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The metaethics of psychotherapy codes of ethics and conduct

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Abstract

Codes of ethics and conduct are important documents in health care practice, and must be evaluated alongside an understanding of the role of the organisations which write and publish them. In the UK, established professions like medicine and nursing are subject to statutory regulation and codes which delineate ethical best practice from minimum conduct. However the regulation of psychotherapists in the UK has been the subject of changes in government policy during the last decade, resulting in a fragmented regulatory environment where a number of organisations function both as regular and professional body. There are about 40 codes of ethic and/or conduct in the UK relating to the various professions of psychotherapy. The chapter details the regulatory framework in the UK, and the places of codes within it. The codes' regulatory role in establishing minimum practice is difficult to assess because so few cases of malpractice are brought, and their role in guiding practice is questioned by using disclosure of confidential information as an example. Psychotherapists are invited to assess whether the codes and associated guidance they operate under are sufficiently detailed to guide practice.

Keywords: Regulation, codes, ethics, conduct, confidentiality, disclosure.

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Introduction

Codes are written statements detailing expected or required standards and have become seen as important documents within a range of occupations, especially so within healthcare. Codes come in different varieties. Codes of Conduct, largely written by organisations with a regulatory function, tend to articulate quasi-legal minimum standards against which poor practice can be measured and sanctioned. Codes of ethics, often written by professional organisations tend to be more aspirational in nature, detailing higher levels of practice and guidance. Both sorts of codes inform clients and the public more generally of the nature of professional practice and provide action guidance to varying degrees. However, the distinction is not clear cut; some organisations fulfil more than one role and some codes articulate both minimum and aspirational standards with varying levels of clarity of purpose. Codes have also become associated with the process of professionalization whereby occupations have transitioned into professions (Allan 2011)

Within a wide understanding of professional healthcare, the dominant profession has been medicine, one of the traditional professional troika of medicine, law and the church (Quick 2017). In the US, The American Medical Association was founded in 1847 and released its first code of ethics, though as Sinclair (20xx) details in this volume, codes of various sorts have been a feature of medical practice since antiquity. In the UK, professional conduct was placed under the statutory framework of the Medical Act in 1858, predated by the formation of the British Medical Association, the professional body which was established in 1832.

The first code of the American Psychological Association was published in 1953, during a period when a number of professions allied to medicine began formulating codes partly in response to the horrors of medical practice and experimentation uncovered towards the end of the second world war. Since then codes have become ubiquitous within healthcare practice and wider. For example, codes are widely seen in politics (Cabinet Office 2018), business (Bombardier 2012) and trades (Chartered Institute of Plumbing and Heating Engineering nd).

This chapter considers the place of codes in psychotherapy practice. Codes are published by organisations and cannot be meaningfully assessed outside the writing organisation's purpose. The chapter starts with a discussion of the roles of different organisations involved in professional healthcare practice, followed by a description of the regulatory framework in the UK which includes around 40 different codes published by organisations representing or regulating psychotherapy in one form or another. Different forms of code are discussed and compared with codes written by other more established professional groups. The ability of codes to guide practice, exemplified by the issue of disclosure of confidential information will be discussed and found wanting in important respects. Because of the large number of codes produced, the chapter draws heavily on experience in the UK but similar features of codes can be found in other jurisdictions. The profession(s) of psychotherapy

defy easy categorisation and might more usefully be considered as overlapping roles within a range of therapies, albeit with some common themes. Psychotherapy has other professions at its margins, for example, counselling and psychology, and the chapter resists the temptation to consider codes from organisations that do not use the word psychotherapy in their code for example the, British Psychological Society.

Regulatory regimes have produced different codes in other countries. In the US, the description 'psychotherapy' is largely subsumed with the numerous varieties of counselling and psychological practice, regulated at state level using a wide variety of rules, regulations and laws. For example, in California the Board of Behavioural Sciences regulates Licenced Marriage and Family Therapists, Licensed Professional Clinical Counselors, and Licensed Education Psychologists, but does not issue a code, instead holding practitioners to account using a lengthy directory of statues and regulations (Board of Behavioural Sciences 2019). Both the American Counselling Association (2014, Code of Ethics) and the American Psychological Association (2016, Ethical Principles of Psychologists and Code of Conduct) produce extensive codes. Other codes are produced by pan national co-ordinating organisations for example the European Association for Psychotherapy (2018).

The roles of professional organisations

It is impossible to fully consider the form and content of codes without first considering the nature of the organisation writing them. Organisations involved with professional healthcare practice fulfil at least one, and sometimes more, of three distinct functions.

1. **Regulation:** This function includes maintenance of a register of practitioners and validation of educational preparation programmes for entry to professional practice. In some professions and in some countries, this is undertaken through organisations established through statute, whose declared function is public protection. In these cases, regulation includes a form of licensing, without which individuals cannot practice. Removal of the licence is the ultimate career-ending sanction for serious misconduct. In statutory regulation, professional groups have a clearly understood title and function which can be protected in law, for example, registered midwife and nurse. Though some regulators are responsible for more than one healthcare profession (for example, the Health and Care Professions Council (HCPC) in the UK) statutorily-regulated professions are overseen by an identified regulator which issues prescriptive conduct codes detailing minimum practice used as benchmarks against which complaints about conduct are assessed. Prior to recent reforms, the governing councils of these organisations were comprised wholly or mostly of members of the profession, and so these professions could be regarded as self-regulating. However, this is no longer the case, and now there has to be at least parity of lay and professional members.

For professions not covered by statutory regulation, like most branches of psychotherapy, some organisations have a certifying function, issuing qualifications and other membership privileges as well as maintaining a register. Most certifying organisations issue a code, also used to assess practice where a complaint has been made. Sanctions against members can be applied, up to and including removal from the register, but unlike statutory regulation this does not preclude practice as the professional title is not protected, and sanctioned individuals are free to seek accreditation elsewhere or practice without organisational accreditation.

2. **Practice Development.** This function supports professional practice through acting as a professional organisation, or professional body, promoting best practice through professional standards, education and guidance. In some cases these organisations also issue more discursive ethical codes which articulate best practice. Some of these organisations offer associated membership to non practicing individuals with an interest in a particular field. Governing Boards are almost entirely comprised of members of the profession.
3. **Staff representation.** In some professions, particularly where practitioners are employed, organisations provide individual support and collective bargaining. This function, though important in wider health care practice does not appear to be so important for psychotherapists. Though some therapists are employed in organisations, most are in private practice and individual representation, including insurance cover, can be undertaken by professional bodies or through private arrangements. In large organisations, for example the National Health Service in the UK, therapists can join trades unions separate to professional organisations.

Simply, regulators serve the interests of the public, professional bodies serve the interest of the profession, and trade unions serve the interests of their members. In practice, many organisations fulfil more than one of these roles, and this can lead to tensions if not outright conflict of interests. In Canada, nursing regulatory and professional body functions were served by the same organisations until legislation disconnected them (Garrett and MacPhee, 2013), and in the UK the Francis Report criticised the Royal College of Nursing's role in serious care failures partly because of confusion between its twin roles of professional body and trades union (Francis, 2013). In the UK, psychotherapy organisations which claim a regulatory function also fulfil the function of a professional body, and while this is clearly allowed, caution is required in identifying potential conflicts and interpreting codes which attempt to meet (with varying levels of clarity) both regulatory and development functions

The regulation of psychotherapy in the UK

The regulation of healthcare professions in the UK falls under the purview of the Professional Standards Authority (PSA), a statutory body primarily concerned with overseeing the professional groups which Parliament has decided must be regulated. This includes nursing, midwifery and medicine and a range of other professional groups, some of which have their own regulator and some of which are regulated by the Health and Care Professions Council (HCPC), the regulator of widest range of professional groups including practitioner psychologist and art therapist – for which the title ‘Art Psychotherapist’ has, since 2005, been the only statutorily protected use of the word ‘psychotherapist.’ In general, anyone can describe themselves as a ‘psychotherapist’, but it is unlawful for anyone not registered with the HCPC to claim to be an ‘art psychotherapist’. There is no obvious reason why art psychotherapy, or art therapy more generally is subject to the more stringent regulation provided by a statutory organisation. Waller and Guthrie (2013) describe successful application despite the challenge of the government’s initial opposition to regulation for this professional group.

UK government policy concerning regulation was driven by a growing lack of trust in healthcare professionals following high profile regulatory failures, notably the doctor Harold Shipman who killed many patients leading to conviction for fifteen murders in 2000. The white paper *Trust, assurance and safety: the regulation of health professionals in the 21st century* (Secretary of State for Health, 2007) clearly stated an intention to introduce statutory regulation for psychotherapists and counsellors as a priority, ‘because their practice is well established and widespread in the delivery of services, and what they do carries significant risk to patients and the public if poorly done’ (Secretary of State for Health 2007, p.81). However, by 2011, following a general election, this assessment was reversed. The incoming coalition government reassessed the risk and considered that statutory regulation would not be proportionate, placing instead an emphasis on ‘employers of unregulated workers to take responsibility of the quality of services provided’ (Secretary of State for Health 2011, p.16). This intention was supported to some extent by a system of assured voluntary regulation, ‘a more proportionate way of balancing the desire to drive up the quality of the workforce with the Coalition Government’s intention to avoid introducing regulation with its associated costs wherever possible’ (Secretary of State for Health 2011, p.16), regarded by the PSA as an extension of its Right Touch Regulation (PSA 2015, Bilton and Cayton, 2013) .

Other professional groups unrecognised through statutory regulation are also associated with the PSA through its accredited register scheme, registers operated by professional organisations which have passed an assessment process at the PSA. As the PSA explains on its website:

It’s not compulsory for unregulated practitioners to go on an Accredited Register. They choose to do it because it shows their commitment to their area of work and makes them part of a professional community that works to high standards and policies. When the register

they're on displays our quality mark you can be sure that its commitment to public safety has been verified by us.

(PSA, nd)

The PSA publishes a set of standards (PSA 2016) which set out criteria for inclusion on the accredited register, including that the organisation sets and promotes good standards of personal behaviour, defined in a footnote: ‘Standards for personal behaviour should be based upon an ethical framework – a defined set of values and principles – that include responsibility, honesty, openness, integrity and respect’ (PSA 2016, p.9). Evidence for meeting these standards might include ‘codes of practice, ethical frameworks, guidance, training and examples of decisions taken in relation to registration or complaints that demonstrate registrants being held to account against these standards’ (PSA 2016, p.9). While a code of ethics or practice is not an absolute requirement, it is difficult to see how the standards can be met without one. Figure one shows the organisations regulating psychotherapy in the UK.

Insert figure 1 here

Among accredited registers are eight organisations which refer to psychotherapy all of which have issued codes, three of which also accredit other organisations. Details of the registers and organisations can be found in table 1.

Insert table 1 here

The three accrediting organisations are:

- The UK Council for Psychotherapy (UKCP), which states that they are ‘the leading organisation for the education, training, accreditation and regulation of psychotherapists and psychotherapeutic counsellors in the UK.’ (UKCP, 2019a). It has (UKCP, 2019b, 1st March 2019,), 73 organisational members, including smaller associations, and educational and therapy providers. At least 34 of these organisations also produce their own codes¹.
- The British Psychoanalytic Council (BPC), ‘a professional association and voluntary regulator of the psychoanalytic psychotherapy profession, publishing a Register of practitioners who are required to follow our ethical code and meet our fitness to practise standards’ (BPC 2019a) and ‘is comprised of 14 member institutes and registers their members as 'BPC registrants' (BPC 2019b). Some of these organisations make direct reference to the BPC Code, but two have written their own.
- The British Association for Counselling and Psychotherapy (BACP) ‘is the professional association for members of the counselling professions in the UK.’ It does this ‘by promoting

¹ A search of the organisations’ websites was undertaken using the words ‘Code’ and ‘Ethics’. Where this failed to identify a Code of Ethics, a google search using the name of the organisation plus ‘Code’ or ‘Ethics’ was undertaken. The websites appear to be of variable quality.

and facilitating research to produce trusted best practice, and by providing a robust framework to ensure the profession follows and adheres to the highest possible standards that protect individuals seeking therapy' (BACP 2019). Interestingly the word 'regulation' or its cognates do not appear in the organisational philosophy, objectives or strategy. BACP organisation members agree to abide by the Ethical Framework for the Counselling Professions (BACP 2018). Their website identifies 94 training courses and over 200 providers.

The regulatory environment for psychotherapy is fragmented, partly as a result of government decisions but also because there are differing views between organisations about what standards counsellors and psychotherapists should work to and how they should be prepared. This has resulted in the development of upwards of 40 codes in the UK. Organisations writing codes are a diverse mixture of a statutory regulator (HCPC), and a number of professional bodies who have varying degrees of non-statutory regulatory function, some of which are recognised by the PSA. This means that there is very little consistency in the form of codes. A recent government response to consultation (Department of Health and Social Care 2019) has confirmed the move away from self regulation towards fully independent regulation for at least statutorily regulated professions. The Government indicated that it expects the PSA to refine the process by which recommendations are made to ministers about which professions are to be subject to full regulation. Still further consultation is promised (Department of Health and Social Care 2019), but the prospect of statutory regulation for psychotherapy appears slim, with the fragmented environment and the plethora of associated codes looking set to continue.

A recent development is the SCoPEd project, jointly undertaken by BACP, BPC and UKCP, resulting in draft frameworks for practice and education (BACP, BPC, UKCP, 2018). This tripartite collaboration appears to have progressed without consultation with other organisations who operate PSA accredited registers, some of which have raised serious objections (National Counselling Society 2019). It might be considered that consistency of preparation requires or at least implies a common code but the shared draft framework states that psychotherapists require an 'ability to work with ethical difficulties and dilemmas, including addressing and resolving contradictions between different codes of practice and conduct, or between ethical requirements and work requirements' (BACP, BPC, UKCP 2018, p.5).

Ethics, law and professional influences on action.

In everyday life our actions are guided by a number of considerations, importantly by our personal ethics and the law, and there are a number of differences between them. Ethical considerations can lead different individuals to do different, even mutually exclusive things, which can be subject to genuine disagreement with no hope of objective resolution. Legal considerations provide certainty,

either in clarity of law, or clarity of process for resolution. Ethics provide reasons why we ought, or should, do something. Though these reasons can indicate a minimum standard of behaviour below which our actions become blameworthy, they also can articulate a higher aspiration of ‘good’ behaviour. The law tells us what is required, articulating a minimum standard. Sanctions for falling below an ethical threshold are that people think less of us, they blame us. This might take the form of judgement or some sort of personal censure, in contrast to legal penalty of redress, or in a criminal court, fines or imprisonment.

A further important area of difference between ethics and law is that of character. Many recent accounts of ethics include the notion of character, the nature of a moral agent, as an important element of moral practice, and this has proved especially appealing within healthcare ethics (Waring 2016). Agent-centred virtue accounts of ethical healthcare practice require good practitioners to be motivated to do good acts as part of their character; a good person does good things. This stands in contrast to a person who does adequate things because he is required to do them. The threat of being removed from a register may provide a good reason for following the injunctions of a code (Spielthener, 2015) but it is an impoverished account of adequate, much less good professional practice, complying with rather than adhering to a code. Codes do often acknowledge agent character through stating values but these cannot be regulated for except through behaviour. An example of this is compassion which is usually understood to consist of an emotional response to suffering and a desire to alleviate it. For some professionals, notably nurses, compassion is almost universally contained within codes even though it is impossible to require (Snelling 2016, 2018). Compassion is very rarely mentioned in codes which guide psychotherapy practice, with a few notable exceptions such as that produced by the Association of Christian Counsellors (2004).

Professional considerations are sometimes given as a third set of influences for action whilst performing a professional role and increasingly also in our everyday lives outside work. But these considerations, expressed in codes, are more usefully understood as aligned to either moral or legal influences on action. Regulators have power to sanction practitioners whose behaviour falls below a stated minimum and so their codes can usefully be regarded as quasi-legal prescriptive documents, distinct from documents written by professional bodies whose aspirational codes are often more discursive in setting out good practice. In wider healthcare professional practice, where the primary purpose of a code is regulatory, setting out minimum standards, codes are often written in prescriptive language using the word ‘must’. Where the purpose of to set out aspirational standards the language tends to use the word ‘should’, or in affirmative statements such as: ‘We will do everything we can to develop and protect our clients’ trust. (BACP 2018, p.13)

Codes of ethics or conduct?

The difference between codes of ethics and codes of conduct are often recognised in their titles with variations of the words ‘ethics’ and ‘practice’ or ‘conduct’, though the distinction is not always clear. Many organisations combine both elements in a single document, and few (for example the Institute of Family Therapy, 2018a,b) have separate codes of ethics and practice. Woolfe (2016) suggests, in relation to psychology, that revisions to ethical codes in psychotherapy and psychology (not considered in this chapter) have resulted in codes becoming more aspirational than prescriptive. He suggests that the more a professional group commits to an aspirational code, emphasising individual responsibility, the more important the relationship between psychologist and client. Papers setting out the history and development of codes for psychologists in Australia (Allan, 2011), and South Africa (Wassenaar 1998), describe the dilemmas in writing a code that covers both regulatory and aspirational functions. The challenges can be met in a number of ways.

Must, should, shall, will.

A paradigm example of a quasi-legal conduct code is produced by the HCPC, the statutory regulator of art psychotherapists which states that its code (standards) ‘set out, in general terms, how we expect our registrants to behave’ and prefaces all of its statements with the prescriptive ‘you must’ as in: ‘You must only delegate work to someone who has the knowledge, skills and experience needed to carry it out safely and effectively’ (HCPC 2016, p.7). The word ‘should’ appears just once in the document, in a section addressed to service users, carers and the public. It is also worth noting that this document does not use the word ‘code’ in the title, but the stronger word ‘standards’. There is no doubt that this document is directive and authoritarian setting out minimum rather than aspirational standards.

In contrast, the corresponding professional body, the British Association of Art Therapists (2014, p.1) ‘has issued this Code of Ethics with the aim of providing its members with the fundamental principles, standards and guidelines for good practice.’ This document uses the words ‘must’ and ‘should’ throughout without explaining the difference. ‘Should’ is used throughout the section setting out general principles as in para 2.2: ‘Members should practise lawfully, safely, effectively, accountably and fairly’. Thereafter ‘must’ and ‘should’ are used equally, and in places seemingly against the distinction whereby ‘must’ is directive and ‘should’ represents best practice. So it has ‘Members *should* obtain informed consent prior to the start of treatment which *must* be recorded in their clinical notes’ (para 7.1, emphasis added). For psychotherapists in the UK, this is the only example where the types of codes and issuing organisations are easily identified. Other organisations fulfil both the role of regulator and professional body, and as a result, the codes are often a mixture of the two different types.

Where codes combine both quasi-legal and ethical clauses, some but not all make a distinction between them. One way of doing this is to have difference sections, for example Counselling and Psychotherapy in Scotland (COSCA) (2014) which has a general statement of ethical principles followed by a Code of Practice. Other codes writers, like the UK General Medical Council (2013) are clear about the nature of clauses and language, particularly the words ‘must’ and ‘should’ used to distinguish them. This distinction is rare in the psychotherapy codes reviewed. The BACP elaborates (p.12):

Our responsibilities are set out as full or qualified obligations. We are fully and unconditionally committed to fulfilling a specific requirement of good practice where we state ‘we will...’ or ‘we must...’. Where we consider a requirement may need to be varied for good ethical reasons, we state that ‘we will usually...’.

Where there is no mention of the usages of these different words, the question of whether the different use is intentional is suggested. It is to be hoped that professional organisations can be relied upon to be clear, but this is not always the case. For example, Snelling (2017) demonstrates several errors in the code for UK nurses and midwives, arguing that in consequence the code cannot meet its stated purpose. However, the lack of distinction is less important where the code does not serve a regulatory function. The code produced by the British Association of Art Therapists, for example, appears to use the words interchangeably but since this is an organisation whose full members are drawn from those who have completed recognised courses validated by the HCPC, and which has no regulatory function, ambiguity is of little consequence. Even if the association ejected a member for failing to meet a requirement of its code, they would still be able to use the protected title – art therapist - unless and until the regulator, the HCPC, removes them from their statutory register.

Lack of space in this chapter precludes a detailed analysis of the forms of codes, but an indication of the form of codes can be garnered by a simple word count as indicated on table 1. Since the quasi-legal function of code is to be used as the standard against which misconduct is measured it is reasonable to ask whether ambiguity in construction makes a difference to the outcome of cases. This would be very difficult to show not least because there are so few cases. There are three cases on the UKCP website since May 2015, all of which resulted in the practitioner being removed from the register all for sexual misconduct, which is clearly against the code in operation at the time, expressed in descriptive terms: ‘The psychotherapist undertakes not to enter into a sexual relationship with a client’ (UKCP 2009, p2). In cases like these, even if there is ambiguity about the exact location of the boundary, the examples are clearly on the wrong side of it.

Guidance and disclosure of confidential information.

For most individual psychotherapists practicing a long way from the territory of complaints and minimum standards, a significant value of a code lies in its ability to be of assistance in addressing ethical issues arising from their practice (Welfel, 2013), and to do this there must be sufficient detail. For statutory regulators, the Standards of Good Regulation (Professional Standards Authority 2018) expect regulators to ‘provide guidance to help registrants apply the standards and ensures this guidance is up to date, addresses emerging areas of risk...’ In some cases where codes are lengthy no further guidance is required, while shorter codes may need supplementary guidance documents. Codes for psychotherapists come in varying lengths (as shown in the table 1), and since the practice of psychotherapists affiliated with or regulated by different organisations is not fundamentally different the difference in length and form can be partially accounted for by the difference in organisational function or simple preference. The shortest code of the eight accredited registering organisation is from the British Psychoanalytical Council (2011), which though entitled ‘Code of Ethics’ is presented in a form much more aligned to a quasi-legal code of conduct, with directive vocabulary. The shortest code of the 40 reviewed is published by the Philadelphia Association (nd), an organisation affiliated to the UKCP. At 102 words it is the shortest by a considerable margin, and it is difficult to see a workable action guiding function for it at all:

All practitioners of the Philadelphia Association shall as far as is reasonable uphold the welfare of their patients as paramount. The confidentiality of the patient shall be safeguarded as far as is consistent with the law and with the safety of the patient and others.

Practitioners should bear in mind that psychotherapy involves a relationship between practitioners and patient that is inevitably unequal. The practitioners should always keep in mind the vulnerability of the patient and ensure that they do not exploit the relationship for their own advantage.

Practitioners of the Philadelphia Association shall at all times treat colleagues with due respect.

Longer codes clearly have more scope to turn short injunctions into something more practically useful but this is not always effective. Despite a supporting and guiding function, codes alone cannot be relied upon to provide detailed action guidance, and some organisations publish additional guidance. Table 2 contains extracts from codes from accredited register organisations relating to disclosure of confidential information.

Insert table 2 here

This is not the place for a detailed analysis about the legal and ethical issues concerning disclosure, merely an observation that codes treat the issue rather differently. The General Medical Council, the statutory regulator of doctors (some of whom are also considered psychotherapists) states in its comprehensive guidance concerning disclosure without the patient’s/client’s consent that: ‘You should, however, usually abide by the patient’s refusal to consent to disclosure, even if their decision

leaves them (but no one else) at risk of death or serious harm' (General Medical Council 2017, para 59). A footnote notes that this is an uncertain area of law, but suggests that

'In very exceptional circumstances, disclosure without consent may be justified in the public interest to prevent a serious crime such as murder, manslaughter or serious assault even where no one other than the patient is at risk. This is only likely to be justifiable where there is clear evidence of an imminent risk of serious harm to the individual, and where there are no alternative (and less intrusive) methods of preventing that harm'

(General Medical Council 2017, page 73, and see Brazier and Cave, 2016 p. 98).

This is a very high threshold for disclosure, supported by Department of Health guidance which makes it clear that disclosure must be necessary to prevent *serious* harm. There is also a clear distinction to be made between harm to the patient /client and harm to others such that disclosure can be made to prevent serious harm to others, 'however, an individual's best interests are not sufficient to justify disclosure of confidential information where he/she has the capacity to decide for him/herself' (Department of Health 2010, p.8).

Excluding the Association of Child Psychotherapists (as children are a special case), there are three areas of difference between what (some) psychotherapy codes state and the position articulated by the GMC and DoH. First, there is a difference between required and allowed disclosure which is not always clear. Second, the threshold of serious harm is not reflected in several codes, and third there appears to be a willingness to disclose information where the threat of harm is to a competent patient/client. The advice from accrediting organisations appears to be more consistent with the GMC/DoH, but there is nevertheless something of a lack of detail in the code and/or associated guidance from, for example, the UKCP. This brief analysis shows first, that there is a range of views about what justifies or demands disclosure and that these are in places in conflict both with each other and with authoritative guidance, and second, that the lack of detail in codes and guidance means that they cannot be relied upon to offer meaningful advice to practitioners wrestling with a dilemma in practice. This is often acknowledged, for example, in the Code of Professional Conduct and Ethics produced by the Association of Child Psychotherapists (2017, p.1): 'This Code cannot cover every potential ethical, conduct or competence related concern. When issues arise in their own practice Members will need to exercise their judgement, guided by colleagues and, where appropriate, the Association.'

This provides something of a challenge to regulators and professional groups. How is sufficiently detailed guidance provided to enable practitioners to make defensible decisions within their governing codes and the law? Some regulators, for example, the Nursing and Midwifery Council has minimal guidance because it claims that detailed clinical guidance is not part of its remit as a regulator (Snelling 2017), instead claiming that it is a matter for professional bodies. The Royal College of Nursing – the professional body for nurses – doesn't provide guidance but instead refers back to the NMC Code and other guidance documents (Royal College of Nursing 2019). For doctors both the

regulator (General Medical Council 2017) and the professional body (British Medical Association 2018) provide extensive guidance. Unlike these statutorily regulated professionals, many psychotherapists belong to groups which provide, to some extent, both functions and yet this brief assessment of codes and supplementary guidance suggests that practitioners will need to consult more widely to locate the more detailed and authoritative guidance required to defend a clinical judgement.

Conclusion

Codes are an important part of professional life, and their form may change as the emerging regulatory environment of the professions of psychotherapy evolves. There are many functions of codes and practitioners reading and referring to them should be mindful of the overall purpose and the aims and function of their publishing organisation. This chapter has discussed codes in the UK but the principles can be applied elsewhere. Codes for other more established healthcare professions subject to more stringent though simpler regulation, or the clauses within them can generally be regarded as prescriptive or aspirational. However, the professions of psychotherapy are regulated in a relatively new way through accredited registers operated by professional bodies, an example of self-regulation which is now obsolete for more established professions. For now, when reading codes of ethics and practice, psychotherapists would be well advised to ask themselves if they are clear what they are precluded from doing. All but a few will understand this. But they should also ask themselves if the guidance in their code and associated documents are adequate to fulfil an action guiding function; achieving this may require further clarification or links to further resources.

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Organisation	Organisational members	Title	Compassion	Length (words)	Form
Association of Child Psychotherapists (2017) https://childpsychotherapy.org.uk/		Code of professional conduct and ethics	<u>No</u>	<u>3177</u>	<u>Should (23) must (17) shall (7)</u>
Association of Christian Counsellors (2004) https://www.acc-uk.org/		Ethics and practice	<u>Yes</u>	<u>7257</u>	<u>Discursive. Should (89) and must (38)</u>
British Association for Counselling & Psychotherapy (2018b) https://www.bacp.co.uk/	Yes	Ethical Framework for the Counselling Professions	<u>No</u>	<u>6757</u>	<u>Affirmative. Must (3) should (4) usually (8) will (133)</u>
British Psychoanalytic Council (2011) https://www.bpc.org.uk/	Yes	Code of Ethics	<u>No</u>	<u>839</u>	<u>Should (1) must (23) shall (3)</u>
Counselling & Psychotherapy in Scotland (2014) http://www.cosca.org.uk/		Statement of ethics and code of practice	<u>No</u>	<u>2854</u>	<u>Must (18) should (10) will (29)</u>
National Counselling Society (nd) https://www.nationalcounsellingsociety.org/		Code of ethical practice	<u>No</u>	<u>5586</u>	<u>Should (33) must (25)</u>
UK Association for Humanistic Psychology Practitioners (2018) https://ahpp.org.uk/		Code of Conduct and Ethical Principles	<u>No</u>	<u>2851</u>	<u>Must (6) should (14)</u>
UK Council for Psychotherapy (2019c) https://www.psychotherapy.org.uk/	yes	Code of ethics and professional practice	<u>No</u>	<u>1579</u>	<u>Must prefaces each clause Should (3)</u>

Table 1 – Psychotherapy Organisations offering registers accredited by the Professional Standards Organisation.

Organisation	Detail on Disclosure	Guidance
Association of Child Psychotherapists	the disclosure is in the best interests of a child or young person (Clause 4.5.1)	No
Association of Christian Counsellors	If the client authorises disclosure or the law requires it, members should undertake disclosure in ways that best protect the client and his or her trust in the member (5.1.1.1)	No
British Association for Counselling & Psychotherapy	We may need to act in ways that will support any investigations or actions necessary to prevent serious harm to our clients or others (10) and when legally required or authorised to disclose (55d)	Yes Videos detailed resources
British Psychoanalytic Council	Registrants must take all reasonable steps to preserve the confidentiality of information acquired through their practice (2)	Yes BPC members have a duty to consider disclosure in situations of threat to the life of the patient or another person.
Counselling & Psychotherapy in Scotland	Exceptionally, a member may disclose information obtained during the working relationship with their client in the interests of the safety of the client and/or others (5.4)	No
National Counselling Society	Maintain strict confidentiality within the client/counsellor relationship, always provided that such confidentiality is neither inconsistent with the therapist's own safety or the safety of the client, the client's family members or other members of the public (1)	No
UK Association for Humanistic Psychology Practitioners	A Registrant may disclose client information to a third party without consent if the client discloses information about a threat to their health and safety or the health and safety of others.(3.10)	No
UK Council for Psychotherapy	Notify clients, when appropriate or on request, that there are legal and ethical limits to confidentiality, and circumstances under which confidential information might have to be disclosed to a third party. (21)	No

Table 2 – Disclosure advice in codes of psychotherapy

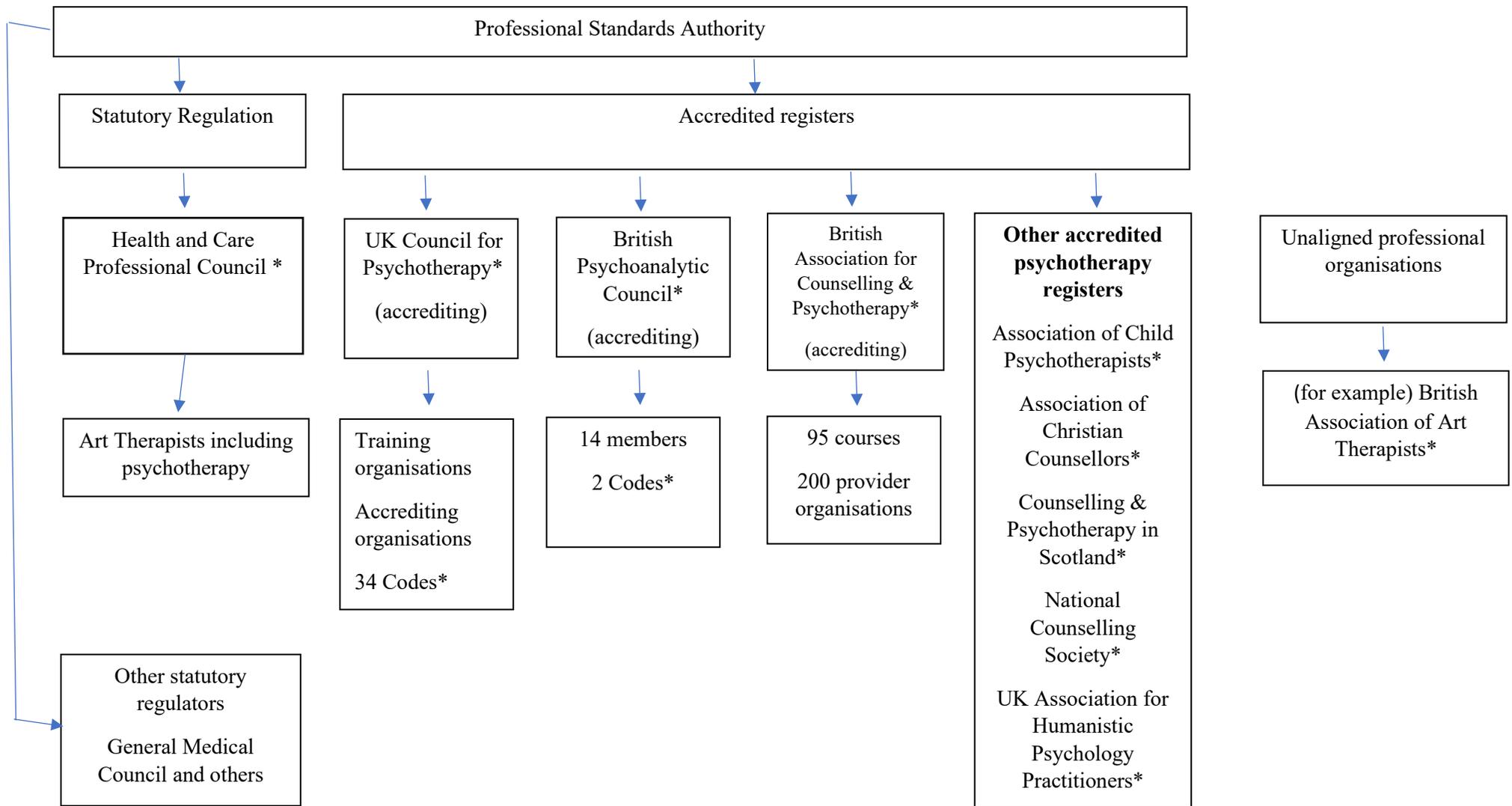


Figure 1 – regulatory organisations covering psychotherapy in the UK * denotes organisations which produces a code