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Supporting and valuing lived experience of mental health difficulties in clinical psychology training

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Division of
Clinical Psychology

This guidance was produced by a small team at University College London (UCL) with input from a working group of clinical psychology trainers, trainees and clinical supervisors.

LEAD AUTHORS

NATALIE KEMP

Research Fellow, Research Department of Clinical Educational and Health Psychology, UCL;
also founder of in2gr8mentalhealth

KATRINA SCIOR

Joint Course Director, Doctorate in Clinical Psychology, UCL

HENRY CLEMENTS

Principal Clinical Tutor and CBT Pathway Lead,
Doctorate in Clinical Psychology, UCL

KATHY MACKENZIE-WHITE

Teaching Fellow, Doctorate in Clinical Psychology, UCL

WORKING GROUP

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Jo Armitage, Rajinder Ballman, Frances Blumenfeld, Anne Cooke, Laura Dickens, Clare Dixon, Julie Evans, Lorna Farquarson, Lorna Fortune, Catherine Gamble, Laura Golding, Dave Harper, Camilla Hogg, Lorna Hogg, Cheryl Hunter, Kirsty Killick, Aliénor (Lili) Lemieux-Cumberlege, Olga Luzon, Jennifer Oates, Richard Payne, James Randall, Molly Rhinehart, Imogen Rushworth, Inke Shreiber, Viv Smith, Rachel Terry, Jane Vosper, Ste Weatherhead, and Nick Wood.



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Executive summary

This document has been produced as guidance for the clinical psychology training community in order to increase the likelihood that trainees who experience mental health difficulties will be well supported. Another central aim in producing this guidance was to recognise that mental health difficulties are just as common among mental health professionals and those in training as they are in the general population, and to challenge the silence, stigma and shame that often surrounds mental health difficulties.

The guidance considers a range of complex issues that trainees, course staff and clinical supervisors may encounter and outlines what good practice may look like. It notes the importance of creating a culture of compassion and openness at course level, and within the training environment more generally, and how this might be achieved in practice. Guidance is provided on how to understand confidentiality and considerations to hold in mind when reaching decisions about sharing experiences of

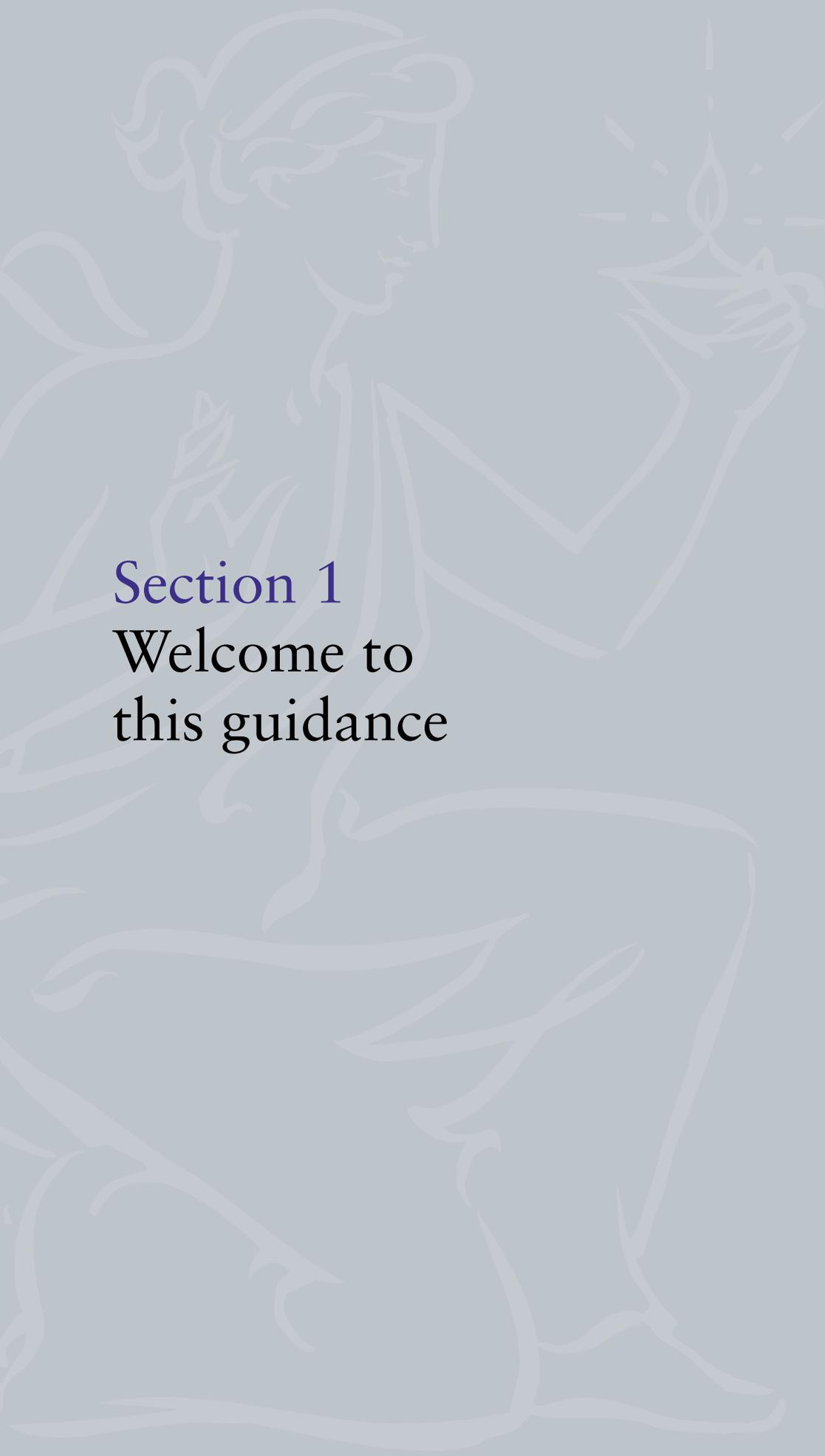
distress with others in the training environment and professional sphere. Detailed guidance is offered on how to support trainees who experience mental health difficulties, resources to draw on, and ways to manage instances when a trainee may need to take time out from training. It also seeks to demystify professional regulations and the rare instances when they may be drawn on, noting that a proactive approach as outlined in this guidance is always preferable to any regulatory actions.

Keeping the needs of those who seek our support central to our work, while affording both them and our colleagues and trainees kindness and compassion should be at the core of our practice and values. Central to this guidance is a belief that where mental health professionals are concerned, knowing when to ask for help and doing so is a sign of professional competence in action and not of failure. We hope this guidance and the recommendations it contains will be received in this spirit.

01

Section 1
Welcome to
this guidance

SECTION



Mental health difficulties are a common human experience – they call for others’ compassion and kindness, whether or not the person seeks support or tries to manage alone. Having asserted that they are a common human experience, Stephen Hinshaw, in *Breaking the Silence* (2008), drew attention to the silence that generally surrounds mental health professionals’ own mental health needs. Since then, it has become increasingly recognised that mental health professionals are as vulnerable to mental health difficulties as the population at large, if not more so. Their potential increased vulnerability is due to numerous factors, not least that work in this area places high emotional demands and stresses on practitioners. In addition, individuals with lived experience of mental health difficulties may be attracted to work in the mental health field, seeking to add value to mental health service provision based on their own experiences. For some this is because they have been inspired by positive encounters with services and individual clinicians; for others, negative experiences of help-seeking have motivated them to ensure that others have more positive encounters with mental health services.

Regrettably the work culture in many services maintains an ‘us-versus-them’ stance and practitioners can be reluctant to engage in wider systemic conversations about their own vulnerabilities, or talk about personal experiences of mental distress. Many mental health professionals can feel pressure to appear invulnerable and to remain firmly on the side of the ‘helper’. They can experience intense dilemmas when considering speaking openly about their experiences of distress or of seeking help. The perspective of experts by experience is increasingly and quite rightly sought by service providers, policy makers and researchers; however, the usual assumption is that these experts are users and not providers of mental health services. This reinforces the polarised notion of an ‘us and them’ divide in mental health services and does little to challenge stigma. It also diminishes opportunities for us to learn from providers who

have lived experience. This guidance hopes to contribute to current efforts to challenge the stigma not only of experiencing mental health difficulties, but also of experiencing them as a mental health professional. In addition, it seeks to move away from thinking of lived experience among service providers only in ‘problem’ terms, and to adopt a more normalising and valuing stance.

When those training in a mental health profession struggle with their own mental health, it can evoke complex emotions and responses, both in the individual concerned and in those tasked with training them. Responding in ways that are sensitive to both service users’ and trainees’ needs, and promoting training environments that are empathic and containing, is not always easy. Distinguishing when things are manageable and when more help is needed is key. While this often calls for flexibility, university regulations and procedures and funding arrangements may well constrain what adjustments to usual training processes are possible. This guidance therefore seeks to provide good practice examples and information about multiple sources of support that trainees and trainers may want to consider in identifying the most helpful way to proceed at a given time.

Clinical psychologists have a responsibility and many opportunities to play a role in destigmatising mental health difficulties. This does not only extend to stigma faced by service users, but also to stigma experienced by colleagues, supervisees and trainees. Accordingly, this guidance seeks to promote a stance that normalises and values lived experience among mental health care providers and others involved in their training. It was produced by stakeholders in key roles within the clinical psychology training community in the United Kingdom: trainees, trainers and clinical supervisors, many of whom are ‘experts with experience’. From the outset, and central to producing a credible document, was representation from members of the training community who identify as having lived experience of mental health difficulties. Their

insights into what it is like to navigate a path through training and to call on active support have greatly enriched this guidance, extending and deepening what we know from research in this area.

The guidance is divided into sections covering key topics relevant to the training community that we hope can be delved into as and when relevant, including:

Ways to create a training culture that is open to and compassionate towards mental health professionals who experience mental health difficulties.

Ways to support trainees who experience mental health difficulties.

Factors to consider if thinking of sharing lived experience, and understanding the responsibilities and limits of confidentiality.

Reflections on the relationship between lived experience of mental health difficulties, professional ethics and legal considerations.

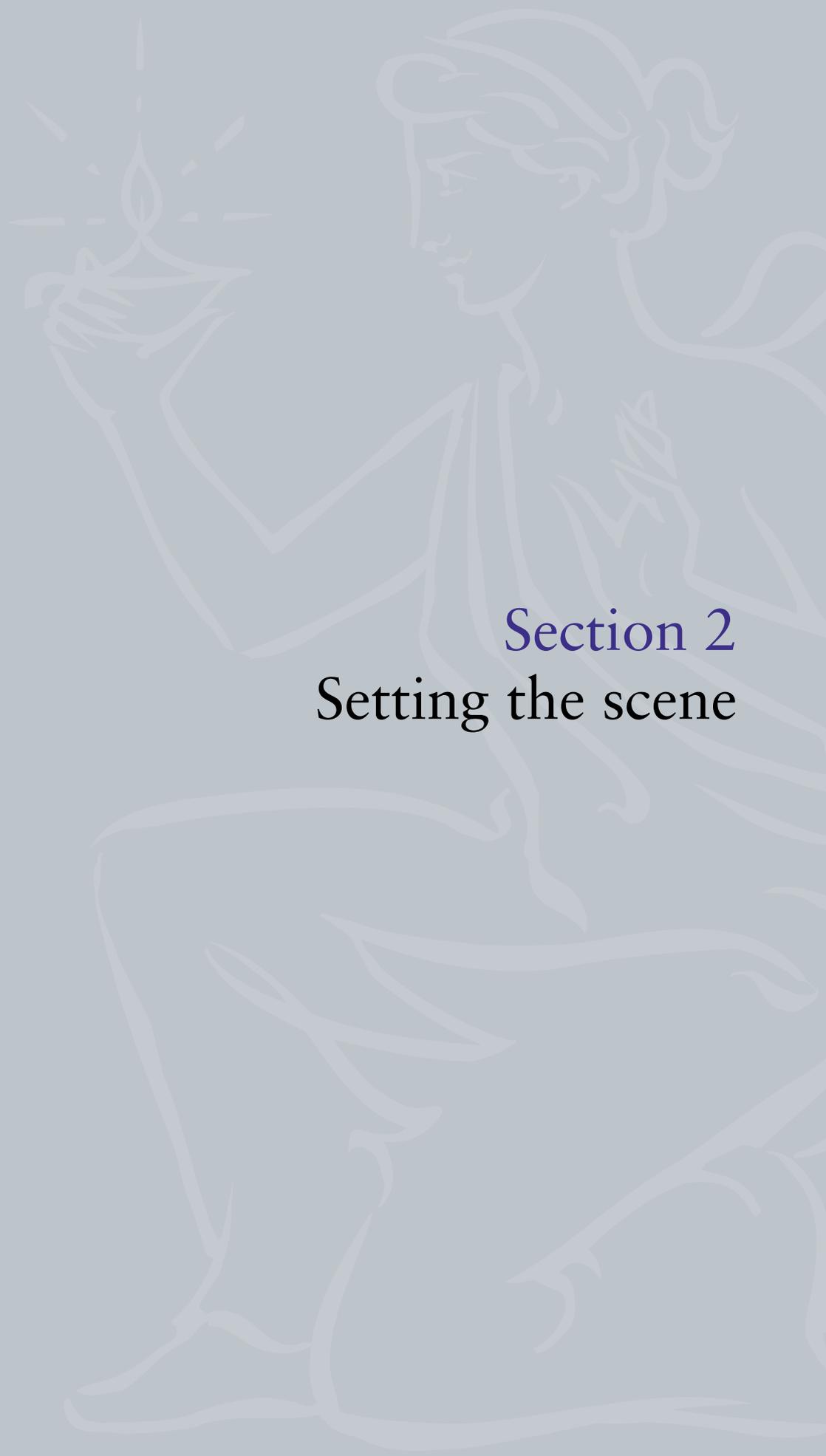
Ways to navigate time out and the return to training.

Sign-posting to relevant policy documents and further resources.

Sample initiatives that training courses have put in place are presented throughout the guidance to offer practical suggestions, and to encourage further discussion and development among training providers.

02

SECTION

A faint, light-colored illustration of a woman with long, wavy hair, wearing a long, flowing dress. She is holding a glowing, multi-pointed orb in her right hand, which is raised towards her face. The illustration is rendered in a simple, line-art style with some shading to suggest depth and light.

Section 2
Setting the scene

ABOUT LANGUAGE

We aim for this document to be accessible guidance to a complex area. We are mindful that the language we adopt can have a powerful impact on how we understand and relate to the topics at hand. There are many ways to describe and conceptualise personal experience of mental health difficulties. In this guidance we use the terms ‘mental health difficulties’, ‘mental distress’ and ‘lived experience’ in the hope to engage with the widest audience. In the interests of generalisability, we have tried to use language which is not wedded to a particular psychological model. However, users of the guidance are encouraged to draw upon diverse psychological understandings of mental health difficulties to support thoughtful and compassionate implementation. We recognise that some users of the guidance might prefer to use different terms and language. Above all, we want this guidance to be helpful to users, whatever their preferred terminology, in different contexts and relationships. We therefore welcome users to adapt the language if that would make the guidance more helpful for them.

When referring to conversations about mental health difficulties in this guidance –

particularly where an individual contemplates telling someone about their experiences – we use the terms ‘sharing’ or occasionally ‘disclosure’, although we acknowledge that the term ‘disclosure’ has some negative connotations.

We have adopted the succinct term ‘trainees’ to refer to trainee clinical psychologists and hope that aspects of this guidance might be relevant and helpful to those in other mental health professions. We also highlight where important distinctions may exist between procedures for trainees whose training is funded along different routes, be this NHS funded, through an international source, or self-funded. We use the term ‘course staff’ to refer to academics and tutors employed by doctoral clinical psychology training programmes. The terms ‘clinical supervisors’ or ‘placement supervisors’ describe those with supervision responsibilities for trainees in the NHS or other placement settings. Where responsibilities are shared between these three key stakeholder groups, we use ‘we’ to indicate the whole training community, mirroring a stance of working collaboratively beyond the unhelpful ‘us and them’ dialogues that can easily be set up.

SCOPE AND CONTEXT

WHAT DO WE MEAN BY LIVED EXPERIENCE OF MENTAL HEALTH DIFFICULTIES?

When we refer to lived experience of mental health difficulties we mean the full range of mental health difficulties, regardless of whether the person has received a diagnosis or whether they have used public or private mental health services. Some sections of this guidance focus explicitly on current mental distress. Other sections are equally relevant to current and past lived experience, consonant with our knowledge that difficulties can be dynamic and

the nature and level of support required may vary over the training period.

While this guidance talks to a spectrum of distress, it focuses on experiences of mental health difficulties and not on the effects of more everyday ‘stress’ on general mental wellbeing. At the same time, we wish to note the negative effects that continued and cumulative stressors can have on wellbeing and everyday functioning, and that they may well lead to mental health difficulties. The recommendations in this guidance are aligned with the staff wellbeing agenda, whilst also intending to go beyond it. Guidance on

supporting staff wellbeing is relevant to all staff in focusing primarily on managing stress at work and promoting daily mental hygiene. Where training environments promote trainee and staff wellbeing and are attuned to the risks of high stress levels for mental health, this is likely to benefit all members of the training community, including those with lived experience. Paying attention to wellbeing generally though is unlikely in and of itself to be sufficient in meeting the needs of trainees who experience mental health difficulties. Whilst the staff wellbeing agenda has an important role to play in ensuring that working environments are conducive to everyone's wellbeing, it does little to challenge the fear and stigma associated with mental health difficulties that are not easily understood purely as responses to stress or that may prove lasting.

LIVED EXPERIENCE AND (TRAINEE) CLINICAL PSYCHOLOGISTS

According to recent UK figures, in the general population about four in ten adults experience a diagnosable mental health problem at some point in their lives; of these, a third have not received a formal diagnosis (Mental Health Foundation, 2016). Studies suggest that mental health difficulties are also common among mental health professionals (Grice, Alcock, Scior, 2018; Meltzer et al., 2008; Rao et al., 2016; Tay, Alcock & Scior, 2018). In one survey of 348 trainee clinical psychologists across 19 UK training institutions, 67% reported lived experience of a mental health problem (Grice et al., 2018). It is likely that these figures overestimate the incidence of mental difficulties among trainee clinical psychologists due to self-selection bias. Nonetheless, they suggest that lived experience among trainees (and similarly qualified clinical psychologists, see Tay et al., 2018) is far more common than hitherto recognised. It appears that it is not a few, but many, who have had to face the silencing effects of stigma and intense fear of 'being found out'. In a training context it is also important to acknowledge contextual factors that may make trainees more vulnerable to mental health difficulties, such as

the fact that some relocate to take up training and as a result move away from established support networks.

TAKING A WHOLE-SYSTEMS PERSPECTIVE

Course staff, trainees and placement supervisors may all have lived experience of mental health difficulties. While this guidance focuses primarily on trainees, it is incumbent on all these stakeholders to contribute to creating training and clinical environments that are compassionate and that seek to destigmatise lived experience, rather than perhaps this being seen as primarily relevant to or the responsibility of trainees. We have taken the position that supporting trainees with lived experience should be a collaborative endeavor with responsibilities for the trainees concerned, course staff and clinical supervisors. Where courses embrace a culture that is open, safe, compassionate and supportive in responding to trainees' needs, trainees and other members of the training community are more likely to feel able to be open about their lived experience and to reflect on its value and impact in their work. In turn, we would hope to decrease situations where opportunities for early support might have been missed and address the paradox that we (at times implicitly) tend to give quite different messages about speaking out and seeking support to service users and members of our own profession.

THE NHS AS TRAINING CONTEXT

The risks of excessive work and stress to all health professionals' mental health have attracted increased attention recently, leading to the establishment of the NHS Staff and Learners Mental Wellbeing Commission in 2017. The Commission's final report, published in February 2019, summarised some of the particular challenges of being a learner in the NHS and actions needed to ensure that learners who experience mental health difficulties are well supported. It noted particular barriers to help seeking, such as those in the position of providing support for wellbeing are often the same people tasked with assessing learners. This common scenario

is likely to increase learners' fears about the detrimental impact that sharing might have on their future career prospects. In this guidance we have therefore identified a need for greater clarity regarding the boundaries of sharing and confidentiality in training.

LEGISLATIVE CONTEXT

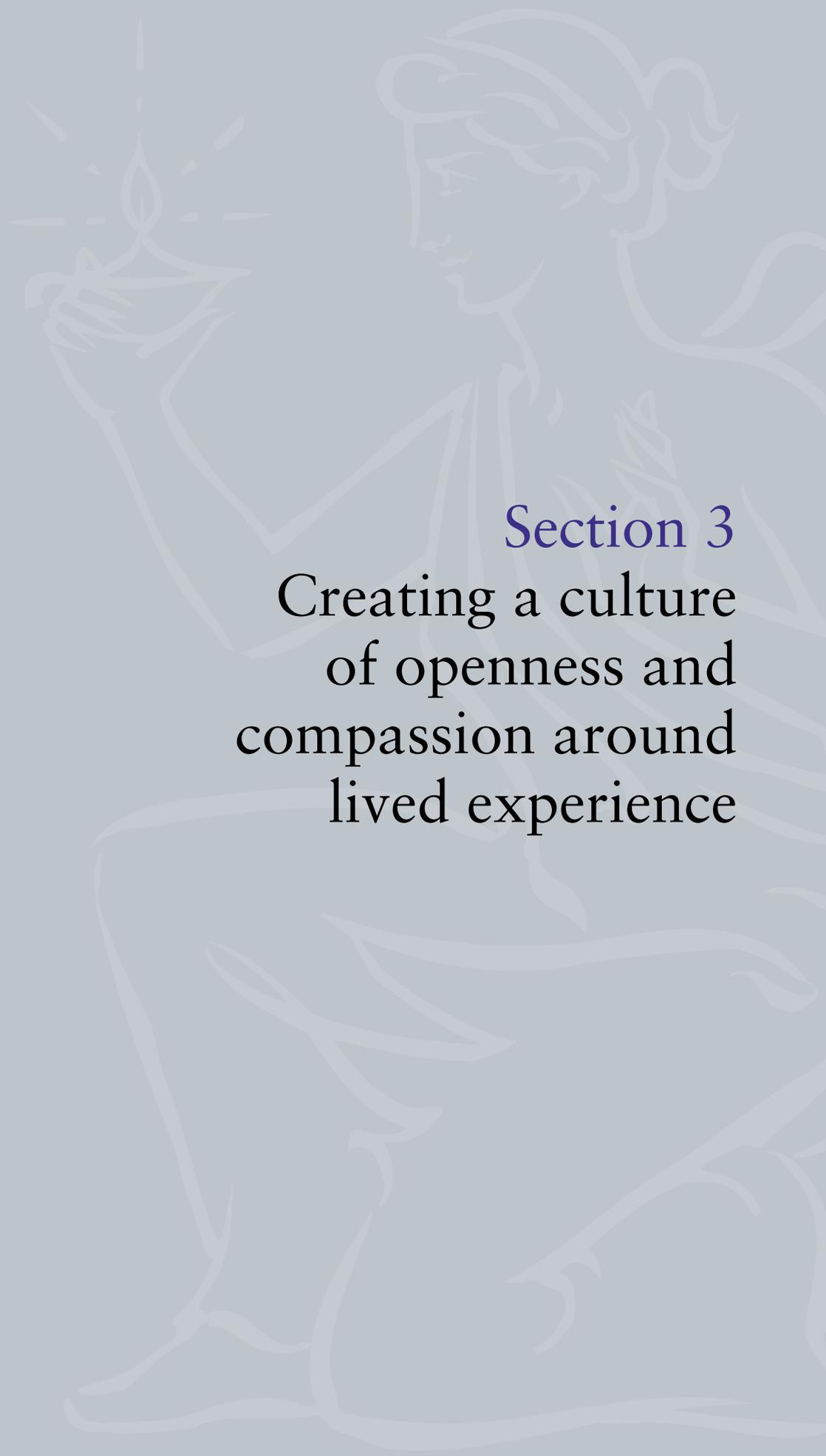
While it is beyond the scope of this guidance to set out the relevant legal context, we wish to briefly draw attention to key legislation which readers of this guidance should familiarise themselves with in order to ensure that they understand their legal rights and obligations.

Under the Equality Act 2010 it is unlawful to discriminate against disabled applicants, employees and students in admission or enrolment or by failing to make reasonable adjustments to the study or work environment. Many people with mental health difficulties do not think of themselves as 'disabled' but they

may have rights supported by the Act. A person with mental health difficulties is covered under the Act if their condition has a 'substantial' and 'long-term' (defined as lasting 12 months or more) negative effect on their ability to carry out usual day-to-day activities. The Act also covers those who have experienced mental health difficulties in the past, even if they have recovered, and those whose condition is successfully managed by treatment or therapy, as long as they meet the definition above. Universities have a common law duty of care to students. This includes provision of pastoral support and taking steps required to protect the health, safety and wellbeing of students. Of relevance to issues of confidentiality is the Data Protection Act 2018 and the UK's implementation of the General Data Protection Regulation (GDPR). These set out regulations around the handling of data, in particular, the handling of personal and sensitive data which includes personal health data.

03

SECTION

A faint, light-colored illustration of a woman in profile, facing left. She has long, wavy hair and is wearing a simple, draped garment. She is holding a lit candle in her right hand, with a flame and radiating lines above it. The illustration is rendered in a minimalist, line-art style.

Section 3
Creating a culture
of openness and
compassion around
lived experience

The importance of creating working environments in which mental health and available support are discussed openly with employees at regular intervals has become increasingly recognised. The 2017 seminal report *Thriving at work*, by Stevenson and Farmer, notes that “This is not just about discussing mental health problems, but about creating an environment in which employees feel able to talk openly.” (p.68)

Training institutions should champion a training environment that encourages openness to lived experience in the profession and among trainees. They should be mindful that trainees may experience shame and fear of negative consequences in relation to their

lived experience; in some cases these may be informed by past negative responses when they have told others about their mental health difficulties. Some have had positive experiences of sharing at interview stage but have felt frustrated once on the course by a lack of further dialogue about what their lived experience might mean for training. Hence courses are encouraged to think more actively about how to create a culture where trainees and staff feel able to talk openly about personal struggles generally and lived experience specifically, and where those with lived experience feel that they can make a meaningful and positive contribution rather than being viewed primarily in problem terms.

HOW WE TALK ABOUT MENTAL HEALTH DIFFICULTIES

In the context of clinical psychology training, talking about mental health difficulties, past or current, is a collaborative practice involving the whole training community through creating a culture of openness and compassion. Everyone involved in clinical training should be encouraged to think about how they perceive and talk about lived experience: not just among service users, but also among colleagues and other service providers. Course staff may benefit from making time to think together about the messages they want to communicate about mental health within the profession, their own modelling around this, inviting lecturers who openly identify as having lived experience and briefing external lecturers about being open to lived experience among trainees.

Taking time to view lectures and documents through the lens of someone with lived experience can help alert training providers

to implicit messages which may reinforce an ‘us and them’ polarity and suggest that vulnerability is only to be found ‘outside the room’. Trainers should also be mindful, particularly when considering simulated and experiential components of training, of assumptions that trainees will not have experienced the issues in question personally.

Importantly, in addition to requiring trainees to undergo occupational health assessments ahead of starting their training, courses routinely ask those who have accepted a place to disclose health difficulties and disabilities that the course needs to be aware of, above all for the purpose of placement planning. Courses should consider carefully how they ask for this information and ensure that they make it clear why this information is sought, how it will be used and what the boundaries of confidentiality are.

WHAT CREATING A CULTURE OF OPENNESS MAY LOOK LIKE IN PRACTICE

Here we provide selected examples of steps that courses have taken to promote a culture of openness and to normalise lived experience.

EVENTS AND WORKSHOPS PROMOTING INCLUSIVITY

The Lancaster course held an event in 2018 focused on identities as professionals and

service users/experts by experience entitled ‘Humanity & Commonality: No More Them & Us’ with speakers including Natalie Kemp, Rufus May and Elisabeth Svanholmer. Natalie Kemp has also provided talks, advanced reading seminars and workshops to trainees across seven clinical psychology courses: destigmatising lived experience through modelling her own navigation of lived experience as a mental health professional, and inviting reflection on the positioning of vulnerability in the mental health field and the impacts of us/them narratives.

MAKING SPACE FOR CLINICAL SUPERVISORS TO CONSIDER THIS TOPIC

Sections on supporting trainee sharing of mental health difficulties have been added as standard to all Introductory and Advanced Supervisor workshops, which are delivered by clinical tutors across the three North Thames programmes (Royal Holloway, UCL and UEL). This has the key aim to encourage new and established supervisors to be open to talking about personal struggles and lived experience of mental health difficulties, and build compassionate support for trainees. Supervisors are encouraged to be thoughtful and explicit in considering their relationship to lived experience of mental health difficulties (their own and others’), the power imbalance that exists in the supervisory relationship and to model a culture in which discussing personal struggles and potentially mental health difficulties is normalised.

NORMALISING LIVED EXPERIENCE AMONG TRAINEES

At UCL, during Year 1 induction, personal response systems (PRs) are used to normalise lived experience, create a culture of openness and tackle stigma by allowing trainees with lived experience to see that they are by no means ‘the only one’. As part of an induction workshop on the stresses inherent within training, staff model talking about emotional challenges that they have experienced and invite trainees to indicate through an anonymous ‘vote’ using the PRs, whether they have lived experience. Usually at least half of each cohort respond that they have,

which helps to normalise lived experience. NB: More recently the course has switched to the free software Mentimeter to complete this and similar exercises.

ESTABLISHING TRAINEE-LED LIVED EXPERIENCE PEER GROUPS

At both Salomons and UEL, trainee-led groups have been established for those with lived experience. In addition to normalising lived experience, these groups offer valuable peer support.

On other courses, such as Lancaster, trainees can request to be put in touch with other trainees who may experience similar issues for support: this can include trainees with mental health difficulties. The system is coordinated by the course’s Personal Development Associate Tutor, an honorary member of staff who is separate from the course team. Smaller courses may want to consider joining with other courses to allow trainees to be part of similar schemes.

INDEPENDENT PERSONAL ADVISORS

Many training courses have independent personal advisor schemes in place. As a confidential person, who is entirely independent of the course, personal advisors may offer a helpful space where trainees can consider what personal experiences to share with trainers and how to do so.

THERAPEUTIC CONSULTATION SYSTEM

A ‘therapeutic consultation’ system was set up at Leicester for a period of time when funds were available. Trainees had access to three to five hours of funded consultancy space to explore an aspect of the personal-professional interface. Many who made use of this went on to engage with personal therapy to explore further. Trainees were supported to find a match in terms of person and approach, and time was given for them to attend sessions. The scheme was popular and the majority of trainees to whom it was available made use of it. Trainee feedback was that it was very helpful, not least in experiencing the help-seeking position for those who had not done so before.

SUPPORT IN ACCESSING PERSONAL THERAPY

Some, but by no means all, courses have funding for short term therapy available to trainees. Trainees who wish to access personal therapy should have information about how to access this through their university readily available to them. Those who wish to access personal therapy privately often greatly value guidance or support in accessing this. Some

courses publish information about organisations and networks through which personal therapy can be accessed. Others, such as Lancaster, have a database of therapists, which can be accessed through the Personal Development Associate Tutor (see above). While expectations and support for personal therapy vary between training courses, it is our view that when and where trainees access therapy should always be a personal choice.

MAKING PLACEMENT AND RESEARCH DECISIONS AROUND THEMES OF PERSONAL RESONANCE

A culture of openness and normalising is also of great importance at points during training when decisions need making, for example around what thesis topic and research methodology to opt for or what clinical placements to pursue. Throughout their training, trainees (and trainers) may face times when such decisions may bring trainees close to their own lived experience. There are no 'standard' responses to such situations – some people are happy and well placed working in areas they have lived experience of themselves, and may have considerable experience of doing so before coming on the course. Others may prefer to work in areas that are far removed from their own experiences. Whatever choices are made, it is important to consider from early on, in discussion with tutors, that some lived experience themes may resonate across various placement and research areas and how this may affect the trainee, clinical work, research, and the course of training at various points. Wherever possible, trainees and trainers are advised to discuss any themes of personal resonance together ahead of making placement and research choices. It is helpful to have open conversations about the extent to which the trainee themselves feels comfortable around resonant themes, any past experience they have of working more or less comfortably

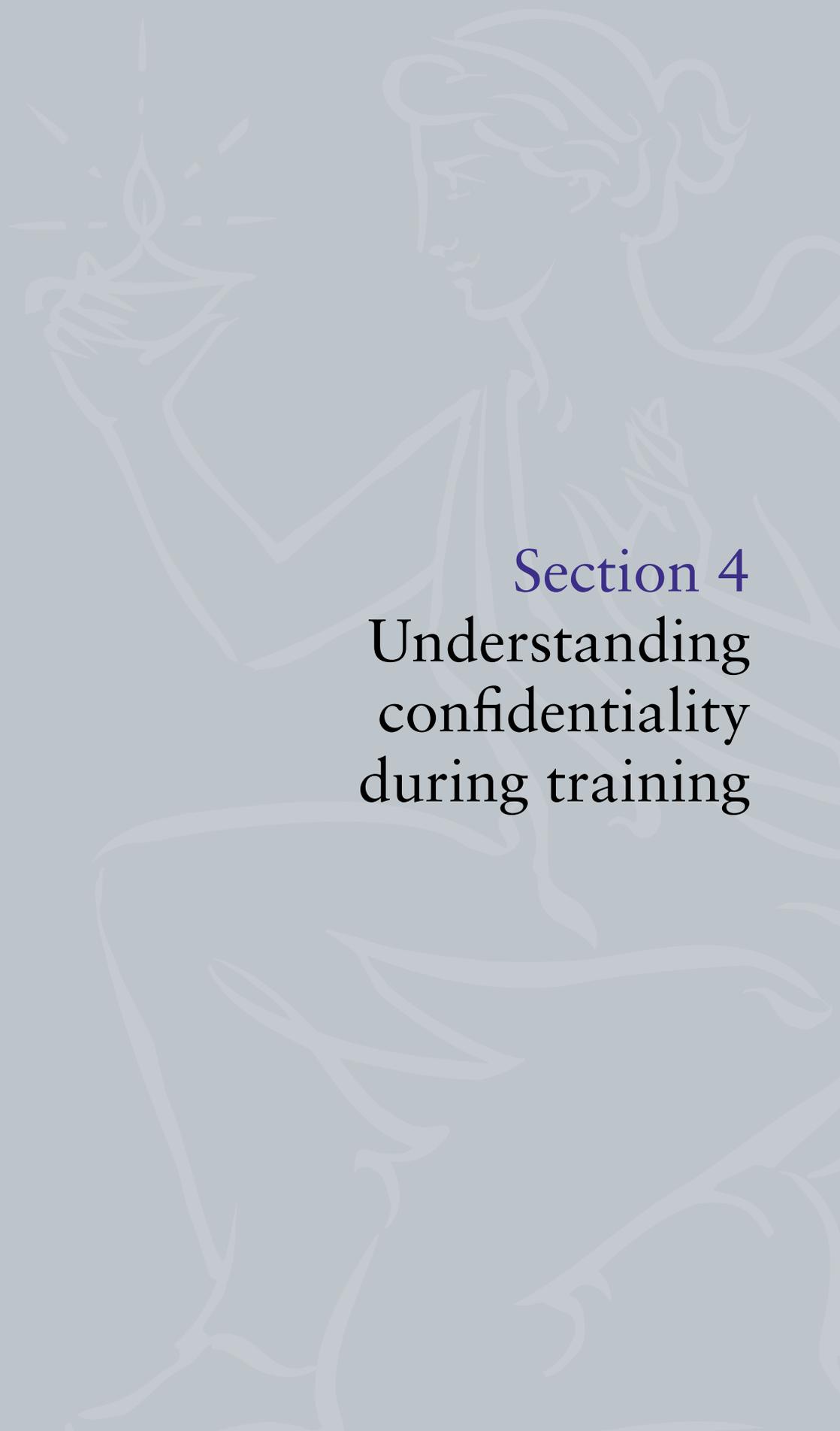
around them and any potential impact on the trainee, service users or research participants of doing so. It should also be taken into account that any potential impact could be somewhat magnified at times of high demands and stress. Where the trainee or trainers doubt the trainee's ability to manage certain themes of personal resonance at this stage, it would be important to consider this carefully together and caution would be advisable, with alternative options considered instead. If the trainee is interested in working in areas of personal resonance in the future, they could identify this as a part of their personal and professional development plan to be reviewed.

Such conversations and planning should be informed by a conviction that bringing knowledge of the self to inform decisions about placements and/or research shows reflective skills and competence. They must avoid conveying a sense that by making decisions *not* to pursue something a trainee is 'not good enough'.

Of course there may well be occasions when it is not possible to predict in advance when people we work with may bring material that has personal resonance; open conversations from early on will facilitate open thinking about such occasions.

04

SECTION

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Section 4
Understanding
confidentiality
during training

Many people are understandably concerned regarding who knows what when they share personal information, including about their mental health. In deciding what to share when and with whom, it is important to be clear

regarding boundaries of confidentiality. In this section we therefore look at guiding principles governing confidentiality when a trainee experiences mental health difficulties.

NEED TO KNOW

A key guiding principle in relation to confidentiality and mental health difficulties is that only those people who need to know should be informed; in other words, information about mental health difficulties should only be shared with others if there is a need to do so.

Wherever possible a trainee should be made aware when information is being passed to someone else and why this is being done. Trainee consent should be sought for this, although consent may not always be needed;

for example, where there is a significant risk to self or others and consent cannot be sought, or it is sought under these circumstances and withheld.

What needs to be shared and with whom should be reviewed regularly; for example, a trainee may have needed support for mental health difficulties early on in their training, but this may no longer be relevant and may not need to be shared with later supervisors.

POLICIES

All trainees are students within a university setting and also either employees or honorary employees of an NHS Trust or other organisation. Each course must therefore consider the following: university and course policies on student mental health difficulties and confidentiality, where applicable the employer's policy on mental health difficulties and confidentiality, and potentially the placement's local policy on mental health difficulties and confidentiality.

Trainees cannot be expected to understand how these various policies may interact and, as set out below, it would be helpful for each course to have a clear confidentiality statement in relation to confidentiality and mental health difficulties.

The University Mental Health Charter (Hughes & Spanner, 2019) is a helpful document for considering the importance of being explicit with students about confidentiality and its limits, and also gives some helpful guidance in relation to information sharing.

BEING EXPLICIT ABOUT CONFIDENTIALITY AND ITS LIMITS

Whilst trainees are trained to be very clear and explicit about confidentiality and its limits when working with clients, the rules around confidentiality and its limits in relation to sharing their own mental health difficulties with people involved in their training are sometimes not clearly set out. This lack of clarity may discourage trainees from sharing their mental health difficulties and may add to a fear that

sharing will result in something bad happening, for example being forced to withdraw from training. In fact, withdrawal from training is a rare event and the most common outcome is that the trainee gains access to help and support. It would be helpful for courses to have a clear confidentiality statement in relation to health and personal difficulties that trainees may experience (including but not limited to

mental health difficulties) so that respect for confidentiality and the limits of it are clear. It would be good practice for this confidentiality statement to be given to all trainees as early as possible and for its contents to be covered in their training induction; it should also be circulated to all other relevant people involved in training. Whilst each course will need to draft the wording to fit its particular context, the confidentiality statement should cover the following:

Respect for confidentiality and the guiding principle of 'need to know'.

Summary of the relevant policies covering confidentiality with links to those policies. This summary will need to make clear that some contexts in which information is disclosed, for example, placements, may have different professional/legal obligations regarding confidentiality.

Reference to a clear course policy about information sharing between trainees, course staff including administrative staff, placement supervisors and placement staff, employers/honorary employers, and Occupational Health.

What will happen if a trainee shares a past or current mental health difficulty with the following people?

- (a) another trainee
- (b) their tutor
- (c) another member of staff, including administrative staff
- (d) a supervisor
- (e) another person on placement

Specifically, will the information remain confidential or will it be shared with someone else, and if so with whom, how and on what basis?

What will happen if a trainee, tutor, another member of course staff, a supervisor or another person on placement is concerned a mental health difficulty may be affecting a trainee's ability to function / train / practise – how will that concern be raised and how and where will it be recorded and with whom will it be shared?

When it would be necessary to consider referring a trainee to Occupational Health, how this referral works and what information Occupational Health will share and with whom.

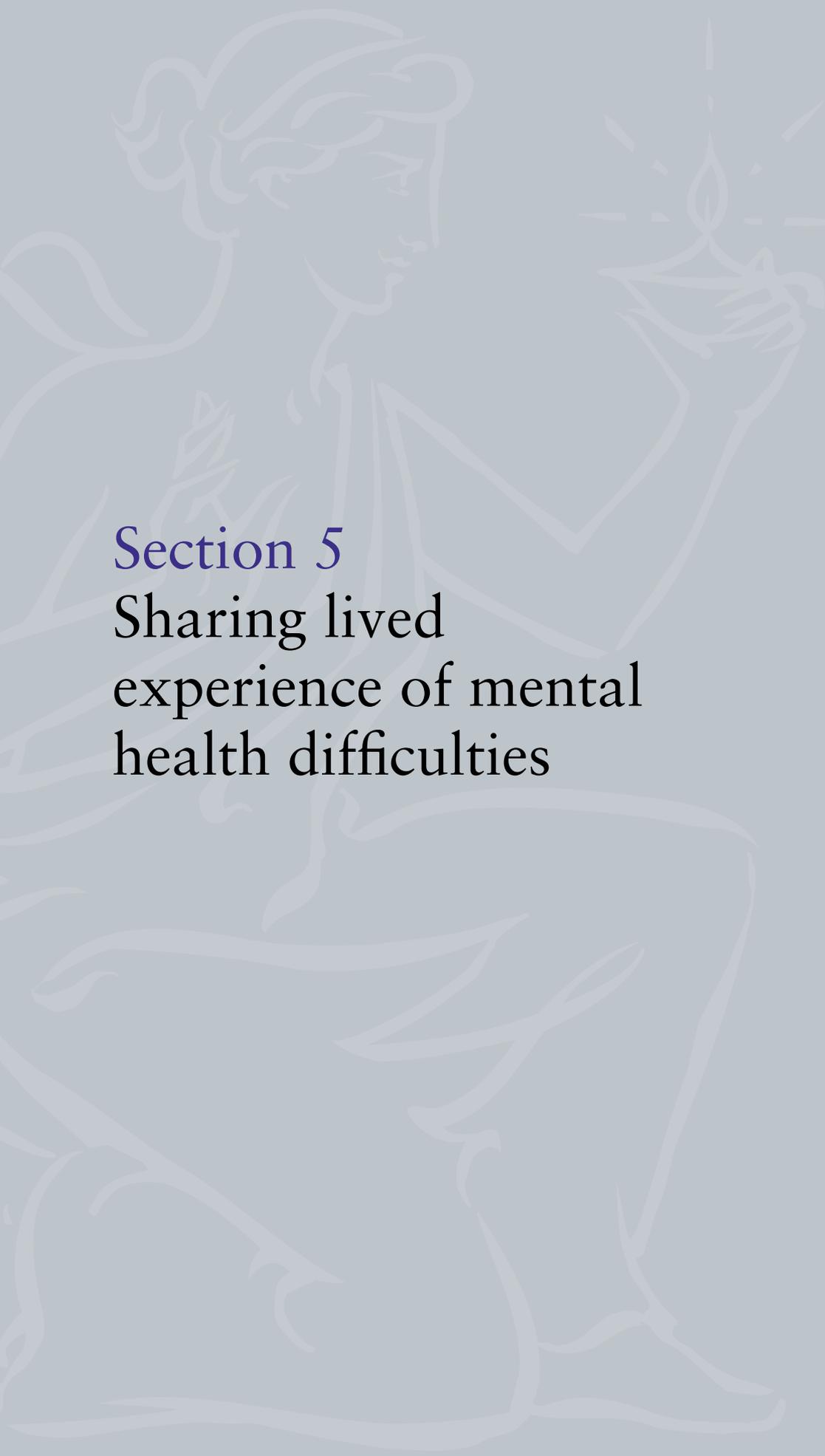
When confidentiality will be broken, both with and without consent (for example when the trainee is considered to be a risk to themselves or others), and how it will be broken, i.e. who will be told what and how will the trainee be informed? It may be helpful to include a section on dealing with a crisis.

Where information shared is recorded, how it is recorded, who has access to that information and for how long it is held.

What information will be shared and with whom about mental health difficulties and absences (if any) beyond the course. For example, if asked for a reference, what information will the course/course staff share?

Procedure for sharing confidential information about mental health difficulties. Some trainees may be reluctant to share information with a particular member of staff and where a procedure is in place for sharing information with a particular member of staff, for example with a course tutor, there should be a clear alternative member of staff whom the trainee can approach instead.

Section 5
Sharing lived
experience of mental
health difficulties



DECIDING WHETHER, AND IF SO HOW AND WITH WHOM, TO SHARE LIVED EXPERIENCE

Sometimes trainees may not have a choice about having to disclose their lived experience, for example where it is adversely impacting on their clinical work. This section of the guidance addresses the common situation in which a trainee can choose whether or not to disclose their lived experience.

Trainees face difficult decisions about whether, and if so how and with whom, to share aspects of or all of their lived experience during training. A trainee may decide to disclose within one context, for example to a fellow trainee, but not in another, for example to a supervisor on placement where their lived experience is clearly not impacting on their clinical work.

Any decision to share needs careful consideration and there is no one-size-fits-all answer to the question about whether, and if so how and with whom, to share personal experience of mental health difficulties; it is for each individual to consider what the right decision might be for them at any given time and in different contexts. It can take a lot of strength to share, and the costs and benefits need to be weighed up in the knowledge of mental health stigma and recognition that sharing is not a one-off decision and act, but a continued negotiation over time. The decision to share may be driven by a need for help and support, but it may also, or alternatively, be part of personal-professional development and/or a way of actively challenging stigma.

RESOURCES TO HELP MAKE DECISIONS AROUND SHARING

There are a number of resources which may help trainees reach decisions around disclosure. We recommend that course staff and supervisors, as well as trainees themselves, are familiar with these resources so that everyone in the training community is mindful of decisions trainees may face and can help support them.

Heads up, an Australian organisation, have produced helpful [resources and guidance for employees to plan a conversation about their mental health difficulties with someone at work](#). This website also has free tools to help someone weigh up the potential benefits and costs of disclosing a mental health problem at work, and [videos of people talking about their experiences of talking to supervisors and colleagues](#).

Conceal or Reveal: [A guide to telling employers about a mental health condition](#) (CORAL), is a short practical guide to help employees reach a decision about telling an employer about their mental health difficulties. The guide provides helpful exercises to guide someone through

the process of considering different aspects of sharing their lived experience in a work context.

Honest, Open, Proud is a peer-group programme which aims to help people with lived experience make empowered disclosure decisions. [The manual which guides the programme is freely available online](#) and it comprises useful sections which may help someone in weighing up the potential benefits and costs of sharing, consider different ways in which they might share and how others might respond, and a detailed guide with a template on how to tell one's story.

Isolation is commonly reported by mental health professionals with lived experience and trainees may find it helpful to link in with other professionals with lived experience:

in2gr8mentalhealth offers a private and moderated [members-only forum](#), and one to one and group mentoring for mental health professionals with lived experience. They also offer wider consultation and training to the mental health scene and host public anti-stigma campaigns on provider lived experience.

SHARING ON SOCIAL MEDIA

Social media have played an important role in promoting more open conversation about mental health and anti-stigma campaigns, such as Time to Change use social media to reach large and diverse audiences. Public campaigns on social networking sites such as [The Only Us campaign](#) and [in2gr8mentalhealth's Twitter feed](#) play an important role in challenging the stigma of mental health difficulties amongst mental health professionals. Some trainees come into training with prior experience as peer workers, and in these and other roles may have used social media effectively to raise awareness, campaign for user rights and/or encourage peer support.

Having said that, trainees and those who support them need to be mindful that sharing lived experience on a publicly available social networking platform may by default mean disclosure to colleagues and service users. The BPS Ethics Committee has published guidance on use of social media: links to the full

guidance can be found in the resources section, but the following are of note:

Practitioners should remember that social networking sites are public and permanent. Once something has been posted online, it remains traceable even if deleted later on.

Practitioners should protect their privacy and consider the kinds of information that they want to be publicly available about themselves. They should ensure that they regularly check their privacy settings on social networking sites.

We recommend that courses ensure that trainees and those who support them are aware of this guidance and are able to reflect thoughtfully and carefully about the pros and cons of a trainee being public about their lived experience.

SHARING LIVED EXPERIENCE IN THE THERAPEUTIC RELATIONSHIP

Different psychological approaches have different views about therapist disclosure of lived experience within the therapeutic relationship. However, most therapeutic approaches caution against such disclosure, or suggest it should only be done in relation to a specific client after being carefully discussed and agreed to be clinically helpful

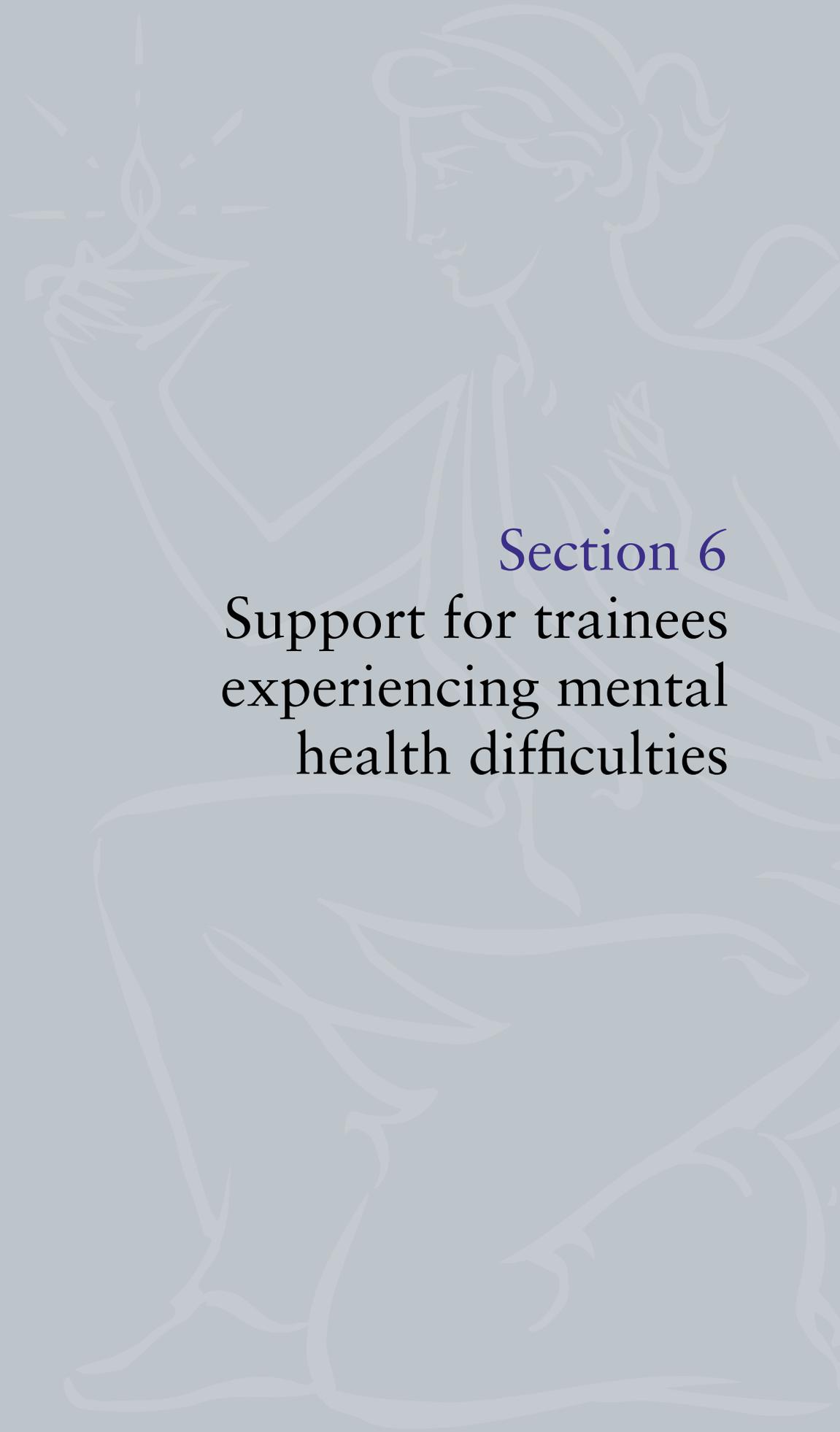
within supervision, with the focus at all times remaining on client need. Research into the impact of sharing lived experience with clients in the therapeutic relationship is in its infancy but suggests it is important carefully to weigh up potential risks as well as benefits (Lovell, 2017).

06

SECTION

Section 6

Support for trainees
experiencing mental
health difficulties



There will be many occasions when trainees may experience mental health difficulties but manage these well with or without support from course staff, placement supervisors or indeed peers. Differentiating between such occasions and times when there may be a need for additional support or 'intervention' is likely to be much easier where there is a culture of openness from the outset and where trainees have been able to develop trusting relationships with course staff.

Even where trainees feel able to talk about their lived experience and are able to access support as and when needed, there will be occasions when trainees experience mental health difficulties that may affect their ability to function in training. This section seeks to offer guidance for occasions when a trainee experiences acute distress, whether the trainee identifies this first or someone else does.

It is important to respond promptly and compassionately in the event of mental distress, yet to refrain from reacting too quickly or decisively. Often an initial period of active monitoring in discussion with the trainee and relevant stakeholders will be most appropriate, paying close attention to transparency around confidentiality. Guidance from experienced members of the system should be sought where possible, and any decisions and actions tailored to the specific trainee and context. Agreeing what support is needed and who should provide this should be a shared responsibility between the course, the trainee, their placement supervisor, and employer, where appropriate. Both the trainee and service users should be kept at the heart of thinking and everyone's responsibility to safeguard service users must be taken seriously at all times. Where there is concern that a trainee is not able to meet service user needs at a given time, an interruption to training may be called for (see Section 7).

How concerns about a trainee's mental health first arise, and who they are initially raised by, will affect how conversations proceed. The majority of the time trainees and course staff or placement supervisors —depending on who is involved in initial conversations

about a trainee's mental health — will make decisions together about what is helpful to share, and with whom, and what the process for sharing will be. As summarised in section 4, it is essential that confidentiality is attended to clearly throughout any support process. Trainees who are in placements within the same trust as their home, for example, may well have understandable concerns about confidentiality when accessing support. As far as possible, 3- or 4-way-conversations between the trainee, course staff, supervisor, and occupational health, where involved, are encouraged to support a transparent, tailored and integrated approach. They should also be mindful that there will be lots of different relationships that may need thinking about – some of these may cross usual boundaries and require thinking about sensitively on a case by case basis, for example, where a trainee receives support from a clinical service in which one of their peers or a lecturer is located. Furthermore, the peer environment will need careful thought, and trainees should be involved in deciding what their peers are told, for example, about extended periods of absence.

It is important to consider in some detail the experience of the trainee during the process and ways to ensure that processes do not inadvertently add to their distress or become barriers to open dialogues, for instance, in needing to have multiple conversations about absences. For trainees it will be important to know how and to whom to communicate information pertaining to their current difficulties, including who to inform if they need to take a day off sick and how much detail to go into. It will often be helpful if trainees are required to communicate details only to one trusted person while notifying others in general terms, without having to give details, for example of the reason for an absence.

It is recommended that important conversations are documented in clear language, are collaborative and include agreeing when and with what frequency to review any decisions made, and who communications are shared with.

SOURCES OF SUPPORT

We encourage courses (and their hosting institutions) to provide information about the range of sources of support available to trainees at the outset of training, and to update this regularly. It is hoped that such information is communicated in different ways, including during introductory sessions, written information and within 1-to-1 conversations. We encourage courses to design such information to be accessible and approachable to those who may be anxious or in distress when referring to it. In some universities student support services, including student mental health services, attend during induction to allow students to put faces to names.

Sources of support that should be considered include:

Counselling or personal therapy via the NHS, their employer, the third sector and privately.

GP consultation to access medication and/or psychological treatments.

Mentors and Independent Personal Advisors.

University based support systems (many universities and organisations such as Student Minds provide comprehensive information about sources of support for students).

Online sources of information, including ideas included in our reference section.

Informal and peer support (some courses and NHS trusts have lived experience peer support groups).

Access to information about Union support.

Courses and placement trusts may also wish to consider helpful models, such as appointing mental health advocates or champions within course and placement contexts. It is hoped that courses can continue to learn from each other and share different models.

In thinking about sources of support, courses should be mindful that many trainees will have moved either from a different part of the UK or a different country altogether, and therefore may not have a local support network, particularly earlier in training. However, trainees may also know from past experience how best to form the support they need and their support needs should be openly discussed and not assumed.

MAKING REASONABLE ADJUSTMENTS

Decisions about referring to NHS occupational health services and/or university based student support services in order to identify what adjustments may be called for will of necessity be locality based and should be clarified at local level.

Identifying and making reasonable adjustments will often be a shared responsibility between multiple stakeholders, i.e. the trainee, course, university, host employer, placement provider and supervisor. As set out in section 2, whether a mental health problem fulfils the definition

of a disability or not, it is advisable to consider whether there are reasonable adjustments which could reduce the pressures on a trainee's mental health and support them to meet training demands. Wherever possible, any adjustments should only be made following discussion and agreement between trainee, course staff and where relevant the placement supervisor about both what might be helpful and what is possible. It may also be necessary to consult with those providing health support to the trainee (of course with the trainee's

consent) and with occupational health. Once an adjustment has been agreed, this should be documented and shared with all on a need to know basis. Adjustments should be regularly reviewed as to whether they are helpful or necessary and any changes documented and communicated.

Adjustments may come in many forms and there is not a one size fits all but they may include:

Increasing the frequency or length of meetings with a course tutor or placement supervisor.

Adjustment to teaching and/or placement hours to temporarily reduce demands, avoid having to travel in rush hour, or to enable a trainee to take up personal therapy.

Adjustments to the allocation of placements by location (e.g. where a need for a shorter journey has been identified) or the means of transport to travel to placement.

A possible reduction, at least temporarily, to part-time hours.

Extra time for academic work (but see below).

At least temporarily tailoring the structure and contents of placements to the trainee's needs; however, caution must be exercised to ensure that this does not shift too far towards removing usual training demands and that a possible interruption should not be considered instead.

Trainees should be aware that adjustments governed by university regulations, for example, around submission deadlines for course work, may well be outside of the course programme's remit and governed by the university's extenuation process. As such, trainees and course staff are encouraged to familiarise themselves with the relevant regulations and processes.

Courses are encouraged to develop, in liaison with their Occupational Health department, guidance on how to plan, put into action and review reasonable adjustment options. It is important such guidance includes the process for the rare instance when reasonable adjustments have not met their desired intention, including how that process may overlap with any fitness to study procedures.

DEVELOPING GOOD PRACTICE

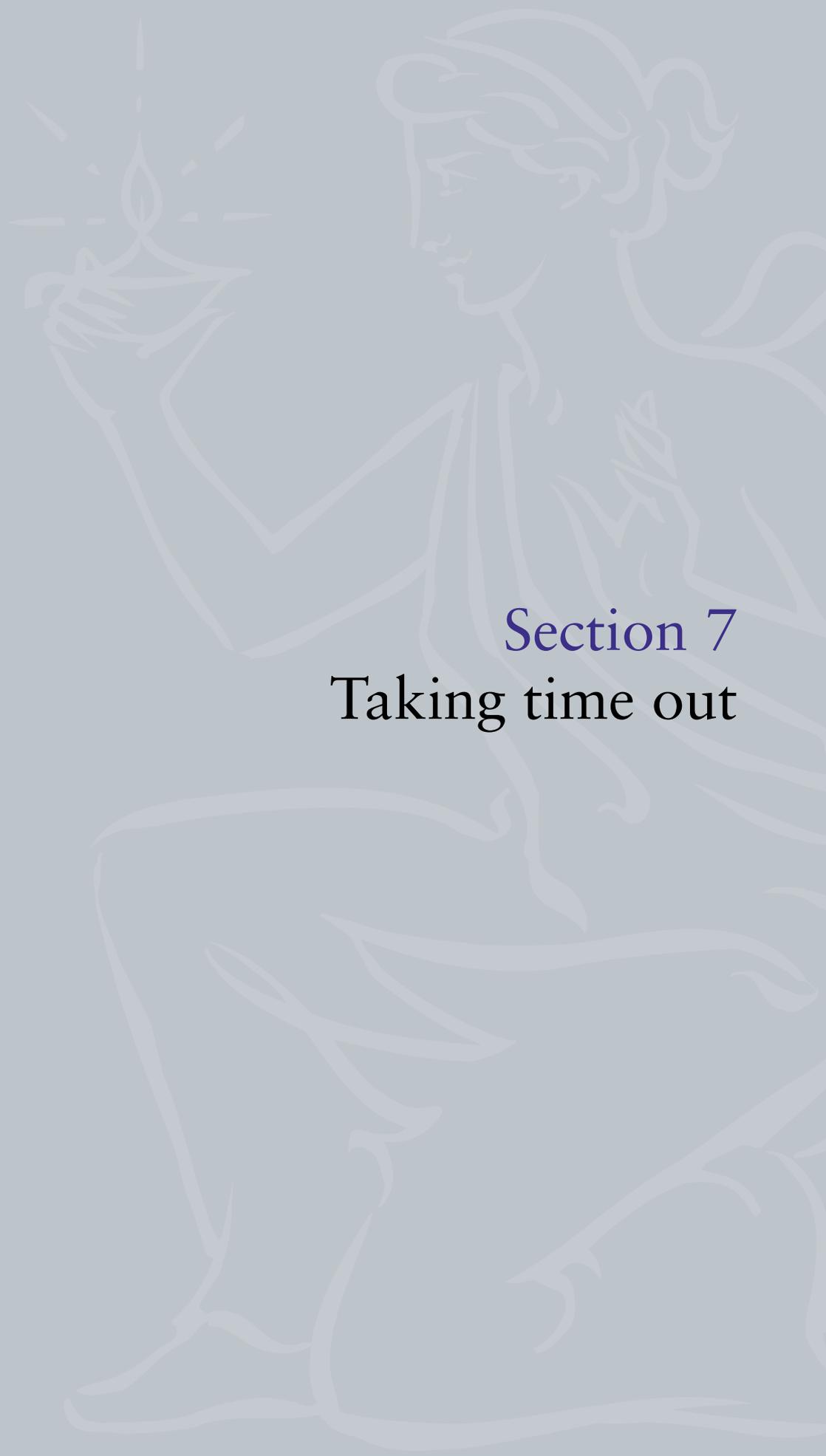
When trainees are in distress, it makes sense that the focus is on the system supporting the trainee in a compassionate manner during the acute situation. At the same time, it is important that feedback mechanisms are embedded within processes to enable the trainee and the system to learn about what support and adjustments are more or less useful. Courses are encouraged to formalise mechanisms by which good practice and lessons learnt are shared between those within

the training community, maintaining attention to confidentiality.

We also encourage course staff, supervisors and trainees to consult guidance and e-learning available outside of psychology, including through Mindful Employer and ACAS and their advice for employers regarding staff who need immediate mental health support (see Section 9).

07

SECTION

A faint, light-colored illustration of a woman with long, wavy hair, wearing a long, flowing dress. She is holding a glowing, multi-pointed orb in her right hand, which appears to be emitting light. The illustration is rendered in a simple, line-art style.

Section 7
Taking time out

A trainee in discussion with course staff may decide they need to take time out from training to attend to their own mental health. It is important to acknowledge that there can be worry about stigma around this; it is likely to be very helpful at such times to convey the message that identifying a need for time out is seen as a strength in a trainee's personal-professional development and as 'competency-in-action'.

Where an interruption is to be considered as an option, some courses will generally expect a talk with a course tutor or the trainee's line manager (usually the Programme or Clinical Director) in the first instance while others may be more flexible. If possible, a trainee should be able to approach whoever they feel most comfortable talking to initially.

Where a trainee is an NHS employee, NHS policies on sick pay apply and the trainee should consult local employment policies. Trainees who require a visa to complete training will need to understand the implications of an interruption on their visa status and will likely need support in negotiating an interruption.

If a trainee does take time out, it can help to think through what they would like the course to share with peers and other staff about their period of interruption, and if they are happy for peers to be in touch: some trainees value contact, while others prefer a rest from it. Due to confidentiality, usually a trainee's peers on the course would not know why a trainee is interrupting unless the trainee chose to inform them themselves. What is or is not communicated to others needs to be carefully negotiated with the trainee and their choice respected. When a trainee is absent, check-ins can help the course to understand any changes to initial conversations about what can be shared with others on the course.

Crisis moments can happen and there can be little time to talk through sharing considerations as outlined in Section 4. It is for courses to consider the guidance on confidentiality and sharing in this document in parallel with local guidance, and embed procedures that safeguard the trainee's privacy to only those who are identified as needing to know, and who have the responsibility of keeping in supportive contact during an interruption.

KEEPING IN TOUCH

When a trainee is taking time out it can be useful to have a single link person as a point of contact and not to have to worry about keeping on top of different communications, for example between the training course and placement.

In general it is helpful to agree with the trainee the extent to which some time is needed

completely away from training, when and how to check-in for reviews and to ascertain when the time is right to start planning ahead. A discussion could include preferred format (in person or by phone or by video call) and frequency of contact, the best day and time of day, what to discuss (and perhaps what not to discuss), and how contact is feeling.

RETURNING TO TRAINING

Coming back into training is an important transition for a trainee and presents a key opportunity to show that value is seen in lived experience. Conversations may include how the trainee is doing, how effective any continuing support is and also hearing trainee reflections on their time away and what they might want

to take forward into their professional life.. This would generally be done with the support of Occupational Health and possibly also the University's Student Disability Service. It can be helpful for trainees and course tutors to think together about the following aspects:

What kinds of work may call for some additional support.

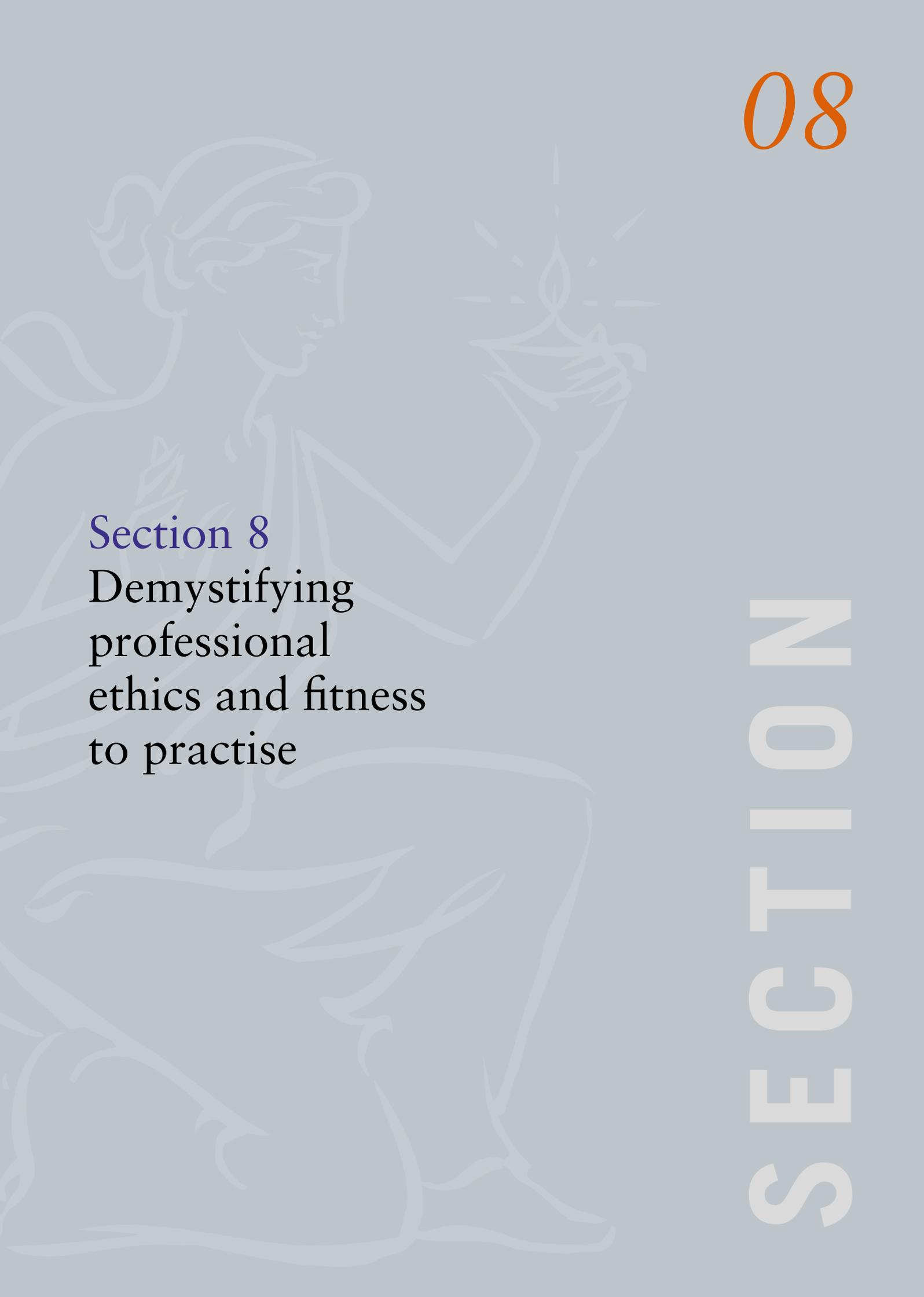
What hours feel workable initially and how these can be increased over time. Where Occupational Health recommend that a trainee returns to work part-time to facilitate the return to work, trainees should be made aware that this is likely to have an impact on their salary if they have a funded place.

If adjustments are needed to deadlines or exams, this would usually fall under the University's Student Disability Service who may issue a SoRA (Statement of Reasonable Adjustments). A trainee looking to return to training should contact the service for an appointment as early as possible once they know their planned date of return.

If re-starting a year with a new peer group, support to facilitate how to meet the new group and to think through beforehand what, if anything, is shared should be offered, alongside acknowledgement of how difficult it can be to join a different year group.

A safe space to discuss what personal lived experience brings to professional practice in supervision and, if wished, the possibility of sharing this with others.

These issues are often best addressed through regular planned meetings to check how things are going, discuss changes in support or adjustments, and when those may stop being necessary.



Section 8
Demystifying
professional
ethics and fitness
to practise

TIMES WHEN A TRAINEE HAS TO DECLARE MENTAL HEALTH DIFFICULTIES

Monitoring and responding to instances when a trainee's mental health difficulties may affect their practice is a shared-care endeavour between course and trainee. Ethical practice means that trainees should seek to recognise when they are experiencing mental health difficulties, ask for support where needed, and, if necessary, consider taking time out from training in discussion with training providers. In turn, training programmes must ensure that they provide a context where trainees feel able to come forward to discuss any need for help and that they will be met compassionately in response.

In certain circumstances trainees may have an obligation to share mental health difficulties with their supervisor, tutor or to occupational health. For example, if a course tutor or placement supervisor had concerns that difficulties in the trainee's mental health may be impacting on their ability to engage in study or clinical practice and an

assessment was needed to help gain support. In line with the guiding principles of confidentiality (Section 4), the tutor or supervisor should always seek to discuss this with the trainee themselves in the first instance. It is hoped that by promoting an open and compassionate culture in the training community, and by normalising lived experience at the outset of training, such conversations would feel possible, helpful opportunities to approach them plentiful, and a mutually agreed plan of support was put in place before any obligation to share or indeed breach trainee confidentiality was deemed necessary.

Should the need to share with occupational health be necessary, it is hoped that the trainee experience of the occupational health service and liaison with the course is supportive and there is opportunity for feedback on this. Trainees can be re-referred to occupational health services if they have a period of extended sick leave.

PROFESSIONAL PRACTICE GUIDELINES

Clinical psychology training courses must meet training standards set out by the Health and Care Professions Council (HCPC) and British Psychological Society (BPS) as part of the accreditation process. They may also need to meet other professional bodies' standards, such as the British Association for Behavioural and Cognitive Psychotherapies (BABCP) or the Association for Family Therapy and Systemic Practice (AFT). The HCPC, as the statutory regulator for practitioner psychologists in the UK, sets 'standards of education and training' (SETs) 'to make sure that learners are prepared for safe and effective practice'. The following HCPC SETs are particularly relevant to this guidance:

3.13 There must be effective and accessible arrangements in place to support the wellbeing and learning needs of learners in all settings.

3.16 There must be thorough and effective processes in place for ensuring the ongoing suitability of learners' conduct, character and health.

The BPS accreditation standards (January 2019 edition) state that programmes should support trainees to:

2.1.3.7 Develop resilience but also the capacity to recognise when own fitness to practise is compromised and take steps to manage this risk as appropriate.

5.5 Develop strategies to handle the emotional and physical impact of their own practice and to seek appropriate support when necessary, with good awareness of boundary issues. However, trainees should also have the capacity to monitor their own fitness to practise, recognise when this is compromised, and take steps to manage this risk as appropriate.

They also state that trainees who experience severe stress, psychological disturbance, or emotional upset should be given assistance in obtaining appropriate help (5.7).

FITNESS TO PRACTISE

In most cases mental health conditions will not raise fitness to practise concerns, provided the trainee receives the appropriate care and reasonable adjustments necessary to study and work safely. Even then, training programmes prefer to resolve any issues before they become a matter for more formal investigation. Accordingly, and as noted throughout this guide, it is for training providers to create a culture where trainees feel able to talk about mental health difficulties at an early stage to gain any support needed. For trainees, recognising difficulties, seeking support and where necessary talking to programme staff and/or supervisors should be seen as positive courses of action that demonstrate professionalism, competence and ethical conduct and should be met as such. When qualified, considering altering or stopping one's practice if experiencing mental health difficulties over the career-span is part of dynamic and responsive good practice for all members of the profession.

It can be helpful to name the rare occasions when Fitness to Practise procedures may be invoked – depending on local regulations, these might include instances where trainees fail to seek appropriate treatment or other support; fail to follow medical advice or care plans for a chronic and serious mental health condition,

including monitoring and reviews; fail to recognise current limits to their abilities.

Practitioner psychologists are also bound by the HCPC's code of conduct and ethics. The HCPC works on the principle of 'professional self-regulation', by which they mean that students who are studying to be a member of a profession they regulate, and qualified professionals, have personal responsibility to maintain and manage their own fitness to practise. The HCPC Guidance on Conduct and Ethics for Students (2016) states:

Managing Risk

- You should be aware that you may put your service users or yourself at risk if your performance or judgement is affected by your physical or mental health.
- You should ask for appropriate support and adapt your study or stop studying if your performance or judgement is affected by your physical or mental health and could put service users, yourself or others at risk.
- You should get advice from a doctor or other appropriate professional if you are worried about your physical or mental health.

FITNESS TO STUDY

Each training programme, or rather the university hosting the programme, will also have Fitness to Study procedures in place. These can be called upon, ideally as a last resort, when a course deems a student unfit to engage with their studies at a given time but the student is unable or unwilling of their own accord to seek an interruption to their studies. The general principle applies that it is preferable by far to raise and address concerns early and wherever possible put support or adjustments in place, rather than reach a point where formal procedures are called upon. In terms of mental health, instances when Fitness to Study procedures may be evoked include those where

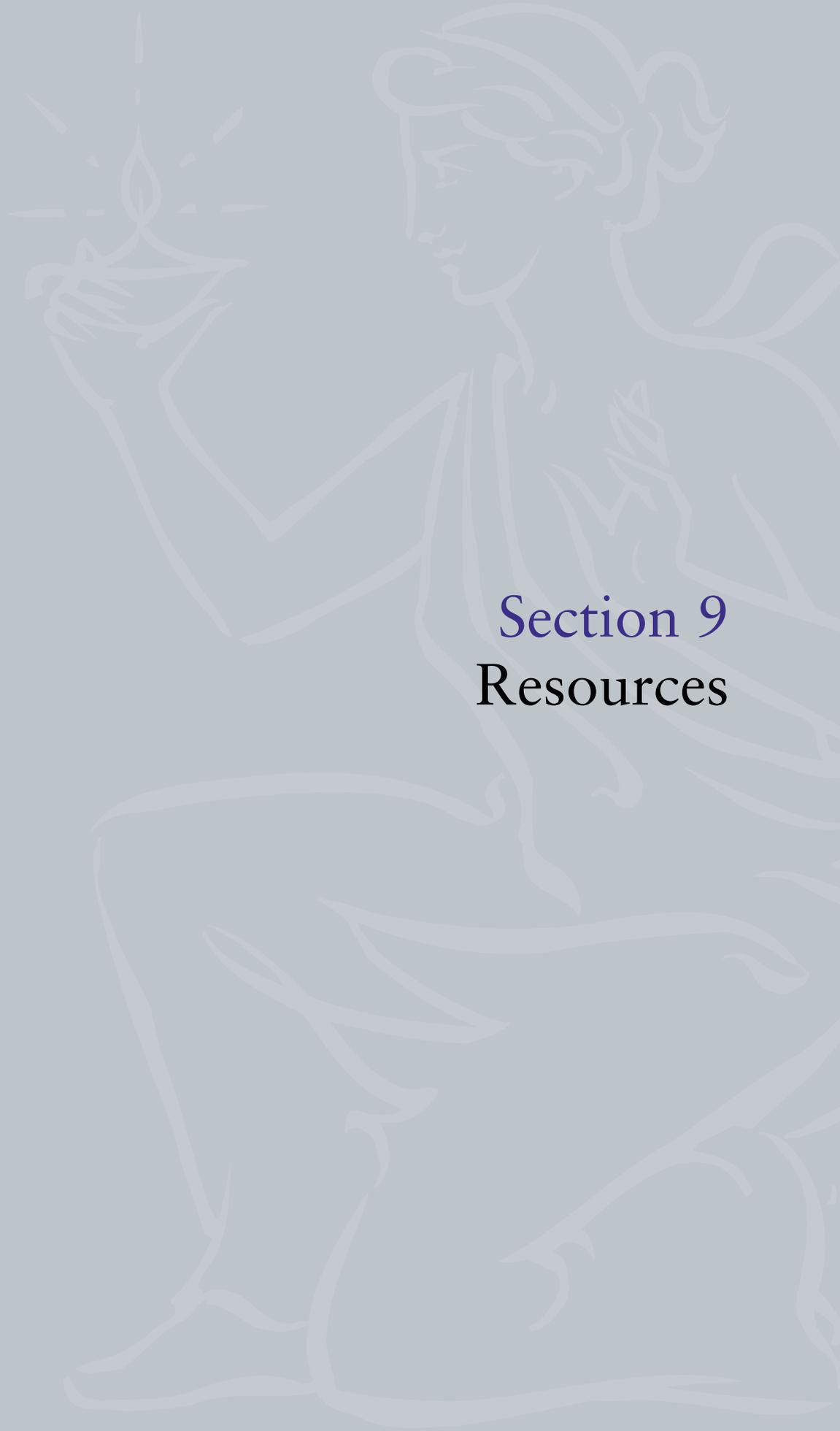
a trainee's behaviour, attendance record, or academic performance do not meet a minimum standard and this is believed to be the result of a physical and/or mental health problem, or where the student's behaviour presents a serious and immediate risk to self or others and/or the University's reputation. Fitness to Study procedures can vary widely across institutions and have a range of outcomes: hence, we advise readers to consult local policies.

Should trainees feel that they need support or advice around these issues, they should have access to support and advocacy via their local student union or other Unions.

09

SECTION

Section 9
Resources



RESOURCES

Resources designed to support someone in weighing up whether to share their lived experience with others and how to go about this are detailed in Section 5. Other useful resources are listed below:

[ACAS](#)

BPS Ethics Committee: [Supplementary guidance on the use of social media](#)

Hughes, G. & Spanner, L. (2019). [The University Mental Health Charter](#). Leeds: Student Minds.

[Mindful Employer](#)

[NHS Employers website's health and wellbeing section](#)

[NHS Workforce Health and Wellbeing Framework](#)

NICE Quality Standard (2017). [Healthy Workplaces: Improving employee mental and physical health and wellbeing](#).

Randall, J. (2019). *Surviving clinical psychology: Navigating personal, professional and political selves on the journey to qualification*. London: Routledge

[Student Minds](#)

[Time to Change](#)

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the british
psychological society
promoting excellence in psychology

St Andrews House,
48 Princess Road East,
Leicester LE1 7DR, UK

☎ 0116 254 9568 🌐 www.bps.org.uk ✉ info@bps.org.uk