

Child MA – Code of Ethics

Code of Ethics and Professional Conduct for working with children

This Code of Ethics takes into account the Children's Act 1989 and the UKCP Standards of Education and Training: Guidelines for the Development of Codes of Practice and Professional Conduct for Working with Children.

In all decisions the practitioner makes in relation to his/her child client, **the child's welfare shall be the paramount consideration** (1.1. Children's Act). A child is any person under the legal age of maturity of 18 years.

1 General Issues

- i. The practitioner carefully selects clients suitable to the type of therapy she or he is offering.
- ii. All child clients must participate voluntarily.
- iii. At the beginning of the therapy an explicit contract must be made with the child about the rationale of sessions, restrictive and permissive ground-rules of sessions, confidentiality, timing and spacing of the sessions.
- iv. Practitioners must ensure that parents are in full knowledge that their child is attending therapy and are in full agreement with this. An explicit contract must be made with the parents about rationale of sessions, times, plus fees/payment schedule/payment policy if required for missed or cancelled sessions. Parents must sign a Form of Consent for their child to have therapy, including consent for recording sessions if required.
- v. There must be open information for both children and parents **upon request**, about the practitioner's experience, qualifications and training.
- vi. There must be no exploitation or oppression of the client's emotional vulnerability, for the gratification of the practitioner's sexual, financial or power-oriented impulses or for any distress-determined compulsion in the practitioner.
- vii. In order to work with children, the practitioner must have adequacy of preparation and training, and commitment to self and peer assessment, to supervision, to the setting of standards, to personal development and to training development.
- viii. The practitioner must be open to research issues.

2 Relations with clients

- i. The therapist accepts clients commensurate with his/her training, skill and supervision arrangements. The therapist should practice only within the limits of his/her professional competence. When faced with a client outside the competence of the therapist, she/he will either refer the client on to a practitioner with the required skills or obtain appropriate extra supervision.
- ii. The client-therapist relationship is professional. Sexual exploitation or any other

exploitation of the client-therapist relationship, either financial or emotional, is considered unethical.

- iii. Contracts with clients are explicit regarding frequency of sessions, holidays, cancellation of sessions by client (or client's parent/s) and cancellation of sessions by the therapist. Therapists make it clear what type of therapy is being provided.
- iv. Therapists are open about their training, qualifications, years of experience, and other related information regarding professional competence.
- v. Therapists maintain suitable facilities and conditions for the type of therapy provided.
- vi. Therapists respect the dignity of clients and their worth as human beings.

3 Professional Issues

- i. Therapists maintain professional relationships with colleagues (skill sharing, support and concern for ethical issues, promotion of the theory, research and practice of therapy).
- ii. Therapists should support themselves sufficiently in life, and manage their practice in such a way as to avoid burnout, over tiredness, overloading, which would adversely affect their ability to be fully present in the therapy sessions. Therefore it is advised that therapists will endeavour to engage in meaningful relationships and activities outside the work situation, in order to prevent the need to use clients for emotional satisfaction.
- iii. Therapists do not discriminate against clients in terms of race, age, gender, sexual orientation or belief systems. Therapists should be most cognisant in not attempting to influence their clients with their own value systems and belief systems.
- iv. Advertising shall be limited to accurate information regarding qualifications and services. Demeaning and comparative statements about other therapies or therapists are considered inappropriate.

4 About the sessions themselves

- i. The practitioner is clear that during the therapy sessions she/he is acting in loco parentis, and has full responsibility for the safety and welfare of the child during this time.
- ii. Should a child wish to leave a therapy session part way through, the practitioner will ensure that there will be adequate supervision of the child until they are returned to another responsible adult.
- iii. The practitioner will endeavour to prevent a child from hurting themselves physically during the session and will follow the policies and procedures for Health and Safety of the school or other clinical setting.
- iv. The dress of the therapist should be appropriate, e.g. she/he should not wear sexually provocative clothing.
- v. Therapists should at all times maintain therapeutic boundaries.

- vi. Therapists should not work under the influence of drugs or alcohol.
- vii. Therapists should recognise when they are not able to be fully present with clients and take appropriate action, e.g. a holiday, consider further supervision or personal therapy.
- viii. Therapists should see that they have sufficient time to assimilate the process and content of each session, i.e. there should be a sufficient time interval between one client and the next, and days not working.
- ix. Any changes to the client's regular appointment, or any changes to the circumstances of the therapy, e.g. change of venue or time, must be made well in advance.
- x. Any necessary interruptions or termination of the therapy must be told to the client well in advance to allow the client sufficient time to discuss and work through this.
- xi. The child's parents should be very clear how to contact the therapist during working and non-working hours. This may be via the therapist's place of work.
- xii. Therapists should constantly monitor the usefulness and effectiveness of the therapy. If she or he feels that, over time, it is not proving useful, this should be looked at in supervision before considering referring on.

5 Touch policy

Policy and Guidance on Safe Touch: (updated August 2019)

Rationale

IATE is committed to establishing a safe physical and emotional learning environment where basic needs are met; safety measures are in place; and staff responses are consistent, predictable, and respectful.

Our approach to physical contact within the context of safe relationships is underpinned by research and evidence. 'Social touch is a powerful force in human development, shaping social reward, attachment, cognitive, communication, and emotional regulation from infancy and throughout life' (Cascio et al 2019)

Touch is the earliest sense to develop and is significant in the way we perceive our own bodies and our sense of self. In the first months of life, touch is key in the development of secure attachment and the formation of relational bonds. Touch communication is associated with immediate reductions in both behavioural (Stack and Muir, 1990) and physiological (Feldman et al., 2010b) response to stress.

In the classroom, positive, contingent touch from teachers has been demonstrated to increase on-task behaviour and decrease disruptive behaviour in young children (Wheldall et al., 1986).

It is right that DfE has now stipulated that schools cannot have a no touch policy as physical intervention can have a profound impact on stressed out or dysregulated children, often preventing escalation and the need for exclusion or isolation. A "no touch policy" would be depriving to children who need to be soothed and calmed.

Legal Framework and terminology

The current legal context and guidance is informed by the following documents

DFE-00023-2014 Behaviour and Discipline in Schools (updated 2016)

DFE 00295-2013 Use of Reasonable Force (reviewed 2015)

Where touch is used to support a child/young person through reassurance, regulation at an early opportunity it is legally deemed to be '**physical intervention**'

Where the child's/young person's movement is controlled either through passive physical contact, such as standing between pupils or blocking a pupil's path, or active physical contact such as leading a pupil by the arm out of a classroom, this is legally referred to as '**restrictive physical intervention**'.

Bernard Allen 2014 Improving Guidance on Managing Risk and Restraint in Children's Services

DFE-00023-2014 gives school staff the legal right and power to use **reasonable force** in specific circumstances to prevent pupils:

- committing an offence
- injuring themselves or others
- damaging property
- disrupting good order and discipline in the classroom.

DFE 00295-2013 defines the term '**reasonable force**' to cover the broad range of actions used that involve a degree of physical contact with children and young people. Force is usually used either to control or restrain. This can range from guiding a pupil to safety by the arm through to more extreme circumstances such as breaking up a fight or where a child/young person needs to be restrained to prevent violence or injury. 'Reasonable in the circumstances' means using no more force than is needed.

Restraint means to hold back physically or to bring a pupil under control and is used in extreme circumstances where the physical safety of the child/young person or another is in question. This is also referred to as '**restrictive physical intervention**'.

Where touch is used to support a child/young person through reassurance, regulation at an early opportunity it is legally deemed to be '**physical intervention**'.

In IATE we refer to **physical intervention** as the use of **safe touch** to support and regulate a child and **restrictive physical intervention** as **supportive holding**. **They are not different or additional to those terms defined in law.**

DFE and ruling on reasonable force

DFE 00295-2013 permits **all** members of school staff have a legal power to use reasonable force when the situation satisfies the circumstances outlined above. This power applies to any member of staff at the school regardless of whether they have received training in restrictive physical intervention or not. It can also apply to people whom the head teacher has temporarily put in charge of pupils such as unpaid volunteers or parents accompanying students on a school organised visit or where a professional from another agency is working with the child/young person e.g. therapist

Further situations when physical intervention may be required include to

- remove disruptive children from the classroom where they have refused to follow an instruction to do so;
- prevent a pupil behaving in a way that disrupts a school event or a school trip or visit;
- prevent a pupil leaving the classroom where allowing the pupil to leave would risk their safety or lead to behaviour that disrupts the behaviour of others;
- prevent a pupil from attacking a member of staff or another pupil, or to stop a fight in the playground;
- restrain a pupil at risk of harming themselves through physical outbursts.

The decision on whether or not to physically intervene is down to the professional judgement of the staff member concerned and should always depend on the individual circumstances informed by the risks of using physical intervention and the risks of not.

IATE believes it is fundamental, in meeting the emotional needs of the child/young person, to provide containment and appropriate boundaries to a child/young person. This may include preventing the child/young person escalating in the destructiveness of their behaviour. This can sometimes be a call for support by the child who may not be able to articulate this in any other way.

What is appropriate Safe Touch (physical intervention)

DFE 00295-2013 guidance is clear. It is not illegal to touch a pupil. There are occasions when physical contact, other than reasonable force, with a child/young person is proper and necessary. Schools should **not** have a 'no contact' policy. There is a real risk that such a policy might place a member of staff in breach of their duty of care towards a child/young person or prevent them taking action needed to prevent a pupil causing harm.

Used in context and with empathy, touch supports the development of strong, nurturing relationships with the children and young people we care for. It can support the development of an effective stress management system, altering a child's biochemical profile and balancing key emotional systems in the brain (Panksepp and Biven 2012). It can also be key to developing fundamental social, behavioural and attention skills, whilst offering physical support to those children/young people who need it.

DFE 00295-2013 offers examples of appropriate use

- Holding the hand of the child at the front/back of the line when going to assembly or when walking together around the school;
- When comforting a distressed pupil;
- When a pupil is being congratulated or praised;
- To demonstrate how to use a musical instrument;
- To demonstrate exercises or techniques during PE lessons or sports coaching;
- To give first aid or medical support (administering an EPI pen or insulin injection)

In addition, /IATE supports the use of touch for the following reasons and circumstances:

Communication – touch is an important aspect of communication and plays a significant role in establishing good connection with children and young people at early communication levels. (Nind and Hewett, 2006).

Where a child displays difficulty in focusing on the human voice, touch may be necessary to gain attention or reinforce other communication (e.g. hand on shoulder when speaking) or to function as the main form of communication in itself. Touch enables staff and pupils to respond non-verbally or to respond to another person's own use of physical contact for communication and to make social connections. Touch may steady a child/young person who desperately seeks connection with an adult, confirming they have been seen and heard.

Educational, Health and Care Tasks- Touch can also be used to direct children in educational tasks and developing skills. Physical prompting and support, gestural and physical prompts during learning activities such as hand-over-hand support and hand-under-hand support (particularly for children who have profound or complex additional needs)

Play activities naturally include touch. TISUK supports the use of attachment play activities as targeted interventions to build and develop supportive, nurturing relationships with children and young people. These activities involve appropriate physical contact.

Physical support may also be necessary to include and teach, in activities such as; PE or swimming or to carry out therapy programmes such as; massage, sensory integration, occupational therapy, physical therapy either by the therapist or by another member of staff carrying out a programme or following therapy advice.

Emotional and Physical Regulation: Touch is an effective way to communicate acceptance and emotional warmth. It can provide containment and reassurance, communicating safety and

comfort. Touch affecting both tactile and pressure receptors stimulates the central nervous system into a state of relaxation and calm. It affects both behavioural and neurochemical indicators of stress – decreased heart rate, blood pressure, cortisol and oxytocin levels (Field 2016) resulting in a more relaxed, attentive state. Cautionary touch should be used with pupils who are sensitive to touch, touch defensive or may have a history of receiving negative touch.

Intimate Care- occasionally children and young people may need support with personal care skills as a result of medical or additional needs. Touch is necessary in order to carry out and support pupils' personal care and intimate care routines. A separate **Intimate Care Policy** should detail procedures and responsibilities. Intimate care should only be carried out by staff that the child/young person is comfortable and familiar with.

Physical Intervention: Safe Touch: Key Considerations for Staff

Staff should always consider the purpose and intended outcome of the use of safe touch (**physical intervention**). It should always be with the best interest of the child/young person at heart and meet an emotional or physical need in the child.

Staff should be aware of how safe touch may be interpreted by the child themselves, and by other people. So, use of safe touch, should always be preceded by a reflective process, on the part of the child professional. Communication of effective working practice with children/young people will ensure that physical intervention practices are not misinterpreted.

To protect themselves, staff should operate an open-door policy when delivering a programme of intervention involving safe touch or when supporting a pupil's sensory needs such as with massage or sensory integration session (if appropriately trained to do the latter). Staff must not lone work when providing intimate care or personal care programmes where the child/young person will be undressing and/or requiring physical support behind a closed door.

What Constitutes Inappropriate/Unsafe Touch?

- Physical intervention should never be used as a form of punishment
- Touch that is instigated to meet a need in the adult is **not** deemed appropriate or safe e.g. to reassure the adult or make the adult feel better.
- Touch that replicates an element of a traumatic experience for a child/young person
- Any physical intervention that the child experiences as unwanted, uncomfortable or invasive (except in the use of restrictive physical intervention where safety is paramount)
- Touch with children/young people who are identified as sensitive to touch or touch defensive e.g. children with sensory integration/processing difficulties, ASC or traumatic associations with touch
- It is not acceptable to kiss pupils. Occasionally younger children or children with complex needs may initiate a kiss between themselves and a member of staff as a genuine, instinctual demonstration of affection. It is the role of school staff to support children to understand safe touch and develop appropriate boundaries to keep themselves safe. Staff should withdraw from the situation, gently reminding the child of their role and appropriate people to demonstrate their affection to in this way.
- It is never appropriate to touch children/young people in the following areas; genitals, chest/breast or bottom

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6 Dual Relationships

- i. Therapists should avoid taking on a client with whom they would then have a dual relationship. Thus they should therefore avoid taking on relatives, close friends or intimates of their existing clients, or of themselves, as individual clients. Family therapy sessions with existing child clients, or joint sessions with a parent and the child, do not fit into this category.
- ii. Therapists should avoid seeing clients in any social circumstances outside of the therapy room. If the safety or the containment of the therapy becomes impaired and cannot be worked through satisfactorily the therapy may need to be terminated. Where this contact happens accidentally, e.g. bumping into a client on the street, the impact of this needs to

be considered in the session.

- iii. Therapists should not take on a client who is being seen by another therapist, counsellor or psychotherapist.

7 Confidentiality

- i. If there is evidence of probable danger to the client or any other child, e.g. when a child has made a disclosure in the therapy session and is viewed to be at risk, the practitioner is **ethically bound** to disclose this to the appropriate body in the circumstances, e.g. the School Head, or Social Services Child Protection team direct. When a child has made or is threatening to make a suicide attempt, the therapist will contact the child's GP.
- ii. The practitioner must therefore make it clear to the child from the outset of the therapy, that where he believes the child to be in emotional or physical danger, he will have to tell someone, which may include disclosing details of actual sessions, so that the child is not at risk. If possible, the practitioner will endeavour to talk to the child before talking to a third party.
- iii. The practitioner will obtain the telephone number of the child's GP before the commencement of therapy.
- iv. In the school setting, the practitioner should ensure that he makes himself familiar with the school policy for disclosures, and the school's set of Child Protection Procedures.
- v. Practitioners must be very clear that they are not trained to deal with disclosures, only to report them. In other words, having reported the disclosure, it is not up to them to make any decision as to the future of the child. They have neither the training nor resources to do so. There are systems set up to protect children and the therapy practitioners are not part of these.
- vi. Practitioners must keep detailed notes on any disclosure, and write down a verbatim account of what the child has said.
- vii. The practitioner is ethically bound to report any medical issues about the child to their parent or to the appropriate person in the work setting, if relevant.

8 Exceptions to Confidentiality

Apart from the circumstances detailed above, all information provided by the client in terms of exact content and process of the session is confidential. However, the following exceptions apply:

- i) Parents and teachers can be given:
 - a) General impressions
 - b) Guidelines for help
- ii. Teachers and parents can of course be given information about the specifics of the therapy with the child's consent.
- iii. When working in a multi-disciplinary team, relevant information is shared.

- iv. In transfers and referrals mutually agreed between client and therapist, pertinent information may be shared with the new therapist with the client's permission.
- v. For supervisory or teaching purposes, but the client's identity is protected.
- vi. When required by law (however courts are usually sympathetic to the desirability of keeping confidential sessions of this type confidential and, where applicable, the therapist should ask the court for permission to do so).
- vii. When any report to other professionals, e.g. GP, Psychiatrist, Child Protection Officer etc., is requested or exchanged involving disclosures of the client's identity. It is of utmost importance to discuss in supervision whether or not to discuss with the child:
 - a) The fact that the report is being written;
 - b) The contents of the report.

9 Storage of Case Notes

All case notes must be stored under lock and key/password protected.

10 Ownership and Archiving

- i. Where practitioners are not working in private practice, they should clarify with their employing body who claims ownership of their case notes.
- ii. Where the therapist does not have ownership they should be aware that this may place their case notes at risk of being used for a purpose other than a strictly psychotherapeutic one. This is a particularly important issue where, as in the NHS, the employing body has a policy of storing records for between 8 and 20 years after discharge and it is unlikely that the therapist will have direct control over the destruction of the case notes.

11 Audio Recording and Video Taping of Sessions

Where audio recording or video recording of sessions by the therapist are required for supervision or examination purposes, verbal consent **must** be obtained from the child and written consent from the parent/s.

12 Photographing images made by clients during sessions

It is useful to photograph images made in therapy in order for the therapist to discuss the work in clinical supervision. Integrative Child Psychotherapists take great care in ensuring that all photographic images are made anonymous. All digital photographs are to be stored securely and anonymously in a computer system which is password protected for the sole purpose as stated above.

Written consent **must** be obtained from both the child and parent/carer.

Integrative Child Psychotherapists regularly research and evaluate their work. We also use our experiences with clients in teaching and learning environments such as Universities, and within academic papers published in professional journals. If photographs are published in research publications, you may not be able to control the future use of these photographs.

On no account must Integrative Child Psychotherapists take photographs of the client.

13 Case Presentations and Publishing

The anonymity of clients should be protected, by disguising their identity as far as is possible, when presenting a case at professional seminars and when submitting material for publishing.

14 Liaison with Psychiatric Profession

Therapists shall obtain a psychiatric assessment of a client when necessary.

15 Criminal Convictions

Practitioners will not be deemed suitable to work with children if they have been convicted under the Sexual Offences Act or are List 99 offenders.

16 Complaints Procedure for Children

Integrative Child Psychotherapists should make a child aware of what to do if they are unhappy with the therapy that they are receiving. In most cases, it would be hoped that the child would be able to raise this with the therapist within the process of the therapy itself. Where this is not possible, then a child may speak to their parents, carers or a named safe person within school. In the case of students working on the 'Helping Where it Hurts' schools programme, children can also approach their initial referrer (e.g. Senco, Head Teacher) who would pass the complaint in the first instance to the IATE Placement Co-ordinator. Formal complaints are handled by the IATE Complaints Committee.

16 Limits of professional qualification

UKCP Integrative Child Psychotherapists cannot work with any IATE student unless they have also trained as an adult psychotherapist.