principles that guide our approach to child protection. It applies to anyone working on behalf of SCPTI, including the Executive Directors, paid staff, therapists and trainees.

We believe that:

- children and young people should never experience abuse of any kind;
- we have a responsibility to promote the welfare of all children and young people, to keep them safe, and to practise in a way that protects them.

We recognise that:

- the welfare of the child is paramount;
- all children, regardless of age, disability, gender reassignment, race, religion or belief, sex or sexual orientation, have a right to equal protection from all types of harm or abuse, in line with the SCPTI EEEDII Policy;

- some children are additionally vulnerable because of the impact of previous experiences, their level of dependency, communication needs or other issues;
- working in partnership with children, young people, their parents, carers and other agencies is essential in promoting young people's welfare.

We will seek to keep children and young people safe by:

- valuing, listening to and respecting them;
- developing child protection and safeguarding policies that reflect best practice;
- making sure all trainees and therapists are in supervision, and recommending that they seek and complete their own specific safeguarding training to support safe practice;
- using our safeguarding procedures to share concerns and relevant information with agencies who need to know, and involving children, young people, parents and carers appropriately;
- creating and maintaining an environment free from bullying, and using the SCPTI Grievance Procedure and Complaints Procedure to deal effectively with any bullying that does arise;
- following the SCPTI Social Media Policy for online safety;
- recruiting staff and volunteers safely, making sure all necessary DBS checks are carried out;
- providing support, training and quality assurance;
- requiring staff, trainees and therapists to follow the SCPTI Code of Ethics and Professional Practice;
- using our procedures to manage any allegations against staff, therapists and trainees appropriately;
- making sure we have effective complaints and whistleblowing arrangements in place;
- providing a safe physical environment for children, young people, staff, therapists and trainees, by applying health and safety measures in line with the law, regulatory guidance and the SCPTI Health and Safety Policy and Lone Working Policy;
- recording and storing information professionally, confidentially and securely, in line with the SCPTI Data Protection, Management and Retention Policy.

SCPTI Designated Safeguarding Lead

SCPTI's UKCP-accredited diplomas train therapists to work with adults. SCPTI also runs a Relational Diploma in Child and Adolescent Psychotherapeutic Counselling, which is taught to a Level 6 UKCP standard but is not currently UKCP accredited; we expect accreditation in 2027. SCPTI has one Designated Safeguarding Lead, who covers safeguarding for adults and for any children and young people who access our building, or who relate to adult clients, if and when safeguarding issues arise. The Designated Safeguarding Lead is a highly qualified clinician with the experience to provide safeguarding support.

Trainees on placement must find out who the safeguarding lead is in their placement organisation, and must contact that lead with any safeguarding concerns.

Therapists can also seek safeguarding support from their own clinical supervisor if the SCPTI Designated Safeguarding Lead is unavailable, and vice versa.

SCPTI Designated Safeguarding Lead: Emily Rooney

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Responding to concerns and disclosures

The steps therapists and trainees should follow are set out in the Therapist's procedures section below, so that therapists and clients know what happens next when they seek support.

For advice and guidance, you can also call the NSPCC Helpline on 0808 800 5000.

To make a direct referral to Social Services, follow the "make a referral" link on www.safeguardingchildren.co.uk.

Assessment of clients

All clients who look for a therapist through SCPTI are assessed by a senior SCPTI therapist, and the assessment includes a risk assessment that takes account of any areas of concern. If the assessor thinks there is a high risk of harm to life or of suicide, the client will not be passed to a trainee therapist.

Therapist's procedures

These procedures set out what therapists need to do in a range of situations to protect the client as well as possible within the therapeutic setting.

As with all these procedures, the first step is supervision. The main focus of supervision is to help the therapist give the client their best service. Supervision is where the therapist brings their anxieties, worries and concerns.

Through supervision, the therapist will also work to develop their skills in therapy and therapeutic discourse. This includes learning how to work with clients effectively, techniques and treatment planning.

If the client discloses that they are being abused, are harming themselves or have been abused in the past

- First, gently enquire and check what you have heard, to make sure you have understood correctly. This is not an interrogation, but you need to be specific to establish the facts. Do this in a relational way.
- Remember that this may be very difficult for the client to talk about, and that it will have taken them a lot of courage to disclose at this level. It is essential to treat them with empathy, integrity, authenticity and respect.
- It is vital not to lead the client to the conclusion that they are being, or were, abused. For example, do not put thoughts into the client's head.
- If there is a risk to the person, or you are not sure whether there is, speak to your supervisor as soon as possible to discuss the situation fully. In some situations you may decide to contact the SCPTI Designated Safeguarding Lead. Record this in your own notes.
- If there is a risk, you may need to disclose, depending on its level. If you think the client may harm themselves or other people, you must disclose this immediately. If there is no immediate risk, discuss it at your next scheduled supervision.
- Note every action you take in your client records, and tell your supervisor about these actions, with the date and time of each.

If the client discloses that they are abusing someone

- Check what you have heard to make sure you have understood correctly, and remind the client of what you contracted about confidentiality and its limits.
- Try to get them to take appropriate action, for example contacting the police with your support.
- You will need to disclose the information you have been given, and you must make this clear to the client.
- If the risk is significant and imminent, you must disclose it straight away to your supervisor, the SCPTI Designated Safeguarding Lead, and/or Social Services or the police.
- Offer to continue supporting the client through therapy, if this is appropriate and safe.
- If you no longer feel safe working with the client, seek advice from the SCPTI Designated Safeguarding Lead and/or your supervisor.
- Make notes of all the actions you take, with dates and times and who you spoke to, including discussions with your client, supervisor and the Designated Safeguarding Lead.
- Make sure you get your own support to explore the impact the disclosure may be having on you.

If the client discloses that a third party is abusing someone

- Check what you have heard to make sure you have understood correctly.
- Encourage the client to take appropriate action.
- Whether or not they are prepared to act, speak to your supervisor and the SCPTI Designated Safeguarding Lead as soon as possible.
- Record in your client notes all discussions with the client, your supervisor and the Designated Safeguarding Lead, with dates and times.

Suicidal ideation, suicide, self-harm and risk

The World Health Organization estimates that more than 700,000 people die by suicide worldwide each year, and suicide is one of the leading causes of death among young people. Although links to high-risk groups are well known, suicide attempts are often made impulsively, when the person is in crisis.

Suicidal ideation is when clients have fantasies, dreams or imaginings about what it would be like to take their own life, and may think through how their suicide would affect the people around them. Reporting suicidal ideation often does not mean that a person will go on to take their own life. However, it is important that they have told you, and you must take it extremely seriously. This is where supervision is essential.

The following information draws on a suicide risk document produced by Newcastle, North Tyneside and Northumberland NHS and the Manchester Institute for Psychotherapy.

The threshold model

The threshold model shows how different types of risk and protective factors interact to produce an individual's threshold for suicidal behaviour. The types of factor are:

1. Long-term predisposing risk factors, which can be present at or soon after birth and identify people in risk groups. Genetic or biological influences include: (a) a family history of suicide or attempted suicide; (b) a family history of depression; (c) a family history of alcohol or other substance misuse.

2. Personality traits: rigid thinking, with patterns of thought that are difficult to change; black-and-white or "all-or-nothing" thinking; excessive perfectionism, where high standards cause distress to the person or others; hopelessness, with bleak and pessimistic views of the future; impulsivity, tending to act on the spur of the moment; and low self-esteem, with feelings of worthlessness.
3. Short-term risk factors. Environmental factors include: (a) being divorced, separated or widowed; (b) being older or retired; (c) having few social supports; (d) being unemployed. The three psychiatric diagnoses most strongly correlated with suicide are depression, substance misuse (including alcohol) and schizophrenia.
4. Precipitating factors are events that may tip the balance when a person is at risk. They include high stress or life crises, divorce, imprisonment or the threat of imprisonment, recent job loss, recently moving home, recent loss or separation, unwanted pregnancy, and interpersonal problems.

Depression

Depression is the most common mental illness. People often report low mood and lack of energy. Depression takes many forms. It is often described as "anger turned inwards", a repression of feelings, an incapacitation, or a general sense of worthlessness and lack of purpose. Depression may be accompanied by self-harming behaviour. At the milder end of the continuum, a person may report the above and still be able to move out of this state with some ease. At the other end, which we might call "high-intensity" depression, the person reports feeling "stuck" or "fixed" in that state and is unable to move towards feeling well.

Symptoms: below is a checklist of the most common symptoms of depression. If at least three to five of these have been present for at least 2 weeks, the person is likely to be experiencing clinical depression (moderate to high intensity).

1. Depressed mood
2. Loss of interest and enjoyment
3. Increased fatigue or loss of energy
4. Appetite or weight disturbances
5. Disturbed sleep
6. Ideas of self-harm or suicide
7. Reduced concentration and attention
8. Incapacitation
9. Reduced self-esteem and confidence
10. Lack of proactivity
11. Lack of purpose or structure in life

Working with clients and assessing risk

It is important for therapist and client to establish a therapeutic alliance so that the client feels comfortable sharing personal information. This does not have to be an interrogation, and it is equally important that the therapist does not panic when the client appears to present high risk factors.

Through the relational process, the therapist can learn about the client's emotional state, support network, high risk factors and any thoughts or plans of suicide. The therapist should use their supervisor or the SCPTI Designated Safeguarding Lead for support and for passing on risk information.

If the therapist believes the client is in imminent danger, they should call 999 or the local Crisis Team. Contact numbers can be found online.

Therapists have a duty to inform the client's GP if they are concerned about risk to their client. Therapists must tell the client they are doing so before sharing the information.

Managing suicide risk

Managing suicide risk goes hand in hand with risk assessment, and the approach differs according to the assessed level of risk.

1. If the risk is low, keep the usual contact and session arrangements, and keep risk open for discussion.

2. A therapeutic approach helps to maintain contact and encourages the client to share responsibility for their future care and safety. (The FRAMES approach to brief therapy is summarised below.)

3. If you are concerned or anxious, talk to your supervisor, the SCPTI Designated Safeguarding Lead or your placement supervisor. Do not wait for your next booked supervision session. Most supervisors will have agreed with you that they can be contacted if your concern is urgent.

4. Use the person's existing support system by encouraging them to engage with their contacts, friends and family.

5. If you believe the risk is more urgent, contact your placement or supervisor. Talking with colleagues or therapist peers may also help.

6. If the client is at the high end of suicide risk, call your supervisor immediately to work out an action plan, including for future sessions.

7. Imminent risk: as above, contact your supervisor immediately. Immediate plans may be needed, such as an urgent mental health assessment (A&E or Crisis Team) or a 999 call.

8. In the situations in points 6 and 7, you must notify your supervisor. If the emergency services are called to SCPTI, also notify the SCPTI Designated Safeguarding Lead.

Conclusion

(a) Always be aware of suicide risk.

(b) It is vital to keep good and accurate records.

(c) Use the FRAMES approach as a therapeutic style to promote contact and change:

Feedback to the client

Responsibility for recovery or change lies with the client

Advice to recover or change

Menu of strategies for bringing about recovery or change

Empathy as a therapeutic style

Self-efficacy or optimism

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