

The Association for Dance Movement Psychotherapy UK

ADMP UK

CODE OF PROFESSIONAL PRACTICE

Dance Movement Psychotherapy (DMP), the most physical of the arts therapies, recognizes body movement as an implicit and expressive instrument of communication. Harnessed therapeutically and irrespective of age, culture and background dance movement offers both a way of assessment and of treatment for a range of neurological, psychological, relationship and social problems. It moreover yields opportunities for people who wish to develop their own creative potential. DMP is practiced as individual and as group therapy in health, education, social service and other settings and in private practice. The profession is continually informed by the results of international research and by initiatives and projects that open up and extend the field of DMP practice.

Introduction

Dance Movement Psychotherapists (hereinafter referred to as practitioners or therapists) who are members of the ADMP (also referred to as the Association) agree to work within the ethical framework of the *ADMP UK Code of Professional Practice*. Its purpose is to help safeguard the professional standards of the Association, its members and trainees and thus to protect the client from unethical practice. With its guiding principle that the practitioner strives always to act in the best interest of the client, and particularly so when working with children, the *Code* is binding upon all registered members and trainees.

The *Code* entrusts the practitioner with a number of important legal and other responsibilities. Whilst it cannot be exhaustive, it is intended to serve as a practical guide and as a touchstone for the ADMP therapist whose own judgement, integrity and other personal qualities are equally brought to bear on the therapeutic relationship and on difficult ethical decisions that may be encountered in his/her practice.

Members with any doubts or difficulties concerning such decisions or with specific questions of professional practice are encouraged (as indicated in some clauses of the *Code*) to contact the Association's Chairperson (admpchair@hotmail.com) who may, at her/his discretion, discuss the matter with the Executive Council.

Acknowledgements

It is in the nature of psychotherapy and the arts therapies that they have in common many ethical rules and guidelines. In this light the *ADMP UK Code of Professional Practice* draws not only on the Association's 2003 *Code* and on the Codes of the American Dance Therapy Association, the Dance Voice Dance Movement Therapy Centre and the draft Code for the future European Association of Dance Movement Therapy but also on those of the British Association of Dramatherapists, the British Association for Counselling and Psychotherapy and the British Psychological Society.

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1. Registration, Supervision and Continuous Professional Development

1.1. Following its change of name to the *Association of Dance Movement Psychotherapy* (ADMP) in 2008, practitioners are now registered under the title of Dance Movement Psychotherapist (RDMP). More senior practitioners can apply to be on the Supervisors Register (SRDMP). (*See* www.admt.org.uk). ADMP will be introducing separately the requirements - and the necessary application procedures - for RDMPs to qualify for the Supervisors Register and to have a private practice. In the interim, members of the Association are asked to keep abreast of developments as these are posted in due course on a new ADMP website.

1.2. The therapist must ensure adequate supervision for his/her practice. To this end, appropriate verbal or written agreements with supervisors are useful. It is strongly recommended that practitioners and supervisors take account of, and work within, the published Guidelines for Supervision. (*See* www.admt.org.uk).

1.3. Members must sign the Continuous Professional Development (CPD) declaration on the membership renewal form and, retaining a copy for themselves, submit the completed CPD log sheet in order to be eligible to renew their licence to practice.

2. Scope and limits of practice

2.1. Whilst enjoying considerable freedom of therapeutic approach and using a range of movement and dance-making techniques, the therapist practices within the limits of her/his own level of training, experience and competence. Thus, for the purposes of diagnosis, treatment planning or research, the practitioner employs only those assessment techniques (verbal or non-verbal) for which training has been received.

2.2. Before accepting clients in therapeutic contexts that are outside the therapist's area of skill and experience, he/she is expected to acquire the requisite knowledge and/or training. If necessary, the therapist will consult with - or refer clients to - relevant specialists.

2.3. The therapist will refrain from practice if his/her professional competence is significantly impaired by health-related or other problems or by being under the influence of intoxicants or drugs.

3. Therapeutic environment, contracts and confidentiality

3.1. The practitioner shall ensure that the therapeutic environment meets satisfactory standards of safety, security and privacy.

3.2. A therapeutic contract may be entered into freely between the practitioner and a prospective client or her/his confirmed guardian (parent, carer or other responsible person hereinafter referred to as 'representative'). Nevertheless, if the client is already in therapy or under medical treatment communication among all parties is encouraged notably, for example, if DMP is a concomitant therapy in the client's overall health treatment plan.

3.3. The therapist and client or client's representative shall, at the outset and in their common interest, agree on terms of engagement which specify 1) the frequency and duration of sessions 2) arrangements concerning holidays, missed appointments and payment of fees (where applicable) and 3) the manner and timing of termination of therapy.

3.4. The therapist, before asking for their necessary signed consent will make sure that clients and/or their representatives are fully informed about the purposes and use of any audio/video recordings made or photographs taken within the therapeutic environment. In addition, clients and/or their representatives will be informed that they can, at any time, withdraw their permission.

3.5. The therapist will, at the outset, explain to the clients and /or their representatives the nature of and limitations to confidentiality surrounding therapeutic material. There may be a need to discuss aspects of the therapy not only with supervisors but with colleagues too in order to ensure effective overall treatment. Substantial breaches of confidentiality may be

justified if the therapist has sufficient evidence to be concerned about the health, welfare or safety of the client or of other people who may be endangered by the client's actions or behaviour. Imperative limitations on confidentiality are those imposed by law.

4. Responsibilities to clients

4.1 The therapist is aware of, and works within a framework of legal, political and social contexts pertinent to the U.K. or, if abroad, those of the host country. In doing so, she/he assures a practice in which the client is treated in a just and fair manner, and the therapeutic activities the client is drawn to participate in are considerate of the person's culture and beliefs and respect his/her rights.

4.2. In endeavouring to keep an open mind towards the many and various protocols, conventions and customs proper to different cultures the therapist aims always to act and make decisions based on anti-discriminatory principles and values and adapts practice to meet the needs of people and groups of people of different backgrounds.

4.3. If confronted with what seem to be professionally or deontologically compelling reasons for believing that an ADMP colleague is placing a client or clients at serious risk of harm, the therapist should raise his/her concerns with the practitioner in the first instance and, if necessary, follow the therapeutic setting's protocol for complaints. If none of these approaches is effective, the Association's Chairperson may be consulted.

4.4. Whether the issue(s) relate(s) to health, standards of professional conduct or to other matters, a supervisor with major concerns about her/his supervisee's fitness to practice are advised to take these to supervision and, if necessary, to consult the Association's Chairperson on how best to help that supervisee.

4.5. Should a client or representative have a grievance which cannot be resolved through discussion with the therapist, the client or representative ought to be informed about the existence of the Association's Complaints Procedure (see article 11) and be given advice on how to proceed.

5. Responsibilities to trainees, trainees on placement and in supervision

5.1. The practitioner will most carefully consider possible implications of dual relationships involving clients: for example, accepting as a client anyone with whom she/he has personal or professional connections, including assistants and trainees/students.

5.2. Any practitioner serving as a training course convenor/coordinator (CCC) or who is connected with the training, supervision or placement of a trainee shall not act as the individual or group therapist for that trainee.

5.3. It is the duty of the CCC to ensure that a trainee is well supervised in the carrying out of any clinical responsibilities delegated to her/him.

5.4. If there are serious doubts about a trainee's development into a competent therapist the CCC should, in the interests of the trainee and of potential future clients on her/his placement, discuss these concerns with the trainee. If appropriate, the CCC may suggest additional or alternative actions, for example, that the trainee increase personal therapy or re-apply for training after a specified time.

6. Boundaries of the therapeutic relationship

6.1. The boundaries of the therapeutic relationship must be respected at all times. The therapist complies with moral, ethical and legal standards of behaviour; refuses to participate in activities that are illegal or inhumane, that result in discrimination or violates another's legal or civil rights; respects regulations concerning the conduct of research with individuals.

6.2. Therapists should be especially aware of the diverse and complex types of physical contact within the therapeutic relationship. DMP necessitates a relational engagement of bodies. Notably, the developmental focus of DMP theory and practice values the potential of physical contact and this is supported by neurological evidence that early life experiences of touch promote brain development, attachment and emotional regulation.

6.3. Consequently, physical contact can be useful and can have positive effects for a range of DMP client groups at different points within the psychotherapeutic process. Through ongoing supervision, the practitioner must be ready to engage with, question and sensitively appreciate the differences between boundary 'crossing' and 'violating' in terms of touch. Under no circumstances does the therapist engage in sexual or abusive physical contact with clients.

6.4. Further discernment requires the therapist to examine her/his own social values about touch and those of clients. Important considerations when working with touch are: levels of physical and cognitive ability, gender, sexuality, ethnicity and history of abuse or political torture. The quality of touch and instances of physical contact may vary: with props only, through peripherals (e.g. finger tips or elbows touching) or whole body (as in a contact improvisation dance). Alternatively, there may be instances in the therapeutic relationship where there is no engagement in physical contact and a 'no touch' ground rule established between therapist and individual, or therapist and group members.

6.5. Most importantly, the client's permission to engage in physical contact during the therapeutic relationship is paramount and must be an issue of ongoing consensual decision-making between client/s and therapist.

6.6 The therapist, aware of the range and complexities of emotions and feelings that can arise within the therapeutic relationship - fully recognizes that, for the duration of the treatment and a minimum of 5 years after the therapy, a personal or social relationship with the client is strongly advised against; and that it is unacceptable (1) to engage in sexual intimacy with a client or 2) to employ or involve a client in a business venture. The therapist is mindful too of the importance that any relationship with a client after therapy terminates is not exploitative.

7. Disclosure of confidential material

7.1. Unless authorized by the client or required – at the appropriate level – by the law, the therapist shall shield from disclosure all sensitive information pertaining to the client and shall not allow access of third parties to any video and audio recordings or photographic images or to identifiable written material, drawings or other art work produced by the client during the course of therapy.

7.2. Legitimate disclosures of a confidential nature should be handled with due care and in a manner that respects the client's trust in the therapist and the Association.

7.3. In current ADMP practice all therapeutic records whether digitally stored or not (e.g. written notes, photographs) must be held in a safe place for a minimum of 7 years following the termination of therapy.

Note: The *Data protection Act 1984* gives clients access to computer held records. The *Access to Health Records Act 1990* gives clients the right to access manual health records made after 1 November, 1991. Further information can be found in *Guide to Access to Health records Act 1990* published by Government Health Departments. In some cases, a client may be declined access to his/her records.

8. Research protocol

8.1. The practitioner shall explain to clients and/or their representatives the objectives of any research project in which they are asked to participate, what the project would involve, how it would be organized and whether or not it would include photography, filming etc. In addition he/she shall ensure that for those who agree to participate their consent is both informed and freely given and that it is understood that they can withdraw from the project at any time.

8.2. The therapist strictly respects the right of the client to anonymous representation in both published and unpublished reports of a research project in which the client features.

8.3. Research is conducted and published according to international standards of good practice. These include appropriate recognition of the contributions of colleagues or other participants as well as due acknowledgements for financial or other support e.g. from funding bodies, academic institutions and employers, who may themselves have their own specific guidelines and rules. The researcher needs to be conversant with these, as she/he should seek to be with any pertinent government legislation.

8.4. The researcher takes particular care to ensure that the presentation of results that have therapeutic implications is not open to misinterpretation.

8.5. Data and other material resulting from research projects should be kept in a secure manner for at least 7 years.

9. Public broadcasting

9.1. Before considering a client for possible participation in a public media broadcast, the therapist shall assess the client's emotional and psychological vulnerability.

9.2. Participating clients and/or their representatives must be informed of the intent of the broadcast and that the broadcast itself might affect third parties, possibly leading to litigation. Additionally, for their permission to be considered as freely given the participants must first be advised of any consequences that a change of mind might bring and that a withdrawal of consent during the process of recording could constitute a breach of contract.

9.3. It is recommended that legal advice be sought before any contract with a broadcaster is signed by the therapist, participants, their representatives and/or other parties, for example the Association or the host of the 'setting'. Contracts should be in writing. They should state the intent of the broadcast and cover any boundaries concerning content that are stipulated by the participants.

9.4. Once final approval has been given, the material commonly belongs to the broadcasting/production company. However, it is advisable that the therapist asks to be actively associated with the editing process in order to facilitate respect of agreed limits of content and other terms of the contract.

10. Insurance

10.1. Holding a certificate of insurance against possible claims for damages arising from their work either in private practice or undertaken for an employer, is a *sine qua non* for the ADMP therapist. The therapist who relies on an employer's indemnity arrangements is advised to verify that these are adequate. The practitioner must provide evidence of insurance when required by the client and/or ADMP.

11. Complaints and legal action

11.1. In the event of facing possible legal action in connection with his/her practice, an ADMP member must inform the Association's Chairperson without delay.

11.2. A complainant who contacts the Association will be sent a copy of the Complaints Procedure and an attached form on which the complaint should be written. This form is forwarded to the Association's Chairperson who will, at her/his discretion, refer it to the Executive Council of the Association for an opinion.

11.3. The therapist concerned will be informed of any such complaint and invited to comment on it. In doing so it may be in the therapist's interest to consult any relevant sections of the Public Interest Disclosure Act/Order, 1999.

11.4. The Executive Council shall have recourse to the following recommendations: reprimand; a period of required supervision; suspension or withdrawal of registration and/or membership of the Association.

11.5. The Executive Council will treat any pending proceedings involving a member of the Association as confidential.

11.6. The complainant will be kept appropriately informed.

Note to reader

This *Code* relates to the current *status quo* of ADMP UK. It is subject to modification pending a decision of the Health Professional Council (HPC) and the Department of Health (DoH) on the formal recognition and regulation of the Dance Movement Psychotherapy (DMP) profession, the protection of professional titles and the associated registration of its members. The same reservation holds true for our projected membership of the future European Association of Dance Movement Therapy (EADMT) and the Association's own forthcoming procedural changes (notably e.g. for qualifying as a supervisor). In this evolving context, ADMP recommends that therapists be aware of and inform their practice in accordance with any relevant guidelines published by NICE (the National Institute for Health and Clinical Excellence) (www.nice.org.uk) and the HPC Standards of Proficiency (www.hpc-uk.org).

FOR ANY ADDITIONAL INFORMATION OR QUERIES CONCERNING THIS CODE PLEASE CONTACT admin@admt.org.uk

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