# The Metanoia Institute

# Touch Policy

# 2026

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**Principal Authoring Department:** Peter Pearce, Director of Clinical Training

**Approved by:**
Academic Board

**Date approved**: 30th June 2026

**Version Control**

| **Document title: Touch Policy** | **No of pages:** |
|---|---|
| **Version Number: 2.0** | **Date first published: July 2026** |
| **Approved by: Academic Board** | **Last review date: n/a** |
| **Date originally approved**: 30th June 2026 | **Due for next review:** June 2030 or earlier if standards, legislation, PSRB requirements or institutional risk require review |

# Table of Contents

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**Document Control dates:**

- Joint Staff Student Consultation Committee, 2nd June 2026, for discussion.
- Ethics Committee 9th June 2026 for endorsement.
- Education Committee, 18th June 2026, for endorsement.
- Academic Board 30th June 2026, for approval.

**Related Metanoia policies**

This Document works in collaboration with the following Metanoia policies/framework(s):

- Clinical Ethics Handbook Safeguarding; Fitness to Practise; Student Conduct; Complaints; Clinical Placement; Equality, Diversity and Inclusion; Data Protection; Supervision; Academic Regulations

# Introduction

### 1. Purpose and policy statement

Metanoia Institute is committed to maintaining safe, ethical, inclusive and professionally accountable practice in psychotherapy, counselling, psychological therapies education, supervision, clinical placement and associated teaching and learning activity. This policy sets out the Institute expectations for considering, using, responding to, documenting and supervising physical touch in professional and educational contexts.

Metanoia Institute neither promotes nor prohibits touch as a therapeutic intervention. Touch may only be considered where it is clinically or pedagogically justified, ethically defensible, consistent with the practitioner or trainer competence and modality, and compliant with all relevant professional, organisational, legal and safeguarding requirements.

The policy is intended to support reflective, trauma-informed and culturally responsive decision-making. It does not replace professional judgement, supervision, safeguarding duties, placement requirements, client contracts, programme handbooks or the ethical frameworks of the relevant professional body. It establishes a minimum institutional standard. **Where any other applicable standard is stricter, the stricter requirement must be followed.**

### 2. Professional, legal and regulatory context

This policy is informed by the ethical and professional expectations that apply to counselling, psychotherapy and psychological therapies education in the United Kingdom. It should be read alongside current requirements of the relevant professional, statutory and regulatory bodies, awarding bodies, validating partners and placement organisations.

Reference has been made to:

- UKCP Code of Ethics and Professional Practice and relevant UKCP standards, guidance and college requirements.
- BACP Ethical Framework for the Counselling Professions and BACP good practice resources on boundaries, consent, supervision and professional conduct.
- BPS Code of Ethics and Conduct, where programmes, staff or students are working in contexts where BPS principles of respect, competence, responsibility and integrity are relevant.
- Equality Act 2010 and the public and institutional duties to prevent discrimination, harassment and victimisation and to promote inclusive practice.
- Safeguarding legislation and statutory guidance applicable to work with children, young people and adults at risk.
- Higher education governance expectations relating to student conduct, fitness to practise, complaints, quality assurance, clinical placement governance and risk management.

This policy does not provide legal advice. Where legal, safeguarding, clinical or professional uncertainty exists, practitioners and trainees must seek advice through supervision, programme leadership, safeguarding procedures, placement management or relevant professional bodies as appropriate.

## Roles and Responsibilities

### 3. Roles and responsibilities

| Role | Responsibility |
|---|---|
| **Practitioners and trainees** | Apply this policy, work within competence, obtain consent, document appropriately, use supervision and escalate concerns. |
| **Supervisors** | Support reflective ethical decision-making, challenge unsafe practice, review documentation and escalate concerns where necessary. |
| **Trainers and assessors** | Ensure touch-based learning is justified, consent-based, inclusive, supervised and appropriately assessed. |
| **Heads of Programme** | Communicate expectations to students, monitor placement compatibility and ensure concerns are managed through appropriate procedures. |
| **Placement providers** | Communicate local boundary and touch policies, including any no-touch requirements, and collaborate with programme teams where concerns arise. |
| **Ethics Committee** | Maintain oversight of ethical guidance, review policy effectiveness and advise on complex ethical issues. |
| **Education Committee/ Academic Board** | Ensure implementation across programmes, curricula, supervision expectations and quality assurance processes. |
| **Safeguarding lead** | Advise on safeguarding concerns and ensure compliance with statutory and institutional safeguarding duties. |

## Purpose and Scope

### 4. Scope and application

This policy applies to all Metanoia Institute staff, trainees, students, supervisors, trainers, assessors, clinical placement supervisors, visiting lecturers, agency workers and any person acting on behalf of the Institute in a learning, clinical, supervisory or assessment capacity.

The policy applies to:

- therapeutic work undertaken as part of training, placement, research clinics, clinical services or supervised practice;
- teaching, demonstrations, simulations, experiential learning, skills practice and assessment;
- supervision, consultation and reflective practice where touch is discussed, modelled or reviewed;
- clinical work with adults, children, young people, couples, families and groups;
- in-person professional activity occurring on Institute premises, placement premises, community settings or other approved learning and practice environments.

The policy applies to touch initiated by practitioners, trainers, supervisors or trainees, and provides guidance for responding to client-initiated or student-initiated touch. It is not intended to regulate accidental contact or ordinary movement within shared spaces, but such events may still require sensitivity, reflection and documentation where clinically significant.

## 5. Definitions and categories of touch

For the purposes of this policy, touch means intentional physical contact between a practitioner and client, trainer and student, supervisor and supervisee, or participants in a formal Institute learning activity. Touch may include, but is not limited to, handshakes, a hand on the arm or shoulder, holding a hand, hugging, body-oriented contact, grounding contact, demonstration of therapeutic techniques, or modality-specific body psychotherapy interventions.

This policy distinguishes the following categories:

| Category | Description | Examples | Governance expectation |
|---|---|---|---|
| Level 1: Socially normative contact | Brief, ordinary, culturally situated contact that is not intended as a therapeutic intervention. | Handshake; brief greeting contact; culturally normative parting gesture. | Professional judgement. Record only where clinically significant, declined in a significant way, repeated, ambiguous or relevant to therapy. |
| Level 2: Supportive or stabilising contact | Brief touch used with a clear therapeutic purpose, normally time-limited and explicitly consented to. | Touch to forearm for grounding; brief handhold in exceptional circumstances; supportive touch on shoulder if appropriate. | Clear rationale, explicit consent, documentation and supervision where indicated. |
| Level 3: Structured therapeutic touch | Planned or repeated touch forming part of a recognised modality or structured body-oriented intervention. | Body psychotherapy technique; sensorimotor intervention; sustained holding or structured contact. | Enhanced consent, full documentation, competence evidence, regular supervision and review. Written consent is normally required. |
| Prohibited touch | Any touch that is sexualised, coercive, exploitative, confusing, outside competence or unsafe. | Sexual contact; touch for practitioner comfort; touch where consent is absent or compromised. | Not permitted. Escalation through safeguarding, conduct, complaints or fitness-to-practise procedures as appropriate. |

The categories are intended to support proportionate judgement. They do not remove the need to consider context, power, culture, trauma, capacity, consent and safeguarding in every case.

## 6. Core ethical principles

All decisions about touch must be guided by the following principles:

- **Autonomy:** Clients and students have the right to make informed choices about participation, bodily boundaries and withdrawal of consent.
- **Beneficence:** Touch must be in service of the client therapeutic need or the student learning objective, not the practitioner or trainer preference.
- **Non-maleficence:** Practitioners must actively avoid foreseeable harm, including retraumatisation, dependency, misattunement, shame, confusion or sexualisation.
- **Integrity:** Practitioners must be honest with themselves, clients, students and supervisors about motivation, uncertainty and risk.
- **Professional competence:** Touch must only occur within the limits of training, assessed competence, modality, role and supervision.
- **Accountability:** Decisions must be capable of being documented, explained, supervised and reviewed by an appropriate professional or governance body.
- **Safeguarding:** Protection from harm is paramount, especially for children, young people and adults at risk.
- **Cultural humility:** The meaning of touch must never be assumed to be universal or benign.

## 7. Equality, diversity, inclusion and anti-oppressive practice

The Institute recognises that touch is culturally, socially, relationally and historically situated. Its meaning may be shaped by ethnicity, race, nationality, religion or belief, disability, neurodivergence, age, gender identity, sex, sexual orientation, pregnancy and maternity, relationship status, class, migration history, trauma, attachment experience, body image, health status and previous experiences of discrimination or abuse.

Practitioners must not assume that a gesture considered ordinary or acceptable by one person, culture or professional tradition will be experienced in the same way by another. This includes greetings and partings such as handshakes, hugs or kisses, which may be normative in some cultural or social contexts and unwelcome, unsafe or confusing in others.

Anti-oppressive practice requires practitioners and trainers to consider power, privilege and institutional authority. Students and clients may feel unable to decline touch because of perceived dependence, assessment, immigration status, disability, previous coercion, cultural politeness norms or fear of disappointing the practitioner. Consent must therefore be invited in ways that make refusal genuinely possible and free from adverse consequences.

## 8. External organisations, placements and stricter no-touch settings

Where trainees, practitioners or staff are working in external organisations, including NHS services, schools, colleges, charities, community agencies, hospitals, social care settings, prisons, private providers or placement settings, the requirements of the host organisation must be followed. If the host organisation operates a no-touch policy or a more restrictive boundary policy, that policy overrides this Institute policy.

This policy must not be used to justify touch in any setting where it is prohibited by local policy, contract, professional code, safeguarding plan, care plan, programme requirement or placement agreement. Trainees are responsible for knowing the requirements of their placement and seeking

clarification before any touch is considered. Programme teams and placement providers should ensure that relevant expectations are communicated at induction and reviewed where risks arise.

## Policy

### 9. Therapist-initiated touch

Therapist-initiated touch means touch proposed, offered or initiated by a therapist, counsellor, practitioner, trainee, supervisor or trainer. The threshold for therapist-initiated touch is high because of the power imbalance inherent in therapeutic and educational relationships.

Therapist-initiated touch may only be considered where all the following apply:

- there is a clear and specific therapeutic or pedagogical rationale;
- the proposed touch is consistent with the practitioner's modality, training and competence;
- non-touch alternatives have been considered and documented where appropriate;
- client-specific or student-specific factors have been assessed, including trauma, attachment, culture, disability, safeguarding and capacity;
- the practitioner has reflected on their own motivation and potential transference or countertransference dynamics;
- informed consent has been explicitly obtained and remains ongoing;
- the proposed touch could be documented and justified to a supervisor, programme lead, safeguarding lead, Ethics Committee or professional conduct panel.

Touch must not be introduced spontaneously as a response to practitioner discomfort, rescue feelings, affection, attraction, frustration, dependency, curiosity or desire to be helpful without adequate reflection. Where there is uncertainty, touch should not proceed until supervision or appropriate consultation has occurred, except where immediate physical intervention is necessary to prevent imminent harm and is lawful, proportionate and documented.

### 10. Client-initiated touch

Client-initiated touch means touch offered or initiated by the client, for example extending a hand, reaching for the therapist hand, moving towards a hug at the end of a session, or initiating culturally normative greeting or parting contact. The fact that the client initiates touch does not remove the practitioner responsibility for boundaries, safety and professional judgement.

Practitioners should respond in a manner that is respectful, culturally sensitive, clinically attuned and ethically defensible. Possible responses include accepting brief socially appropriate contact, gently declining, redirecting verbally, naming the moment for reflection, or exploring the meaning of the request within the therapeutic dialogue. The appropriate response will depend on the client, context, relationship, setting, safeguarding considerations, cultural meaning and the nature of the therapeutic work.

Refusing client-initiated touch must be handled with care. A client may experience refusal as rejection, shame, punishment, cultural disrespect or emotional abandonment. Conversely, accepting touch may also be experienced as confusing, intimate, parental, sexualised, rescuing or boundary-blurring.

Practitioners should be prepared to explore the meaning of either acceptance or refusal where clinically appropriate.

Where client-initiated touch is repeated, intense, ambiguous, emotionally charged, linked to trauma or attachment material, or otherwise clinically significant, it must be documented and discussed in supervision.

## 11. Greetings, partings and ordinary social conventions

The Institute recognises that changing social norms and cultural diversity mean that greetings and partings may include different expectations about handshakes, hugs, kisses, gestures of respect or avoidance of contact. There is no single institutional rule that will fit all therapeutic and educational contexts.

Brief socially normative contact, such as a handshake, may occur and does not automatically constitute a therapeutic intervention. However, practitioners should remain aware that even ordinary social touch can affect the therapeutic frame, particularly at beginnings, endings, moments of distress, assessment points or transitions.

The following expectations apply:

- do not assume that greeting or parting touch is expected, harmless or universally understood;
- where possible, allow the client or student agency and avoid imposing touch as a social norm;
- decline or redirect touch in a warm and respectful way where required by boundaries, policy or clinical judgement;
- consider whether the meaning of the greeting or parting should be explored in the therapeutic dialogue;
- document where the contact, acceptance or refusal is clinically significant, unexpected, repeated or potentially ambiguous.

## 12. Consent and capacity to consent

Consent is a continuing relational process, not a single event or a signature alone. It must be informed, specific, freely given, reversible and revisited. Practitioners must attend to verbal and non-verbal signs of discomfort, compliance, dissociation, freeze responses, appeasement or withdrawal.

Before any Level 2 or Level 3 touch, the practitioner must explain:

- why touch is being considered;
- what kind of touch is proposed, including location, duration and likely experience;
- what alternatives are available;
- that refusal will not negatively affect the therapeutic relationship, assessment, service access or training progression;
- that consent may be withdrawn at any point;
- how the intervention will be reviewed and documented.

Meaningful consent may be compromised by fear, distress, dissociation, intoxication, cognitive impairment, acute mental health crisis, developmental stage, dependency, coercion, assessment

pressure or unequal power. Where meaningful consent cannot be obtained, touch must not proceed except where immediate physical action is legally and ethically necessary to prevent imminent harm.

Written consent is normally required where touch forms part of an ongoing structured therapeutic approach, body psychotherapy intervention, repeated practice arrangement, or training exercise involving planned physical contact. Written consent does not remove the need for ongoing verbal and embodied consent at the point of contact.

### 13. Clinical decision-making and risk assessment

Practitioners must use reflective decision-making before initiating touch. The following areas must be considered proportionately to the proposed level of touch:

- clinical purpose and expected benefit;
- non-touch alternatives;
- client history, trauma and attachment patterns;
- safeguarding status and risk of harm;
- capacity and consent;
- cultural and social meaning;
- power differentials and dependency;
- modality, competence and training;
- transference and countertransference;
- placement, organisational and professional requirements;
- record keeping and supervision.

The central test is whether the decision would remain ethically defensible if reviewed later by the client, supervisor, placement provider, safeguarding lead, complaints investigator, fitness-to-practise panel, professional body or court. If the answer is uncertain, practitioners should pause and seek supervision or advice.

### 14. Prohibited touch and boundary breaches

The following are prohibited:

- sexual contact, sexualised touch, eroticised touch or touch that could reasonably be experienced as sexualised;
- touch used to meet the practitioner emotional, relational, physical or sexual needs;
- touch initiated without meaningful consent;
- touch that is coercive, punitive, shaming, intrusive, secretive or exploitative;
- touch outside the practitioner training, competence, role, modality or placement permission;
- touch where the client or student is unable to consent meaningfully;
- touch that breaches safeguarding, risk management or host organisation requirements;
- touch that creates or reinforces dependency, role confusion, dual relationships or special status;
- touch where the practitioner would not be willing to document and discuss the decision openly in supervision.

Any breach may be addressed under safeguarding, complaints, disciplinary, student conduct, fitness-to-practise, professional conduct or regulatory procedures. Serious misconduct may require notification to professional bodies, placement providers, statutory agencies or other relevant authorities.

## 15. Documentation and record keeping

Documentation must be proportionate to the nature, duration, frequency and significance of the touch. Records must be factual, timely, respectful, clinically relevant and sufficient to demonstrate ethical decision-making.

For Level 2 and Level 3 touch, records should normally include:

- the rationale for considering touch;
- the alternatives considered;
- how consent was sought and obtained;
- the type, location and duration of touch;
- the client or student response during and after the contact;
- any observed benefit, discomfort, ambiguity or adverse impact;
- follow-up discussion and meaning-making within the therapeutic or learning relationship;
- supervisory consultation or planned review;
- any safeguarding, placement or organisational considerations.

For Level 1 contact, such as a handshake, routine documentation is not required unless the interaction is clinically significant, refused in a way that becomes therapeutically meaningful, repeated, ambiguous, linked to endings or attachment themes, or relevant to safeguarding or complaint risk.

## 16. Supervision and escalation

The use, proposed use, refusal, client initiation or impact of touch should be reflected upon in supervision where clinically relevant. Supervision is essential for sustaining safe, ethical and professionally accountable practice.

Supervisors should attend to:

- the therapeutic rationale and proportionality of touch;
- patterns of recurring touch;
- boundary maintenance and the therapeutic frame;
- dependency and attachment dynamics;
- transference, countertransference and enactments;
- practitioner rescue fantasies, attraction, avoidance or discomfort;
- EDI and cultural meaning;
- safeguarding implications;
- placement requirements and competence limits;
- quality and adequacy of documentation.

Trainees must discuss any planned Level 2 or Level 3 touch with their supervisor before proceeding, unless immediate safety considerations require proportionate action. Any incident, complaint, uncertainty or adverse client response must be escalated promptly to the supervisor and, where appropriate, the programme lead, clinical lead, placement manager or safeguarding lead.

## 17. Teaching, training, skills practice and assessment

Touch in teaching and training requires a clear pedagogical rationale and must be consistent with the learning outcomes, modality, assessment requirements and student welfare responsibilities of the programme. Trainers must not assume that students are willing to participate in touch-based exercises because they are enrolled on a particular programme.

Before any planned touch-based exercise, trainers must:

- explain the purpose, boundaries, process and learning outcomes;
- identify the type, location and duration of proposed touch;
- make explicit that students may decline participation without penalty;
- provide alternatives where reasonably practicable;
- address confidentiality, privacy and respect within the group;
- check for relevant access, disability, trauma, cultural or religious considerations;
- ensure appropriate supervision, observation and debriefing;
- avoid using assessment power in a way that compromises free consent.

Touch-based demonstrations must be undertaken only by appropriately competent trainers. Students must not be required to disclose personal trauma, body history or reasons for declining. Participation or non-participation must not adversely affect academic progression unless touch competence is an explicit, professionally justified and previously communicated learning outcome of the programme, and even then, reasonable adjustments and alternative assessment arrangements must be considered.

## 18. Children, young people and adults at risk

Enhanced safeguarding duties apply when working with children, young people and adults at risk. Touch may carry additional developmental, legal, institutional and relational implications in these contexts. Practitioners must ensure that any touch is demonstrably in the interests of the client, consistent with safeguarding procedures, and compliant with the placement or service setting.

Care is required where clients have experienced abuse, neglect, institutional harm, coercive control, exploitation, grooming, disability-related dependency, attachment disruption or boundary violations. Practitioners must consider whether the client developmental stage, communication needs, neurodivergence or disability affects understanding, consent or ability to object.

Where touch occurs in child, adolescent or adult-at-risk contexts, documentation and supervision expectations are heightened. If there is any safeguarding concern, practitioners must follow the Institute safeguarding policy and local safeguarding procedures immediately.

## 19. Remote, online and hybrid contexts

Touch cannot be directly used in remote or online therapy, but the meaning of touch may still arise in online work through discussion, imagery, self-touch grounding exercises, somatic interventions, online skills demonstrations or client requests relating to future in-person contact. Practitioners must apply the same principles of consent, competence, safeguarding and documentation to any instruction or suggestion involving the client touching themselves or being touched by another person.

Practitioners must not direct clients to engage in self-touch or body-based exercises without explaining purpose, consent, alternatives and risks. Care is required where cameras, recording, privacy, sexual trauma, dissociation or safeguarding issues are present.

## 20. Complaints, concerns and fitness to practise

Concerns about inappropriate or unsafe touch may be raised by clients, students, staff, supervisors, placement providers or third parties. Concerns must be responded to promptly, respectfully and in accordance with relevant institutional procedures.

Depending on context, concerns may be addressed through:

- safeguarding procedures;
- client complaints procedures;
- student conduct or fitness-to-practise procedures;
- staff disciplinary procedures;
- clinical placement procedures;
- professional conduct, accreditation, registration or membership procedures of the relevant professional body;
- referral to statutory agencies where required.

No person should be disadvantaged for raising a genuine concern about touch, boundaries, consent or safety. The Institute will take immediate action where there is evidence of risk of harm.

## 21. Monitoring, reporting and review

The policy will be reviewed every two years, or earlier where there are changes in legislation, PSRB requirements, professional standards, safeguarding guidance, institutional risk, complaints learning, serious incidents or Ethics Committee recommendations.

Programme teams should ensure that the policy is communicated through student handbooks, placement guidance, trainer induction, supervision guidance and relevant module materials. Ethics Committee should receive periodic assurance that the policy remains fit for purpose and that learning from concerns, complaints or incidents has informed practice.

## Appendix A. Touch continuum and documentation framework

| Level | Indicative examples | Consent expectation | Documentation expectation | Supervision expectation |
|---|---|---|---|---|
| Level 1 | Handshake; brief greeting or parting contact. | Do not impose. Respect refusal. | Document only if clinically significant, repeated, declined in a significant way or ambiguous. | Discuss if clinically meaningful. |
| Level 2 | Brief grounding touch; brief hand-hold; supportive contact. | Explicit consent at the time, with right to decline and withdraw. | Document rationale, consent, type of touch, client response and follow-up. | Discuss where planned, repeated, uncertain or impactful. |
| Level 3 | Structured or repeated body-oriented touch; modality-specific therapeutic contact. | Explicit and ongoing consent. Written consent normally required. | Full record including risk assessment, alternatives, consent, response, review and supervision. | Prior supervision normally required for trainees; regular review for all practitioners. |
| Prohibited | Sexualised, coercive, exploitative, secretive, unsafe or competence-inconsistent touch. | Consent cannot legitimise unethical or exploitative touch. | Record and escalate as incident or concern. | Immediate escalation to supervisor, safeguarding lead or programme lead as appropriate. |

### Appendix B. Decision-making checklist

Practitioners should use the following checklist before initiating Level 2 or Level 3 touch and after any clinically significant client-initiated touch.

#### Clinical purpose

- What is the therapeutic or pedagogical purpose?
- Is touch necessary, or would a non-touch intervention meet the aim?
- How does this link to the agreed therapeutic goals or learning outcomes?

#### Client or student factors

- What is known about trauma, attachment, disability, culture, religion, neurodivergence or previous boundary harm?
- Can the person meaningfully consent today?
- Is there any safeguarding risk or power-related pressure?

#### Practitioner factors

- Am I competent and authorised to use this form of touch?
- What are my motivations and emotional responses?
- Could transference, countertransference or enactment be influencing this decision?

**Context**

- Does the placement, organisation or programme permit this?
- Would stricter external requirements override this policy?
- Would I be comfortable documenting and explaining the decision?

**Consent and review**

- Has explicit consent been obtained?
- How will consent be checked during and after contact?
- How will the intervention be documented and reviewed in supervision?

## Appendix C. Sample client consent record for therapeutic touch

This template may be adapted for clinical records. It should not be used as a substitute for ongoing consent and clinical judgement.

| | |
|---|---|
| **Client name / identifier** | |
| **Practitioner name** | |
| **Date** | |
| **Therapeutic rationale for proposed touch** | |
| **Type, location, duration and frequency of proposed touch** | |
| **Alternatives discussed** | |
| **Risks, safeguards and boundaries discussed** | |
| **Review date / supervision arrangements** | |

Consent statement: I understand the purpose of the proposed touch, what is being proposed, and the alternatives available. I understand that I may decline or withdraw consent at any time without negative consequences for my therapy or care. I understand that the practitioner will check in with me and that the use of touch will be reviewed.

Client signature: _____ Date: _____

Practitioner signature: _____ Date: _____

**Appendix D. Teaching and training consent protocol**

Before any touch-based learning activity, trainers should ensure that students receive a clear pre-brief covering the points below.

- learning objective and relevance to the modality or competence framework;
- what touch is proposed and what will not occur;
- right to decline or observe without penalty;
- alternative learning arrangements where reasonably practicable;
- confidentiality and group respect;
- process for pausing, stopping or opting out;
- debriefing arrangements;
- route for raising concerns after the session.

Students should not be asked to disclose personal reasons for declining. Trainers should model respectful boundary negotiation and ensure that power, assessment and group pressure do not undermine consent.

## Appendix E. Case examples and reflective prompts

**E1. Grounding contact in trauma work**
**Scenario:** An adult client becomes disoriented during trauma processing. The therapist is trained in the relevant approach, pauses the work, offers non-touch grounding first and then asks whether brief forearm contact would help orient the client. Consent is obtained, checked and documented. The intervention is reviewed in supervision.

**Governance point:** Appropriate if clinically justified, consensual, competent, documented and supervised.

**E2. Client reaches for therapist hand**
**Scenario:** A client reaches for the therapist hand at the end of a painful session. The therapist briefly acknowledges the gesture and considers whether to accept, decline or explore it verbally, taking account of the client history, cultural context, boundaries and the meaning of endings.

**Governance point:** The client initiation does not remove practitioner responsibility. The meaning of acceptance or refusal may need exploration.

**E3. Hug offered by therapist without consent**
**Scenario:** A therapist offers a hug to a lonely client after an emotionally intense disclosure. There has been no prior discussion, no consent and no clear modality-based rationale. The client later feels confused and ashamed.

**Governance point:** Inappropriate. Requires supervision and possible escalation depending on impact and context.

**E4. Training exercise involving body psychotherapy**
**Scenario:** A trainer demonstrates a grounding technique involving touch. The exercise is pre-briefed, students may opt out, alternatives are available, boundaries are clear and the activity is debriefed.

**Governance point:** Appropriate where pedagogically relevant, consent-based and inclusive.

**E5. Placement no-touch policy**
**Scenario:** A trainee working in a school placement believes brief supportive touch would help a distressed pupil. The school policy prohibits touch except for safeguarding or care-plan reasons.

**Governance point:** The placement policy overrides this Institute policy. The trainee must use non-touch alternatives and seek supervision.

## Appendix F. Equality impact and accessibility considerations

Policy implementation should be reviewed for equality impact. Attention should be given to whether students or clients from minoritised groups experience pressure to comply with dominant cultural norms around touch, whether disabled and neurodivergent students have equitable access to learning activities and whether religious, cultural or trauma-related boundaries are respected without stigma.

Reasonable adjustments should be considered for touch-based teaching and assessment. Alternative forms of participation should be made available where they preserve the integrity of learning outcomes and professional standards.

**POLICY BACK COVER**
**Section 1 - to be completed by policy proposer and forwarded to Committee Servicing Officer.**

| | |
|---|---|
| **Policy Title:** | Touch Policy |
| **Author/Owner:** | Peter Pearce, Director of Clinical Training |
| **Rationale:**<br>*Outline the purpose of the policy, and its scope e.g. credit-bearing provision* | Institutional policy for practitioners. |
| **Consultation undertaken:**<br>*List all groups and/or committees where consultation was undertaken e.g. students, administration, external advisor, EdC,, etc.* | JSSC, 2nd June 2026<br>Ethics Committee, 9th June 2026<br>Education Committee, 18th June 2026 |
| **Resource implication:**<br>*Outline the potential financial, human and technological resource implication of the policy* | **None** |

**DOCUMENT CONTROL**
**Section 2 - to be completed by receiving committee.**

| | |
|---|---|
| Choose an item. | |
| **Circulated to:** | |

| | | | |
|---|---|---|---|
| **Approved:** | | **Date for adoption:** | |

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|---|---|---|---|
| **Version and document Code:** | | **Date for review:** | |

**END OF TEMPALTE**