Clinical Ethics Handbook

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Updated: January 2022

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<u>SECTION ONE: POLICIES AND PROCEDURES</u>

Code of Clinical Ethics and Professional Conduct[1]

GUIDANCE FOR USE

1. The purpose of the Code of Clinical Ethics and Professional Conduct is to set out ethical principles which inform practice and which practitioners commit to, and actively endeavour to maintain. All members of the Metanoia Institute are required to abide by this Code of Clinical Ethics and Professional Conduct, including all students, and all graduates who are registered as members.

2. Student members are advised to read this Code of Clinical Ethics and Professional Conduct in conjunction with the Student Handbooks of their course, the guidelines relevant to particular aspects of this Code of Clinical Ethics and Professional Conduct and other Institute policies as appropriate

3. All members are advised to familiarise themselves with the Codes of other professional bodies to which they belong e.g. BACP, BPS, UKCP, GPTI, UKATA.

4. This Code of Clinical Ethics and Professional Conduct may be taken into account by the Clinical Ethics Committee when considering allegations made against any member of the Metanoia Institute being dealt with under the Institute's Complaints and Professional Conduct Procedure, or the equivalent procedures of BPS, BACP, UKCP, HCPC and other professional bodies. This Code of Clinical Ethics and Professional Conduct may also be taken into account when dealing with other matters pertaining to this Code.

5. Practitioners are advised that the clauses contained in this Code of Clinical Ethics and Professional Conduct are not to be taken as fully inclusive, exclusive or definitive of what may, or may not, constitute either professional misconduct or concerns about fitness to practice. Practitioners are also advised to familiarise themselves with the Institute's "Fitness to Practice Policy".

6. The term 'service' in this Code of Clinical Ethics and Professional Conduct applies to counselling, psychotherapy and counselling psychology.

7. The term 'practitioner' in this Code of Clinical Ethics and Professional Conduct applies to all members of the Metanoia Institute, except where indicated otherwise.

8. In the text of this Code of Clinical Ethics and Professional Conduct the terms "trainee" and "trainee practitioner" are used to describe students who have commenced seeing clients and are not fully qualified practitioners until final graduation. This is to avoid misunderstandings by clients and other members of the public about trainee and/or fully qualified practitioner status. All students are expected to familiarise themselves with the use of these terms, as specified in this Code of Clinical Ethics and Professional Conduct, and to apply as described above.

[1] The Metanoia Institute Code of Clinical Ethics and Professional Conduct draws heavily on the work of UKCP's Ethical Principles and Code of Professional Conduct (2009), and their content/assistance is acknowledged in the formulation of this document.

GENERAL ETHICAL PRINCIPALS

1. Best interest of clients

1.1 The wellbeing and best interests of the client is the practitioner's primary concern. Practitioners commit to:

- respecting the best interests of the client
- respecting the autonomy of the client
- respecting the dignity and privacy of the client
- promoting the wellbeing of the client
- honouring the trust placed in the practitioner
- avoiding harm to the client
- treating all clients fairly and impartially

1.2 Practitioners acknowledge their power and position of trust within the relationship with their clients and agree to actively avoid exploitation of any client, or former client, in any manner e.g. legally, financially, emotionally or sexually. Practitioners agree not to encourage or solicit gifts from clients or former clients.

1.3 Practitioners agree not to enter into sexual relationships with any of their clients. This includes behaving in a sexual manner towards any client.

1.4 Practitioners agree not to enter into sexual relationships with, or behave in a sexual manner towards, anyone they know to be closely connected to a client.

1.5 Practitioners agree to respect the gender, sexual and relationship diverse identities and consensual practices of their clients and avoid offering or providing any kind of therapy or intervention which aims to alter or suppress these identities and practices. This includes therapies or interventions which aim to alter or eliminate same sex attraction or gender identity, also known by other terms such as conversion or reparative therapy.

1.6 Practitioners commit to knowing and understanding their legal responsibilities towards children, young people and vulnerable adults, and to taking appropriate action when they consider a child or vulnerable adult to be at risk of harm.

1.7 Practitioners commit to knowing and understanding current legislation on post adoption issues.

1.8 Practitioners commit to knowing and understanding how current data protection legislation (The Data Protection Act, May 2018 and the UK General Data Protection Regulation,), applies to their work with clients and commit to familiarizing themselves with the Institute's Data Protection Policy, IT and Telephone Acceptable Use Policy, Bring Your Own Device Acceptable Use Policy and Disclosing Data to Third Parties guidance. All four documents are closely inter-linked.

1.9 Practitioners acknowledge that their behaviour in their personal and professional lives may impact on their relationships with clients and commit to working with both potential positive and negative effects with clients, to the benefit of the client's best interests.

1.10 Practitioners commit to ensuring, as far as reasonably possible, that they manage their personal and professional social media/internet-based activities in ways that are not detrimental to the best interests of their clients. In particular, practitioners agree to respect the privacy of clients, protect client confidentiality, and preserve the boundaries of the professional relationship.

1.11 Dual/multiple relationships and conflict of interest. Practitioners agree to avoid entering into dual and multiple relationships with clients, including any relationship which may cause confusion for an existing client. For example, entering into social or business relationships with clients, or accepting as a client someone who is closely connected to an existing client. In circumstances where dual/multiple relationships may be unavoidable, for example, in small communities, practitioners are responsible for clarifying and managing boundaries with the client(s) concerned and for protecting client confidentiality. Practitioners agree to review any such arrangements at regular intervals.

1.12 Relationships with former clients. Practitioners agree to exercise reasonable care before entering into a personal or business relationship with a former client, and to carefully consider important aspects of the former relationship, such as the duration and nature of the work. When a potential relationship with a former client is one of choice, practitioners are expected to carefully examine their own motives. Practitioners are advised that should a relationship with a former client prove to be detrimental to the former client, they may be called to account.

1.13 Practitioners accept that, in essence, the responsibilities assumed in working with clients continue after the ending of the relationship.

1.14 Should anything in the work with a client go significantly wrong, the practitioner commits to promptly informing the client concerned, to taking action to remedy the situation and limit harm, whether or not the client was aware of it, and offer an apology when appropriate.

1.15 Problem solving/ethical dilemmas. It is not possible to cover every possible concern or situation practitioners may encounter in their work with clients in this Code of Clinical Ethics and Professional Conduct. In unexpected situations/dilemmas practitioners are expected to engage in thoughtful consideration of the relevant circumstances using ethical principles and seeking confidential guidance from their supervisor(s) and senior colleagues. This may involve considering which principles to prioritise. It is the practitioner’s responsibility to take into account all the relevant circumstances with as much care as possible and to be accountable for decisions made.

2 Consent

2.1 Practitioners commit to making informed agreements with clients about the nature of the work at the outset, appropriate to the expressed needs of the client, and to explaining the modality and methods of working when requested and as appropriate.

2.2 Practitioners commit to respecting client’s choices about whether or not to participate in any proposed intervention or suggestion.

2.3 Practitioners are expected to accurately and honestly disclose their qualifications and/or trainee status, and experience to clients when requested, and agree to not intentionally providing misleading information of any kind.

2.4 Trainee practitioners commit to informing clients that they are trainees at the outset of the professional relationship.

2.5 Practitioners who work with children and young people commit to taking into account the capacity of the child/young person to give informed consent with reference to Gillick competency (1985). Practitioners take responsibility for knowing and understanding when it is appropriate to seek and obtain the consent of adults who hold parental responsibility for the child/young person, and their best interests.

2.6 Practitioners who work with vulnerable adults commit to taking into account the capacity of the vulnerable adult client to give informed consent, to carefully consider how consent is obtained, to respecting the consent given by the vulnerable adult client and to knowing and understanding when it is appropriate to involve other adults who provide care for vulnerable adult clients.

2.7 Practitioners commit to observing the requirements specific to their course/faculty concerning a) obtaining consent from clients for the use of clinical material, including recordings, and b) the protection of the clients identity in case studies, dissertations, academic assignments and other relevant work. In situations unconnected with course/faculty work practitioners commit to obtaining consent from clients for the use of clinical material, including recordings, agree to inform clients how the clinical material will be used and agree to protect the identity of the client.

2.8 Publication of clinical material. Protecting the welfare, best interests and anonymity of clients is of the utmost importance, and practitioners commit to obtaining consent from clients for clinical material being considered for publication. Clients, or former clients, may recognise themselves in

published clinical material despite using pseudonyms and anonymising the work, and this possibility should be discussed with the client from whom consent is being sought. Practitioners are advised to consult with the Clinical Ethics Committee and/or the Research Ethics Committee about future publication of clinical material where the issue of consent is unclear.

3. Equality, Diversity and Inclusion

3.1 Practitioners accept that no-one is immune from the experience of prejudice, and acknowledge the need to non-defensively explore and question their own attitudes to differences in relation to their working practices, as part of their on-going personal and professional development.

3.2 Practitioners commit to actively engaging with the issues of diversity and equalities in all aspects of their professional lives and activities, including careful consideration of current legislation.

3.3 Practitioners commit to actively preventing prejudice about gender, colour, race, age, sexuality, lifestyle, social status, economic status, immigration status, disability, and cultural or religious beliefs from having an adverse effect on the way they relate to each individual client.

3.4 Practitioners commit to actively desist from using any behaviours that are abusive or detrimental to any client, to anyone who belongs to the Metanoia Institute community or to members of the wider community on the above grounds.

4. Confidentiality

4.1 Practitioners commit to respecting, protecting and preserving client confidentiality.

4.2 Practitioners commit to protecting sensitive and personally identifiable information obtained in the course of their work as counsellors, psychotherapists or counselling psychologists.

4.3 Practitioners agree to inform clients that they discuss their work with supervisors. The client's identity remains confidential to the relationship with the client.

4.4 Practitioners agree to inform clients that confidentiality may be broken where the safety of the client or others is at risk.

4.5 In circumstances where it is considered necessary to break confidentiality practitioners commit to informing the client concerned beforehand, when ethically appropriate and legally permitted, and to giving careful consideration to how to manage such situations, including the continued support of the client concerned.

4.6 In circumstances where a practitioner is required by law to be involved in any legal proceedings concerning any client, they are expected to seek clarity about the extent and nature of the confidential information required at the outset. Practitioners are responsible for ensuring that only necessary and sufficient information is disclosed, and that all other confidential information is protected throughout. Practitioners are advised to seek legal and ethical advice in these cases. Trainee practitioners agree to inform, and seek guidance from, their supervisor(s) in these situations.

4.7 MCPS. Practitioners who practice within MCPS commit to observing the MCPS Disclosure Policy.

5. Qualifications, knowledge, skills and experience

5.1 Practitioners agree to disclose their qualifications and/or trainee status when requested and commit to not making false or misleading statements concerning their qualifications and/or trainee status, experience or relationship to the Metanoia Institute, or their tutors and supervisors. Members of the public must be reasonably informed about the relevance of qualifications to the practise of counselling/psychotherapy/counselling psychology, including in any published material/material posted on the internet.

5.2 Practitioners agree not to claim or imply qualifications they do not possess.

5.3 Practitioners commit to engaging in a continuing process of professional and personal development, including evaluating strengths and weaknesses, enhancing knowledge and skills, keeping up to date with relevant legislation and thoughtful self-enquiry and challenge. This includes collaborating with tutors, supervisors and senior colleagues, as applicable, and the use of other resources, to enhance the services offered to clients.

5.4 a) Practitioners commit to maintaining supervision to a level which enables them to work effectively with clients. This includes careful consideration of how to manage the process of onward referrals, should this be in the best interests of the client. b) Trainee practitioners should maintain supervision, as a minimum, according to the specific requirements of their course. c) Students must ensure that any proposed profession related activities/projects which lie outside of work with clients and/or Research Ethics Committee approved research projects complies with the required professional and ethical standards. Such activities/projects must be discussed and agreed with primary tutors and Director of Studies prior to commencement and, if approved, reviewed with them on a regular basis.

5.5 Should it become clear, either in the initial assessment or later, that the practitioner is practising beyond his or her competence the practitioner commits to informing the client and to arranging an onward referral to another practitioner or other professional, as appropriate, and as requested/agreed with the client.

5.6 Practitioners agree not to commence work or offer to commence work with a client who the practitioner knows is already working, as a client, with another counsellor, psychotherapist, psychologist, psychiatrist or other professionally qualified person unless a) this is part of an openly agreed arrangement by all concerned e.g. when a client is in individual therapy with one practitioner and engaging in couples therapy with another practitioner, or b) is a properly managed referral arranged between the two practitioners/professionally qualified persons and the client concerned.

5.7 Medical support. Where it is indicated, either in assessment or later, that there may be serious medical/psychiatric issues practitioners commit to ensuring they have adequate medical back-up for the continuation of work with the client concerned, to discussing this with the client, and agreeing referral arrangements with the client. This would usually be the clients GP. In these circumstances practitioners are advised to seek supervision.

5.8 Practitioners commit to adhering to the requirements for professional development of the Metanoia Institute, and of other organisations of which they are members.

6. Professional Conduct

6.1 Practitioners agree to avoid engaging in behaviour that brings the professions of counselling, psychotherapy and counselling psychology, the Metanoia Institute and other organisations in the field, into disrepute. This includes refraining from derogatory statements, implications and/or innuendo's that disparage the standing, qualifications or character of colleagues, tutors, supervisors and fellow trainee practitioners in statements, including public statements, whether written, verbal or any other communication medium.

6.2. Practitioners acknowledge that their behaviour in their professional and personal lives may positively and/or negatively affect the way they are experienced by a client, and commit to critically examining the impact this may have on the relationship with the client, with priority on preserving the client's best interests.

6.3 Practitioners agree to co-operate with the Clinical Ethics Committee in any lawful review or inquiry of their capacity to carry out their work with clients. In these situations practitioners are advised to obtain legal and ethical advice.

6.4 Practitioners agree to co-operate with the Clinical Ethics Committee on any matters pertaining to the Code of Ethics and Professional Conduct.

6.5 Practitioners agree to inform Human Resources and the Clinical Ethics Committee of the following:
- criminal convictions, conditional discharges and cautions.
- current investigations or sanctions brought against them by another professional body
- suspensions or practice restrictions by an employer or similar body due to concerns about their practice, competence or health.
- financial difficulties that could lead to bankruptcy or other debt-related formal arrangements.

6.6 In the event of any of the above being reported, consideration will be given to the implications for the practitioner's professional practice, possible risk to clients and public confidence in the profession. In some circumstances the training contract and/or membership of the Metanoia Institute may be terminated.

7. Exploitation and Harmful Practice by Other Practitioners

7.1 Practitioners accept they share a responsibility to protect all clients from exploitation and harmful practice, and agree to challenge colleagues/other practitioners when appropriate.

8. Physical or Mental Health

8.1 Practitioners have a responsibility to monitor and maintain their fitness to practice at a level that enables them to provide an effective service. If their effectiveness becomes impaired for any reason, including health and personal circumstances, they should seek the advice of their supervisor, experienced colleagues or line manager and, if necessary, withdraw from practice until their fitness to practice returns.

8.2 Practitioners agree not to work with clients when their ability to provide an effective service is impaired by alcohol, drugs or medication.

8.3 Practitioners, particularly those in private practice, commit to giving careful consideration to how clients might be notified in the event of their sudden unavailability. This includes how clients might be informed of a practitioner's death or illness, and how a client would be supported to deal with such a situation. Practitioners commit to making arrangements for a practice executor, if appropriate.

9. Fees, Contracts and Arrangements with Clients

9.1 Practitioners commit to charging fees appropriate to their qualifications and/or trainee status, and level of experience. Trainee practitioners agree to discuss fees with their course tutor(s) and/or supervisor(s).

9.2. Practitioners agree to inform clients, and potential clients, of the terms and conditions of their practice including fees, confidentiality, termination, and cancellation at the outset, and are advised to provide clients with a written copy of this agreement.

9.3 Practitioners agree to provide information, on request, about modality, methods of working and the likely duration of the work.

9.4 Practitioners agree to establish informed agreements with clients about any mutually agreed use of internet based activities and/or digital communications in the work together, and to discuss with clients the management of risks, as appropriate. Practitioners are advised to have a written policy on internet based activities/digital communications included in their written contracts with clients and/or professional website.

9.5 Practitioners commit to stating to which Code(s) of Ethics and Complaints/Professional Conduct Procedure(s) they subscribe either in their written contract/agreement with clients or in a form which is easily accessible for clients e.g. on their professional website.

9.6. Practitioners are responsible for ensuring that their working accommodation and conditions are suitable for the practise of counselling, psychotherapy.or counselling psychology.

10. Records

10.1 Practitioners are responsible for keeping records appropriate to the type of service they offer to clients, and in accordance with the requirements of placements or employing organisations, if applicable. Records should be written in a clear and legible way so that they can be read by clients, if requested.

10.2 Practitioners are responsible for keeping identifiable confidential records under secure conditions and for disposing of them in a secure manner to prevent unauthorised access. Practitioners are responsible for observing the requirements of placements or employing organisations concerning the security and disposal of confidential records, if applicable.

10.3 Practitioners in private practice are advised to keep client records for a period of 6 years, following the ending of the work with the client.

11. Advertising Material

11.1 Practitioners commit to making accurate and honest descriptive statements about the services they offer in any advertising material and agree to refrain from making false claims or misleading statements about their experience, qualifications and/or trainee status, and the type of service they offer. Practitioners agree not to claim or imply qualifications they do not possess. Misrepresentation of qualifications and/or trainee status, and experience may have serious legal implications under current legislation governing standards in commercial advertising and may jeopardise practitioners' present and future standing with the Metanoia Institute and other professional bodies.

11.2 Members of the public must be reasonably informed about the relevance of qualifications to the practise of counselling/psychotherapy/counselling psychology.

11.3 Practitioners agree to refrain from soliciting or using testimonials from clients, or former clients, for the purposes of advertising.

11.4 Practitioners agree to refrain from making comparative statements or any statement which implies the services being advertised are more effective than those provided by other schools, modalities, organisations or practitioners.

11.5 Trainee practitioners agree to review any advertising material with their course tutor(s) and/or supervisor(s) prior to public distribution/publication, and to engage in subsequent reviews, as appropriate.

12. Professional Insurance

12.1 Practitioners commit to ensuring that they have sufficient professional indemnity insurance of at least £1 million to cover the full range of their professional services/activities, which should include provision for legal advice and legal costs, and cover for any claims made against the owner of the premises in which the practitioner works.

12.2 Practitioners are responsible for ensuring that their work is sufficiently covered by their placement's or employer's indemnity insurance, if applicable.

12.3 Practitioners who are considering retirement/sabbaticals are advised to contact their professional insurers for advice on appropriate cover.

13. Complaints

13.1 Unethical conduct will be tested against the published Metanoia Institute's ethical codes and against behaviour that would be seen as ethically acceptable to a group of professional peers. Unethical conduct refers to conduct which falls outside the ethical standards practitioners are expected to maintain. This may, for example, include exploitation of clients in any way, failure to maintain professional boundaries, failure to provide an adequate service, failure to work within limits of competence, breaches of confidentiality and making false claims in regard to services

offered and advertised, and/or qualifications. Unethical conduct also includes criminal convictions directly relevant to clinical practice, using behaviours which are abusive, discriminatory or detrimental to clients and colleagues, and/or undermine the trust clients and members of the public place in practitioners and are entitled to rely on.

13.3 Impaired fitness to practice will be tested against the published Metanoia Institute's ethical codes and against competence that would be seen as ethically acceptable to a group of professional peers. Impaired fitness to practice refers to the inability of the practitioner to provide a service which is competent, safe, and meets the needs of the client to a satisfactory standard over time. This may, for example, be because of ill health, including lack of self-care and failure/inability to seek medical care or other appropriate assistance, or, because of lack of skills and knowledge, poor clinical judgement, failure to seek sufficient confidential supervision and consultation, or failure to maintain sufficient on-going professional development to keep up to date with current practice and legislation.

Code of Ethics for Tutors, Interns, and Visiting Tutors in Counselling, Psychotherapy and Counselling Psychology[2]

INTRODUCTION

The purpose of this Code of Ethics is to establish and maintain standards for Tutors at the Metanoia Institute and to inform and protect members of the public seeking training in counselling and psychotherapy.

For the purposes of this Code the word 'Tutor' also applies to all Tutors and Interns. Interns do not have the same responsibilities as Tutors. Nevertheless, they are expected to conduct themselves in a manner appropriate to their professional role. This Code of Ethics also applies to Visiting Tutors.

Tutors shall be aware that the clauses below, and in other Metanoia Institute Codes of Ethics and/or Conduct, are not to be taken as fully inclusive, exclusive or definitive of what may or may not constitute professional misconduct. This Code should be read in conjunction with the Metanoia Institute Code of Clinical Ethics and Conduct.

CODE

1. a) All Tutors are expected to conduct themselves in their training activities and associated responsibilities in ways which do not undermine public confidence in: their role as Tutors, the work of other Tutors, the Metanoia Institute, and professional and academic organisations to which Metanoia Institute courses are connected and accountable.
b) Tutors are required to exercise their professional judgement and discretion when dealing with students from other Metanoia Institute courses for whom they do not have direct responsibility. In these deliberations the interests of the students and their continued professional development, and the professional responsibilities that all Tutors assume under the Code(s) of Ethics take precedence.
c) Tutors are reminded that the training status of students/trainees continues until graduation and/or formal withdrawal from the course.

2. Ethical standards comprise such values as integrity, impartiality and respect. Anti-discriminatory practice should underpin these basic values of counselling and psychotherapy and other professional activities. Tutors acknowledge the value and dignity of all humanity, regardless of such differences as gender, race, age, culture, class, sexuality, religion and disability.

3. a) Tutors are responsible for establishing and maintaining appropriate boundaries between themselves and students, so that working relationships are not confused with other relationships. In general, the provision of training should be separate from the provision of counselling and psychotherapy.
b) Tutors must not accept as clients students with whom they are actively involved in a training role. Former students must not be accepted as clients until a period of time has elapsed for reflection and after consultation with a supervisor.

4. a) Tutors must not exploit students financially, sexually, emotionally, or in any other way.
b) Sexual relationships with students are unethical.

5. a) Tutors are expected to commit themselves to their continuing professional development, and to monitor and evaluate the limits of their competence.
b) Tutors have a responsibility to themselves, their students and to the Metanoia Institute, to maintain their own effectiveness, resilience and ability to work with students. They are expected to monitor their own personal functioning and to seek help and/or withdraw from their role as Tutor, whether temporarily or permanently, when their personal resources are sufficiently depleted to require this.

[2] The Metanoia Institute Code of for Tutors draws heavily on the work of BACP and their content/assistance is acknowledged in the formulation of this document.

6. a) Tutors are responsible for negotiating a confidentiality agreement with any training group they teach and for making explicit the limits of confidentiality between themselves, other staff members, the Metanoia Institute, and the students. Tutors are expected to conduct discussions about students in respectful and purposeful manner.
b) In those instances where a Tutor believes it necessary to break confidentiality they will, wherever possible, discuss this in advance with the student concerned, making clear their reasons for this course of action, and seeking their co-operation. Confidentiality agreements may be broken where there are serious safety, legal or ethical concerns.
c) The anonymity of anyone whose material is used for the purposes of publication, teaching and seminars is of paramount importance.
d) Tutors who are Members of the Metanoia Institute, who wish to undertake academic and/or clinical research and/or publication of clinical material involving staff, other Members or clinic clients of the Metanoia Institute are expected to observe the Metanoia Institute Code of Research Ethics and relevant clauses in the Metanoia Institute Code of Clinical Ethics and Conduct relating to publication.

7. Tutors are required to report any current investigation or sanctions brought against them by another professional body to the Metanoia Clinical Ethics Committee and to Human Resources.

CODE OF ETHICS FOR SUPERVISORS IN COUNSELLING, PSYCHOTHERAPY AND COUNSELLING PSYCHOLOGY[3]

INTRODUCTION

The purpose of this Code of Ethics is to establish and maintain standards for Supervisors at the Metanoia Institute, and to inform and protect counsellors/counselling psychologists/psychotherapists seeking supervision. This Code should be read in conjunction with the Metanoia Institute Code of Clinical Ethics and Conduct.

Supervisors shall be aware that the clauses below, and in other Metanoia Institute Codes of Ethics and/or Conduct, are not to be taken as fully inclusive, exclusive or definitive as to what may or may not constitute professional misconduct.

CODE

1. a) All Supervisors are expected to conduct themselves in their supervisory activities and associated responsibilities in ways which do not undermine public confidence in: their role as Supervisors, the work of other Supervisors, the Metanoia Institute, and professional and academic organisations to which Metanoia Institute courses are connected and accountable.
b) The primary purpose of supervision is to ensure that the supervisee is addressing the needs of the client.
c) Supervisors are reminded that the training status of Metanoia Institute students/trainees continues until graduation and/or formal withdrawal from the course.

2. Ethical standards comprise such values as integrity, impartiality and respect. Anti-discriminatory practice should underpin these basic values of counselling and psychotherapy, and other professional activities. Supervisors acknowledge the value and dignity of all humanity, regardless of such differences as gender, race, age, culture, class, sexuality, religion and disability.

3. Supervisors are responsible for establishing and maintaining appropriate boundaries between themselves and supervisees, so that working relationships are not confused with other relationships. In general, the provision of supervision should be separate from the provision of counselling and psychotherapy.

4. a) Supervisors must not exploit supervisees financially, sexually, emotionally, or in any other way.
b) Sexual relationships with supervisees are unethical.

5. a) Supervisors are expected to commit themselves to their continuing professional development, and to monitor and evaluate the limits of their competence.
b) Supervisors have a responsibility to themselves, their supervisees and the Metanoia Institute, to maintain their own effectiveness, resilience and ability to work with supervisees. They are expected to monitor their own personal functioning and to seek help and/or withdraw from their role as Supervisor, whether temporarily or permanently, when their personal resources are sufficiently depleted to require this.

6. a) As a general principle, Supervisors must maintain confidentiality with regard to information about their supervisees and their supervisees' clients.
b) In those instances where a Supervisor believes it necessary to break confidentiality, either in relation to the supervisees' practice or client issues, they will, wherever possible, discuss this in advance with the supervisee concerned, making clear their reasons for this course of action and seeking the co-operation of the supervisee. Confidentiality agreements may be broken where there are serious safety, legal or ethical concerns.

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[3] The Metanoia Institute Code of Ethics for Supervisors draws heavily on the work of BACP and their content/assistance is acknowledged in the formulation of this document.

c) The anonymity of anyone whose material is used for the purposes of publication, teaching and seminars is of paramount importance.
d) Supervisors who are members of the Metanoia Institute who wish to undertake academic and/or clinical research and/or publication of clinical material involving staff, other Members or clinic clients agree to observe the Metanoia Code of Research Ethics and the relevant clauses in the Metanoia Institute Code of Clinical Ethics and Conduct relating to publication.

7. Supervisors are required to report any current investigation or sanctions brought against them by another professional body to the Metanoia Clinical Ethics Committee and to Human Resources.

PATHWAYS TO DEALING WITH CONCERNS AND COMPLAINTS

- ***Alternative Dispute Resolution***
- ***Complaints and Professional Conduct Procedure***

INTRODUCTION

Both the ADR process and the CPCP are based on the important principles of natural justice which means that both client and practitioner have an equal right to be heard and to be treated fairly, without bias.

When clients have a concern or complaint about a practitioner there are two possible pathways for addressing the issues:

a) the informal Alternative Dispute Resolution (ADR) process; and
b) the formal Complaints and Professional Conduct Procedure (CPCP).

The Clinical Ethics Committee will indicate which pathway may be appropriate following the receipt of a written concern or complaint, providing the concern or complaint meets the criteria for acceptance specified in the CPCP. ADR allows the Institute to use resources more effectively when it may be clear that the concern or complaint could be resolved by the use of options available in this informal process, providing that both parties agree.

Before raising a concern or complaint we always recommend that clients attempt to resolve the issue directly with the practitioner first, unless it is clearly not appropriate to do so.

The Clinical Ethics Committee can be contacted by email or phone for confidential advice, and the office at North Common Road will provide contact details on request.

ALTERNATIVE DISPUTE RESOLUTION

INTRODUCTION

The purpose of this informal ADR process is to provide a fair and transparent way of resolving concerns and complaints when it is not necessary, or appropriate, to use the formal Complaints and Professional Conduct Procedure throughout, and when both parties agree to participate. ADR also avoids the stress and emotional cost of being involved in the formal procedures.

There are several options under this process, including:

- Telephone calls
- Letters or emails
- Facilitated meetings

The wishes of both client and practitioner will be taken into account when considering which options may be appropriate.

Alternative Dispute Resolution (ADR) is an informal process designed to address and resolve concerns and complaints in a fair and transparent manner by using mediated/ facilitated meetings and other options in a way that can be closely matched to the particular nature of the concern or complaint, and the differences and misunderstandings that may have arisen between client and practitioner. Meetings and other options are facilitated by senior members of the Institute or senior members of another professional organisation.

When mediated/facilitated meetings are used both parties have the opportunity to be fully heard, to resolve differences and misunderstandings between them, and to reach mutual agreement about practical solutions. The practitioner also has the opportunity to apologise directly to the client about mistakes they may have made. The meeting is concluded by the client and practitioner making a written agreement.

ADR avoids the stress and emotional cost of being involved in the formal CPCP in circumstances where it is not necessary to use formal procedures throughout. Formal procedures may be halted in the earlier stages to allow both client and practitioner the opportunity to resolve the issues which have arisen between them using ADR, if both parties agree. ADR is not used when the concern or complaint indicates that there are public safety issues.

PROCESS

<u>Confidentiality</u>
All options under this process are confidential to the client and practitioner concerned, and those who have a role in this process.

<u>Information about mediated/facilitated meetings</u>
Mediated/facilitated meetings involve a collaborative, decision making process where both the client and practitioner have the opportunity to say what they think and feel about what has happened between them, identify the difficulties between them, consider options and attempt to reach a mutually agreed outcome, with the help of a neutral facilitator.
The role of the facilitator is to help both the client and practitioner communicate with each other, and help them identify and clarify issues, consider possible solutions and negotiate their own agreement.
Arrangements for dates, times and venue with both the client and practitioner will be confirmed with all parties at least two weeks in advance.

<u>The mediated/facilitated meeting process</u>
Usually the facilitator will meet both people separately to ask them to explain how they perceive what has happened, and to ask them what suggestions they have for resolving the issues. If both parties agree to meet then:

- The facilitator will explain the time structure, and agree ground rules e.g. listening without interrupting.

- Each person has the opportunity to say how the difficulties have affected them, and the other person has the opportunity to respond. The facilitator will try to make sure each person understands what the other person has said.

- The facilitator will help the client and practitioner identify the issues that need to resolved, help them both consider possible options for resolving the issues, and help them to reach an agreement. Some agreements may also be written down in draft form.

- Following the meeting, and where a written agreement is being used, the Head of Faculty and/or a member of the Clinical Ethics Committee will consider the draft of any concluding agreement. If amendments are suggested both parties will receive an amended draft agreement with a clear statement giving the reason for any amendment(s). Both parties may then sign the agreement.

Other information

- Possibilities for resolution using the ADR may be offered, if appropriate, after the written concern or complaint is received by the Clinical Ethics Committee for consideration, providing the concern or complaint meets the acceptance criteria specified in the CPCP, and providing both parties agree. In these circumstances the formal procedures will be put on hold.
- If satisfactory resolution is unable to be achieved using ADR the matter will be dealt with under the formal CPCP.

- In the unlikely event that any issues of public safety come to light at any stage in the ADR process, the process will be terminated and the matter will be dealt with under the CPCP.

- Both parties are required to refrain from using abusive behaviour towards anyone, including members of the Institute, staff and visitors to the Institute's premises. This includes contact by any other communication medium. Failure to observe this requirement may result in the termination of the ADR process or action under the Institute's Conduct and Discipline Policies.

COMPLAINTS AND PROFESSIONAL CONDUCT PROCEDURE[4]

INTRODUCTION

The purpose of the Metanoia Institute's Complaints and Professional Conduct Procedure is to provide a means of examining a complaint about alleged breaches in the Metanoia Institute's Code of Clinical Ethics and Professional Conduct by a student who is a member of the Institute and acting in a professional capacity as a counsellor, psychotherapist or counselling psychologist. It is also intended that the document provide guidelines for making decisions regarding a member's fitness to practice.

The aim is to protect individual members of the public, and maintain public confidence in the professions of counselling, psychotherapy and counselling psychology, and the reputation of the Institute.

This Complaints and Professional Conduct Procedure should be read in conjunction with the Metanoia Institute's Code of Clinical Ethics and Professional Conduct which may be referred to when a complaint is being considered under these formal procedures.

Throughout this document 'member' refers to a student member or a graduate member who was a student at the time the events in the complaint took place, unless stated otherwise.

The Complaints and Professional Conduct Procedure is used to deal with concerns and complaints when the events described in the written concern or complaint contain allegations that serious, or very serious, infringements of the Institute's ethical codes may have taken place. Enquiries are carried out to establish, as a far as possible, what has happened between the client and practitioner. The results of the enquiries are then assessed using the "realistic prospect" test to decide whether it is more likely than not that the allegations are true and, if so, whether the allegations concern infringements that are serious and the case would be referred for an Adjudication Panel to decide.

Should the practitioner takes full and genuine responsibility for what has happened before an Adjudication Panel is convened, and they agree to accept the likely sanctions a Panel may impose, the case will not go to adjudication. The sanctions will be imposed by the Enquiry and Assessment Panel.

When an Adjudication Panel is convened both parties must attend, and the client will be represented by a senior member of the Institute, or another professional person, and the practitioner may be represented by an advisor or a solicitor. The Panel will ask questions of the client and the practitioner, or those representing them, and may also ask questions of any witnesses of either party if the Chair has asked them to attend the Hearing. If the case is upheld the Adjudication Panel will decide on sanctions.

Concerns and complaints about less serious matters are assessed under this procedure. There are points early on in the procedure where both the client and the practitioner may be offered an opportunity to resolve the concern or complaint using ADR, and the formal procedure will be put on hold. If either the client or practitioner does not agree, the Enquiry and Assessment Panel may impose sanctions, which are usually educational, such as further training in a specific area.

Some concerns and complaints may be dismissed by the Enquiry and Assessment Panel, because there is insufficient evidence to show that the practitioner has done anything, or omitted anything, which infringes the Institutes ethical codes

At all times during this procedure the Clinical Ethics Committee will communicate in a timely manner with both the client and the practitioner to let them know what is expected, and keep them appropriately informed.

Please note: all references to the Clinical Ethics Committee above also refers to any other professional person the Committee appoint in any part of the CPCP procedure.

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[4] The Metanoia Institute Clinical Ethics Committee acknowledges and appreciates the input and assistance of John Waterston in the drafting of this procedure.

PROCEDURE

1.0 The Scope of the Complaints and Professional Conduct Procedure is limited and can only operate within the remit allowed by the Institute's Code Clinical of Ethics and Professional Conduct and by the fitness to practice test.

1.1 The Metanoia Institute will consider any complaint in respect of the foregoing members of the Institute which demonstrates evidence calling into question the member's professional conduct and may be related to any of the following:

1.1.1 Misconduct

1.1.2 Professional Competence

1.1.3 Conviction or caution in the UK for a criminal offence which is relevant to the member's professional practice.

1.1.4 Ill-health of the member which is relevant to the member's professional practice.

1.2 In considering a complaint due regard will be paid to the Institute's Code of Clinical Ethics and Professional Conduct and the relevant parts of the said Codes will be identified and highlighted by the Case Officer. The Case Officer will be either the Chair of the Clinical Ethics Committee or any other recognised and identified person appointed by the Chair of the Clinical Ethics Committee or by the Executive Committee of the Institute. See also clause 6.0.1

2.0 In respect of clause 1.0 above, a complaint may be raised by:

2.0.1 A member of the public who has been a recipient of a member's services in their role as counsellor, psychotherapist or counselling psychologist.

2.0.2 Other professional organisations, including student placements.

2.0.3 Third parties in circumstances where the recipient of the member's service is a minor or an adult lacking capacity, and may be represented by a legal guardian or appropriately authorised adult, respectively.

2.0.4 Third parties where the recipient of the member's services is unable to represent themselves. In these circumstances both written permission from the recipient of the member's services and a written explanation addressing the nature of the inability is required.

2.0.5 Third parties who have been directly affected by the behaviour of the member, and where sufficient interest can be demonstrated.

2.0.6 The Executive of the Metanoia Institute

2.0.7 The Police or other statutory body demonstrating a sufficient interest in the member's fitness to practice.

3.0 Complaints submitted to the Institute may be brought in respect of the following categories of membership:

3.0.1 The student member or graduate member named in the complaint must have been a student member at the Institute at the time the events described in the complaint took place.

3.0.2 Complaints about graduate members cannot be dealt with under this procedure unless the graduate member was a student member at the Institute at the time the events described in the complaint took place.

3.0.3 Complaints about former student members who are no longer members of the Institute will be kept on file, and other organisations may be informed that there is a complaint outstanding.

3.1 Should the member complained against fail to renew their membership and/or withdraws from the course following receipt of a written complaint the Institute may continue the case if it is in the public interest to do so. This clause will also apply where the member complained about initiates voluntary erasure (voluntary termination of membership and/or disclosure of intention to non-compliance with the complaints procedure) on receipt of the details of a complaint.

4.0 Complaints must be submitted to the Institute within a reasonable time of the alleged behaviour taking place.

4.1 Written complaints must be sent to the Chair of the Clinical Ethics Committee as near as possible to the time that the events described in the complaint took place, and no later than three years from the time of the events described.

4.2 Except in exceptional circumstances the Institute will not deal with complaints which concern events that took place outside the three year time limit, unless it is in the public interest to do so.

5.0 Other considerations and conditions will apply as follows:

5.0.1 This procedure allows for the use of the informal Alternative Dispute Resolution to resolve complaints and concerns when both parties agree to participate, providing the content of the complaint does not indicate there are public safety issues. In cases where a recommendation is made to use the ADR, and both parties accept the recommendation, the Chair of the Clinical Ethics Committee will formally suspend this procedure. Should resolution of the complaint not be achieved using the ADR the complaint may be referred for consideration under this procedure.

5.0.2 Anonymous complaints will not be accepted, except in exceptional circumstances where the information received can be independently substantiated and verified.

5.0.3 Should the complainant withdraw their complaint at any time under this procedure the Institute may continue the case if it is in the public interest to do so.

5.0.4 Where a complaint has already been considered and not upheld by another professional organisation and is based substantially on the same events and behaviours it will not be accepted.

5.0.5 Should a complainant be referred to another organisation no inference whatsoever should be drawn as to the validity of the concern or complaint.

5.0.6 Complaints will not be accepted under this procedure should the complainant not give permission to disclose their identity to the member complained against.

5.0.7 Excepting clause 5.0.2, complaints will not be accepted under this procedure should the complainant decline to submit a signed Release of Confidential Information form.

5.0.8 In every event the Metanoia Institute confirms its commitment to the seriousness of all complaints procedures and is aware of the inevitability of emotional distress and potential for harm to the parties concerned. The Metanoia Institute is committed to proceed with due care and diligence and endeavours to process all complaints from initial contact to resolution as quickly as is practicable.

6.0 The Complaints procedure outlined in this document will be managed and overseen, and reviewed from time to time, by the Metanoia Institute Clinical Ethics Committee. The Clinical Ethics Committee is responsible and reports to the Executive. Upon receipt of a complaint the Clinical Ethics Committee will

appoint a Case Officer whose responsibility is to maintain an overview of the procedure and ensure that due regard is paid to proper process.

6.0.1 The Case Officer may be any senior member of the Metanoia Institute, including members of the Clinical Ethics Committee, but they will not take an active part in the investigation of the complaint, nor the deliberations surrounding it. Their role is to ensure due process is followed and to be available for consultation by all parties on questions of procedure.

6.1 During any period of absence by the Chair another member of the Clinical Ethics Committee will be appointed to act on their behalf.

6.2 The Institute reserve the right to seek legal advice concerning a complaint and/or appoint a solicitor to act on its behalf.

6.3 Should any conflict of interest arise for any senior member of the Institute, any external senior practitioner or any other professional person approached to deal with a concern or complaint under this procedure they are required to recuse themselves at the outset.

6.4 The Clinical Ethics Committee reserve the right to co-opt senior members of the Institute, or external senior practitioners at any time under this procedure.

6.5 The Chair of the Clinical Ethics Committee reserves the right to suspend proceedings under this procedure in the event of legal proceedings.

7.0 All records relating to matters referred to in this document will be confidentially retained for a period of seven years.

8.0 The Metanoia Institute will not be responsible for any expenses incurred by either, or any, party to a concern or complaint, and cannot require one party to reimburse another party's costs.

9.0 Correspondence relating to matters referred to in this document may be digital and sent by email or, if by post, by recorded delivery.

10.0 The Metanoia Institute expects all parties involved in a complaint to behave with due regard to process and professional decorum.

10.1 Both parties to the complaint are required to comply with the implementation of this procedure. Failure to do so may result in the termination of proceedings or action under the Institute's Student Conduct and Discipline Policy.

10.2 The complainant and the member complained against are required to refrain from any contact with each other during the process.

10.3 Both parties are required to refrain from using abusive behaviour towards anyone, including members of the Clinical Ethics Committee, any other member of the Institute, staff and visitors to the Institute's premises. This includes contact by any other communication medium. Should this requirement not be observed by the complainant the proceedings may be terminated. Should this requirement not be observed by the member complained against they may be subject to action under the Institute's Student Conduct and Discipline Policy.

11.0 The following conditions will apply to the form of submission of complaint. In all events, if necessary, the Case Officer may be consulted for assistance by any party in order to comply with the conditions.

11.1 Complaints must be in writing. This can be emailed as an attachment to the Chair of the Clinical Ethics Committee, or marked "Private and Confidential" and sent by recorded delivery to the Chair of the Clinical Ethics Committee, at the Metanoia Institute office at 13, North Common Road, Ealing, London, W5 2QB. Written acknowledgement will be sent out within one week of receipt, outside of usual holiday periods.

11.2 In submitting the complaint in writing the Clinical and Ethics Committee would ask that the complainant outline what efforts, if any, have been made to resolve the matter prior to the complaint. It would also be helpful if the complainant could state why such means did not resolve the matter to their satisfaction.

11.3 The complaint must include a clear and detailed account of the events and behaviour being complained about, including dates, and include all supporting evidence. This may include reference to the Institute's Code of Clinical Ethics and Professional Conduct or the equivalent Codes in force at the time the events took place.

11.4 The member complained against is named, is a current student member of the Institute, or was a student member of the Institute at time of the events described in the complaint and is now a graduate member.

11.5 The complaint is dated and signed, and includes a signed and dated Release of Confidential Information form which is available from the administrator's office as clause 11.1

11.6 The complaint is within the remit of the Institute's Complaints and Professional Conduct Procedure.

11.7 Should the complaint not satisfy the conditions for acceptance the Chair of the Clinical Ethics Committee will write to the complainant stating the reason(s) why the complaint cannot be considered.

12.0 On receipt of the written complaint the Chair of the Clinical Ethics Committee will be informed who will inform the Head of Faculty of the relevant course of the existence of the complaint. They will not at this stage inform the Head of Faculty of the content of the complaint unless immediate and credible harm would be likely in the event of not passing on the details. The Chair of the Clinical Ethics Committee will also appoint a Case Officer, unless they intend to carry out the role themselves.

12.1 The member complained against will be supplied with a copy of the complaint and all supporting evidence, and details of the procedure to follow. They are not required to respond at this stage.

13.0 The Chair of the Clinical Ethics Committee will appoint an Enquiry and Assessment Panel.

13.1 The Enquiry and Assessment Panel will be appointed within 14 days of the receipt of the complaint.

13.2 The Enquiry and Assessment Panel will consist of three persons, including at least one member of the Clinical Ethics Committee and one person representing the student member's modality.

13.3 The Panel will begin to consider the complaint within 21 days of receipt.

13.4 Further information and/or clarification may be requested from the complainant.

13.5 The member will be asked to respond to the complaint within 28 days of receipt of the request. The complainant will receive a copy of the response.

13.6 Further information may be requested from the complainant and/or the member complained against, and copies will be supplied to the other party. The complainant and/or the member complained against may be invited for interview.

14.0 The Enquiry and Assessment panel will consider the evidence before them and, on the basis of this evidence and applying a reasonable prospect test will decide whether or not there is sufficient evidence of unethical conduct and/or impaired fitness to practice.

14.0.1 Unethical conduct will be tested against the published Metanoia Institute's ethical codes and against behaviour that would be seen as ethically acceptable to a group of professional peers. Unethical conduct refers to conduct which falls outside the

ethical standards practitioners are expected to maintain. This may, for example, include exploitation of clients in any way, failure to maintain professional boundaries, failure to provide an adequate service, failure to work within limits of competence, breaches of confidentiality and making false claims in regard to services offered and advertised and/or qualifications. Unethical conduct also includes criminal convictions directly relevant to clinical practice, using behaviours which are abusive, discriminatory or detrimental to clients and colleagues, and/or undermine the trust clients and members of the public place in practitioners and are entitled to rely on.

14.0.2 Impaired fitness to practice will be tested against the published Metanoia Institute's ethical codes and against competence that would be seen as satisfactory to a group of professional peers. Impaired fitness to practice refers to the inability of the practitioner to provide a service which is competent, safe, and meets the needs of the client to a satisfactory standard over time. This may, for example, be because of ill health, including lack of self-care and failure/inability to seek medical care or other appropriate assistance, or because of lack of skills and knowledge, poor clinical judgement, failure to seek sufficient confidential supervision and consultation, or failure to maintain sufficient on-going professional development to keep up to date with current practice and legislation.

14.1 Should there be insufficient evidence of unethical conduct and/or impaired fitness to practice the Panel will dismiss the complaint and inform both parties of the decision within 7 days. A statement of reasons why the complaint has not been upheld will be provided to both parties.

14.2 Should sufficient evidence of unethical conduct and/or impaired fitness to practice have been presented the case will be upheld when the following sanctions apply:

14.2.1 A written apology

14.2.2 A written warning.

14.2.3 A requirement that the student member write a report of what they have learned from the experience, with a date for completion.

14.2.4 Further training in a specified area(s), with a date for completion.

14.2.5 Further supervision and/or personal therapy for a minimum length of time, identifying the goals to be achieved.

15.0 The Panel will write a report of the findings. Both parties will be sent a copy of the report. The Panel will also send a copy of the report to the appropriate Head of Faculty who will decide how successful compliance will be achieved and monitored. All reports will be distributed and delivered within 21 days of the conclusion of the Enquiry and Assessment Panel's deliberations.

16.0 The Chair of the Clinical Ethics Committee will be responsible for ensuring the implementation of sanctions, after the time for appeal has lapsed, or the appeal has been heard. The Chair of the Clinical Ethics Committee will also inform the Executive Committee and the Board of Trustees of the outcome of the complaints process.

17.0 In accordance with contemporary practice in professional complaints procedures this document makes allowance for consensual disposal following the reporting stage of the Enquiry and Assessment panel.

17.1 Consensual disposal may be applied for by the member complained against where the following conditions apply:

17.1.1 Where there is little or no disagreement to the facts of the complaint.

17.1.2 The member complained against and the complainant agree and submit to the finding and sanctions of the Enquiry and Assessment Panel.

17.1.3 That to continue to an Adjudication Panel would not be in the interests of the parties concerned nor of the public.

17.2 Where consensual disposal is agreed by all parties to be an appropriate and acceptable resolution and the member complained against agrees to accept the likely sanctions an Adjudication Panel may impose, the case will be upheld and one of the following sanctions will apply:

17.2.1 Consensual conditions of practice for a specified period of time.

17.2.2 Consensual suspension for a maximum period of two years, accompanied by further training and/or personal therapy.

17.2.3 Consensual termination of the training contract and/or membership of the Institute.

18.0 Where necessary and appropriate the UKCP, BPS, HCPC, and other relevant parties will be informed of the outcome. Where the outcome may be published in relevant professional journals or on websites, all parties involved in the complaint procedure will be informed of this.

19.0 Where the complainant or the member complained against wishes to appeal the findings of the Enquiry and Assessment Panel they may do so, in writing to the Chair of the Clinical Ethics Committee within 14 days of receipt of the findings.

19.1 In appealing the finding, the complainant or the member complained against will be asked to demonstrate good cause and must submit information which would support their appeal. The Chair of the Clinical Ethics Committee will, in consultation with two other persons not previously part of the original Enquiry and Assessment Panel, decide whether there are adequate grounds for granting permission to appeal.

19.2 Permission to appeal can only be granted in the following circumstances:

19.2.1 New evidence has come to light which was not available at the time of the Enquiry and Assessment Panel,

19.2.2 The decision made was against the weight of evidence

19.2.3 It is demonstrated that due process, as defined within this document, has not reasonably and diligently been adhered to.

19.3 If permission to appeal is granted an external professional person will be appointed to consider the appeal. The decision will be final and the possible outcomes of the appeal will be:

19.3.1 Confirmation of the original findings of the Enquiry and Assessment Panel, with or without modification.

19.3.2 Rejection of the original findings of the Enquiry and Assessment Panel and recommendations for alternative resolution.

19.3.3 A recommendation to proceed to Adjudication.

20.0 Both parties will be sent a copy of the appeal report. The external appeal report will also be sent to the appropriate Head of Faculty and the Executive. All reports will be distributed and delivered within 21 days of the conclusion of the appeal process.

21.0 In the event that the Enquiry and Assessment Panel, and appeal where present, fails to reach a resolution upon which all parties can agree and accept the Chair of the Clinical Ethics Committee will convene an Adjudication Panel. Additionally, where the Enquiry and Assessment Panel consider the complaint to be of such a serious nature that there is a reasonable prospect of conditions of practice, suspension or termination of membership being imposed they may recommend immediate referral to the Adjudication Panel. The purpose of the adjudication panel is to review the findings and procedures of the Enquiry and Assessment Panel, seek evidence and clarification if necessary and to reach a

conclusion which will be authoritative and binding upon the parties concerned. The Adjudication Panel will proceed formally with an investigation and hearing to which all parties will be invited.

22.0 The Chair of Clinical Ethics Committee will appoint an Adjudication Panel of at least three persons including one lay person and one person representing the modality of the student member complained against.

> 22.1 Both parties will be notified not less than 28 days in advance of the time, date and venue for the hearing.
>
> 22.2 The Adjudication Panel will receive the documentation not less than 28 days prior to the hearing.
>
> 22.3 Written submissions from both parties must be received by the Chair of the Ethics Committee not less than 28 days before the Hearing. The written submissions will be circulated to members of the Adjudication Panel and both parties.
>
> 22.4 If either or both parties wish to call witnesses they must notify the Chair of the Clinical Ethics Committee in writing not less than 28 days prior to the Hearing. Only witnesses who supplied written statements in the original submissions can be called. The Chair of the Adjudication Panel will decide whether the presence of any witnesses is necessary not less than 7 days prior to the Hearing. Witnesses may be questioned by the Panel and by either party to the complaint, or those representing them.
>
> 22.5 Both the complainant and the member complained against must attend the Hearing. If either the complainant or the member complained against fails to attend, or refuses to attend, the Chair may decide to proceed with the Hearing or adjourn the Hearing to a later date. If the member complained against fails to attend without reasonable cause they may be liable to termination of the training contract and/or termination of membership.
>
> 22.6 The complainant will be represented by a senior member of the Institute or an external person. The member complained against has the right to be represented by an advisor or a legally qualified person, at the member's cost.
>
> 22.7 The Adjudication Panel have the right to invite a legally qualified person to be present at the Hearing to advise them.
>
> 22.8 Should new evidence be presented at the Hearing the Chair of the Adjudication Panel will decide whether to adjourn the Hearing to a later date, or to continue with the Hearing.
>
> 22.9 The Adjudication Panel will examine all the written and oral evidence presented by both parties, and decide whether the complaint is upheld or not. If the complaint is upheld, the Panel will decide which sanctions should be imposed.
>
> 22.10 The Adjudication Panel will make a report of their findings within 21 days of the Hearing. Both parties will be sent a copy of the report.
>
> 22.11 If the complaint is upheld, the Chair of the Clinical Ethics Committee will implement the sanctions after the period of time has elapsed for an application to appeal to be received, or, after the appeal has been heard. The Executive Committee and the Board of Trustees will be informed.

23.0 This document makes explicit the possibility of an appeal of the findings of the Adjudication Panel.

> 23.1 Should either party wish to make an application to appeal, this must be made, in writing, and sent to the Chair of the Clinical Ethics Committee within four weeks of receipt of the Adjudication Panel's report of the findings. The Chair of the Clinical Ethics Committee will appoint an external person to consider the application to appeal, and decide whether or not there are adequate grounds to grant leave to appeal.

23.2 The party making the appeal will be asked to demonstrate good cause and must submit information which would support their appeal. Permission to appeal will only be granted if:

23.2.1 New evidence has come to light which was not available at the time of the Adjudication Panel.

23.2.2 There have been one or more significant departures from the procedures, as outlined in this document, in dealing with the original complaint.

23.2.3 One of the parties is able to provide good grounds for arguing that the recommended sanctions were too severe or too lenient.

23.3 The Chair of the Clinical Ethics Committee will inform both parties of the decision of whether or not an appeal will be heard under the criteria outlined in clause 37.2 of this document.

24.0 Where an appeal is deemed appropriate and is allowed under the criteria outlined in clause 23.2 of this document the Chair of the Clinical Ethics Committee will appoint an Appeals Panel of three new persons, including one lay person and one person representing the student member's modality.

24.1 The Appeal Panel will receive all the documentation not less than 28 days prior to the Hearing.

24.2 Both parties will be given not less than 28 days' notice of procedure to be followed. In general the appeal procedure will be identical to the original Adjudication Panel procedure although the appeal panel will be aware that their deliberations are restricted to the criteria for appeal outlined in clause 37.2 of this document.

24.3 The Appeal Panel will consider the appeal on the oral and/or written evidence presented to them.

24.4 The Appeal Panel will make a report of their conclusions and recommendations within 21 days of the Hearing. Copies of the report will be sent to both parties and the Chair of the Clinical Ethics Committee will implement the decision of the Appeals Panel, which will be final. The Executive Committee and the Board of Trustees will be informed.

25.0 Where necessary and appropriate the UKCP, BPS, HCPC, and other relevant parties will be informed of the outcome. Where the outcome may be published in relevant professional journals or on websites, all parties involved in the complaint procedure will be informed of this.

26.0 In the event that the final resolution of the Complaints and Professional Conduct procedure results in termination of membership of the Metanoia Institute for the member complained against this document makes explicit allowance for reinstatement of that membership in some circumstances.

26.1 Members who have has their membership terminated may make an application to the Chair of the Clinical Ethics Committee for restoration of membership not less than two years following the date on which such a sanction was imposed, and no earlier than any stipulation concerning minimum length of termination recommended by the Adjudication Panel or the Appeals Panel.

26.2 The Chair of the Clinical Ethics Committee will, in consultation with two other members of the Committee, decide whether there is an adequate case for granting permission to have the matter heard by a Re-Admissions Panel.

26.3 Should permission to have the matter heard by a Re-Admissions Panel be granted the Chair of the Clinical Ethics Committee will convene a Panel of three senior members of the Institute who have had no prior involvement in the case.

26.4 The Re-Admissions Panel will meet to consider the matter on the oral and/or written evidence presented to them. The person making the application for re-admission will be required to attend this Panel hearing.

26.5 The Re-Admissions Panel will report their conclusions and recommendations to the Clinical Ethics Committee. The Chair of the Clinical Ethics Committee will implement the decision of the Re-Admissions Panel, which will be final. The Executive and the Board of Trustees will be informed of the outcome of the Re-Admissions Hearing.

26.6 Names of those restored to membership of the Institute will be reported to the relevant governing bodies and organisations within 28 days.

SECTION TWO: GUIDELINES

Introduction

These guidelines aim to provide explanations and guidance on application of various aspects of the Code. All the published guidelines will be included in the annual review of this Handbook. Additional guidelines will be published as they are completed so there will be ongoing additions to this section of the handbook. Accordingly, the numbering of the contents page will change as new additions are included.

Clinical Guidelines: Gender, Sexual and Relationship Diversity

Practitioners agree to respect the gender, sexual and relationship diverse identities and consensual practices of their clients and avoid offering or providing any kind of therapy or intervention which aims to alter or suppress these identities and practices. This includes therapies or interventions which aim to alter or eliminate same sex attraction or gender identity, also known by other terms such as conversion or reparative therapy

(Clause 1.5, The Code of Clinical Ethics and Conduct)

Please note: a) For the purposes of this document the term 'gender, sexuality, and relationship (GSRD) diverse ' broadly refers to those who do not identify as heterosexual, monogamous or cisgender (those who's gender identity corresponds with the gender assigned at birth). This term applies, but is not restricted, to those who identify as asexual, agender, non-binary gender, pansexual and includes those who identify as lesbian, gay, bisexual and transgender. The term also applies to the consensual expressions of GSRD identities including BDSM and non-monogamous relationship (sexual and non-sexual) configurations. The term also recognises that people have several/multiple overlapping identities, known as intersecting identities, e.g. a woman who is cisgender and asexual. b) The term 'intersecting identities' also includes many other forms of diversity e.g. cultural, ethnic, class. c) For ease of reading, therapies which aim to alter or eliminate same sex attraction will be referred to throughout as 'conversion therapy' although 'reparative therapy', 'reorientation therapy' and 'sexual orientation change efforts (SOCE)' and other terms are also in common use.

Introduction

The aim of these guidelines is to support competent and culturally safe practice with gender, sexuality and relationship diverse people and consensual expressions of their identities, to encourage practitioners to oppose and challenge discrimination about GSRD identities and practices (when it is safe and appropriate to do so), and to draw attention to some of the issues which are key to good practice.

Considerations for practitioners

1. GSRD identities and consensual practices are now recognised as a normal part of human diversity and this is the understanding from which practitioners should approach working with GSRD clients. Practitioners are expected to work with GSRD clients from a position of respect and sensitivity, and to demonstrate an affirmative and inclusive stance towards these clients.

2. Attending carefully to issues of equality, diversity and inclusion is central to effective and ethical practice with GSRD clients. Practitioners are encouraged to develop their ability to examine and explore their own attitudes and working practices in relation to gender, sexuality and relationship diverse people and consensual practices and should ensure they have sufficient informed support in place to do so e.g. supervisors, personal therapists and colleagues. Practitioners should also have an accurate understanding of the many forms and sources of oppression which affect the lives of GSRD people as well as other people in their lives. Being knowledgeable about many other aspects of diversity e.g. culture, religion, lifestyle, disability, colour, which may have significance for GSRD people, positive or negative, is also very important.

   Practitioners should also be willing to inform clients about other services or resources which offer support, as appropriate. Practitioners have a responsibility to oppose and challenge all forms of discrimination against GSRD people, when it is appropriate and safe to do so. Those who are members of faith-based groups and organisations are expected to adhere to the same ethical requirements when working with people whose gender, sexuality and relationship identities and practices are different from their own. Practitioners are advised that the use of faith and/or culture-based beliefs predicated on negative attributions and assumptions about

gender, sexuality and relationship diversities as a defence in the event of an alleged ethical breach will not be accepted.

3. Practitioners are expected to engage in continuing professional and personal development about the diversity of gender, sexuality and relationship identities and practices to ensure their work with clients is supported by accurate, unbiased information and understanding. Practitioners are encouraged to proactively seek out information from alternative sources e.g. internet communities/resources and organisations which offer services as well as suitable professional literature. At the same time, practitioners are expected to remain alert to negative attributions and assumptions about GSRD identities and practices embedded in some professional literature. Practitioners must not use any approach with GSRD clients which regards them, or consensual expressions of their identities, as wrong, unnatural or pathological.

   Practitioners are asked not to rely on their clients to educate them about GSRD issues. Practitioners are expected to reflect on their own relationships, gender and sexuality - both as part of their work with clients and as a planned part of their ongoing professional and personal development – and particularly when a client's GSRD identities differ from their own. As BPS Guidelines (p15) state: - "*This may be especially useful for those … whose identities and practices are not commonly questioned, such as those who are cisgender, heterosexual and/or monogamous.*".

4. Clients themselves may request some kind of conversion therapy or therapy to change or suppress their GSRD identity and/or consensual practices. In these circumstances the work with the client should include careful and sensitive exploration of pressures that may have led to the request. Practitioners should share and discuss research findings with clients which evidence the lack of effectiveness and risk of possible harm resulting from the practice of such therapies. Consideration as to how the client's GSRD identity and practices can be integrated into their lives is also part of the work. Practitioners need to be aware that the fact a client may request conversion therapy or other therapy aimed at changing or suppressing their GSRD identity and/or consensual practices will not be accepted as a defence for offering and/or practicing any such therapy in the event of an alleged ethical breach.

5. Practitioners should take care not to mistakenly attribute presenting difficulties and distress to a client's GSRD identity and consensual practices. Marginalisation and stigmatisation are much more likely to be the cause of distress rather than GSRD identities and practices themselves. In the very rare cases where some aspect of a client's GSRD identities or practices might be the cause of their distress then robust clinical reasoning is required to support such a determination and BPS Guidelines (p.6) state *"In these instances consideration should be given as to how any GSRD identity or practice could be expeditiously supported in the future."*.

   When working with clients who are experiencing uncertainty or conflict about their GSRD identity and/or practices practitioners should take care to maintain the exploratory nature of the therapeutic process rather than agree or assume any pre-determined outcome. Practitioners should also keep in mind that gender or sexuality may be fluid for some people and others may wish to avoid identity labels.

6. Practitioners are expected to carefully assess and identify the limits of their competence with GSRD identities, practices and issues. When a practitioner does not have sufficient competence or knowledge to work with a GSRD client and/or GSRD specific issues, or has difficulty working from a respectful and affirmative position, they should inform the client and take steps to make a suitable referral to another practitioner. This may involve seeking advice from supervisors or colleagues and/or referring to another professional who has specialist training. Knowingly referring any client to another practitioner, individual, organisation or group who offer and/or practice conversion therapies or interventions, or any other kind of therapy or intervention which aims to alter or suppress GSRD identities and/or consensual practices is not consistent with ethical practice.

References

BPS. (2018). *Guidelines for psychologists working with gender, sexuality and relationship diversity*. BPS.

Guidelines on the legal and ethical aspects of counselling and psychotherapy for post adoption issues

Practitioners commit to knowing and understanding current legislation on post adoption issues.

(Clause 1.7, Code of Ethics and Professional Conduct)

In 2010 legislation came into force that states that only practitioners registered as an Adoption Support Agency with Ofsted are able to offer specialist adoption services to clients when issues concerning adoption are the main concern of the client. This legislation applies to children and adults who have been adopted, their birth relatives and adopters, irrespective of how long ago the adoption may have taken place.

This is a significant legal change to the Adoption and Children Act 2002 concerning post adoption counselling, and it is important that practitioners in private practice and other work settings are aware of this to help them make informed legal and ethical choices in their work with clients to whom this legislation may apply. For the purposes of understanding this legislation the word "counselling" also applies to psychotherapy.

The following are extracts from the Counselling Directory website:

"*Approved Adoption Counselling*

In December 2010, the law changed so that only counsellors and psychotherapists registered as an adoption support agency (ASA) with Ofsted are able to offer specialist adoption services. These amendments to the Adoption and Children's Act of 2002 were designed to ensure that the one in four UK individuals affected by adoption in some way, are provided with support and services from practitioners who hold the proper qualifications and experience. The introduction of this legislation now means that any counsellor working with a client for whom any aspect of adoption is the main focus, must be registered with Ofsted (or RQIA in Northern Ireland) and subject to regular inspections.".

and

"It may be that some individuals are seeking counselling for issues they feel may be related to adoption (such as low-self esteem) but where adoption is not the key issue. In cases such as these where the entire counselling experience is not likely to revolve solely around the adoption itself, it is fine to seek help from a professional who is not an Approved Adoption Counsellor.".

The following extract is from Ofsted:

"- A counsellor would need to register as an adoption support agency if they set themselves up in business to provide an adoption-related service to adults, children or families who need counselling around adoption issues. This can include circumstances surrounding their own adoption or their child being adopted.

- If an adoption related issue only emerges after counselling is established and is not the primary concern or focus of counselling the law does not require you to register. However, it is good practice for you to seek advice from someone registered to provide adoption support services. It may be better for your client to be referred to a specialist service. If however, during the first counselling session it becomes clear that matters related to adoption is the main purpose for the counselling, you should make clear to the client their right to access adoption support services and consider referring the client to a registered adoption support agency. The law says you cannot provide counselling on adoption matters without registering or being under contract with an approved adoption support service. ".

This means that practitioners may work with clients affected by adoption when other presenting issues are the primary focus of the work but it is not lawful to accept clients when it is clear in the assessment that the primary focus of the work concerns adoption itself, unless the practitioner is registered or seeing

clients in an approved adoption service setting. The legislation and related guidance appears to lack some clarity therefore practitioners are always advised to seek consultation with Ofsted, either with the national or a local office, or a registered specialist practitioner, when uncertainties related to post adoption legislation arise with clients.

At present it is unclear how widely this legislation is known to clients for whom it may be relevant and, for that reason, we draw the attention of practitioners and their supervisors to maintaining the quality of assessments when considering whether an onwards referral may be appropriate.

When primary adoption issues emerge later on in the therapeutic relationship as the probable major focus of the work going forwards the ethical and legal dimensions need to be addressed carefully. This particular dilemma is expressed succinctly by Mitchels (2015), who states:- *"Good practice requires that we work within the limits of our qualifications and skills, and also that we offer the client the best possible support. We may have built up a good rapport with the client and it could be seen as a risk to the client's therapeutic progress to change therapists at this stage. Ethical practice also requires us to work within the law.".*

In these circumstances practitioners, in consultation with their supervisors and Ofsted, may reach a professional view about the most appropriate way forwards for themselves and client to take, which may include continuing to work together. It is also wise to seek legal advice from professional insurers, and practitioners are advised to carefully document the process of the ethical/legal decision making.

Mitchels draws attention to the importance of the client's needs being met, and the practitioners working within the limits of their skills and knowledge:- *"If the counsellor decides, after the appropriate supervisory and legal and/or Ofsted consultations, that in the particular circumstances they have the necessary knowledge and skill to meet the client's needs and that it would be of no benefit to the client to refer them on, then it is possible that they could continue to provide counselling for this client, with support and advice from an adoption support agency or adoption agency.".*

It is good practice for practitioners to provide clients with information about the legal position on post adoption counselling in situations when this legislation applies, to discuss with the client the reason for any possible/potential referral and to manage any onward referral with sensitivity to the circumstances of the original adoption situation.

This is a complex legal and ethical area, and it is recommended that practitioners read the detailed and useful guidance by Mitchels, which is a BACP publication and available on the BACP website.

BACP, in Therapy Today, (Dec 2019) state:-

"In **Wales**, similar principles apply, and registration is with the Care and Social Services Inspectorate in Wales (CSSIW), and you should contact CSSIW, your local authority, or a local registered adoption support agency if you need help and advice.

In **Northern Ireland**, registration is currently with the Department of Health through the Regulation and Quality Improvement Authority (RQIA). However, the law here is changing and practitioners are advised to take legal advice and/or check with the Department of Health or the RQIA to determine any conditions required to provide the adoption-related counselling services you wish to offer.

In **Scotland**, you should obtain legal advice and/or check with your local authority to determine any conditions required before providing the adoption-related counselling services you wish to offer.".

Additional guidance for Northern Ireland, Wales and Scotland is available for BACP members on the BACP website.

References

Ofsted. (2015, reviewed 2019). Introduction to adoption support agencies. A children's social care guide to registration. Ofsted.

Counselling Directory. (year of publication unknown). Adoption. Counselling Directory. <counselling-directory.org.uk/adoption/html>.

Mitchels, B., (2015, reviewed 2017). Adoption Law in England within the Counselling Professions. Good Practice in Action 003. Legal resource. BACP.

Questions and answers: "Adoption. Is it necessary to register to provide counselling on adoption issues?". Therapy Today, December 2019 Volume 20 Issue 10

Clinical and Practice Guidelines: Social Media and Digital Communications

Practitioners commit to ensuring, as far as reasonably possible, that they manage their personal and professional social media/internet-based activities in ways that are not detrimental to the best interests of their clients. In particular, practitioners agree to respect the privacy of clients, protect client confidentiality, and preserve the boundaries of the professional relationship.

(Clause 1.10, Code of Clinical Ethics and Professional Conduct)

Practitioners agree to establish informed agreements with clients about any mutually agreed use of internet based activities and/or digital communications in the work together, and to discuss with clients the management of risks, as appropriate. Practitioners are advised to have a written policy on internet based activities/digital communications included in their written contracts with clients and/or professional website, if appropriate.

(Clause 9.4, Code of Clinical Ethics and Professional Conduct)

Introduction

Most practitioners use social media and digital communications to some extent in their professional lives and there are undoubtedly many benefits to doing so e.g. accessing online CPD, professional networking, sharing information about services with the public and more options for communicating with clients. These technologies also bring with them different ethical difficulties and limitations for both practitioners and clients.

It is important for practitioners to assess the possible effects, both positive and negative, of using social media and digital communications on their relationships with clients and make decisions about how to work with them. In particular, practitioners need to take steps to prevent known risks especially to privacy, confidentiality and boundaries, as far as reasonably possible, and keep a watchful eye for later necessary adjustments in the face of rapid developments in technology. It is also important for practitioners to think about how they might deal with situations that may arise accidentally and could not have been foreseen or averted.

Please note:- practitioners are expected to familiarise themselves with the Institutes "Social Media Policy for Students" which is a key policy document and should be read in conjunction with these guidelines.

1. Competence

Practitioners should be knowledgeable about the benefits and limitations of using social and digital technologies in the work with their clients especially when the work takes place outside the face to face consulting room setting. They should ensure they have the necessary skills and knowledge in the use of all the technologies they use with their clients and colleagues in order to provide a reliable and satisfactory service. Back up methods of communicating should be in place if the method(s) normally used are not available for any reason and practitioners should have in place technical support which "…respects the confidentiality of the work being undertaken." (Bond, 2015, p.6).

2. Protecting client confidentiality

Careful thought needs to be given to the protection of client confidentiality especially as social and digital technology can never be completely secure. Practitioners are expected to maintain a high level of security and to keep up to date with new developments, especially in the technologies they use to

communicate with clients and colleagues. This includes using encrypted systems when possible and making sure that other internet security systems such as firewalls, virus protection and passwords are updated and/or changed as often as is necessary to prevent unauthorised access to client material by third parties.

Where audio–visual technology is being used e.g. Skype or Facetime, practitioners should ensure, as far as reasonably possible, that the communications with clients are not observed or overheard, or can be interrupted (emergencies excepted) at either side by a third person(s). Sufficient information about these potential risks should be provided to clients, as appropriate, to ensure they are able to take care of security and confidentiality on their side. Email systems used to discuss or convey confidential information should be encrypted.

Clients may inadvertently breach confidentiality themselves by e.g. following and participating in the Twitter account or contributing comments on the blog of the practitioner. Information should be provided to clients about these risks.

It is not consistent with ethical practice for any information confidential to the relationship with the client to be posted onto the internet without the client's consent or knowledge, unless the informed consent of the client has been obtained and other ethical requirements about publishing have been met.

3. Maintaining boundaries

The personal and professional lives of practitioners should be kept as separate as possible to avoid the blurring of boundaries, and practitioners should consider setting up separate professional accounts and ensure their personal social media accounts are kept private.

It is not appropriate to accept 'friend' invitations from clients or former clients on social media accounts nor is it appropriate to offer them and clients should be provided with this information.

Establishing agreements at the outset of the professional relationship with clients about practice/business arrangements e.g. appointment times, cancellation policy, alternative arrangements should there be a technology failure and so on are also a part of maintaining clear professional boundaries.

4. Online searches and client privacy

When practitioners are considering whether or not to search for or view online information about clients, including prospective or former clients, they need to be clear about their reasons for doing so before taking action. Although uploaded information is in the public domain this does not mean that all searches are ethical. There are occasions when the practitioner and client may agree to view online information together in the session as part of the therapeutic process, or the practitioner may agree with the client to view online information outside of the sessions. In these specific situations' practitioners are advised to consider whether viewing the information would be in the client's best interests, and if material is viewed the prior informed consent of the client is needed.

There are also emergency situations where it is necessary to breach confidentiality because of threat of possible serious harm to the client or others and it may be ethically justifiable to search for information online when such action may help resolve the crisis. However, in the absence of either the client's knowledge and consent or an emergency situation searches should not be conducted on clients or those connected to them. Information acquired as a result of a secret search may subtly, or not so subtly, affect the relationship between the practitioner and client, depending on the significance and nature of the material contained in the results. Secret searches lack respect for client privacy and impair client autonomy by limiting their right to choose what information they wish to disclose in the therapeutic process and when, and such searches are not consistent with ethical practice.

5. Online searches by clients and practitioner privacy

Information is easily accessible on the internet about most people and many clients will have already conducted some kind of search for information about the practitioner before the first meeting. Some search results may well include personal information about the practitioner – and possibly those close to them too. For that reason, it may be useful for practitioners to carry out a search on themselves from time to time so they have a reasonable idea of what information is available online about them and they are prepared to deal with any related queries clients may bring. It is normally beneficial to the work together for clients to refrain from (further) searches about the practitioner and this information should be part of the practitioner's policy.

Because of the inevitable limits to privacy on the internet practitioners are asked to think very carefully about what personal information and images they upload about themselves, their families and friends - with an eye to potential safety issues as well. Material that has ever been posted on the internet can still be found by those who wish to do so even after it has been deleted, and the use of privacy settings cannot reliably prevent material from becoming widely accessible, especially as material can easily be replicated and forwarded by others. Nonetheless, it is recommended that practitioners check their privacy settings from time to time, particularly since personal settings may be deleted by service providers.

6. Accidental access to information and unintentional contact

Anyone who uses the internet could accidentally come across information about another individual they know, and there are many ways this could come about. For example, a practitioner may search for a service online and a client could appear in the results or information about a client may have been posted on a social media account such as Facebook by a third party. Accidental contact can also occur when, for example, a client responds to a practitioner's eBay listing, or vice versa, where the identities of one or both people may quickly become clear. Unintentional compromises to privacy and confidentiality may also be created by clients themselves, for example, clients disclosing their identity and relationship to a practitioner by following and actively participating in the practitioner's Twitter account.

When situations arise unintentionally and without the knowledge of the client practitioners are asked to think through whether or not the significance and nature of the information that has come to light indicates that it should be disclosed and/or discussed with the client concerned. Unplanned online contact that the client knows about should at least be acknowledged and some encounters may need to become part of the work together. Accidental acquisition of professional information is probably less likely to pose difficulties than personal information because most professional information has been posted with the intention of being widely viewed.

7. Vulnerable clients and emergencies

Practitioners should be aware that there are limitations to the kind of services that can be offered or provided for clients online. Bond (2015, p.9) draws attention to the importance of assessing whether it is even appropriate to work online with a client who may be vulnerable in some way and says:- "…it is good practice to provide an assessment of their suitability for the services being provided that includes their suitability for working online.". Careful assessment is essential to ensure that vulnerable clients are not put into a situation that may be beyond their present personal resources and, consequently, is unlikely to be in their best interests.

Bond also highlights the responsibility of practitioners who work online to consider how they will provide appropriate and timely support to clients "…who become so distressed and disturbed that they require additional services or support from healthcare providers or their social network."(2015, p9), and goes

on to say:- "It is good practice to have discussed with clients how they might be assisted before such a situation arises.".

All practitioners who work online need to have in place assistance and resources for their clients in the event of an emergency and this information should be included in contracts and/or policies for clients.

8. Emails and text messages

Emails are retained in the logs of service providers, are vulnerable to viruses and unintended forwarding or replication. Text messaging lacks context and can easily lead to unnecessary misunderstandings. Email and texts are best kept for dealing with simple business matters such as arranging appointments, or notice of a delay but encrypted systems should always be used by practitioners who work with clients by email or when confidential information is being conveyed in another professional context e.g. supervision. Otherwise, clients should be informed that when it may be necessary to communicate sensitive and confidential material outside of the arranged sessions it is probably safer to do this by telephone - otherwise this material is best kept within the agreed sessions.

9. Supervision

In the event of a serious ethical difficulty posed directly by, or involving, some aspect of technology practitioners are advised to seek supervision. As Bond points out it is also good practice to receive some supervision using the same technology that a practitioner may be using for working with clients to "…experience the strengths and limitations of the chosen way of working." (2015, p.12).

10. Agreements and policies

It is good practice for practitioners to have a written policy about the use of social media/digital communications for clients which provides sufficient information about both the possible known risks (as appropriate) and how practitioners and clients can deal with them. Even practitioners who make little use of social media/digital communications in their work could consider having a short piece providing information about e.g. emails, text messaging and relevant aspects of privacy and confidentiality included in their written/online contracts. As a minimum practitioners are expected to discuss these issues with clients, as appropriate to the client and the setting, and verbal agreements should be documented.

For practitioners who make more use of social media/digital communications in their professional lives e.g. use audio visual technology such as Skype or Facetime, and/or have a significant online presence e.g., a Twitter account or blog, it is probably now essential to have a written/online policy which can be discussed and clarified with clients as appropriate.

Not all potential difficulties of using social and digital technologies can be foreseen or averted but practitioners are expected to do their best to prevent known risks which may be detrimental to their work with clients as far as reasonably possible and to deal thoughtfully with the unexpected.

11. Other ethical considerations

In general, practitioners are expected to use online and digital technology responsibly and to communicate with clients and colleagues in a professional manner. The accepted values of the professions of psychotherapy and counselling, and ethical principles are the starting points from which to think through knotty dilemmas and potential difficulties.

Practitioners are respectfully reminded to always give careful thought to what they are posting online, regardless of whether they are posting in their professional or personal capacity, and regardless of whether the information is posted on a professional or personal site. It is best to assume that anything

that has ever been uploaded onto the internet can be found by those who wish to do so even after it has been deleted, and important to keep in mind that material can easily be replicated and passed on by others, including material on sites where privacy settings are used. Practitioners are also asked to give the same thoughtful attention to communications in emails and other electronic messages.

The immediacy and ease of use of online and digital technologies make it much easier to get caught up or involved in behaviours which constitute professional misconduct e.g posting offensive or improper material or engaging in inappropriate conversations/contact. Posting derogatory remarks or inferences online about individuals and organisations, on professional or personal accounts, is not consistent with ethical practice either and practitioners should be aware that defamation legislation applies to the internet.

Practitioners should refrain from posting any comments or identifiable information about any client anywhere online and are asked to have an eye to possible alternative understandings by clients of online material they have posted. The only exceptions to posting any potentially identifiable information about clients online are planned professional publications where the matter has already been discussed with the client concerned and their consent has been obtained.

Practitioners also need to ensure they are compliant with current data protection legislation (GDPR) in relation to information about clients acquired through digital means and that their insurance cover is adequate for any services they provide online.

Trainees working in placements and other practitioners working in organisational settings are expected to observe the particular digital policies of the organisation concerned.

Acknowledgement

These guidelines are mostly based on the work of Dr Aaron Balick and the Institute acknowledges his contribution. Dr Balick's Digital Policy, available on his website, is a helpful resource for practitioners, particularly those who have more than a minimal professional presence online.

Reference

Bond, T. (2015). "Working Online", Good Practice in Action 047. BACP.

Clinical and Practice Guidelines – Advertising/promotional material.

Practitioners commit to making accurate and honest descriptive statements about the services they offer in any advertising material and agree to refrain from making false claims or misleading statements about their experience, qualifications and/or trainee status, and the type of service they offer. Practitioners agree not to claim or imply qualifications they do not possess. Misrepresentation of qualifications and/or trainee status, and experience may have serious legal implications under current legislation governing standards in commercial advertising and may jeopardise practitioners' present and future standing with the Metanoia Institute and other professional bodies.

(Clause 11.1, The Code of Clinical Ethics and Professional Conduct)

Members of the public must be reasonably informed about the relevance of qualifications to the practise of counselling/psychotherapy/counselling psychology.

(Clause 11.2, The Code of Clinical Ethics and Professional Conduct)

Practitioners agree to refrain from soliciting or using testimonials from clients, or former clients, for the purposes of advertising.

(Clause 11.3, The Code of Clinical Ethics and Professional Conduct)

Practitioners agree to refrain from making comparative statements or any statement which implies the services being advertised are more effective than those provided by other schools, modalities, organisations or practitioners.

(Clause 11.4, Code of Clinical Ethics and Professional Conduct)

Trainee practitioners agree to review any advertising material with their course tutor(s) and/or supervisor(s) prior to public distribution/publication, and to engage in subsequent reviews, as appropriate.

(Clause 11.5, Code of Clinical Ethics and Professional Conduct)

Introduction

The aim of these guidelines is to support professional, honest and accurate advertising so that prospective clients and others may rely on the information presented in advertising material to make reasonably informed decisions. Advertising material must comply with current legislation governing both advertising standards and consumer protection as well as meeting the required profession specific ethical standards. These legal and ethical requirements are complementary and they apply to all other published promotional material even when the material may not be specifically intended for the benefit of prospective clients (for example, networking platforms such as LinkedIn) and may also be relevant to material posted on the internet by students who are not yet working with clients.

Please note:- since most advertising/promotional material is posted on the internet practitioners are expected to familiarize themselves with both the Institute's "Social Media Policy for Students" which is a key policy document and the "Clinical and Practice Guidelines: Social Media and Digital Communications" which is contained in this Handbook.

Considerations for practitioners

1. Best practice indicates that practitioners should maintain a thoughtful and considered approach to writing advertising/promotional material and that the material should be considered through the lens of the reader as a means of evaluating accuracy - especially material that is intended for potential clients and/or those who may refer them.

   All information included in advertising and promotional material must be clear, accurate and honest and it is very important that all objective claims can be verified with the relevant documentation if necessary or when requested to do so. This includes qualifications, professional affiliations, training, trainee status (as applicable), knowledge, skills, education and experience.

   Sufficient proportionate information should be included in order for prospective clients and others e.g., those who wish to make a referral, to make informed decisions. As a minimum this would cover qualifications and/or trainee status (as applicable), the client group(s) with whom the practitioner is qualified and/or in training to work with and the type of service(s) offered. Practitioners should also

ensure that important facts are not omitted since these may affect how the reader interprets the material.

2. Practitioners and trainee practitioners are asked to avoid including anything in advertising material which states or suggests that they have specific expertise in working with children and young people under the age of 18 in private practice unless they have already completed a recognised training course and achieved the relevant qualifications necessary to do so. Placements with organisations who provide services to children and young people can be part of training course requirements and offer trainees valuable opportunities to experience working with this particular group of clients that, for those trainees who may wish to continue working with children and young people in the longer term, may later shape professional career decisions.

3. The relevance of stated qualifications/post nominal letters after a name to the practice of counselling, psychotherapy and counselling psychology of stated qualifications should be clear to the reader. Whilst some qualifications/post nominals may be self-explanatory in the context in which they are used some may require the practitioner to provide additional explanation and clarification. This also means that when practitioners wish to include qualifications and/or other information that is not directly related to counselling, psychotherapy or counselling psychology they should ensure that the particular significance of all such information is explicit and explained in a way that makes misunderstandings unlikely.

4. Students are expected to be familiar with the appropriate use of the word “trainee”, which is part of Institute policy (point 8 under “Guidance for Use” in the Code of Clinical Ethics and Professional Conduct), and to ensure that their trainee status is included in all advertising and promotional material, as applicable. Those who hold trainee membership of UKCP are contractually obliged to use the words “UKCP trainee therapist” on all advertising and promotional material. Students who are not yet working with clients but have, for example, online networking material are advised that the ethical and legal requirements concerning advertising and promotional material apply, as appropriate.

5. Following on from and linked to the above, practitioners are advised that whilst the words “counsellor” and “psychotherapist” are not protected titles the use of them as standalone terms should be avoided as descriptors by those who have yet to achieve qualifications relevant to either term. Using either or both terms inappropriately constitutes misleading advertising.

6. Practitioners are expected to use the term “experienced” in a way that is appropriate to their level of experience to avoid misleading by exaggeration, as follows: -

   a) Trainee practitioners who have not yet achieved relevant qualifications on a recognised course should not use “experienced” in relation to the practice of counselling, psychotherapy or counselling psychology at all and are advised that the use of “experienced” in relation to working in placements is misleading.
   b) Practitioners who are already qualified and with less than five years’ experience since qualification should specify the number of post qualification years.
   c) Only practitioners with five years, or more, post qualification experience may use the word “experienced” without qualification.

7. Practitioners are advised to make sure that their intended use of logos of organisations with which they are affiliated is permitted and that any conditions attached to their use are met. This applies in particular to members of BACP and BPS. Both organisations have more than one logo and specific conditions are attached to their use depending on the membership category of the individual practitioner.

8. Practitioners should be aware that requesting testimonials from clients, or former clients, is not compatible with ethical practice and doing so may risk undermining a client’s former satisfactory perceptions of the work together. Feedback and comments from clients and former clients may be acceptable if unsolicited and freely given, and the client has consented to publication. For the

avoidance of doubt any disclosure of identifying details can only be made with the clients' or former clients' explicit consent.

9. Reviewing the accuracy of advertising material. Trainee practitioners must review their advertising material prior to publication with their supervisor and continue to take material to supervision for further reviews as and when further changes are made. Students who are not yet seeing clients are advised to review any material which may contain profession specific content/references with their course tutors. Students and trainees are also encouraged to engage in constructive discussion about advertising and promotional material with their peers.

   Carefully reviewing advertising material before publication, and as described above, ensures the reader is more likely to grasp an accurate understanding of the qualifications/training status and the services offered in a way that is consistent with the facts, and this is consistent with good practice

Practitioners, particularly trainee practitioners, may wish to read the regulations concerning misleading advertising that is published by the Advertising Standards Authority. These can be found on asa.org.uk.

Legislation: UK Code of Non-Broadcasting Advertising and Direct and Promotional Marketing

Metanoia Institute Clinical Ethics Committee

- Dr. Peter Pearce, Chair
- Gill Donaldson, Vice Chair
- Dr. Dagmar Edwards
- Kate Ward

POLICY BACK COVER

Section 1 - to be completed by policy proposer and forwarded to Committee Servicing Officer.

Policy Title:	Clinical Ethics Handbook
Author:	Gill Donaldson
Rationale: *Outline the purpose of the policy, and its scope e.g. credit-bearing provision*	Add narrative
Consultation undertaken: *List all groups and/or committees where consultation was undertaken e.g. students, administration, external advisor, QSC, etc.*	Clinical Ethics Committee, Academic Board
Resource implication: *Outline the potential financial, human and technological resource implication of the policy*	Add narrative

DOCUMENT CONTROL

Section 2 - to be completed by receiving Committee

Recommending Committee:	Clinical Ethics Committee

Approved:	23/07/2020	**Date for adoption:**	23/07/2020

Version and Document Code:	10/01/2022	**Date for review:**	