MANCHESTER INSTITUTE FOR PSYCHOTHERAPY

SAFEGUARDING HANDBOOK

FRAMEWORKS AND GUIDELINES

FEBRUARY 2018

The Manchester Institute For Psychotherapy

454 Barlow Moor Road Chorlton, Manchester. M21 0BQ
Tel: 0161 862 9456 • www.mcpt.co.uk • Email: bob@mcpt.co.uk

Bob Cooke BA T.S.T.A. Principal Director

CONTENTS PAGE

1. **Policy - definition of safeguarding - adults.**
2. **Definition of Adult at Risk**
3. **MIP Procedures**
4. **Therapists Procedures**

1. Definition Of Safeguarding - Adults (Mip) 2017

The Manchester Institute recognises that the LBGT community experience other types of discrimination or disadvantage and in its work to achieve equality for lesbians, gay men and bisexual people it will ensure full consideration of the needs of Black people and those from minority ethnic groups, people with disabilities and other relevant groups.

The Manchester Institute for Psychotherapy promotes a pro-active safeguarding policy for children and vulnerable adults, when appropriate.

Vulnerable Adults are defined as :-

Vulnerable adult

For the purpose of this procedure, a **"Vulnerable Adult"** is defined as a person aged 18 or over –

" who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm".
(No Secrets, Department of Health, 2000)

This may include :

- People with a learning disability;
- People who experience mental ill health;
- Disabled people;
- Older people;
- People who are experiencing short or long term illness.

The practitioner will contact their own supervisor and inform the MIP's safeguarding lead. When appropriate a referral will be escalated to the local authority, the police and other professional agencies.

It is a requirement that every trainee and practitioner who works with the general public has a DBS Certificate. This needs to be updated every 3 years.

When working with children, appropriate regular supervision by a child and adolescent specific supervisor must be in place.

All practitioners working at M.I.P who have clients under 18 years of age, need to have a specific qualification at working towards qualification to work with children and young people, that is recognised by the UKCP and/or the BACP.

2. Definition of Adult at Risk

An adult at risk is defined by the Department of Health as “a person aged 18 years or older who is or may be in need of community care services by reason of mental or other disability, age or illness: and who is or may be unable to take care of him/herself or unable to protect him/herself against significant harm or exploitation.”
(Taken from the Department of Health and Home Office 2000 - No Secrets - Guidance on developing and implementing multi agency policies and procedures to protect vulnerable adults from abuse”.

Please note the term “adult at risk” has replaced the term “vulnerable adult” in line with the guidance from the Social Care Institute for Excellence 2011 - “Protecting Adults at Risk; London multi-agency policy and procedures to safeguard adults from abuse” London SCIE.

3. MIP Procedures

(a) Safe recruitment and selection
(b) Health and Safety
(c) Consistent and regular supervision
(d) Assessment of clients prior to therapy
(e) MIP ongoing CPD and training
(f) Appropriate MIP safeguarding lead
(g) Responding quickly and appropriately to concerns, anxieties, and disclosures.
(h) Whistle-blowing Procedure
(i) Review and Update

Safe Recruitment and Selection:

The Manchester Institute for Psychotherapy, as an organisation that provides private therapy, counselling and placement allocation, is an organisation of excellence that constantly monitoring the accountability and responsibilities of the private therapists who work from the Institute.

In that respect, all the therapists that work from the Manchester Institute are firstly vetted and interviewed by the director of the Institute before commencement of work at the Institute.

All therapists who work from the Institute will have had to go through the above procedure and have the appropriate training background and qualifications to be competent in the services that they are offering. This is regularly monitored and reviewed by the Manchester Institute in terms of overseeing their CPD and training programmes and advanced specialisms.

The Manchester Institute not only is regularly reviewing and monitoring the therapists who work from the Institute, they only make sure that the therapists have regular supervision and are registered with their relevant professional regulating bodies.

Health and Safety

Apart from the legal responsibilities, the health and safety of volunteers, staff and clients is critical in providing a safe environment for help to take place. MIP's policy and procedures on health and safety provides assurance and security in this area.

Consistent and Regular Supervision

Therapists and MIP and placement volunteers will receive individual supervision with regards to their client caseload. MIP will ensure that the correct client contact ratio vis a vis supervision is maintained and actioned with the appropriate supervision (UKCP).

Assessment of clients prior to therapy

As said above, the Manchester Institute will provide a qualified assessor who will carry out the assessments with the clients and make sure that the clients that are passed on to the student placement therapists are at the developmental level appropriate for that student placement therapist.

As well as a high quality assessment process, which is monitored and consistently reviewed by the Manchester Institute, the assessor who carries out the assessment with regards to filtering out the appropriate clients for the student placement therapist will be appropriately qualified to not only do this assessment but also have a high clinical standard themselves (UKCP).

MIP CPD and Ongoing Training

MIP provides ongoing CPD courses throughout the year and new trainings are reviewed and monitored.

MIP encourages therapists and student placement therapists alike to enhance their training and post qualifying training with continued enhanced CPD.

Appropriate MIP safeguarding lead

The Manchester Institute will provide at least two safeguarding leads. These people will be highly qualified clinicians and be trained to a level in order to deal with this particular post.

All the placement therapists will have the MIP lead contact details and will be required to contact immediately the MIP safeguarding lead contact if they have any anxieties, worries or concerns over any safeguarding issues with regards to their clinical practice. It is important that the placement therapists do not wait for contact with their supervisor if they have any safeguarding concerns vis a vis any of their placements.

The contact details will be email and telephone number with reference to the MIP lead persons.

It is also important to note that the administrative office needs to be kept in the loop with regards to any potential safeguarding issues. (This does not mean a sharing of safeguarding content, simply that the administrative office will be able to make sure that the MIP lead persons are aware of situations).

Responding quickly and appropriately to concerns, anxieties, and disclosures.

As indicated above, the procedural process with regards to MIP lead persons are publicly on the website and appropriate documentation so that people and the placement students know this information.

Once again, all placement students will have verbal discussions with the placement provider on the importance of acting swiftly if they have any concerns over potential safeguarding issues with their clinical placements.

Whistle-blowing Procedure

The Manchester Institute uses a whistle-blowing policy to help ensure there is an atmosphere in which people feel able, positively supported, and encouraged to raise concerns, even where the concerns relate to the practice of Manchester Institute or the people that work within the Manchester Institute at a therapist, staff, or placement levels.

Review and Update

The above procedures relating to all the above and safeguarding concerns will be reviewed yearly or sooner if appropriate.

4. THERAPISTS PROCEDURES

The therapists procedures outlines what therapists need to do in a range of situations in order to best protect the client within the therapeutic setting.

As with all these procedures, the first step at a general level is **Supervision**.

Supervision's major focus is to help the placement therapist to provide their best services for the client. It is in the supervision hour that the placement therapist brings their anxieties, worries and concerns to the supervisor.

As well as the above, the placement therapist will endeavor through supervision to develop their skills in the area of therapy and therapeutic discourse. This will include learnings in how to work with clients, techniques and treatment planning towards resolution.

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

* Your first port of call is to gently enquire and check out what you have heard to make sure you are understanding correctly - this is not interrogation - though you have to be specific to make sure of the facts this needs to be done in a relational manner.

* Remember that the information you will be hearing in this context will be very difficult for them to talk about and it will have taken a lot of courage for them to disclose at this level, so it is imperative that you treat the person in an empathic manner with a great sense of integrity, authenticity and respect.

* It is imperative that you do not lead the client to the conclusion that they were 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 if there is a risk to the person, it is imperative you speak to your personal supervisor as soon as possible to discuss the situation fully. (In specific situations you may decide to contact the safeguarding lead at MIP) - certainly this needs to be recorded in your own notes.

* If there is a risk you may need to disclose - dependent on level of risk, ie if you think they are of harm to themselves or other people, you will need to disclose this immediately. If there is no immediate risk, then discuss it at your next scheduled personal supervision.

* In your personal notes, vis a vis your client, this must be recorded as said above, even if you choose not to take this to your supervisor. However, it is highly recommended that you do take all considerations to your supervisor.

* All actions that you have taken have to be noted in your client records and you need to tell your supervisor of these actions, with dates and times against each of the actions.

If the client discloses they are abusing:

***** Check out gently what you have heard to make sure you have understood them correctly and remind them of the contracting about confidentiality and its limits.

* Try to get them to take the appropriate action, for example with your support contacting the police.

* You will need to disclose the information that is being given to you and you must make this clear to your client.

* If the risk is significant and imminent you will need to disclose it straightaway to the MIP safeguarding lead and/or social services or the police.

* Offer to continue to support the client through the ongoing therapy if appropriate and safe to do so.

* If you no longer feel safe to work with the client seek advice from the MIP safeguarding lead and your supervisor.

* Make sure that you made notes of all your appropriate actions and discussions with your client, supervisor and safeguarding lead.

If the client discloses that a Third Party is Abusing:

***** First of all check out gently what you have heard to make sure you have understood correctly.

* Try to get them to take appropriate action.

* Whether or not they are prepared to take appropriate action speak to your supervisor and the safeguarding lead at MIP as soon as possible.

* In your client notes you need to record all discussions with the client, supervisor and the safeguarding lead.

SUICIDE AND SELF HARM FRAMEWORK

This document has been informed by the BACP Information Sheet P7 Working With Suicidal Clients, and the Suicide Risk Document produced by Newcastle, North Tyneside and Northumberland NHS as well as the information produced by Beacon Counselling.

When working with Placement clients who present with a wide variety of issues, such as depression, anxiety, stress, repression of feelings, hopelessness, and a feeling of helplessness in the world and indeed in their levels of functioning, you may well find as the therapeutic sessions evolve that sitting underneath these presenting issues the placement client may report feelings/thoughts of suicide/suicidal idealisation.

Suicidal Idealisation

This is when clients may have fantasies, dreams or even imaginations of the ideas of what it's like to take their own life and indeed may have whole thought processes on how their suicide may impact other people around them.

More often than not when people report suicidal idealization it does not mean that they are then going to go and take their life. However, their reporting of this to yourself is important and must be taken extremely seriously by yourself. This is where supervision is imperative.

Assessment

At MIP all placement clients that are referred to the placement therapists will have undertaken a “risk assessment” where the above areas will be taken into consideration. If at the assessment the assessor thinks that there is a high risk in the area of suicide, these high risk clients will not be passed to the placement therapists. However, that does not mean that the clients feelings of suicide or suicidal idealization may not be triggered through the placement.

The Threshold Model

The threshold model shows how different types of risk and protective factors interact to produce a threshold for suicidal behaviour for the individual. The different types of factors are:

1. **Long term predisposing risk factors** that can be present at birth or soon after birth - these identify people who are in risk groups.

    Genetic or Biological Influences:

    (a) Family history of suicide or attempted suicide
    (b) Family history of depression
    (c) Family history of alcohol or other substance misuse

2. **Personality Traits**

    Rigid thinking characterized by patterns of thought that are difficult to change.

    Black and white thinking or “nothing thinking”

    Excessive perfectionism, where high standards are causing distress to the person or others.

    Hopelessness with bleak and pessimistic views of the future

    Impulsivity, tending to do things on the spur of the moment

    Low self esteem with feelings of worthlessness

3. **Short Term Risk Factors**

    Environmental Factors:

    (a) Divorced, separated of widowed
    (b) Being older and/or retired
    (c) Having few social supports
    (d) Being unemployed

Psychiatric Diagnosis

The three psychiatric disorders most strongly correlted with suicide are:

* depression
* Substance misuse (including alcohol)
* Schizophrenia

4. **Precipitating Factors**

These are events that may tip the balance when a person is at risk. They include:

* High stress/life crises
* Divorce
* Imprisonment or threat of imprisonment
* Recent job loss
* Recent house move
* Recent loss or separation
* Unwanted pregnancy
* Interpersonal problems

Depression

Depression is the most common of mental illnesses. People may often report low mood and lack of energy as criterias for depression.

Depression comes in many forms. Often it is defined as “anger turned inwardness”, repression of feelings, an incapacitation or/and a general sense of worthlessness and lack of purpose.

In a continuum of health you may get mild depression where a person may report the above and will be able to move from this state with relative ease.

If a person reports “at the other end of the health continuum” which we might call “high intensity” depression the person will report “stuck” or “fixed” in that particular state and an inability to move from one ego state to another.

Symptoms:

What follows is a check list of the most common symptoms of depression. If at least three-five of the symptoms below have been present for at least 2 weeks the person is likely to be suffering from clinical depression (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. Problems with sleep or indeed incapacitation
9. Reduced self esteem and self confidence
10. Lack of pro-activity
11. Lack of purpose or structure in life

Process of Assessment (*taken from Suicide Risk Document- Northumberland NHS)*

Key stages in applying the threshold model to suicide risk and assessment are:

1. To establish a working relationship with the placement client. This means developing rapport and a trusting relationship with your client.

   This working relationship will provide a container and a secure safe space for the placement client to feel more able to disclose important information with regards to what they are presenting.

   The use of empathy, active listening, and genuineness is imperative in this, not only throughout therapy but also particularly important at this first stage of meeting.

2. Phenomenological Inquiry about the person's presenting issues and narrative is vitally important within the therapeutic sessions.

   You will also need to be aware of inquiring about their current mental health, physical health and any substance problems.

3. When listening to their historical and presenting issues you will also be able to assess their previous methods of coping with similar problems within what we call in Transactional Analysis their "Script".

4. It is imperative to seek information on their support system which would include availability and help provided by families and friends, for example do they live by themselves, with other people, within the family or do they in fact access any other type of service help.

5. Ask about current circumstances, life events and worries. Through this inquiry you will be able to assess any precipitating factors which/could be triggering any suicidal thoughts, feelings or indeed potential actions.

6. Finally, through the above you will have been throughout assessing the potential existence and specificity for any plans for suicide, including any nearby dates that have special significance for the person. Investigating the availability of means to commit suicide is crucial at this stage. This information will help to assess any suicidal intent.

After evaluating the placement client's narrative and information that you will have gleaned throughout the stages above, will help you to judge how close the person is to his or her threshold for suicidal behaviour. This then is your assessment of risk.

Having stated the above stages of risk assessment, it is important that you have this framework and information with regards to working in the area of mental health. Please note, as said above, that the MIP initial assessor will also have done their own risk assessment and will have made clinical judgements in terms of the clients that they will be referring to you in terms of the placement.

Managing Suicide Risk

Managing suicide risk in many ways comes with the territory of risk assessment and management techniques will differ depending on the assessed level of risk. For example, if your risk assessment is low then the management techniques will differ from working with a high assessment risk.

Low risk

1. If a risk is low, maintain usual contact/sessional arrangements.
2. A therapeutic approach is useful in promoting contact and encouraging the client to take a shared responsibility for their future care and safety. (The FRAMES approach to brief therapy is summarized below).
3. If you are concerned or anxious **talk to your colleagues at the placement service and/or contact your Placement Supervisor (do not wait necessarily for your next booked supervision session).**
4. Use the person's **existing support system** by encouraging them to engage with their contact/friends/family.
5. As said earlier, if you believe the risk is more urgent **contact your Placement Supervisor** and also talking with your colleagues may well be useful at this junction.
6. If they are the high end of suicide risk **Supervisor immediately to work out an action plan** with regards to future sessions.
7. The same as above - **immediate contact with your Supervisor** and immediate plans may need to be implemented, such as an urgent mental health assessment or even a 999 call.
8. Please note with regards to point (7) and (8) you will need to notify the Safeguarding Lead person at MIP.

High Risk

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 change lies with the client
Advice to change
Menu of strategies for bringing about change
Empathy as a therapeutic style
Self-efficacy or optimism

This menomic is a useful technique for memory recall and may be useful if this context.

FLOWCHART OVERVIEW - SAFEGUARDING CONCERNS