# Advanced Professional Practice: Complexity, Risk and the Law

THE TALKING THERAPIES UK PRACTITIONER SERIES



# Advanced Professional Practice: Complexity, Risk and the Law

Ethical complexity, risk formulation, the legal frame of UK practice, and leadership of the profession.

Advanced level · 14 hours of continuing professional development

**TALKING THERAPIES UK**

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This manual accompanies the Advanced Professional Practice: Complexity, Risk and the Law course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 6. This printing was set on 8 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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# How to use this manual

Senior practice is defined less by clinical technique than by what lands on your desk: dilemmas with no clean answer, risk that must be formulated and carried, law that binds practice whether or not you have read it, and colleagues, complaints and a profession that need leading. This course prepares experienced practitioners for exactly that territory.

The first module works through ethically complex terrain, competing duties, third parties, courts and families, using structured deliberation that can be defended afterwards, then reframes risk as formulation: beyond checklist prediction, whose evidence base is bleak, towards understanding the mechanisms of a particular person's risk and managing them collaboratively. The second module teaches the legal frame of UK practice, capacity, safeguarding, information law, court reports and duties to warn, followed by the profession's own machinery: complaints and fitness-to-practise processes, surviving them with integrity, and the responsibilities of supervision, gatekeeping and leadership that senior clinicians carry.

Extended written lessons with key points and practice tasks at case and service level, with a study tutor available throughout. Fourteen hours of CPD, around a year of access, a final assessment, and a personalised certificate on passing.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 14 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

### What this manual will leave you able to do

- Assess and manage suicide risk clinically, collaboratively and defensibly
- Apply mental capacity and safeguarding law as it bears on therapy with adults and young people
- Manage complaints, subpoenas, notes requests and court involvement correctly
- Navigate complex ethical dilemmas with a structured decision-making method and consultation
- Run a legally and ethically sound practice: insurance, wills for practice continuity, and digital records
- Hold professional resilience: fitness to practise, burnout prevention and self-care as ethical duties

PART 1

# Ethical Complexity and Risk Formulation

*Explores ethically complex situations, risk as formulation, proportionality, and confidentiality issues including duty to warn and information sharing.*

CHAPTER 1

# Ethically complex terrain

The terrain of advanced ethical decision-making in psychotherapy extends beyond the prescriptive language of professional codes, into a landscape where competing duties, contextual pressures, and legal obligations intersect. In this lesson we explore four recurrently complex scenarios that confront the seasoned practitioner: the inevitability of dual relationships in small or specialised communities, the imperative of a therapeutic will to protect clients from unmarked abandonment, the challenges posed by social media and the blurring of professional boundaries, and the ethical ramifications of externally imposed terminations of treatment. Across each of these domains a consistent procedural compass is advocated: the conflict must be named with precision, consulted with appropriate colleagues and supervisory structures, and recorded in a narrative style that could be read aloud, thereby ensuring transparency, accountability, and future defensibility.

The first and perhaps most immediate ethical terrain is the management of dual relationships in small or specialised communities. In rural settings the practitioner may find that the only plumber in town is the spouse of a client, or that the local school counsellor is also a neighbour who attends the same church. In minority or culturally specific contexts – for example within a Deaf community, a religious minority, or an LGBTQ+ enclave – the pool of potential therapists is often so limited that professional and personal spheres inevitably overlap. The classic guidance from the British Association for Counselling and Psychotherapy (BACP) and the Health and Care Professions Council (HCPC) to “avoid dual relationships” is simply not feasible in these environments; to do so would either withdraw essential services from those most in need or create a pretence that undermines trust. The ethical response, therefore, is not avoidance but management through transparency. The practitioner must openly acknowledge the overlap with the client, delineate the specific risks – such as the potential for role confusion, loss of confidentiality, or the perception of favouritism – and negotiate clear ground rules. These may include stipulations about how greetings will be conducted, what topics are off-limits outside the therapy

room, and how any incidental information will be handled. This negotiated agreement should be revisited regularly in supervision and documented in the client's record as a deliberated decision. Such a practice is not a compromised version of professional standards; rather, it is an adaptation of those standards to the realities of the client's context, preserving the core ethical principle of beneficence while respecting the principle of fidelity.

A concrete illustration of this process can be drawn from a therapist, Dr Patel, working in a remote Scottish Highland village where the only available mental health professional is also the local GP's partner. One of Dr Patel's clients, Mrs MacLeod, is a widowed farmer who also relies on the same GP for routine medical care. During the intake assessment, Dr Patel recognises that the GP's partner, who is also a community member, will inevitably be encountered at local events. In supervision, Dr Patel names the conflict: "I am simultaneously the therapist for Mrs MacLeod and a community member who will likely encounter her in non-clinical settings, creating a potential dual relationship." He consults with his supervisor, who advises that the therapeutic relationship should be protected through explicit discussion with Mrs MacLeod. In the next session, Dr Patel says, "Mrs MacLeod, I want to be open about the fact that I am also a neighbour and may see you at the local shop. This could affect how we interact outside of therapy, so I propose that we agree on how we will greet each other and what we will discuss in those settings." Mrs MacLeod agrees that they will keep any personal conversation brief and limited to non-clinical topics, and that any health-related concerns will be directed to her GP. Dr Patel records this agreement verbatim in the case notes, noting that the decision was made after supervision and that the arrangement will be reviewed at each supervision session. This transparent management of a dual relationship illustrates the ethical principle that the client's right to a safe therapeutic space is upheld through open negotiation rather than avoidance.

The second ethically complex terrain concerns the practitioner's mortality and the potential for unmarked abandonment. Historically, the profession has been reticent to discuss the eventuality of a therapist's illness or death, leaving clients to discover the loss through indirect means such as a returned envelope or a sudden cessation of contact. Contemporary ethical frameworks, including the BACP Ethical Framework for the Counselling Professions and the HCPC Standards of Conduct, now require practitioners to engage in succession planning. The therapeutic will – a formal document

that designates a trusted colleague to assume responsibility for client records, to make contact, and to provide bridging sessions or referrals – is the instrument through which this duty of care is operationalised. Preparing a therapeutic will involves identifying a colleague with appropriate competence and availability, granting them access to electronic health records, and delineating the steps for client notification, including the timing and tone of correspondence. It also requires the practitioner to organise practical matters such as keys, passwords, and diary entries, ensuring that the transition can occur without disruption. This preparation is not a sign of professional weakness; rather, it is an expression of the ethical commitment to non-maleficence and continuity of care. The duty to manage a temporary or permanent absence, whether due to illness, bereavement, or a planned leave of absence, is an extension of the same principle that obliges the therapist to avoid abrupt termination of therapy without adequate preparation.

A worked example of a therapeutic will can be drawn from a psychologist, Ms Jones, who anticipates a six-month sabbatical for research. In accordance with the BACP guidance, Ms Jones identifies Dr Lee, a colleague with a similar therapeutic orientation, as her nominated successor. She drafts a therapeutic will that includes: (1) a list of all current clients, their contact details, and a brief summary of treatment progress; (2) a written consent form for each client authorising Dr Lee to access their records and to contact them on Ms Jones's behalf; (3) a schedule of planned bridging sessions for each client, with dates and times; (4) a contingency plan for clients who decline the transition, including referrals to alternative services. Ms Jones discusses the plan with each client in a dedicated session, explaining the rationale, the steps that will be taken, and inviting any questions. She records the discussion verbatim in the client's file, noting the client's consent and any concerns raised. The therapeutic will is then filed securely, with Dr Lee granted limited electronic access to the records for the duration of the sabbatical. By undertaking these steps, Ms Jones ensures that her clients are not left to discover her absence by accident, thereby upholding the ethical principle of beneficence and protecting the therapeutic alliance.

The third domain of ethical complexity is the infiltration of social media into the therapeutic relationship. The digital age has introduced novel boundary challenges: clients may locate a therapist's personal profiles, send friend

requests, or post public reviews of the therapeutic experience. The BACP's "Social Media and Online Conduct" guidance advises that practitioners embed a social-media clause within the informed-consent process, outlining expectations and limits regarding online interaction. The practitioner must maintain a clear separation between professional and personal digital identities, employing privacy settings that minimise inadvertent exposure of personal content to clients. When a client initiates contact via a personal platform, the therapist should respond in a manner that re-establishes the professional boundary, for example by directing the conversation back to the therapeutic setting or by politely declining the request while reaffirming the commitment to the client's care. Reviews posted online, whether positive or negative, present a further dilemma; responding to a review can be construed as a breach of confidentiality, yet ignoring defamatory content may expose the practitioner to legal risk. The recommended approach is to refrain from public engagement, instead addressing any substantive concerns through private, confidential channels, and, where necessary, seeking legal counsel. All such boundary events should be discussed in supervision and recorded in the client's file as a narrative account of the decision-making process.

Consider a scenario involving a counsellor, Mr Ahmed, who discovers that a former client, Ms Patel, has sent a friend request on a personal Facebook account. Mr Ahmed recognises the potential for role confusion and the risk of inadvertent disclosure of personal information. He names the conflict: "I have received a friend request from a former client, which could blur professional boundaries." He consults his supervisor, who advises that he should decline the request and send a brief, professional message explaining that, in accordance with ethical guidelines, he maintains separate personal and professional online presences and that any future communication should occur through the practice's secure email system. Mr Ahmed follows this advice, documents the interaction in Ms Patel's file, and notes the supervisory input. This transparent handling of a social-media boundary maintains the integrity of the therapeutic relationship and demonstrates adherence to professional standards.

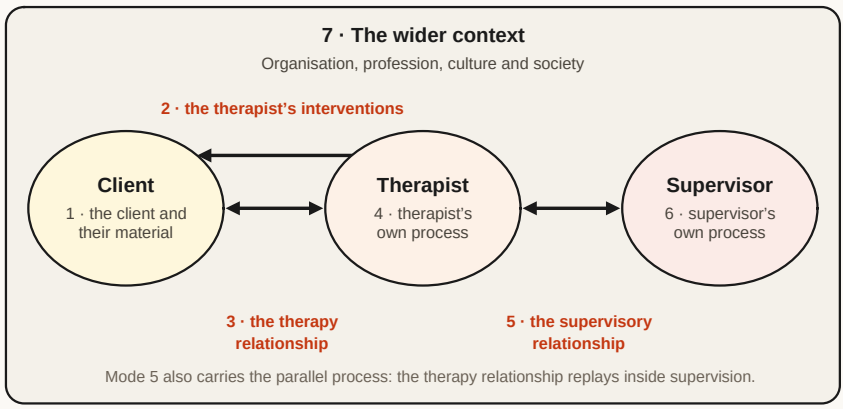
The fourth and final terrain concerns externally imposed terminations of therapy, often arising from funding constraints, insurance authorisation limits, or organisational policies that dictate a fixed number of sessions. When a client's therapeutic needs exceed the allocated frame, the

practitioner faces the ethical tension between respecting the client's right to adequate care and the practical realities of resource availability. The ethical response is to disclose the limitation early, ideally during the initial assessment, and to collaboratively develop a treatment plan that aligns with the available resources while preserving the therapeutic intent. This aligns with the principle of justice, which obliges the therapist to advocate for the client's needs and to challenge systemic barriers where possible. The practitioner should also prepare a comprehensive exit strategy that includes reviewing progress, consolidating gains, and arranging referrals to longer-term services if required. Documentation of these discussions, including the client's informed consent to the limited frame and the agreed-upon termination plan, is essential for both ethical and legal protection.

A worked illustration of this scenario involves a psychotherapist, Dr Green, working within a community mental health service that funds a maximum of eight sessions per client. During the initial intake, Dr Green explains the funding parameters and outlines a brief, solution-focused approach that can be delivered within the eight-session limit. After four sessions, Dr Green recognises that the client, Mr Brown, is still experiencing significant anxiety that is unlikely to resolve within the remaining four sessions. Dr Green names the conflict: "The client's therapeutic needs exceed the funded session limit, creating a risk of premature termination." She consults her clinical supervisor, who advises that Dr Green should discuss the situation with Mr Brown, explore possibilities for extending funding, and, if that is not feasible, arrange a referral to a longer-term service. Dr Green meets with Mr Brown, presents the situation transparently, and together they develop a plan that includes a focused review of coping strategies, a final consolidation session, and a referral to a specialised anxiety clinic. The conversation is recorded verbatim in the case notes, noting Mr Brown's consent to the plan and the supervisory input. By confronting the funding constraint openly, Dr Green upholds the ethical principle of justice and protects the client from the harm of an abrupt, unplanned termination.

Across all four of these ethically complex terrains, the method that underpins sound professional practice is identical. The practitioner must first name the conflict with exacting clarity, articulating the specific ethical principles at stake – for example, the tension between beneficence and fidelity in a dual relationship, or between non-maleficence and justice in a

funding-driven termination. The next step is to widen consultation, drawing upon supervision, peer discussion, professional bodies' ethics services, and, where appropriate, legal advice. This collaborative deliberation ensures that the decision is not solely the product of individual judgment but is informed by a broader professional perspective. The final step is to record the reasoning in a narrative style that could be read aloud, thereby creating a transparent account that can be reviewed by supervisors, auditors, or, in the event of a tribunal, by a judge. This approach not only safeguards the client's interests but also provides the practitioner with a defensible record of ethical decision-making, reinforcing the profession's commitment to accountability, integrity, and the highest standards of care.




After Hawkins and Shohet.

**FIGURE 1.1 The seven-eyed model of supervision**

*Hawkins and Shohet's seven modes give supervision its lenses: the client and their material, the therapist's interventions, the therapy relationship, the therapist's own process, the supervisory relationship itself (including parallel process), the supervisor's process, and the wider organisational and social context around all of it.*

## Points worth keeping

- Small communities: manage dual relationships by transparency, not pretence
- A therapeutic will protects clients from unmarked abandonment
- Method: name the conflict, consult, record as if read aloud

**PRACTICE TASK**

*Draft the outline of your own therapeutic will in four lines: who acts, who informs clients, records, and continuing care.*

CHAPTER 2

# Risk as formulation, not checklist

Risk practice at the advanced level begins with an honest reckoning that the very notion of prediction, when applied to an individual client, is fundamentally limited. The meta-analytic literature on suicide risk assessment, most notably the reviews by Large and Nielssen (2019) and Franklin et al. (2017), demonstrates that standard tools such as the PHQ-9, GAD-7, and the Columbia-Suicide Severity Rating Scale (C-SSRS) classify the overwhelming majority of eventual deaths as low risk, while the minority of high-risk classifications rarely culminate in suicide. In other words, fifty years of risk-factor research have not yielded a reliable individual-level prognostic instrument. The implication is structural rather than methodological: checklists and rating scales can floor the standard, ensuring that the right questions are asked, but they cannot carry the practice. Services that mistake a completed form for managed risk create an illusion of safety that is, in reality, an automated false assurance.

What replaces prediction is formulation – a dynamic, person-centred construction of how risk operates for a particular client at a particular moment. Formulation asks, in concrete terms, what moves the individual towards the edge: an anniversary of loss, a custody hearing, the fourth drink of the evening, a sudden contact from an abusive partner. It asks what has held the person back, and whether those protective factors remain intact. It asks about access to means, because means matter enormously and are the one factor that intervention reliably reaches; it asks about the client's warning pattern, the specific behavioural signature that precedes escalation; and it asks about the function of the suicidality – escape, communication, control, reunion – because the function shapes the therapeutic response. Formulation is not a static statement but a living hypothesis that is revisited as the client's circumstances evolve. A risk formulation drafted in January will be weathered by June, and the rhythm of review is itself part of the formulation, providing a scaffold for ongoing decision-making.

The evidence-based interventions that follow from this honest appraisal of prediction are grounded in engagement and protection rather than in the illusion of certainty. Safety planning, as articulated by Stanley and Brown

(2012) in their collaborative, structured approach, consistently outperforms the no-harm contract, a ritual that has been discredited for protecting paperwork rather than people. A safety plan, co-constructed in the client's own words, enumerates warning signs, internal coping steps, external distractions, trusted contacts, professional crisis resources, and, centrally, means restriction. The plan is negotiated with the client, ensuring that restriction is agreed upon and, crucially, enacted. Engagement itself is protective; the therapeutic relationship becomes the conduit through which a client can call for help, and therefore it is an integral component of risk management, not an adjunct.

Chronic suicidality, often organised around personality pathology, demands a distinct logic that the advanced practice textbook outlines. For a client whose baseline includes years of pervasive ideation, treating every expression as an acute emergency generates a perpetual crisis response, leading to repeated hospitalisations that disrupt the therapeutic work that could ultimately reduce risk. This approach also reinforces the very crisis economy that therapy seeks to renegotiate. Advanced practice therefore holds the distinction firmly: the chronic baseline is addressed through long-term therapeutic work, employing frameworks such as Dialectical Behaviour Therapy (DBT) or Mentalisation-Based Treatment (MBT) to build enduring coping capacities. Acute-on-chronic spikes – genuine departures from the baseline – are identified by the formulated signature and met with a crisis protocol that is proportionate, time-limited, and documented. The long-arc rationale for why this client's risk is managed in this way is recorded once, thoroughly, and referenced at each decision point, because the 3 a.m. decision not to admit is defensible only insofar as the reasoning was written in daylight.

To illustrate the practical application of a formulation-based approach, consider the case of Maya, a 34-year-old woman with a long-standing diagnosis of borderline personality disorder and a history of intermittent self-harm spanning fifteen years. Maya's baseline, as documented in her case file, includes daily passive suicidal ideation, occasional urges to overdose, and a pattern of self-injury using cutting. Over the past twelve months she has engaged in weekly DBT skills groups, and her therapist has noted a gradual reduction in the frequency of cutting episodes, although the ideation remains persistent. One evening, Maya contacts her therapist after a heated argument with her ex-partner, reporting that she feels "completely

trapped" and that she has "found a bottle of pills in the kitchen." The therapist, drawing on the formulation, recognises that this is an acute-on-chronic spike: the trigger (relationship conflict) aligns with Maya's known precipitants, the presence of means (the pills) represents a new escalation, and the client's stated feeling of entrapment matches the functional description of escape. The therapist therefore activates the safety plan that had been co-constructed in Maya's own words, which includes (1) a list of internal coping strategies such as grounding exercises and diaphragmatic breathing, (2) a hierarchy of external distractions like a 30-minute walk or a phone call to a supportive friend, (3) a clear protocol for means restriction – Maya agreed to place the bottle of pills in a locked box that she does not have the key to, and to hand the key to her sister, and (4) a crisis contact list that includes the local crisis team, the 24-hour suicide helpline, and the therapist's out-of-hours email. The therapist documents the formulation, noting the trigger, the functional appraisal, the protective factors (Maya's willingness to involve her sister), and the specific steps of the safety plan. Within two hours, Maya follows the plan, contacts her sister, and the pills are secured. The therapist follows up the next day, revises the formulation to incorporate the recent conflict, and updates the safety plan to include a scheduled check-in with the crisis team. This concrete example demonstrates how a dynamic formulation guides the selection of interventions, rather than a checklist that would have merely recorded "low risk" on a standard form.

The contrast between a formulation-driven file and a checklist-driven file is stark. Imagine two files belonging to clients who both die by suicide after a similar tragedy. File A consists of six months of identical checklists, each indicating "low risk," the last completed forty-eight hours before death. The documentation reads like a ritual, with no narrative of how the client's risk evolved, no record of means restriction, and no evidence of therapeutic engagement. File B, by contrast, contains a richly detailed formulation: the mechanism of risk, the client's behavioural signature, the evolving protective factors, the safety plan, revisions at each turn, and a record of consultation at each escalation. The reasoning for each decision is clearly articulated, and the file demonstrates that the practitioner understood the client as a person, not as a score. While outcomes cannot be guaranteed by either approach, the second file reflects a practice that engaged the actual person, restricted the actual means, and can stand up in any coroner's court as

evidence that the practitioner acted on a nuanced understanding of risk.

The shift from checklist to formulation is not a matter of abandoning structure; rather, it is a re-orientation of structure around the client's lived experience. Checklists still have a role in ensuring that certain baseline information is gathered – for example, confirming that the PHQ-9 item 9 has been explored, that the client's current access to means is known, and that a basic safety plan exists. However, these tools become the scaffolding upon which the formulation is built, not the end in themselves. The practitioner must move beyond the binary of "high" versus "low" risk and attend to the fluid interplay of stressors, protective factors, means, and function. This dynamic approach aligns with the broader evidence base that emphasises the importance of therapeutic alliance, means restriction, and collaborative safety planning as the most robust protective factors against suicide (Cox et al., 2021; Zalsman et al., 2022).

In practice, the formulation should be revisited at regular intervals – for example, at each session, after any significant life event, and whenever the client reports a change in mood or behaviour. The documentation should capture the evolving narrative: what has changed, why it matters, and how the intervention plan adapts. This iterative process not only enhances clinical decision-making but also provides a defensible record that demonstrates thoughtful, evidence-informed risk management. It respects the client's autonomy by involving them in the construction of the safety plan, and it recognises the limits of prediction, thereby fostering a therapeutic stance of humility, vigilance, and proactive engagement.

Ultimately, treating risk as formulation rather than as a checklist embodies the core principles of advanced professional practice: it acknowledges the complexity of human behaviour, integrates the best available evidence, and upholds the ethical imperative to protect life while respecting individual agency. By moving beyond the illusion of certainty that checklists provide, clinicians can offer a more responsive, compassionate, and legally sound approach to risk management, one that truly serves the needs of the people they are there to help.

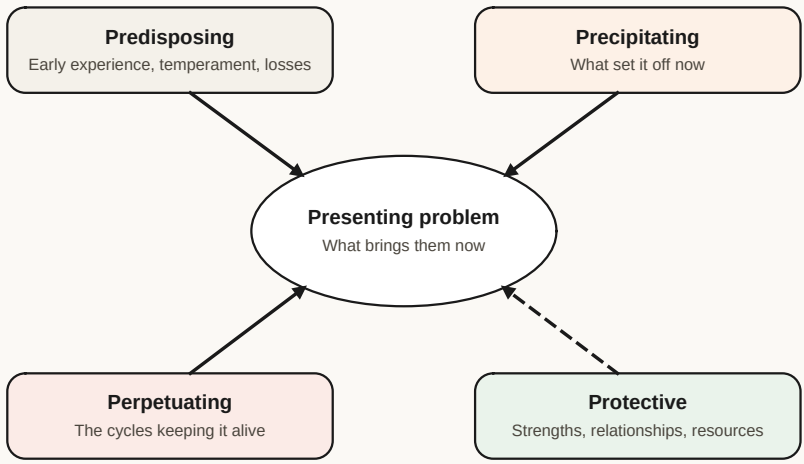



**FIGURE 2.1 The five Ps of formulation**

*A shared map of how a difficulty came to be and what keeps it going: the presenting problem at the centre, with predisposing vulnerability, the precipitating trigger, perpetuating cycles, and protective strengths around it. A good formulation is provisional, collaborative, and rewrites itself as understanding deepens.*

## Points worth keeping

- Formulate risk dynamically; checklists only floor the standard
- Safety plans work; no-harm contracts do not
- Acute-on-chronic spikes need their own logic, per the textbook

**PRACTICE TASK**

*Write a five-line collaborative safety plan structure you could complete with a client in fifteen minutes.*