# Standardised Whole-Field Conduct Practice Note

## A Fieldethics Conduct Standard for Human Services

## Purpose of this note

This practice note sets out a whole-field conduct standard for human services.

It is written for services where people arrive with need, distress, risk, vulnerability, complexity, uncertainty, or reduced capacity.

That may include health, recovery, social care, housing, justice, education, welfare, community support, family services, lived-experience projects, charities, public services, commissioned services, and contracted or agency-supported environments.

The central point is simple:

**Before formal work begins, the person has already entered a conduct field.**

That field is created by everyone.

Not only clinicians.

Not only specialists.

Not only managers.

Not only frontline practitioners.

Everyone whose conduct affects the person's experience of the service contributes to the field the person must move through.

This includes permanent staff, temporary staff, agency staff, contracted staff, reception staff, cleaning staff, security, volunteers, peer workers, administrative staff, drivers, call handlers, managers, practitioners, clinicians, and anyone else whose presence affects the environment.

The purpose of this standard is not to turn every role into a clinical role.

It is to recognise that every role can affect whether a person feels able to remain present, speak honestly, ask for help, understand the next step, return after difficulty, and receive the work the service exists to provide.

**Treatment, support, assessment, or intervention may be delivered by specialists, but the field is created by everyone.**

## Why whole-field conduct matters

Many services treat care, support, assessment, or intervention as something that begins when the formal worker enters the room.

Fieldethics challenges that.

A person’s capacity may already have been affected by:

the phone call;

the appointment letter;

the online form;

the reception desk;

the waiting room;

the tone of first contact;

security presence;

cleaning staff conduct;

overheard comments;

signage;

privacy;

delays;

how confusion is handled;

how distress is responded to;

whether the person feels watched, welcomed, suspected, rushed, dismissed, exposed, or respected.

By the time the formal appointment begins, the person may already be more regulated or more dysregulated.

They may already feel safe enough to speak, or too ashamed to be honest.

They may already trust the service more, or trust it less.

They may already feel like a person, or like a problem.

This matters because human services depend on accurate feedback.

People need to describe pain, fear, risk, confusion, symptoms, side effects, relapse risk, financial pressure, family concerns, safeguarding issues, housing instability, medication effects, mental-health changes, barriers, needs, mistakes, and uncertainty.

If the conduct field makes honesty harder, the service receives poorer information.

Bad conduct does not only hurt feelings.

It can damage the quality of service knowledge.

A system receives the kind of feedback its sequence makes possible.

## Conduct is infrastructure

Conduct is often treated as personal style.

One person is warm.

One person is abrupt.

One person is patient.

One person is dismissive.

One person explains things clearly.

One person makes people feel stupid for asking.

One person protects privacy.

One person gossips.

One person calms the room.

One person adds pressure to it.

Fieldethics treats conduct differently.

**Conduct is infrastructure.**

It is part of how the service actually works.

A policy may promise dignity, respect, inclusion, participation, recovery, safety, compassion, or empowerment.

But the person does not meet the policy first.

They meet the field.

They meet the voice on the phone.

They meet the reception desk.

They meet the waiting area.

They meet the forms.

They meet the worker’s tone.

They meet the way staff speak about people when they think no one important is listening.

They meet the difference between what a service says it values and what its conduct actually makes possible.

Policy sets the promise.

Conduct decides whether the promise reaches the person.

## Equal dignity, different responsibility

This standard is not a hierarchy of human worth.

No person is worth more because they have a title, qualification, salary, uniform, office, professional registration, or senior role.

Every person in the field deserves basic dignity.

But roles do carry different responsibilities.

A cleaner does not have the same duty as a clinician.

A receptionist does not have the same duty as a psychiatrist.

A volunteer does not have the same duty as a service manager.

A peer worker does not have the same duty as a prescriber.

A contracted security worker does not have the same duty as a safeguarding lead.

However, no role is outside the field.

The cleaner does not provide treatment, but the cleaner may still affect whether the person can receive treatment.

The receptionist may not decide the care plan, but access conduct may decide whether help is reachable.

The security worker may not assess risk, but their conduct may affect whether the person feels safe or suspected.

The manager may not be present in the waiting room, but management decisions shape whether staff have enough time, training, and capacity to behave well.

The clinician may know the treatment, but the person may know the day that treatment creates.

Responsibility is therefore role-specific and asymmetrical.

The closer a role is to shaping the conditions another person must navigate, the greater the responsibility for the effects of those conditions.

## The shared conduct floor

Every person working in or around a human service should be expected to meet a shared conduct floor.

This applies across roles, including contracted, temporary, agency, and external workers.

The shared conduct floor is:

do not shame;

do not mock;

do not gossip;

do not expose private information;

do not speak about people as if they are less than human;

do not treat distress as inconvenience;

do not treat poverty, addiction, illness, disability, fear, confusion, trauma, or reduced capacity as moral failure;

do not escalate unnecessarily;

do not make people perform deservingness;

do not punish people for not understanding a route that has not been clearly explained;

do not turn system limits into personal judgement;

protect dignity where possible;

protect privacy where possible;

keep the field calm where possible;

route concerns to the right person;

ask for help when something is outside your role;

remember that your conduct may affect whether the person can use the service.

This is not advanced practice.

It is the minimum ground.

## Level One: Whole-Field Conduct

Level One applies to everyone adjacent to the service field.

This includes cleaning staff, security, porters, drivers, volunteers, reception-area staff, catering staff, agency workers, contracted workers, maintenance workers, peer supporters, administrative staff, and anyone else whose presence affects the environment.

Level One does not require clinical knowledge.

It does not require interpretation of symptoms.

It does not require assessment of risk.

It requires recognition that the person is entering a human service field and may already be carrying pressure.

Level One conduct affects:

dignity;

shame;

privacy;

safety;

belonging;

trust;

suspicion;

agitation;

exposure;

willingness to return;

willingness to speak honestly.

The Level One standard is:

protect dignity;

do not shame;

do not gossip;

do not mock;

do not expose private information;

do not treat people as a nuisance for being unwell, distressed, poor, confused, frightened, intoxicated, disabled, angry, or overwhelmed;

do not escalate unless necessary;

route concerns to the right person;

keep the field calm enough for the person to remain present.

Whole-field conduct is not clinical care.

It is the ground clinical care, support, assessment, or service work lands on.

## Level Two: Contact and Access Conduct

Level Two applies to people who shape first contact, access, appointments, communication, and practical movement through the service.

This may include receptionists, appointment staff, call handlers, pharmacy counter staff, housing contact staff, benefits administration staff, service coordinators, support workers, peer workers, referral administrators, and people who explain system processes to service users.

These roles often decide whether a service is usable before formal work begins.

Level Two conduct affects:

whether the person can get through the door;

whether they understand what is happening;

whether they feel believed;

whether they feel like a burden;

whether they can ask for help without shame;

whether urgency is handled proportionately;

whether practical barriers are recognised;

whether the person returns after difficulty.

The Level Two standard is:

explain clearly;

check understanding;

reduce unnecessary pressure;

protect privacy;

recognise distress without overstepping role;

avoid making people perform deservingness;

avoid turning system limits into personal judgement;

route accurately;

record access issues without blame;

make the next step usable where possible.

Access conduct decides whether help is reachable before formal work decides whether help is effective.

## Level Three: Practice Conduct

Level Three applies to workers who directly support, assess, supervise, review, plan with, or respond to the person.

This may include nurses, social workers, support workers, addiction workers, recovery workers, housing officers, justice workers, family support workers, community mental-health workers, occupational therapists, case workers, advocacy workers, and similar roles.

These workers carry more interpretive responsibility.

Their conduct shapes:

what the person feels safe to disclose;

how behaviour is interpreted;

how risk is understood;

how records are written;

whether complexity is collapsed;

whether support becomes usable;

whether accountability becomes domination;

whether the person is treated as a participant or an object.

The Level Three standard is:

separate observation from inference;

separate concern from judgement;

ask what behaviour is doing before deciding what it means;

avoid premature meaning;

recognise professional reaction;

record proportionately;

hold uncertainty honestly;

make the next honest disclosure safer where possible;

align expectations with capacity;

distinguish support from surveillance;

distinguish accountability from domination.

Practice conduct is where the service either learns from the person or turns the person into an interpretation.

## Level Four: Specialist Conduct

Level Four applies to people with formal specialist authority or decision-making power.

This may include doctors, prescribers, psychiatrists, psychologists, senior nurses, pharmacists with specialist responsibility, clinical leads, legal decision-makers, safeguarding leads, senior assessors, and others whose formal decisions strongly shape a person's route, record, liberty, treatment, support, eligibility, or future options.

Level Four conduct affects:

the person's body;

treatment route;

record identity;

risk status;

medication ecology;

trust;

future access;

eligibility;

rights;

liberty;

how other services interpret the person.

The Level Four standard is:

hold authority with humility;

do not let training override lived sequence before listening;

ask what the intervention creates inside the person’s actual day;

treat service-user feedback as knowledge, not noise;

avoid using risk language to conceal professional anxiety;

avoid collapsing uncertainty into certainty for administrative ease;

preserve responsibility without domination;

make decisions that improve future feedback quality;

remember that specialist decisions travel through the whole field.

Specialist authority becomes safer when disciplined by field awareness.

## Level Five: Organisational and Policy Conduct

Level Five applies to people and bodies who design the conditions under which all other conduct happens.

This includes service managers, senior leaders, boards, commissioners, local authorities, government, regulators, inspection bodies, training bodies, public health teams, policy teams, funders, and organisational decision-makers.

This level decides whether good conduct is supported or merely demanded.

It shapes:

staffing levels;

time pressure;

caseloads;

supervision;

training;

appointment systems;

record systems;

complaint routes;

physical environments;

outsourcing;

contracting;

eligibility rules;

thresholds;

risk culture;

workload;

whether staff have enough capacity to practise well.

The Level Five standard is:

do not make ethical conduct impossible and then blame individuals for failing it;

build systems that support calm, accurate, dignified interaction;

design for feedback quality;

treat conduct as infrastructure;

make good conduct possible through time, training, supervision, and realistic workload;

ensure policy language reaches the person through actual conduct;

include contracted and agency workers in conduct expectations;

evaluate systems by what they make possible, not only what they intend.

A service cannot demand dignity from staff while designing conditions that constantly produce pressure, impatience, fragmentation, or burnout.

Good conduct requires organisational conditions.

A service must create capacity for staff as well as service users.

## Agency, contracted, and external workers

Whole-field conduct cannot stop at the boundary of direct employment.

Many human service environments are shaped by people who are not employed by the service itself.

Cleaning may be contracted.

Security may be outsourced.

Transport may be provided externally.

Reception or call handling may be centralised.

Digital systems may be designed elsewhere.

Agency staff may rotate through the service.

Volunteers may be informal or partially trained.

Partner organisations may share the same building or field.

This matters because the person using the service does not experience these distinctions first.

They experience the field.

A humiliating comment from a contracted worker still affects trust.

A privacy breach by agency staff still affects safety.

A hostile security interaction still affects whether someone returns.

A confusing external appointment system still affects access.

A dismissive phone call still affects capacity, even if the person on the phone is not part of the main team.

Therefore, any whole-field conduct standard must include:

direct staff;

agency staff;

contracted staff;

temporary workers;

external partners;

volunteers;

shared-site workers;

anyone whose conduct affects the person's movement through the service.

If a service benefits from someone's labour inside its field, it must also take responsibility for the conduct expectations attached to that labour.

Outsourcing a role does not outsource the field effect.

## Conduct, capacity, and responsibility

Human services often assess responsibility after the person has already spent capacity navigating the route.

A person may miss an appointment, delay a reply, struggle to attend work, submit an incomplete form, cancel a meeting, fail to provide evidence, or appear inconsistent.

Those things may matter.

But they cannot be judged honestly unless the route itself is examined.

What did the route require?

How much memory, time, travel, literacy, digital access, physical effort, emotional tolerance, explanation, confidence, pain management, and recovery capacity did it demand?

Was the person's difficulty a refusal of responsibility?

Or was it a sign that the route had already exceeded the capacity available to them?

This is the link between individual responsibility and design failure.

A person remains responsible for their conduct.

A service remains responsible for the conditions through which that conduct is required.

Fieldethics holds both.

It asks the contradiction to be examined before judgement is made.

## Completion is not capacity

Services often assess whether a person completed a task.

They may not assess what completing the task cost.

A person may attend an appointment and then lose the rest of the day.

They may complete a form and be unable to make the next phone call.

They may go to work once and then need days to recover.

They may speak clearly in a meeting and then collapse afterwards.

They may manage one practical task and lose the capacity needed for parenting, cleaning, recovery, communication, eating properly, or attending the next service.

From outside, the task was completed.

Inside the person’s actual life, the task may have created capacity debt.

Completion is not capacity.

A service should not ask only:

Did the person do it?

It should also ask:

What did it cost?

What recovery did it require?

What did it prevent afterwards?

What responsibility became harder because this one task was completed?

What future harm did the completed task quietly produce?

Without these questions, “you managed” can become a trap.

## Feedback quality

Services rely on feedback.

They need to know what is happening.

But feedback depends on the field.

If the field is rushed, dismissive, shaming, confusing, exposed, or hostile, the person may not give accurate feedback.

They may minimise.

They may exaggerate.

They may shut down.

They may become defensive.

They may forget details.

They may agree without understanding.

They may avoid disclosure.

They may tell the service what they think it wants to hear.

They may not return.

This is not only a communication issue.

It is a knowledge issue.

A service that damages feedback quality damages its own ability to understand what is happening.

Better conduct improves service knowledge.

Better service knowledge improves decisions.

Better decisions improve trust.

Trust improves future feedback.

This is why conduct is not separate from outcomes.

Conduct shapes the route through which outcomes become possible.

## What services should ask themselves

A whole-field conduct standard should be tested through practical questions.

Services should ask:

What field does a person enter before formal work begins?

Who shapes that field?

Are all staff, including agency and contracted workers, included in basic conduct expectations?

Where might shame, confusion, exposure, suspicion, or unnecessary pressure enter the route?

What conduct expectations are shared across the whole service?

What role-specific conduct expectations are needed?

Do staff know what is outside their role and how to route concerns safely?

Are service users expected to show more capacity than the route helps preserve?

Are missed appointments, delays, incomplete forms, or sharp reactions automatically treated as personal failure?

Are staff given enough time and support to practise well?

Does the service receive honest feedback, or only the feedback its route makes bearable?

Does policy language reach the person through actual conduct?

What would need to change for the service field to become calmer, clearer, more dignified, and more usable?

## What this standard is not

This standard is not a replacement for clinical governance.

It is not a safeguarding policy.

It is not a substitute for professional regulation.

It is not a complaint procedure.

It is not a demand that every worker become a therapist.

It is not an instruction to tolerate abuse.

It is not a denial of personal responsibility.

It is not a claim that all roles are the same.

It is not a performance of kindness while the route remains unchanged.

It is a conduct ground.

It names the basic field conditions that allow human service work to become more usable, accurate, dignified, and safe.

## Working principle

The working principle is:

**A service must examine the conduct field it creates before judging the person moving through it.**

This applies across the whole service.

The person has responsibility for their conduct.

Workers have responsibility for their conduct.

Specialists have responsibility for their authority.

Managers have responsibility for the conditions they design.

Organisations have responsibility for the field they create.

The closer a role is to shaping the conditions others must navigate, the greater its responsibility for the effects of those conditions.

## Closing statement

Human services do not begin only when formal work begins.

They begin at first contact.

They begin in the waiting room.

They begin in the tone of the phone call.

They begin in the privacy of the reception desk.

They begin in the way staff speak about people.

They begin in the forms, routes, delays, explanations, thresholds, signs, and small interactions that tell a person whether they are entering a place of dignity or another field of pressure.

A standardised service cannot rely on individual kindness alone.

It needs shared conduct.

It needs role-specific responsibility.

It needs language that every person in the field can understand.

It needs to recognise that the field is created by everyone, even when treatment, support, or decisions are delivered by specialists.

Capacity, dignity, trust, and honest feedback are not protected by policy statements alone.

They are protected by conduct.

**Conduct is infrastructure.**

**Whole-field conduct is the ground formal work lands on.**

**No role is outside the field.**

**No conduct is neutral.**

**No service should judge the person before examining the route through which the person was asked to move.**