Good Practice in Action 014
Legal Resource

Managing confidentiality within the counselling professions

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T: 01455 883300 **F:** 01455 550243
E: bacp@bacp.co.uk **www.bacp.co.uk**

Design by Steers McGillan Eves.

Contents

Context

This resource is one of a suite prepared by BACP to enable members to engage with the current BACP *Ethical Framework* in respect of the law relating to suicide in England and Wales.

Using the legal resources

Legal resources support good practice by offering general guidance on principles and policy applicable at the time of publication. These resources should be used in conjunction with the current BACP *Ethical Framework for the Counselling Professions*. They are not intended to be sufficient for resolving specific issues or dilemmas arising from work with clients, which are often complex. In these situations we recommend consulting a suitably qualified lawyer or practitioner. Specific issues in practice will vary depending on clients, particular models of working, the context of the work and the kind of therapeutic intervention provided. Please be alert for changes that may affect your practice, as organisations and agencies may change their practice and policies. References were up to date at the time of writing but there may be changes to the law, government departments, websites and web addresses.

In this resource, the word 'therapist' is used to mean specifically counsellors and psychotherapists and 'therapy' to mean specifically counselling and psychotherapy.

The terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include counselling, psychotherapy and other modalities, e.g. the practice of coaching and pastoral care.

Introduction

Confidentiality is one of the most fundamental ethical and legal obligations owed by counsellors to their clients.

Over time, society has developed ethical and legal frameworks arising from a perceived need for the protection of sensitive personal information. These frameworks also protect the public and individuals, for example in the areas of terrorism and public health, within which a tension may arise between the need to disclose information in the public interest or for the protection of individuals, and guarding the professional contractual and moral duty of confidentiality.

Professionals, for example accountants, doctors, therapists and others, require a considerable degree of personal frankness on the part of those who seek their services in order for their help to be effective, and those using the services of these professionals need some reassurance that their personal information will be respected and protected from unauthorised disclosure wherever possible.

This general principle seems to be widely accepted by the public and professionals alike, but its implementation raises complex issues of law and practice within which there are occasions where a therapist may see a professional need to breach confidentiality, but where the client may not readily accept the need for that disclosure – and it is in these grey and potentially conflictual areas of practice that an understanding of the law and current ethical guidance is particularly helpful.

This resource should help you to:

- understand the principles upon which client confidentiality depends
- identify situations where confidentiality may need to be breached
- identify situations where legal or other professional advice should be sought and in which advice would be appropriate
- make appropriate decisions concerning breaching confidentiality that are within the law and comply with the current *Ethical Framework* (BACP 2018).

1 The legal basis for confidentiality in counselling

Legal rights to confidentiality are enforceable by legal orders, for example injunctions or orders awarding damages for breach of contract, and the award of damages or compensation in actions under the law of tort (e.g. for breach of the professional duty of care etc.). The right of confidentiality can arise from:

a. common law (decisions made by the courts), which imposes a duty of confidentiality where information is disclosed in confidence or in circumstances where a reasonable person ought to know that the information should be confidential. This will apply irrespective of whether a contract exists between the parties; for example it will apply where a therapist comes to know personal information about a third party. It is not an absolute duty but is based on the balance of public interest in protecting confidences (*A-G v Guardian Newspapers Ltd (No 2)* [1990] AC 109 [1988] 3 All ER 477)

b. statutory provisions (e.g. the General Data Protection Regulation (GDPR), Data Protection Act 2018, Freedom of Information Act

2000, Human Rights Act 1998 Article 8 – right to private life etc. (See list p31.)

c. contracts: between, for example:

- therapist and client
- therapist and supervisor
- therapist and agency/organisation
- therapist/agency/statutory bodies
- trainee therapist/training organisation/placement agency/supervisor.

Confidentiality is also part of a therapist's professional duty of care to a client, and enforceable in the law of tort (in Scotland, Delict).

Client records

There is a duty to keep records appropriate to the service provided, and these may be protected by a degree of pseudonymisation, see Glossary and (GPiA 105). Appropriate records are adequate, relevant and limited to what is necessary. The decision about what is appropriate will take into account the ethical and legal requirements for processing (includes making, keeping, using and sharing) records. See Information

Commissioner's Office www.ico.org.uk for the latest information, and (BACP 2018 C2e)

An example of pseudonymisation would be where a client's contact details and the client's records are kept separately, but linked with a reference number. Pseudonymised information is regarded as personal data, and subject to the data protection law.

By contrast, anonymised information ceases to be 'personal data' with the associated legal requirements and protection when any means of identifying the person concerned has been genuinely and irreversibly removed. The GDPR is very clear:

> *The principles of data protection should therefore not apply to anonymous information, namely information which does not relate to an identified or identifiable natural person, or to personal data rendered anonymous in such a manner that the data subject is not or no longer identifiable. This regulation does not therefore concern the processing of anonymous information, including for statistical or research purposes. (GDPR (26))*
> Ethical Framework 2018 Good Practice 55g, 78, 83a.

2 The practice basis for confidentiality in counselling

These rights are enforceable by complaints, disciplinary proceedings, and in the case of actions by public bodies, possibly legal action for judicial review of administrative or other actions challenged, as follows:

a. professional practice values, principles and guidance, for example BACP's *Ethical Framework for the Counselling Professions (BACP 2018), the (Ethical Framework)*

b. professional conduct procedures, for example, those of BACP

c. agency and organisational practice guidance and codes of conduct.

For someone with a grievance over confidentiality, these procedures often involve less financial risk than court proceedings and the outcomes from a disciplinary hearing may be considered more likely to prevent a repetition by the therapist.

3 Basic rights of the client

These are:

a. to know the extent and limitations of the confidentiality that they are being offered by the therapist

b. to give explicit consent to the making and keeping of records that contain personally sensitive information – a requirement of the GDPR and the Data Protection Act 2018 that will apply to most records and notes written by therapists

c. to be told the circumstances in which the therapist may wish to breach confidentiality and to have an opportunity to discuss and negotiate this with the therapist at the outset of their work together

d. to have a clear therapeutic contract with terms that they fully understand, accept and support (Dale, 2008)

e. to know who will make, keep and have access to their notes and records, how they will be kept, for how long, and for what purposes they may be retained/destroyed/disclosed. For further details see Bond and Mitchels (2015)

f. to be informed when the therapist may have to or is about to breach their confidentiality unless there are cogent, defensible reasons why this cannot be the case, for example in cases of terrorism, certain child protection situations (such as where it may be dangerous to a child or others to alert a person about impending disclosure, or may compromise a police investigation) or mental incapacity

g. to know how, why and to whom information will be given by the therapist

h. to know the importance of and/or see what is being said about the client if they wish to do so.

Please refer to the *Ethical Framework*, and also the ethical principles of: being trustworthy, autonomy, beneficence, non-maleficence and justice.

4 Exceptions to the duty of confidentiality

Crime

A counsellor cannot be legally bound to confidentiality about a crime. Courts have concluded that it is defensible to breach confidence, in good faith, in order to assist the prevention or detection of a serious crime. Good faith requires honesty and reasonable grounds for suspecting or knowing about a crime. However, there is no general duty to report crime except in specific circumstances. See the legal and statutory obligations below, subject to which there is also no general obligation to answer police questions about a client, unless the client consents or the police officer has a court order or statutory authority to require the information. A polite refusal on the grounds of confidentiality is sufficient if this is considered appropriate, but deliberately giving misleading information is likely to constitute an offence.

Balance of public interest

In some situations, clients' needs or the public interest in a specific situation may potentially outweigh the general duty of confidentiality:

a. Prevention of serious harm to the client or to others, for example see the decision in the case of *W v Edgell* [1990] CH 359 where confidentiality was breached because the client, a mental health patient, posed a risk of serious harm to the public. Despite the introduction of the Human Rights Act, a case based on similar circumstances would be likely to reach the same conclusions in favour of disclosure. For a discussion of risk of suicide, please see section 'Clients at risk of suicide or serious self-harm' below.

b. The balance of public interest favours the prevention and detection of serious crime over the protection of confidences. Therefore, the courts may provide a level of immunity against legal liability for breach of confidence when reporting serious crime to the authorities, in good faith and on reasonable grounds of belief that the basis of the report is true. The Department of Health offers the following guidance on what counts as serious crime:

'Murder, manslaughter, rape, treason, kidnapping, child abuse or other cases where individuals have suffered serious harm may all warrant breaching confidentiality. Serious harm to the security of the state or to public order and crimes that involve substantial financial gain and loss will generally fall within this category. In contrast, theft, fraud or damage to property where loss or damage is less substantial would generally not warrant breach of confidence.' (DH, 2003a: 35).

The Serious Crime Act 2007 reflects this general perception of what constitutes serious crime.

Statutory obligations to disclose

These include:

a. The Terrorism Act 2000, s.38B makes it a criminal offence for a person to fail to disclose, without reasonable excuse, any information which s/he either knows or believes might help prevent another person carrying out an act of terrorism or might help in bringing a terrorist to justice in the UK. It is, in our view, unlikely that professional confidentiality would ever be regarded in these circumstances as a reasonable excuse by a court. There is a further offence under s.39 of 'tipping off' by making disclosures to another person that are likely to prejudice a terrorist investigation or interfering with material relevant to such an investigation. There is a separate duty under s.19 for all citizens to report any information that is gained through the course of a trade, profession, business or employment about specified activities related to money and property used to assist terrorist activities. Also under the Counter-Terrorism and Security Act 2015 there is a new legal duty on schools to prevent pupils being drawn into terrorism.

b. Recent developments in the reporting of drug trafficking and money laundering for any crime have increased the obligations of people working in legal and financial services. Psychotherapists and counsellors are now less likely to acquire the kind of information that is required to be reported under the Drug Trafficking Act 1994, Proceeds of Crime Act 2002 or the Money Laundering Regulations 2007. If in doubt, seek legal advice. In many cases, disclosure of this type of information may be justified on the balance of public interest – see above.

c. Under s.21 of the Road Traffic Act 1991 (which imports new wording into s.172 of the Road Traffic Act 1988), if the police require information about the driver of a vehicle at the time of an offence, it must be disclosed, and failure to do so is a criminal offence. See *Mawdesley v Chief Constable of Cheshire Constabulary, Yorke v Director of Public Prosecutions* [2003] EWHC 1586 (Admin) [2004] 1 WLR 1035. The police have the right to issue a notice requiring information about the driver of a vehicle, and answers are compulsory. The last case of which we are aware concerning use of confidentiality as defence was *Hunter v Mann* [1974] 2WLR 742. Dr Hunter, a GP, was fined £5 for failing to disclose the identity of patients involved in the theft of a vehicle from an East Croydon car park. They had an accident, and had run away from the scene. Dr Hunter treated them and later refused to tell the police who was driving.

d. In the context of working with children and young people, the family court can make a recovery order under s.50 of the Children Act 1989 in relation to a child who is in care, under police protection or subject to an emergency protection order, and who has been abducted, has run away or is otherwise missing. The court may require any person who has information as to the child's whereabouts to disclose that information, if asked to do so, by a constable or the court, see section 51(3)(c). Failure to comply with the order may constitute the offence of contempt of court.

e. Under the Serious Crime Act 2007, parts of which are now implemented, the courts can make a Serious Crime Disclosure Order requiring a person in possession of information or documents relevant to an enquiry about a serious crime to disclose them to a nominated person, usually a police officer, or to the court.

f. The Female Genital Mutilation Act 2003 (as amended by s.74 of the Serious Crime Act 2015) introduced a mandatory reporting duty for all regulated health and social care professionals and teachers in England and Wales. Professionals must make a report to the police, if, in the course of their duties:

- they are informed by a girl under the age of 18 that she has undergone an act of FGM; or
- they observe physical signs that an act of FGM may have been carried out on a girl under the age of 18.

For disclosures in child protection matters, please refer to the separate section below. The law will usually protect someone who discloses confidences in response to public duty or a statutory requirement. However, a therapist is wise to take reasonable care in ensuring the accuracy of what is reported and that they honestly believe what they are reporting. A false accusation that is not honestly believed and that damages someone's social standing or business, could lead to a person being sued for defamation, even if the decision to disclose was made in consideration of the public interest or in compliance with a statutory duty.

g. client requests and statutory requests for access to personal data made under the General Data Protection Regulation (GDPR) and the Data Protection Act 2018, for details see GPiA 105 (BACP 2018a).

Court orders

A court may order disclosure of documents or information, or order the therapist to attend court and to bring notes and records with them. Refusal to answer the questions of the court may constitute contempt of the court. Death does not end the duty of confidence. The Coroners and Justice Act 2009, the Coroners (Investigations) Regulations 2013 and the Coroners (Inquests) Rules 2013 make provision for the Coroner to require evidence

to be produced when making inquiry into the cause of death in specific circumstances. Under the new rules, to foster openness and transparency of process, the Coroner must, on request, normally disclose information received (e.g. reports and other relevant documents) to 'interested persons' defined in the legislation. Under Rule 14 of the Coroners (Inquests) Rules 2013, documents may be redacted where appropriate.

Paragraph 1 of Schedule 5 to the 2009 Act gives a Coroner power to summon witnesses and to compel the production of evidence for the purposes of an investigation (paragraph 1(2)) or an inquest (paragraph 1(1)) by way of written notice. A new non-statutory form is available for these purposes. Therapists required to disclose evidence relevant to the cause of death (e.g. following a possible suicide) to the Coroner may have concerns about the extent to which information from therapy is relevant to the inquiry, which may on occasion be resolved by discussion with the Coroner prior to the court appearance.

Therapists may be asked to produce a report for the court relating to work with a client. Consent should be obtained directly from the client wherever possible and in writing. Clients may ask to see the reports written about them, and in accordance with the legislation on human rights, data protection, freedom of information, the principles of autonomy, beneficence and justice in the *Ethical Framework* and other legislation listed at the end of this *Good Practice in Action* resource, clients should have access to their reports in the same way as records, unless there is a cogent reason in their interest or that of the public not to do so (see the notes below and Bond and Sandhu (2005), Bond and Mitchels (2015) and Mitchels and Bond (2010)).

Requirements to produce counselling records

Family courts dealing with child protection cases have different rules of evidence from other civil and criminal courts. They may order the production of documents, including personal medical reports, which would otherwise have been protected from disclosure. It has also been held that no privilege is attached to video recordings of therapy in which a child makes allegations of abuse against their parents. This means that the tapes have to be produced but the court is able to restrict who is able to see them. Courts exercise considerable investigative powers in many situations in which they are trying to determine the best interests of the child.

In criminal cases the police, acting on behalf of the Crown Prosecution Service and usually with the written consent of the client, may seek access to therapy and counselling notes. This is most likely to happen if they contain reports by the client of allegations of serious violence, rape or sexual abuse.

This practice is problematic for counsellors because there is doubt about:

a. the quality of the client's consent, as refusal would almost certainly result in the case being dropped

b. the records which will have been made from a therapeutic perspective, may not distinguish objective facts from subjective experience, and

c. the court's tendency to view any factual changes in the client's account as evidence of the unreliability of the allegations rather than as evidence of e.g. post-traumatic stress rape trauma causing partial and progressive recall, which could be a counselling interpretation.

The courts and the Crown Prosecution Service may consider that any objections to current practice are outweighed by the difficulty of judging rape trials and that the court should have all known sources of information made available to it, including counselling notes, particularly if these contain the first allegation of rape or sexual assault. This is a situation where the counsellor may consider it appropriate to request to be present at a directions hearing to review the evidence, so that a judge has an opportunity to review the notes and, if appropriate, only release those parts directly relevant to the case. An alternative is for the therapist to offer to provide a report for the court. The Crown Prosecution Service provides guidance for therapists who are working pre-trial: *Provision of Therapy for Vulnerable or Intimidated Adult Witnesses Prior to a Criminal Trial – Practice Guidance* (CPS, 2005a), and The CPS Provision of Therapy for Child Witnesses Prior to a Criminal Trial – Practice Guidance (CPS, 2005b). These are downloadable as .pdf documents at www.cps.gov.uk. These guidance documents are still in force at the moment, but they may be updated soon, so watch the CPS website for changes.

For further details, see the statutes and guidance listed in this resource, Bond and Sandhu (2005), Bond and Mitchels (2015), and Mitchels and Bond (2010).

Disclosures to enhance the quality of service provided

Technically, it may constitute a breach of confidence when counsellors discuss cases in counselling supervision, training and research. If a client is identified or identifiable from information discussed, then the client's explicit consent should be obtained to discuss their case with others. If the client is not identified, it is best practice to obtain consent. Even if this has not been obtained, the public interest in the proper training and supervision of counsellors, and in the development of a professional body of knowledge may probably outweigh the public interest in confidentiality to the extent of making defensible discussions which protect the identity of clients.

Child protection

A 'child' is defined as a person under the age of 18. The Children Act 1989 (CA 1989), in conjunction with subsequent legislation including the Children Act 2004, places a statutory duty on health, education and other services to co-operate with local authorities in child protection. There is a statutory duty to work together, including information sharing, in conducting initial investigations of children who may be in need, or be subject to abuse and in the more detailed core assessments carried out under s.47 of the Children Act 1989. The guidance in Part 1 of *Working Together to Safeguard Children* (HM Government, 2015, updated 2017) sets out and explains the standards and procedures with which local authorities are to comply and what is expected of professionals, including information sharing. Part 1 carries the force of statute under s.7 of the Local Authorities Social Services Act 1970, and Part 2 contains cogent guidance. Anyone working with children and families should read this comprehensive guidance, which provides details of local authority and inter-agency duties and procedures and lists all the relevant law, government publications and useful resources.

For details of the assessment process, see the *Framework for Assessment of Children in Need and their Families* (DCSF, 2000). Other useful references are *What to do if you are worried that a child is being abused: Advice for practitioners providing safeguarding services* (DfE, 2015) and *Information Sharing: Advice for practitioners* (DfE, 2015) and its supporting materials. All are available from the website www.gov.uk. The relevant law and child protection procedures for England and Wales are fully set out in the guidance documents listed above. Scotland and Northern Ireland have separate procedures and guidance: resources are listed in the references and further reading list at the end of this resource.

Referral in child protection matters may also raise issues of consent. Adults, children over 16 and children who are under 16 but competent in terms of the 'Gillick' case may refuse to consent to a referral or to co-operate with assessments (see *Gillick v West Norfolk and Wisbech Area Health Authority and Another* [1986] 1 AC 1212; [1985] 3 All ER 402 (HL) [1986] 1 FLR 224).

Therapists working with children and young people should be suitably qualified and experienced and have supervision with a person suitably qualified and experienced in child protection matters. If there is a concern that a child may be at risk of serious harm and the therapist does not have consent to make a referral from the child or from a person with parental responsibility for the child, then the therapist will have to decide whether to make a referral anyway, without consent.

Those working within government, organisational or agency settings should already have policies and procedures in place. For those who work independently, this is a matter for supervision, and where necessary for expert professional advice on child protection law and practice, which should be available from the legal department of the local authority,

local authority social care services, specialist lawyers (e.g. Children Panel solicitors, the Department of the Official Solicitor, CAFCASS duty officers), and professional organisations (e.g. GMC, BMA, BPS, UKCP and BACP). The 'disclosure checklist' below in this resource will also be helpful in thinking these decisions through.

Clients at risk of suicide or serious self-harm

Responding appropriately to suicidal clients presents one of the most challenging situations encountered by counsellors (for further discussion, see *Counselling Suicidal Clients* (Reeves, 2010)). The ethical management of confidentiality is inextricably linked to decisions about when to act in order to attempt to preserve life and when to remain silent out of respect for a client's autonomy. There is no general consensus among therapists about these issues, or which, if any, approach should predominate.

A counsellor who adheres strongly to one view or the other is advised to make that information available in pre-counselling information or to build in an appropriate agreement in the counselling contract. As there is no general duty to rescue in British law, (see Menlowe and McCall Smith, 1993), counsellors need to be explicit about reserving the power to breach confidentiality for a suicidal adult client. To do so without explicit agreement may constitute an actionable breach of confidence. Reserving the power to breach confidentiality does not necessarily mean that the counsellor must notify every instance of suicidal intent. For consideration of criteria for assessment of suicidal risk see Reeves (2010) and Bond (2015: 109-129).

A therapist who knows that a client is likely to harm himself or others but who will not give consent for referral must carefully consider the ethics of going against the client's known wishes (see BACP *Ethical Framework*) and also consider carefully the level of immediacy of risk to the client or others and the possible consequences for their client of referral or non-referral.

Referral may be defensible in the public interest where the therapist holds a reasonable belief that the client or others are at immediate risk of serious harm. However, careful consideration needs to be given to the seriousness and immediacy of the risk, the ethics of the situation, consent issues, and the appropriate action to be taken.

Discuss with the client if appropriate, and ideally also discuss in supervision, these issues:

- what has the client given me permission to do?
- does that permission include referral?
- if I refer, what is likely to happen?
- if I do not refer, what is likely to happen?

- do the likely consequences of non-referral include serious harm to the client or others?
- are the likely consequences preventable?
- is there anything I (or anyone else) can do to prevent serious harm?
- what steps would need to be taken?
- how could the client be helped to accept the proposed action?
- does my client have the mental capacity to give explicit informed consent at this moment in time?
- if the client does not have mental capacity, then what are my professional responsibilities to the client and in the public interest?
- if the client has mental capacity, but does not consent to my proposed action (e.g. referral to a GP), what is my legal situation if I go ahead and do it anyway?

Counsellors' professional responsibility requires that they must act within the scope of their personal expertise, and should consider their own limitations. The implication of this is that when they reach the limits of their expertise, consideration should be given to referral on with the client's consent. If the client does not consent to referral on and if the client or others may be at risk of harm, the therapist should address the issues listed above in supervision and with their professional organisation and/or seek other professional advice.

The issue of mental capacity, age and the ability to give valid consent (or refusal) are addressed below.

5 Mental capacity and consent issues in information sharing

Explicit and implicit consent

If a client consents to referral on or to a change in the confidentiality agreed with them at the outset of the work with their therapist, then there is little likelihood of any ground for legal or other action against the therapist if the actions then taken are with the full knowledge and consent of the client. If possible, obtain the client's explicit consent. Implicit or implied consent may be relied upon by the therapist, but it can be nebulous and is rather more difficult to prove. A client who is anxious and perhaps confused at the commencement of therapy is less likely to recall in any detail a discussion with their therapist about the terms of their therapeutic contract. In the event of a complaint or legal action, both therapist and client are best protected by a therapeutic contract, with terms including explicit consent, that are evidenced in writing.

Information sharing in a health team or agency

Consent may be given for others, e.g. those in a healthcare team, to share patient or client information.

This is usually subject to professional codes of conduct and agency/organisational restrictions. For example, in working with children and families the guidance made under the Children Act 1989 and Children Act 2004 applies; in a GP surgery or hospital setting the GMC guidance applies – for useful references please see those listed at the end of this resource. The Caldicott Principles relating to sharing information between agencies were developed by the Caldicott Committee in their *Report on the Review of Patient-Identifiable Information* (DH, 1997).

These are:

Principle 1 – Justify the purpose(s) for using confidential information

Principle 2 – Only use it when absolutely necessary

Principle 3 – Use the minimum that is required

Principle 4 – Access should be on a strict need-to-know basis

Principle 5 – Everyone must understand his or her responsibilities

Principle 6 – Understand and comply with the law.

In 2006, the Department of Health produced the *Caldicott Guardian Manual* (updated in 2010) (DH, 2010). Other relevant resources are listed at the end of this resource.

Adults: mental capacity and consent

A client's ability to give legally valid consent to any medical, psychiatric or therapeutic assessment or treatment, or to enter into either a valid therapeutic contact or a legally binding contact for services, will depend on their mental capacity to make an informed decision.

Mental capacity is a legal concept of a person's ability to make rational, informed decisions. It is presumed in law that adults and children over the age of 16 have the mental capacity and legal power to give or withhold consent in medical and healthcare matters.

This presumption is rebuttable, for example in the case of mental illness (see the Mental Capacity Act 2005, the Mental Health Act 2007 and the regulations made under these). Relevant publications and websites are listed at the end of this resource.

6 Assessment of mental capacity

Assessment of mental capacity is situation specific and depends upon a person's ability to:

- take in and understand information, including the risks and benefits of the decision to be made
- retain the information long enough to weigh up the factors to make the decision, and
- communicate their wishes.

Adults can appoint another person to act on their behalf under a Lasting Power of Attorney and that person may make decisions about their health and welfare under that power, coupled with parts of the Mental Capacity Act 2005.

Therapists may be asked to assist clients in developing plans or expressing their wishes for present or future healthcare arrangements. While they have mental capacity, some clients may wish to make an 'advance directive' (otherwise known as an 'advance statement' or 'living will') about the forms of medical treatment to which they may (or may not) consent if they should subsequently lose capacity to decide for themselves.

Advance directives refusing treatment are legally binding, provided that they are made while the person has capacity, without duress, and the circumstances to be applied are clear. Sections 24-26 of the Mental Capacity Act 2005 empower, (subject to safeguards) those who wish to do so to make 'advance decisions' concerning their wish to refuse specified treatment.

7 Children and young people under the age of 18: consent issues

Therapists working with children and young people will need to have valid consent to enter into the therapeutic contract. The legal issues surrounding work with children and young people are complex because of the requirement to provide services for children in need and to protect children from abuse.

Not all parents have the power to make decisions for their children. The ability of a parent, or anyone else, to make a decision for their child depends on whether they have 'parental responsibility', which is the legal basis for making decisions about a child, including consent for medical or therapeutic treatment.

Under the new GDPR and the Data Protection Act 2018, the provisions regarding children and consent are clarified, for details please see GPiA 105 (BACP 2018a) and 11 below.

Please note that under the General Data Protection Regulation (GDPR) and the Data Protection Act 2018, there are special provisions for consent relating to children receiving certain online services, with an exception for children receiving counselling and psychotherapy services, for details please see GPiA 105 (BACP 2018a) and 11 below.

8 Parental responsibility

Parental responsibilty is defined in the glossary in this resource. Every mother (married or not) has parental responsibility for a child born to her; every father who is married to the child's mother at the time of or subsequent to the conception of their child automatically has parental responsibility for their child, which may be shared with others and will be lost only by death or adoption or the child attaining the age of 18 (see section 91(7) and (8) Children Act 1989 and also *Re M (A Minor) (Care Order: Threshold Conditions)* [1994]).

Unmarried fathers may currently acquire parental responsibility for their biological child in one of several ways, including:

- marrying the child's mother
- being named as the father with the mother's consent on the child's birth certificate
- entering into a written Parental Responsibility Agreement with the child's mother
- various court orders.

Parental responsibility may be acquired by other people in a variety of ways, including:

- adoption
- parental responsibility agreement by parent(s) of child with married partner or civil partner
- various court orders.

See the Children Act 1989 as amended, s.4. It is only those who have acquired parental responsibility through one of the methods laid out in s.4, 4ZA and 4A who can have that parental responsibility revoked by court order, with the exception of an adoption order, which will revoke all previously existing parental responsibility in relation to the child. For an exploration of the law, see the Court of Appeal decision in the case of *Re D (A Child) [2014]* EWCA.

Local authorities may acquire parental responsibility for a child through a Care Order made under the Children Act 1989.

9 What constitutes valid consent in law for medical examination or treatment of a child or young person under the age of 18?

Such consent is legally valid if it is the:

- consent of a person with parental responsibility for the child
- consent of the child, if aged over 16 (under the Family Law Reform Act 1969 s.8(1))
- consent of a child aged less than 16 years, if they have sufficient age and understanding of the issues involved and the consequences of consent (i.e. the child is 'competent' as defined in *Gillick v West Norfolk and Wisbech Area Health Authority and Another* [1986] 1 AC 1212, [1985] 3 WLR 830, [1986] 1 FLR 224)
- direction of the High Court.

Therapists may be asked to carry out an assessment with a child or young person and then to provide a report and perhaps also to attend court to give evidence. In the case of child protection or family conflict, for example care proceedings or contested contact matters, one or more of the parties may disagree with the assessment and require a second opinion. Repeated medical and psychiatric examinations for forensic purposes can cause a child unnecessary stress. The court can regulate such examinations and make appropriate directions, which may nominate the practitioner(s) to carry out the examination or assessment, the venue, those to be present, and those to whom the results may be given. Breaches of these rules are viewed seriously, and any evidence obtained without compliance with the rules may be disallowed in court.

Please note that under the new GDPR and the Data Protection Act 2018, the provisions regarding children and consent are clarified, for details please see GPiA 105 (BACP 2018a) and 11 below.

Please also note that under the General Data Protection Regulation (GDPR) and the Data Protection Act 2018, there are special provisions for consent relating to children receiving certain online services, with an exception for children receiving counselling and psychotherapy services, for details please see GPiA 105 (BACP 2018a) and 11 below.

10 Making a decision about breaching confidentiality

In each case where a therapist considers breach of confidentiality, it is necessary to be able to justify the action both to ourselves and to others if the decision is challenged. There are no hard and fast rules here; each decision has to be made on its own merits. Therapists need to consider all the factors set out in this good practice resource, and be cautious in making disclosures of confidential information until sure of the legal and ethical basis for the disclosure. Where appropriate, they should consult their supervisor and/or seek legal or other professional advice from a person with the relevant expertise.

In addition, it is advisable to take all issues of potential breach of confidentiality to supervision, whenever possible, and to discuss them fully and openly with the supervisor.

11 The Impact of the General Data Protection Regulation

New legislation, the European Union's *General Data Protection Regulations (GDPR)* came into force on 25 May 2018, and has a direct effect in all European states. The documents and guidance are available at https://ico.org.uk And for details about the impact of the new law on the counselling professions, see GPiA 105 (BACP 2018a).

Despite Britain's intended exit from the European Union, the Data Protection Act 2018brings in the GDPR as law within the UK to continue post 'Brexit'.

Key changes to the UK's data protection regime, includes:

- Consent – there is a wider definition of consent. Anyone processing the personal data of another individual (the data subject) must ensure that the data subject's consent was a *freely given, specific, informed and unambiguous indication of the data subject's wishes by which he or she by statement or by a clear affirmative action, signifies agreement to the processing of personal data relating to him or her.*" Asking a data subject to tick a box agreeing to a general or vague statement will not be sufficient evidence of consent.

- Data subjects have the right to be informed about how you are using or processing their personal data and should be provided with a 'fair processing notice' (typically given through a privacy notice) meaning all controllers must provide more detailed information to data subjects about how their data will be processed.

- Data breach notification – the Information Commissioner's Office (ICO) must be notified about any breaches which may pose a risk to the rights and freedoms of individuals.

- Fines – the ICO can impose mammoth fines on organisations, up to the higher rate of 4% of worldwide annual turnover and EUR 20 million, depending on the nature, gravity and duration of the infringement.

- Data subjects' rights – these are bolstered, with the right to be forgotten, to correct data which are wrong or to restrict certain processing, and the right for data subjects to ask for their personal data to be handed back so that they can be sent to another controller (known as 'data portability'). Data subject access requests must be responded to, within a month and without a requirement to pay a fee, unless the request is 'manifestly unfounded or excessive'.

- Data protection officers – some controllers and processors are required to appoint data protection officers to oversee their data processing activities. There may be further changes, so practitioners are advised to check the Information Commissioner's website www.ico.org.uk at regular intervals for updates on the operation of the GDPR and other legislation as it comes into force.

- Under the GDPR there is no longer an obligation to register (ie notify) data processing with the Information Commissioner's Office, but a fee is payable by controllers processing personal data electronically for business purposes.

- Contracts – Controllers will be required to have written contracts in place with any data processors appointed by them

Sensitive Personal Data

In current data protection law, briefly, most of the information held by therapists will be regarded as 'sensitive personal data'. Sensitive personal data contain information about:

- Racial or ethnic origin

- Political opinions

- Religious beliefs or beliefs of a similar nature

- Trade union membership

- Physical or mental health condition
- Sex life
- Criminality, alleged or proven
- Criminal proceedings, their disposal and sentencing.

The GDPR continues to define these categories of data as 'sensitive data' and adds to this list genetic data, and biometric data where processed to uniquely identify an individual.

The use of sensitive personal data already requires the client's explicit consent and will continue to do so. The client has to actively state that they are agreeing to a record being kept and used in the knowledge of the purpose(s) for which the record is being made, how it will be used and any limitations on confidentiality. This should be the routine practice of therapists who hold computerised records or who hold manual records in any form of an organised filing system.

Personal data relating to criminal convictions and offences are not included, but similar extra safeguards apply to its processing.

A therapist will need to comply with the GDPR in relation to entering into a contract for services with any person and will need to consider:

- **what information must be provided to that person before any services are provided;**
- **how personal data and, in particular, any sensitive personal data that the therapist hold are processed and stored;**
- **what additional security measures should be implemented to ensure the security of personal data processed by the therapist.**

12 Disclosure checklist

It may help therapists in the decision-making process about sharing information to consider these points:

- Is this information regulated by the Data Protection Act 1998 (DPA)/ General Data Protection Regulation (GDPR) or the Freedom of Information Act 2000 (FOIA) (for example, do the records comprise client-identifiable, sensitive personal data sorted electronically, held on computer or in a relevant filing system)?
- Were the notes made by a professional working for a public body in health, education or social care?
- What are the relevant rights of the person concerned under the Human Rights Act 1998?
- If working in the health community, is disclosure compliant with the Caldicott principles and guidance?
- Is the information founded on observed fact or on a reasonably and honestly held belief in its truth?
- Is there a formal legal requirement to share this information, for example a statutory duty or a court order?
- Is it in the public interest to share the information?
- What is the purpose of sharing the information?
- If the information concerns a child, young person or vulnerable adult, is sharing it in their best interests?
- Is the information confidential? If so, do you have consent to share it?
- If consent is refused, or there are good reasons not to seek consent, does the public interest necessitate sharing the information?
- Is the decision and rationale for sharing the information recorded?
- What is the most appropriate way to share this information?

13 Conclusion

This resource provides a basic outline of the main issues of law and practice relevant to confidentiality and therapeutic practice. It cannot provide a comprehensive or definitive statement about the law but is based on an analysis of current information. This is a rapidly changing area of law, and anyone with current concerns about confidentiality is encouraged to discuss the matter in supervision and, wherever necessary, to seek appropriate professional assistance, including legal advice.

Therapists faced with dilemmas regarding confidentiality need to think through what is to be disclosed, who requires the information, why disclosure is necessary, to whom the information should be given, and the most appropriate method of disclosure. The Disclosure checklist will assist practitioners to address the salient issues in making their decision.

It is increasingly important for therapists and organisations providing counselling services to develop clear policies and procedures regarding confidentiality, disclosure and data protection, which should include those situations in which it may be necessary to release information without client consent, for example, terrorism, child abuse, suicide, or threat of serious harm to a third party.

BACP and Sage have published a book by Tim Bond and Barbara Mitchels *Confidentiality and Record Keeping in Counselling and Psychotherapy (2nd Edition)* (2015), which contains further explanations of the law and examples of good practice developed in response to current law. See also Good Practice in Action Legal Resources 030: *Safeguarding vulnerable adults in England and Wales* and 031: *Safeguarding children and young people in England and Wales* (Scottish resources will be published in 2017).

14 Glossary of terms

Anonymised data

The removal of any information that would allow the person concerned to be identified or identifiable by any means from what is being communicated. Failure to anonymise adequately within the counselling professions can lead to a breach of trust with the person concerned and cause harm resulting in significant embarrassment, anxiety or distress. Where there is any uncertainty about whether anonymisation will protect someone's identity, it is ethically and legally good practice to seek that person's explicit consent to use that information and for how that information will be used.

Anonymisation

is different in meaning from 'pseudonymisation', a term used in current data protection regulations. 'Pseudonymisation' is defined as:

> *the processing of personal data in such a manner that the personal data can no longer be attributed to a specific data subject without the use of additional information, provided that such additional information is kept separately and is subject to technical and organisational measures to ensure that the personal data are not attributed to an identified or identifiable natural person* (GDPR Article 4.5)

Confidentiality

A wide-ranging duty of managing information in ways that keep it secure and control its disclosure. It is concerned with protecting information that is identifiable with a specific person, typically because they are named, but the law will also protect the confidences of people whose identity can be deduced from the available information, perhaps because the listener knows some of the circumstances of the person being referred to. Thoroughly anonymised information in which the identity of specific people cannot be discerned is not protected by the law of confidentiality.

Circle of confidentiality

A group of people sharing confidential information with the client's consent, for example a healthcare team or a counselling organisation with group supervision.

Client records

Generic term that includes all notes, records, memoranda, correspondence, photographs, artefacts and video or audio recordings relating to an identifiable client, whether factual or process related, and in whatever form they are kept.

On a practical level, all practitioners who keep paper records are strongly recommended to keep them as a logical and orderly filing system for their client records for ease of use and to deliver the best possible service. This will

be a 'filing system' that falls within the GDPR definition, and therefore the data protection legislation will apply to them.

See GDPR Art 4 (6):

(6) *'filing system' means any structured set of personal data which are accessible according to specific criteria, whether centralised, decentralised or dispersed on a functional or geographical basis;'*

> *In order to provide an appropriate standard of service, we are fully and unconditionally committed to fulfilling the requirement of Good Practice that all practitioners providing services to clients will keep records that are adequate, relevant and limited to what is necessary for the type of service being provided, and comply with the applicable data protection requirements*, (BACP 2018: Good Practice 5, 15)

Note: There is therefore a strong legal and ethical expectation that appropriate records will be kept. Practitioners have been criticised in court and in complaints proceedings for failing to keep appropriate and adequate records.

The term 'Records' is defined in the 'Glossary' to the *Ethical Framework*:

> **Record**
>
> *A catch-all word that includes all notes, records, memoranda, appointments, communications and correspondence, photographs, artefacts, video or audio recordings about an identifiable client. Records may exist in any format, typically but not exclusively, on paper or electronically. There is no distinction between factual and process notes in what the law regards as a record* – (BACP 2018: C2e, GP15, 31d, 31e, 71)

In some rare situations, and *very exceptionally* practitioners may consciously and deliberately decide to provide services to clients without keeping any form of records if:

- the circumstances prevent making and keeping any records securely and adequately protected from misuse or intrusion by others
- clients refuse to provide the consent necessary to permit the keeping of records and the practitioner is willing to provide a service on this basis, and/or is permitted to do so by agency policy
- keeping records is deemed to be unnecessary for the type of service being provided. For example, a community-based service in which clients drop-in on an informal basis without prior appointment or any expectation of an on-going service or if there is a public good being served by the provision of a service and clients would be deterred by the existence of records. Good practice in these circumstances requires that the absence of any records is the outcome of a deliberate policy decision, and communicated to clients and any service stakeholders.

Note: Practitioners who decide not to keep any records should be aware that the absence of any records will make resolving any disagreements with clients about what has occurred much harder to resolve and may leave the practitioner unable to successfully defend themselves in any professional conduct proceedings or to provide supported and reliable evidence in any court proceedings related to their therapy practice. Advice from lawyers and insurers consistently supports keeping records.

Data defined in section 1(1) of the Data Protection Act 2018

The term 'data' denotes a collection of statistical or other information gathered in the course of research. (See also 'personal data' and 'sensitive personal data' below.)

'Controller' is defined in the GDPR Art 4 (7) as:

> *(7) 'controller' means the natural or legal person, public authority, agency or other body which, alone or jointly with others, determines the purposes and means of the processing of personal data; where the purposes and means of such processing are determined by Union or Member State law, the controller or the specific criteria for its nomination may be provided for by Union or Member State law.*

'Processor' is defined in the GDPR Art 4 (8) as:

> *(8) 'processor' means a natural or legal person, public authority, agency or other body which processes personal data on behalf of the controller.*

Examples:

A therapist working as a sole trader, at home, or renting a room from which to work, is likely to be both a controller and a processor.

An organisation or agency which makes the decisions about the purpose and means of processing the data may be a controller, and a therapist who is employed by that organisation or agency, or working as a volunteer for it will be a processor.

Duty of confidence

A duty of confidence will arise whenever the party subject to the duty is in a situation where s/he either knows or ought to know that the other person can reasonably expect his or her privacy to be protected.

Explicit consent

Term used in the Data Protection Act 2018 and the GDPR to mean consent that is absolutely clear and specific about what it covers, i.e. not implied from surrounding circumstances, or given in a general form such as a pre-ticked box. Explicit consent may be given orally, but for the avoidance of doubt it is good practice to have some evidence that confirms it, e.g a recording or in writing wherever possible.

Express consent

Involves active affirmation, which is usually expressed orally or in writing. If clients cannot write or speak, other forms of unequivocal communication of consent may be sufficient, but should be supported by confirming evidence, e.g a recording or written note.

'Gillick competence'

A term referring to the capacity of a child under the age of 16 years to make their own decisions, as defined in the case of *Gillick v West Norfolk and Wisbech Area Health Authority and Another* [1986] 1 AC 1212, [1985] 3 WLR 830, [1986] 1 FLR 224. The child's ability to make each decision is dependent on their age and level of understanding; the nature of the decision to be made, and the information given to the child to enable them to understand the implications of their situation and the consequences of the decision to be made.

Implied consent

Agreement that is inferred from circumstances. For example, implied consent to disclosure may be inferred where clients have been informed about the information to be disclosed and the purpose of the disclosure, and that they have a right to object to the disclosure, but have not objected. Under the GDPR, implied consent is not sufficient to evidence the consent of the data subject to his or her personal data being processed.

Healthcare team

The healthcare team comprises the people providing clinical services for each patient and the administrative staff who directly support those services.

Mental capacity

Is a legal concept, within which a person's ability to make rational, informed decisions is assessed. It is assumed in law that adults and children over the age of 16 have the mental capacity and therefore the legal power to give or withhold consent in medical and healthcare matters. This presumption is rebuttable, for example in the case of mental illness. A person lacks capacity in relation to a matter if at the material time s/he is unable to make a decision for her/himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain (whether permanent or temporary) but there is no one practical test for assessing mental capacity to consent. Assessment of mental capacity is situation specific, and will depend on the ability of the person to take in, understand and weigh up information, including the risks and benefits of the decision to be made, and to communicate their wishes. See the Mental Capacity Act 2005 and the Mental Health Act 2007, and GPG 013: *Mental Health*.

Parental responsibility

The legal basis for decision making in respect of children under the age of 18, created by the Children Act 1989 and defined in section 3(1) as 'all the rights, duties, powers, responsibilities and authority which by law the parent of a child has in relation to a child and his property'. More than one person can have parental responsibility for a child at the same time. It cannot be transferred or surrendered, but aspects of parental responsibilities can be delegated (see section 2(9) of the Children Act 1989).

Patient-identifiable information

Facts or professional opinions about a client or patient learned in a professional capacity and from which the identity of the individuals concerned can be identified.

Personal data

Personal data means data relating to a living individual who is or can be identified either from the data or from the data in conjunction with other information that is in, or is likely to come into, the possession of the controller.

Processing

'Processing' is defined in the GDPR Art 4 (2) as:

> *(2) 'processing' means any operation or set of operations which is performed on personal data or on sets of personal data, whether or not by automated means, such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure or destruction.* (GDPR Art 4 (2))

Pseudonymisation:

A means of protecting data by, for example, use of coded identifiers linking session notes to other file records. Pseudonymised personal data remains subject to data protection law.

'Pseudonymisation' means the processing of personal data in such a manner that the personal data can no longer be attributable to a specific data subject without the use of additional information, provided that such additional information is kept separately and is subject to technical and organisational measures to ensure that the personal data are not attributed to an identified or identifiable natural person; (GDPR Art 4 (5))

(28) The application of pseudonymisation to personal data can reduce the risks to the data subjects concerned and help controllers and processors to meet their data-protection obligations. The explicit introduction of 'pseudonymisation' in this Regulation is not intended to preclude any other measures of data protection.

Public interest

The interests of the community as a whole, or a group or individuals within the community.

Structured filing system

Defined in GDPR as any set of information that is structured either by reference to individuals or to criteria relating to individuals in such a way that specific information relating to an individual is readily accessible. In a relevant filing system, data about specific individuals can be located by a straightforward search. Under the GDPR, a relevant filing system will include paper filing systems as well as electronic filing systems

Sensitive personal data

Defined in section 2 of the Data Protection Act 1998 as information relating to a specific individual that relates to racial or ethnic origin, political opinions, religious beliefs or other beliefs of a similar nature, trade union membership, physical or mental health condition, sexual life, criminality, alleged or proven, and criminal proceedings, their disposal and sentencing. The GDPR continues to define these categories of data as 'sensitive data' and adds to this list genetic data, and biometric data where processed to uniquely identify an individual.

Serious harm

A threat to life, inflicting serious physical harm; rape and child abuse would be examples of serious harm. The risk of a car accident or the spread of serious disease could amount to serious harm. The prevention of psychological distress without any associated serious physical injury, criminal activity or child protection issue may not justify a breach of confidentiality in English law, especially for adults and young people capable of giving valid consent. The prevention of psychological distress without other associated forms of harm is therefore best resolved by consent. See also the reference to guidance on confidentiality from the Department of Health (DH, 2003: 35) above (p8).

About the authors

Content for this resource was authored by:

Dr Barbara Mitchels, who is a psychotherapist in Devon, and a Fellow of BACP. A retired solicitor, she also runs a web-based consultancy and mediation service for therapists at www.therapylaw.co.uk. Barbara provides CPD workshops across the UK on a range of topics linking law, therapy and conflict resolution.

And:

Professor Tim Bond, who is a Fellow of BACP and a specialist in professional ethics for the psychological therapies and other roles. He was a consultant to BACP's Professional Ethics and Quality Standards Committee (PEaQSC), and writes extensively on ethical issues.

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