Good Practice in Action 014
Legal Resource

Managing confidentiality within the counselling professions

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T: 01455 883300 **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 working with confidentiality and disclosures.

Using the Legal Resources

The membership agreement with BACP establishes a contractual commitment by members to abide by the *Ethical Framework for the Counselling Professions*, which includes a responsibility for members to keep the skills and knowledge relevant to their work up to date.

The Legal Resources cannot constitute legal advice or guidance in specific cases, nor are they sufficient on their own to resolve legal issues arising in practice. The Legal Resources do not give a full statement of the law. They are solely intended to support good practice by offering general information on legal principles and policy applicable at the time of writing. The Legal Resources are intended for information purposes only and are not a substitute for professional advice. BACP and the author accept no responsibility for and accepts no liability as a result of any person acting or refraining from acting on the basis of the Legal Resources.

Practice issues and dilemmas are often complex, and may vary depending on clients, particular models of working, the context of the work and the therapeutic interventions provided. We therefore strongly recommend consulting your supervisor, and also, wherever necessary, a suitably qualified practitioner or lawyer. Some professional insurers will provide legal advice as part of their service.

BACP and the author make no representation or warranty as to the completeness or accuracy of the information contained in the Legal Resources.

References in this resource were up to date at the time of writing but there may be changes in particular to the law, government departments, government policies and guidance, websites and web addresses. Organisations and agencies may also change their practice or policies, so please be alert for any changes that may affect your therapy practice.

In this resource, the words 'counselling,' 'therapist' and 'therapy' are used to refer specifically to counselling and psychotherapy.

The terms 'practitioner', 'counselling professional', and 'counselling related services' are used generically in a wider sense, to include the practice of the counselling professions, including counselling, psychotherapy, coaching, professional mentoring and pastoral care.

Introduction

Confidentiality is one of the most fundamental ethical and legal obligations owed by counsellors, psychotherapists, and counselling practitioners 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, counselling professionals, 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 are 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 BACP's current *Ethical Framework* (BACP 2018).

Please see also the GPiA 069 Legal Resource: *Sharing records with clients, legal professionals and the courts in the context of the counselling professions*; and GPiA 128 Legal Resource: *Working with the Crown Prosecution Service Pre-trial Therapy Guidance (CPS 2022) in therapy with adult and child witnesses in the criminal courts in England and Wales.*

Quick Guide – Where to find information

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 ought to 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 and regulations** (e.g., the United Kingdom General Data Protection Regulation (UK-GDPR), Data Protection Act 2018, Freedom of Information Act 2000, Human Rights Act 1998 Article 8 – right to private life etc. (See list.)

c. **contracts:** legal agreements made between two or more parties, for example:

   - counselling professional or therapist and client
   - counselling professional or therapist and supervisor
   - counselling professional or therapist and agency/organisation
   - counselling professional or therapist andagency/statutory bodies
   - trainee therapist or counselling professional andtraining 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

As counselling professionals, particularly since BACP qualified practitioner members now register voluntarily with the PSA, we have a duty regarding record keeping, reflected in the *Ethical Framework*:

'We will keep accurate records that:

- are adequate, relevant and limited to what is necessary for the type of service being provided
- comply with the applicable data protection requirements, see www.ico.org.uk.' (BACP 2018: GP 15).

Appropriate records are adequate, relevant and limited to what is necessary. The decision about what is appropriate to be included in a client record will take into account the nature, modality and terms of the client work undertaken, and the ethical and legal requirements for processing (includes making, keeping, using and sharing) records. Watch for updates from the Information Commissioner's Office www.ico.org.uk for the latest information, and (BACP 2018, C2e; GP15).

Records may be partially protected by a degree of pseudonymisation. 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 – i.e. the client would still be identifiable, with a complete search of the two separate records. Pseudonymised information is regarded as personal data, and subject to the data protection law, in that pseudonymised records would be regarded as part of the client record if client notes are requested, for example by a court or under the UK-GDPR. See the Glossary and GPiA 105 for more detailed explanation.

By contrast, completely 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 UK-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.* (UK-GDPR (26), Ethical Framework 2018 Good Practice 55g, 78, 83a.)
>
> **Practice Note:** For training, or other purposes, some practitioners may wish to write process notes and to keep them separately from a client record. In this case, they would need to ensure complete anonymisation of the process notes, i.e. that the client cannot be identified in the process notes in any way.

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. Mediation can provide an effective and satisfactory outcome for all parties where it is available within a disciplinary procedure.

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 or counselling professional

b. to give explicit consent to the making and keeping of records that contain personally sensitive information – a requirement of the UK-GDPR and the Data Protection Act 2018 that will apply to most records and notes written by therapists or counselling professionals (see GPiA 105 for UK-GDPR requirements)

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 or counselling professional at the outset of their work together

d. to have a clear therapeutic contract with terms that they fully understand, accept and support (see GPiA 039 *Making the contract within the counselling professions*)

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 Mitchels and Bond (2021)

f. to be informed when the therapist or counselling professional 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 or counselling professional

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: being trustworthy, autonomy, beneficence, non-maleficence and justice.

4 Exceptions to the duty of confidentiality

Crime

A counselling professional 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 cogent, 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 in situations where the client may not have consented, but the police officer has the lawful authority of a court order or statutory authority to require the information. Where there is no appropriate consent, and in the absence of any other lawful authority, a polite refusal by the practitioner on the grounds of confidentiality is sufficient if this is considered appropriate. The consent may then be provided by a court – the police officer requiring the information may then go and obtain the appropriate court order for disclosure if the information is required for the investigation of a crime. Note that 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.

A disclosure may be justifiable in the public interest where the practitioner is aware of any serious danger to the client, to another, or to the public health and welfare, provided that the practitioner holds a cogent, reasonably held belief that the information disclosed is accurate, and that the risk is imminent and that the disclosure would help to prevent or reduce the harm – please see the checklist *Risk, referral, and consent: Issues for reflection*, and the checklist at 12. For a discussion of the risk of suicide, please see the 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.

4.1 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 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 as amended by subsequent legislation, , 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 UK law to protect girls at risk of Female Genital Mutilation (FGM) is in the Female Genital Mutilation Act 2003 as amended by section 74 of the Serious Crime Act 2015, and the government guidance on FGM was recently updated, and can be found at www.gov.uk. Although the guidance is aimed at local authorities, it contains information which is helpful for regulated health and social care professionals, and is useful reading for counselling practitioners in private practice, as the updated version includes a resource pack with case studies, information on awareness raising in local communities, and links to local and national resources for information and support. Section 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.

Where therapists know that they are working in circumstances where they have a specific obligation to pass on information, or where they sense that a client is about to give information during therapy that could create an obligation on the therapist to pass the information on to others, there is an ethical case for alerting the client to the consequences of their impending disclosure before it is made, **but please note there are important exceptions**: it is illegal to give a warning to clients in certain situations e.g. cases such as terrorism. Also, in any situation involving child safeguarding or child protection, or the safeguarding or protection of a vulnerable adult, therapists should exercise great caution and/or take appropriate advice, before giving a warning to clients (or to those with parental responsibility for a child client), because in certain situations, a prior warning of disclosure might endanger a child or vulnerable person or it could seriously compromise a police investigation.

The Crown Prosecution Service guidance is available at www.cps.gov.uk/legal-guidance/female-genital-mutilation.

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Reference to safeguarding practice in *Working Together to Safeguard Children* (DfE 2018, updated Dec 2023), and *Working together to safeguard children (Wales)* is helpful for regulated and private practitioners, and there is also a free NSPCC helpline, available on **0800 028 3550** or email fgm.help@nspcc.org.uk.

Practitioners who have a role as regulated health or social care professionals, teachers, or working with a local authority, have specific responsibilities to report FGM.

Other BACP member practitioners who are not so regulated (and therefore may not be under a compulsory duty to report FGM in that role) must nevertheless comply with BACP's *Ethical Framework* (BACP 2018), which requires us to work within the law and pay heed to relevant government guidance. For more on this please see GPiA 031 *Safeguarding children and young people in England and Wales*.

For disclosures in child protection matters, please refer to the separate section below. The law will usually protect someone who discloses confidences in an appropriate, ethical and proportionate response to public duty or a statutory requirement. A practitioner therefore needs to take reasonable care in ensuring the accuracy of what is reported and hold an honest belief in the validity of what they are reporting.

A false accusation (for example a false allegation arising solely from a malicious rumour) that is not honestly believed and/or not made with careful consideration for ethics and law, and which then seriously damages someone's social standing or business, could lead to claim in court for defamation.

g. client requests and statutory requests for access to personal data made under the United Kingdom General Data Protection Regulation (UK-GDPR) and the Data Protection Act 2018, for details see GPiA 105 LR: *United Kingdom General Data Protection Regulation (UK-GDPR) legal principles and practice notes for the counselling professions*.

4.2 Court orders

A court may order disclosure of documents or information relating to client work, and it may order the practitioner 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, but the Coroner's Court has a range of powers. 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 of 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 to the Coroner (e.g. following a possible suicide) 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 or Coroner's Officer prior to the court appearance.

Evidence is required to satisfy the burden of proof in all courts. Any of the courts may make an order requiring a witness to attend court and to give evidence (usually referred to as a 'subpoena', or 'witness attendance order'), and the courts may also issue an order for the production of documents, including counselling or other relevant records (known to lawyers as a 'subpoena duces tecum' meaning an order to 'attend and bring the documents with you.') Failure to obey a court order is regarded in law as contempt of the court, and punishable by a fine, and in some instances by imprisonment.

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 it may be considered good practice 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 legislation listed at the end of this *Good Practice in Action* resource, that 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 also Bond and Sandhu (2005), and Mitchels and Bond (2021; 2010).

4.2.1 Tribunals

Tribunals are part of the court system in the UK, regulated by the Ministry of Justice. They cover a wide range of case hearings (for example in Asylum support, Employment, Schools Admissions, Finance and Commerce, Health and Care, Intellectual Property, Pensions, Transport and many more). Tribunals are, like the other courts, organised in tiers. The Upper Tribunal hears appeals from the First Tier Tribunal, and other authorities. The First Tier Tribunal hears appeals from regulators and others. Other cases are heard in the appropriate Tribunal for the issue to be heard. The way in which tribunals are run is decided by the *Tribunal Procedure Committee* and in sets of rules. In tribunal hearings, a witness statement is prepared in advance and will form the basis of the evidence at the hearing.

The rules of evidence for Employment Tribunals are set out in Rules 31-32 of The Employment Tribunals Rules of Procedure 2013 (as amended); www.gov.uk/government/publications/employment-tribunal-procedure-rules.

Disclosure of documents and information
31. The Tribunal may order any person in Great Britain to disclose documents or information to a party (by providing copies or otherwise) or to allow a party to inspect such material as might be ordered by a county court or, in Scotland, by a sheriff.

Requirement to attend to give evidence and to produce documents
32. The Tribunal may order any person in Great Britain to attend a hearing to give evidence, produce documents, or produce information.

For Northern Ireland, see The Industrial Tribunals and Fair Employment Tribunal (Constitution and Rules of Procedure) Regulations (Northern Ireland) 2020 at www.legislation.gov.uk.

4.2.2 The Civil Courts: Family court and other divisions of the civil courts:

The Family Court tries cases involving divorce, children and family matters. The Family court has a tiered system, with the Supreme Court at the top, followed by the High Court, the County Court, and the family division of the magistrates' court as the lowest tier.

Other civil matters (for example civil disputes and claims for damages etc) are heard in other divisions of the Civil court, which also has a tiered system. The law of evidence in all the civil courts is different from that of a criminal court. The burden of proof in a civil court is a finding that the thing to be proved 'is more likely than not' to have happened, rather than the stricter requirement in criminal cases of proof of the alleged facts and events 'beyond reasonable doubt'.

The civil courts may order the production of documents, including personal medical reports, which would otherwise have been protected from disclosure.

It has also been held that, in relation to the court, 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. The family courts exercise considerable investigative powers in many situations in which they are trying to determine the best interests of the child.

4.2.3 Criminal courts

In criminal cases the police, acting on behalf of the Crown Prosecution Service may seek access to the therapy and counselling notes of a prosecution witness in the case – usually with the written agreement of the counselling client.

This is most likely to happen if the notes are thought to contain statements by the client relevant to allegations of serious crime, for example violence, rape or sexual abuse.

The Crown Prosecution Service has produced detailed guidance for investigators and prosecutors, and an additional note for therapists, on pre-trial therapy with prosecution witnesses (CPS 2022). For details and discussion of the new guidance, please see the new GPiA 128 *Working with the Crown Prosecution Service Pre-trial Therapy Guidance (CPS 2022) in therapy with adult and child witnesses in the criminal courts in England and Wales.*

4.2.4 Issues regarding the production of counselling records in the courts

The production of counselling records in court will depend on a number of factors, one of which is the nature of the court proceedings. Criminal and civil cases and those in the Coroner's court each have different rules of evidence, and the Family court cases, including child protection matters, are governed by the relevant Family Procedure Rules. In each of these courts, the ultimate control over the evidence lies with the judiciary in the court. The comments that follow here are therefore of necessity generalised, and if a therapist is called to be a witness in a specific case, it would be wise to seek appropriate legal advice or consult a supervisor or practitioner experienced in the relevant area of work. The witness may be willing to attend voluntarily with the knowledge and consent of the client, and/or a court order may be made to produce counselling records.

Such an order will be made if the court considers that the content of the record (or a certain part of the record) is relevant to the issues to be decided in the case.

The issue of evidence is usually discussed and resolved in one or more pre-trial case management hearings, in which the court may also choose to make directions as to who may see and/or have copies of the therapy records (i.e. an order may include all parties, or possibly just the court and the respective lawyers, or it may grant access to the records to nominated persons, etc).

The parties and the witnesses (i.e. including a practitioner who has been asked to produce their records but who wishes to limit the extent of the records disclosed or limit those who may see the records), may make representations to the court about access to the records, and also make representations about which parts of the records may or may not be relevant.

If a court order is made requiring the attendance of a witness, the witness may be able to claim witness expenses for their attendance.

Most therapists will be regarded solely as a witness of fact, and so will not be required to give an opinion. Expert witnesses are identified and appointed by the court, and in that case, a court order will usually specify the range of evidence required from the expert witness. An expert witness is usually allowed to sit in court to hear the evidence of others, and is permitted to give a professional opinion.

For further details, see the statutes and guidance listed in this resource, Bond and Sandhu (2005), Mitchels and Bond (2021; 2010).

4.3 Discretionary disclosures made in the public interest

4.3.1 Disclosures to enhance the quality of service provided

Unless appropriate consent is obtained, discussion of identifiable client information in the course of counselling supervision, training and research may constitute a breach of confidentiality. If a client is identified or identifiable from the information discussed, then the client's explicit consent should be obtained to discuss their case with others.

Even if the client is not identified, it is best practice to obtain appropriate consent. However, in relation to purely professional discussions, where the client is not identified, Cohen has suggested that even if consent has not been obtained, the public interest in the proper training and supervision of counselling practitioners, 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 (Cohen, 1992: 22-23).

4.3.2 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, place 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, 2018, updated December 2023) 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.

Other useful references are *Information sharing – advice for safeguarding practitioners.* Department for Education (2015, updated 2018); *Child abuse concerns: guide for practitioners Department for Education* (2015); and its supporting materials. Links to access these government guidance documents on-line are in the resources list at the end of this resource. 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 and relevant guidance for Scotland and Northern Ireland 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 to make decisions 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 (or children) may be at risk of serious harm and the therapist does not have consent to make a referral either from the child concerned 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, in the public interest, to safeguard the child or others.

Those working within government, organisational or agency settings should already have appropriate child protection and safeguarding policies and procedures in place to follow.

For practitioners who work independently, the decision whether or not it is necessary to make a child protection disclosure in the public interest is likely to be a matter for discussion in supervision, and where necessary, to seek expert professional advice on child protection law and practice. Advice and information should be available from the legal department of the local authority, local authority social care services, MASH, 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).

Practitioners may also have legal advice included as part of their professional insurance cover. The 'disclosure checklist' below in this resource may also be helpful in thinking through these decisions.

4.3.3 Protection of vulnerable adults

Adults who are at imminent risk of harm may also be in need of protection and disclosures may be justifiable in the public interest, particularly if the adult is living in any situation where they are vulnerable to abuse, for guidance relating to adults in the care system, see *No Secrets: guidance on protecting vulnerable adults in care*. (DH 2020).

4.3.4 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, 2015); (Mitchels and Bond 2021) and GPiA 042 *Talking about suicide risk with clients in the counselling professions*).

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 themselves 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 to their clients in pre-counselling information, and as part of their compliance with UK-GDPR requirements to build in an appropriate agreement in their privacy notice and 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 in every instance of suicidal intent.

For consideration of criteria for assessment of suicidal risk see Reeves (2010; 2015); GPiA 042, and Reeves and Bond (2021: 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 and the immediacy of risk to the client or others and the possible consequences for their client of referral or non-referral. There may be an inherent risk of harm to others in the method of suicide which is contemplated.

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.

4.3.5 Risk, referral, and consent: issues for reflection

It may be helpful to discuss with the client if appropriate, and ideally also consider in supervision, these issues:

- how serious is the degree of risk?
- how urgent is the need for referral?
- does my client have the mental capacity to give informed consent at this moment in time?
- if the client does not have mental capacity to give consent, then what are my professional responsibilities to the client and in the public interest?
- 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 of the risk preventable?
- is there anything I (or anyone else) can do to prevent serious harm?
- what steps would need to be taken to avert the risk?
- If the client has mental capacity, but does not consent to my proposed action (e.g. referral to a GP, social care, police, or other agency), what is my legal situation if I go ahead and do it anyway?
- how could the client be helped to understand and accept the proposed actions I may need to take for their protection and/or that of others?

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 practitioner, then there is little likelihood of any ground for legal or other action against the practitioner 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 practitioner, 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 practitioner about the terms of their therapeutic contract. In the event of a complaint or legal action, both practitioner and client are best protected by a therapeutic contract, with mutually agreed terms including explicit consent, and then that contract is evidenced in writing, or a form appropriate for the client's needs.

Information sharing in a health team or agency

Consent may be given for others, (e.g. practitioner working 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, guidance made under the Children Act 1989, Children Act 2004 and other relevant legislation may apply; in a GP surgery or hospital setting the GMC, BMA and NMC guidance may apply – 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).

In 2006, the Department of Health produced the *Caldicott Guardian Manual* (DH, 2010) (updated in 2010 and subsequently amended in 2013 and 2020), see www.gov.uk/government/publications/the-caldicott-principles (issued on 8 December 2020). Other relevant resources are listed at the end of this resource.

The principles stated are:

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

Principle 2 – Use confidential information only when it is necessary

Principle 3 – Use the minimum necessary personal confidential information

Principle 4 – Access to confidential information should be on a strictly need-to-know basis

Principle 5 – Everyone with access to personal confidential data should be aware of their responsibilities

Principle 6 – Comply with the law

Principle 7 – The duty to share information for individual care can be as important as the duty to protect patient confidentiality

Principle 8 – Inform patients and service users about how their confidential information is used.

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 contract or a legally binding contract 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, government guidance 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, if 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.

For more information on legal issues relevant to mental capacity please refer to GPiA 029 *Mental health*, and see also the Department of Health (2020) *Mental Capacity Act 2005 Code of Practice*, download at: www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpgacop_20050009_en.pdf, and Department of Health (2015, updated 2017) *Mental Health Act 1983: Code of Practice* available at www.gov.uk/government/publications/code-of-practice-mental-health-act-1983.

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

Practitioners 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 other therapeutic treatment.

Under the UK-GDPR and the Data Protection Act 2018, the provisions regarding children and consent are clarified, for details please also see the ICO website www.ico.org.uk; GPiA 105, and 11 below.

Please note that under the United Kingdom General Data Protection Regulation (UK-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, and 11 below.

8 Parental responsibility

Parental responsibility 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. The married father and mother's parental responsibility will be lost only by death or adoption or their 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, subject to legal conditions, including:

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

Note: These lists are by no means exhaustive, for more information see (Hershman and McFarlane; Mahmood and Doughty 2019).

See the Children Act 1989 as amended, section 4.

It is only those who have acquired parental responsibility through one of the methods laid out in section 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.

Practitioners 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 UK-GDPR and the Data Protection Act 2018, the provisions regarding children and consent are clarified, for details please see GPiA 105, the Information Commissioner's Office website at https://ico.org.uk and 11 below.

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

10 Making a decision about breaching confidentiality

In each case where a practitioner 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. Practitioners need to consider the reliability of their information, and all the ethical, legal and practical factors relevant to the situation. For example, it is helpful to consider what may happen to all the parties concerned if a disclosure is made, and also to assess the likelihood of serious harm if a disclosure is not made. The *Disclosure Checklist* at 12 may be a helpful resource for discussion and reflection.

It is wise to be cautious in making disclosures of confidential information until sure of the legal and ethical basis for the disclosure. Where appropriate, consult your supervisor and/or seek legal or other professional advice from a person with the relevant experience and expertise. As a matter of good practice, 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.

It is also important to consider whether it is legal, ethical and safe, to discuss a disclosure with the client in advance. There are situations discussed earlier in this resource in which it may be illegal or unsafe to warn the client or others of an impending disclosure, for example where statute forbids us to do so, or situations where warning the client or others in advance of disclosure may impede a police or safeguarding investigation, or may put a child or others at risk.

11 The impact of the United Kingdom General Data Protection Regulation (UK-GDPR)

The *General Data Protection Regulations ('GDPR')* came into force on 25 May 2018 and has a direct effect in all European states. The Data Protection Act 2018 ensured that after the UK left the European Union, the GDPR would remain in force in the UK, then changing its name to the *United Kingdom General Data Protection Regulation (UK-GDPR)*. The documents and guidance are all available at https://ico.org.uk and for an exploration of the impact of the new law on the counselling and psychotherapy professions, see GPiA 105.

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 data 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 real and serious risk to the rights and freedoms of individuals.

- Fines – the ICO can impose fines on organisations, depending on the nature, gravity and duration of the infringement.

- Data subjects' rights – these include 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 data 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 data 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 UK-GDPR and other legislation as it comes into force

- Under the UK-GDPR, the data protection law applies to all who maintain a relevant (i.e. organised) filing system – which will apply to most, if not all counselling professionals. A fee is payable by controllers processing personal data 'automatically' for business purposes, i.e. using any form of electronic processing of personal client data in all or any part of their records – including a computer, tablet, smartphone, etc.

- Contracts – data 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 UK-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 clear 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 practitioners 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 their processing.

A therapist will need to comply with the UK-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 holds are processed and stored;
- what additional security measures should be implemented to ensure the security of personal data processed by the therapist.

There is always a need to consider the differences between disclosures made for safeguarding purposes, (see 11.a) the ICO '*10-step guide to sharing information to safeguard children*') and disclosures which may be made or withheld in response to subject access requests about children's data (see 11.b) the *ICO Guidance on Exemptions*).

Practitioners should be aware of certain specific legal safeguards concerning sharing information relating to child abuse, child protection issues and other information that, if disclosed, may cause a risk to the child or others. Also see GPiA 105 Legal Resource: *The United Kingdom General Data Protection Regulation (UK-GDPR) legal principles and practice notes for the counselling professions*, and the data protection law and guidance in 'References and further reading' at the end of this resource.

11 a) ICO guidance 'A 10-step guide to sharing information to safeguard children'

Practitioners working with children and young people should be aware of the ICO guidance '*A 10-step guide to sharing information to safeguard children*' available at https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/data-sharing/a-10-step-guide-to-sharing-information-to-safeguard-children.

This ICO guide is not intended to tell practitioners how to safeguard children, but to give practical advice on data protection as part of the safeguarding process. It states that 'Sharing information to safeguard children (persons under the age of 18) includes:

- preventing harm;
- promoting the welfare of a child; and

- identifying risk in order to prevent harm (especially helpful where the risk may not be obvious to a single person or organisation).'

The 10 steps outlined are helpful in thinking through safeguarding issues, discussion of practice safeguarding issues in supervision, and ethical and legal decision making.

11 b) Exemptions to the right of access to records under the UK-GDPR and Data Protection Act 2018

Essential reading for all practitioners is the ICO Guidance to UK-GDPR Exemptions, which sets out a full list of the situations where client information may have special protection from disclosure under the UK-GDPR and the Data Protection Act 2018 available at https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/exemptions.

Under these exemptions, which apply to data held about children and vulnerable adults, in the circumstances outlined in the ICO guidance, data controllers may refuse disclosure of information when a subject access request is made about the data subject where the potential result of that disclosure could cause serious harm to the physical or mental health of the data subject or another individual (e.g. in child protection, medical, social work or educational situations). They may also refuse a subject access request made by those with parental responsibility for a child who is the data subject, or by those with legal responsibility for a vulnerable adult, where those data concern information about child abuse, as defined in the Data Protection Act 2018.

Please note that some decisions may be made by the counselling practitioner (e.g. protection of 'child abuse data'); while others (such as the 'serious harm test' cases in healthcare, social work and education) may require additional support. It is important to read the ICO Guidance on Exemptions and be aware of the circumstances in which you may refuse a data access request in the context of your therapy work, and the additional circumstances in which your decision may need the support of a health professional, or other appropriate authority.

Child abuse data. The *ICO Guidance on Exemptions* cites Part 5 of Schedule 3 of the Data Protection Act 2018 – this provision is intended to protect the confidentiality of child abuse data where disclosure is not in the best interests of the data subject, by allowing the refusal of a data subject access request made by either a person with parental responsibility for the child; or made by those with legal responsibility for a vulnerable adult. 'Child abuse data' are defined in paragraph 21(3) and (4) of Schedule 3, Part 5 of the DPA 2018 – "Child abuse data" are personal data consisting of information as to whether the data subject is or has been the subject of, or may be at risk of, child abuse.

(4) For this purpose, "child abuse" includes physical injury (other than accidental injury) to, and physical and emotional neglect, ill-treatment and sexual abuse of, an individual aged under 18.

Health, social care, and other data. Please refer to the *ICO Guidance on Exemptions* for details, and if in doubt, seek legal or other appropriate advice.

The *ICO Guidance* recommends that each decision concerning a potential exemption under the UK-GDPR and the Data Protection Act 2018 should be considered on a case-by-case basis.

Certain specific exemptions listed in the *ICO Guidance* are particularly relevant to counselling practitioners. These exemptions can apply if a subject access request for data is received, to provide exemption from the UK-GDPR's provisions on the right of access (i.e. to enable the practitioner to refuse to access to data if they would be likely to cause *serious harm to the physical or mental health* of any individual. This is known as the 'serious harm test' for health, social work or education data.

This exemption can only apply in England, Wales and Northern Ireland. It cannot apply in Scotland.'

It will be seen from the *ICO Guidance on Exemptions* that some of the 'serious harm test' exemptions set out in the Data Protection Act require that refusal of subject access requests should be made or supported by a registered 'health professional' or 'social work professional' (defined in the DPA 2018 section 204), and if this applies, check whether you are included in this definition. The HCPC maintains a list of registered practitioners, see the HCPC website at www.hcpc-uk.org, and see also the NHS Register of suitably qualified persons at: www.england.nhs.uk/ahp/role:

the NHS Register includes: 1. Art therapists, 2. Drama therapists, and 3. Music therapists.

12 Disclosure checklist

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

1 Legal issues

- Is this information regulated by the Data Protection Act 2018, the United Kingdom General Data Protection Regulation (UK-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 (organised) filing system)?
- Are any of the *ICO Guidance* and resources (at www.ico.org.uk) applicable to this situation?
- Were the notes made by a professional working for a public body e.g. in health, education or social care?
- If working in the health community, is disclosure compliant with the Caldicott principles and guidance?
- What are the relevant rights of the person concerned under the Human Rights Act 1998?

2 Decision making about sharing information

- Is the information founded on observed fact or from a reasonable and/or truthful and reliable source?
- Does this information stand alone, or is it supported by any other corroborative data? If unsupported, should it nevertheless be relied upon?
- Is there a formal legal requirement to share this information, for example a statutory duty or a court order?
- Is there a statutory requirement or other legal directive which limits or forbids warning the client or others about an impending disclosure (for example in terrorist activities),
- What is likely to happen to the client and others if a disclosure is made?
- Would advance warning of a disclosure place someone at risk?
- What is the likelihood of serious harm in this case?
- If I refer/disclose this information, what is likely to happen as a consequence?

- If I do not refer, would the likely consequences of non-referral include the risk of any serious harm to the client or others?
- If so, are the likely consequences of non-referral preventable? What would have to happen to prevent or mitigate the risk of serious harm to my client or others?
- Is there anything I (or anyone else) can do to assist in preventing this harm to my client or others?
- What steps would need to be taken to implement such assistance?
- How could the client be helped to accept assistance/or to support the proposed action?
- 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?
- Does my client have the mental capacity to give explicit informed consent (or refusal of consent) at this moment in time?
- If the client does not have mental capacity to make their own decisions, then what are my professional responsibilities to the client and in the public interest?
- If the client has mental capacity to make the decision, but does not consent to my proposed action (e.g. referral to a GP, or to the police, or to social care services, etc.), does the public interest outweigh my client's wishes and justify the intended disclosure or referral?
- Am I acting within the law?
- Am I acting according to the guidelines of BACP's current *Ethical Framework* (BACP 2018)? What would be my professional situation if I go ahead and make the referral without client consent?
- If working in the health community, is disclosure compliant with the Caldicott principles and guidance?
- Is there a legitimate requirement to share this information: e.g. a statutory duty or a court order?
- Is the information confidential? If so, do I 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 there specific government guidance that might apply to this client, or to their situation, and does that guidance apply to this situation for me/my client/in my practice?
- If the *Crown Prosecution Service (England and Wales) Pre-Trial therapy Legal Guidance* (2022) applies to this situation, is it being followed? Am I aware of its provisions, and of the Therapist Note?
- Is there information in the BACP safeguarding page in the Ethics Hub that would be of assistance to me? (See the link in the reference list.)

3: When to share information – is this the right time?

- Is there a risk of serious harm?
- Is the risk of serious harm imminent?
- Is there anything I (or anyone else) can do to assist in preventing this harm to my client or others?
- What steps would need to be taken to implement such assistance?
- How could the client be helped to accept assistance/or to support the proposed action I may need to take?
- Is there time to try to avert the harm, or do I need to disclose immediately?

4: Sharing information with the right person/organisation

It is important to give information to the right person or agency. This will be someone who has the power or necessary contacts to enable them to act quickly to avert or minimise the risk of serious harm, or to step in and prevent the harm happening. The client may have given information in the course of the counselling or psychotherapy, which will assist the practitioner in identifying the right person to approach for help.

In the case of safeguarding and the protection of children and vulnerable adults, there may be organisational policies and procedures in place, which should be followed by the practitioner.

5: Presenting information in an appropriate way

- If working in the health community, is disclosure compliant with the Caldicott principles and guidance?
- If the therapist is unfamiliar with the practice of the person or agency receiving the information, it is reasonable to ask how the information will be protected or treated in advance of disclosing it.

- Mark written or emailed communication 'Confidential' or 'In confidence.' Oral communications should be preceded by a clear statement that what is being disclosed is confidential.

- Inform the client, **except** in circumstances where telling the client:

  - is illegal (tipping off), or

  - will cause or increase any risk of harm to the client or others, or

  - may prejudice a police or inter-agency investigation of a serious crime.

6: Recording information sharing

If sharing the information is necessary and appropriate, limit the information disclosed to the minimum necessary in order to avert the risk, and make a note as soon as possible of the following:

- the date of providing the information

- to whom the information is given

- the content of the information shared

- the method of disclosure or referral

- whether consent was given (and by whom)

- if the disclosure is made without consent, record the reasons why this decision was made.

The Disclosure Checklist above is adapted from (Mitchels and Bond 2021), and included with the consent of the co-authors, Tim Bond and Barbara Mitchels.

For writing reports, see GPiA 083 *Writing reports and giving evidence in court.*

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.

When working with a child client, consideration of safeguarding issues is part of the practitioner's duty of care to their client, and so, where there is a risk of serious harm in any form to a child, practitioners may need to consider making a disclosure to safeguard the child, and where necessary, should consult their supervisor, or an appropriate professional, and consider the issues in the Disclosure checklist.

Practitioners 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 practitioners and organisations providing counselling services to develop clear policies and procedures regarding confidentiality, disclosure and data protection, which should include how they would make decisions to prevent or avert risk of serious harm.

To know how to act, practitioners should discuss in training and in supervision the legal requirements of consent and confidentiality. Practitioners then need to consider how they will contract with clients and others regarding the boundaries of confidentiality, and how they will handle those situations in which it may become necessary to release information under the law, for example terrorism, FGM, or in response to court orders.

They also need to understand where there is a need to disclose information in the public interest, possibly without client consent, for example, where there is a real and imminent risk of child abuse, suicide, or any other risk of serious harm to the client or toothers. .

Confidentiality and Record Keeping in Counselling and Psychotherapy 3rd Edition (Mitchels and Bond 2021) includes discussion of the law and contains further explanations and examples of good practice developed in response to the law.

See also GPiA 105 Legal Resource: *the United Kingdom General Data Protection Regulation (UK-GDPR)*; GPiA Legal Resources 030: *Safeguarding vulnerable adults in England and Wales*, GPiA 031: *Safeguarding children and young people in England and Wales*; GPaCP 002 *Safeguarding vulnerable adults in Scotland*; GPiA 053 *Understanding the children's hearing system in Scotland*; GPiA 026 *Counselling children and young people in school contexts in Scotland*; GPiA 052 *Understanding child protection in Scotland,* and the *Ethical Framework for the Counselling Professions* (BACP 2018).

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)

Child Abuse Data

'Child abuse data' is defined in paragraph 21(3) and (4) of Schedule 3, Part 5 of the Data Protection Act 2018 –

"Child abuse data" is personal data consisting of information as to whether the data subject is or has been the subject of, or may be at risk of, child abuse.

(4) For this purpose, "child abuse" includes physical injury (other than accidental injury) to, and physical and emotional neglect, ill-treatment and sexual abuse of, an individual aged under 18.

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 UK-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 ongoing 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.)

'Data Controller' is defined in the UK-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.

'Data Processor' is defined in the UK-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 data controller and a data processor.

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

Female Genital Mutilation

Defined in the government guidance, which also sets out the appropriate action to be taken: see *Department for Education (2016, updated 2020) Multi-Agency Guidance on Female Genital Mutilation*. www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation.

'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 UK-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 he is unable to make a decision for 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 GPiA 029: *Mental health law*.

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.* (UK-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 remain subject to data protection law:

'pseudonymisation' means the processing of personal data in such a manner 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; (UK-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 UK-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 structured filing system, data about specific individuals can be located by a straightforward search. The UK-GDPR and Data Protection Act 2018 will apply to, paper-based structured filing systems as well as to automatically processed (e.g. electronic/digital) 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 UK-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 all 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 co-authored by Dr Barbara Mitchels and Professor Tim Bond. It has been updated in recent years by Barbara Mitchels.

Dr Barbara Mitchels is a practising psychotherapist and Fellow of BACP. Formerly a solicitor and now retired from legal practice, Barbara combines her experience of therapy and law in writing practice resources, CPD workshops, and providing a professional mentoring and consultancy service for therapists at: www.therapylaw.co.uk.

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

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Legislation in relation to breaching confidentiality

Care Standards Act 2000

Children Act 2004

Children Act 1989

Coroners and Justice Act 2009

Data Protection Act 1998

Data Protection Act 2018

Data Protection (Charges and Information) Regulations 2018 (the 2018 Regulations)

Female Genital Mutilation ACT 2003

Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020

Freedom of Information Act 2000

General Data Protection Regulation 2018

Health and Social Care (Safety and Quality) Act 2015

Health and Social Care Act 2012

UK- General Data Protection Regulation

Human Rights Act 1998

Mental Capacity Act 2005

Mental Health Act 1983

Mental Health Act 2007

Offender Rehabilitation Act 2014

Police and Criminal Evidence Act 1984

Prohibition of Female Genital Mutilation (Scotland) Act 2005

Protection from Harassment Act 1997

Rehabilitation of Offenders Act 1974

Social Services Act 1970

Vulnerable Witnesses (Scotland) Act 2004.

Statutory instruments

Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003

Data Protection (Charges and Information) Regulations 2018 (the 2018 Regulations)

Family Procedure Rules 2010

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Health and Personal Social Services (Northern Ireland) Order 1977

Health Services (Northern Ireland) Order 1972.

Useful contacts and resources

Legal resources

- British and Irish Legal Information Institute (BAILII, www.bailii.org). Publishes all High Court, Court of Appeal and Supreme Court judgments
- Care Council for Wales (http://sites.cardiff.ac.uk/childrens-social-care-law). Publishes Child Law for Social Workers in Wales in English and Welsh, with regular updates
- Family Law (www.familylaw.co.uk). Access to Jordans Publishing's *Family Law Reports*
- Family Law Directory (www.justicedirectory.co.uk/directory/family-law)
- Family Law Week (www.familylawweek.co.uk)
- Justis (www.justis.com). Online resource
- UK statute law (www.legislation.gov.uk)
- UK statutory instruments (https://statutoryinstruments.parliament.uk)
- *Regional Legal Contacts*

Regional legal contacts

England

For a list of the courts and links to regional courts' contact details, see www.justice.gov.uk/contacts/hmcts/courts

For CAFCASS see www.cafcass.gov.uk National Office 3rd Floor 21 Bloomsbury Street London WC1B 3HF Tel: 0300 456 4000 Fax: 0175 323 5249 *(local offices are listed on the website or available from National Office)*

NAGALRO (The Professional Association for Children's Guardians, Family Court Advisers and Independent Social Workers) see www.nagalro.com/ Nagalro PO Box 264 Esher Surrey KT10 0WA Tel: 01372 818504 Fax: 01372 818505 Email: nagalro@globalnet.co.uk

Northern Ireland

See www.courtsni.gov.uk for contact details of all courts, publications, judicial decisions, tribunals and services.

The Northern Ireland Guardian Ad Litem Agency (Email: admin@nigala.hscni.net)

Wales

Children and Family Court Advisory and Support Service (CAFCASS) Cymru: (http://new.wales.gov.uk/cafcasscymru). National Office, Llys y Delyn, 107-111 Cowbridge Road East, Cardiff, CF11 9AG. Tel: 02920 647979; Fax: 02920 398540; Email: Cafcasscymru@Wales.gsi.gov.uk; Email for children and young people: MyVoiceCafcassCymru@Wales.gsi.gov.uk

EIRE: Republic of Ireland

An Roinn Slainte Dublin
Republic of Ireland Department of Health, Hawkins House, Hawkins Street, Dublin 2, Ireland. ain switchboard for the Department is 01 6354000. Dial +353 1 6354000 from outside Ireland.

Ombudsman for Children's Office Dublin
Millennium House,52-56 Great Strand Street, Dublin 1, Ireland Complaints free-phone 1800 20 20 40. Otherwise call on 01 865 6800. Email: oco@oco.ie Fax: 01 874 7333. www.oco.ie.

Multi-Agency Safeguarding Hub (MASH)
This multi-agency safeguarding system operates in each geographical area, and information about how to make a referral via MASH in your area is provided by each one online. To access information, search MASH and your county name online.

Mental Health
Good Practice Guidance in Mental Health & Incapacity Law Scotland.
www.mwcscot.org.uk/good-practice

Mental Health Practice Guidance Northern Ireland
Mental Health Practice – rcni.com
www.rcni.com/mental-health-practice

MIND
www.mind.org.uk
www.youngminds.org.uk

NICE
www.nice.org.uk
www.nice.org.uk/guidance

Royal College of Psychiatrists Publications
www.rcpsych.ac.uk

Samaritans
www.samaritans.org.