

# Code of Professional Conduct and Ethics

*Adopted 28<sup>th</sup> April 2023*

Applicable to Full, Trainee, Honored, Not Working and Overseas Members of the Association (Rules 4 and 5).

## 1. General principles

- 1.1. Patients' welfare and best interests are paramount and accordingly a Member of the Association of Child Psychotherapists ('the Association') shall in the conduct of his/her profession maintain the highest professional and ethical standards.
- 1.2. The nature of psychotherapy is such that professional and ethical obligations survive the termination of the psychotherapeutic relationship, the life of the patient, and the termination of Membership of the Association. Any neglect or disregard by a Member of their professional duties to their patient, or any abuse of the professional relationship between the Member and their patient, may raise a question of professional misconduct.
- 1.3. This Code cannot cover every potential ethical, conduct or competence related concern. When issues arise in their own practice Members will need to exercise their judgement, guided by colleagues and, where appropriate, the Association (and those supervising Trainee Members have a particular responsibility to offer them guidance on ethical matters whenever it is sought or appears to be needed). The Code is, however, intended to set out the main expectations the Association has of its Members, particularly those concerned with promoting the health, safety and well-being of patients and ensuring that public confidence in the profession is maintained.
- 1.4. Issues of equality, diversity and inclusion affect all aspects of psychotherapy. Throughout their practice and whenever interacting with prospective patients, students, colleagues, and other members of the profession, ACP Members are therefore expected to:
  - 1.4.1. understand how discrimination, prejudice and bias operate (including unconscious bias);
  - 1.4.2. constructively reflect on their own actions and assumptions;
  - 1.4.3. actively avoid and challenge unlawful discrimination based on the legally protected characteristics of age, disability, reassignment, pregnancy and maternity, race (including ethnic origin), religion or other protected belief, sex and sexual orientation;
  - 1.4.4. actively avoid and challenge unlawful harassment and victimisation;

- 1.4.5. make any adjustments that are legally required to avoid disadvantages that relate to disability and positively consider what further steps should be taken to advance equality of opportunity and foster good relations between people with different protected characteristics; and take action to address unfair discrimination, prejudice and bias based on other individual characteristics, such as culture or socio-economic status.
- 1.5. Members should promote fair access to psychotherapy and not allow potential or actual patients' characteristics to influence decisions about offering access to or ending psychotherapy, or about the type of psychotherapy provided unless legally justified (for example, because a Member is providing a service legitimately targeted so as to meet the needs of a particular group).
- 1.6. Subject to paragraph 1.7. below, failure to fulfil the obligations laid down in this Code and serious impairment to fitness to practice can result in the commencement of an investigation, the final outcome of which may be suspension, withdrawal of registration or other sanctions. Members must co-operate with any investigation by the Association and may not resign while they are under investigation. Any such resignation will not be accepted until the investigation is completed and a final determination has been made.
- 1.7. On 15 September 2014, the Association's Rules were revised to confirm that it is responsible for raising and maintaining professional standards in relation to child psychotherapy practiced in the UK. Overseas Members as defined in the Rules are expected to comply with this Code. However, with the exception of any issues arising in relation to:
  - 1.7.1. providing of services to a UK Court, whether as expert witness, professional witness, or as author of a court report or letter (paragraph 2.10. of this Code);
  - 1.7.2. conforming with Association Rules (paragraph 2.12.); or
  - 1.7.3. conduct that might cause serious damage to the standing of the profession of child psychotherapy (paragraph 7);

All of which may be investigated by the Association under its Disciplinary Procedure, Overseas Members are answerable to the responsible authorities in the countries in which they reside and practice. For the avoidance of doubt, where an issue arises under paragraph 7 which may raise issues under other paragraphs of the Code, it may be investigated by the Association.

## **2. Responsible practice**

- 2.1. A Member should practise only within the limits of their professional abilities and not offer or undertake any form of treatment in which they lack competence. The ACP accredits its members on the public register to work with infants, children, adolescents (up to the age of 25) and parents (where the child is the identified patient).
- 2.2. Members must inform prospective and current patients of any relevant restrictions on their practice imposed by the ACP as a result of a disciplinary or fitness to practise investigation. If a Member becomes subject to an investigation by an employer or another professional regulatory body of which they are a member which was prompted by an allegation which might, if proven, amount to a breach of this Code, the Member must promptly inform the ACP of the allegation and the nature of the investigation in writing.

- 2.3. Where a Member's fitness to practise is so seriously impaired by reason of a physical or mental disability (including addiction) so as to imperil their patients they should cease practising. If they fail to do so promptly, then any other Member of the Association or other concerned person who is aware of the situation, should draw it to the attention of the Director of Professional Standards.
- 2.4. A Member must not use their professional position to exploit a patient financially or otherwise, or to pursue a sexual or other relationship which is inappropriate in the context of therapeutic treatment.
- 2.5. A Member must be fully cognizant of and compliant with current child protection legislation and safeguarding procedures. Most importantly, Members must be aware of, and promptly take, the steps expected of them to protect patients, other children or vulnerable adults from harm.
- 2.6. Whenever Members offer a patient guidance as an exception to the default principle of neutrality in therapy, this should have a sound clinical justification, be in the patient's best interests and take account their capacity and autonomy under paragraphs 4.3 and 4.4 below. Members must never pressurise or coerce their patients in any particular direction for example in relation to decisions about their sexuality or gender.
- 2.7. All practicing Members shall comply with current Association policies on standards of education, training and continuing professional development.
- 2.8. Members must ensure that there are adequate supervisory and/or consultative support arrangements for their practice. Members supervising trainee members should also ensure that contact with their patients takes place subject to adequate supervision.
- 2.9. A Member shall exercise clinical judgment in securing psychiatric opinion about a patient where necessary in any psychotherapy.
- 2.10. Where a Member provides services to the Court, whether as expert witness, professional witness, or as author of a court report or letter, that Member shall ensure that they are familiar with, and conduct themselves in accordance with, any Court directions and established legal principles and guidelines which apply to the provision of such services.
- 2.11. If a Member advertises their services, such advertising may include name, relevant qualifications, e mail and postal address, telephone number and details of the services offered. Such statements must be descriptive, factually correct and supportable and not evaluative or comparative.
- 2.12. A Member shall conform to the existing Rules of the Association.

### **3. At the outset of the psychotherapeutic relationship**

- 3.1. Members must be confident that all psychotherapeutic relationships with their patients are founded on an understanding of what will be involved in terms of treatment and information sharing, and consent to both has been sought and obtained. If Members do not practise in settings where others seek and obtain any necessary consent under clear and robust procedures, they must seek and obtain such consent personally.
- 3.2. In particular, prospective and new patients and, where appropriate, parents or persons with parental responsibility, are entitled to an explanation of:

- 3.2.1. the nature of the psychotherapy offered;
  - 3.2.2. Members' duties to keep information given during psychotherapy and the fact of the relationship confidential;
  - 3.2.3. what, if any, information about the psychotherapy will be shared with professional and/or other persons who will be collaborating with the Member/s providing the psychotherapy, why sharing information with them is necessary and that they will also be obliged to keep the information confidential;
  - 3.2.4. what, if any, information about the psychotherapy the Member intends to share with the patient's parents or other persons with parental responsibility (for example, it may be appropriate to inform parents of a child patient's progress in psychotherapy, but not what is discussed); and
  - 3.2.5. the arrangements which practicing Members are expected to make with one or more nominated clinical trustees who will be informed in confidence of the identities and contact details of current patients and responsible for notifying them of the member dying or becoming incapacitated.
- 3.3. Before the psychotherapy begins, consent to:
- 3.3.1. the psychotherapy offered; and
  - 3.3.2. the information about the psychotherapy being shared in these ways;
- must also be sought and obtained from the prospective patient or, when the patient cannot take part in decision making and give consent, then from a parent or a person with parental responsibility (see below).
- 3.4. It is not, however, necessary or appropriate to seek consent for every conceivable sharing of information at this point, only to what will occur in the ordinary course of the psychotherapy offered. It is also legitimate for seeking consent to disclosure of information to specific persons to be deferred until the time when such consent is needed.
- 3.5. The fact and the nature of the treatment envisaged may be communicated to the prospective patient's general medical practitioner subject to consent being given by the prospective patient or, when they cannot take part in decision making and give consent (see below), a parent or a person with parental responsibility. The person from whom consent is sought should be told these records they may be accessed, with consent, by persons not involved in the patient's care. If consent is withheld, the Member will need to inform the person from whom it has been sought what the consequences are for the proposed treatment and invite them to reconsider (e.g. some Members will be unwilling to proceed with treatment in such circumstances; others may be unable to do so because information sharing with a GP is a condition of the funding or other arrangements under which the treatment is provided).

#### **4. Respect, trust and maintaining confidentiality**

- 4.1. Respect for the patient, trust and maintaining confidentiality are critical elements of all psychotherapeutic relationships.

- 4.2. Members must show respect for their patients, including by being honest and open with them. Members are expected to be candid and truthful whenever mistakes or significant omissions occur in their practices, and when they are, or may be, responsible for damage or suffering. This means being open not only with patients about what has happened (or with family members, carers or advocates, where appropriate), but with also colleagues, the ACP and any other investigating body. Members should also take corrective action and apologize meaningfully whenever appropriate. The NMC and GMC produce useful guidance on the candour expected of their members in similar circumstances.”
- 4.3. Patients’ autonomy and rights to be involved in decision-making should be respected as far as their individual circumstances allow. These rights are ongoing: Members should always be mindful of their patients’ rights to understand what is happening in the course of therapy and that consent to it must be ongoing. General consent given at the outset will not cover every conceivable development in the psychotherapy.
- 4.4. Whether a patient can take decisions about their own treatment and give consent to disclosure of information about them held by Members depends on:
  - 4.4.1. the patient’s age - the law presumes that young people aged 16 or 17 to be adults for the purposes of consent to treatment and to disclosure of confidential information (but a 16 or 17 year old may be unable to give consent if, for example, they are unable to make a meaningful choice, even with appropriate support, because of a disability); and
  - 4.4.2. their capacity and understanding to make decisions - patients under the age of 16 who have the capacity and understanding to take decisions about disclosure and the use of information they have provided in confidence, with advice, are entitled to make those decisions for themselves (a parent or other person with parental responsibility cannot give consent for a child with sufficient understanding and intelligence to be capable of making up his/her own mind).
- 4.5. Obtaining consent to disclosure of information, even to professional and/or other persons who will be collaborating with the Member in his/her professional relationship with the patient, is the normal course. There may, however, be special circumstances when disclosure of information of a confidential nature without consent may be justified. These are when:
  - 4.5.1. the disclosure is in the best interests of a child or young person; or
  - 4.5.2. there is an overriding public interest in the disclosure (for example, because neglect or sexual, physical or emotional abuse or other serious harm may result to the patient or another person if there is no disclosure); or
  - 4.5.3. when disclosure is required by law (for example because it is directed by a Court);

and, in any such circumstances, either:

- 4.5.4. the child or person who does not have the maturity or understanding to make a decision about disclosure and it is impractical or inappropriate to seek consent from a parent or a person with parental responsibility (for example, the child patient is very young and indicates that they are at immediate risk of abuse from the person from whom consent to disclosure of information would normally be sought); or

- 4.5.5. consent has been sought but withheld and the reasons for disclosure are so compelling that it should happen despite consent being withheld.
- 4.6. Members must maintain confidentiality. Members have an ongoing ethical and legal duty not to disclose any information of a confidential nature which the Member has acquired during his/her professional relationship with the patient to any third party during the lifetime of the patient or thereafter, unless special circumstances apply, as discussed above, or where consent is given.
- 4.7. Information of a confidential nature may be disclosed with the consent of the patient or, where they are unable to take part in decision making and give such consent, a parent or other person with parental responsibility. Even when consent has been obtained, Members should carefully consider whether disclosing confidential information is appropriate and ethical, especially where the patient may not have anticipated sharing it with the Member at the time any general consent was given. In such situations it may well be appropriate to seek further consent.
- 4.8. A Member must always be prepared to justify his/her disclosure of confidential information. If a Member is in doubt as to whether the circumstances justify disclosure in any particular situation, he/she should seek advice from the Director of Professional Standards.
- 4.9. A clear record of the reasons for disclosing confidential information and any attempts to seek consent should be made.
- 4.10. Where disclosure on best interests or public interest grounds has been considered and a Member has decided against it, s/he should also make a record of that decision and the supporting reasons.

## **5. Using information about patients for purposes of professional development, research and related purposes**

- 5.1. The best interests of the patient are paramount and must be protected in all reports of contact with patients made or shared for the purposes of education, training, the professional development of the member, of the profession as a whole, and of other professionals to whom members provide training and support. The common law and the Data Protection Act 2018 ('the 2018 Act') and the UK General Data Protection Regulation (GDPR), require recorded information about living patients ('personal data' in this context) to be kept confidential unless strict criteria for sharing it are met (including those set out in the National Health Service Act 2006 and the Health Service (Control of Patient Information) Regulations 2002 (which apply in England and Wales) and the Health and Social Care (Control of Data Processing) Act (Northern Ireland) 2016). The Human Rights Act 1998 also obliges public authorities, such as NHS Trusts, to respect privacy rights. Further, in most circumstances, the 2018 Act and the GDPR prohibit the use of personal data for purposes that are different to those for which it was originally gathered.
- 5.2. Information about patients can be shared within any team that is responsible for a patient's case, for purposes directly connected to the provision of that care. However, when considering whether to publish, orally present or otherwise share information about patients for educational, training or professional development purposes, Members must ensure that:
  - 5.2.1. there is no clinical reason why publishing, orally presenting or otherwise sharing such material is inappropriate or creates a risk of an adverse impact on the patient;



- 5.2.2. they have made themselves aware of their legal obligations under the common law and the legislation mentioned above (for example, by reviewing an adequate and up to date data sharing policy maintained by any NHS Trust that employs them, or their own policy if they are a 'data controller' for the purposes of the 2018 Act);
  - 5.2.3. they only use the minimum amount of information about patients that is necessary to achieve the educational, training or professional development purposes;
  - 5.2.4. anything that would enable the patient to be identified is removed or anonymised unless this is wholly impractical or identification of the patient is necessary and, in either case, one of the exceptions at paragraph 5.4 below applies.
- 5.3. Members should be aware that anonymisation involves eliminating not only the information from which a patient can be directly identified but also anything that allows patient identification when it is combined with other available information and should familiarise themselves with the Information Commissioner's Anonymisation: Managing Data Protection Risk Code of Practice when anonymising patient information in this context.
- 5.4. Where anonymisation is impractical or identification of a patient is necessary in order to use information about them for education, training or professional development purposes, the information should not be used for any of those purposes unless:
- 5.4.1. the patient has capacity to and practically can give explicit consent on a properly informed basis (i.e. following an accurate and comprehensive explanation of how the information will be used, the specific purpose or purposes, who will have access to it and when) and the patient has given consent on that basis; or
  - 5.4.2. if the patient lacks capacity to give consent on that basis, a person with the legal authority to make decisions on their behalf can give that explicit consent, again on a fully informed basis; or
  - 5.4.3. if no person with capacity practically can give explicit consent under subparagraph 5.4.1 or 5.4.2, the Member has satisfied themselves, after taking legal advice wherever appropriate, that the use of the information without consent can be legally justified bearing in mind the obligations mentioned at paragraph 5.1 above.
- 5.5. Where a Member concludes that an exception under paragraph 5.4. above applies, they should use only the minimum amount of information about the patient that is necessary, anonymise it as far as practicable and make a comprehensive and accurate record of either the consent given and the information on which it was based or the legal justification for use of an alternative lawful basis, as applicable. Any consent should be sought a reasonable time before publishing or orally presenting the material (to take account the patient's current views and allow them time to consider their position). General consent given at the start of the psychotherapist-patient relationship is not sufficient to meet this requirement and consent for the use of information about a patient in this way cannot be implied.

## **6. The end of the psychotherapeutic relationship**

- 6.1. Any patient or, when the patient cannot take part in decision making a parent or a person with parental responsibility, is entitled to bring the psychotherapeutic relationship to an end, whether by withdrawing consent to treatment or otherwise.

- 6.2. There will be circumstances in psychotherapy where indications are given, particularly by patients, about a wish to end the relationship but these are not clear, unequivocal or sustained. In these circumstances the psychotherapist has a special responsibility to ensure the relationship is not ended prematurely and to ascertain the underlying wishes of the patient and, if consent to treatment was given by another person, that person.

## **7. Conduct that might cause serious damage to the standing of the profession**

- 7.1. A Member shall not, whether in practice or otherwise, commit or engage in conduct that might cause serious damage to the standing of the profession of child psychotherapy. Any breach of this requirement may be treated as professional misconduct under this Code.
- 7.2. The following are examples of unacceptable behaviour:
- 7.2.1. conviction of a crime rendering the Member unfit to practise as a child psychotherapist (for example a crime involving harm to a child or other vulnerable person, or a crime of involving dishonesty in a position of trust);
  - 7.2.2. acting in a way which has compromised or may compromise the welfare of a child or a vulnerable adult to the extent that public confidence in the profession of child psychotherapy is likely to be undermined;
  - 7.2.3. unlawfully discriminating against, harassing or victimising an actual or prospective patient, family member or other carer, colleague or other Member;
  - 7.2.4. setting out to undermine trust in another child psychotherapist or another professional colleague by making unsustainable comments about them in bad faith or recklessly or outside of established procedures for raising concerns unless there is good reason not to use them; or
  - 7.2.5. treating or offering to treat a person who, to the knowledge of the Full Member, is undergoing psychotherapy with another qualified child psychotherapist.
- 7.3. Members are required to notify the Chair of the Ethical Practice Group in writing:
- 7.3.1. within 7 days, if they are convicted of any crime covered by paragraph 7.2.1. above;
  - 7.3.2. as soon as practicable, if they become aware of another Member who appears to have committed or engaged in conduct that might cause serious damage to the standing of the profession of child psychotherapy.

## **8. Records**

- 8.1. Publishing any audio or video recording of anything said or done by a patient during the course of psychotherapy patients for education, training or professional development purposes will be a highly exceptional course because of the difficulties of preserving patient confidentiality and controlling access to and use of such information outside the strict confines of the psychotherapy relationship. Publication of such recordings should also only occur with the consent of the patient under subparagraph 5.4.1. and subject to paragraph 5.5. It is not permissible to rely on consent of a person with the legal authority to make decisions on a patient's behalf to publish recordings, or to proceed without any consent.



- 8.2. Members should keep such records as are necessary to properly carry out the type of psychotherapy they provide to patients. The content shall be accurate, up to date and respectful of patients' and others interests.
- 8.3. Any records and other information from which patients can be identified should be securely stored and maintained in a way that ensures they are accessible but that confidentiality is maintained. Members should make themselves aware of risks to confidentiality (including by familiarising themselves with the data risk management policies maintained by any organisations in which they work, or creating and maintaining such a policy if they work independently in private practice on their own or with others). If there is a breach of confidentiality, Members should take steps to mitigate the effects and report it appropriately, including to the Information Commissioner's Office (ICO) if necessary.
- 8.4. Patients should be advised as to how long any records of information about them will be kept, normally through a privacy notice provided to the patient, or the person legally responsible for making decisions about their information if the patient lacks capacity to make such decisions. The notice should be provided as soon as possible and before treatment commences.
- 8.5. When it is no longer necessary and justified to store records of information about patients for the purpose for which they were made, they should be disposed of securely including, in the case of electronic records, by putting them beyond operational use. The periods and purposes for which records can permissibly be kept under the 2018 Act will vary depending on the nature of organisations in which Members work and, alternatively, whether they are working independently in private practice by themselves or with others. Members who are not data controllers for the purposes of the 2018 Act (typically this will be Members employed by an NHS Trust) should ensure all records they create and maintain are stored and destroyed in line with the policy of the data controller with overall responsibility, seeking advice when appropriate. Members who are data controllers should be fully familiar with, and adhere to, their obligations under the 2018 Act.